# PORTFOLIO COMMITTEE NO. 2 - HEALTH

**Monday 2 March 2026**

**Examination of proposed expenditure for the portfolio areas**

# HEALTH, REGIONAL HEALTH, THE ILLAWARRA AND THE SOUTH COAST

## CORRECTED

**The Committee met at 9:15.**

## MEMBERS

Dr Amanda Cohn (Chair)

Ms Abigail Boyd
The Hon. Mark Buttigieg
The Hon. Susan Carter (Deputy Chair)
The Hon. Greg Donnelly
Ms Cate Faehrmann
Ms Sue Higginson
The Hon. Stephen Lawrence
The Hon. Sarah Mitchell
The Hon. John Ruddick

## PRESENT

**The Hon. Ryan Park,** *Minister for Health, Minister for Regional Health, and Minister for the Illawarra and the South Coast*

# CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

**Corrections should be marked on a photocopy of the proof and forwarded to:**

**Budget Estimates secretariat**
**Room 812**
**Parliament House**
**Macquarie Street**
**SYDNEY NSW 2000**

**CORRECTED**

**The CHAIR:** Welcome to the first hearing of Portfolio Committee No. 2 - Health for the additional round of hearings for budget estimates 2025-2026. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respect to any Aboriginal and Torres Strait Islander people joining us today. My name is Dr Amanda Cohn, and I am the Chair of the Committee. I welcome Minister Park and accompanying officials to this hearing.

Today the Committee will examine the proposed expenditure for the portfolios of Health, Regional Health, the Illawarra and the South Coast. I ask everyone in the room to please turn their mobile phones to silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures.

**CORRECTED**

**Ms SUSAN PEARCE, AM**, Secretary, NSW Health, on former oath

**Ms ELIZABETH WOOD**, Deputy Secretary, Health System Strategy and Patient Experience, NSW Health, on former oath

**Mr MATTHEW DALY**, Deputy Secretary, System Sustainability and Performance, NSW Health, on former oath

**Mr ALFA D'AMATO**, Deputy Secretary, Financial and Corporate Service and Chief Financial Officer, NSW Health, on former oath

**Dr KERRY CHANT, AO, PSM**, Chief Health Officer and Deputy Secretary, Population and Public Health, NSW Health, on former affirmation

**Mr LUKE SLOANE**, Deputy Secretary, Rural and Regional Health, NSW Health, on former affirmation

**Ms FATIMA ABBAS**, Deputy Secretary, People, Culture and Governance, NSW Health, affirmed and examined

**Ms EMMA SKULANDER**, Deputy Secretary, Infrastructure and Asset Management Division and Acting Chief Executive, Health Infrastructure, NSW Health, on former affirmation

**Ms MELISSA COLLINS**, Executive Director, Workplace Relations Branch, NSW Health, on former affirmation

**Ms WENDY HOEY, PSM**, Chief Executive, Justice Health NSW, affirmed and examined

**Ms TRACEY McCOSKER**, Chief Executive, Hunter New England Local Health District, affirmed and examined

**Mr VINCE McTAGGART**, Executive Director, Strategic Capital Planning and Asset Management, NSW Health, on former affirmation

**Dr DOMINIC MORGAN, ASM**, Chief Executive, NSW Ambulance, on former affirmation

**Ms KATE MEAGHER**, Deputy Secretary, Delivery and Engagement Group, Premier's Department, on former affirmation

**Ms DEB WILLCOX**, Chief Executive, Sydney Local Health District, affirmed and examined

**The CHAIR:** Welcome, everyone, and thank you for making the time to give evidence. Today's hearing will be conducted from 9.15 a.m. to 5.30 p.m. We are joined by the Minister for the morning session from 9.15 a.m. to 1.00 p.m., with a 15-minute break at 11.00 a.m. In the afternoon, we'll hear from departmental witnesses from 2.00 p.m. to 5.30 p.m., with a 15-minute break at 3.30 p.m. During these sessions, there will be questions from Opposition and crossbench members only, and then 15 minutes allocated for Government questions at 10.45 a.m., 12.45 p.m. and 5.15 p.m. We will begin this morning with questions from the Opposition.

**The Hon. SARAH MITCHELL:** Thank you, Minister. Good morning to you and your officials as well. Thank you for being here today. Minister, could you clarify when you first became aware of an increase in invasive fungal infections in transplant patients at the RPA?

**Mr RYAN PARK:** My office became aware on or around Christmas Eve. That was when we were first alerted to the issue.

**The Hon. SARAH MITCHELL:** Your office or you personally?

**Mr RYAN PARK:** My office. I was away at the time.

**The Hon. SARAH MITCHELL:** You told media on Friday that you became aware on Christmas Eve, but—

**Mr RYAN PARK:** Because I didn't want to be—to be fair, my office became aware. As far as I'm concerned, as the Minister, I don't get to hide behind—when my office knows, they know.

**The Hon. SARAH MITCHELL:** Sure. You were away. My understanding is you were on leave until 5 January. Is that when you became aware of this issue?

**Mr RYAN PARK:** No, later than that, probably a few weeks ago.

**The Hon. SARAH MITCHELL:** Sorry, exactly when did you become aware of this issue?

**Mr RYAN PARK:** A few weeks ago.

**The Hon. SARAH MITCHELL:** Do you have a rough date of when that would have been?

**Mr RYAN PARK:** I'd probably say in the first part of February. I don't have a date where I've written something down, no.

**The Hon. SARAH MITCHELL:** You gave the impression, though, to the media and the public last week that you knew about this from Christmas Eve. What you're now saying is your office knew. You were on holidays for a few weeks. No-one in your office thought to ring or tell you that there'd been an outbreak that patients had died due to this fungal infection. No-one told you while you're on holidays.

**Mr RYAN PARK:** No, they didn't. But to be fair on a couple of fronts, I just want to address that this was an issue I think we've got to be very careful around how we describe it. It was being managed by NSW Health through Deb Willcox and Dr Chant. They had already set up what is called a clinical group around this. They had made sure that, first and foremost—and this comes down to around hundreds of people—patients, outpatients, staff were informed of the issue, about the issue, what action was being taken. So my office, in the feedback, got an assurance that that was being, and it was being, managed by NSW Health.

**The Hon. SARAH MITCHELL:** I appreciate that, Minister. But what you're saying now is that all of those people knew about it before you did, because you didn't know about it until early February. That's just been your evidence.

**Mr RYAN PARK:** Sure—

**The Hon. SARAH MITCHELL:** You're the health Minister. How can you not know when there's been a major outbreak and people—hundreds of people, you say—needed to be informed about it, but you didn't know about it until February? How is that possible?

**Mr RYAN PARK:** My office was dealing with it. They were dealing—

**The Hon. SARAH MITCHELL:** But it's your job. You're the Minister.

**Mr RYAN PARK:** Sure, and I'm not saying that that's not the case. As soon as I became aware of it, I asked what processes had been put in around the time. I got some assurances that what had occurred at the time was around making sure that patients were informed, the outpatients were informed, staff were informed. I don't know what we would do any differently, because I've got to assure you that this is not something that we were trying to hide in any way—far from it. In fact, opposite, we were—

**The Hon. SARAH MITCHELL:** It was hidden from you. You didn't know about it until months after the event.

**Mr RYAN PARK:** My office knew about it. They were dealing directly with Dr Chant.

**The Hon. SARAH MITCHELL:** With respect, Minister, your office is not sworn in as the Minister for Health in this State. You are.

**Mr RYAN PARK:** Sure.

**The Hon. SARAH MITCHELL:** Nobody told you about it until you came back—not even immediately after you came back from holidays, possibly weeks later. Do you think that's acceptable?

**Mr RYAN PARK:** Can I just go back to something? In the same way that I think in one of your schools you didn't inform the community about asbestos when you were—

**The Hon. SARAH MITCHELL:** I'm not asking about that.

**Mr RYAN PARK:** Because what I'm saying is—

**The Hon. SARAH MITCHELL:** Minister, I'm asking—

**The Hon. GREG DONNELLY:** Point of order—

**The Hon. SARAH MITCHELL:** Deflection from this does not make you look good.

**The CHAIR:** I need to hear the point of order.

**The Hon. GREG DONNELLY:** The member is entitled to ask the question, we know. But the member must allow the Minister the opportunity to answer without cutting him off.

**The CHAIR:** Yes, procedural fairness requires us to give the Minister time to answer the question but, also, the Minister is not able to ask questions of Committee members in this hearing.

**Mr RYAN PARK:** I wasn't asking a question. I was just simply saying, Ms Mitchell, you would know, being a former senior Minister of a large portfolio, that I've got over 4,400 buildings amongst our assets. From time to time, given the age of those buildings, issues occur. My office was informed—

**The Hon. SARAH MITCHELL:** Sure, Minister, but this isn't a "from time to time". This is a cluster of seven cases of people who are transplant patients who have had this fungal infection and two of them have passed away. This is not a small issue. Surely you would agree this is a pretty major issue that occurred in one of the public hospitals in this State, correct?

**Mr RYAN PARK:** It's definitely an issue. But what I'm—

**The Hon. SARAH MITCHELL:** You should have been told about it.

**The Hon. GREG DONNELLY:** Point of order—

**The Hon. SARAH MITCHELL:** Do you now say you should have been told about it sooner?

**The CHAIR:** There's another point of order.

**The Hon. GREG DONNELLY:** The point of order is identical. The Minister can't even get out two sentences without having his knees cut off. He's entitled to answer the questions without being interrupted. I'll continue to interrupt if the member doesn't pull her head in.

**The Hon. SARAH MITCHELL:** Sorry, what was that?

**The Hon. GREG DONNELLY:** I said I'll continue to interrupt and take points of order—

**The CHAIR:** Mr Donnelly, it's my role to maintain order on this Committee. I appreciate you've taken a point of order. There are rules for procedural fairness for both the witnesses and Committee members today.

**The Hon. GREG DONNELLY:** The Minister is not being provided with procedural fairness.

**The CHAIR:** I've ruled consistently that members have a fair bit of leeway to interrupt witnesses if needed after the Minister's had some time to start answering the question. I'll make the same ruling again.

**The Hon. GREG DONNELLY:** Further to the point of order—

**The CHAIR:** I've ruled on the point of order, Mr Donnelly.

**The Hon. GREG DONNELLY:** The Minister is not being given an opportunity to answer the questions.

**The CHAIR:** I've just repeated my previous ruling. We're back to the Opposition's time, thank you.

**The Hon. GREG DONNELLY:** We'll see.

**Mr RYAN PARK:** To be fair, Chair, my office knew. I'm a person—like Dr Chant and like Ms Willcox—who is extremely transparent. I wasn't given any impression that I only found out about this at a date later than my office because I was away when my office knew. I don't play those games. When my office knew, my office knew. They liaise directly with Dr Chant. They are liaising directly with the CE of the local health district. They were managing the issue. Patients had been informed. Staff had been informed. Outpatients had been informed. The process had been contained down that area, and those investigations. In fact, what people are missing in some of this is that, because of the strength of our staff and the system, it was actually clinicians who identified some internal clinical issues that actually made them think, "Jeez, is there an issue here? Wasn't mould on the wall?" Because, aspergillus, as we all know, is common in our environment. The challenge is when it impacts someone with low immune. For a person who is immunocompromised—as these very unwell patients were—that's when it becomes a challenge.

**The Hon. SUSAN CARTER:** Minister, when did the clinicians identify that there was a problem?

**Mr RYAN PARK:** Back in October, and Ms Willcox—

**The Hon. SUSAN CARTER:** So clinicians identified a problem in October—

**Mr RYAN PARK:** Could I—

**The Hon. SUSAN CARTER:** —and your office knew on Christmas Eve.

**The Hon. STEPHEN LAWRENCE:** Point of order—

**The Hon. SARAH MITCHELL:** And you knew in February.

**The CHAIR:** There has been a point of order.

**The Hon. STEPHEN LAWRENCE:** The Minister said the words "in October". He clearly wanted to say something else. I don't think we can assume that the whole answer is "in October".

**The CHAIR:** Can we let the Minister get at least a sentence out before redirecting?

**Mr RYAN PARK:** Back in October—and I'll throw to Deb around the specifics—we started to pick up these cases. They were not identified yet as a cluster. That came later on, in December. Aspergillus is in and around the environment. From time to time, both under the last Government and this Government, a place like RPA has had the odd case of this popping up. That's the truth. Deb, did you want to add anything in terms of clinician timing?

**DEB WILLCOX:** The first suspicion of our clinical teams was a patient on 3 December who started to exhibit some symptoms, and another patient on 9 December who they determined was clinically likely to have an aspergillus infection. It does take around seven to 10 days for laboratory results, quite normally, for these types of infections. What these two cases did—there was a level of clinical suspicion over and above the background health of these patients, who are already quite complex and already dealing with significant infections and opportunistic infections by the very nature of immunosuppression medication they're on to prevent graft rejection. When these two index cases, for want of a better term, were identified, they then looked back at other cases to see if there was any possibility that this fungus could've impacted on anybody else. That's when they picked up the other four cases. The six cases were between October and December, and there was a patient in May that wasn't considered part of the cluster, because we normally get one or two of these patients a year. That isolated patient in May was not considered but, for completeness, for the year period, there were seven patients.

**The Hon. SARAH MITCHELL:** Minister, to you, but I'm happy if Ms Willcox needs to answer it: Are you aware of any reports of a patient also in this ward in March last year contracting a similar infection?

**Mr RYAN PARK:** I'll let Deb—I'm not 100 per cent sure.

**The Hon. SARAH MITCHELL:** You're not aware?

**Mr RYAN PARK:** If you're talking about the third patient that sometimes gets brought up—

**The Hon. SARAH MITCHELL:** No, the briefing you got—and Ms Willcox just mentioned it—talks about cases between May and December. Are you aware of a potential case in March 2025?

**DEB WILLCOX:** No, I'm not aware of an isolation.

**The Hon. SARAH MITCHELL:** How confident are you of that time frame of potential cases between May and December 2025?

**KERRY CHANT:** If I could just add here, in the population of immunocompromised patients, there's always a background rate of aspergillus. For each of the cases, the clinicians look back at the incubation period—the time in which they could be exposed—and look at whether they spent time in hospital during that exposure period, because they could be exposed in the community. What they've noticed, and what triggered this concern from the clinicians, was that it was above the background rate. That's what led them to do the detective work in that December period. The clinicians did have a mind to the pattern overall. In general, there is one or two cases of aspergillus every year in patients. There was no unusual pattern presented in the data. I believe the clinicians, as part of this review, are doing a more comprehensive review. That's the circumstance.

**Mr RYAN PARK:** Everyone realises that aspergillus is common. I just want to say that so everyone understands this is not some rare issue. It's in the environment. That's all.

**The Hon. SARAH MITCHELL:** I understand that, but in the advice that you've been given by your agency, it talks about a cluster and a large number of patients. That is unusual, what has happened at RPA. That's the whole reason you're investigating it, right, because there are seven?

**Mr RYAN PARK:** In that December period, clinicians, as Ms Willcox said, identified that there was a larger number that we don't normally have. Whilst investigations are ongoing, a view has been formed by experts that it's likely because of the major redevelopment of the hospital next door.

**The Hon. SARAH MITCHELL:** We'll get to that, Minister. For absolute clarity, are you able to tell me when you were first made aware of this? You said early February. Was it a formal briefing? Did one of your staff tell you about it? How did you become aware of it in February?

**Mr RYAN PARK:** One of my staff would've told me, probably related to the standing order and documents and briefing notes that we were receiving. I can't give you time, date and person—not because I don't know; just because I'm not aware. I don't have that. I don't record that.

**The Hon. SARAH MITCHELL:** So until I moved a call for papers in which these documents were going to become available and in the public arena, you were not aware of this particular issue? Is that your evidence?

**Mr RYAN PARK:** Not that particular issue.

**The Hon. SARAH MITCHELL:** So had I not done that, would you have been told about this at all?

**Mr RYAN PARK:** Of course.

**The Hon. SARAH MITCHELL:** When? If you weren't told for months and patients had died—

**Mr RYAN PARK:** I'm not saying it just came about because of the call for papers. It might've come up—

**The Hon. SARAH MITCHELL:** That's literally what you just said.

**Mr RYAN PARK:** I didn't. I said it may be as a result of that or it may be part of the regular briefings.

**The Hon. SARAH MITCHELL:** But you can't remember. A few people have died with these infections at a major hospital and you think it's linked to construction, but you can't remember exactly when you got told or if it was because of the call for papers?

**Mr RYAN PARK:** No, what I'm saying to you is, because I respect the integrity of this Committee, I'm not going to say something when I wasn't aware of the exact time, date, location and the context. Likely, it would've been a discussion with myself and the secretary or myself and a staff member. The context at that particular point on that particular day, I don't know. Let's get the context in. What more would Health officials have done other than immediately identify it, immediately make sure they keep patients in the loop, inform outpatients, inform staff, thoroughly brief staff and thoroughly clean and assess the area? In 4,400 buildings, we are, from time to time, going to have challenges. You had them with asbestos. You had them with mould in your hospitals. You had them with pests in your hospitals. That is the nature of a portfolio that has a large number of buildings. I would like every building to be perfect and new. The challenge is that, with a portfolio this size, you're always going to need to be on top of maintenance. That's what we're trying to work through.

**The Hon. SARAH MITCHELL:** I'm just focusing on one particular issue. To your earlier evidence, this isn't a maintenance issue. We'll get to those. This is about the linkage between this particular issue and the construction work. You've said then, "What more could have been done?" I think you made some comments in *The Daily Telegraph* this morning that if there are things that you uncover during the review that should change, you will. Are you aware of some of the guidelines that already exist in relation to how infection prevention and control should be managed during construction?

**Mr RYAN PARK:** I'm aware that there are guidelines in relation to infection management and control for construction areas. It's probably best that Ms Skulander talks about the specifics but, yes, I am aware of the broad nature to have infection control as part of construction works.

**The Hon. SARAH MITCHELL:** There are Health documents that are publicly available. There's one from the Clinical Excellence Commission called the *Infection Prevention and Control Practice Handbook*. It goes into what are some of the steps that should be taken. There's a particular procedure from one of your health districts—the South Eastern Sydney one—that says to, if possible, relocate at-risk patients who are adjacent or near to the construction zone and inform high-risk patients of the risks of exposure. Did that happen at RPA prior to construction beginning?

**Mr RYAN PARK:** Construction has been going for a long time there. It predates me. Deb?

**DEB WILLCOX:** The construction of our redevelopment of the RPA commenced in 2023. We've undertaken some relocations in recent times, principally due to noise. We did not relocate the transplant ward on the basis that we were working through the clinical suspicion that our clinicians had raised. Upon dealing with some mitigation issues around ventilation and cleaning et cetera, and then escalating to Dr Chant and standing up the expert advisory panel, we took no more new admissions to that ward and we admitted our transplant patients to another surgical ward in the hospital, which had been tested. The air had been tested and it was clean.

**The Hon. SARAH MITCHELL:** Prior to this outbreak or this cluster occurring, there's a briefing that I'm assuming went to you, Minister—it was certainly authored by people within your agency—which talks about how the transplant ward abuts the construction site on three different aspects. There is a patient-accessible balcony off the ward that has been available to patients during the construction. It also says that invasive fungal infections are a known possible complication in transplant recipients, with a mortality rate between 60 per cent and 80 per cent, and there is data that shows that. Prior to construction beginning, this ward was directly abutting the

construction site on three different aspects. You have a known risk to the patient mortality when construction is occurring. Is it your evidence that those patients were not moved prior to construction beginning and no precautionary measures were taken? Is that correct?

**Mr RYAN PARK:** Respectfully, the advice at that level about what we do with particular wards is not done or directed by a Minister. I know you definitely know this, as a former Minister. That is not in my remit to determine that ward A moves to that part of the hospital. That's something that hospital leadership and management do with those guidelines in place. Emma?

**EMMA SKULANDER:** In relation to the plans and the standards that you reference, our construction program implements all the standards. There are a number of controls in place around things like dust. There is an infection control plan that is documented and that you would have seen in the documentation. At the moment, we're in the process of reviewing, as part of the cluster review that Deb has referenced, all those plans and all the information available to us in relation to the linkage. I can't answer the specific questions due to that review currently being underway. However, I do know that, within the documentation for our own program at Health Infrastructure and the contract that is in place with the building contractor, there are the obligations that you refer to.

**The Hon. SARAH MITCHELL:** Minister, in hindsight, do you wish these patients had been moved earlier?

**Mr RYAN PARK:** I would always, on this type of an issue, lean into the advice of the experts at the Ministry of Health and the experts who are doing the infrastructure and the clinicians on the ground. They would give me advice.

**The Hon. SARAH MITCHELL:** The advice is here in your documents. Why have procedural documents that say, when you have patients that could be exposed—and we know that transplant patients are at risk from this type of mould, which can be stirred up by construction—where possible, relocate at-risk patients. They were relocated after this cluster occurred but not before. Why not?

**Mr RYAN PARK:** What I'm sure the Committee may or may not know is that moving patients who are immunocompromised is also a risk, to be really blunt about it. A decision was made about the location of the patients by the health team. The health team consists of the Ministry of Health, the local Health Infrastructure team as well as the local hospital. That is, to be fair, a clinical assessment and decision that is made.

**The Hon. SARAH MITCHELL:** Were these deaths avoidable?

**DEB WILLCOX:** Could I just add to the Minister's comments? There was remediation work undertaken in the ward once the clinicians raised the suspicion of the aspergillus cluster. In addition, the works had ceased for Christmas and did not recommence until 5 January. There was no risk to patients at that time. We had done a deep clean and inspection of the ward, including up in the ceiling. We had done air sampling. There was no evidence of aspergillus or any other pathogens in the air. Those patients were not being re-admitted to the ward until all those works had been completed. There was no construction—

**The Hon. SARAH MITCHELL:** I appreciate that, Ms Willcox. My issue is that that only happened after you were aware of that clinical advice, whereas some of the documents indicate that that could have been done in a preventive fashion and it wasn't. That's my question.

**KERRY CHANT:** Ms Mitchell, I think all of the matters that you raise will be subject to the critical investigation. But I would note that that ward is now being utilised. That's because sometimes these specialised wards have additional infection prevention and control called HEPA filters and other controls. We are trying to balance infectious risk. There might be the fungal risk or there might be other infections, so it's also the best setting at the time. It's the clinicians, the transplant conditions and the infectious disease people. Once the air monitoring came in and once construction had started and they were clear that the controls in the ceiling of the actual—there were further antechambers put in place. Everyone was comfortable that that was the best place for the transplant patients to be managed ongoing, with those additional layers of protection. As the document says, it is where possible and it has got to be that clinical balancing of risks.

**The CHAIR:** Good morning, Minister. I'll start with some questions about public-private partnerships. Staff and patient safety concerns were raised years before the Northern Beaches Hospital was finally brought back into public hands, thanks to the tremendous advocacy of Joe Massa's parents and your work as well. Staff and patient safety concerns have been raised regarding the Calvary Mater hospital in Newcastle for years prior to this parliamentary attention. Last year the Parliament passed Joe's law, which restricts some future public-private partnerships but doesn't impact any existing public-private partnership. What have you done to ensure adequate provisions to safeguard staff and patient safety under those existing PPPs?

**Mr RYAN PARK:** Thank you for the question; it's a good one. I won't go into PPPs broadly because I don't want to waste the Committee's time, other than to say that I don't support them and the way they operate in health at the moment. The one at Calvary was administered by or put in place by the former Labor Government. That doesn't worry me. I don't support these types of models. Even though we had this PPP in place and people were contracted to do the work, I was getting too many reports coming through of concerns around mould and concerns around rectification issues not being done in time. I made a decision to bring in the various partners to the PPP. I did that multiple times.

Then, over the summer, as a result of those meetings at the back end of last year, I didn't feel that that plan was moving fast enough. The secretary and I, therefore, decided to essentially step into the contract, which is not something that governments tend to do because it puts in a whole range of legal risks. We are now undergoing the cladding works, which will essentially begin this month, and then we have a range of other measures in place that we are working through as a part of that contract to try and address some of the issues that staff raised.

I have subsequently met with staff and with the secretary multiple times, including going up there. I have made it clear to them that I'm not happy with where this is. It is a contract, so I can't just simply rip it up and walk away. I've got to operate within those boundaries, which is somewhat frustrating, particularly for someone like me who just wants to get in there and try and get it resolved. But we are making significant progress in relation to the Calvary issue. But there's still a lot more work to do. We have also improved the communication. I was getting frustrated that only certain staff were being informed about what was happening because of the nature of the work. The Health Services Union and the Nurses and Midwives' Association have also been involved in those conversations to make sure staff are informed about what is happening.

**The CHAIR:** I'll come back to the Calvary Mater specifically in a moment, but my question was much broader than that. I asked what have you done proactively to ensure adequate provisions to safeguard patient and staff safety. You've given me another example where the staff have had to raise those concerns, in this case, through the media because they didn't get the outcome they should have through the proper channels. There are hundreds of other public-private partnerships at NSW Health right now. Are you saying that you are waiting to have critical safety concerns brought up through Parliament or through the media or are you doing proactive work to look at what safeguards are in place now?

**Mr RYAN PARK:** As partners to any contract, we engage with that. Tracey McCosker from the local health district was engaging with that. Our team at the ministry engaged with the contractors to that. We will continue to do that. What I probably wanted to say is that it's not my ideal model of the delivery of health care in New South Wales. That doesn't mean that I can just rip up every contract—it doesn't. But there is always an expectation from me and, therefore, from taxpayers that, for private providers involved in this, they have to abide by the contracts and their terms too.

I have to make sure that I'm doing my best to hold them to account, otherwise these contracts are not worth the paper they're written on. It's frustrating for me and the secretary because we felt we had some progress in relation to some of these issues. That progress wasn't happening as fast as what we would we have liked. Therefore, we made a decision to step in. But they are closely managed by NSW Health. I don't want people to think any of our contracts are set and forget because they're not. I'm just making the contextual discussion that I don't think these are the best ways to deliver public health services.

**The CHAIR:** Staff and community have raised concerns about other facilities in New South Wales—of the ones I'm aware of off the top of my head, Orange hospital, Bathurst hospital and some of the regional cancer care providers. Are you confident those contracts have adequate safeguards in place?

**Mr RYAN PARK:** I'm confident that we are managing those contracts well. That doesn't mean that, from time to time, staff don't—and I expect them to, to be honest. I never want to be the Minister of a department and portfolio where we don't have staff advocating either for themselves, patients or their colleagues. That doesn't mean we don't have issues in those settings, like we have issues in public hospitals that have no relationship to a PPP.

**The CHAIR:** Coming back to the Calvary Mater specifically, when were you made aware of the infrastructure issues?

**Mr RYAN PARK:** Some time ago now—a fairly long time ago. Calvary has been a challenge for a bit. It was unusual that I brought everybody in, and I did it twice. I just felt it wasn't progressing as quick as I would've liked. I felt that I was getting too much corro, and every time someone would say—whether it was a local MP or someone else—that the staff weren't happy about this. In a PPP arrangement where you don't have all of the levers, I wanted to try and pull as many as I could as quickly as I could. I felt we had a pathway to rectification of the

cladding issue. People may know this, but just very quickly, the cladding is one of the key concerns up there. It contributes to the water ingress. I felt we had a pathway with the private providers involved in that contract. That wasn't happening as quick as I would have liked.

**The CHAIR:** I'm trying to specifically get at the time frame. You became the Minister in first half of 2023. I know from your public ministerial diary disclosures that you had meetings mid- to late last year with relevant providers at the Calvary Mater. At some point in that 2½-year period, you must have become aware of the infrastructure issues. When was that?

**Mr RYAN PARK:** Absolutely, I did. I just don't have a specific date. I can try and track one back. That's an issue that we've been monitoring for a while. We've had varying levels of feedback. I've had discussions with Calvary from time to time. Last year was the time when I brought in the other components, or the other organisations, privy to that contract. Chair, for some time now I've been dealing with the Calvary issue, but I don't want to put a specific date on it because I don't have one here and I can't recall.

**The CHAIR:** You made a comment in one of your earlier answers that you have to operate within the boundaries of the contract. When the Government was unable to act within the parameters of the contract for the Northern Beaches Hospital, it brought forward legislation to be able to bring that hospital back into public hands in a way that met the Government's objectives. Why is the Newcastle community being treated differently from the northern beaches community in that regard?

**Mr RYAN PARK:** I've made it clear that, first and foremost—like we did with Northern Beaches—we wanted to try to hold those privy to the contract accountable. That's what I am doing. But I've also made it clear that our team is working through every option around what the current level of intervention is and what may or may not be further intervention. I want to assure the Newcastle and Hunter community that this is an issue that both the secretary and I are personally extremely invested in. I have been extremely unhappy with what I would call the spirit of cooperation and the attention to the concerns raised by the maintenance partners in that contract. That's why we made a decision as a government to go over and above our responsibilities and do that. That doesn't mean that we are finished there. I can't give the Committee a commitment that we are going to rip this contract up and resolve it, because I'm not at that point yet. I respect the members on this Committee too much to try and be misleading in any way. We're not at that point yet. That doesn't mean that we are not examining what our rights are in relation to the contract and where we think we can get the best benefit and value going forward.

**The CHAIR:** With the work that's been done when, as you say, you stepped directly into that contract, what has the cost of that been to the taxpayer?

**Mr RYAN PARK:** We'll be trying to get those costs back from the private operator; don't you worry about that. It's not cheap to do cladding. We're in a process of working through with the private operator who is doing that what the end costs will be. To be fair, probably some of that information will be, at a point in time, commercial in confidence. I don't have the specifics, but I can say that we will be doing our best to make sure that the parties responsible for their components of the contract pay up. What I didn't want to do was have lawyers at 20 paces and there be delays.

**Ms CATE FAEHRMANN:** Minister, it's been close on 12 months since the trial for pill testing began. I expect that there will be an evaluation plus a report on that soon. Firstly, when can the public expect to see that, and is the trial going to continue?

**Mr RYAN PARK:** Absolutely, the community will see it. I have no problems in giving that data and evaluation over. I don't have a timeline yet. I can throw to Dr Chant if one has been developed, but I don't have a specific timeline committed, from memory. I think the evaluation work will be completed over the next few months. Dr Chant?

**KERRY CHANT:** As you're aware, there's an independent consortium. The University of Sydney is leading that piece of work. My understanding is that that's going to be finalised quite shortly. They'll pull together their evaluation in March, and then the normal briefing processes for government will occur.

**Ms CATE FAEHRMANN:** Was it 12 music festivals?

**KERRY CHANT:** There were 12 music festivals that were subject to—

**Ms CATE FAEHRMANN:** That's okay. You don't need to go through the list. How much is it costing NSW Health to operate their services? I'm asking about each individual festival. I know there's a $1 million budget, but what's the cost? How many paid staff are working there?

**Mr RYAN PARK:** I don't have that figure, so I'll rely on Dr Chant.

**Ms CATE FAEHRMANN:** I assume that most of them are paid. Is that correct?

**KERRY CHANT:** Yes. The component is very much a partnership with NUAA. We obviously have peer educators doing it, but we also have staff from our Forensic and Analytical Science Service unit. They're the chemists and scientists that man the machines. Obviously, some Health staff coordinate onsite as well. I can provide some indicative costs. Obviously, that will vary depending on where the festivals are—travel and those sorts of things—but I'm happy to provide that on notice, Ms Faehrmann.

**Ms CATE FAEHRMANN:** Thank you. I will put detailed questions in about that. The reason I'm asking is because even though we've seen Queensland's unfortunate turnaround under the conservative government, in both Queensland and the ACT, they've had private community providers, if you like—Pill Testing Australia, the Loop—that have operated the service. Some of the data that I've seen is that there seems to be a better take-up of patrons in terms of the number of participants at the festival. There's a bigger take-up for Pill Testing Australia than there is for NSW Health, firstly. Secondly, most, if not all, of their operations are staffed by volunteers, which is very important as well in terms of the overall acceptance by the community. For example, at one multi-day event in regional Queensland recently, 22 volunteers operated it for a total of 24 hours across two days, and 372 samples were tested and provided to 373 patrons. The overall cost of that was $11,149. Why isn't NSW Health considering going with these tested, trusted private providers like Pill Testing Australia?

**Mr RYAN PARK:** I don't think that once the evaluation is completed, we would rule that out, Cate.

**Ms CATE FAEHRMANN:** But you have done the trial, though, with NSW Health, as opposed to the private providers. So the monitoring and the evaluation—

**Mr RYAN PARK:** I know what you're saying. You could have done one or the other.

**Ms CATE FAEHRMANN:** Or both.

**KERRY CHANT:** Ms Faehrmann, if I could answer the question. It's very important to say that NUAA is the face of this. We have a strong partnership with NUAA. As you know, we fund NUAA to do a lot of peer interventions in the festivals. Pill testing is part of that continuum. NUAA is being paid additional money to support pill testing, and they're very much the front.

**Ms CATE FAEHRMANN:** I'm aware of that.

**KERRY CHANT:** The reason we have chosen to take this tack is that, as you're aware, Ms Faehrmann—I think you've raised it in previous budget estimates—it is important that, for many of the samples, the speedy testing of those samples comes back to the lab for testing. We also have a clinical staff and clinical toxicologist that can be escalated on the day so that if there are any unusual patterns of presentations, there are toxicologists that can provide real time. It's a more holistic service, but I'm really happy to and I will make sure that Sydney University does reflect, in their evaluation, on other models and addresses that, perhaps, as a view.

**Ms CATE FAEHRMANN:** From what I have observed, from the information that I've gathered, from the evidence and from the evaluation of these private pill testing service providers, everything you've just said, Dr Chant, happens with them as well. But I did want to ask about the Knockout Outdoor festival. NSW Health provided a pill testing trial there. I think that was the one where there were 12 overdoses and four people with medical emergencies.

**Mr RYAN PARK:** That was the one recently, Cate? Was that the most recent one?

**KERRY CHANT:** You mean 4 October 2025?

**Ms CATE FAEHRMANN:** Yes. What did NSW Health do at that festival? Did they spot anything or identify anything of concern at that pill testing service on that day?

**KERRY CHANT:** I can say that at the Knockout festival on 4 October 2025 we had 318 service users, there were 212 samples tested and, in 14 cases, results were different to what people expected they were coming with. Onsite, there were 10 inconclusive results. Post-event, on 7 October, there were multiple high-dose MDMA tablets and capsules. There were multiple capsules of various appearances, which were more than 150 MDMA. There was blue shield Punisher, at 209 MDA, and a blue skull, at 152. We issued a—

**Ms CATE FAEHRMANN:** I think one of the issues there is that you're saying "post-event".

**KERRY CHANT:** The issue is that, as you're aware, Ms Faehrmann, the capacity is limited in what they can actually do. The technology is limited, and I think it's really important that users of pill testing get taken through what the test can show and what can't get shown.

**Mr RYAN PARK:** Cate, do you mean why didn't we say something during the—

**Ms CATE FAEHRMANN:** Yes.

**Mr RYAN PARK:** Sorry, I don't want to pre-empt the question.

**Ms CATE FAEHRMANN:** With the private pill testing providers, there are multiple examples of them going out of their way to notify the patrons then and there. That's the whole point of it, isn't it, for the safety of people at that festival to know if there are dangerous drugs? For example, the festival isn't jumping to mind right now, but they got up on stage—I think we've spoken about that.

**KERRY CHANT:** That was initiated by and in conjunction with NSW Health, and that was the Mighty Hoopla.

**Ms CATE FAEHRMANN:** That was not this year.

**KERRY CHANT:** That was in 2026. On 21 February 2026, during the event, there was a high-dose MDMA—

**Ms CATE FAEHRMANN:** I've got limited time. Dreamstate music festival, which was on Saturday 7 February—the very tragic death of a man there in his forties—that day NSW Health had chosen to have pill testing at Laneway Festival, not Dreamstate. Again, there are pill testing providers like Pill Testing Australia that are begging the Government to allow them to provide these services. They are well tried. Canberra does it, and they are very successful there. But you weren't at Dreamstate, which, to be honest—from what I know about these festivals and who goes—was the risk over Laneway. How did you choose Laneway over Dreamstate, firstly?

