DECISION

Fair Work Act 2009
s.789FC - Application for an order to stop bullying

Dr Ngoc Le
(AB2019/209)

COMMISSIONER HARPER-GREENWELL MELBOURNE, 4 OCTOBER 2020

Application for an FWC order to stop bullying.

[1] This decision concerns an application made by Dr Ngoc Le (the Applicant). Dr Le has lodged two applications with the Fair Work Commission (the Commission), the first being an application made pursuant to s.789FC of the *Fair Work Act 2009* (the Act) for an order to stop bullying. The second is an application pursuant to section 739 of the Act for the Commission to deal with a dispute in accordance with the dispute settlement procedure in clause 11 of the *AMA Victoria-Victorian Public Health Sector-Medical Specialists Enterprise Agreement 2018-2021*[1] (the Agreement).

[2] Dr Le lodged her s.789FC application with the Commission on 17 April 2019. Conferences were convened before another member of this Commission, however the matter remained unresolved. The matters were subsequently allocated to me for determination.

[3] Directions were issued from my Chambers that the Applications be heard concurrently. This decision concerns the application for an order to stop bullying (the Application). A decision in regard to the s.739 application will be issued separately.

[4] Dr Le's Application concerns allegations that on repeated occasions Dr White has behaved unreasonably towards her and that Dr White's behaviour created a risk to Dr Le's health and safety. Dr Le further submits that the bulling behaviour of Dr White was endorsed and supported by Western Health.

[5] Dr White and Western Health deny the allegations and submit that Dr Le has not been bullied at work and therefore the Application must be dismissed.

[6] Dr Le was represented by Mr Bryan Mueller Special Counsel and she gave evidence on her own behalf.

[7] Dr White and Western Health were represented by Mr Matthew Minucci of Counsel. Dr White gave evidence on her own behalf. Evidence was also adduced from the following Western Health employees:

- Mr Lebe Malkoun, Divisional Director (Aged, Cancer & Continuing Care)
- Dr Paul Eleftheriou, Chief Medical Officer
- Ms Debra Hill, Manager of Employee Relations & Business Partnerships

Background

[8] It is appropriate in the current application to set the context for the specific grounds principally relied upon by Dr Le in her application.

[9] Dr Le is a registered medical practitioner holding specialist registration in Rehabilitation Medicine. Dr Le gained her Fellowship of the Australasian Faculty of Rehabilitation Medicine in July 2011 and has worked as a Consultant Rehabilitation Physician for 8 years.[2]

[10] Western Health manages three acute public hospitals in the western region of Melbourne.[3] Dr Le commenced employment as a fractional specialist (part-time employee) with Western Health on 7 February 2011.[4] Since April 2017 Dr Le has worked at the Sunshine Hospital working two days per week (Tuesdays and Thursdays) as a Rehabilitation Physician[5] and on a day to day basis she manages up to 15 beds[6]. Dr Le also works at a number of other hospitals and health services.[7] Dr Le reports directly to the Head of Unit of Rehabilitation Medicine. The Doctor that previously held that position resigned in or around June 2018. Since September 2018, Dr Le has reported directly to Dr Clare White.[8]

[11] Dr Le's bullying application named Dr Clare White as a person she believes had engaged in bullying type behaviour towards her. Dr White is a trained Geriatrician and has been a Fellow of the Royal Australian College of Physicians since 2011. Dr White is the Clinical Services Director for the Sub Acute & Aged Care Division at Western Health, she has been performing this role since December 2017. Dr White is responsible for the clinical management of a number of areas within Western Heath's Aged, Cancer & Continuing Care Services Division (the Division). Those areas include Rehabilitation, Aged Care, Palliative Care, Cancer Services (including Haematology); and Geriatric Medicine. Dr White is also the acting Head of Unit of Rehabilitation Medicine, being the division in which Dr Le works. [9]

[12] In her role Dr White is responsible for the clinical resource decision making having oversight of a number of beds within the Division and how it is that patients are managed through the Division to ensure appropriate care. Dr White reports directly to Dr Paul Eleftheriou and the Executive Director of Operations, Ms Natasha Toohey.[10]

[13] Dr Paul Eleftheriou is the Chief Medical Officer (CMO) of Western Health. Dr Eleftheriou is responsible for all professional matters pertaining to all medical staff at Western Health and has operational oversight for various other units and divisions of Western Health.[11]