**KERRY CHANT:** The trial on that weekend operated at Laneway. Laneway was a bigger festival. It had 45,000 expected patrons versus 16,000 expected patrons. It was selected on the basis of its total risk profile. Dreamstate has been associated with one prescribed event in the past, one ICU admission and one urgent transfer in 2025. Laneway has been associated with prescribed events in multiple editions: one ICU admission from two urgent transfers in 2019, and one ICU admission—

**Ms CATE FAEHRMANN:** Why isn't NSW Health providing the stats on what was found—which, again, is what CanTEST, for example, does in Canberra? It provides very comprehensive results of everything they have tested and the numbers. Why isn't NSW Health doing that in terms of transparency? I know you've got a report coming, but that's not the point in terms of people wanting to know what's going on. One of the major objectives of pill testing is to be public, and for the public to know what's going on.

**Mr RYAN PARK:** Cate, just very quickly—people can have longer at the end, so I don't lose any of the Opposition's time. You would agree that we do regularly put out, through NUAA and through the public, alerts when we come across—I'll just use "a batch"; that may not be the street name or term—a batch of drugs that are highly problematic in terms of their composition. We do do that. I want to be clear.

**Ms CATE FAEHRMANN:** I'm aware. But not at the time.

**The Hon. SARAH MITCHELL:** Minister, were the deaths of the two patients at RPA Hospital in December last year avoidable?

**Mr RYAN PARK:** That'll form part of the review that we're doing and the investigation into that. I'll make sure that that investigation is clear, public and transparent. That will be done by experts in the field, and they will make a determination around that. I want to be clear about this: These are very unwell patients; they're transplant patients. They are arguably some of the sickest patients we have in our hospital. But our view or our hypothesis at the moment from clinicians is that—before we do the investigations that are currently on—aspergillus likely contributed to their passing.

**The Hon. SARAH MITCHELL:** Do you think that will be much comfort to their families?

**Mr RYAN PARK:** We've engaged with the family.

**The Hon. SARAH MITCHELL:** Have you spoken to the families?

**Mr RYAN PARK:** I'm glad you asked that, because I've asked NSW Health for the families' details. When they are ready to speak to me, I'm happy to do that. I'm not going to force myself onto anyone, the same way that—I know the sort of person you were—you wouldn't do that if an incident happened.

**The Hon. SARAH MITCHELL:** When did you ask for the families' details? Was it as soon as you became aware of the deaths?

**Mr RYAN PARK:** I don't know. Early on I made it clear that, at a point in time, I would like to speak to the family members. But, as I do with all of these things when there are issues, I rely on the CE at the ground

or a clinician at the ground to say, "That might be an appropriate time now." It's not about me forcing myself on anyone.

**The Hon. SARAH MITCHELL:** No, I'm not suggesting that; I'm just wondering when you asked for the family details. That was the question. But if you're not sure, that's fine.

**The Hon. SUSAN CARTER:** Minister, you're aware that hospitals have a duty of care?

**Mr RYAN PARK:** Yes, we all do.

**The Hon. SUSAN CARTER:** Yes, absolutely. You're also aware that, certainly in medical matters, that includes a duty to warn?

**Mr RYAN PARK:** Yes.

**The Hon. SUSAN CARTER:** I'm curious about the draft press release dated 24 December that would have warned the broader community and especially any visitors who may have been immunocompromised—thinking about RPA—that there was a risk from fungal infection. Why was that press release never released?

**Mr RYAN PARK:** It's a fair and reasonable question, so let me just take you through that. I'll also ask Ms Willcox to further elaborate on the question as well, to make sure the Committee has maximum information. There was a decision made. Again, as Ms Mitchell would know from being a Minister, often statements are prepared by—

**The Hon. SUSAN CARTER:** Minister, I'm aware that you weren't actually in the office on 24 December. Who made that decision?

**Mr RYAN PARK:** Could I just get through? It's an important one. I'm happy to give you more time. Often the agency prepares statements about a range of different issues. They don't necessarily get out the way that it was in the initial draft of that. A decision was made that the priority was informing the patients, outpatients and staff.

**The Hon. SUSAN CARTER:** A decision made by whom, Minister?

**Mr RYAN PARK:** Give me a moment. We had to balance that—not my decision. I didn't make a decision not to put out anything.

**The Hon. SARAH MITCHELL:** You didn't know?

**The Hon. SUSAN CARTER:** Who did make that decision, Minister?

**Mr RYAN PARK:** We had to balance the fact that we wanted to make sure staff were informed and patients were informed. That's a large number of people. But we didn't want to unnecessarily concern the community about a mould that exists in the environment. I did not want, or Health did not want, that to be a concern for them going into one of the State's largest hospitals.

**The Hon. SUSAN CARTER:** Minister, do you not know who made the decision to withhold that information from the public?

**Mr RYAN PARK:** Deb?

**DEB WILLCOX:** It is convention that draft statements are prepared in the event they're needed. It would be fair to say—

**The Hon. SUSAN CARTER:** Thank you, Ms Willcox. My question has been, repeatedly, who made the decision not to release that draft statement? Do you know the answer to that, Ms Willcox?

**DEB WILLCOX:** I do.

**The Hon. SUSAN CARTER:** Who did make that decision?

**DEB WILLCOX:** We took the question around releasing a public statement around this to the expert advisory panel, which is chaired by Dr Chant and had a number of senior mycologists from Westmead Hospital, Clinical Excellence Commission, our own transplant clinicians and infectious diseases clinicians. Dr Chant's far better placed than myself, possibly, but these things are always a balance. We had a situation that was completely under control—

**The Hon. SUSAN CARTER:** Just to be clear—it was that commission chaired by Dr Chant that made the decision not to release. Is that right?

**DEB WILLCOX:** We took the question of "should we release a public statement?" to the panel. The recommendation was, on this occasion, it was not necessary. The situation was under control. The air sampling had indicated the air was clear, and the patients, outpatients and clinical staff who were directly affected were absolutely aware of the situation.

**The Hon. SUSAN CARTER:** And visitors?

**DEB WILLCOX:** No. We didn't need to contact visitors, because the air sampling had showed the hospital was clean.

**The Hon. SUSAN CARTER:** When was that decision made? Was that on 24 December?

**KERRY CHANT:** It's probably important to say that the focus of the issue on 24 December—and there was rapidly changing information—was to make sure that all mitigants had been put in place. At that stage, the ward was still having patients and there was a discussion about risk management—

**The Hon. SUSAN CARTER:** I'm really grateful for all the discussion about process, but the question is who made the decision and when the decision was made. I understand Dr Chant chaired a committee that made the decision. When was that decision made?

**KERRY CHANT:** At the time, on 24 December, the committee was meeting. The discussion about the communication and who needed to be told and what was the nature of the thing was discussed. It was considered that because there was lots of evolving information, the people that needed to be advised were the people on the transplant ward. Progressively, the patients that were—when the clinicians defined a look-back period, the rest of the clinical staff in terms of why we were air monitoring—

**The Hon. SUSAN CARTER:** Thank you. I think that's the best answer I'm going to get, so thank you very much. Minister, there's a duty of care and a duty to warn, and the standard of care that that duty requires is very clearly set out in the Clinical Excellence Commission's *Infection Prevention and Control Practice Handbook,* which refers of course to the South Eastern Sydney Local Health District procedures. You're aware of those, set as the standard by NSW Health for how these issues to do with infection control, especially with respect to aspergillus, are dealt with?

**Mr RYAN PARK:** I'm aware that we have strict infection control procedures and requirements as a part of the accreditation of hospitals, like other institutions, I'm assuming—

**The Hon. SUSAN CARTER:** Those standards all talk about proactive measures that are taken, risk assessments that are taken, especially when there's any construction abutting transplant patients.

**Mr RYAN PARK:** I don't have that document in front of me, but you're a person who's reading it, so that's what I'll take it as.

**The Hon. SUSAN CARTER:** We heard this morning that the measures that were taken were after the deaths, rather than proactively, and that deaths occurred. We've got a duty of care and a duty to warn. We've got a clear standard of care that's the reasonable response to that duty. There are significant questions about whether that standard was met. Minister, what advice have you taken about the legal liability for negligence?

**Mr RYAN PARK:** I haven't sought that advice at all. What the two individuals—some of the finest public servants that this State has ever had in Deb Willcox and Dr Kerry Chant—and the team at RPA as well as some of the best transplant clinicians have been focused on is they picked up through clinical analysis a bit of an unusual trend and they then took that action and raised their concerns. Health took the subsequent action, what they did, and now we are having a look at that and looking at that as a part of our investigation into those matters.

**The Hon. SUSAN CARTER:** Minister, I am not contesting the excellent work that's being done.

**Mr RYAN PARK:** I haven't looked at the legal issues.

**The Hon. SUSAN CARTER:** Minister, I'm asking you. I'm not contesting the excellent care given to patients in difficult circumstances. I'm not contesting the work done by Dr Chant and her team, or by Ms Willcox. What I'm asking you, the person who has overall responsibility for the system, who's meant to look at all the levers, who has the care of every patient in their responsibility, is whether you made sure that the procedures of NSW Health were followed, whether you exercised responsibility and whether negligence has occurred on your watch—negligence which has led to the deaths, sadly, of two people.

**The Hon. STEPHEN LAWRENCE:** Point of order—

**Mr RYAN PARK:** That is a very big claim.

**The Hon. STEPHEN LAWRENCE:** The Minister was responding, essentially, to that accusation because he was asked "Have you taken legal advice?" in a particular context. He was in the course of responding to that, which is a very significant suggestion. I would suggest he should be able to complete his answers without being interrupted with a barrage of further accusations.

**The CHAIR:** I'll go to the Minister to respond to that.

**Mr RYAN PARK:** Ms Carter, I'm not going to and would not ever pre-empt a clinical review into when we have issues like this. I'm not going to do that, other than to continue to say that Health took all of the measures that it needed and felt was the best course of action at the time. If there are things as a part of the review that experts and Dr Chant's team and transplant clinicians say to me, "Look, in the future we would do this," then I will transparently show that and highlight that. I'm happy for people to look at that. But at the moment, I don't have that in front of me. What I have in front of me in an analysis of what the team did on the ground, doing what they thought was the very best pathway for these patients, the patients broadly in the hospital and the staff in the hospital.

To be fair, I think it's reasonable for a Minister to back them, given what they did and the time that they spent on it. This was not something that they just brushed aside at all. They informed patients, they informed staff, they informed outpatients. They took, based on their clinical expertise, a view about what needed to happen. We've also taken the opportunity to have a look at this broadly, but I will wait to see what that review does, make it transparent in its nature—importantly, before I do that, making sure that the community or the families involved have an opportunity to have their say as a part of that. We'll be keeping them informed. That, I think, is the expectation of the community.

**The Hon. SARAH MITCHELL:** Minister, I want to go to the Calvary issues that Dr Cohn raised. You said that you had been aware of the challenges at Calvary Mater for some time.

**Mr RYAN PARK:** Yes.

**The Hon. SARAH MITCHELL:** There were reports in the *Newcastle Herald* last week that there was an incoming ministerial brief prepared for you in the first days of being sworn in as a Minister in relation to these issues. Did you receive that brief, and do you remember it?

**Mr RYAN PARK:** I don't remember that one—could have been. I know that this issue certainly predates me and this Government. That doesn't mean we're not focused on it—we are. We're the Government; I'm the Minister. That's my responsibility. But this issue's been around for a long time. I don't want to speak for the previous Government, but I'm assuming they were trying to manage it in some way. I don't have access to that information because it's not appropriate for me to have access to Cabinet information or documents around that. But I'm going to take an assumption that either Minister Taylor or Minister Hazzard was actively trying to manage—

**The Hon. SARAH MITCHELL:** I'm asking about when you knew, because there are reports that, I think, that brief was prepared a couple of days before the election. Could you take on notice if you received a copy of that particular incoming brief, and on what date?

**Mr RYAN PARK:** Absolutely, happy to.

**The Hon. SARAH MITCHELL:** That would be great. Just moving through some other issues, Minister—challenges at Tamworth Hospital in relation to mould in operating theatres and the ICU. They were reported as far back as December 2023, but documents that came through the call for papers reveal that those issues were still unresolved at the end of November last year. Is that acceptable?

**Mr RYAN PARK:** I have an expectation—with your experience in a big agency I think you would have too—that we try and get issues like that resolved as quickly as possible.

**The Hon. SARAH MITCHELL:** That's a two-year delay, Minister. That's not quick, is it?

**Mr RYAN PARK:** I'm not saying it hasn't been resolved yet, I just want to get some advice about the specifics. But other than to say that my expectation is that when staff makes us alert on things, we as quickly as possible rectify that. If, by some chance, the rectification is a bit more complex and a little bit more detailed—like if asbestos was in schools, you can't just take a panel down and remove it; you have to do a range of things. I'm sure you were privy to that type of challenge. That's what we do.

**The Hon. SARAH MITCHELL:** But just specifically to that one—a two-year delay between it being reported and it still being unresolved, between December 2023 and November 2025. That's not being done as quickly as possible, is it? You can't say that.

**Mr RYAN PARK:** I just want to clarify to see if that is accurate. Ms Skulander?

**The Hon. SARAH MITCHELL:** I have the documents.

**EMMA SKULANDER:** I am able to comment on that.

**The Hon. SARAH MITCHELL:** Sure.

**EMMA SKULANDER:** In relation to mould—and I'm sure we'll talk more about it—I guess it crops up, we clean and it goes away. In particular, this issue in relation to Tamworth Hospital is associated with leaks. The leaks are going to require a longer-term remediation plan, and the district is reviewing what is required in relation to that. In the meantime, the issue is logged by the staff, cleaning occurs to ensure that the safe environment remains, and if it crops up again, it starts to infer that there underlying issues that need to be rectified. That is the case here in the theatres. I'm aware that a remediation plan is being developed.

**Mr RYAN PARK:** To clarify, I think leaks in that particular facility maybe were first raised in 2021.

**The Hon. SARAH MITCHELL:** Minister, I have a document here, though, that said that things were raised in December 2023, reported again in June and September 2024 and February 2025, and reopened again in November 2025. This has been two years under your watch where this hasn't been fixed. That's correct, isn't it?

**Mr RYAN PARK:** It could have been a lot further back in 2021.

**The Hon. SARAH MITCHELL:** I'm asking about the two years that you've been Minister that this has been reported and it's not fixed.

**Mr RYAN PARK:** I'll need to take—

**The Hon. SARAH MITCHELL:** You can take it on notice; that's fine.

**SUSAN PEARCE:** Could I just add a comment, Ms Mitchell?

**The Hon. SARAH MITCHELL:** I want to go to bird lice at the same hospital.

**SUSAN PEARCE:** Sorry, if I could just add a comment. I think to Ms Skulander's point, the issue is that the area of this problem is leaking. It does go back to 2021. The maintenance team at Tamworth have attempted to fix that a number of times. We're now looking at a broader remediation plan to deal with that issue. I just want to make sure that the Committee understands that it is not a matter of the issue being reported and no-one doing anything about it. There have been attempts to address it, and unfortunately it has obviously continued to present a problem. There is a full remediation plan under development.

**The Hon. SARAH MITCHELL:** Thank you, Ms Pearce. Minister, I want to go to the issue of bird lice, also at Tamworth Hospital.

**Mr RYAN PARK:** Yes, I have that one. You mean pigeons?

**The Hon. SARAH MITCHELL:** Yes. A spokesperson from the department told *The Sydney Morning Herald* in an article over the weekend that there had been no issues with staff being impacted since 2022. Is that accurate?

**Mr RYAN PARK:** I'd have to ask that person. I have some information here, but that particular comment I'm not aware of.

**The Hon. SARAH MITCHELL:** It ran in print, so obviously someone told a journalist that that was the information that was available. But you're not sure if that's correct?

**Mr RYAN PARK:** I'm just not sure of that particular comment and what they were referring to or the veracity. I don't have that, other than to say that there have been issues across the campus, both during our time and during the Coalition's time. Actions to date include a hole in the ceiling being repaired, spikes currently being installed across the site to prevent pigeons from roosting, and a comprehensive pigeon eradication plan being prepared—that was in February—including a site audit, habitat removal, deep cleaning of droppings, food source control, installation of netting and spiking, humane trapping, nest management and ongoing maintenance. The pigeon action plan is current and being implemented. Bird lice was an issue a few years ago, with a remediation including pest control complete at the time. There are no known ongoing issues with patients and staff at that place. That's my latest advice.

**The Hon. SARAH MITCHELL:** Are you aware, though, that a staff member was treated back in November, having to attend the ED due to a reaction to bird lice?

**Mr RYAN PARK:** I'm not aware of that individual case.

**The Hon. SARAH MITCHELL:** There's a long list and I'm not going to have time, but I wanted to also go to some of the issues at Orange hospital. You'd be aware, I would assume, Minister, where a ceiling has fallen on a doctor's head—that has been reported in the media, in *The Daily Telegraph* today—and concerns around the mental health Macquarie Unit in Bloomfield Hospital in Orange having a five-bedroom closed due to serious mould for a number of months. You were in Orange a few weeks ago, or the Premier was, at your Labor conference there and said, "Everyone deserves access to health care."

**The Hon. STEPHEN LAWRENCE:** Hear, hear!

**The Hon. GREG DONNELLY:** It was a good conference.

**The Hon. SARAH MITCHELL:** How can you do that when you have these serious issues at Orange hospital under your watch?

**Mr RYAN PARK:** What you're inferring is that this is an issue that started and finished over the last couple of years.

**The Hon. SARAH MITCHELL:** No, I'm asking about these specific ones. Do you think it's okay that a doctor has a panel fall on their head while they're at work?

**Mr RYAN PARK:** No, I don't. Neither do I accept that at Robertson Public School back in 2018—

**The Hon. SARAH MITCHELL:** Minister, this does not do you any favours.

**Mr RYAN PARK:** —a girl fell dangerously ill after mould exposure at a New South Wales school.

**The Hon. SARAH MITCHELL:** Minister, going back to things in schools is doing you no favours.

**Mr RYAN PARK:** At Wee Waa High School in 2021—

**The Hon. SARAH MITCHELL:** You are the health Minister. We are talking about staff under your direction.

**Mr RYAN PARK:** "Cricket incursion disrupts surgery at Goulburn".

**The Hon. SARAH MITCHELL:** A doctor at Orange hospital had a piece of ceiling fall on his head. You can try and deflect this all you want. This is bad for you, Minister, and you cannot avoid it. What do you say to these circumstances that are happening in many hospitals across the State? You said you wanted to improve the healthcare system. It's getting worse, isn't it, Minister, under your watch?

**The Hon. GREG DONNELLY:** Is there a question or is this a speech?

**Mr RYAN PARK:** A couple of things on that. No, it isn't. There are tangible—

**The Hon. SARAH MITCHELL:** So this is fine? All of this happening is fine.

**Mr RYAN PARK:** No.

**The Hon. GREG DONNELLY:** Point of order—

**The Hon. STEPHEN LAWRENCE:** Point of order—

**The Hon. SARAH MITCHELL:** You can go on defence all you want, boys.

**Mr RYAN PARK:** I just want to be clear—

**The CHAIR:** There are two points of order.

**The Hon. GREG DONNELLY:** Do I need to repeat what I said earlier about allowing the Minister to answer the question and not have a speech followed by a series of questions, which makes it very difficult for the Minister to know which question he is expected to answer?

**The CHAIR:** Many members of the Committee, including yourself, Mr Donnelly, occasionally ask very long questions. I ask the Minister be given time to answer the question.

**Mr RYAN PARK:** I'm never going to commit in a portfolio the size, scale and breadth of NSW Health, which has over 4,400 buildings, that we are not going to have from time to time maintenance issues, including mould and other problems. When that happens, of course that is not something that any of us want to see. But what we want to try and do is get them rectified as quickly as we possibly can in the same way that when Ms Mitchell was the Minister for Education and Early Childhood Learning—

**The Hon. SARAH MITCHELL:** This is not about me, Minister.

**Mr RYAN PARK:** —she could not have committed to ensure all of her buildings did not have any issues.

**The Hon. SARAH MITCHELL:** This is the Health budget estimates for you.

**Mr RYAN PARK:** The scale and breadth of that and the age of them is very significant.

**The Hon. SUSAN CARTER:** Is this two wrongs make a right, Minister?

**The Hon. STEPHEN LAWRENCE:** Point of order: The constant peppering of interjections is most discourteous.

**The CHAIR:** The Opposition's time has expired regardless, so there's no need to rule on the point of order. We'll go to crossbench time. Minister, the first recommendation of the Special Commission of Inquiry into Healthcare Funding was that preventive health should be a whole-of-government priority. Estimates for the value of preventive health spending are as high as $14.30 saved for every dollar spent. Would you consider a standalone preventive health agency like VicHealth in Victoria to bring together this work, particularly where it cuts across government portfolios?

**Mr RYAN PARK:** Probably not necessarily a standalone agency because I just don't want to create more bureaucracies than we already have. What my focus is through Dr Chant is that going forward we need to have across our agencies a focus on preventative health and the impacts that our varying issues have on health care as we as Ministers, not just me as the health Minister but perhaps the planning Minister or the housing Minister, and how they contribute to health broadly. That is what the conversation and the focus, from my perspective, needs to be. Yes, Health plays obviously a role in preventative health care, whether it be through smoking or vapes—sure. But so too does planning, so too does local council, so too does mental health and so too do other portfolios.

My focus is to make sure that preventative health is a part of the analysis and the work that gets done through my agency. If we were commenting on a particular minute—and it might be to do with a land release or a housing development—then I would want to make sure that we've factored in whether there is adequate green space and if we can raise suggestions about access to fresh fruits and vegetables. This is a broad issue that needs to be a focus of, from my perspective, all governments going forward. LHDs also have targeted actions in their own communities that they are doing based on the type of population and demographics that they have within a particular area. For some, that might be around diabetes prevention. For some, that might be around smoking prevention. Those cases are dealt with in the LHD, but we need to go beyond Health if we're truly going to try to delve into this preventative focus.

**The CHAIR:** Minister, in your answer you've given a couple of great examples of where that cross-portfolio work would be beneficial for the health of people in New South Wales. But at a practical level, how is that being implemented since the Government accepted that important recommendation of the special commission?

**KERRY CHANT:** I can give a couple of good examples; they're a little bit historical. One particular piece of work was to influence how Treasury evaluates preventative measures and preventative health benefits. They've agreed to a model, and that will then underpin any evaluations of, say, a cycling pathway or anything within a development. Changing that—I can give you a better description of it. It's the discounting rate or underpinning algorithm by which Treasury values future health gain. Changing that can make a substantial cost-benefit for us in achieving some of those things we'd like to see in terms of more liveable, walkable communities that are going to support health and wellbeing. I can give some other examples about our cross-agency work with the Food Authority, through the food ministerial council, around health labelling and health warnings.

**The CHAIR:** I'd love to come back to that this afternoon with you. The Victorian Government recently passed the Health Safeguards for People Born with Variations in Sex Characteristics Bill, which provides support for the making of decisions around medical treatment for persons who have an innate variation of sex characteristics, including provisions around the giving of informed consent and prohibiting medical treatment in certain circumstances. Will you be progressing similar reform in New South Wales?

**Mr RYAN PARK:** I'd want to have a look at it. We're always committed to making sure our practices are evidence based and reviewing our current practices. I think that's an ongoing piece of work that we do. I don't want to comment on the specific piece of legislation because I don't like to mislead the Committee. I haven't read that particular piece of legislation. We are constantly reviewing our practices and we're constantly making sure that those practices reflect the evidence in this space.

**The CHAIR:** I appreciate your honesty in telling us that you haven't read that. Will you now read it now that we've raised it with you?

**Mr RYAN PARK:** Yes. I'm always happy to have a look at legislation.

**The CHAIR:** Similarly, Equality Australia produced a terrific report called *The Missing Voice* report that explicitly platforms the lived experience of people impacted by a variety of issues but particularly unnecessary medical procedures or inadequate consent processes. Are you aware of that report? Have you read that report?

**Mr RYAN PARK:** Not me individually, but I understand NSW Health is looking at that report and it is a part of that ongoing piece of work around the evidence. Elizabeth, did you want to quickly—

**ELIZABETH WOOD:** We are aware of the report. I actually met with the chief executive of Sydney Children's Hospital last week to discuss the best way forward. We are looking at a care coordinator type position specifically for individuals to make sure that they're aware of the options that are available to them. We are working very closely on that, Dr Cohn.

**The CHAIR:** I might come back to you this afternoon to talk about that. I'm pleased to hear it's on your radar. Minister, back in December 2024 it was publicly reported that only three of the 220 public hospitals in New South Wales are routinely providing abortion services. The Committee's subsequently been told that there are 40 NSW Health sites providing abortion services, but that figure includes sites which only provide abortion in limited circumstances or where those services are inconsistent. Do we really genuinely have reproductive choice in New South Wales when public services are so limited?

**Mr RYAN PARK:** My expectation is that women have access to affordable and timely care. We are having a look at this policy space right now. You would be aware though that in most cases medical and surgical abortions can be provided in the community and non-hospital settings. That may be a private provider or a primary care. My expectation is that women have access to that level of health care in a way that is accessible for them. I'm not going to pretend, however, that there are not parts of New South Wales where that becomes more challenging for women.

In the same way that when I'm out in regional, rural and remote New South Wales, I don't pretend that NSW Health can have every service in every country or regional and rural town. What I'm interested in making sure that we do over a period of time is making sure that that accessibility is as good as it can be, and it is as close to where women are located as we possibly can. That doesn't mean there are not pockets of challenges at the moment. Our commitment is to improve that and to improve safe and transparent pathways to abortion care for women.

**The CHAIR:** In December the chief executive of Murrumbidgee Local Health District confirmed to this Committee that there was no surgical abortion provision on request within the Murrumbidgee LHD. What have you done to address this?

**Mr RYAN PARK:** I'll probably ask Elizabeth.

**ELIZABETH WOOD:** We're in the process at the moment, as Ms Ludford outlined, of working out what that service provision will look like with Wagga Wagga Base Hospital particularly. We are in the process of looking through what that position description will be. We are progressing that at the moment. What I can say though is that there are absolute requirements that every district has got referral processes in place. If a woman does find herself in a facility that does not provide that service, it is upon the district to make sure that they can have timely access to care for that woman to meet her circumstances.

**The CHAIR:** I understand that, Ms Wood. I am aware, and I am sure you are aware, that those referral pathways particularly out of Murrumbidgee are often interstate to Victoria or the Australian Capital Territory or even up to Orange. This is the significant distance that people are being required to travel. Is travelling that kind of distance acceptable to the ministry in terms of timely and affordable access?

**Mr RYAN PARK:** The advice that I've got—I just want to be clear and if I've misspoke or there's updated advice, one of the officials can tell me. The women's health service—I know it's a different type, but it provides medical termination of pregnancy through a free nurse-led model that includes counselling and consultation with GPs like yourself. Wagga Wagga and Griffith Base Hospital provide surgical termination for clinically complex cases under 12 weeks. Later gestations are managed medically with surgical intervention if required. When the hospital can't provide a surgical termination service, a referral is provided, which is what I think you just got to, for access to surgical termination services in a timely way. I just want to make sure that's still—

**ELIZABETH WOOD:** That's correct, Minister. Dr Cohn, with reference particularly to the individual that travelled to Orange, that was a preference of that particular individual, as I understand it.

**The CHAIR:** I will come back to that this afternoon.

**Ms CATE FAEHRMANN:** Minister, how many people were treated in Sydney hospitals after the protest against the visit of Israeli President Herzog in Sydney on Monday 9 February?

**Mr RYAN PARK:** I'd have to be advised on that one. I don't know if I could take it on notice? It wasn't a huge number, Cate, but I don't have the specific number.

**Ms CATE FAEHRMANN:** Could you take that on notice? Obviously across Sydney.

**Mr RYAN PARK:** Let me try to get you that answer back to the Committee. I know it wasn't a very large number. I'll get advice, but I think it was in the order from memory of 10 or so. Let me just double-check that.

**Ms CATE FAEHRMANN:** I wanted to turn to the Cadia deep dive investigation that NSW Health undertook. It was in fact a recommendation from this Committee that inquired into the impact of heavy metals on the environment and community health. The deep dive investigation was undertaken last year. I've got a summary report in front of me. Is there any more information that is publicly available on top of this summary report that's been published, firstly? I know, Dr Chant, this is probably for you.

**KERRY CHANT:** Sorry, I'm just looking at my briefing. I'd have to double-check. I know that there is a report publicly available on the website, and I just want to acknowledge the community's assistance in doing that deep dive. I can just get back to you, Ms Faehrmann, if that would assist, by looking at what's on our website.

**Ms CATE FAEHRMANN:** I'm actually curious as to—because the data essentially isn't provided. There's a kind of summary, if you like. It's an eight-page report which isn't much of a deep dive. Fourteen participants were involved in this. The summary report makes quite a few assumptions based on this deep dive into 14 participants, including:

> Environmental findings: no significant contamination was identified in indoor dust, soil, water or homegrown produce. Detected metals were present at concentrations consistent with expected background levels and below health-based risk thresholds.

What I'm wanting to know is who inputted into this report? What background information did you have, Dr Chant? I can see in the references, for example, that Environmental Risk Sciences, or enRiskS, provided a confidential report to NSW Health. Why is that report confidential?

**KERRY CHANT:** I'd be happy to look at making that available, just noting that individuals volunteered, so there might've just been some sensitivity about having any identifiable information that could be tracked back to a particular individual. There is no issue in relation to full transparency in relation to Cadia. My only caveat would be the privacy of the individuals and their understanding of what they were disclosing when they were participating in the study.

**Mr RYAN PARK:** Cate, did you say you wanted to check who was on the panel? Sorry if I've missed—or you know that?

**Ms CATE FAEHRMANN:** That would be good information, if that's not public as well.

**Mr RYAN PARK:** I've got here that the panel consisted of environmental scientists, toxicologists, clinicians, public health practitioners, water and air experts, who conducted the investigation deep dive into dust exposure in the community. I thought you said that, so I just wanted to—

**Ms CATE FAEHRMANN:** Yes, if you could provide the details, the names, of those people again.

**Mr RYAN PARK:** Sure.

**Ms CATE FAEHRMANN:** There are certain assumptions that have been made here, for example:

> Most blood and urine test results were within the reference range. A small number of individuals—

a "small number of individuals", we're talking 14; that was the total number of participants—

> had slightly elevated concentrations of arsenic … and mercury … in their blood.

And then this statement:

> These concentrations are not considered to pose any health risk, with the most likely contributor being recent dietary intake, rather than environmental exposure.

On what basis did—

**KERRY CHANT:** The participants actually had full—I'm happy to go back and get more detail, but I understand this was truly a deep dive, where there were actually toxicologists speaking to the individuals around things like their food and water ingestion, their sources of exposure. I'm happy to get those details, but I would

have assumed that that is the basis for their assumptions around the dietary intake. I can get more details for you, Ms Faehrmann.

**Ms CATE FAEHRMANN:** The final sentence in the summary before the conclusion is:

> Overall, clinical findings in this group did not indicate a need for ongoing health surveillance related to potential exposure from the Cadia mine.

However, again, there were 14 participants, including:

> In one case, repeat and alternative testing through an existing specialist was suggested to further explore a health concern.

Then you've got, before that, "no definitive health concerns"—although a couple of people were told maybe it was their diet or not. I find it extraordinary that NSW Health would make the assumption, after testing just 14 participants, that there was no need for ongoing health surveillance. Why is that?

**KERRY CHANT:** Ms Faehrmann, this was done in conjunction with the community, in terms of discussing what would allay their concerns. It was members of the community that had had test results to explain who were concerned, so the process was discussed with them around doing a deep dive and the community members volunteered to be part of this. As you know, some of these products can occur in hair shampoo, diet—

**Ms CATE FAEHRMANN:** Did they ask for no ongoing health study? Are you going back to the participants now, Dr Chant?

**KERRY CHANT:** I'm saying, based on the—

**Ms CATE FAEHRMANN:** I know they participated, but did they not want follow-up? Is that what you're suggesting?

**KERRY CHANT:** No, I'm not saying that, Ms Faehrmann. I'm just commenting that I'll have to go back to the Environmental Health Branch and ask about the process. But my understanding is there was feedback to the community of the results, and that was discussed. I'm also happy to take offline to assure you around whether the toxicologists took full details of food ingestion and what was the basis for those comments. I'm happy to take that on notice.

**Ms CATE FAEHRMANN:** I want to turn to the issue of Broken Hill and the lead problem. Firstly, would you be aware that South Australia has lowered the intervention level in children, in terms of blood lead level, from five micrograms per decilitre to 3.5? This is particularly in the situation of Port Pirie, with the lead smelter there. They've got a lot of programs. Firstly, are you aware that they've done that?

**Mr RYAN PARK:** I'm not, Cate.

**KERRY CHANT:** The NHMRC criterion is five, I'm happy to acknowledge. I will follow up with South Australia about a reduced level. Can I just put on the record that we aim to reduce blood lead levels as low as possible, so we do provide generic advice to everyone, irrespective of the level, around how to reduce their lead exposure. In terms of more prioritised action, given the scale of the issue in Broken Hill—as you know, it's ubiquitous—we are guided by intervening with those who have the higher blood lead level. Just to be clear, we're embedding lead messages and lead advice on how to minimise that, irrespective of your blood lead level, with the aim to bring it down as low as possible.

**Ms CATE FAEHRMANN:** Is NSW Health considering going back to screening babies under 12 months of age? That has changed recently, over the past year or two.

**Mr RYAN PARK:** I understand we've got about 92 per cent of children under the age of five being screened.

**Ms CATE FAEHRMANN:** Yes, but I'm talking about under 12 months. That was a recent policy change—based on emails that I've raised in this Committee before from Maari Ma—that was essentially about funding cuts. The services weren't provided.

**KERRY CHANT:** There has been no budget cut to Maari Ma. We're very committed—and I'm personally very committed—to having a sustainable funding source for Maari Ma into the future. They're a key partner in relation to blood lead testing. We're always looking at opportunities to increase blood lead testing.

**Ms CATE FAEHRMANN:** Can I check, Minister, that Maari Ma is a key partner?

**Mr RYAN PARK:** Yes.

**Ms CATE FAEHRMANN:** The EPA has been the one funding Maari Ma. There was, I understand, a budget pitch put in for the last budget that didn't make the cut. Maari Ma has a small amount of funding from the EPA. Why isn't NSW Health providing more for the Broken Hill community to deal with the lead issue?

**Mr RYAN PARK:** The advice I've got about this—this is something that I have looked at and I've spoken to Dr Chant, and I know you've got a genuine interest in this—is the screening program is funded by Far West LHD, the Ministry of Health and the EPA. It's available for children under the age of five. In 2025-26—so this current fin year—Health will provide around $570,000 to support childhood blood testing, follow-up and support. Far West LHD is contributing 295, and the Ministry contributes 276 of that.

**The CHAIR:** There's a short amount of time left before Government time, which we will share. Minister, there has been an application made to the TGA federally to allow GPs to prescribe Roaccutane, or isotretinoin. This has been happening in other jurisdictions, like New Zealand, since 2009. If the TGA were to approve that, would you then update New South Wales legislation to enable that change here?

**Mr RYAN PARK:** Yes. That's our normal process. When the TGA makes that decision, subsequent legislation flows from States and Territories—well, I don't know if it's other States and Territories, but certainly in ours.

**KERRY CHANT:** Dr Cohn, this issue has been raised by the RACGP with us. We have been—including our pharmaceutical regulatory unit—quite supportive of this. If the TGA change occurs—

**Mr RYAN PARK:** We'll move.

**KERRY CHANT:** —we would be very keen to move.

**The CHAIR:** I'm really pleased to hear that. I know it's a very different issue, but for MS-2 Step there was a two-year delay and a private member's bill required to bring us in line with TGA regulations. I don't think you can blame me for asking.

**Mr RYAN PARK:** Hopefully it won't be that long.

**The CHAIR:** Hopefully it'll be quicker this time. I'll go to the Opposition.

**The Hon. SUSAN CARTER:** Minister, I'm just curious. We know that there were seven transplant patients at RPA this year who contracted an invasive fungal infection caused by aspergillus. The first was in May, then October and escalating quickly to December. What specific measures were taken from October to deal with the aspergillus infection at RPA?

**DEB WILLCOX:** As I previously outlined, the clinicians suspected aspergillus in two patients, both in early December. The background ill health of these patients—it's not always obvious they're immunosuppressed. It's not always obvious with certain infections. After the two index cases became clear—one on the 3rd and one on the 9th—that was a trigger to look back, because of the incubation period and those other factors, to see whether any other patients might have contracted this or been affected by it. With that look-back process, that's when the additional patients were identified. The May patient was an isolated patient. As has been mentioned already, we would get around one a year in any case, so that patient of itself did not trigger any concern by the clinicians.

**The Hon. SUSAN CARTER:** But from October to December, there was nothing until the December patients?

**DEB WILLCOX:** It was not obvious to the clinical treating teams that aspergillus was at all an issue. As the professor in infectious diseases said to me, it's somewhat like a puzzle. You pick up a bit of clinical suspicion, you identify a patient, you do the testing, which takes 10 to 14 days, and then they start to look back and try to work through whether there are any other linkages. There may be other fungal infections in these patients, but it's getting down into the genotypes of the type of fungi that's in the person. Unfortunately for these patients, they are at high risk of these opportunistic infections because they have been immunosuppressed to preserve their graft, or donor organ, in this case.

**The CHAIR:** Are there any questions from the Government?

**The Hon. STEPHEN LAWRENCE:** No Government questions, thank you, Chair.

**The CHAIR:** There being no questions from the Government, we'll break for morning tea. We'll be back at quarter past 11.

**(Short adjournment)**

**The CHAIR:** Welcome back, everyone. We'll resume this session with questioning from the Opposition.

**The Hon. SARAH MITCHELL:** Minister, do you recall awarding a $150,000 grant to the Lebanese Muslim Association for community preventive health and wellbeing initiatives?

**Mr RYAN PARK:** I've got a vague recollection that we have provided some funding to that group for preventive health or, what I would say, health awareness. I am probably best to take it on notice, just in case I've got that wrong.

**The Hon. SARAH MITCHELL:** In September 2024, a $150,000 grant from the Government was awarded looking at different campaigns and, you're right, screening opportunities and vaping.

**Mr RYAN PARK:** I remember something in relation to vaping out in different multicultural groups, but I just don't want to mislead the Committee.

**The Hon. SARAH MITCHELL:** There's a press release. It's pretty public that you did it. Do you recall how that grant came to be awarded? What program did it go through? Was it a tender process for that organisation?

**KERRY CHANT:** If it was administered by the Cancer Institute for a vaping prevention campaign, we follow normal procurement processes.

**The Hon. SARAH MITCHELL:** It was a New South Wales Government grant to the Lebanese Muslim Association of $150,000.

**Mr RYAN PARK:** I can get some information, Ms Mitchell.

**The Hon. SARAH MITCHELL:** You're listed on the press release, and so is Minister Kamper, Minister Cotsis and Minister Dib. There are quite a few of you backing it in. But you can't recall if there was a tender process or how that money came to be allocated to that group?

**Mr RYAN PARK:** Not that specific grant. I'll get some information. That's what I'm saying.

**The Hon. SARAH MITCHELL:** Did any of your colleagues raise any conflicts of interest in relation to that particular association being funded?

**Mr RYAN PARK:** Not that I recall, no.

**The Hon. SARAH MITCHELL:** Are you aware that the president of that association made monetary donations to both the Labor Party and Minister Dib ahead of the 2023 election?

**Mr RYAN PARK:** I'm not aware of that, sorry, Ms Mitchell.

**The Hon. SARAH MITCHELL:** If you were aware, would you have awarded that grant?

**Mr RYAN PARK:** Like any Minister, you expect the normal process to take place and people to declare conflicts of interest. I'm not aware of what you're saying. I'm saying in broad terms that there's an expectation that, if there are conflicts of interest, then you do that through the normal Cabinet Office process. I don't know if that has happened or didn't happen. I'm just saying that I'm not aware of it.

**The Hon. SARAH MITCHELL:** Did Minister Dib lobby you for that funding to be made available to that community group?

**Mr RYAN PARK:** No, I don't recall that.

**The Hon. SARAH MITCHELL:** Could you take on notice, then, Minister—perhaps you could come back to us by lunchtime before you finish up—what was the process for that funding and were any conflicts of interest declared, particularly that that individual, who is the president of that organisation, made personal donations to both the Labor Party and Minister Dib? It's pretty concerning if there is a conflict, right, Minister?

**Mr RYAN PARK:** It's how you manage the conflict. There are conflicts at different times. There were some concerns around how fire grants and help for fire impacted communities was divvied out under the last Government.

**The Hon. SARAH MITCHELL:** I'm not asking about that. I'm asking about a particular one. This is a very specific example where it appears there has been a one-off health grant given to this organisation where the president made specific donations to both your party and to one of your Ministers who is listed on the press release. If you could provide clarity on that and, if you get a chance, maybe do that in Government time before lunch, that would be good for you if that's made clear.

**Mr RYAN PARK:** We'll see what we can do.

**The Hon. SARAH MITCHELL:** In relation to some of the challenges that we're seeing at Blacktown Hospital, obviously, you would be very aware of the 7NEWS investigation recently into some of the cases there, particularly the tragic case of Maria Osborn, who waited in the emergency department for 44 hours in pain and in a wheelchair at Blacktown Hospital. She was admitted to ICU but then, sadly, passed away. What response would you have for her family, Minister, who believe that the delay in her being diagnosed and receiving appropriate treatment led to her death?

**Mr RYAN PARK:** I recall I spoke to her husband. We are, as a system, extremely sorry whenever we feel we haven't met the expectations of the community. Blacktown is, as you and Committee members will know well, a very fast-growing community. That is why we have invested in both Blacktown and Mount Druitt hospitals an additional 60 beds. That is why we have tripled the investment that the former Coalition Government put into Rouse Hill to $900 million. It is why we are investing heavily in safe staffing at that hospital.

**The Hon. SARAH MITCHELL:** But to Ms Osborn's family, that, to be fair, Minister, would not be much of a consolation. Did you apologise to her partner for what happened to Ms Osborn?

**Mr RYAN PARK:** I won't ever go into private conversations I have with members of the community. That is just something that is between us and them, other than to say that I'm very clear that when we don't meet the community's expectations that is disappointing for the secretary and it is disappointing for me as the Minister. We always want our system to be operating perfectly. We have about 8,000 people come through our emergency departments every day. From time to time, we are not going to meet their expectations. When that happens, as the head, along with the secretary at the peak of the organisation, that's something that I am always disappointed in. At Blacktown, what is important is a couple of things. The LHD is conducting a full internal review of the care of the patient at that hospital, as well as the length of time in the ED.

**The Hon. SARAH MITCHELL:** Will that investigation be made public?

**Mr RYAN PARK:** We'll have a look at it. Patient confidentiality would be at the forefront of everything. I would want to speak to the family again before I make a decision to release someone's personal health record or journey.

**The Hon. SARAH MITCHELL:** I respect that.

**SUSAN PEARCE:** For the abundance of clarity, can I just add, Ms Mitchell, if it's okay, that, in any circumstance where we have let someone down, the full report and open disclosure occurs with the family once that matter has been investigated, as is our practice. It will certainly occur in that case.

**The Hon. SARAH MITCHELL:** Minister, on the Northern Beaches Hospital transition, you made some announcements—and, I believe, clinicians and some local members were made aware yesterday—and I think you put a media release out today in relation to the provision of private services continuing until 30 June 2027. Is that just for surgeries or is that the full scope of services offered by the hospital?

**Mr RYAN PARK:** It's a good question and a very apt question. That PPP has been an unfettered disaster, to be brutally honest. It has cost the taxpayer an enormous amount of money and it has caused an enormous amount of time and angst across government and, more importantly than government, within the community. What we are trying to do with that hospital, which we take back into public hands at the end of April, is make sure that there is time for us to transition to whatever model of private service offering we do. Mr David Swan, who is certainly an expert in private hospitals and has had, from memory, a role in public hospitals as well, is providing advice through consultation and feedback from the community but also, importantly, from clinicians and others around what that model eventually looks like. That is not going to be determined by the end of April. We needed to be able to seek advice on how we can continue those operating services and surgery services out of that hospital in a way that allowed us to properly and calmly transition. That was not going to be able to take place in the next—whatever that is—month and a half or something.

**The Hon. SARAH MITCHELL:** A handful of weeks. What changes at the end of April, then, for that hospital?

**Mr RYAN PARK:** What changes at the end of April is that that hospital comes under public control and we are no longer under the control of a private entity. It was previously under the control of Healthscope. That now comes under us. We were then able to manage elective surgery in a way that we can use that additional capacity that has been brought into the system effectively but, at the same time, transition or continue to operate private services there. What we haven't done yet is be able to nail down what that private model looks like at this stage. A big change, for instance, is that the very visible part of the ED is now in public hands. That part of the hospital is now under the control of NSW Health through the Northern Sydney Local Health District.

**The Hon. SARAH MITCHELL:** But in terms of the patients who go there, say, for orthopaedic surgery—if you booked in with a private surgeon to have your knee done—that all continues as it's currently operating now until June 2027. That was what the announcement was today.

**Mr RYAN PARK:** Yes. They don't fall off a cliff. Ms Mitchell, you can imagine that because this PPP was so bad, we're trying to bring it in as quickly as possible. But it's got to be done in a live hospital, where things are changing every day—appointments and schedules are being booked—so that we can continue almost the long runway, or a long transition, into that process.

**The Hon. SARAH MITCHELL:** Clinicians were obviously concerned about that—which you're aware of, Minister—not knowing if they could book patients, so I'm sure that clarity is appreciated. In relation to the high-volume surgical unit that you've announced for Northern Beaches Hospital, what consultation was done with clinicians at that hospital prior to the announcement?

**Mr RYAN PARK:** Not a huge amount in relation to that. We think that with the additional capacity that we bring into the system and managing it as an LHD, we can get additional surgery for northern beaches patients. First and foremost, the priority is for northern beaches patients. That's their hospital. We're adding additional capacity into a public system where, to all intents and purposes, we would have had to go and build another public hospital at the northern beaches. What we've had to do is take over a hospital with a very bad contract that was outsourced by the Coalition Government for reasons I still don't know. It had not worked effectively, so we've had to bring that into the fold. With bringing that into the fold, we believe that, over time, we can get some additional capacity going through some high-volume surgery through that process.

**The Hon. SARAH MITCHELL:** At the press conference on the day, I think the Premier made a comment that there will be a focus on ophthalmology. Is that correct?

**Mr RYAN PARK:** Yes. There will be a focus on what I call high-volume services—I think ophthalmology. There are some other ones in that list that are frequent and high volume. We can get through them on the same day, which is important, and we can get through as many as we can.

**The Hon. SARAH MITCHELL:** How are they going to do those ophthalmology operations when they don't currently have any ophthalmologists on staff? I might come back to that this afternoon, unless someone has an answer for that.

**MATTHEW DALY:** I can talk to it either now or this afternoon.

**The Hon. SARAH MITCHELL:** We might come back to that, if that's all right. As Minister, have you been briefed on that, or not at this point?

**Mr RYAN PARK:** Yes, but I just want to get some advice from Matthew on that.

**The Hon. SARAH MITCHELL:** That's fine. I have more questions this afternoon, so I might come back, if that's all right.

**SUSAN PEARCE:** I think the point is that ophthalmology is an example of high-volume procedure in our theatre list.

**Mr RYAN PARK:** In our world.

**SUSAN PEARCE:** That is, in fact, one of the highest volume procedures that we perform across the State—orthopaedics and others. So it's possible that it was used as an example, but Mr Daly will be able to confirm those arrangements.

**The Hon. SARAH MITCHELL:** This is a little forewarning that I'll come back to that this afternoon for you, Mr Daly. Minister, I want to talk about some of the community concerns that have come to me in relation to what's happening down at Albury and the Albury Wodonga Health service, particularly in terms of the workforce challenges and some of the staff feeling that it's not a great culture through Albury Wodonga Health. What oversight do you have of that particular hospital? Are you aware of votes of no confidence from senior clinicians and people being stood down from the hospital? What is your response to those concerns?

**Mr RYAN PARK:** Just for 30 seconds, the Committee needs to know that we contribute funding to it and it is largely operated by Vic health in terms of the day-to-day operation. I've had some concerns around some feedback around the culture and around management and the way in which they interact with staff. It is not for us to directly, so to speak, get involved in, but I asked the secretary very recently—I'm going to say last week, but Susan will give more updated times around this—to meet with the management down there. At the last Health Ministers' Meeting, I think the secretary caught up with the Victorian secretary to say that we wanted to have a further discussion around it. It's a challenging model because it's a border community. We put a significant amount

of funding in. Vic health operate it, per se, on our behalf. We make sure that funding goes in from our patients, and I understand that further discussions are going to be had around that. But I might throw to Secretary Pearce in case I've misspoken in any way.

**SUSAN PEARCE:** I gave commitments in this hearing in December with respect to Albury hospital. That included speaking to my counterpart in Victoria, which I certainly did. Mr Sloane and I met with the chief executive and the board of Albury Wodonga last Thursday. We were actually meant to be there in person, but unfortunately Qantas cancelled our flights.

**The Hon. SARAH MITCHELL:** It happens when you live in the regions, unfortunately.

**SUSAN PEARCE:** I'm well aware of living in the regions, as you know.

**The Hon. SARAH MITCHELL:** That's why I came last night. I didn't want to miss this morning, Minister.

**SUSAN PEARCE:** If I'd had time, I would have gone the night before as well. But unfortunately I didn't. We still proceeded with the meeting, however, and talked through with them some of the issues that they are experiencing, including the capital arrangements and those plans for the future. This Thursday I have a meeting with a number of groups of staff, including medical staff, Better Border Health and others—

**The Hon. SARAH MITCHELL:** Great.

**SUSAN PEARCE:** —which we will be participating in with the Victorian health secretary and her team. It's important to ask whether we have a degree of oversight. Obviously, notwithstanding the fact that Victoria manages the facility, New South Wales residents access those services, and we take that very seriously. My counterpart in Victoria and I are having conversations around this. I specifically asked the chief executive last week about some of the staffing issues and how they're going with recruitment and so on. Like a lot of rural facilities, they have some challenges, although I think they have seen some improvement in their staffing. There are also some longer-term discussions for us to have with them around clinical service planning into the future, being clear with them around the processes that we use here in New South Wales and the processes that Victoria use, to continue to provide as much certainty as we can, obviously subject to government approval, to that community.

**The Hon. SARAH MITCHELL:** I've also met recently with Better Border Health and I know they have some concerns, so I'm sure they'll appreciate the opportunity to raise those directly with you, Ms Pearce.

**Mr RYAN PARK:** Your member and your colleague Mr Clancy—

**The Hon. SARAH MITCHELL:** Justin Clancy, the member for Albury.

**Mr RYAN PARK:** I just want to make sure that the Committee knows that he's been a very strong advocate around these things.

**The Hon. SARAH MITCHELL:** Absolutely.

**Mr RYAN PARK:** I want to put that on the record, because he fought hard under the former Coalition Government to get a funding allocation to that hospital. I've been keeping him abreast. I know Dr Cohn also has an interest in that part of the world.

**The Hon. SARAH MITCHELL:** To a different part of the world, regarding the Lower Mid North Coast Health Service project, there's the Manning Base Hospital—

**Mr RYAN PARK:** Forster and Manning?

**The Hon. SARAH MITCHELL:** —yes, the Manning Base Hospital in Taree—but I particularly want to ask about the Forster-Tuncurry health facility project. I know that there have been meetings with Tanya Thompson, the local member, and some of the community there about, I believe, the $20 million allocation to effectively set up an urgent care clinic to operate in Forster going forward. To be frank, Minister, there's been radio silence on that for quite a period of time. Can you give the community any update, particularly in relation to what will be available at Forster?

**Mr RYAN PARK:** Let me just have a quick look. I have talked to Tanya about this issue broadly—Manning et cetera. Emma, jump in after if I miss anything here, but in July last year we developed a proposal for the district for an urgent care service. An allocation of funds from the 180 would contribute to the fit-out of the space. The district at the moment is evaluating potential locations. If Emma has an update on that, I'll throw to her. Commencement of the urgent care service is subject to the allocation of workforce availability, obviously. The urgent care service model is proposed to operate out of business hours with a more efficient mix of staff.

**The Hon. SARAH MITCHELL:** That's great. They're all the right words, but when is the action going to actually happen?

**EMMA SKULANDER:** I'm expecting that the district will be able to make an announcement around that in the coming months. They're certainly actively working on establishing that centre—the location of it, the staffing model and everything else. I think we're just a little bit premature to be able to provide some of that detail today, but it is certainly not very far away.

**Mr RYAN PARK:** I'm happy to take it on notice.

**The Hon. SARAH MITCHELL:** If you can, that would be great.

**Mr RYAN PARK:** But I don't want the Committee to think that we're skirting around it. This is an issue that Tanya has raised with me—rightly so, as a local MP—a number of times. One of the challenges around the Forster allocation was that it wasn't in the previous budget, or any budget, as a result of the last Coalition Government, but we are trying to go as quickly as we can. They're legitimate things that she raises, and I'll get back to the Committee ASAP about it, but I have spoken to her.

**The Hon. SARAH MITCHELL:** I just want to take you to the issue of regional maternity services—something I've raised with you many times before. Can you tell me how many vacancies there are currently for midwife positions in rural and regional health services?

**Mr RYAN PARK:** The specifics around that I would have to take—

**SUSAN PEARCE:** We do not collect vacancy data in the way that I think you're asking the question, Ms Mitchell. We can probably, on notice, provide any areas where we have issues with recruitment, but we don't collect vacancy data.

**The Hon. SARAH MITCHELL:** I might come back to that.

**The Hon. JOHN RUDDICK:** Minister, your counterpart in Queensland, Tim Nicholls, the Queensland Minister for Health—

**Mr RYAN PARK:** Yes, I know him well.

**The Hon. JOHN RUDDICK:** Good. In January this year he announced that he's suspending the use of stage one and stage two treatments for children and adolescents under the age of 16 with gender dysphoria. He's basically suspending puberty blockers until 2031, pending a comprehensive review. Do you agree that Queensland is in tune with the global trend on this issue and that New South Wales is now an outlier?

**Mr RYAN PARK:** No. What I would outline to the Committee is that we, as a health system, use a very evidence-based approach. We are constantly looking at the evidence and we are constantly looking at what is happening overseas. My expectation is that that health care, like all health care, is delivered in a way that is tailored, best practice, multidisciplinary, age appropriate and evidence based. They're probably the five things, in relation to that part of health care, that I have an expectation from. I don't know if other Committee members want to add to that, but I'm happy for them to.

**ELIZABETH WOOD:** I can add to that, Minister. We actually provided a written response to that Queensland review. I think it's important to note that, of the recommendations of that independent review, they align with and support NSW Health's current approach. Queensland have taken a different approach, as is their option to do, but as the Minister has said, our focus is very much on looking at each piece of evidence as it arises, with the clinical needs of the young person.

**The Hon. JOHN RUDDICK:** I'm pleased to hear from both of you that it appears you are basing your policy on evidence. I think we would also agree that this is an evolving question of science. Minister, can you tell us what data are you relying on to allow stage one and stage two treatments to continue in New South Wales for under-18s? If they're over the age of 18, they can do what they want, but what data are we relying on to continue in New South Wales—against the trend of the entire world?

**Mr RYAN PARK:** Mr Ruddick, in relation to clinical operations I'd have to ask the department for advice on that.

**ELIZABETH WOOD:** Mr Ruddick, we are participating in what will be the NHMRC outlines that will come through. We're expecting them, I think, mid this year, in terms of the early advice in this space. I think it's important to note that our consent guidelines for this actual treatment are some of the most robust in the country, if not internationally. We have to absolutely at all times have a diagnosis of gender dysphoria achieved from the multidisciplinary team review. The young person themselves and the parents have to consent to that treatment. If

the child is under 18 and they are of Gillick competence, then the consideration has to go before the NCAT, if that's to be considered the treatment, which would be a special medical treatment.

**Mr RYAN PARK:** Mr Ruddick, you would know we did the Sax review, just as an overarching check that what we were seeing at a point in time was matching overseas, but that doesn't mean it's not a contested space, so I take your point.

**The Hon. JOHN RUDDICK:** I'm glad you mentioned the Sax Institute's review, which they conducted first in 2020, and then I think you commissioned one and they reported back in 2024. The Sax Institute found that puberty suppression treatment is still safe, reliable and reversible—this was just two years ago. In New York in the United States, just in January this month a psychologist and surgeon was found liable for malpractice after they supported and performed breast removal surgery on a 16-year-old girl who at the time identified as transgender. That lady's name is Fox Varian. She has just won a $2 million lawsuit against the surgeon and psychologist. Do you think these types of legal actions are going to become a thing in New South Wales?

**Mr RYAN PARK:** I can't comment on specific legal actions, nor do I want to hypothesise about future legal actions, other than saying that in this area of health care—I know this Committee well enough to know that we are being sensitive—we need to be very careful and sensitive in our commentary because, having met with patients and families in this space, it can be a very difficult time for them. I just want to make sure that we exercise, during this discourse, an appropriate level of decorum. What I'm going to say is that the treatment we provide is evidence based and age appropriate. It is designed to make sure that we are giving the very best care to the person at the appropriate time. Not every patient goes down a path of puberty suppression or hormone treatment. That's not the case. Nor do I want the Committee to think that, after one appointment, a person can just walk out with a complete barrage of drugs and things like that. There's often a multidisciplinary team, because this is a part of health care that is not just clinical in nature; there is also a large psychosocial element.

**Ms CATE FAEHRMANN:** Minister, do you or the department have the annual data for blood lead levels in Broken Hill for 2025 yet?

**KERRY CHANT:** Can I just check and I'll get back to you?

**Mr RYAN PARK:** I haven't seen it, but I'm not saying we don't have it. We could.

**Ms CATE FAEHRMANN:** That's undertaken annually, as I understand it. The reason I'm asking—I'm obviously very interested to see—is I did an extensive call for papers, again, which came in early this year. That included a couple of drafts from the Office of the Chief Scientist and Engineer's report into blood lead levels in Broken Hill. The notes around discussion points and site visit themes does say that—and you can see it in the data over the last couple of years, in fact—there was a drop in blood lead levels over 2020-21 but they've now increased and they're plateauing. The office has said that one of the reasons is many programs have ceased, including health programs. It also says—I'm just wondering about Dr Chant's take on this—that Health has indicated there has been a higher presentation rate of complex positions to ED based on blood lead levels. Do you have any more information about that, firstly?

**KERRY CHANT:** Yes, probably just to say that Health—and I want to acknowledge the work of the local teams involved. There has been a lot of work on the ground, and we've actually taken an opportunity to look at how we can further strengthen it. I'd like to welcome the chief scientist's report, and I've read it. What we're basically doing is making sure that we're embedding the lead messaging throughout our programs. There's also some new funding that has been provided to support—it's called "SNF Plus", which my colleague Elizabeth Wood's area has done—families that have vulnerabilities.

**Ms CATE FAEHRMANN:** Sorry, what was the acronym?

**ELIZABETH WOOD:** Sustaining NSW Families.

**KERRY CHANT:** We're embedding the lead program within all of our early childhood programs, and there has been some new funding to expand our early childhood footprint in the Far West. We're very much looking at an integrated model. We're also strengthening our engagement with Maari Ma, and I note the chief scientist's report also says we can do better in the way we present the data. I think he's very much interested in having a little bit more contextual information, and the message that we need to be more guided in our remediation. Health has committed to those. We've reviewed the report and we're initiating those actions.

**Mr RYAN PARK:** I don't have that data. I had a look through mine, just in case I had it in my material.

**KERRY CHANT:** I can confirm that the latest report is 2024, and I'll get an update on when the 2025 will come.

**Ms CATE FAEHRMANN:** I've got the 2024 report. Minister, are you putting in for funding from next financial year's budget for more money to be allocated to NSW Health, and lead programs in particular in Broken Hill?

**Mr RYAN PARK:** We are looking at providing dollars to Maari Ma to make sure that that program, which I value, can continue on.

**Ms CATE FAEHRMANN:** Additional?

**Mr RYAN PARK:** I don't know additional. I know that there is a period of time—I'm going to say in about 12 months—where that grant expires. I say 12 months—I'm talking financial years, just so everyone's clear. I want to make sure that that is an ongoing program, because I think it does good things and has worked well. I want to make sure that funding is secure—what I'd loosely call medium to long term. I just don't know the dollar amounts yet, and what's coming back, Cate.

**KERRY CHANT:** Ms Faehrmann, just to say that the office of the chief scientist's report has just been finalised. There is a whole-of-government process to consider it. As you are aware, in the report a lot of the suggested actions, particularly the zonal remediation, fall within more whole-of-government initiatives. I can just say that we've had multiple meetings and the teams in Far West are very committed to supporting the additional needs that are required to support our part of this problem, but really acknowledge that it also is the whole of government in that processes are yet to go through.

**Ms CATE FAEHRMANN:** The proportion of children tested—recognising that not all of the kids in Broken Hill are tested—with levels above five micrograms per decilitre rose from 32 per cent in 2021 to 43 per cent in 2023. For First Nations kids, this increase was even greater, from 51 per cent to 74 per cent over that same period.

**KERRY CHANT:** I'm sorry, Ms Faehrmann, I haven't got that data in front of me. Could I just call it up so that I understand where you—

**Ms CATE FAEHRMANN:** Sure, but just let me continue with the question. It is clear that the data is showing an increase. The question is, Minister—just continuing the same funding is not going to bring different results. I don't think it's satisfactory for anybody—surely you, as Minister—that kids in Broken Hill have that level of lead in their blood, so why isn't more funding being put in? It's a tiny, piddling little amount, to be honest, with respect.

**Mr RYAN PARK:** Cate, I'm happy to have a look at more funding. I suppose what I've focused on at the moment is just making sure that there was an adequate pipeline of funding going forward, given that this phase of the funding is due to stop, I'm going to say, mid-2027. I just wanted to make sure that that service, which I think is doing excellent work, had a continuation plan. I am happy to have a look at additional dollars in that particular space.

**Ms CATE FAEHRMANN:** I am aware of the stopgap measure. Really, that's what it was. With respect, I do understand the Far West Local Health District and the good people at Maari Ma and the EPA really want this to continue. But they're frustrated, as well. Has NSW Health recently changed their protocol around blood lead level notifications? Has something happened late last year so that, if pathology labs get blood lead levels over five—have you changed something or got a new arrangement with SafeWork, Dr Chant? Or would you need to find that out?

**KERRY CHANT:** My understanding is we've updated the lead guidelines, but I'll have to get back to you in terms of that. I'm not aware of any particular change. We certainly have an arrangement with SafeWork so that occupational exposures are managed with SafeWork. It's really important that we address those occupational exposures, as well.

**Ms CATE FAEHRMANN:** I'll come back to that in the afternoon.

**The CHAIR:** I wanted to come back to the previous line of questioning around Albury Wodonga Health. I'm pleased to hear that you're aware of some of the issues, Minister. You said that because of the governance arrangement, it's not for New South Wales to directly get involved in. What is your understanding of the intergovernmental agreement that governs Albury Wodonga Health, and what opportunities for leverage do you have on behalf of the tens of thousands of New South Wales residents that rely on this health service?

**Mr RYAN PARK:** We do a lot of their funding, so we certainly want to have a say in how it's managed. It's a Victorian public health service, and it's responsible directly through that, but there is a cross-border Victorian service. It's managed under Victorian legislation. We retain joint funding responsibility. AWH then provides funding directly to the Department of Health in Victoria as the system and performance manager. This

arrangement, as you touched on, is governed by the intergovernmental agreement—which is 2022-2035—in relation to the provision of services in that area. Under that agreement, Albury Wodonga Health is managed in line with Victoria legislative and policy requirements, and applies New South Wales policy when New South Wales policy is required to comply with New South Wales legislation. It's a key service in the region. It provides acute and subacute mental health services. As you know, the area is also serviced by private and community rehab and mental health services.

**The CHAIR:** In this context, where the senior medical staff association has overwhelmingly voted no confidence in both the current CEO and chair of the board, is that IGA arrangement sufficient to allow New South Wales to influence what's happening, or does that need to be re-evaluated?

**Mr RYAN PARK:** I think you can take from the fact that I've asked our most senior Health official in the secretary to engage directly with the service down there as an indication that we think there can be improvements in relation to the culture and the way in which management deal with issues. I'm not going to get into individual cases, because I would never do that—respectfully, that's a person's private workplace business—other than to say that I asked the secretary, and the secretary and I have had a number of discussions about this. I know the member for Albury has also raised this with me, as you have, Dr Cohn. I wanted to give it the priority by asking the Health secretary to go down—she had to do it virtually—to attend to that. Those discussions are ongoing.

**The CHAIR:** Ms Pearce, I'm pleased that you've kept the commitment you made to the Committee in December to engage with Victoria on this.

**SUSAN PEARCE:** Of course.

**The CHAIR:** You mentioned, or I think Mr Sloane mentioned, other groups that you're meeting with in addition to the Albury Wodonga Health executives themselves. Can you tell me who those people are—or who those groups are, not individuals?

**SUSAN PEARCE:** Yes. Mr Sloane will provide that list. But just to cap off that last question to Minister, as I said at the start it is very important to us that we engage with Victoria health on this. Yes, there is an intergovernmental agreement that substantially deals with the funding arrangements between the two States, and there are various comings together between New South Wales and Victoria in respect of those processes. We've probably intervened more than we otherwise would in an arrangement like this, because we do need to be respectful of the fact that Victoria health manage that facility. In the same way that if another State was coming into New South Wales management of a facility, I would want to make sure that that was a collaborative approach. Certainly, the health secretary in Victoria is well engaged in this process. That has been our undertaking. We have given the Committee that commitment and we've lived up to that commitment. Luke, can you provide the list? In addition to that, I know that Mr Sloane has also spoken to the Nurses and Midwives' Association about an opportunity to engage with them. Luke, do you want to talk about who we're seeing on Thursday, please?

**LUKE SLOANE:** These are all based on representations that've been made directly to the secretary. There is the Border Medical Association and Albury Wodonga Health Senior Medical Staff Association, which I understand is a group that has been formed by people who were previously in the medical staff council but have formed a separate group. We've got the Wodonga Council and Albury City Council representatives as well, and representatives from Better Border Health. Then we've also got a representative from the medical staff council. As the secretary has just said, I have contacted the NSW Nurses and Midwives' Association to ask them for the most appropriate branch member for Albury Wodonga Health to provide representation, as well.

**The CHAIR:** Ms Pearce, you mentioned in your earlier answer that your discussion with the organisation had included the capital plans for the future. Are you able to provide any more detail on that?

**SUSAN PEARCE:** It was more about the process, as opposed to the substance. Noting that we've referenced the special commission of inquiry already today, you'll note in there also there is a recommendation that's been accepted with regard to statewide clinical service planning. We touched on that last week with the chief executive and the board that we would ongoingly, as part of the process, look at how we better approach statewide clinical service planning. It will clearly be important for us to consider Albury in that into the future. Our capital planning horizon, Ms Skulander can comment on, but obviously there are stages, as you well know, in regard to these, and we require a process to be put in place. It was really more about how that process works in New South Wales as opposed to talking about specifically what next, if that makes sense. Emma, did you want to add anything to that?

**EMMA SKULANDER:** Yes, just to note that ordinarily in our capital planning processes, the clinical services plan will outline the service requirements that then we're looking for capital to support. In all of our redevelopment projects, particularly at the moment, we have had to prioritise scope within that, and what it leaves

is a list of priorities that can't be funded by the redevelopment funding at that point in time. That will often go through another capital cycle to seek funding to be applied to that as it's determined to be a lower priority to the first scope that gets into the first build. This process with Albury-Wodonga would not be dissimilar within New South Wales in the clinical services planning information and, referencing Susan just there, making sure that that is up to date and in line with the rest of our State planning processes.

**The CHAIR:** That process you've just outlined where things can be, I suppose, added back in, is that what happened with Shellharbour Hospital? I understand the helipad got added back in during the Kiama by-election after the concrete pours had already started.

**EMMA SKULANDER:** In all of our capital planning cycles, ultimately the information gets collated and prepared as a recommendation and it becomes a decision for government as to what is prioritised within that. The district itself will put forward recommendations. Sometimes those recommendations will need a government decision of the funding if it doesn't work within the funding envelope. That is a standard process.

**The CHAIR:** I'll come back to that this afternoon.

**The Hon. SUSAN CARTER:** Minister, you'd be aware that NSW Health has a range of programs and services for children from zero to 17 who've displayed or engaged in problematic or harmful sexual behaviours?

**Mr RYAN PARK:** I probably haven't had a direct interface with that, but I imagine it's in our sort of stronger communities and families type of support. I'd probably need a little bit more information.

**The Hon. SUSAN CARTER:** Safe Wayz program is for children zero to 10. Do you know what the waiting list is for that program?

**Mr RYAN PARK:** No.

**The Hon. SUSAN CARTER:** Could you take it on notice?

**Mr RYAN PARK:** I can take it on notice. Unless—

**The Hon. SUSAN CARTER:** I'm happy to get it later. The New Street Services program is for children 10 to 17. Minister, one of NSW Health's own experts Dr Dale Tolliday gave evidence to the Legislative Council inquiry into the effects of harmful pornography last year that children and young people under the age of 18 are responsible for at least half of the abuse on young children. Is it important that these programs are properly resourced?

**Mr RYAN PARK:** Yes. I think the exposure to pornography by young people, particularly young boys, is something that concerns me as a legislator, but it also concerns me as the dad of a teenager. This is a trend, probably in recent times, when the access to that type of violent sexual behaviour is a concern I think—I'm going to say—for all of us as legislators and for the community. That remains a concern.

**The Hon. SUSAN CARTER:** We got clear evidence that this was one of the reasons for the rise in child-on-child and young-person-on-child sexual assault.

**Mr RYAN PARK:** That could be the case. I'm just not 100 per cent sure.

**The Hon. SUSAN CARTER:** Dr Tolliday indicated in his evidence that neither the Safe Wayz program nor the New Street Services program, those programs that are specifically targeting children who exhibit problematic or harmful sexual behaviours, "can come close to meeting the demand for services at the moment". He said further "that waiting lists are not kept at those services". What are you doing to resource these services appropriately?

**Mr RYAN PARK:** I just want to double-check that this is a Health program and not a FACs or communities—

**The Hon. SUSAN CARTER:** They are both NSW Health programs. This is evidence given by somebody from NSW Health.

**Mr RYAN PARK:** Let me take it on notice. If I can get it, as I will always try to do, during the Committee hearing or this afternoon, you'll have it, Ms Carter. I'm just not aware of that specific program.

**The Hon. SUSAN CARTER:** There are two programs: Safe Wayz for the under-10 and New Street for the 10 to 17.

**Mr RYAN PARK:** Apologies, I meant two.

**The Hon. SUSAN CARTER:** In the committee's report, recommendations were made, one of which called on the Government to adequately resource these programs. When the Government's response to the

committee's recommendations was received, it essentially said, "Yes, New South Wales has this all under control," and didn't flag the need for any extra resources. What exactly is your Government doing to support young people with problematic and harmful sexual behaviours and, very importantly, drive down child-on-child sexual abuse?