[14] Mr Lebe Malkoun is the Divisional Director, Aged, Cancer & Continuing Care. He is a trained registered nurse who has worked in hospital management and administration for approximately 15 years.[12] Mr Malkoun has operational oversight of the Western Health Aged, Cancer & Continuing Care Services Division (the Division) and works with Dr White.[13]

[15] Dr Le submits since Dr White took on the role of acting Clinical Services Director her experience in working at Western Health changed significantly and she has been subjected to a series of instances of objectively unreasonable behaviour by Dr White. Dr Le says her experience with Dr White since early 2018 has been that she was not nearly as prepared as the previous Directors to listen to her concerns or give due weight to her clinical opinions and professional judgement.[14]

[16] Dr Le further submits given the nature and extent of the behaviour it was likely to be destructive of her self-esteem, her self-confidence and her ability to perform her role and overall compromised her health and safety at work. Dr Le also submits there will continue to be a substantial risk that Dr White will continue to bully her at work if the order sought is not made.[15]

[17] Western Health submit that Dr Le has not been bullied at work and that there had been a number of issues with Dr Le and the overall operation of the Rehabilitation Ward over a period of time. They submit Dr White commenced a formal performance management process against Dr Le on 15 February 2019. Dr Le has been absent from her work at Western Health since 25 February 2019.[16]

Jurisdiction

[18] Part 6-4B of Chapter 6 of the Act prescribes a regime that allows "workers" to obtain orders from the Commission to stop bullying at work. Section 789FF confers on the Commission a broad discretion to make any order it considers appropriate to prevent a worker from being bullied at work by an individual or group of individuals.[17]

[19] Section 789FC of the Act relevantly provides as follows:

> "**789FC Application for an FWC order to stop bullying**
>
> (1) A worker who reasonably believes that he or she has been bullied at work may apply to the FWC for an order under section 789FF.
>
> (2) For the purposes of this Part, ***worker*** has the same meaning as in the *Work Health and Safety Act* 2011, but does not include a member of the Defence Force."

[20] There is no dispute that Dr Le is a 'worker" as defined in s789FC(2) of the Act. There is no dispute that Western Health is a constitutionally-covered business within the meaning of s.789FD(3) of the Act.

[21] The Commission's jurisdiction may only be enlivened if Dr Le reasonably believes that she has been "bullied at work".[18] The expression "reasonable belief" was considered by Vice President Hatcher in *Mac v Bank of Queensland Limited and Others*[19], the Vice President observed as follows:

> "[79] An applicant under s.789FC must not only be a worker but must be one who "*reasonably believes that he or she has been bullied at work*". The expression "reasonable belief" and similar expressions are utilised in a wide variety of contexts by the statutory and common law. It is clear from cases decided in those differing contexts that not only must the requisite belief be actually and genuinely be held by the relevant

person, but in addition the belief must be reasonable in the sense that, objectively speaking, there must be something to support it or some other rational basis for the holding of the belief and it is not irrational or absurd. For example, in the context of the Federal Court rules concerning applications for preliminary discovery, which require the holding by the applicant of a reasonable belief that that there may be a right to obtain relief against another person not presently a party to a proceeding in the Court, it has been held that "there must be some tangible support that takes the existence of the alleged right beyond mere 'belief' or 'assertion' by the applicant" or that "there must be some evidence that inclines the mind towards the matter of fact in question". In relation to a NSW statutory provision prohibiting legal practitioners from providing legal services on a claim or defence of a claim for damages unless the practitioner reasonably believed that the claim or defence had reasonable prospects of success, it has been held that the practitioner's belief that there was material which justified proceeding will not be reasonable if it "unquestionably fell outside the range of views which could reasonably be entertained". In relation to the concept of a "reasonable hypothesis", it has been held that in order to be a reasonable one a hypothesis must be rationally based and possess some degree of acceptability or credibility, and must not be irrational, absurd or ridiculous. These examples all illuminate the way in which the Commission should approach the task of considering whether the applicant worker has the necessary reasonable belief such as to confer standing to make an application under s.789FC." (references omitted)

[22] In considering the requirement for "repeated unreasonable behaviour" the Vice President made the following observations:

"**[**87] The requirement for repeated unreasonable behaviour is clearly a core element of Part 6-4B. The Explanatory Memorandum to the *Fair Work Amendment Bill 2013* through which Part 6-4B was enacted discloses that the definition of bullying at work in s.789FD, including this element, reflected a recommendation for such a definition contained in the report of the House of Representatives Standing Committee on Education and Employment "*Workplace Bullying - We just want it to stop*". In referring to that report, the Explanatory Memorandum said:

> "109. The Committee went on to note that 'repeated behaviour' refers to the persistent nature of the behaviour and can refer to a range of behaviours over time and that 'unreasonable behaviour' is behaviour that a reasonable person, having regard to the circumstances may see as unreasonable (in other words it is an objective test). This would include (but is not limited to) behaviour that is victimising, humiliating, intimidating or threatening."