**Mr RYAN PARK:** Elizabeth?

**ELIZABETH WOOD:** Thanks, Ms Carter. We will get some further information about the specifics of those programs.

**The Hon. SUSAN CARTER:** Perhaps we can come back to that later this afternoon. That'd be great, Ms Wood.

**ELIZABETH WOOD:** Yes. But I would like to just say that we have—

**The Hon. SUSAN CARTER:** I look forward to talking to you then.

**ELIZABETH WOOD:** NSW Health led the development of *Children First, 2022 – 2031*.

**The Hon. SUSAN CARTER:** Great. I have limited time with the Minister, Ms Wood. We can talk later today.

**ELIZABETH WOOD:** No problem.

**The Hon. SUSAN CARTER:** Minister, a service plan for people with eating disorders, where are we with that? Will there be a new one that's prepared?

**Mr RYAN PARK:** I'd have to take some advice on the currency of that.

**ELIZABETH WOOD:** I can take that. Ms Carter, we are in the process of considering the evaluation and the next steps that need to occur for that work.

**The Hon. SUSAN CARTER:** When will the evaluation be finalised?

**ELIZABETH WOOD:** I don't have a date, but we can certainly come back to that today.

**The Hon. SUSAN CARTER:** In the interim, who's responsible for managing services for people with eating disorders?

**ELIZABETH WOOD:** It continues as is, Ms Carter.

**The Hon. SUSAN CARTER:** On an LHD-by-LHD basis?

**ELIZABETH WOOD:** With statewide oversight, correct.

**The Hon. SUSAN CARTER:** Who's responsible for the statewide oversight?

**ELIZABETH WOOD:** It sits within my division but also within the mental health branch.

**The Hon. SUSAN CARTER:** I have some more questions. We'll come back later today.

**Mr RYAN PARK:** Ms Carter, it's largely led through the mental health service. I'm happy to get back to you, but I just want to take some advice from Minister Jackson as well.

**The Hon. SUSAN CARTER:** Sure. Is there a separate mental health budget or does it come out of the health budget?

**Mr RYAN PARK:** There's a mental health budget that is a part of the health budget that Minister Jackson ably manages. I know this space falls within that broadly. It's not that we won't come back to you, we will, but I just want to take some advice from Minister Jackson and her team as well.

**The Hon. SUSAN CARTER:** Of course. Minister, do you think that there are ever any issues that arise with the mental health budget sitting inside the larger health budget? There are so many competing priorities in mental health that something as important as eating disorders may have to fight for funding with other mental health needs.

**Mr RYAN PARK:** I think former Minister Taylor, when she was the mental health Minister, and Minister Hazzard were, from all accounts, able to work through those priorities and challenges.

**The Hon. SUSAN CARTER:** Are you confident you're doing that?

**Mr RYAN PARK:** Yes. I engage with Minister Jackson very frequently. She probably doesn't enjoy it as much.

**The Hon. SUSAN CARTER:** In terms of the need for provision for people with eating disorders, are you aware of the comparative death toll in Australia of people from road traffic accidents and people with eating disorders?

**Mr RYAN PARK:** Not compared to that dataset. I don't have that line of sight.

**The Hon. SUSAN CARTER:** More people die of eating disorders than in road traffic accidents. Is the funding anywhere near comparable? I'd be really happy if you take it on notice. I can tell you what the answer is: It's not.

**Mr RYAN PARK:** Then you probably didn't need to ask the question.

**The Hon. SUSAN CARTER:** It's time for action, Minister, is what I'm suggesting. On another matter, Minister, you'll recall the testimony of Ms Ludford at the budget estimates hearing of 2 December. Do you recall the letter that I wrote to you on 4 December in relation to that testimony?

**Mr RYAN PARK:** I have some corro from you recently that I was reviewing.

**The Hon. SUSAN CARTER:** It was sent on 4 December, Minister. I understand that you're busy. When can I expect a reply?

**Mr RYAN PARK:** No, I recall it. Just give me the topic.

**The Hon. SUSAN CARTER:** Ms Ludford's testimony on conscientious objection. I can give you a copy.

**Mr RYAN PARK:** No, I remember it. I've also had a chat to Mr Donnelly about this.

**The Hon. SUSAN CARTER:** I'm pleased you spoke to Mr Donnelly. I'd love a reply to my letter from you, Minister.

**Mr RYAN PARK:** I know that, but let me tell you that that right remains. That's an important part of health care. We understand that. We expect our department to follow both employment law and follow the Abortion Law Reform Act. That's what I understand. I think a response either has been or is being sent to you. I read your corro, Ms Carter. Don't worry about that. I just want you to know that.

**The Hon. SUSAN CARTER:** In the letter I invited you to communicate with the LHDs to make sure that they were not drafting employment descriptions or employment positions in such a way that anybody with a conscientious objection would be unable to apply for those positions. Have you done that, Minister?

**Mr RYAN PARK:** I'm not saying that I have personally done it. But I just want to say this about it, because it is important for me: My expectation is that they follow industrial and employment law. They are also, in the delivery of their duties, following other legislation including the abortion law amendments. That should be all of our expectation, but does anyone want to add? Fatima?

**FATIMA ABBAS:** I can address that, Minister, thank you. We are in the process of reviewing the policy directive to ensure that we can provide advice to the districts about how to deal with these issues.

**The Hon. SUSAN CARTER:** Sorry, which policy directives?

**FATIMA ABBAS:** We have a policy directive around conscientious objection and we want to make sure that that aligns with the legislation, so we will be issuing some direction on that.

**The Hon. SUSAN CARTER:** Is there any issue that the existing directive doesn't align with the legislation?

**FATIMA ABBAS:** No, I think we just want to provide some clarity just to make sure that people are making the appropriate decisions and, as the Minister said, making sure that we're compliant with employment law.

**The Hon. SUSAN CARTER:** Clarity about what issue exactly?

**FATIMA ABBAS:** As the Minister indicated, we want to make sure that when people are writing position descriptions or advertising roles that we are really clear about these issues.

**The Hon. SUSAN CARTER:** So that they're really clear that it's illegal to discriminate on the basis of belief or conscience?

**FATIMA ABBAS:** That's correct. We will reinforce those obligations in our communication.

**The Hon. SUSAN CARTER:** And that Parliament was recently asked to reconsider the issue of conscientious objection in the Abortion Law Reform Act and quite conclusively decided it did not wish to do that?

**Mr RYAN PARK:** We aren't changing the conscientious objection component. It's an important part of that. We respect that. What I'm saying to you—I'm trying to be as clear as possible—is I expect the CEs, when they're doing these positions, to make sure that it is following legislation. That legislation is both industrial/employment as well as existing legislation. We are doing a policy directive review that I have touched base with Mr Donnelly on. I just checked with my office, Ms Carter, I think you'll—

**The Hon. SUSAN CARTER:** Just a note, Minister, it's lovely you're talking to Mr Donnelly but—

**Mr RYAN PARK:** I hadn't finished, but I just wanted to say that I understand a response has gone out to you in relation to that corro. I wasn't being—

**The Hon. SUSAN CARTER:** The Shepherd Centre and NextSense, Minister—this was raised at the last budget estimates. You'd be aware that it's wonderful when children get a cochlear implant. It can open the world to them, but they need to be taught how to use it and that's where Shepherd Centre and NextSense come in. About 750 New South Wales children look to that program every year and they look to you for funding. Has there been a decision made yet about continued funding?

**Mr RYAN PARK:** No, but I am aware of the issue and I'm working through it. I've met with both of them. I think I also had a chat with, and I'll stand corrected on this, former Prime Minister Mr Howard, who I think is involved in NextSense, but I'll rely on others to tell me that. I've had a discussion both within my own community with Shepherd Centre and broadly, centrally, we are working through what I would call all of the budget priorities and issues to date. We haven't landed on a decision around that. Let me assure you that I'm cognisant of the work they do. The work they do is important. As former Minister Mitchell knows, in big portfolios there are big priorities everywhere. All of them are important. We've just got to make sure that we can deliver the very best possible services for the allocation of funds that the community provide the portfolio.

**The Hon. SUSAN CARTER:** Are you aware that the Government of Japan was so impressed by the work that NextSense and Shepherd Centre do, they reached out directly because they want the service that they provide to New South Wales to be offered in Japan? They are funding them to offer them in Japan. Shouldn't New South Wales children have the same opportunities as Japanese children?

**Mr RYAN PARK:** They have been having those opportunities. I think from one of my discussions, I actually recall that piece of information. Though it's a lot of information in my head at the moment, so I'm just making sure that is accurate. I do remember Shepherd Centre, I think it was, may have informed me around the work they are doing with Japan. We've also, as you know, Ms Carter, got a world-class health system. It stands the test against any other health system in the world when we do comparatives with our health system to other health systems. If you're going to be getting treated in a system, then New South Wales is by far and away the best in this country, by the length of the straight. It is one of the best in the world. Not perfect, a lot more work to do, a lot of improvements still to be made, but it is still a very strong, robust and effective health system broadly.

**The Hon. SARAH MITCHELL:** Minister, just back to regional maternity. Can you tell me how many times Tamworth Hospital has been on bypass for maternity services in the past 12 months?

**Mr RYAN PARK:** No, I don't think I can say.

**The Hon. SARAH MITCHELL:** Could you take that on notice, maybe?

**Mr RYAN PARK:** Yes, I will. Sorry, Tracey McCosker from the—

**The Hon. SARAH MITCHELL:** I can come back to that this afternoon. I'm after Tamworth, Inverell, which perhaps Ms McCosker might be able to help with this afternoon, but also Griffith hospital as well. If you could take that on notice and come back, Minister, that would be great.

**Mr RYAN PARK:** I've got advice here that I want to just clarify that it has not been on bypass in 2025. This is Tamworth, sorry.

**The Hon. SARAH MITCHELL:** At all in 2025?

**Mr RYAN PARK:** It has not been on bypass; however, transfers to alternate or higher level care are made when necessary. That includes to Armidale and John Hunter, that's for specialised maternity and neonatal care when unexpected workforce shortages occur. That was an MGP. I'm not sure if you're aware of this, but that was a midwifery group practice that I think was suspended under the former Government in 2022.

**The Hon. SARAH MITCHELL:** If you could just take on notice Tamworth, Inverell, Griffith and what you can provide me about each of those three, that would be great. In relation to how many maternity services

have closed, there was information to the parliamentary select committee I think that talked about issues at Muswellbrook, Parkes, Cootamundra, Milton, Ulladulla, Gunnedah and Woy Woy. Do you know how many of those services in the three years since you've been Minister have ceased to provide that maternity option for local families?

**Mr RYAN PARK:** I'll answer this question broadly because I want to make sure I give the accurate information. I've been looking at this. One of the things that I've been working with Luke Sloane and my team on, to be blunt, is trying to provide more birthing services as close as possible to home as we can. That was a big issue coming out of the regional and rural health inquiry.

**The Hon. SARAH MITCHELL:** And it's just a big issues for families, Minister.

**Mr RYAN PARK:** I was going to say, members like yourself, with the greatest respect, have raised that with me. I've said to NSW Health that the risk here is a two-sided coin. Yes, it is a risk if we can't provide the level of maternity services that we need and are sustainable. But, yes, it's also a risk if women drive 200 kilometres—I'm making this up—to try and access health care. What I know is that the Opposition, or the Coalition, closed or suspended 14 regional birthing services.

**The Hon. SARAH MITCHELL:** I'm asking about the last three years though, Minister, to be fair.

**Mr RYAN PARK:** Glen Innes, Muswellbrook, Wyong, Gloucester, Milton, Bourke, Casino, Manilla, Wee Waa, Bellinger River, Ku-ring-gai and Narrandera and suspended Parkes in 2019 and in 2022. We opened eight new regional MGPs at Cooma, Glen Innes—

**The Hon. SARAH MITCHELL:** I'm not asking about midwifery group practice, with the greatest of respect, Minister. I just want to know, and I'm happy for you to take it on notice, since March 2023 how many maternity services have closed. If you want to come back to me, or maybe I can go to Mr Sloane this afternoon on that?

**Mr RYAN PARK:** My understanding is that zero have closed in the last three years.

**The Hon. SARAH MITCHELL:** You're saying patients are getting the same access to those services now that they were three years ago? Is that your evidence?

**Mr RYAN PARK:** I'm actually probably saying, in some areas, that they're getting better through our MGP and the homebirthing units.

**The Hon. SARAH MITCHELL:** I'm not talking about MGP. That's not appropriate for every patient, Minister.

**Mr RYAN PARK:** I'm just saying in relation to maternity care and birthing care, what I'm saying is that we've opened eight new MGPs and we've opened two homebirthing on the Central Coast and Maitland.

**The Hon. SARAH MITCHELL:** Have you opened or reopened any regional maternity services in the last couple of years in hospitals specifically? Not MGPs, not homebirthing.

**Mr RYAN PARK:** Of the ones you shut?

**The Hon. SARAH MITCHELL:** I'm asking have you opened any new ones?

**Mr RYAN PARK:** But you shut 14.

**The Hon. SARAH MITCHELL:** Minister, I'm asking how many have been reopened. I think Queensland are on track to reopen another two. I'm just wondering whether that's happening in New South Wales.

**Mr RYAN PARK:** I need to get some advice. I suppose what I'm trying to say is that we've expanded some of these services in the way that I've said. I'll take that particular part on notice.

**The Hon. SARAH MITCHELL:** If you take it on notice, that would be great.

**Mr RYAN PARK:** But you might also know, and the Committee might also be aware, that we've increased the nursing and midwifery workforce in regional New South Wales by about 2,400, give or take, which is about a 9.4 per cent increase from the previous Government. That's a substantial increase in midwifery and nursing for what is known as rural and regional New South Wales, which is a number of LHDs.

**The Hon. SARAH MITCHELL:** In relation to the Chief Midwife role that you announced in August 2025, coming out of the birth trauma inquiry, has somebody been appointed to that position as yet?

**Mr RYAN PARK:** We're about to announce that position. I don't want to probably do that—

**The Hon. SARAH MITCHELL:** I'm not asking for an exclusive today—that's fine—but is it imminent?

**SUSAN PEARCE:** The answer is yes.

**Mr RYAN PARK:** I don't mind if you do.

**The Hon. SARAH MITCHELL:** I'm sure you can put out a press release. It will be welcomed, Minister.

**Mr RYAN PARK:** It's an important position, and the sector has been calling for it.

**The Hon. SARAH MITCHELL:** Absolutely. It's been about six months since it was announced, so I'm wondering about the implementation. In terms of a broader monitoring plan for maternity services in rural and regional areas—and you've spoken about MGPs and homebirthing—is there a document, an implementation plan and how you're going to manage what success looks like for rural and regional families under your watch? You're talking about different models that are available, and I agree midwifery group practice is great for some patients but not everybody. What is the way that you will be evaluating success when it comes to the delivery of these services in rural and regional communities and for these families?

**Mr RYAN PARK:** There's probably a couple of elements. The $83 million package that we put in place includes about $44 million or $45 million for about 53 FTE midwives in rural and regional locations. I will want to see as many of those rolling out as quickly as we can. So that is one element—what I'd call boots on the ground. There is around about $27 million, give or take, for family care centres and mobile services and in the northern part of the State—I think it's around Macksville—a residential unit. Then there is, obviously, the MGPs and the three homebirthing services. Over time, what I will want to see is a couple of things: those measures implemented and then the improvements for women to give birth as close to home as they possibly can and, in doing so, reduced birth trauma that the inquiry highlighted, and regional and rural members like you have spoken about over a sustained period of time. They're probably the metrics that I will want to see delivered on.

**The CHAIR:** Minister, I've got a couple of questions about the pharmacy trial, particularly the expansion of management of—

**Mr RYAN PARK:** Is this scope of practice?

**The CHAIR:** Yes, pharmacists prescribing treatment for uncomplicated UTIs and oral contraceptive pills. It's my understanding that that trial was extended or became permanent while the evaluation was still underway. I've asked about this previously and been told that the University of Newcastle's independent evaluation would be provided to Government in 2025. It's now March 2026. Why haven't you published that report?

**KERRY CHANT:** I can speak to that. There was a component of the study which involved aspects of economic analysis. There was a cost-benefit component to the study. There was feedback on some of the underlying assumptions to that that needed to be amended. That is being undertaken, and so we aim to have that out as soon as we can. It was really not around the clinical data or the safety data; it was really around the economic methodology.

**The CHAIR:** When you said that needs to be amended, who was saying that it needed to be amended?

**KERRY CHANT:** The issue was the universities had made some certain assumptions around the fact that people—this was not being subsidised under, say, MBS or PBS, and so there was some factoring in of the cost to the patient that needed to be adjusted. That work has been done and it will come back. When we reviewed it, we noted some of the assumptions underpinning the economics. We then had an interaction with the economists that had done the health economic component of it, and they agreed that they needed to amend that.

**The CHAIR:** Is that your standard process when you disagree with assumptions—that rather than having a dialogue in public, you're asking providers of an independent academic publication to amend their findings?

**KERRY CHANT:** I'm happy to take them offline, but there were very clear misunderstandings. It's not anything that we wouldn't be able to put out there, but it was clear comments around some factors that were not incorporated because that information had not been provided in that form. I'm very happy to be transparent also about what that dialogue was and the comments—nothing concerned at all here.

**The CHAIR:** I appreciate your suggestion around some transparency. I think it would give the public a lot more confidence in the findings to understand what—

**KERRY CHANT:** What changes.

**The CHAIR:** —amendments were made and why.

**KERRY CHANT:** I'm happy to do so.

**Mr RYAN PARK:** Dr Cohn, in the scope of practice, it is an important part of work that we are doing, because we need to make sure—for instance, GPs, with ADHD, is an important part of the way in which we deliver health services. My preference, to be brutally honest, is to have all our practitioners working at full scope wherever they can, including our paramedics. I get sometimes that's not always feasible. But that's the actual gold standard, because then we're using the skills most broadly and we're able to deliver the services most broadly. That's all.

**The CHAIR:** I understand that, and I understand the pharmacy trial has been largely popular. But many people supported it on the grounds that there was a framework for robust evaluation, particularly around clinical safety. Dr Chant's previously advised me too about a sub-study being undertaken to examine the potential contribution of the trial on antimicrobial resistance. Is that part of the report that you're still sitting on as well?

**KERRY CHANT:** Just to be clear, we're not sitting on the report. We've just done the fact check of the report and there are some issues and underlying assumptions, but I'm happy to brief you. When we publish the report, we can be very clear about the areas of feedback that were provided. They weren't around the clinical safety. But I'll get an update on that sub-study, the antimicrobial.

**The CHAIR:** I'm changing topics completely, in my remaining time, to heatwaves. The new heatwave emergency sub-plan makes Ambulance the combat agency for heatwaves, which is an excellent change. I was certainly someone who previously banged on about the fact that you can't arrest a heatwave; this is obviously a health issue. Heatwaves kill more Australians than any other kind of disaster. We know that the impact of heatwaves disproportionately impacts older people, people with chronic complex medical conditions and people living alone, so there are particular vulnerable populations. What's being done to support those at-risk individuals during heatwaves?

**Mr RYAN PARK:** I'll get Dr Morgan in a moment. What we try to do is a lot of our messaging at that point in time is around making sure that individual community members who have vulnerable people within their family sphere or within their street or their own community are aware to check on them. For instance, in my own community, I've got older parents who I just wanted to make sure were doing the things that we were recommending—staying indoors, dropping the blinds, making sure they're not exercising in the middle of the day. I didn't want my father mowing the lawn in the middle of the day. Things like that we have been trying to do, and making sure when we responded as an ambulance system that we were responding in a way that tried to actually keep people out of the emergency department, but did it in a way that we could stabilise them. Often that's through shade, water and making sure their body temperature is coming down. Commissioner Morgan?

**DOMINIC MORGAN:** I appreciate the question because, yes, it is quite groundbreaking. We're only the second ambulance service in the country to become the combat agency for heatwave. Importantly, this is going to be an iterative process for whole of government. If you've had a look at the heatwave plan, at this point it goes to great lengths to be clear about what it's not. For example, it's not looking after climate change and it's not doing urban planning. But what it does do in its first iteration is really look at public messaging. Certainly we're well geared up for that.

In the last season we put out 21 advice-level warnings based on the BOM information, and 11 watch and acts. The next important piece of work is really about these vulnerable communities that you're touching on—our culturally and linguistically diverse community and certainly the elderly and infirm at one end of the spectrum, the medically ill at the other end of the spectrum, and obviously, disproportionately, young children are affected. So we've sort of started with the bits that we can do with general public messaging. The second body of work for the organisation is now how do we actually get into these key groups that the literature clearly tells us are vulnerable. It's a work in progress is the answer to your question.

**The CHAIR:** Minister, in South Australia and Western Australia, those State governments fund a service delivered by the Australian Red Cross which is an outreach service to those vulnerable groups. Are you aware of that program? Are you considering something similar in New South Wales, whether that's run by Ambulance directly or contracted out?

**Mr RYAN PARK:** I'm not aware of it, but Commissioner Morgan may very well be.

**DOMINIC MORGAN:** There have been representations around this. There's a whole range of public health initiatives that actually can be brought into effect. You're probably also aware of cooling centres around councils et cetera. This is another program. The reality is that at this time there is no specific budget for additional initiatives beyond public messaging, which we're doing.

**The CHAIR:** I suppose my question is then back to the Minister. If there's no specific budget beyond public messaging, coming into the next budget, will you be advocating for specific programs to support those vulnerable cohorts during heatwaves?

**Mr RYAN PARK:** I'll have a look at it, without a doubt. I've always been very transparent about this. I've got a range of priorities and I've got to make sure that taxpayers are getting the very best value for money around all the programs we do. I'm happy to have a look at it as a part of the mix, absolutely. That doesn't mean it will result in a funding allocation.

**KERRY CHANT:** Dr Cohn, I know I'm telling you what you know, but a lot of the prevention activities—we know that people with chronic disease are more adversely affected. A lot of the acute impacts of heat manifest over the weeks after a heatwave position, tipping people over who have got physiological vulnerabilities. By creating a healthier population, they will be more resilient to those threats. Government settings in relation to affordable energy, mitigants in relation to cooling places and a lot of the stuff we're doing around addressing mental health, wellbeing and other things will also play a part in this. Just to let you know, even though there may not be a dedicated bundle, we are weaving this into a lot of the programs we're running.

**The CHAIR:** Dr Chant, I suspect this question will get flicked to you. I understand that in New South Wales, the heatwave emergency department data doesn't capture people who are seeking emergency care because of exacerbations of their underlying chronic conditions; it only captures people whose sole or acute presentation is heat related. In other States—again, South Australia has done a report where they quantified heatwave impact by comparing periods of heatwave with other periods. What is the barrier in New South Wales to us being able to report data in that way?

**KERRY CHANT:** We have done that piece of work historically. Basically, that requires algorithms and agreeing on the science, because it's really around the attribution effect, and it's complex modelling. We have done that. We're actually doing a piece of work now that is looking at the feasibility of that and the utility. Does it tell us anything new? Do we need to do it on an ongoing basis or do we do a more in-depth study? We're looking at that as we speak.

**The CHAIR:** Please tell me more about it this afternoon.

**Ms ABIGAIL BOYD:** Minister, when was the last time you received a briefing on the rates of occupational violence being experienced by Health workers in New South Wales hospitals?

**Mr RYAN PARK:** It's an issue that I have talked with the Nurses And Midwives' Association and the HSU about—I can assure you of that—and potentially ASMOF as well. As a formal brief, I don't have that information at hand, sorry.

**Ms ABIGAIL BOYD:** Are you aware of the current rate at which Health workers are experiencing occupational violence?

**Mr RYAN PARK:** No. Fatima?

**Ms ABIGAIL BOYD:** The recommendation—

**Mr RYAN PARK:** Sorry, I'm just making sure if I can answer it now.

**FATIMA ABBAS:** I'll need to take that on notice, Minister.

**Ms ABIGAIL BOYD:** Recommendation 2 of the parliamentary inquiry into violence against emergency services personnel, which was tabled in August 2017, recommended that NSW Health considers publishing data concerning violence against its hospital staff, broken down by hospital. In its response to the inquiry on 8 February 2018, the Government responded with qualified support, saying that it will publish data on physical incidents, but it needs to consider the appropriate way to publish it. There was some concern that if you published it by hospital, that might have an unintended impact on hospital attendance. Instead, the response was that consideration would be given to publishing data at a local health district level, which is broadly consistent with the way that the Department of Education does things. Why has that data never been published?

**Mr RYAN PARK:** Obviously, that inquiry predates my time.

**SUSAN PEARCE:** We would have to take that on notice.

**Mr RYAN PARK:** We'll take that on notice. Fatima?

**FATIMA ABBAS:** No. I'll need to take that on notice.

**Ms ABIGAIL BOYD:** Minister, do you understand the difference between a physical incident and a workers compensation claim?

**Mr RYAN PARK:** Yes. A physical incident doesn't always result in a workers compensation claim. Sorry, I'm not trying to be tricky.

**Ms ABIGAIL BOYD:** No, I would say they're completely different things. In questions I asked last budget estimates, I asked about numbers of physical incidents, which I know get recorded, but the answer that you returned was all in relation to workers compensation information, which doesn't tell me numbers of physical incidents. What I would like to know from you is if I was to put in those same questions again—and there were many of them—will I actually get the data that I have requested?

**Mr RYAN PARK:** If I can provide the data. I'm not trying to hide it.

**FATIMA ABBAS:** We'll take that on notice, if we can provide it.

**Mr RYAN PARK:** I'll be honest with you. I'm glad you raise it, because this issue is pretty important to me because I've been concerned for some time that the behaviour in the community—when Ms Mitchell was education Minister, it was probably similar, that behaviour in the community can sometimes come into schools. Behaviour in the community can sometimes come into hospitals. That behaviour, from my perspective, is worsening—I'll be blunt—particularly with the use of various illicit drugs in the community. It's something that the Health Services Union has raised with me for their members and the Nurses and Midwives' Association has raised with me for them. We're trying to look at ways in which we can better protect our staff. You wouldn't be able to get into most hospitals now without very clear messaging that that type of behaviour is not tolerated and is not acceptable. It's from that point, all the way down to what we do in relation to our security staff and our body-worn cameras. For what it's worth, I hope every Minister is focused on it, to be honest.

**Ms ABIGAIL BOYD:** I asked specifically for data on assaults against NSW Health workers. I was pointed towards workers compensation data in the NSW Health annual report, which, as I say, is not what I was after. I asked for the data by hospital. Given that response in the 2018 inquiry, I also asked for it to be provided at least at local health district level so that we could get a bit of an understanding. Again, Minister, I'm hoping for your assurance that if I put those questions in again, that data can be provided at a local health district level.

**Mr RYAN PARK:** I'm looking at others just in case I don't have a dataset.

**FATIMA ABBAS:** We do collect data globally. I'll need to check if it's available by local health district, but we certainly have the statistics across the health network.

**Ms ABIGAIL BOYD:** That would be very good. Minister, in October last year I wrote to you and the Minister for Work Health and Safety requesting that you meet with an injured worker regarding serious unresolved issues within NSW Health and their management of serious allegations of bullying and harassment within a particular NSW Health facility, which I will not name. A SafeWork investigation into the incident previously identified systemic governance failures, racism and retaliation. My understanding is that following pressure from Health, SafeWork withdrew that enforcement action, which has left critical safety issues at that facility unresolved. I have not had a response to that letter that I sent you. I followed up with your office a number of times. Would you commit to looking into that particular representation?

**Mr RYAN PARK:** It'd be disappointing if you didn't get a response. I read through my corro twice every day—in the morning and in the evening, coming to and going back from home. I would need to check the individual piece of corro. I might, if you are okay, get a copy of the corro that you sent me just to make sure it hasn't been missed or whatnot. My expectation is the same way that I like answers for my community sent back by Ministers or the Parliamentary Secretary. I'll follow it up.

**Ms ABIGAIL BOYD:** You agree that allegations of serious governance failures—racism and harassment and retaliatory action by management against work health and safety complainants—is pretty shocking conduct?

**Mr RYAN PARK:** Across any workplace, racism is abhorrent behaviour. Whenever there is an insinuation that people can't speak up, that is not the health system that I want to be a Minister for and it's certainly not the health system that the secretary drives. In fact, I have seen in private and public forums, on many occasions, the health secretary and the deputy secretaries and the CEOs of the local health district make it clear that we actually want people to speak up. That is how you make a better system. We have never once said we have a perfect system. But, yes, I want a system where people feel that they can speak up.

**Ms ABIGAIL BOYD:** I will pass this document to you before I leave so that you have got it in your hand. In that letter I ask if you will meet with this person. I give you my assurance that she is very well spoken and sets the issues out in a succinct way. Will you meet with her?

**Mr RYAN PARK:** I will have a look at my diary. Let me have a look at the piece of correspondence first. I am sure I would like to meet with someone who has raised concerns like that.

**Ms ABIGAIL BOYD:** I'll move to something different. Nurses have an increasing number of mental health claims and deal with cumulative exposure to multiple psychosocial hazards, but they have what appear to be some of the worst employee assistance program arrangements. Health leaves those arrangements for EAPs up to each individual health district and all of those health districts then provide different numbers of sessions and have different hours of availability. Again, I asked in the last estimates about what those EAPs looked like across different LHDs and facilities, but I didn't get a real answer. I asked about how many sessions and what hours they are available et cetera. Instead, I got that my answer was to be directed to the policy directive, which basically allows them to have whatever EAPs they like. I already knew that. That is why I was asking the question. Would you be able to, if I ask that question again here now, provide me with that information?

**Mr RYAN PARK:** Fatima, are we able to provide some additional information about EAPs?

**FATIMA ABBAS:** I think part of the issue is that we like to provide a range of services that people can access. I don't have the specific details for nurses, but I can come back to you on that.

**Ms ABIGAIL BOYD:** I'm looking for what each LHD has. I can put it back in as a supplementary again so that we are very clear on what I'm asking for. I'm curious about the hours that the EAP service is available for that particular local health district, whether they can access sessions during work time without going through their manager and how many sessions they can access without going through management.

**FATIMA ABBAS:** I'll have to take the details on notice. I'm happy to provide that.

**Ms ABIGAIL BOYD:** Minister, will the New South Wales Government commit to extending funding for the NSW Sexual Violence Helpline to allow it to continue operating beyond 2026, when its funding contract expires?

**Mr RYAN PARK:** I'm sure it is a part of what we are looking at in terms of our budget bids going forward. I know a little bit about that line. I think, from memory, we made an election commitment—I'll stand corrected—around that particular line. Does anyone want to add anything in relation to that? No? Let me take it on notice, Ms Boyd.

**The CHAIR:** Minister, I have previously asked about the Australian Human Rights Commission National Anti-Racism Framework. It contains some really important recommendations that are relevant at a State level, particularly in health. I was advised on notice that a strategy is being developed. Can I get an update on what is happening with that and the anticipated time frame around it?

**SUSAN PEARCE:** I might have to come back to you with some specifics, perhaps, this afternoon. We have been attending a process that the Nurses and Midwives' Association has been running, and the commission is involved in that process. Separately, though, we are developing an anti-racism framework for NSW Health. I can come back to you with the specific timing on that, but that is certainly in the works.

**The CHAIR:** I would be keen to come back to that this afternoon.

**The Hon. SARAH MITCHELL:** Minister, have you had a chance to check in on that Lebanese Muslim Association grant and whether there was a declaration of conflict from Minister Dib?

**Mr RYAN PARK:** Not yet, sorry.

**The Hon. SARAH MITCHELL:** I wanted to raise with you the issues at Gunnedah Hospital with the helipad.

**Mr RYAN PARK:** Mr Anderson has spoken to me about this. Luke, I will probably throw to you in a minute. This was in that it was noncompliant, I think, in terms of the mayor—I think it was the mayor.

**The Hon. SARAH MITCHELL:** Colleen Fuller?

**Mr RYAN PARK:** Yes, sorry. The mayor also raised this with me. There were some issues that I think either pilots or the authority that monitors the standards was talking about in relation to that. Luke?

**LUKE SLOANE:** We know there was an independent report that was done by AviPro, which is an aviation expert, that provided a whole list of recommendations. We also know there was correspondence from the Gunnedah mayor and also from Kevin Anderson with regards to them looking forward to resolving those issues between the LHD and the council as well, including landing fees and associated arrangements for NSW Ambulance to land at Gunnedah Airport as well. The issues are related to the helipad onsite. They are firmly related to downwash, proximity to the building and then other things in close proximity to it, like trees, powerlines, the children's playground. All of those details, to my understanding, are being worked through with very much collaboration between the council wanting to work through with us to restore that.

**The Hon. SARAH MITCHELL:** Minister, from the community's perspective—and I won't name the specifics of the individual—there was an incident a couple of weeks ago where, literally, you see the helicopter circling over town for a really long time. Everyone talks about that. It's a small country town. The helipad, with respect, has been located on that site in the hospital for a long time. There is a playground, you are right, and there is the redevelopment, obviously, that is underway as well. Is there any sort of clarity that you, Minister, can give the community about when this problem will be resolved? It is causing quite a lot of angst amongst members of the community.

**Mr RYAN PARK:** I want to try and get it resolved as quickly as possible. You know me. I am not trying to pass the buck here. There are other requirements in terms of the way in which helipads are governed. I will give you a commitment that, if I can get this issue resolved ASAP with the council, with the local health service and with the authorities, I will do so as quickly as possible. Mr Anderson spoke to me about it and the mayor also talked to me about it. I have had Luke look into this issue. Luke, did you want to update on timeline?

**LUKE SLOANE:** We haven't got a timeline at the moment. It's a case of working through it. The only other thing I would mention is the pilots themselves will make a decision on whether it is safe to land at a helipad or not as part of their guidelines and their reality to function. We will continue to work with the council to make sure it is available and safe, or an alternative is in place. Probably the only caveat I would make is that, whether it is landing out at the aerodrome or landing on that helipad, patients need to be stabilised and clinically suitable to be transferred, and the pilots and the retrievalists always make sure that it is safe to do so with regards to their extrication from the facility.

**The Hon. SARAH MITCHELL:** I have one more on Gunnedah Hospital, Minister. The issues around chemotherapy and renal services were originally included in the scope of works for the upgrade but, as part of rescoping, they got removed. Can you explain why that happened and whether there will be a move to reinstate those services at Gunnedah?

**Mr RYAN PARK:** I'll say broadly—and this is not a criticism of the former Government, and I have been clear about this—that there were big cost escalations in trades, supply and labour that we have had to manage, sometimes upwards of 20 or 30 per cent. We are in a position where, at times, that has meant that we have had a look at the entire scope of individual sites. I know that is not perfect for people, but that is the reality when we see big cost escalations like that. Emma, is there anything that you want to add on Gunnedah specifically?

**EMMA SKULANDER:** No, just that within the available budget, we've maximised the scope we could deliver and prioritised within that.

**The CHAIR:** In my last minute, Minister, there have been really serious issues raised around workplace culture and staff safety at the Westpac Rescue Helicopter Service. I understand there's an investigation underway, but my question is whether the contract has been renewed past its end date in 2027 yet or whether you will wait until the results of that review come in before recontracting that service.

**Mr RYAN PARK:** There will be concerns. I pulled them in after that report, which most people would have seen. Commissioner Morgan has made it clear that there are concerns. We've been given—I'm not going to say a blanket—assurance that there have been improvements made. In relation to the contractual process, that is probably one best for Dom. Are you in the best position?

**DOMINIC MORGAN:** Yes. The short version is that we're awaiting the outcomes of the report before we exercise any consideration of options. The Minister has been very clear, as I have been very clear, that we need to be absolutely reassured that this is a fit-for-purpose organisation for a health workforce to be working on—for that matter, any workforce.

**The CHAIR:** Are there any Government questions?

**The Hon. STEPHEN LAWRENCE:** Just one question. Minister, I think you took a question on notice a bit earlier from Ms Susan Carter about the Safe Wayz program. I think your excellent staff might have provided you with something about that.

**Mr RYAN PARK:** Yes. Thank you, Mr Lawrence. Ms Carter, I wanted to try and get this to you today, if that's okay. In relation to the Safe Wayz program, I'm advised that there's no centralised waitlist. The Safe Wayz program can be accessed by professionals for case consultation and as a referral pathway for children and families needing additional support. Most LHDs receive a budget allocation to implement Safe Wayz and New Street Services. Growth in the budget allocation—this is an obvious statement—will change from year to year and is based on the individual LHD's needs and their respective demands. New Street Services procedures information is detailed in the policy and procedures policy directive for that service. In 2023-24 financial year, New Street

Services accepted 257 referrals. In the 2024-25 financial year, the service accepted 271 referrals, representing an increase of approximately 5.4 per cent.

**The Hon. SUSAN CARTER:** Thank you for that.

**Mr RYAN PARK:** That's all right. I would be happy to take on more. That's fine.

**The Hon. SUSAN CARTER:** Could you take on notice how many people sought provision of services but were unable to be accommodated?

**Mr RYAN PARK:** I am happy to take that on. The other issue that I wanted to make clear—I think it was you, Ms Carter, or Ms Mitchell—is in relation to the issue of the testing of air during a construction phase. Ms Willcox and I had a discussion outside. That testing was ongoing. Obviously, as a part of that, in relation to RPA, that testing was happening. It didn't identify any significant particles in the air at that time that alerted to anything. Deb, did you want to clarify that, because I think either Ms Mitchell or Ms Carter asked a similar thing and I wanted to make sure we got to it today?

**DEB WILLCOX:** Thank you, Minister. Between September and December 2025, the dust monitoring results were at low levels, so there were no issues of concern with the air guidelines under the Environment Protection Authority. So that did not raise any concerns. Then the hoarding obviously went on in November, which I think I flagged in an earlier question. But, yes, the dust monitoring is part of the construction plan, and that had been ongoing and showed no levels of concern.

**The Hon. SUSAN CARTER:** Can I ask two questions about that?

**The CHAIR:** We are in Government time, Mrs Carter.

**Mr RYAN PARK:** I am happy to.

**The Hon. SUSAN CARTER:** When did that dust monitoring begin?

**EMMA SKULANDER:** I can comment on that. In relation to all construction projects, there's regular dust monitoring being undertaken. So we have results from the commencement of construction.

**The Hon. SUSAN CARTER:** What was the location? What was being monitored? Was it inside the ward, on the balcony or outside the ward? Where was the monitoring station?

**EMMA SKULANDER:** The monitoring was being undertaken in and around the construction site, so outside of the ward.

**The Hon. SUSAN CARTER:** Was there any monitoring inside the ward?

**SUSAN PEARCE:** No, there was not. I think the other point was that, as I understood it, as the construction got closer to that ward, hoarding went up.

**EMMA SKULANDER:** In relation to how the works were planned to be undertaken, RPA is a very complex hospital redevelopment, as you can imagine. We're operating in a very constrained site. There is a very detailed plan in relation to construction works and where the works are being undertaken, and the disruption notices that are then provided within the hospital. There's quite a significant process that we have across the State around that disruption and the disruption notices. In this particular example, there's a plan of staged works that move locations around the hospital throughout the period of construction. As the construction works were becoming closer to the ward in particular that we're discussing, there were the next steps of protection to be undertaken, and that included the establishment of some hoarding, which was put up in November. You'll have seen the hoarding referenced that we have spoken about. So as the works were getting closer to the ward, that hoarding was put up. There were also other controls in place, such as HEPA filters and other things.

**The Hon. SUSAN CARTER:** What in particular is the hoarding designed to capture?

**EMMA SKULANDER:** The hoarding stops the airflow from outside to the inside.

**The Hon. SUSAN CARTER:** Completely?

**EMMA SKULANDER:** The intention is to stop the airflow from the outside to the inside completely. In the documentation you will have seen some questions regarding the robustness of that hoarding. So that is one of the elements that we are reviewing, whether that hoarding was completely sealed. That's part of that review. I will say that when we became aware of the question around the hoarding being sealed, we immediately instructed for it to be replaced in an abundance of caution to ensure that there was no gap from the moment that we were aware of that concern.

**SUSAN PEARCE:** Chair, if you wouldn't mind, with the indulgence of the Government members, if that would be all right, I wanted to circle back—if you pardon the pun, Ms Mitchell—to Gunnedah. I would like to add to reassure the community of Gunnedah, because this is important, that a helicopter can land at the aerodrome. It is not uncommon for secondary transfers to occur. Whilst we address the issue with the helipad, we have had a lengthy experience with these issues associated with our helipads because of downwash issues from the helicopters where remediation is required. We obviously have to comply with those remediation plans. We always have in place a process to enable a helicopter to land and road paramedics to transfer the patient as necessary to the hospital. I can't explain why a helicopter may have been circling. There could be many reasons for that. But there is a place for a helicopter to land in Gunnedah, and I thought that it is important to clarify that.

**The Hon. SARAH MITCHELL:** Part of the challenge is that the bridge that goes to the aerodrome has been cut off because the council—anyway, we can talk about that offline. But that's probably added to some of the issues.

**SUSAN PEARCE:** Nevertheless, I don't want people to feel afraid that those processes aren't in place, because they are.

**The CHAIR:** There being no further questions from the Government, that finishes the morning session. Thank you very much, Minister, for your time before the Committee today. We will take a lunch break and be back at 2.00 p.m.

**(The Minister withdrew.)**

**(Luncheon adjournment)**

**The CHAIR:** Welcome back, everyone. We will start this afternoon's questioning with the Opposition.

**The Hon. SARAH MITCHELL:** Welcome back, everybody. I want to ask some more questions about RPA and that group. Am I best to direct those to Dr Chant, and perhaps if you want to come up as well, Ms Willcox?

**SUSAN PEARCE:** Perhaps if you ask the question and then we can work out who is best to answer it.

**The Hon. SARAH MITCHELL:** Just in relation to the clinical group that was established, who exactly is on that group?

**KERRY CHANT:** There was Jean-Frédéric Levesque, who was the deputy secretary of—

**SUSAN PEARCE:** Research and innovation.

**KERRY CHANT:** Yes. There was myself, there was a representative from CEC, there were—

**DEB WILLCOX:** Two from the institute of pathology and research. That was me.

**KERRY CHANT:** There were two people from Westmead pathology that had particular expertise in fungus, one of them being Sharon Chen. There was Sebastian, who is the head of the ID department.

**DEB WILLCOX:** Yes. Transplant clinicians, a Health Infrastructure representative, some infection protection control clinicians from RPA hospital and myself.

**The Hon. SARAH MITCHELL:** Is that group still continuing? The Minister was talking about the review that's underway and learning from that. Who is conducting that review? Is that you, Dr Chant, or is it that the group?

**KERRY CHANT:** That operating group is drafting the report and looking at a lot of the issues. I would anticipate that that would probably come back to the expert panel to make sure that all the issues that people around that group had were addressed in the report.

**DEB WILLCOX:** I can add, Ms Mitchell, that the expert advisory panel has not closed down; it's still there to be stood up if we're ready to bring forward the next suite of matters for their consideration. We've got two investigations underway. One is in relation to the clinical incidents—the sad deaths of our patients. There's that normal investigation under our clinical incident management policy, and then there's a separate cluster investigation, which has representatives from the local health district, clinicians and Health Infrastructure. They will look at the cluster and what might be some contributing factors, what might be some linkages between those patients and any other factors we can identify, like system improvements or lessons learnt. Both of those reports—whatever comes out of them, as the Minister said—we will attend to the implementation of, but we would take it back to the expert advisory panel for completeness, given their stature and knowledge in these areas.

**The Hon. SARAH MITCHELL:** Do you have a time frame on how long you think those two investigations or inquiries will take?

**DEB WILLCOX:** I'm obviously mindful for the families in particular, who are very keen to get answers. The clinical incident management review is still underway. It normally takes six to eight weeks, so I'm anticipating another couple of weeks for that. We've got to make a referral through the Clinical Excellence Commission in relation to the cluster investigation. We'll probably do that next week and then start to bring that forward to the panel within the next fortnight, hopefully.

**The Hon. SARAH MITCHELL:** The media release that was drafted and not issued—was there any advice sought from the Minister's office about whether or not a public media release should be issued?

**KERRY CHANT:** I think it's probably important to say that, in the background, those holding statements get issued, and it really wasn't a media release. The focus of the meeting on 24 December was really around deciding what immediate actions we had to take and what was the source of the mould infection. It was important that, whilst construction was evident—and the literature review that was undertaken confirms that; we're aware of that—the key issue was making sure we weren't tunnel vision on the construction. We were also looking at any mould present in the ward and also the roof space, just to make sure of any point of egress to it. There was a range of mitigants recommended and then there was a big discussion around the nature of antifungal medication in terms of prophylaxis that was needed to be administered. That was really the focus of the questions.

That statement, in the usual course, would always get reviewed prior to being issued, but there was a decision that the key focus was making sure that everyone that was needing to be advised was advised, and the information provided to them, to some extent, changed and was still under development. For instance, some of the algorithms of who was going to be offered prophylactic antifungal medication was still being worked through in the clinical groups. I spoke to the Minister's office after the expert panel, in a division of labour with Ms Willcox, and I did keep the Minister's office advised through that process.

**The Hon. SARAH MITCHELL:** Was that the Minister's chief of staff? Who did you speak to?

**KERRY CHANT:** I did speak to the Minister's chief of staff.

**The Hon. SARAH MITCHELL:** Did you want to add something, Ms Willcox?

**DEB WILLCOX:** No, I think Dr Chant has covered it.

**The Hon. SARAH MITCHELL:** Obviously we know that the Minister was on leave at the time. Thank you, Dr Chant, for confirming you spoke to his chief. Minister Cotsis was the acting Minister for Health during that period. Was she briefed at all by Health in relation to what was happening?

**KERRY CHANT:** I can't comment. My contact point was to the chief of staff, with whom I had several conversations over the Christmas and new year period. There were expert panel meetings, from memory, on the 26th and 27th—repeatedly over that period.

**The Hon. SARAH MITCHELL:** If you have to take it on notice, that's fine, but is there any record of Minister Cotsis being briefed that anyone's aware of, from Health specifically, as she was the acting Minister?

**KERRY CHANT:** I can't comment. I did not brief Minister Cotsis.

**The Hon. SUSAN CARTER:** Dr Chant, just to clarify, you said there were meetings on the 26th and 27th—was that of December?

**KERRY CHANT:** Yes.

**The Hon. SUSAN CARTER:** You must have been concerned if you were convening meetings on a public holiday.

**KERRY CHANT:** Of course we were concerned, and all actions were being taken. But, as I indicated, there were decisions at every point around clinical decisions that needed to be made about what was in the best interests of the patients—issues such as should we immediately close down the ward. That was considered—the fact that construction had been ceased and the fact that additional mitigants needed to be put in place—and then that was reassessed, balancing where else they could be relocated to and what would be the appropriate communication. There were lots of decisions being made. It was important that we kept regularly, throughout—

**The Hon. SUSAN CARTER:** Is it common to have meetings on Boxing Day?

**SUSAN PEARCE:** It is for us, yes.

**KERRY CHANT:** It is common to have meetings.

**DEB WILLCOX:** The meetings were on 24, 27 and 29 December and 6 February. It wasn't actually on Boxing Day.

**The Hon. SUSAN CARTER:** So 29 December and then nothing until 6 February?

**DEB WILLCOX:** That's correct.

**SUSAN PEARCE:** But could I just add, Mrs Carter, if I may, that it's also common practice for us. We are a health system; we operate 365 days of the year, so public holidays and weekends mean nothing.

**The Hon. SUSAN CARTER:** Can I just say that we are very grateful that that happens?

**SUSAN PEARCE:** They really genuinely mean nothing to us, because that's the nature of the business that we're in. I think what's also very common for us is that, once an issue is identified and there are a series of actions associated with that issue, there are meetings that then occur to make sure the actions that have been determined have in fact been put in place. It's not uncommon for that cadence of meetings to occur in our system.

**The Hon. SUSAN CARTER:** Just a quick question on the construction shutdown: Was that a permanent shutdown or was that a Christmas period shutdown?

**KERRY CHANT:** It was a Christmas period shutdown, which was the context. The fact that it was shut down was recognised as a factor that meant that the air testing that was conducted there would not be representative of when construction was reignited. That was why there was a period of time—I think it was about five days or a week—that was allowed when the construction occurred, to support the testing in a more real-life environment in terms of construction occurring. That was validated, and then there was a meeting held where all of the information was presented back on the air modelling, where the expert panel concluded that the facility was safe to be reused.

**The Hon. SUSAN CARTER:** The construction has recommenced?

**KERRY CHANT:** Yes.

**The Hon. SUSAN CARTER:** And is currently ongoing?

**EMMA SKULANDER:** The construction shutdown period is consistent across our entire program.

**The Hon. SUSAN CARTER:** No, I'm just thinking about the transplant—

**EMMA SKULANDER:** The shutdown and the start-up again were entirely as planned. There wasn't an impact on that planned—

**The Hon. SUSAN CARTER:** It wasn't shut down to deal with the IFI?

**EMMA SKULANDER:** No.

**The Hon. SARAH MITCHELL:** I just want to turn to another issue. We talked this morning with the Minister about some of the concerns and challenges with hospital maintenance. There was a particular incident that came through in the papers that we received from February, I think—it was only a couple of weeks ago—for John Hunter Hospital and the paediatric wing. Some concerns had been raised by one of the staff there about potential exposure to patients. Is there any update on that that you could provide?

**SUSAN PEARCE:** I might see if Ms McCosker can respond. But if I might just make a broader comment, what I really want to put on the record here is that we take all of these things seriously. NSW Health, as I think you know, is a very large organisation. We have over 220 hospitals, as the Minister said this morning, and over 4,400 buildings. We do deal with these issues quite commonly. The important thing for us and the important thing ongoingly for us, is that they are addressed in a timely manner. We know that our chief executives do so wherever possible. Sometimes remediation, as we touched on this morning, associated with Tamworth and other places, may take longer depending on the nature of the problem.

But I think it is important, and I feel it's incumbent upon me, to put on the record here that we run a very safe health system in New South Wales. Any issues associated with impact on patients is treated with the utmost seriousness. We monitor for trends in our data. We work very closely with the system each and every day. NSW Health is the best health system in Australia, and I'm concerned that this ongoing dialogue about maintenance issues, notwithstanding the fact that they have been impactful, will undermine the confidence in what is a very good health system, and I think that would be a big shame. It's not about us. This is not a defence of the bureaucracy or our managers. We are required to provide safe care to our patients, and we do. When these issues are identified, they are addressed as quickly as possible. I think that is something, as I said, we take very seriously.

I should also add, given I've not had the chance, that we are deeply sorry to the families of the patients at Royal Prince Alfred Hospital, or in fact anyone impacted by these things. That is the last thing any of us would want. With 226 hospitals and thousands of buildings across the health system, ever since I've been in it, which is a very long time, we've had issues to deal with in respect of buildings. I can tell you the building that I used to work in, in Broken Hill, for a very long time had asbestos in it. I'm going back to the '90s in regard to that. I'm not suggesting that that is in any way acceptable, but I guess my point is that we are continually dealing with making sure that we keep up the maintenance work and addressing these issues as quickly as we possibly can. There were a series of them reported to the media, obviously through the standing order, which we understand. The great majority of those issues have been rectified, and some are still ongoing. I just think it's important for me to make that statement for the Committee.

**TRACEY McCOSKER:** In regard to the paediatrics at John Hunter Hospital, you'll be aware of what was noted and the concerns raised by the clinicians. That was escalated urgently. There was an engineering review of the HVAC systems. Air changes and replacement of porous ceiling tiles happened immediately. There was a multidisciplinary risk assessment done. By March 2025, the immediate control measures were all implemented, affected rooms were closed, ceiling tiles repaired and vents cleaned and replaced, infectious cleaning undertaken and clinics were temporarily adjusted—they were not cancelled, but moved into other rooms. But the very next day, we had them back in the original rooms that the clinics would be operating. Now, there is ongoing monitoring of temperature, humidity, ventilation and mould that we do regularly, so that if we find something we can address it immediately, as has just been stated.

**The Hon. SARAH MITCHELL:** Great. Thank you for that. Dr Cohn asked a few questions about this earlier today, but I just wanted to pick up—probably through to you, Dr Chant. I believe the UTI trial and the report, which I know Dr Cohn raised this morning—can you just clarify, because I don't recall from what you said this morning, when was the first version of that report received?

**KERRY CHANT:** I'll just have an update—sorry. The NSW Pharmacy Trial reports for UTI and OCP are expected at the end of this month, end of March. The AMR—antimicrobial resistance—sub-studies are part of the UTI report, so it's part of this timeline. There's also a review of the dermatology report, which will be provided to us by the end of March. So all of the reports will be back to us at the end of March.

**The Hon. SARAH MITCHELL:** But if I'm right, from my recollection with Dr Cohn, you received it, but you've sent it back to the University of Newcastle. Is that right?

**KERRY CHANT:** We tendered the piece of the report, and then our office has reviewed the report, and we noted that, in terms of the economic modelling—not anything about the clinical effectiveness or the clinical safety signals, but in relation to the economic modelling—there were just some assumptions made in that which related to a misunderstanding about—from recollection, I'd have to double check, but my understanding, my recollection is that it related to the fact that patients were charged a fee for the product, for the antibiotic or for the oral contraceptive. In terms of the economic analysis, they just had to redo the economic analysis to make sure it reflected the actual conduct of the trial. I'm happy to make that very clear and transparent: There is nothing at all here that is other than wanting a very solid document that outlines the benefits of this initiative.

**The Hon. SARAH MITCHELL:** So with the process—if it's an independent report into the rollout of this trial, is it normal for Health to then go back and say—notwithstanding what you've said about economic modelling—that things in the report need to be changed?

**KERRY CHANT:** We've not said that nothing needs to change. What we're saying is, "Do you want to go back and redo this?" based on the fact that there are some assumptions in the report that don't reflect the conduct of the trial. There was a discussion with the economic modellers that did it just to give them some information around the issue of the cost of the products, and some of those things. It was a very technical discussion just saying, "By the way, in real life, patients will be expected to pay the pharmacist for this activity as part of a clinical professional service that the pharmacists undertakes, and also the medications won't be covered by the PBS Safety Net, because currently the pharmacists don't have access to MBS or PBS." It's just those issues that, if you're looking at cost economic analysis, would be appropriate. Very happy for the email correspondence and all of the information—

**The Hon. SARAH MITCHELL:** If you want to table that or provide that on notice, that'd be great.

**KERRY CHANT:** I would be happy to do that. I think in many reports, we do look at them just to check that the facts are correct—not that we change the report. The last thing we want to do is have a report put out there and it be contested, if there are simple things that can be adjusted to make it more rigorous.

**The Hon. SARAH MITCHELL:** As I said, if you're happy to provide on notice, that would be fantastic. So the end of March is when you anticipate the final report to be made available?

**KERRY CHANT:** Yes. I expect it at the end of the month, end of March, and the AMR sub-study. It looks like the dermatology report will also be coming to us at the end of March.

**The Hon. SARAH MITCHELL:** Does that need ministerial sign-off, or can that just be released by yourself?

**KERRY CHANT:** In the normal course, we would generally put up a brief to the Minister, but I don't envisage that there'll be much delay in having them published. They're not contentious. We really want to add to the evidence base.

**The Hon. SARAH MITCHELL:** Have there been any briefings with key stakeholders—I'm thinking Pharmacy Guild, AMA and the GPs—about what is in the report so far, or will that occur after the report's released?

**KERRY CHANT:** I generally have a meeting that's with the pharmacy groups—PSA, Pharmacy Guild—AMA, RACGP, Rural Doctors. We also have hospital-based pharmacists. I would anticipate that in the normal course of events, concurrently with briefing up to the Minister, we would feed back to that group what the findings of the reports were. In ordinary course, we would probably get the presenters from the University of Newcastle to be present at that meeting to answer any questions associated with the report to those individuals.

**The Hon. SARAH MITCHELL:** Probably a follow-on but a bit more broadly, obviously this was looking at some of the expanded scope of practice that's in place. What is foreshadowed for that area going forward? Is there any work that you're doing now looking at other areas where pharmacists can play a role in that delivery of health care?

**KERRY CHANT:** New South Wales together with the Commonwealth put forward a paper for there to be a national, like the scope of practice, role for nurse practitioners or enrolled nurses. Currently the Pharmacy Board is doing a piece of work which will be publicly consulted. We've really advocated for a nationally consistent approach where it's informed by the sorts of competencies that you would need to undertake an expanded scope, and you would then have appropriate clinical training and you'd be very clear about that. We have really supported a national approach. That piece of work is underway, and the timeline is really out of our control, but it is being expedited. That has been auspiced by a request from health Ministers. We met with the Pharmacy Guild recently.

**The Hon. JOHN RUDDICK:** My question is to Dr Kerry Chant, the Chief Health Officer of New South Wales. You're coming up to 20 years in the role. When a pharmaceutical manufacturer comes up with a concept vax in the lab, how long does it typically take to get to the market so that people like yourself say that it's safe to consume?

**KERRY CHANT:** In terms of vaccines, it's very, very variable. One of the most difficult aspects is when they're trying to find the part of the organism to target their vaccine against, so finding the vaccine target. As you're aware, some microbes change very quickly.

**The Hon. JOHN RUDDICK:** My question was the typical timing. I know that there are variations, but what's typical?

**KERRY CHANT:** It's hard to say. It's reasonable to say many, many years would be the general course.

**The Hon. JOHN RUDDICK:** My understanding is it's 10 to 15 years typically. Why does it take so long?

**KERRY CHANT:** The first bit is the science of finding the appropriate part of the organism to target. There is actually the developmental work to understand, on the organism, which part of the organism would be appropriate to target. That requires a lot of immunological studies. And then there are a variety of different trials that are done—phase one, phase two, phase three trials that are undertaken.

**The Hon. JOHN RUDDICK:** A very major concern of those trials is unexpected, unintended side effects.

**KERRY CHANT:** That's correct.

**The Hon. JOHN RUDDICK:** You approved the COVID vaccine to be marketed in Australia and you promoted it very heavily. How long did it take the COVID vaccine to get to market?

**KERRY CHANT:** Just to be clear, the TGA, the Therapeutic Goods Administration—

**The Hon. JOHN RUDDICK:** You did promote it.

**KERRY CHANT:** And I certainly do stand by that and I still encourage people to be vaccinated against COVID and influenza. Vaccines are very important in our armoury against—

**The Hon. JOHN RUDDICK:** I don't think people are listening to you anymore. I don't think there's much demand for COVID vaccines at the moment.

**SUSAN PEARCE:** Excuse me, Chair, could I ask that our witnesses are treated respectfully, please?

**The CHAIR:** I ask the member to stick with asking questions.

**The Hon. JOHN RUDDICK:** How long did it take the COVID vaccine to get—so COVID popped into the world in early 2020. How long did it take for you to be able to advocate that people should be taking it, since we've established that it was typically 10 to 15 years before these things?

**KERRY CHANT:** I think the vaccine was used in Australia—I'd have to recall—certainly in early 2021, but internationally there were vaccines available in some countries before that time.

**The Hon. JOHN RUDDICK:** It was described as a warp speed vaccine. Correct?

**KERRY CHANT:** I have heard that term applied.

**The Hon. JOHN RUDDICK:** Do you think there are dangers with warp speed vaccines? There could be unintended side effects, couldn't there?

**KERRY CHANT:** I think there is always, as we develop new drugs and medicines, the need to balance risks and benefits.

**The Hon. JOHN RUDDICK:** Looking back, do you think you got that balance right?

**KERRY CHANT:** It's clear that all vaccines are associated with risks and benefits. There were side effects that became evident as the vaccines were rolled out. As that information became known, then clearly that did change the risk-benefit profile for some individuals and it did influence the advice around the frequency or who was most appropriate. But I'd also like to say that the COVID virus itself is associated with quite severe outcomes and many of the outcomes associated with the vaccination as well.

**The Hon. JOHN RUDDICK:** Most people in New South Wales who did take the COVID shots, they were taking an mRNA type of vaccine, which was an entirely new type of vaccine. Correct?

**KERRY CHANT:** That's correct.

**The Hon. JOHN RUDDICK:** It was a warp speed vaccine. It wasn't just a tweak of the old flu shot. It was an entirely new type of vaccine and it was warp speed.

**KERRY CHANT:** I think it's important to know that internationally we were very lucky that there had been a lot of developmental work with the mRNA vaccines associated with—

**The Hon. JOHN RUDDICK:** Yes, but they'd never been used on people before.

**KERRY CHANT:** They had been used and there was development used not in vaccinations but as immune stimulants. In terms of the development work, those vaccines were actually being developed in the context of cancer. At the time of COVID—

**The Hon. JOHN RUDDICK:** Cancer?

**KERRY CHANT:** In terms of stimulating the immune system. That is my understanding of the parallel pieces of work. To say that they came out of nowhere, there was actually a lot of fundamental science around how those vaccines worked at that time. But I acknowledge that we did end up with a vaccine very quickly.

**The Hon. JOHN RUDDICK:** Looking back, do you think it was good public policy to all but force these warp speed vaccines, which were an entirely novel type of vaccine, on people? Do you have any regrets about having a goal of having 100 per cent of people take these vaccines?

**KERRY CHANT:** I think that there is a risk-benefit analysis with the vaccines, but I really support that vaccination was an appropriate risk mitigant in balancing risks and benefits.

**The Hon. JOHN RUDDICK:** So no regrets?

**KERRY CHANT:** I think you will always reflect on the fact that we can do better in communicating those risks and benefits, but in terms of the guiding policy, it was always around what was in the best interest of individuals. But I acknowledge that we can do better at communicating risks and benefits and describing that for individuals to make those decisions.

**Ms CATE FAEHRMANN:** I just wanted to firstly go back to the lead in Broken Hill issue. I have a few questions there. Firstly, in terms of the notifications statewide of blood lead levels over a certain threshold, are they all reported in the one spot in the—acronym—"nick-ems"?

**KERRY CHANT:** Notifiable diseases database.

**Ms CATE FAEHRMANN:** How do you say that acronym?

**KERRY CHANT:** I think it's the NDIS, notifiable diseases—

**Ms CATE FAEHRMANN:** What is the NCIMS?

**KERRY CHANT:** It's that—"N-sims". National Communicable—

**Ms CATE FAEHRMANN:** It's like *Utopia*.

**KERRY CHANT:** Sorry, that thing.

**SUSAN PEARCE:** At least you know there are cameras in here.

**Ms CATE FAEHRMANN:** That's where it gets reported. When did that start? Has that been an ongoing thing? Is it above five or 10 years?

**KERRY CHANT:** I would have to check, but I would believe that given the NHMRC changed the threshold down, it would have changed—

**Ms CATE FAEHRMANN:** It was in 2016.

**KERRY CHANT:** These are lab-based notifications and it's an automated system. Originally it was not automated but then moved to automation where the labs upload the data. I envisage that the level required to notify changed when the NHMRC—but I'd have to take that on notice and just confirm that.

**Ms CATE FAEHRMANN:** In Broken Hill, does NSW Health conduct any type of population-wide monitoring in terms of blood lead levels? I know there's the report that's done every year on children under five, but is NSW Health doing anything else for people over five? Basically population-wide health studies.

**KERRY CHANT:** We do take cord blood from new babies, which reflects their exposure in pregnancy. There would be a lot of occupational screening. I would have to find out what the occupational requirements are, but I would expect the mines are doing occupational screening, which would also feed into our data. As you said, our focus has been on the under-fives.

**Ms CATE FAEHRMANN:** When you are saying "feed into the data", what does NSW Health do with that data in a proactive way?

**KERRY CHANT:** In terms of the adults, we follow those up and have arrangements in place with SafeWork where we can look at whether additional mitigants need to be happening. We've got information that's being prepared so all people with blood lead levels over five are notified and followed up. The move got changed in the 1990s—we changed to the NHMRC level of five.

**Ms CATE FAEHRMANN:** I have been trying to work out the role of SafeWork versus the Resources Regulator versus NSW Health. Just to be clear, you're saying that every—I assume it's just occupational—

**KERRY CHANT:** So all blood lead levels over five—

**Ms CATE FAEHRMANN:** NSW Health gets in contact with that person?

**KERRY CHANT:** Depending if it's very clear that it's part of a workplace screening. We may liaise with SafeWork if there's a pattern of noncompliance in a certain area, because we will expect the workplace lead levels to be higher in some of those situations. The focus we have, particularly in Broken Hill, is for the children because the neurodevelopmental issues are most important in terms of reducing exposure for the young children.

**Ms CATE FAEHRMANN:** Yes, however, NSW Health also acknowledges in its publications on lead the dangers of anything over 10 micrograms per decilitre, in terms of health impacts, whether it's a child or an adult. I just wanted to ask you using one example—because I'm trying to work out who's responsible for following up on something like this. I've got something from the Cobar mines, particularly Endeavour Mine in Cobar. The Resources Regulator has said that the New South Wales public health unit has raised concerns regarding an increase in elevated blood lead levels in adult workers associated with Endeavour mining. This is a gold mine.

The documents that I've obtained via this SO 52 show a fair bit of this for the gold mines in Cobar—Peak as well as Endeavour. It also says that while this company Polymetals has demonstrated compliance with the improvement notice, additional health and safety concerns remain—for example, no evidence of ongoing GP or

occupational physician involvement, particularly for the worker who recorded 51.7 micrograms per decilitre. So the New South Wales public health unit has raised concerns. Are you aware of this particular issue with the mines in Cobar, because my question is going to be what's happened since then?

**KERRY CHANT:** No, I would have to go back to the local public health unit. I would have hoped that that's been escalated in SafeWork because the companies have strict occupational health and safety obligations to provide safe workplaces and to have health care provided where it relates to occupational risks. I am happy to follow that up and ascertain what has been done about that case.

**Ms CATE FAEHRMANN:** Do you know whether NSW Health more broadly, or is it just the local public health unit, is working more closely with the Resources Regulator, say in the last 12 months, around these issues? Because it does also say that the public health unit has proposed a collaborative approach with the Resources Regulator around workplace exposure, contaminated contractor management and coordinated follow-up. Is there anything that's changed within NSW Health around liaising with the Resources Regulator and SafeWork about blood lead levels? Or is it all the Far West LHD?

**KERRY CHANT:** In terms of the Far West LHD, they are based within the Far West Local Health District. They are part of us and we link with them through the public health unit network. I would hope that all of our public health units would work collaboratively with partners across government, including SafeWork and any other relevant regulatory agencies that are necessary to tackle the issue. But I can follow up on the specifics of that if you like?

**Ms CATE FAEHRMANN:** That would be great.

**The CHAIR:** Commissioner Morgan, I am aware that NSW Ambulance have backdated a cohort scaling process for the recruitment of station officers which had resulted in an unusually small number of successful candidates. Is that process going to be implemented for the other recruitments that took place in 2025 for other roles?

**DOMINIC MORGAN:** It's important to give you a bit of context here around the whole thing. Last financial year, the team managed more than 18,000 applications for either transfers or for promotional positions. There was about 2½ thousand roles and transfers that were involved. It's very large and complex. I'm really comfortable to say, with anything as large and complex, there is probably a balance to be struck between the experience of the individuals and the need to get it repeatable and into a system. The system is geared in a way to ensure that, in effect, the best candidates pop out the top.

In any given year, we normally get approximately the right number of people that are qualified and appropriate for the role and match them to it. In the last particular year, we introduced a new level of frontline management and that resulted in 60 new positions being available to front line. Normally, it might only be 10. So the system produced the system that it did. It produced nine successful applicants for it. As a result of that, we went back and asked the team to look at introducing scaling to ensure that we filled all of the roles with appropriately qualified people, but we didn't only have to get the top nine. So that's where the scaling comes into it and we're looking at doing that going forward for the number of positions. We're confident there's a more tailored outcome in the future.

In terms of retrospective ones, we've definitely done that for the last course that was the course of concern. We have received representations in relation to other levels; however, I have asked them to look and make sure there are no unintended consequences. What that means is that someone may well have been offered a position, moved their family into an area, and then, because we go back and retrospectively change it, if they weren't to be the next person, that could have an unintended consequence. I won't give you a guaranteed answer today but I will confirm we are definitely looking at it.

**The CHAIR:** You've answered my question that you're considering the retrospective ones. Moving forward, what positions will that be applied to?

**DOMINIC MORGAN:** All promotional positions going forward, they will approach the scaling. You can imagine, there is ultimately a floor where people must meet the minimum criteria but, because we are going for the most meritorious applicant, there is usually a lot of light and day between those two levels. I've said to the team, "Just make sure that we are calibrating to ensure we don't go below the minimum-qualified person." Of course, we've got to fill all of the positions that are vacant.

**The CHAIR:** I recently asked a question on notice about the recruitment working group, which you kindly answered. Have the terms of reference for that working group now been finalised?

**DOMINIC MORGAN:** I don't believe they have but I will take that on notice. We're negotiating that with the Health Services Union at the moment.

**The CHAIR:** Have that group met yet?

**DOMINIC MORGAN:** No.

**The CHAIR:** Will you also work with the Australian Paramedics Association in addition to the Health Services Union?

**DOMINIC MORGAN:** Yes. The Health Services Union specifically requested a working group, which we've agreed to in accordance with all of our responsibilities. We've got seven unions to NSW Ambulance. Whatever is developed there, we will of course consult with the other unions as well.

**The CHAIR:** Are you aware of the concerns that had been raised around the proposed frontline leadership model?

**DOMINIC MORGAN:** I am aware that there is a proposal to introduce another 130 new frontline leaders to support our clinical workforce. The shift is to move towards what you would probably understand more closely as a nurse manager or a nurse unit manager. It's a more clinically focused role rather than what we've had historically, which is a station manager, so someone that managed a facility. We believe it's a right and proper way to support a growing registered health profession, and there are some industrial consultations that have been protracted in relation to that.

**The CHAIR:** My understanding is that the funding previously allocated for that might expire by the next financial year.

**DOMINIC MORGAN:** That's not correct, no. We've actually brought that workforce on, so they're actually on the books today. In effect, individuals are working as additional paramedics, so they're providing support to the community today. But those positions will be converted into frontline leadership, clinical managers and group managers when we finish the consultative process.

**The CHAIR:** I might come in my last couple of minutes to Mr Sloane. I've asked before about IPTAAS and the possibility of including access to GP specialists and general dental care, and you've talked about a review that was underway. Where's that work now up to?

**LUKE SLOANE:** The review was happening previously. We've currently added in several more things into the IPTAAS policy as it stands. We'll roll through this budget year and see where we land with regards to spend and expenditure for the IPTAAS program. Then we'll go back through and reassess what should be included into the next year or beyond this program to make sure that there's equitable access for everybody.

**The CHAIR:** If there's a demonstrated demand or need for those additional items, does that go into a pitch to increase the overall budget for IPTAAS or are you required to cannibalise your own budget?

**LUKE SLOANE:** We'll weigh it up. No, we're not required to cannibalise our own budget, but we do have to stick inside the envelope, as you can imagine. Ultimately, we're looking at getting some of those services and processes back in communities with regard to building the capability, so that people don't have to travel from the start. It's a tension between do we invest in and put all these things into the IPTAAS budget, or do we go out and try to build capability in rural and regional areas so that people don't have to travel at all from the start?

**The CHAIR:** What's the communication process been with rural and remote communities about those changes that you're trialling?

**LUKE SLOANE:** The communication around the different changes is what we heard within the inquiries and then our community consultation with regards to IPTAAS. We've absorbed those into the IPTAAS policy where they have been the priority items, whether it be high-risk foot clinics or GP obstetricians, those sorts of things that otherwise aren't available that people are using IPTAAS for. We also break it down to see what people are using it for or applying for through our analysis or review of it on a regular occurrence. We include those. The communication process then goes out to the community. It's been very successful. We've seen a massive uptick in the use of IPTAAS, through the comms in general but also through those changes that we've made through the policy, whether it be removal of the GP signature or going out and communicating what people can use it for now.

**The Hon. SUSAN CARTER:** Ms Skulander, if I could ask you a couple of questions, I confess I am not an expert on building materials or hoarding, so I have taken some advice from some people who are. With respect to the issue of how the patients were protected with the hoarding that you said had been erected, I understand from people who I've consulted—their advice to me is, "Complete sealing off of a hospital to stop outside air getting inside is unrealistic. The cladding is most often used to prevent inside air from getting out." Can you comment on the type of cladding and whether it is realistic to seal off the hospital to stop outside air from getting in?

**EMMA SKULANDER:** It's not completely realistic to seal off somewhere, because doors need to open and close for people to get in and out. In relation to what the purpose of the hoarding is, in this instance it was hoarding to protect from the outside environment into that ward. There are different types of hoarding that can be used as well. Depending on the type of environment, then different materials might be used. In this instance, there was a plastic sheeting hoarding that, when we realised there were some concerns in relation to it, was replaced with some solid plastic cladding. There's also a secondary point with a door behind that. There's a couple of layers to access up to where the ward is. It isn't, though—to the second part of your comment—hoarding intended to stop inside air going out. It really was for the protection of the ward.

**The Hon. SUSAN CARTER:** And it was realistic that it could be a seal that would stop outside air from going in.

**EMMA SKULANDER:** In that location, but it doesn't stop outside air from coming in the doors, in and out of a ward. There are obviously practices that go with that. There's an operational component to this where you mitigate as much risk as you can but, realistically, it also relies on the operational procedures of people closing doors behind them and that sort of thing.

**The Hon. SUSAN CARTER:** I also wonder if you could give me any information about whether there was increased maintenance of the hospital's HVAC system when there was a known issue.

**EMMA SKULANDER:** "When there was a known issue"—sorry, can you just—

**The Hon. SUSAN CARTER:** Was there increased maintenance of the hospital's HVAC system when construction started?

**EMMA SKULANDER:** I might have to refer to Ms Willcox in relation to that.

**The Hon. SUSAN CARTER:** Ms Willcox, are you able to help us with that?

**DEB WILLCOX:** Yes, there had been some preliminary work done earlier in December to check the filters and check the airflow in the ward.

**The Hon. SUSAN CARTER:** Sorry, if I can take you back, when did construction start?

**DEB WILLCOX:** In 2023.

**The Hon. SUSAN CARTER:** Was increased maintenance of the HVAC system begun in 2023?

**DEB WILLCOX:** We have annual inspections across all of our wards in terms of their plant and their air handling equipment. Every three months those things are serviced. If there are any issues, obviously they're escalated and our local engineering team attended.

**The Hon. SUSAN CARTER:** Given we had a transplant ward next to a construction site, was additional maintenance of the HVAC system undertaken?

**DEB WILLCOX:** Not required, to the best of my knowledge. That was our routine servicing and looking after our equipment and attending all the normal practices in the transplant ward, which is on a dedicated air system. As Ms Skulander said, it has a door and people go in and out. Yes, there is an internal balcony that had louvres, but it also had a glass door closing it into the ward. Upon the identification of the cluster, we did another round in terms of the filters, turned off the negative pressure because—I won't go into the air mechanics, but basically to keep the air still. Then, as I said, a fresh round of filters were put into place and the additional seal put over the balcony hoarding, which was on two levels. It wasn't just one area closed. There was another layer, and then we applied the plastic seal to make like an anteroom, so it was vacuum sealed. Now there's a hard-set insertion into that to add to its closure.

**The Hon. SUSAN CARTER:** Just to make sure I've got it straight, routine maintenance of the HVAC system until December 2025?

**DEB WILLCOX:** It is ongoing. That is a—

**The Hon. SUSAN CARTER:** Sorry, when was there the particular intervention? When was the negative pressure turned off and the filters changed? That was December 2025?

**DEB WILLCOX:** No, there was already some work done on the air filters, to check on them, check the airflows, that was done in early December. Then subsequent to the expert advisory panel meeting on the 24th, we then went about replacing all the filters, just out of an abundance of caution around all of this. The maintenance on the ward was being maintained, but we thought best just to remove everything, put something fresh in and make sure we're absolutely confident. As it turned out, all of the measures that we put in place, when we sampled

the air, there was no evidence of any aspergillus, which gave us confidence that our mitigation strategies have been successful.

**The Hon. SUSAN CARTER:** Just so I understand, because this is not my field, when I hear you say that now there is in place a vacuum seal, in my head that says there's like a spaceship chamber. Is that what's happening—there's a vacuum area that you walk through?

**DEB WILLCOX:** Now it's a hard-set wall in there. The plastic parts have been removed, because as a normal part of the construction, the plan was always to put a hard-set wall into where the balcony was, so they can abut the new hospital redevelopment against that wall. The ward is permanently closed at the moment. But the plastic seal was an additional measure we did, just out of an abundance of caution around the hoard enclosure.

**The Hon. SUSAN CARTER:** Sorry, if the ward is permanently closed, where are the transplant patients now?

**DEB WILLCOX:** The wall. Pardon me. Sorry—my language. The wall, not the ward. The ward is open. The wall is permanently closed—my apologies.

**The Hon. SUSAN CARTER:** That was done as a protective measure, or that was done because it was on the plan for the redevelopment?

**DEB WILLCOX:** It was on the plan, yes.

**The Hon. SUSAN CARTER:** I've got a couple of questions for Dr Morgan now. Can you tell me how many ambulance stations have been opened since June 2022?

**DOMINIC MORGAN:** How many ambulance stations have been opened?

**The Hon. SUSAN CARTER:** How many new ambulance stations have we had since June 2022?

**DOMINIC MORGAN:** I might ask my Health Infrastructure colleague whether she's got a particular—

**The Hon. SUSAN CARTER:** I'm happy—I was trying to direct it.

**SUSAN PEARCE:** We'll take it on notice. We'll try and come back to you.

**EMMA SKULANDER:** Yes. I'll see if I can find the answer while we're here.

**DOMINIC MORGAN:** Because I think there are a few of the regional ones that—

**The Hon. SUSAN CARTER:** Thank you, because I understand that there was a plan announced—with significant funding attached—for 30 new stations, as well as a boost in paramedic numbers. Can you tell me how many extra paramedics have been employed since 2022?

**DOMINIC MORGAN:** Yes, I can.

**SUSAN PEARCE:** Could I just ask you, Mrs Carter, to clarify when in 2022 you're referring to?

**The Hon. SUSAN CARTER:** June 2022.

**DOMINIC MORGAN:** In the first year, it was 957. In financial year '24, it was 383. That included 125 of the rural 500. In FY25, 327. We're projecting this year by 30 June for 332 additional.

**The Hon. SUSAN CARTER:** Are we keeping all of those paramedics or is there an attrition rate?

**DOMINIC MORGAN:** That takes account of the attrition rate.

**The Hon. SUSAN CARTER:** So this is net growth?

**DOMINIC MORGAN:** That's net growth.

**The Hon. SUSAN CARTER:** We're doing well. That's fantastic.

**SUSAN PEARCE:** Don't sound so surprised, Mrs Carter.

**The Hon. SUSAN CARTER:** No, I'm happy. I'm delighted.

**DOMINIC MORGAN:** Can I honestly say it is a superhuman effort by our education teams and our recruitment people. It has been stellar. I remember when I returned to New South Wales in 2016, we were debating whether we could do classes of 36 paramedics. These teams literally pull up every single time and they're doing 120 quite routinely now. It's quite amazing.

**The Hon. SUSAN CARTER:** That's excellent news. You said that in 2024, 125 of those were the rural—

**DOMINIC MORGAN:** FY25 is another 125 included in the 327. This year we're on track for the third phase of the rural 500 of 125 as well.

**The Hon. SUSAN CARTER:** The funding for that rural and regional paramedic program, was that diversion from the capital program for building new ambulance stations? Where did that money come from?

**DOMINIC MORGAN:** All the rural 500 have basically gone into existing ambulance stations.

**The Hon. SUSAN CARTER:** Sorry, to fund those positions.

**DOMINIC MORGAN:** The capital is completely separate to our operational ongoing funding.

**The Hon. SUSAN CARTER:** So if I was told that there was a $120 million budget cut in the NSW Ambulance service in 2026, could you comment on that?

**DOMINIC MORGAN:** This year?

**The Hon. SUSAN CARTER:** On any year. I wonder whether that—

**DOMINIC MORGAN:** No, we haven't had a $120 million budget cut. I don't know where that would come from.

**The Hon. SARAH MITCHELL:** Related to that, the allocation for the 500 extra paramedics was just shy of $439 million. That was the commitment. Does that money go to employing the paramedics? Are there capital works? Are there vehicles with that? What's the breakdown of that 439?

**DOMINIC MORGAN:** Part of that was operational expenditure—so recurrent salaries for the 500. Another part was for fleet and equipment. Largely, we've targeted towards where we've had historical overnight on call and to retire that, because it's really fatiguing. We largely had sufficient fleet, which was a significant reprieve for us because we were able to put the staff out there. The remainder of the capital is for doing minor works around, for example, where we've gone from a staff of five in one location to 12. We've replaced kitchens and that sort of thing.

**The Hon. SARAH MITCHELL:** Are you able to provide—and I'm happy for it to be on notice—of that 439, a breakdown of those three categories and the funding allocations to staffing costs, capital works and vehicles?

**DOMINIC MORGAN:** Yes, I think so.

**SUSAN PEARCE:** I think it's also worth noting—and Mr D'Amato might correct me if I've got this wrong—that over the last 14 years, the Ambulance budget has increased by 170 per cent. It has had a substantial increase over time.

**The Hon. SUSAN CARTER:** We've got new paramedics, which is fantastic. How are we going with the bottleneck of unloading—that's probably not the right word—or bringing patients urgently to a hospital and then having that transition from ambulance to hospital happening in a timely fashion?

**SUSAN PEARCE:** Mr Daly, this is your opportunity to shine.

**MATTHEW DALY:** Transfer of care is the formal term.

**The Hon. SUSAN CARTER:** Thank you. That is much more elegant than "unloading".

**SUSAN PEARCE:** While Mr Daly is finding his data, I will add that NSW Health is the best performer for ambulance offloads in the country. We outperform Victoria, which has a transfer-of-care target of 40 minutes. Ours is in 30 minutes and we still beat them. I just need to get that out, because it's a very important thing for us.

**The Hon. SUSAN CARTER:** I don't doubt that, but you'll appreciate that we are contacted—

**SUSAN PEARCE:** It's just that I've lost a lot of sleep over it, Mrs Carter. I like to be able to state those things when I get the chance.

**The CHAIR:** Where's that energy for beating Victoria in other things?

**The Hon. SUSAN CARTER:** We are contacted repeatedly by people who have unfortunate experiences in transferral of care.

**MATTHEW DALY:** I could give a State by State comparison or I could talk about—

**The Hon. SUSAN CARTER:** What I'm really interested in knowing is—we still hear from paramedics that they are spending a lot of time waiting to transfer care. We still hear from patients that they are waiting a long time to transfer care. I'm wondering what the issues are and what levers can be pulled to make an excellent process even better.

**MATTHEW DALY:** Which is essentially what we aspire to. Unfortunately, like most things in Health, there's not a simple solution, particularly in metropolitan Sydney. The reasons really vary from hospital to hospital. Sometimes there's back-of-house flow. Sometimes it's workforce, particularly FACEMs—ED physicians within the department—in order to speed up decision-making. That's why we work individually with an LHD and with individual hospitals. We have a number of improvement teams that are essentially ED clinicians who come together in teams, overseen by the ED taskforce, to go into those individual hospitals and the emergency departments, working with the staff to tailor solutions.

**The Hon. SUSAN CARTER:** Do we have enough ED clinicians?

**MATTHEW DALY:** The FACEM workforce has improved dramatically.

**The Hon. SUSAN CARTER:** Do we have enough, though?

**MATTHEW DALY:** I would think the numbers—

**The Hon. SUSAN CARTER:** Do we have enough in regional hospitals?

**MATTHEW DALY:** There'd be paucity in some parts of outer metropolitan Sydney and in some regional areas, where I'm sure they'd like to attract more.

**The Hon. SUSAN CARTER:** What are we doing to attract more in those areas?

**MATTHEW DALY:** There's a whole host of workforce issues that go to that.

**The Hon. SUSAN CARTER:** On notice, could you provide me with a list of those workforce initiatives to attract—

**SUSAN PEARCE:** Could I just add that I think it's important to note that the Government is currently rolling out safe staffing levels to emergency departments. That does substantially increase the number of nursing staff across the EDs. I was formerly also the chair of the Health Workforce Taskforce, reporting to health Ministers across the country. There has been substantial effort to assist us, where necessary, bringing doctors in from overseas to help with some of our workforce maldistribution issues. There is no silver bullet to that issue. I'm not suggesting that is one single solution. It's ongoingly a challenge; I will say that. I know that in a number of the districts—and Tracey may wish to comment on this—we've put in place lots of things to welcome people into rural communities as well. We appreciate that if you come from another country into Australia and into New South Wales, that transition can be hard, so we seek to make sure that they're well looked after from a social perspective as well as from a workplace perspective.

**The Hon. SUSAN CARTER:** Can you confirm that that welcome program is currently operating?

**SUSAN PEARCE:** Yes.

**The Hon. SARAH MITCHELL:** Ms Pearce, you just made mention of safe staffing. I think the commitment was 2,480 nurses over four years. Was that correct?

**SUSAN PEARCE:** Yes. That's the number I recall.

**The Hon. SARAH MITCHELL:** And there are about 600 that have been recruited so far.

**SUSAN PEARCE:** I'd have to take on notice the number that have been recruited so far. There is substantial effort going into the recruitment against that number.

**The Hon. SARAH MITCHELL:** I appreciate that it's not for you to speak for the Government, but my recollection is their election commitment was 2,480 in four years, which I assume means that target is June next year. I'm just wondering whether that will be met if only 600 have been recruited so far.

**SUSAN PEARCE:** Ms Abbas may wish to comment, but when we're given a commitment to meet, we make it. Clearly, we're working through those issues with the Nurses and Midwives' Association. Fatima, did you have anything else to add?

**FATIMA ABBAS:** Just to confirm we're in the process of allocating the remaining roles. Our intention is to recruit to those as quickly as possible.

**The Hon. SARAH MITCHELL:** That would be another 1,800 over the course of the next 12 months. You're on track to do that?

**FATIMA ABBAS:** That's correct.

**The Hon. SARAH MITCHELL:** Good luck. I hope it works. I go back to the ambulance issues and the broader question around patient transfer services. I'm more interested in that in rural and regional areas because, obviously, some of the paramedics that I meet with operate low acuity transports. They might be taking people from one hospital to another. I understand that there has been some work in relation to that in a couple of the regional LHDs, but I'm just wondering what work is being done in terms of those regional transfer pressures and the impact it has on the frontline paramedics in conjunction with Health. I'm happy for any or all of you to answer that.

**LUKE SLOANE:** Perhaps I'll go first, Ms Mitchell. We work with our colleagues from HealthShare, who run the Patient Transport Service in the majority of the State. They have engaged with several of the regional and rural local health districts to either put patient transport services in or start to utilise patient transport services where the district has formerly done it themselves, in order to increase efficiency or increase the fleet and workforce with regards to doing that, in order to take that stress off NSW Ambulance. Where they aren't doing that, they are engaged with the district to make sure that the district themselves are optimising their own patient transport services to make sure those transports are happening.

Before handing over to Mr Morgan, the thing to really note—and I've had this conversation quite a bit in the last couple of weeks—is there will always be a spot for New South Wales paramedics to transport certain categories of patients based on their clinical acuity. Whilst the patient might be stable at that very point in time, whatever their illness is or what they've come to hospital for might actually just determine that New South Wales paramedics are the most appropriate transport to take that patient from one place to another.

We know that in some spots—and I was talking to the Muswellbrook mayor about this just last week—where they have to be transported out after hours to go to a CT scan or otherwise, that's not exactly optimal because we would love to have that service closer to the hospital or based within the hospital. But there will always be a place, because of the clinical acuity, for that patient to go with New South Wales paramedics. We work closely between patient transport services, whether they're district based or HealthShare based, and NSW Ambulance to make sure that they are the appropriate transfers and it's not just an overflow where PTS can't do it and so it gets handed to Ambulance. We've done a lot of work to make sure that that number is reducing.

**The Hon. SARAH MITCHELL:** I have a couple of quick ones to you, if I can, Dr Morgan. The last budget had $10 million of funding for accommodation and housing in rural and regional communities for paramedics. Is there an update on that? I'm happy if you want to take it on notice. I think Dungog has had some accommodation.

**DOMINIC MORGAN:** Key worker accommodation.

**The Hon. SARAH MITCHELL:** Yes, but I'm keen for any other updates on that.

**DOMINIC MORGAN:** Emma, have you got key worker accommodation? We're just looking for that.

**The Hon. SARAH MITCHELL:** If you want to take it on notice, that's fine. I'm just curious about the breakdown of that $10 million.

**LUKE SLOANE:** Let us have a quick look and we'll probably be able to come back to you today.

**DOMINIC MORGAN:** I actually do have the answer to the infrastructure question.

**The Hon. SARAH MITCHELL:** Could I just ask about the staffing enhancements for the Hunter New England? Are there any plans for additional staff in Glen Innes, Tenterfield and Inverell?

**DOMINIC MORGAN:** That would be subject to the phase 4 locations, and I can help you with those. Sorry, what were the positions?

**The Hon. SARAH MITCHELL:** Glen Innes, Tenterfield and Inverell.

**DOMINIC MORGAN:** Not for the announced year three, so this year, and others would be subject to announcement of government. I can give answers about the new services that Ms Carter was after.

**The CHAIR:** We haven't started the clock yet, so I'll allow that.

**DOMINIC MORGAN:** There was $100 million allocated since June 2022. I think that was your start date, wasn't it?

**The Hon. SUSAN CARTER:** Yes, thank you.

**DOMINIC MORGAN:** We have opened five new services and we have done eight rebuilds and 17 major refurbishments. Would it help if I gave you those locations?

**The Hon. SUSAN CARTER:** Yes, thank you.

**DOMINIC MORGAN:** Fairy Meadow was new service, and Forster, Lake Cathie, Medowie and Old Bar. That is the last of the new services. The new builds are in Casino—

**The Hon. SUSAN CARTER:** New builds or rebuilds?

**DOMINIC MORGAN:** New builds. Basically, the station was so old we've built a whole brand-new one.

**The Hon. SUSAN CARTER:** So a knock down and rebuild.

**DOMINIC MORGAN:** Yes, nearby.

**The Hon. SUSAN CARTER:** That's my language.

**DOMINIC MORGAN:** Casino, Coffs Harbour, Kingscliff, Tamworth, Tumut, Glen Innes, Woy Woy and Jindabyne. They're all the complete new rebuilds. And then the refurbishments were Armidale, Blayney, Bulahdelah, Bomaderry, Coleambally, Evans Head, Gloucester, Lockhart, Macksville, Manilla, Mudgee, Narooma, Stockton—

**Ms CATE FAEHRMANN:** Maybe this could have been provided another time.

**DOMINIC MORGAN:** Nearly there. Tea Gardens, Taree, Tenterfield and West Wyalong.

**The CHAIR:** Because that answer was very long, I'll let the Committee know that it's my intention to take that out of the Opposition time before afternoon tea. My colleague has been waiting very patiently. There's a full 10 minutes on the clock for you, Ms Higginson.

**Ms SUE HIGGINSON:** Hello, all. I have some questions for Ms Hoey from Justice Health, if that's okay. I'm assuming these questions may be to you but, if they are to go elsewhere, please direct as you see fit. Last year recorded the highest number of First Nations deaths in custody. I'm just curious about what alert systems Justice Health has in place to ensure that potential for First Nations deaths in custody is being mitigated.

**WENDY HOEY:** Before we start, I just acknowledge the families and the loved ones of lost people in custody. When we speak about figures, it does get a bit impersonal. Every unexpected death is a tragedy. I put that up there before we go. I acknowledge the increase in deaths in custody. It's a real concern to us, as it is to you, Ms Higginson. We really enjoy your advocacy. I think there's no one reason that we can find. We've done a lot of reviews. We've worked very closely with Corrective Services, doing rapid reviews and having a look at what has happened in the last two years, in fact. In 2022-23 there were only 12 deaths in custody and then in 2023-24 and 2024-25 it increased dramatically.[1]

The population has increased considerably within the Corrective Services remit. As you know, remand has increased dramatically. With that has come an extreme rise in the population of Aboriginal people in custody as well, to over 34 per cent. The demographic changes within the custodial setting are certainly driving some of those numbers. We have been very active with the national program, looking at the improvements to Aboriginal health in custody. It's a really good program, which has been driven by the Aboriginal controlled sector, about what we can do within prisons to ensure that that Aboriginal leadership is there. Certainly, from our perspective, Justice Health has been working tirelessly over the last couple of years through the NSW Health Aboriginal transformation program and Aboriginal Health Plan to improve our own Aboriginal governance within custodial settings, ensuring that we have Aboriginal leadership right at the top. We've done that now.

I would just like to acknowledge my Aboriginal peers that I work with within the justice sector. They do a really good job under hard circumstances. We have also increased our partnerships with the Aboriginal controlled sector, ensuring that those Aboriginal voices and that transitional care and access to cultural support for those workers is in place. There has been a two-tiered approach. There's our internal Aboriginal governance, but we have also got a lot more partnerships with the Aboriginal sector. Last week we just had our first Aboriginal

[1] In correspondence to the committee provided on 27 March 2026, Ms Wendy Hoey, Chief Executive, Justice Health, clarified their evidence.

community advisory committee meet, and that's quite a diverse group of Elders and different organisations to provide us expert advice on how we go about our business. It's a huge concern for us.

Corrective Services as well started a rapid review. I think the commissioner has talked about that. We've been very engaged in that. One of the things that we have improving is peer support. We've found that really helpful for the inmates within the correctional centre. We are providing training to other inmates to provide support and access to care, because sometimes, through past policy, we know that it is difficult for Aboriginal people to trust us to access that care. So we're trying to break down those barriers.

**Ms SUE HIGGINSON:** That leads me to the next matter I really want to raise. In my experience corresponding with inmates, which I do quite a bit, often they end up punished by Corrective Services NSW staff simply for reaching out to me or other oversight bodies. We know it's not meant to happen. We know there are rules to say that can't happen. But, the fact is, it does happen. I'm wondering if there's anything that Justice Health staff and the people within these places are doing to make sure that inmates advocating for health care are protected from repercussions.

**WENDY HOEY:** I'm really sorry to hear that's happened. I'm sure you would've told me if it was health services. I don't want to comment on the actions of Corrective Services. You know that we work very closely the with Inspector of Custodial Services in ensuring that any recommendation she gives us, we attend to. We provide really good information and have a good relationship there. One of the things we have done across the State in probably the last six months is roll out what we call open clinics, which means that inmates can access health services without having to go through Corrective Services. So we're available without an appointment—without a bluey, as they call it, as you would know—trying to make it so that there's no barrier between us and Corrective Services. The feedback from that has been really good. We've done some evaluation with the inmates on that. It's really good.[2]

I think the other thing is that we all learnt lessons from Astill. One of the things we spoke to the women quite a lot about, and did some co-design with them around, was why they didn't come and tell us and what were the barriers between the inmates and ourselves as advocates for our patients. We went through our staff and did a lot of curiosity training with them so that they ask the next question and dig a little deeper. So there's lots happening. I think a lot of cultural change as well is happening within Corrective Services, and the commissioner is really driving that, which then impacts on us and makes our job that bit easier.

**Ms SUE HIGGINSON:** That's good to know. The Minister for Corrections has asked me to direct all my correspondence to him now, rather than the health Minister or Justice Health directly. I know that's clearly a matter for the Minister, but I'm just curious, is it helpful when I am providing correspondence that I believe is really important to go directly to Justice Health that I am able to correspond directly to you and your officers?

**WENDY HOEY:** I don't want to speak on behalf of any Minister. However, Ms Higginson, you do have the ear of a lot of inmates, and if there's an issue with health, we want to hear about it as quickly as possible. Particularly if it pertains to suicidality, self-harm or any risk, I think it's really opportune to tell us as quickly as possible.

**Ms SUE HIGGINSON:** The Ombudsman's investigation into the inmate disciplinary procedures found that Justice Health was not notified of inmates being locked in solitary confinement—confinement to their cell as a penalty—in 48 per cent of cases. You would be aware of that. Has Justice Health taken steps to ensure that they are notified when inmates are locked in solitary confinement?

**WENDY HOEY:** Yes. That was a real concern to us, considering that we have a responsibility to do a welfare check on anybody who's in solitary confinement. Therefore, we weren't able to fulfil our responsibilities. So we have worked really closely. I'm actually co-chairing a working group with one of the deputy commissioners on reducing restrictive practices and trying to improve the policies and procedures around that. Also, two of our forensic psychiatrists are working with that group around welfare within solitary and how we can support that. So I think we've broken it down. Mr Taylor, the deputy commissioner, is working really closely with us around making sure that happens. There's a lot—it's a lot of work—but it's good work.

**Ms SUE HIGGINSON:** I was recently made aware from a call for papers that on 29 September last year, the Public Service Association recorded that the Prison Officers Vocational Branch indicated that they will not complete confined-to-cell checklists. Are you aware of that?

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[2] In correspondence to the committee provided on 27 March 2026, Ms Wendy Hoey, Chief Executive, Justice Health, clarified their evidence.

**WENDY HOEY:** That would be something you'd have to refer to Corrective Services NSW. I wouldn't be able to answer that. I wasn't aware of that.

**Ms SUE HIGGINSON:** It's my understanding that that is the point at which you are notified that somebody is being sentenced, or punished, to solitary confinement. That's the point that Justice Health gets notified, right?

**WENDY HOEY:** Yes. I think there are a number of ways. That's one of the things that we identified after the Ombudsman's report, that there wasn't one way. We are trying to work out what is the best way for us to know all the time. It is identified to us through the OIMS system, but we weren't sure how reliable that was either. I think it brings to the fore the importance of the relationship between ourselves and Corrective Services and how we work together, particularly our nurse unit managers and our governors. They're the ones in the centres that have that communication.

**Ms SUE HIGGINSON:** Given that Justice Health staff can be called as witnesses during inmate discipline proceedings for alleged correctional centre offences, what steps have Justice Health taken to provide support to staff who are involved in those proceedings?

**WENDY HOEY:** I don't know how to answer that. Obviously, we've got policies and procedures around what we do and don't do. Our clear recommendation to our staff is that we can comment on health but we can't comment on any custodial environment or punishment. It's not our place. We could give advice around what we think from a clinical perspective might happen if somebody in cell placement were in a cell with two people and then they were going to go into a cell with one person, but our recommendation to our staff is to only comment on health-related aspects of care into Corrective Services. We don't get involved in the outcome of any punishment.

**Ms SUE HIGGINSON:** That's been so helpful. Thank you, Ms Hoey.

**The CHAIR:** I had a couple of quick questions for Justice Health as well, so I'll keep you in the hot seat. Why have the network medication guidelines not been published?

**WENDY HOEY:** There are a number of reasons. We haven't published our policies and procedures. We published a list of policies and procedures, and guaranteed that anybody can write to us and access that. That's because a lot of those policies and procedures have parts of them redacted because of the security aspects. So we often work with Corrective Services and ourselves. But if you want those guidelines, you can ask us and we will give you them.

**The CHAIR:** The reason I'm asking is that it's my understanding that the Information and Privacy Commission has specifically advised that the network medication guidelines should be an open-access information document.

**WENDY HOEY:** We've actually written to the privacy commission to get some advice on that around our policies and procedures, because we're trying our best to be a transparent organisation. We're quite clear in our leadership that sharing information is the best thing to do. However, we always have to balance that with the security of the environments that we work within, and our policies and procedures have security information in them. We're speaking to the Privacy Commissioner. We've actually written to her to get some advice around that.

**The CHAIR:** When was that?

**WENDY HOEY:** I'm trying to think if it was this year or last year. I'm in the middle of SDPR, so my head is a bit—I can't tell you exactly when it was. I think the last communication we possibly had was at the beginning of January, maybe when we came back from holidays, but I can let you know.

**The CHAIR:** So fairly recent.

**WENDY HOEY:** Yes, within the last couple of months.

**The CHAIR:** My last question for you is, the Improving Medication Administration in Custody project was completed in 2023. What action has been taken since then? Has it achieved its outcomes?

**WENDY HOEY:** A few things have been implemented. We're still implementing it. One of the changes was to have trial clinical pharmacists within our MRRC environment, our reception environment, because there were delays to people getting onto medication. We put some pharmacists in to do medication reconciliation at the front end. It's working really well, saving nurses a lot of time. Also, we have increased our patient self-medication program, where they deliver their own medications. I think sometimes we can be a bit parental when people come into prison and take everything off them. So we are trying to improve access so that people can deliver their own medications and empower them to look after that.

We've been looking at ways of delivering the buprenorphine injection, and whether that's drug and alcohol or primary care, because there's been a lot of concern about the increases within that and the workloads around that. I think there were about 24 recommendations, and we're working our way through them. We believe that with the implementation of SDPR, as well, our medication management will be a lot easier to track and trace around what we are prescribing and what we're not prescribing. We've done lot a of de-prescribing around that, too, so lots of things are happening. I'm happy to give you an update at some point.

**The CHAIR:** Many of the findings or statistics that led to that project were really concerning.

**WENDY HOEY:** Definitely.

**The CHAIR:** Will that be re-evaluated, or when will the progress of that be measured?

**WENDY HOEY:** Medication management is one of our most challenging aspects within the prison environment. It's a concern to me. It's a concern to me about patient safety but also productivity. That's why we've put so much investment into the medication management. I think, once we get a few of these things in and trialled, then we will evaluate how we've gone with them going forward. I definitely know the clinical pharmacist—the evaluation is happening just now and is coming back quite positive. I would expect we'll expand that when we move into Parklea.

**The CHAIR:** I'm not sure who my next question is for, but I'll direct it to Ms Pearce. You can let me know if you're not the right person. I'm following up the LGBTQIA+ health strategy again. I understand the flexible fund final report was written in September last year. That summarised the outcomes, challenges and lessons learnt from the 21 projects that were funded in the initial round. Have any of those projects since been continued or expanded?

**ELIZABETH WOOD:** I'm just trying to find that now.

**SUSAN PEARCE:** We're just trying to find it for you. If we can't do that quickly, we might be able to come back.

**ELIZABETH WOOD:** We'll come back, I think.

**SUSAN PEARCE:** Is it okay if we come back to you?

**The CHAIR:** No problem. That brings me back to Dr Chant. The RACGP is calling for a State-funded vaccination package, including expanded access to influenza, meningococcal B, RSV and pertussis. What consideration have you given to that proposal?

**KERRY CHANT:** This year we have announced a nasal flu preparation which will be available. I've got to say that that will be limited, but we are trying to distribute that on an equity basis, particularly focusing on general practices that have a large paediatric population. We are also making that available through pharmacies, but I stress it's a limited supply. We'll evaluate the acceptability of the nasal and whether that does improve our childhood vaccination coverage. With respect to meningococcal B, we understand that the Minister has written to the Federal Minister to continue to ask for that to be re-evaluated. I would just have to check, but I think it may well be listed for reconsideration. Could I just confirm whether that's being considered?

**The CHAIR:** Please.

**KERRY CHANT:** RSV—I can't declare, but I would be optimistic that there might be announcements by the Federal Government in due course around the RSV vaccine, so that is good news. The other vaccine?

**The CHAIR:** Pertussis was the last one.

**KERRY CHANT:** Which aspect of pertussis, I wonder?

**The CHAIR:** From memory, it was to do with expansions to particular vulnerable populations. I haven't got in front of me.

**KERRY CHANT:** I'll just have to ask the team. We haven't really focused on pertussis, but I will review that. Certainly we'll look at those opportunities.

**The CHAIR:** I also cut you off this morning. You were providing some examples where there had been cross-portfolio work or where the preventative health aspect of projects had been considered.

**KERRY CHANT:** That's fine. I did a very poor job at describing a wonderful active transport health model, which was work done across Health, Transport, Treasury and Planning. Basically, it's a consistent method for incorporating the health outcomes in planning assessment processes for active transport infrastructure, and it addressed a key policy gap. That has now been accepted by Treasury. That's a very useful thing for us in ensuring

that those incidental benefits associated with active transport are taken into account in the cost-benefit analysis for those pieces.

**The CHAIR:** You said that had been accepted by Treasury. When did that happen?

**KERRY CHANT:** I think it was probably about a year ago or something like that. It was a key piece of work. The models, parameters and values are included in NSW Treasury's Outcomes Values Database and on the Treasury website as a key sector framework providing supplementary guidance for use alongside the whole-of-government guide to cost-benefit analysis. That's probably one example. I work with Education, and we have a memorandum of understanding. We work incredibly closely—and it's not just my portfolio area; it'd be across the ministry—in terms of supporting the school curriculum, supporting health and wellbeing nurses and looking for opportunities to engage with Education in terms of vaping, cigarettes, vaccination or other health issues.

The food regulation committee—we work closely and have an ongoing partnership with the NSW Food Authority. The two agencies work together to present a coordinated and single New South Wales position at the binational Food Regulation Forum—both food Ministers and the Food Regulation Standing Committee. One example is the front-of-pack labelling scheme and the health star rating. New South Wales has been supporting the move towards a mandated health star rating system, which was agreed by food Ministers at their last meeting. It will certainly strengthen the significant investment that we've made to date in ensuring consumers can find health stars on all products, not just those that choose to display it. They're just some examples, but our local health districts also do work with their local government on particular cross-sectoral work as well. They're probably examples of stuff we've done at the State level, but there's certainly a lot of deep-rooted engagement with local council.

**The CHAIR:** I have a question about the safe staffing levels rollout. I note that, as of October last year, there was an update that there were 50 emergency departments across the State that had started implementing safe staffing levels. Can you provide an update of where that's up to, including whether those positions have been filled?

**FATIMA ABBAS:** Sure, if you'll just bear with me for a moment. As of earlier this month, 27 level 5 and level 6 EDs and 27 level 3 and level 4 EDs have commenced recruitment towards safe staffing levels. So far, we've recruited more than 770 additional nurses. If you'd like the breakdown of those numbers, I will need to take that on notice.

**The CHAIR:** Please. My other question is, is there a time frame for when you expect all emergency departments who are slated to have safe staffing levels to be completed?

**FATIMA ABBAS:** The target is as per the election commitment, but we are working our way progressively through those categories of ED departments. I can come back to you on notice. We don't have the full rollout schedule yet, as of this point, but we're working our way through the plan.

**The CHAIR:** I anticipate you'll take the next question on notice too, but so you've got them all together, what consideration is being given to other departments in hospitals in addition to emergency?

**FATIMA ABBAS:** So far, we are working through the emergency departments and some of the postnatal wards, as per the commitment that the Government has provided. That's the extent of the work that we're doing so far, but I can take on notice what plans we may have beyond that.

**The CHAIR:** Thank you, I appreciate that. With my last bit of time I might come back to Ms Wood. You provided an answer to one of my questions to the Minister this morning about *The Missing Voice* report, that you'd taken that up with the children's network. I think I cut you off, so I wanted to come back to it. Can you provide a bit more detail about that meeting?

**ELIZABETH WOOD:** Absolutely. I just met with the chief executive of Sydney Children's Hospital last week on a number of items, and we did happen to discuss the report that has come out. We are considering the report. Obviously, it came out in December last year, and we are considering implementing any appropriate refinements to the existing models of care. Any changes would obviously be informed by robust and evidence-based data using a sequential and stepped approach. I think it's probably important to note that a really important part of this is a well-resourced and supported MDT operating in close proximity to the child or young person and their families.

We do actually have a robust, structured MDT with Sydney Children's Hospital at the moment. It is actually benchmarked internationally as best practice. It certainly is beneficial and safeguards patients, families and clinical staff. I think in terms of moving forward, one of the challenges obviously is in terms of the number of different specialties involved, and really thinking about how we enhance that MDT approach to support that

care navigation type role. Bringing the voices into how we design and continue to review models of care will be really important. Personally, I was quite surprised by how many specialties are involved in that MDT. Obviously, it's very important that we continue to look at that very closely.

**The Hon. SUSAN CARTER:** Ms Hoey from Justice Health, thank you for being here. During the psychiatry dispute last year, did you lose any staff specialists who resigned?

**WENDY HOEY:** I think three of our staff specialists resigned, but we didn't lose any numbers.

**The Hon. SUSAN CARTER:** How were those staff specialist positions filled?

**WENDY HOEY:** We recruited and filled them.

**The Hon. SUSAN CARTER:** As staff specialists, VMOs or locums?

**WENDY HOEY:** During the dispute, a number of our staff specialists went on leave without pay from their staff specialist position and moved across to VMO positions.

**The Hon. SUSAN CARTER:** How many specialists was that?

**WENDY HOEY:** I don't have the figures in front of me.

**The Hon. SUSAN CARTER:** On notice, could I have those figures?

**WENDY HOEY:** Definitely, yes. We've got all that.

**The Hon. SUSAN CARTER:** And now the dispute's resolved, do they remain as VMOs or have they become staff specialists again?

**WENDY HOEY:** No, everybody has gone back to their original positions. That happened quite quickly on the resolution of the dispute.

**The Hon. SUSAN CARTER:** And the three staff specialist positions were filled with external recruitment?

**WENDY HOEY:** Yes. At this point, there may be new vacancies, but we didn't have any vacancies at some point. We hadn't had the same issues, I think.

**The CHAIR:** We will break for afternoon tea and be back in 15 minutes.

**(Short adjournment)**

**The CHAIR:** Welcome back, everyone. Before we go to Opposition questioning, I indicate that we don't have any questions for Ms Meagher. You are welcome to go.

**(Kate Meagher withdrew.)**

**The CHAIR:** Ms Hoey, there are only a few questions left for you from Ms Higginson. After Ms Higginson has finished her next round of questioning, you can also go.

**The Hon. SUSAN CARTER:** I want to ask some questions about workplace safety and psychosocial hazards in the workplace. Is that you, Ms Abbas?

**FATIMA ABBAS:** Yes.

**The Hon. SUSAN CARTER:** If you can in one sentence, what is happening at Concord hospital?

**FATIMA ABBAS:** Can you be a bit more specific?

**The Hon. SUSAN CARTER:** Is it common that there be a scheduled secret ballot vote for a vote of no confidence in health management?

**FATIMA ABBAS:** It's not common. I've only been in the role eight weeks, but I do understand that the ministry has worked really closely with Concord over the last couple of years on a range of issues, and we've provided a significant level of support to them.

**The Hon. SUSAN CARTER:** But clearly, from what we're hearing from doctors in particular at Concord, that level of support is insufficient or misplaced and there's a strong feeling, not just from doctors at Concord but from other hospitals who have approached us, that there isn't a safe mechanism for them to raise issues about safe places of work and safe systems of work, and raise issues that they think are inappropriate with

senior staff. What are we doing to create a culture where all members of medical staff feel that they can appropriately report incidents and be heard?

**SUSAN PEARCE:** Mrs Carter, I might, if you don't mind, address that. Deb Willcox is here as the chief executive who's responsible for Concord so she can specifically talk to that, but I might mention it as well. I, along with Minister Park, have created a quarterly meeting with the statewide Medical Staff Executive Council. We recently met with them and they were able to share with us a recent survey of medical staff councils in which there's substantial improvement over the last five years in regard to the view of medical staff councils as they relate to the NSW Health executive broadly across the State. I categorically refute any suggestion that there is no safe place for people to raise their issues. The New South Wales health system absolutely depends on people raising their issues. It is not to say that every time someone raises an issue there is agreement as to the substance of that issue.

In regard to Concord in particular, there are a number of things that I would like to put on the record. When issues were identified at Concord three years ago now, NSW Health immediately, with the former Deputy Secretary in People, Governance and Culture, commissioned an assessment of the issues there and actions that were then intended to address them. We then, on top of that, between December 2023 and March 2024 sent in Dr Marianne Gale and another colleague to ensure that those recommendations and action plan were rolled out. We sent them back again in August 2025 to ensure that those recommendations indeed had been rolled out. We have a new chief executive for the district. We have a new general manager for Concord hospital.

I met with the chairs of the medical staff councils at Sydney Local Health District in August of last year. I attended a combined medical staff council meeting with all medical staff councils in Sydney Local Health District in September of last year, despite the fact that I'd offered to go hospital by hospital and meet with them. We've also commenced a "shaping the system" initiative, and we currently have a team led by a clinician, an intensivist, Nhi Nguyen from Nepean, going around talking to our system about how we can create and improve better opportunities for people to raise their issues to ensure their voices are heard. As I said, we've established the meetings, Minister Park and I, with the statewide Medical Staff Executive Council. We know our system's not perfect, and I'm not suggesting it is.

**The Hon. SUSAN CARTER:** No system ever is.

**SUSAN PEARCE:** No system ever is. But in regard to the efforts to address those issues at Concord, I genuinely believe that we have done all that could be reasonably expected of us. That includes me writing to all staff at Concord hospital in which I've apologised for the fact that some of those actions were ever required in the first place. I've also apologised verbally, and the People Matter Employee Survey of Concord hospital that was conducted last year, which Ms Willcox can speak to, has shown substantial improvement. To put a question to us about what is going on at Concord in terms of cultural safety, I think, without referencing that is not the full picture. But I'll hand to Ms Willcox to further elaborate.

**The Hon. SUSAN CARTER:** Just before you do, Ms Pearce, I've seen that People Matter survey and I agree. You would have also, I'm sure, seen the minutes from the meeting of 6 February 2026.

**SUSAN PEARCE:** Sorry, which meeting, Mrs Carter?

**The Hon. SUSAN CARTER:** Sydney Local Health District, Medical Staff Executive Council, Concord Repatriation General Hospital Medical Staff Council—the chair's report for the meeting of 6 February.

**SUSAN PEARCE:** No, I would not normally see those.

**The Hon. SUSAN CARTER:** I apologise. This report acknowledges the changes that have been made, but it then goes through two pages that include a failure to adequately address allegations of bullying and harassment, failure to adequately address the concerns of the medical staff council in the strategic plan, failure to adequately consult in relation to the service agreement between NSW Health and Sydney Local Health District, failure to adequately fund the rebuild or maintenance of Concord Repatriation General Hospital, draft social media policy—a whole lot of issues.

**SUSAN PEARCE:** I understand that list. Can I say that I respect the fact that people raise issues, and I think that the issues were raised by the medical staff council in Concord in 2023. I absolutely acknowledge that there were things that needed attention. My point is that they received the attention. Myself and Mr D'Amato, our chief financial officer, as I said, have met with the medical staff council executive across the district. We've explained our budget setting process and service agreement setting process. I understand why people may feel that the service agreement perhaps doesn't adequately address what they think it should. If you asked anybody across the health system, they probably would say the same.

I'm aware of the proposed vote of no confidence that was to be held last week, but I'll leave that to Ms Willcox to address. It is an untenable situation from my perspective to continue to have allegations levelled at myself and my team, which, for the most part, we are absolutely unable to defend ourselves against publicly, when we have done our level best to address those issues. Our view of this is that we want a safe place for our workforce to work in, and that means everyone. The "shaping the system" work, as I said, led by Nhi Nguyen and Dr Levesque, who's away presently, is a very substantial piece of work across the State so that we can ensure that the voices of our staff are heard. It doesn't mean, though, that we agree with everything that they say. Deb, do you want to comment about the meeting on Thursday?

**DEB WILLCOX:** Yes. The first thing to say is that Concord hospital is an extremely high performing hospital. The People Matter Employee Survey results really strongly represent the efforts of myself, the general manager and the whole team to strongly engage with that hospital and engage with staff. I attend sessions called speed dating, as I affectionately call them, where people can come and talk to me about anything in 15-minute slots. I visit the hospital regularly. The general manager is actively engaged with the staff down in the ED on busy days et cetera. It has a great culture. It's got strong community support. It's a terrific hospital. It would be fair to say that there are individuals on staff who, like in any organisation, have a slightly different view about matters and continue to raise the same matters in relation to the strategic plan, in relation to the service agreement et cetera. I'd like the Committee to understand that these issues have been raised repeatedly and have been repeatedly answered, to try to assist certain members of staff that these are the processes, this is how we do things and let's keep talking about it. It's an open-door policy. We're happy to engage at any time, any place. I did attend—

**The Hon. SUSAN CARTER:** Can I just stop you there, Ms Willcox. Is that perhaps an issue? If the same issues are being raised and the same answers are being given, does that then lead to a feeling that we're hearing about that concerns that are being raised are not being heard?

**DEB WILLCOX:** There may be a very small minority of people, I expect, that may still feel dissatisfied with the responses. But, again, I need to emphasise to the Committee that our efforts to communicate and engage with all staff on all matters have been intense. I've attended hundreds of meetings, engaged with hundreds of staff. Many issues are raised and everybody's entitled to a response. The medical—

**The Hon. SUSAN CARTER:** If it's just a small group, why then have we got to the point where there is a planned secret ballot vote of no confidence?

**DEB WILLCOX:** I attended the medical staff council meeting last week when this motion of no confidence was to be discussed. There were two people who supported it. The remaining members of the medical staff council in the meeting did not, and spoke up very strongly that they did not feel this was an appropriate response, and that the local health district and the local management have been highly engaged with the hospital. As I said, the results of the PMES speak for themselves. They felt like many of the issues were historic and had been prosecuted on many occasions, and that some of the more contemporary issues around primary care and aged care were valid issues that we should collectively discuss. But they certainly did not support the vote of no confidence.

**The Hon. SUSAN CARTER:** The other issue that we're hearing—and not just from Concord but across—is that there may be not mechanisms within Health, but mechanisms internally within the culture of some hospitals, that if more junior doctors want to report something, they feel that they're facing their career being blocked or—

**SUSAN PEARCE:** By whom?

**The Hon. SUSAN CARTER:** By more senior doctors. But that's a cultural issue in that hospital. Is that a valid concern? If it is, what work is being done to address those cultural issues?

**SUSAN PEARCE:** Deb might be able to talk to some of the more specifics. In fact, Tracey from the Hunter has done a lot of work in this space with junior medical officers as well. It's really important that our staff have the ability to raise issues. We're also aware that, at times, the hierarchical nature of Health can impede that. You won't be surprised to know that across 185,000 headcount staff in NSW Health, I get quite a lot of communication directly from staff within our health system. I can tell you that I respond to those people every single time. They do express to me, at times, a degree of trepidation about reaching out.

What we're trying to do is establish a system within our health system that no matter who you are—no matter whether you're a junior medical officer, a junior registered nurse, a cleaner or a porter—you have the ability to raise your issues. This is a very important piece of cultural work, because we are slowly breaking down some of the hierarchical nature of our health system. But it does take time. My message to our chief executives has been consistent: If it's good enough for me to pick the phone up and talk to someone, it's good enough for anyone.

**The Hon. SUSAN CARTER:** Are you satisfied that all the chief executives are doing that—they're following your lead?

**SUSAN PEARCE:** I am satisfied that our chief executives do their level best to address every issue that they can, as quickly as they can. Could we do it better? Absolutely. But there are forums for junior medical officers where they can come together. There are other forums, and the unions obviously advocate on behalf of their members. But this is an area that we genuinely want to see improved. You mentioned the social media policy. Can I just say the social media policy within NSW Health is part of a whole-of-government process. It is not NSW Health specific.

We have consulted widely with unions and made changes to it as a consequence of that. Of course people need to be able to speak up. But to be perfectly honest, the place for them to speak up is in their workplace. If that doesn't work, there are other avenues, which we publish to our staff. The use of social media is fit for many purposes. People do use it and they're entitled to use it, of course. But our policy is not designed to quell the voice of our staff from reporting issues.

**The Hon. SUSAN CARTER:** Ms Abbas, this morning we were talking about conscientious objection. I'm trying to understand. I didn't believe that there were policies across Health for conscientious objection. Are you developing a whole-of-Health policy?

**FATIMA ABBAS:** We are developing a policy, yes.

**The Hon. SUSAN CARTER:** So it will be whole of Health; it won't be procedure specific?

**FATIMA ABBAS:** We provide guidance. On issues like this, we would provide guidance across Health.

**The Hon. SUSAN CARTER:** Sorry, what is the document on which you're working?

**FATIMA ABBAS:** It will be a policy directive.

**The Hon. SUSAN CARTER:** Does it relate specifically to certain procedures or is it for the whole of Health?

**FATIMA ABBAS:** This is for the whole of Health.

**The Hon. SUSAN CARTER:** What drove the development? This is a new document, then?

**FATIMA ABBAS:** I will need to come back to you on that, unless one of my colleagues can clarify.

**The Hon. SUSAN CARTER:** Are you revising an existing document or creating a new document?

**FATIMA ABBAS:** I need to come back to you on that. Like I said, I need to check.

**The Hon. SUSAN CARTER:** Who's doing the work on it?

**FATIMA ABBAS:** I'll just check if Mel is able to answer that.

**MELISSA COLLINS:** The work's being done by a range of branches, in consultation with districts.

**The Hon. SUSAN CARTER:** Just so I've got it straight in my head, is it a new from-scratch document or is it a revised document?

**MELISSA COLLINS:** At the moment it's an existing document. But it may well be, as we review it, that we might need a companion document.

**The Hon. SUSAN CARTER:** So the existing document isn't whole of Health. It just relates to specific procedures, doesn't it?

**MELISSA COLLINS:** That's right.

**The Hon. SUSAN CARTER:** So the intention is it would still be procedure specific?

**MELISSA COLLINS:** I think it's probably too early to answer that. Probably.

**The Hon. SUSAN CARTER:** What's driving this work? What was the impetus for it?

**MELISSA COLLINS:** I didn't start the work. It's been in the works for some time, the policy.

**The Hon. SUSAN CARTER:** Who can answer that? There must be so many projects. Why did this one get to the top?

**MELISSA COLLINS:** In terms of our policies, we have regular reviews of all our policies. Generally our policies are five-year documents, but some of them—

**The Hon. SUSAN CARTER:** Is this a five-year review?

**MELISSA COLLINS:** I'd have to take that on notice.

**The Hon. SUSAN CARTER:** If it's going to change from its existing scope to a broader scope, what's driving that piece of work?

**MELISSA COLLINS:** It's the consultation.

**The Hon. SUSAN CARTER:** Consultation with whom?

**MELISSA COLLINS:** All NSW Health documents and policy directives have a consultation, principally with our staff, with our districts, with other branches in the ministry to some extent—

**The Hon. SUSAN CARTER:** When is the consultation about this document going to occur?

**MELISSA COLLINS:** I'll have to take that on notice.

**The Hon. SUSAN CARTER:** If you could, that'd be great. At the moment, it's a piece of work but it's in draft and—

**SUSAN PEARCE:** I think we'll have to take the issue on notice, Mrs Carter. I just don't think we're sufficiently informed to address it today.

**The Hon. SARAH MITCHELL:** Coming back to the surgical unit at Northern Beaches Hospital that I asked about this morning, in terms of the process for patients who might be allocated to have their surgery there, how is that going to work in practice? Will somebody be able to say no to being on a list there and still have their surgery closer to home? What will that look like?

**SUSAN PEARCE:** Mr Daly can respond to that.

**The Hon. SARAH MITCHELL:** I did mention I'd be coming back to this, Mr Daly, so—

**MATTHEW DALY:** So I should give you a superb answer then.

**The Hon. SARAH MITCHELL:** Absolutely.

**MATTHEW DALY:** It is being worked up at the moment. We're working with a little bit of a black box in terms of the Northern Beaches Hospital, in as much as the activity that's gone on in there, particularly the private component—it was unknown to us. They weren't contractually obligated to report their private activity. So we're going in, post-29 April, really to cement the delivery of this unit. I have no doubt we'll be able to do it. In terms of some of the logistics that you referred to there, yes, every patient in New South Wales has an option to decline an offer of surgery. We facilitate patients every other day of the week. If they can't get it as quickly in one district, we offer them a surgical appointment in another district. They can say no or they say yes, picking up on the use of IPTAAS and those types of programs.

**The Hon. SARAH MITCHELL:** Say you're a patient in Western Sydney, there's space for you to have your surgery at the northern beaches hub when it opens and you say no because that distance is not something you wish, do you then go back down the list for your local hospital? How will that be managed in practice?

**MATTHEW DALY:** No. Surgical policy prescribes all this—that the system operates to. You're entitled to say no. It just means you'll sit on your list until you can get it done. By June the vast majority, if not the whole system, will be pretty much pre-pandemic levels in terms of patients being treated within their clinically recommended time frames. At the moment, we're about 4,000 patients above that. That's too high. There's a natural level that the surgical taskforce identified. People say no, which might force them to breach, but we've got to respect individuals' choices.

**The Hon. SARAH MITCHELL:** When do you expect this hub to be up and operational—pardon the pun—at the northern beaches?

**MATTHEW DALY:** We're aiming for 1 July. The ministry will play a brokering role to feed into these 5,000 additional cases right across the State and facilitate patient access, if that's their desire to get a quicker surgical appointment than at their home hospital.

**The Hon. SARAH MITCHELL:** I note that there has been an announcement that one of the storerooms will be converted into a new theatre, which I'm sure is not unusual. You repurpose spaces. That's not having a go at that. In terms of the clinical staff—not just the surgeons but nursing theatre staff—my understanding is that a number have left that hospital in recent months after changes have been announced. Are you confident you'll have the staffing capacity to bring this on board so quickly?

**MATTHEW DALY:** Yes. We've got enormous retention of clinical staff that have come straight over. It's something like 95 or 96 per cent. There are individuals who have perhaps chosen to leave, but they're very small in number. It certainly doesn't jeopardise, at this point, acute units like emergency departments, ICUs and operating theatres, to your question. The more certainty that comes out—hence the Government announcement this morning—will give some reinforcement that we're fair dinkum and that there will be a public-private component on that site. But it needs to be developed and, ultimately, go to market in a sensible way to get the right mix and the right complementary services to the public services on the site.

**Ms SUE HIGGINSON:** Ms Hoey, the Inspector of Custodial Services found the Metropolitan Special Programs Centre in a terrible condition. I'm not sure if you're aware. It was covered in cat hair, cat faeces, mould, rust, ligature points, broken tiles and cockroaches. The inspector also found that the facilities were too small to facilitate access for inmates with disabilities. The doors were too small for wheelchairs, for example. I recently asked the commissioner in the Corrections estimates, and he sort of said, "It was pretty bad form. We've tidied it all up." I'm just curious, firstly, whether you share the concerns of the inspector's findings.

**WENDY HOEY:** I've read the inspector's report of MSPC, obviously. We've got a couple of recommendations there as well. The MSPC buildings are old. We have spoken to the commissioner and the deputy commissioners on a number of occasions about access, double bunks for people with disability and accommodation for older persons. Certainly, up in the MSPC sites, that's a real concern for us.

**Ms SUE HIGGINSON:** Do you feel that your concerns are being listened to or, if you can say, are you getting what I think I'm getting, which is, "That's just the facility and that's what we've got to work with"?

**WENDY HOEY:** I don't want to comment on Corrective Services NSW. I've developed a very good working relationship with them, and they really are quite honest with us. We know, particularly around disability, aged care and appropriate placement, it's really difficult. The commissioner does acknowledge that the MSPC is old. I think they had slowed down using those areas, but, unfortunately, the population rise has been such that they've had to open back beds that they probably had closed previously. So I would agree that MSPC is not the best environment. I haven't actually been back up since they said they've cleaned it up. I will probably go back up next week. I've been up to the hospital, but I've not been back up to MSPC.

**Ms SUE HIGGINSON:** Is it your understanding that when your Justice Health staff are also dealing with the increase in patients and the increase in presentations of people with health and disability issues, it is harder for your staff as well?

**WENDY HOEY:** Definitely. I'm very supported by the ministry, and we certainly have had conversations about the increased population and how we manage that. Obviously, with the remand growing more, that's probably our most risky population as well from a health perspective—and also women. Yes, the pressure is on our services right now. We're just reorientating to make sure that we cover those most risky areas as much as we can.

**Ms SUE HIGGINSON:** Earlier we were talking a little bit about the inmate disciplinary procedures and systems, and that you've been involved, to whatever extent, in looking at the Ombudsman's report recommendations. Given that Justice Health workers can get called in those proceedings, if your staff have witnessed or been part of complaints around Corrective Services staff misconduct or allegations about that, do they have really clear guidance around what they should do where they can be involved to assist with those kinds of complaints?

**WENDY HOEY:** I'm trying to think about the number of times that's got to me. I don't think it has many times. I'd like to take on notice how many times we've been formally involved in those processes. I know that after use of force and suchlike, our staff will assess the patient and document that. That has at times been used; that's in staff discipline as opposed to inmate discipline. But I'd really like to take on notice to see how often our staff are used in inmate discipline. As I said, our clear direction to them would be "You can give health advice and clinical advice about placement, but we don't get involved with any decisions around discipline of inmates. It's not our job or our role." We're pretty clear about that. You can imagine, working in the environment we do, that we work very closely with Corrective Services, but we have different principles and different ways of working. How we work together is really important, but we don't cross that line into security. We provide health advice.

**Ms SUE HIGGINSON:** Given that inmate discipline procedure has been under significant iterative review, would you mind taking on notice whether you see that there is a greater role for Justice Health in that system, whether that's something that you are identifying or has been identified for you?

**WENDY HOEY:** I can take it on notice, but I think it's not a health role to be included. We might be able to give advice around deficits or disability, around why somebody is or isn't behaving the way they are, but

I don't think it is a health role to get involved in discipline. I would say that up-front here, but I'm certainly happy to take it away and have a think about it with Corrective Services as to which role we play.

**Ms CATE FAEHRMANN:** Dr Chant, I will come back to you again. I've just got some questions broadly around population health to understand what work the department is undertaking. I can see that there was a Population Health Research Strategy from 2018 to 2024. Is there a revised or new strategy?

**KERRY CHANT:** The first thing we're doing is some pieces of work on the health of the New South Wales population. We're in the process of doing a report. We have moved a lot of our data online, but I think one of the foundational pieces we need to do is document that in a more accessible way. We are pulling together a report on the health of the population. We are focused on two particular areas. I acknowledge that there are broad pieces of work that are being done across Health that impact the health of the community, but there are two key priorities that we are focusing on.

One is reducing the prevalence of diabetes, and the next, which I share with Elizabeth Wood, is basically the first 2,000 days. We think those are areas where there is significant opportunity of return on investment, particularly with an equity lens. We have created an expert advisory committee on diabetes to look at the sorts of interventions that we should be putting in place and the scale of those interventions. We are proceeding to formulate plans in that regard. There are a lot of opportunities in even the tertiary prevention aspects with the new Ozempic-like drugs. There are low-kilojoule diets. There is bariatric surgery, and primordial prevention as well.

**Ms CATE FAEHRMANN:** The report that you're referring to that NSW Health is pulling together, is that based on, for example, that strategy I was referring to that is out of date now? Is that report in place of an ongoing new strategy or are we going to see that as well?

**KERRY CHANT:** I think that data will then inform the strategy documents or research priorities. I should mention, probably, one new initiative that we've put in place which I'm really excited about as well. We've changed one of our, albeit small, amounts of money we've got for prevention research. We've actually identified the first 2,000 days, healthy birth weight, and we've called together a research consortium across the universities to work in partnership with us on that project. And then the other one is around primordial prevention and diabetes. That's an example of how we're trying to leverage off the university sector as well.

**Ms CATE FAEHRMANN:** I'm trying to find where and if NSW Health does particular research. I'm looking at the Environmental Health page of HealthStats, which has heat problems in terms of heat presentations, ED presentations, housing for health, lung dust diseases, smoke-free cars and smoke-free households. That's what's under environmental pollution. I'm just wondering, with the various things that have emerged over the last few years where populations are concerned about particular environmental pollution incidents, whether it's PFAS in the Blue Mountains, Cadia in the Central West in terms of mining or Broken Hill lead, at what point does NSW Health—and I asked this before. Where do the population-level health studies come in?

To give you an example, Trail in Canada, which has an operating smelter, has very good programs. The Office of the Chief Scientist and Engineer referenced this in the report. They have undertaken IBS, Crohn's disease and ulcerative colitis, and how much that is in the community versus the rest of the community. Indeed, they found in Trail that people are getting Crohn's disease earlier. But NSW Health, for some reason, are not doing this in the Blue Mountains for PFAS and you're not doing it in Broken Hill for lead. Looking at Environmental Health, there just doesn't seem to be anything around environmental pollution issues.

**KERRY CHANT:** Studying the environmental health impacts, we really support research that adds to the knowledge about environmental impact. The research to actually add to knowledge requires quite a lot of intensity and well-designed methodological studies to actually add to it, rather than just being a descriptive analysis. We really encourage people to apply to NHMRC and we are happy to support them for those very detailed analyses. If you're exploring, for instance, motor neurone disease, you need quite detailed characterisation of a person's exposure over their life course, blood biomarkers and quite intensive studies.

We see the National Health and Medical Research Council and the MRFF funding as being, really, the level of magnitude that we would need for that, albeit that NSW Health has provided some support for some motor neurone disease research. But a lot of that stuff is going to require those very big-scale research studies that are really incredibly well designed, because otherwise they don't yield meaningful result. That's probably my answer there. But if there are opportunities that we can make it easier for researchers to partner, easier for researchers to understand what data we can bring to the table—I'm really very excited about our Single Digital Patient Record. I'm so excited. That's in 2028. That will really revolutionise the way we can do research. It will really simplify data analysis and data collection because people will have a single record.

**Ms CATE FAEHRMANN:** We asked again about the lead notifications that are coming through. The question was what does the department do. You have these records that are over six. You've got records that are between 10 and 20.

**KERRY CHANT:** There's a control—

**Ms CATE FAEHRMANN:** Is there any analysis? Other than working with the employer, for example, are there any broader studies that are undertaken on that data that comes through?

**KERRY CHANT:** I suppose it goes to the question, Ms Faehrmann, about why we're doing the research. If we're trying to establish whether lead causes harm then that requires a particular study design.

**Ms CATE FAEHRMANN:** It does.

**KERRY CHANT:** But we've already established that at a population level, and we understand that because lead has been studied in particular occupational settings and in children. We have asked the NHMRC to do a review of any literature that's been published since the last review to see if there's any updated guidance. We have updated our control guidelines. We've got a control guideline—and perhaps I can make that available to the Committee—which goes through what the role of the public health unit is in following up.

**Ms CATE FAEHRMANN:** I've seen that. Quick question of clarification: You said you've asked the NHMRC to undertake a review to update the research on lead, is that correct?

**KERRY CHANT:** To update whether there has been any additional research and review that to look at if there's any—

**Ms CATE FAEHRMANN:** On lead in particular?

**KERRY CHANT:** As you are aware, at the time when they lowered it, because of the issue of confounding, the issue of the health effect between five to 10 was very hard to demonstrate. That's probably one of the other things that we're very conscious of. We want to optimise health outcomes overall for the communities in Broken Hill or any community, so we will also take a multifactorial approach. If they're impacted by other things, like hearing issues or anything else, we will address their lead plus also those broader health issues. That's one of the literature aspects that has been hard to tease out—the contribution of lead. We've asked the NHMRC to re-look at those studies and see if there's any new information that gives light to that. But, as I said—I know we've had these conversations before—looking at the epidemiological and the methods that have been employed in the studies is really so critical to understanding what you can draw from them.

**The CHAIR:** I just had one very quick follow-up question for Ms Wood. You were telling me about the meeting that you had with the children's hospital. Can you confirm if there are any plans for yourself or the hospital to consult with people who are living with innate variations of sex characteristics as part of their work?

**ELIZABETH WOOD:** It was a passing conversation, Dr Cohn, just on a couple of items, as I said. The chief executive was aware of the report, so we were discussing her thinking around it and also what we would do next steps. Absolutely, whatever we do next steps, it would be the intention that we would be consulting with people with lived experience, because there's not really a lot of point in considering models of care if not to do that with those who we're seeking to design the model for.

**The CHAIR:** I'll come across to Ms Skulander. I have a question about Deniliquin hospital. What funding, if any, is currently allocated to infrastructure upgrades at Deniliquin?

**EMMA SKULANDER:** I will have to take that one on notice. I don't have it here. I will try and get that while we're talking, but I'll just figure that out.

**The CHAIR:** I don't know who my second Deniliquin question is for. When services aren't available at Deniliquin, patients are travelling across the river into Victorian health services. Do we know what the volume is of patients being referred to Victorian hospitals?

**LUKE SLOANE:** We would have some idea of it. I'd have to take it on notice down to the specifics but, just so the Committee is very aware, Murrumbidgee Local Health District quite often engages in clinical service planning with Victorian counterparts. Most recently, we held a cross-border get-together with South Australia and Victoria, and had representatives from Echuca and several other cross-border communities come together and talk about that, with some expressed commitment to continue that clinical services planning with regard to renal services and cancer services that are offered across the border as well. But with regard to specific volumes, I'd have to take it on notice.

**The CHAIR:** Just to clarify, I'm interested in the unmet need. I suppose the concern is that if they're going interstate, there might not be an awareness. But I'd be very pleased to hear that you're counting them.

**LUKE SLOANE:** I think a lot of the cross-border communities with the districts working together factor that in. Where there isn't a service on the New South Wales side of the border, as you'd be well aware with Albury-Wodonga, they work together with the services across the border to be able to provide that under the Medicare or intergovernmental agreements between the different jurisdictions. Robinvale and Mildura are examples of where that would happen. The districts that border either side of the river, or any of the other borders, would work together with regard to addressing that volume or the services available so that there are not duplicated services, but people have equity in access to services.

**EMMA SKULANDER:** Just to confirm in relation to capital, there isn't any allocated capital at the moment for Deniliquin, aside from the key worker accommodation, which has been announced as a site by the district.

**The CHAIR:** Where in the cycle are things up to with plans for Deniliquin?

**EMMA SKULANDER:** I would have to take that on notice. It will be a conversation with the district around their service planning and then their prioritisation of that in the capital cycle.

**The CHAIR:** Coming back to Albury, in part of your answer this morning you talked about districts themselves sometimes putting recommendations forward for changes to scope that you then need to negotiate with government. Have you received any representation or requests from Albury Wodonga Health?

**EMMA SKULANDER:** I might clarify my answer from this morning, because I note that you were comparing the process of Shellharbour to the process in Albury in relation to the helipad. When I talked through the prioritisation of scope and how that will happen within a capital redevelopment, I'll clarify that in some instances where there aren't enough funds to be able to fund the full scope that everybody would like to be delivered within a project, we would put something to government as an option to consider whether additional funding could be allocated.

With the Shellharbour example, the funds for the helipad have actually been able to be allocated within the available project budget. The reason for that is that we hold a certain amount of contingency against every project, and throughout the project we will progressively be able to release contingency based on the risk profile of the project at that point in time. With Shellharbour, we took a position that something could be released from that contingency because we were past the point that we would have the most risk of the job getting out of the ground. In particular, that is somewhere we always find we hold quite a bit of money for in relation to risk. Each of the projects will have a list of things that they can afford and then they'll have a wish list below the line. Shellharbour had this at the top of their wish list below the line that we were able to pull up and utilise the contingency. It wasn't a decision that we needed to put to government; it was actually a decision that we made ourselves within our capital framework within Health for Shellharbour.

In relation to Albury and your query around representation in relation to the helipad, the helipad has been something that's been talked about over a long period of time. It's certainly been in the list as we've considered what we can prioritise within the capital scope. It hasn't made it up to above-the-line status within that project. Over time, we'll obviously review the risk profile of the job. We have been planning for the ability to put a helipad on the site in a future stage of that redevelopment, and we've already covered the planning process for that future stage.

**The CHAIR:** Is there anything else on that list of things that Albury Wodonga Health has made representation or requests to you for?

**EMMA SKULANDER:** In relation to scope?

**The CHAIR:** Yes.

**EMMA SKULANDER:** In relation to what's in the clinical services plan, Albury Wodonga Health have been very clear with us that they would like more scope within this project, as you know. This is the same as any other, where we prioritise working with them on the items above the line and there's a number below the line. That will be worked through as the process progresses. It would be captured in the business case. We've spoken about the business case before, I think.

**The CHAIR:** We have. I'm expecting you to release it any day. I'm holding my breath.

**EMMA SKULANDER:** Once completed, a summary of that business case does go—we don't always release the below-the-line items. Obviously, all of them usually can't be achieved. It really depends on the status of the project and its risk. But we always hope we can put as much as we can into every project we deliver. We just have to make sure we can get to the end of the job.

**The CHAIR:** With regard to future staging, I know a previous version of the plans for the Albury hospital redevelopment had a stage two that would've required demolition of the new ED they had just built. When I drew the Minister's attention to that, he subsequently ruled out that the ED would be demolished as part of stage two. Is there a functioning design for any future stages after the new clinical services building is built?

**EMMA SKULANDER:** I'm going to talk to this without having every bit of detail of this particular project and its master plan and its staging plan, but the master plan we would all be working to would have a sensible staging plan to enable future stages to be built. I feel very confident that there are feasible future stages at Albury. We have certainly interrogated that in relation to the review of being able to redevelop on that site. It sounds like a very silly idea to demolish an emergency department that you've just built, so I acknowledge that. I think that the consideration of the overall master plan would be something that we'd refresh in the next phase. In any phase of planning a project, we'll kick off with a refresh of the master plan or a review of the master plan to make sure it's the right thing to do. That site certainly has the potential to be able to develop the next stage, and if we've had something in the past that didn't seem logical, we'd absolutely be testing that in future.

**The CHAIR:** I'll come back to this, but I'm out of time. I'll go to the Opposition.

**The Hon. SUSAN CARTER:** A couple of quick questions for you, Ms Willcox, if I may. I understand that there's a mosquito infestation at RPA. Is that correct?

**DEB WILLCOX:** I wouldn't necessarily describe it as an infestation. There was a complaint about some mosquitoes being in one of our post-natal wards. That was attended to upon being made aware. Clearly, we can't spray when there are mothers and babies in the area, so we have to be cautious about how we undertake that.

**The Hon. SUSAN CARTER:** Is that related to the construction, or separate?

**DEB WILLCOX:** It would be mosquitoes in Sydney—wet summer puddles everywhere with the rain, doors open in the hospital. It would be impossible for me to guess how, but the important thing is, once raised—of course that's an unpleasant thing for any patient to experience—it was attended to promptly, as I understand.

**The Hon. SUSAN CARTER:** In relation to the construction, is it true that—I'm guessing it must be the neonatal ward or the maternity ward was moved because of noise issues for the babies?

**DEB WILLCOX:** Yes, that's correct. As part of the program of works, the work that Health Infrastructure and the construction team are doing is mostly around that eastern end of the hospital. Our neonatal intensive care unit, our intensive care unit and some of our maternity wards are co-located in those areas. We've been doing some acoustic monitoring and testing, working through with the construction company on what is happening.

**The Hon. SUSAN CARTER:** Were they moved? Or you've just—

**DEB WILLCOX:** Yes, we moved the postnatal ward up onto level 10 in the block and relocated our geriatric ward. It's a complex build. There will be a lot of dominoes as we move around the site. Importantly, patient safety and comfort, and particularly those with little babies, is absolutely paramount. I've been stringently overseeing that sound and noise testing to ensure our patients are at the front of our care.

**The Hon. SUSAN CARTER:** What did the Hunter New England LHD do to fix the mould growth problem in the John Hunter paediatric outpatient unit reported in February 2025?

**TRACEY McCOSKER:** When I reported on that earlier, we just had a program of work. We knew where the mould was. We went through it all. We moved some clinics so that we could clear that space. There were some ceiling tiles that needed to be replaced. We did it relatively quickly in a few days but now we've got this monitoring system so that we don't end up in that place again.

**The Hon. SUSAN CARTER:** So the outbreak in November 2025 was the same process?

**TRACEY McCOSKER:** Yes, I think it was the same one.

**The Hon. SUSAN CARTER:** How often are you getting outbreaks of mould?

**TRACEY McCOSKER:** It seems to happen around about summertime. The indications are all why you get mould anywhere. We've got a program in place to look out for it, especially when we know that it's been detected in the past.

**The Hon. SUSAN CARTER:** What does the acronym PODU stand for?

**TRACEY McCOSKER:** I don't know.

**The Hon. SUSAN CARTER:** It's a unit at John Hunter Hospital.

**SUSAN PEARCE:** I don't think we should be guessing about acronyms.

**TRACEY McCOSKER:** I've not heard that acronym.

**The Hon. SUSAN CARTER:** Anybody got a best guess what it might be?

**SUSAN PEARCE:** Sorry, what was it?

**The Hon. SUSAN CARTER:** PODU.

**LUKE SLOANE:** We'll find that out and not guess.

**SUSAN PEARCE:** Yes, we will take that on notice.

**The Hon. SUSAN CARTER:** Thank you, because I understand that that part of John Hunter also has a mould problem.

**EMMA SKULANDER:** It's a secondary location that's noted with identification of mould.

**The Hon. SUSAN CARTER:** What is PODU? What is that location?

**EMMA SKULANDER:** I don't know the answer to that. We'll take that on notice and confirm the detail of that.

**The CHAIR:** It might be helpful for the Committee: I think it's the paediatric oncology day unit.

**The Hon. SUSAN CARTER:** We think it's the paediatric oncology day unit. Does that sound right?

**TRACEY McCOSKER:** It could be, and that was in the remediation plan.

**The Hon. SUSAN CARTER:** The paediatric oncology day unit was part of the remediation plan?

**TRACEY McCOSKER:** Yes.

**The Hon. SARAH MITCHELL:** Just a couple of quick and very specific ones. Grafton Base Hospital—I've just got some reports coming through that staff have been told they're no longer able to order or receive skin cleansing wipes for patients. I note your facial expression, Ms Pearce.

**SUSAN PEARCE:** Sorry, I'm trying to keep it calm.

**The Hon. SARAH MITCHELL:** No, it's fine. I thought the same thing. It seemed a little bit odd that the hospital wouldn't be able to do that. Is there any update in terms of if that's—

**SUSAN PEARCE:** I have no knowledge of that, but we're happy to follow that up on notice.

**The Hon. SARAH MITCHELL:** Parkinson's NSW funding—my understanding is that they have a current grant which I think is due to expire in June this year. They're also looking for some longer term support, particularly for the specialist nurse network. Is anyone able to update me on that particular program of work?

**ELIZABETH WOOD:** In this budget year, we worked very closely with the districts to make sure that that funding was embedded into what is our normal activity funding-based processes, so that it was an ongoing confirmation that we would have that service available. With regard to the grant, I think that would be part of next year's budget review processes with that organisation, which is a different question.

**The Hon. SARAH MITCHELL:** That's obviously a matter for government in terms of their budget.

**ELIZABETH WOOD:** Yes.

**The Hon. SARAH MITCHELL:** Sorry, I didn't quite understand. The nursing positions, were they ongoing?

**SUSAN PEARCE:** We've built it into the budget, rather than it being year by year, because I think that was obviously causing a lot of angst.

**The Hon. SARAH MITCHELL:** Yes, that was the feedback—just having that certainty for staff and physicians.

**SUSAN PEARCE:** Yes. It's now part of the current budget process that the districts have.

**The Hon. SARAH MITCHELL:** For how many positions across New South Wales, specifically for Parkinson's nurses?

**ELIZABETH WOOD:** We'd have to take that on notice, Ms Mitchell, but we're trying to move now into it as a standard growth application each year. So with all of our services, they're all subject to growth. For

example, the emergency department would have a particular growth allocation added on top that would include increase of FTE. We're happy to take it on notice, but that's part of building it into our recurrent budget process, so that it grows as our growth budget grows.

**SUSAN PEARCE:** Rather than treating it programmatically, I think is the point, so it's a service that's delivered and it's funded ongoingly.

**The Hon. SUSAN CARTER:** Ms Wood, is that growth budget linked to projected population growth in the area served by the hospital or the LHD?

**ELIZABETH WOOD:** Yes, it is.

**The Hon. SARAH MITCHELL:** The issue of illegal tobacco and managing that, which I know is very problematic and certainly has its challenges—I note the Minister issued a media release earlier today about 100 short-term closure orders. I know some of that information is publicly available. Is that all on the website, those hundred, and broken down by region?

**KERRY CHANT:** If it was released today, it was 105.

**The Hon. SARAH MITCHELL:** Yes, you're right. It is 105. Sorry, I rounded down. But that's all on that register, on the website that's available?

**KERRY CHANT:** That's correct. We update the website I think on Thursday or Friday at about three o'clock with the closures for the preceding week, because sometimes we are operating in a particular region and we don't want to flag that activity by loading them daily. But, yes, that is regular and closures will be a regular part of our operations, as are our prosecutions, so that we're using the full suite of regulatory tools that Parliament has provided us.

**The Hon. SARAH MITCHELL:** I know, again, there have been some announcements recently by the Minister in terms of the authorised officers and the compliance staff, but how many are currently deployed on the ground to undertake those investigations?

**KERRY CHANT:** I think the media statement summarises how many are in the team. If you're asking how many people are on the ground at the moment, I'll have to just double-check because we do have movement in and out. For some of the aspects of the work, we can also use contractors to do some aspects of the work—for instance, disposal of the products and counting the products. We are looking at having our workforce quite flexible and using contracting staff for some elements as well.

**The Hon. SARAH MITCHELL:** If you are able to take on notice as best you can obviously the Health staff, but also even the numbers of contract staff. I appreciate that that could fluctuate, but it would just be good to get an idea of the level of authorised officers that you've got out and about. For which particular areas that you target, is there a system behind that? Is it just going around the State? Is it when people raise particular issues with you? How do you determine where the activity is taking place?

**KERRY CHANT:** There's a combination of factors. We do want to spread our activity over the State, because part of the closure orders are—I probably shouldn't use this term but, obviously, the visibility of the closure orders and the fact that we're out there overtly closing premises is an important signal to tobacconists and others, so we use that. We also then use intelligence we get from police, Border Force and other agencies, and that factors in one component of our work. We obviously have our complaint line, when people are complaining about things. We also are minded to schools or proximity to schools. But, at the moment, you've got to admit that there is widespread—

**The Hon. SARAH MITCHELL:** They're everywhere.

**KERRY CHANT:** So it's not that hard. But we are trying to move our resources around everywhere so that there is a sense that, even if—we went out to Cobar and closed down—so there is a sense we could be anywhere in closing you down. We will be also taking a few cases forward for long-term closure orders to the courts, which is a court process.

**The Hon. SARAH MITCHELL:** What's the interplay—you just sort of touched on it then—with New South Wales police? Obviously if those visits and closures then uncover potential criminal activity, how does that interplay work?

**KERRY CHANT:** The safety of our officers is paramount, so we have a police liaison that sits embedded within our team. They can allow risk assessments to be done. Before we would go and schedule visits to any premises, there would be a risk assessment undertaken. For some premises, we would only attend those premises with police. Generally, when we are closing premises—because you can imagine that's a time when we

are going to be shutting down a business for three months—all of them, to date, have been done with police presence. We work hand in glove with police, and police will accompany our officers. We will seize any product, apply the closure, and then we'll also continue to monitor that. Police also, if they're in the vicinity and see breaches of closure—as do the general public—will notify us.

**The Hon. SARAH MITCHELL:** That probably leads to my last question on this. I appreciate it's an insidious problem and that there is effort going into addressing it, but one of the areas of community concern is that Health comes and shuts them down, but—it feels like days later—some of them have the audacity to just open up again. It's a bit like you're constantly needing to do that. Is there any way to better enforce those closures so that you're not wasting resources on going back again and again?

**KERRY CHANT:** The Parliament has currently got legislation before it, which is the landlords provision. That will mean that, if we draw it to the landlord's attention that their premises is being used for illegal activity, it will set a threshold for action against the landlord, which we would hope would prompt the landlords to not provide the premises. We also have seen that landlords do help us and assist us. They've put additional padlocks on premises. Many have asked us to provide the—we provide the details of the closure order to the landlords so that they can use that for terminating leases, notwithstanding that's ahead of the legislation. This is going to be a challenge.

**The Hon. SARAH MITCHELL:** It must be frustrating for your staff when they go and close and then people just flout the rulings. But I guess that's difficult—

**SUSAN PEARCE:** They're breaking the law.

**The Hon. SARAH MITCHELL:** Exactly.

**KERRY CHANT:** That's right, and we do also have prosecutions. I hope that the courts would take a very dim view, in addition to selling illegal tobacco, if you've been closed and then continue to do it. I hope that would factor into—it's a matter for courts. I respect that separation, but I would hope that the courts take into account the recalcitrant behaviour of some of these premises, particularly when we're going there for long-term closure orders, but also the prosecutions. The prosecutions do take a little bit of time. They require evidence and court processes. That's why the closure orders are an effective more short-term issue, but they are backed up by prosecutions, which have got some very significant penalties. We are looking forward to those prosecutions coming in under a higher prosecution regime. Some of the prosecutions that we've reported were actually in the legislation that existed 12 months ago.

**The Hon. SARAH MITCHELL:** So the tougher penalties might help with some of the issues.

**KERRY CHANT:** Yes. But I think we just need to recognise this is going to take a lot of concerted effort at all levels of government, and it's going to take time. I really do understand the community's frustration. As a member of the community, it causes me frustration. I can understand that it's not great when you can see such overt flouting of the law.

**The Hon. SARAH MITCHELL:** And to Ms Pearce's point, they're breaking the law when they do that. I think there's furious agreement amongst us all on that one.

**The Hon. SUSAN CARTER:** Mr Daly, the medical staff in urgent care clinics, are they employed, are they VMO, are they locums? How are they staffed, the medical staff?

**MATTHEW DALY:** There's fundamentally two models. One is where we contract or establish them at the urgent care centre through a local health district, and they will tend to employ them either on a sessional basis as a VMO, GP or employed GPs—there are both—or we contract the service through the PHNs. They in turn contract, on our behalf, a group of general practitioners who might come together, and it'll be a contractual arrangement. That would guarantee minimum labour and hours of operation and those types of things.

**The Hon. SUSAN CARTER:** Are you finding any difficulties with attracting staff to urgent care clinics?

**MATTHEW DALY:** Yes. We've had a couple of occasions, mostly where we've contracted with PHNs, which is a little bit ironic considering the PHNs are meant to be much closer to the primary care interface, much closer relationship with general practitioners than ourselves. There have been a couple of examples where we've had to close the service because they simply could not guarantee the workforce. It was becoming sporadic, so people in the community were turning up. One day they could get an appointment, the other day—

**The Hon. SUSAN CARTER:** We've had a number of reports of urgent care clinics not being open during advertised hours and people turning up. On notice, can you provide the list of the clinics that have had to be closed because of staff issues?

**SUSAN PEARCE:** Can we clarify though, Mrs Carter, that not all of those clinics are NSW Health.

**MATTHEW DALY:** Yes, some might be Medicare. Then there's the Commonwealth Medicare clinics.

**The Hon. SUSAN CARTER:** As I understand it, the urgent care clinics, from what I was reading, it appears that it's a shared activity between Medicare and New South Wales?

**SUSAN PEARCE:** There are multiple models, so if you would like to be specific with us about the areas.

**The Hon. SUSAN CARTER:** For example, the one in Caringbah. Is that NSW Health?

**MATTHEW DALY:** Caringbah is. It's funded through NSW Health, yes.

**The Hon. SUSAN CARTER:** We've had reports that Caringbah isn't open the advertised eight to eight, or sometimes it is and sometimes it's not because of staff issues. What are we doing to provide it as a service?

**MATTHEW DALY:** I guess it's like any contractual arrangement. You manage the contract. Whilst we engage with the Primary Health Networks in a very collegial sense—we're all here for health—it's still a contract, and we have to performance manage the contract. I guess where there might be closures for a Saturday when they couldn't staff it, it tends to be a bit of a symptom that they're not sustainable.

**The Hon. SUSAN CARTER:** The Rouse Hill urgent care clinic, is that NSW Health?

**MATTHEW DALY:** Rouse Hill I think is one of our funded ones, yes.

**The Hon. SUSAN CARTER:** I understand that there's a very limited range of services available at Rouse Hill. Is it standard to just be GP, or is it standard to be GP, imaging services—what's the NSW Health model?

**MATTHEW DALY:** Normally the contractual arrangement is—whether it be through an LHD or PHN—that it will provide general practice support, that it will provide nurse practitioner support often, but also have ready access to diagnostics such as medical imaging. Again, that can sometimes be a catalyst for the contract not proceeding if suddenly the arrangements they had in place or thought they had in place they couldn't actually deliver.

**The Hon. SUSAN CARTER:** We've had reports of people presenting at Rouse Hill and then needing ultrasound and/or X-rays and being told at four o'clock in the afternoon that service isn't available. Four o'clock in the afternoon on a weekday seems a reasonable time to expect a radiographer to be present. Then, go to the hospital or take tomorrow off work and go to some other imaging service. It just seems that it's not fulfilling the role that urgent care clinics are meant to, taking pressure off our emergency departments, if they're not being offered with that range of services.

**MATTHEW DALY:** Absolutely, because the idea is to relieve emergency departments. But, I mean, those examples—and I can take on notice, if you'd like, the circumstances around Caringbah and Rouse Hill.

**The Hon. SUSAN CARTER:** Yes, thank you.

**MATTHEW DALY:** They're the exception rather than the rule. There are 26 of these services that we've set up around the State and some of them are experiencing what is a national workforce shortage, and so they're finding it just as difficult as ourselves.

**The Hon. SUSAN CARTER:** What can we do to make sure that we don't have these exceptions? Two out of 26 is significant, and they're just the ones we've been told about.

**MATTHEW DALY:** I'd need to get the data on the frequency of those closures, but I'm very happy to pull that out and shoot it—

**The Hon. SUSAN CARTER:** If you could provide that data, that would be great, and also where imaging services are available and when.

**MATTHEW DALY:** Yes. The fundamental premise of setting up the urgent care services was to direct patients, particularly triage 4 and 5 patients, away from the emergency department.

**The Hon. SUSAN CARTER:** It's a very good model. Absolutely.

**MATTHEW DALY:** It's highly successful—between 7 per cent and 12 per cent decreases when there's a 5 per cent to 6 per cent increase in cat 1, 2 and 3 presentations.

**The Hon. SUSAN CARTER:** But I'd appreciate, on notice, any of the New South Wales ones where they've had to be closed or they haven't opened all hours, and whether imaging is available or not in those hours.

**MATTHEW DALY:** Okay.

**The CHAIR:** I might just follow up on this line of questioning very briefly. When consideration is being given to NSW Health funding an urgent care clinic, is there ever a consideration of providing that funding to an existing GP clinic, if there is one willing? I know there are plenty of places where you haven't got the workforce to provide after-hours care, but where there is the option of people actually seeing their regular GP out of hours, is that part of the process?

**MATTHEW DALY:** Yes. Certainly, the PHNs, in setting up the contractual ones that we funded through the PHNs, did set them up through established practices in order to expand capacity, because it wasn't just for us to fund what is a Commonwealth responsibility but to provide expanded capacity, particularly for referral to calls through the single front door, the Healthdirect number. It was contracting to give us capacity that we could feed into the single front door, the Healthdirect number, in order to offer appointments to patients. I know the PHNs did engage in order to expand capacity within already established practices in various spots of the State. But there were different models, depending on the geography and the workforce availability, around the State.

**The CHAIR:** It is a Federal document, but the recent interim evaluation of the urgent care clinics found that the average cost for a patient to be seen in ED was $617 versus $236 in urgent care. Obviously, there's a significant benefit in doing urgent care over ED. The Medicare rebate for a GP appointment is in the order of 50 bucks. A lot of people are arguing it should be more than that. I'm interested if that comparison is made between urgent care versus regular GP clinics.

**MATTHEW DALY:** I'm familiar with the study you're referring to and that was specifically on Medicare urgent care centres, however titled. We fund them differently to the Commonwealth. It'd be no surprise that we funded significantly less than what the Commonwealth funds those centres that they set up. But, yes, there is a cost differential between a presentation at an ED and a presentation at either a general practice or an urgent care centre, absolutely.

**The CHAIR:** But specifically, there is a consideration of GP usual clinic after-hours care as part of your—

**MATTHEW DALY:** Yes. I mean, the fundamental—when you ring through Healthdirect we try to steer you back into your established general practitioner relationship. That's the model of best or better care.

**The CHAIR:** I'm not asking at the level of where an individual patient gets directed. I'm asking in the context of system-level decisions about what you're establishing when you partner with the Commonwealth to create a centre.

**MATTHEW DALY:** Sorry, I thought I was answering that. We try to steer patients back to their general practitioner. Where they don't have a general practice relationship, that's when we steer them to an urgent care centre with a GP-type service that might be available that we would contract through a PHN or fund through our LHDs.

**The CHAIR:** Sure. I think I'm asking about a level higher than that. At that level where you're contracting with a PHN, is the cost-benefit analysis done between urgent care centres and those kinds of partnerships with GP clinics?

**MATTHEW DALY:** Not that we've undertaken, but I know the study you're referring to. But that was the Commonwealth study around their own Medicare centres, is my understanding of it.

**The CHAIR:** The figures might be different in a different model, but I can't imagine they would be different by an order of magnitude.

**MATTHEW DALY:** No, they wouldn't be significantly different.

**The CHAIR:** Coming back to Ms Skulander, in answer to my questions around Albury, I just wanted to follow this up. You were talking about what is called for in the clinical services plan. Obviously, in Albury there's particular contention around which clinical services plan you use. But even if you're talking about the 2022 master plan, not the 2021 master plan, the current redevelopment doesn't provide what's called for in that clinical services plan. In your answer, there was a lot of "should" and "would" rather than "does". In terms of future stage planning for this current redevelopment, is there planning for future stages that will meet the needs for either of those master plans?

**EMMA SKULANDER:** Putting aside the discrepancy in the master plan because I recall that but it's probably irrelevant for the purpose of the answer now, I think the clinical services plan articulates the full scope

of clinical services that will be required to a certain date. I don't have the date from this one in front of me, but it's usually got a good planning horizon, like a 10-year-plus planning horizon you'll probably know.

**The CHAIR:** It did, but you're four years down now.

**EMMA SKULANDER:** It is always a point in time. The redevelopment will take its direction from that, it will take what would be required in order to deliver the full scope of services of that, and then it will prioritise within that. That is what we do in every project across the State, and it is very, very rare that the full scope of the clinical services plan will be delivered. It will be prioritised at a point in time. What needs to happen then to come back for the next round of planning and the next round of capital funding to come through is that clinical services plan needs to be refreshed so that it then has the appropriate horizon and we can make sure the right information is providing input to the next round of the capital scope request, where we will reprioritise what the next pieces of that puzzle will be.

**The CHAIR:** Sure. So that process of what a stage two would theoretically look like hasn't happened or won't happen until after stage one?

**EMMA SKULANDER:** That is the responsibility of our local health districts in New South Wales—and would be Albury Wodonga Health with this example—to look at their clinical services planning. We will absolutely, as New South Wales, be supporting that because of the earlier reference to the clinical services planning work that Elizabeth has been doing and will continue to do, and we need to pick up Albury within that. But the lead would come from Albury Wodonga Health. The funding request would come through that pathway in the same way it does with our other districts.

**The CHAIR:** There was a document. There was a previously mooted stage two, which was the one that required the demolition of the new ED that has just been built. I don't know whether that document was produced by Albury Wodonga Health or Health Infrastructure off the top of my head. But you're saying there's no replacement document for that? There isn't a stage two that's viable that you know of?

**EMMA SKULANDER:** There will be a viable approach to a stage two on that site. What needs to happen is that the clinical services planning would need to be updated at the point in time that we're looking to put that through the next capital planning cycle and the master plan would be refreshed. I would suggest that putting something in the place of the ED is not the right answer and that we would absolutely look to refresh something that was a more viable stage two. But I would say there is no restriction from that process occurring or that happening. It will just be a timing thing as to when the clinical services plan is refreshed and the proposal can be put forward through government processes, which will be New South Wales and Victorian government processes, to seek capital funding, and that will be considered by government in their prioritisation.

**The CHAIR:** I have a couple of questions for Hunter New England. Sorry, you probably thought you were off the hook. My first question was about staffing at Cessnock Hospital. I'm sure you're aware of the case that was reported in the media of the 88-year-old woman who was taken by ambulance to Cessnock Hospital and there was no doctor on the site. The reporting said that the patient waited for six hours before her family drove her to another hospital. That is certainly not the first case I'm aware of. I regularly receive representations around staffing at Cessnock Hospital. When I asked about this last year, the answer I got was that the ED is appropriately staffed by both local and agency GP VMOs. Given that these kinds of cases landing in the media and being represented to us are ongoing, is it still your view that that model is working and that that hospital has appropriate medical staffing?

**TRACEY McCOSKER:** I think there is always the intention that we have a medical presence onsite in emergency departments right across our district. When we don't for whatever reason—because medical staff is hard to consistently have onsite—we have the virtual services that we do rely on and put a lot of faith in. Those virtual emergency services are staffed by fully qualified emergency department specialists that are FACEM accredited. But there will be times when it doesn't work out as people would like. I haven't got the details of the specific one at Cessnock, but I think that we try our hardest to fill all the vacancies across the State with medical people onsite. But we do rely also—and have since 2022, successfully—on using My Emergency Doctor services.

**The CHAIR:** It's my understanding that in a previous staffing model there was an emergency doctor actually rostered on at Cessnock and that that was part of—there were staff that were coming from Maitland, and that service was removed. I'm sure you can understand for a rural community—people know you can't access the same services as the city—it's pretty disheartening for the community when things go backwards rather than forwards. What are the barriers to putting that model back in place, where there is actually a staff doctor on?

**TRACEY McCOSKER:** I'm sorry, I'll have to take that one on notice specifically about Cessnock because I don't know the details of that service. As I said, we are constantly trying to put medical staff onsite, but we can't always manage that.

**LUKE SLOANE:** Dr Cohn, I'll just chime in there. We would never, necessarily, remove the service. It would, nine times out of 10, be related to that medical officer discontinuing either their VMO contract or moving away from the service. But we can chase that up.

**The CHAIR:** I appreciate you taking it on notice.

**LUKE SLOANE:** I'm pretty sure that was the case for Cessnock Hospital. The medical staff were no longer keen to provide VMO services there. I think the last one there, as with many regional sites, was a single, independent practitioner so was getting no reprieve with regards to their on-call or overnight support for on-call services at the facility as well.

**TRACEY McCOSKER:** We do have a lot of instances of GPs being longstanding participants in local hospitals. As they age they don't want to do on-call, and then they retire and there is no-one to replace them.

**LUKE SLOANE:** It's probably good to know. I was travelling last week—sorry for the anecdote, but it's quite helpful in the case of the virtual services not ever being a replacement but being complementary in regional, rural and remote areas. Even as recently as last week, there is four new GPs started in Molong Health Service. They're very happy with the fact that they don't have to come in overnight because the virtual care service at Western NSW Local Health District supports them to only come in if the cases are urgent. Same at Crookwell hospital. We're seeing a resurgence of GP and GP VMOs attending country hospitals in larger amounts because they are having—

**The CHAIR:** Thank you, Mr Sloane. I appreciate that. You've already taken the question on notice, so I don't want to hammer the point. My understanding was that they actually had an ED doctor, not a GP, from Maitland Hospital staffing that hospital as a rostered-on doctor in the emergency department rather than a GP VMO.

**LUKE SLOANE:** As in a FACEM?

**The CHAIR:** Or a registrar—I'm not sure. I'm interested in this specific hospital, because it feels to me, and to the people making representations to me, that there has been a real step backwards at this hospital, not because someone has retired but because the model has changed.

**TRACEY McCOSKER:** We'll have a look at it.

**The CHAIR:** Thank you for following that up for me. Sorry, Ms Skulander, I thought I was finished with you but I have one more. There's always more Albury questions from me. The number of car parks as part of this redevelopment has been the subject of some contention. I think the department has stated there is an increase of 300 car parks.

**EMMA SKULANDER:** Yes.

**The CHAIR:** Does that include the 79 informal car parks—where people are parking on the grounds currently—and the 94 verge car parks, or not?

**EMMA SKULANDER:** The informal spaces, it would not. But it would include formalising verge spaces. There is some verge space strategy in the Albury car parking—

**The CHAIR:** There is. This is what I'm trying to get to the bottom of. People in Albury have parked on the verge forever, to the point that the council actually adopted a policy of not fining people because we all accepted that was hospital parking. You're turning that into formalised car parking, which is making it safer and more accessible, but it's not an increase in car spaces—

**EMMA SKULANDER:** There is a net increase.

**The CHAIR:** —because people were parking there anyway. This is what I'm getting at. There were 94 of those verge "spaces".

**EMMA SKULANDER:** And what you want to know is, is the 94 in the 300?

**The CHAIR:** That's right, yes. You're saying there's a 300 increase. There were 94 spaces where people used to just park on the verge, and there were 79 spaces where people used just park on the grounds of the hospital—illegally, but it was unenforced.

**EMMA SKULANDER:** The 74 random parking bits I would say we wouldn't include, because that's not a safe way to consider the parking. The 94, I will need to confirm that. Just so that I have an understanding, are the 94 that you're referring to marked spaces now, or are they just where you know cars can fit and you've counted that 94 cars can fit?

**The CHAIR:** Where people just park on the nature strip. This is from people looking at satellite imagery and counting cars that are typically parked there on a regular day.

**EMMA SKULANDER:** I guess in relation to those spaces, the intention will be to make them safer, to make them marked and to make them formal car parking spaces versus informal.

**The CHAIR:** I understand. It's an important safety and accessibility improvement, but are they in the 300 or not?

**EMMA SKULANDER:** I will need to check. I don't know the answer to that question. Overall, we were counting 300 increase. That takes the site to 1,000 spaces.

**The CHAIR:** Can I clarify the question, which I think you're taking on notice—

**EMMA SKULANDER:** Yes, I will take that on notice.

**The CHAIR:** Taking into account the fact that there are 94 informal spots and 79 illegal spots, how many actual new car spaces are we getting—

**EMMA SKULANDER:** Is the net increase.

**The CHAIR:** —versus how many of those are safety, accessibility improvement of places that people already park?

**EMMA SKULANDER:** I understand the complexity of your question, and I will endeavour to find out the answer to that and bring it back.

**LUKE SLOANE:** Sorry, can I clarify about the wipes. We've contacted—

**The Hon. SARAH MITCHELL:** That's my time. We'll come back to that, maybe in Government time at the end.

**The CHAIR:** There'll be Government time at the end. I want to come back to Dr Chant.

**KERRY CHANT:** Can I also let you know that the consideration of the MenB on PBAC is for March.

**The CHAIR:** That's topical. I was about to ask another vaccination question. I understand there was previously some funding allocated specifically to improve vaccination rates for priority populations. Can you update us on the vaccination rates in those populations and how it's going?

**KERRY CHANT:** Yes, I can, but it's probably better if I provide a report to the Committee using our data. Clearly we are aware that there are lower vaccination rates amongst some of our population. But overall, we need to do better across all our population groups. The priority populations program is particularly targeting some of our culturally and linguistically diverse groups, and it's got a community champions model. Those tenders have been issued. I'm pleased to say that Holly Seale from the university is supporting those community champions with skills to fulfil their roles. We'll be really interested in evaluating that initiative. We're also doing work with GPs and also pharmacists in order to draw on the cultural diversity amongst those practitioners to really support knowledge and better ways we can engage with the community. There's lots of work being done, but there is still clear disparities across the socio-economic divide, and the cultural and linguistic divide.

**The CHAIR:** I'd love an answer that includes the data if you're happy to provide that on notice as well.

**KERRY CHANT:** I would be happy to provide the data. I'm delighted to provide it. We also are trying to embed immunisation as part of the NSW Health system, so that's a particular focus of our activity. We're looking at embedding it as part of proactive care, such as in renal dialysis units, in our rehab, when our patients are being discharged to aged care. That's another dimension—so multiple fronts.

**The CHAIR:** This is a question for Ms Abbas. I've previously asked about overtime for junior doctors and issues around fatigue. I've been redirected to the Fatigue Management in NSW Health Workplaces guideline, which doesn't explain why overtime isn't considered, despite it having been flagged as a cause for fatigue. In a previous estimates, I was told that there were some conversations underway with the union. Can you update me on that?

**FATIMA ABBAS:** Yes, if you would just give me one moment.

**The CHAIR:** That was poorly articulated, right at the end of the day. I suppose the real question I'm trying to get to the bottom of is why isn't overtime considered in maximum hours worked in the fatigue policy?

**FATIMA ABBAS:** I might need to take this one on notice because we are still having some discussions in the commission on various awards about the treatment of fatigue management in particular. I don't have a

specific answer, but I'm happy to take it on notice. I think it's safe to assume that it should be considered as part of our fatigue management, but I'll come back to you with a more specific answer.

**The CHAIR:** I'm pleased to hear that you think it should be. I do too. I'm keen hear where that's up to. I'll give my last minute to Dr Chant. How worried should we be about carbapenem-resistant organisms, and what are you doing about it?

**KERRY CHANT:** We should be very concerned about the growing antimicrobial resistance, and we are. One of the key areas of responsibility of NSW Health is to look at prudent antimicrobial stewardship and also make sure we have strong infection prevention and control to prevent those organisms being transmitted in healthcare settings. I'm happy to take it on notice and describe some of the work that the CEC has been doing in covering those two dimensions.

**The Hon. SARAH MITCHELL:** My question is probably to Mr Sloane. Radiology at Dubbo Hospital has obviously been an issue of late, with the private contractor and concerns in the community about less services being offered. Is there anything you can provide the Committee in relation to that particular issue?

**LUKE SLOANE:** Yes. I know that has been escalated to us by the chief executive of the Western NSW Local Health District. The provider themselves—again, coming back to Mr Daly's earlier comments, we're managing that through the contract requirements in terms of mitigating the risk around that. I understand that the district has engaged a locum radiologist in order to make sure that the services are still continuing, but it's a problem that's being worked through at the moment.

**The Hon. SARAH MITCHELL:** Are you able to provide—I'm happy if you need to do it on notice—what the impacts have been to any particular radiology services? Are there concerns about who is getting CTs, ultrasounds, MRIs and the like? Are you able to take any specifics on notice?

**LUKE SLOANE:** The investigations themselves are not the issue because they're performed by very astute and skilled radiographers. It's a case of then possible delays or otherwise that might be impacted through reporting of those investigations. I'll have to take the specifics of that on notice.

**The Hon. SARAH MITCHELL:** If you could, that would be great.

**LUKE SLOANE:** But there's no delay in people getting the investigations themselves.

**The Hon. SARAH MITCHELL:** I appreciated your anecdotes before about regional visits and more service capacity in regional hospitals. Is there any chance that there are any improvements up in the north-west—places like Moree and Inverell—where there are real challenges with doctors in hospitals?

**LUKE SLOANE:** It's one of those ongoing things and I'm not going to split hairs about it. We're doing everything we can to try to attract medical staff to those regions, and it is happening. There are changes happening. Again, the recruitment for those—not from a general practice point of view, and private, I can't comment on that, because, again, that's something that happens with the private practitioners themselves coming into town. But we have, through the rural generalist single employer model, seen a dramatic uplift, especially in those areas, for registrar training. NSW Health is then the single employer host for those registrars. We've seen an uptick across the State—up to 60 people now on that program, some of those based up in the north-west. I can get you specific numbers on how many.

**The Hon. SARAH MITCHELL:** If you can, on notice, where those 60 are, that would be amazing.

**LUKE SLOANE:** Yes. But it's a slow grind.

**The CHAIR:** I'll come back to Dr Chant because she had started answering my question. I have a much more specific question about the carbapenemase-producing organisms. I understand that they're notifiable under the Notifiable Conditions Information Management System, so you know where they are in New South Wales. I also understand that there are particular overseas areas that are high risk for patients who have returned to those areas, which are known. How would a hospital in New South Wales know if a patient had come from a transmission risk area in another State?

**KERRY CHANT:** The routine—our pathology in our hospitals will, just generally, if infections are not responding to antibiotics, the clinicians will ask for sensitivity testing and collect samples. So there will be—clinically our laboratory systems got structured so that we will pick up these organisms. I think what you're saying is, hopefully, for patients who come from another State, there are good connections amongst our microbiologists around where there might be outbreaks or clusters or we would be circulating those sorts of information. Obviously overseas travel or countries overseas would be part of a history taken. I also note that the quality and safety commission has got some guidance on that. I think you're referring to the fact that we've just made some of these—these conditions have been notifiable for a little while.

**The CHAIR:** My understanding is some pre-emptive testing is required to then determine what precautions are required so that people are recommended to be tested if they've come from these particular transmission risk areas. How do we know if they've come from a hospital outside of New South Wales?

**KERRY CHANT:** I suppose in general there are infection prevention and control guidelines, so maybe if I could take that on notice and provide those to you. But I think that's why we're also very keen that overseas travel and some of those factors are part of the clinical history, including when you're coming in through an emergency department. It can influence what the risk is for having infections that may be resistant. But I'll take it on notice and let you what the guidelines—

**The CHAIR:** I appreciate your taking it on notice. With apologies for the very difficult last question—

**KERRY CHANT:** That's okay. I'm just trying to read the quality and safety commission website as we speak, but I will get further information for you.

**The CHAIR:** We're coming to Government time. There was an update. Was that you, Mr Sloane?

**LUKE SLOANE:** I've got two updates. The first one, to start, is a sincere apology to that patient at Cessnock Hospital. We were made aware that there wasn't a medical officer available in person. However, my emergency doctor was available yesterday and we have confirmed that there are three doctors in the emergency department today at Cessnock Hospital, so they do have their full quotient of staffing. The second one—everybody's waiting with bated breath about the wipes—is that there was a change in brand of wipes due to them no longer being available. The new brand of wipes have been ordered and brought in.

**The Hon. SARAH MITCHELL:** Excellent. I'm sure they'll be very happy to hear that.

**LUKE SLOANE:** Definitely no restrictions to wipes.

**The Hon. SARAH MITCHELL:** Thank you, Mr Sloane—good way to end.

**DOMINIC MORGAN:** Chair, I just have a correction to one of the locations that I said was completed and opened after June 2022 included Jindabyne, but I'm actually mistaken. That's actually in the planning phase. But, apart from that, the rest are correct.

**The CHAIR:** Are there questions from the Government?

**The Hon. GREG DONNELLY:** Not at this time, no.

**The CHAIR:** There being no questions from the Government, we're finished for the day. Thank you all so much for taking the time to answer our questions today. It's much appreciated.

**(The witnesses withdrew.)**

**The Committee proceeded to deliberate.**