[88] In *Re SB*, the Commission (Hampton C) discussed the requirement for repeated unreasonable behaviour in the following terms:

> "[41] Having regard to the approach urged by the authorities, the concept of individuals 'repeatedly behaving' unreasonably implies the existence of persistent unreasonable behaviour but might refer to a range of behaviours over time. There is no specific number of incidents required for the behaviour to represent 'repeatedly' behaving unreasonably (provided there is more than one occurrence), nor does it appear that the same specific behaviour has to be repeated. What is required is repeated unreasonable behaviour by the

> individual or individuals towards the applicant worker or a group of workers to which the applicant belongs.
>
> [43] 'Unreasonable behaviour' should be considered to be behaviour that a reasonable person, having regard to the circumstances, may consider to be unreasonable. That is, the assessment of the behaviour is an objective test having regard to all the relevant circumstances applying at the time."

[89] I respectfully agree with those statements, but I would add three further observations about the interpretation and practical application of the expression "*repeatedly behaves unreasonably*" in s.789FD(1)(a). First, the expression falls within a definition provision. The function of a legislative definition, as was pointed out by McHugh J in *Kelly v R*, is not to enact substantive law, but to provide aid in construing the statute. A definition provision is therefore not to be interpreted in isolation and thereby given a meaning which negates the evident policy or purpose of a substantive enactment. Part 6-4B has the evident purpose of establishing a mechanism by which the bullying of workers at work may be stopped. In interpreting, and applying, the expression "*repeatedly behaves unreasonably*" as it appears in s.789FD(1)(a), the concept of repeated unreasonable behaviour is not to be approached in a manner which divorces it from that purpose. The subject matter is bullying at work, and that must be borne steadily in mind in any consideration as to whether particular behaviours are unreasonable for the purpose of s.789FD(1)(a). A consideration of unreasonable behaviour which loses sight of the objective and subject matter of Part 6-4B may lead to the provisions not achieving their intended purposes, or being used for a purpose that was not intended.

[90] The second observation is that unreasonableness and its converse, reasonableness, are familiar legal concepts applicable in a range of diverse contexts. In *Giris Pty Ltd v Federal Commissioner of Taxation* Windeyer J said: "It is, of course, true that, as a measure in fact of time, space, quantity and conduct, reasonableness is a concept deeply rooted in the common law...". Where, in an anti-bullying case such as this one, the requisite repeated unreasonable behaviour towards the workers is said to be constituted by or include unreasonable discretionary managerial decisions directed to that worker, some useful guidance may be obtained in assessing whether the definitional standard in s.789FD(1)(a) is met from decisions concerning judicial review of administrative discretionary decision-making. In *Minister for Immigration and Citizenship v Li* the High Court considered the standard of unreasonableness applicable to such decision-making. The plurality (Hayne, Kiefel and Bell JJ), in considering the well-known formulation of unreasonableness stated in *Associated Provincial Picture Houses Ltd v Wednesbury Corporation*, said that the legal standard of unreasonableness "should not be considered as limited to what is in effect an irrational, if not bizarre, decision - which is to say one that is so unreasonable that no reasonable person could have arrived at it". They concluded their analysis by saying: "Unreasonableness is a conclusion which may be applied to a decision which lacks an evident and intelligible justification". That formulation provides a useful yardstick for the application of the provision in a case such as this one.

[91] The third observation is that in order for conduct to be reasonable, it does not have to be the best or the preferable course of action. In *Bropho v Human Rights &*

Equal Opportunity Commission, in interpreting the word "*reasonably*" as it appeared in s.18D of the *Racial Discrimination Act 1975* (Cth), French J (as he then was) said:

> "[79] ... It imports an objective judgment. In this context that means a judgment independent of that which the actor thinks is reasonable. It does allow the possibility that there may be more than one way of doing things 'reasonably'. The judgment required in applying the section, is whether the thing done was done 'reasonably' not whether it could have been done more reasonably or in a different way more acceptable to the court."

[92] In considering whether there has been unreasonable behaviour by an individual or group of individuals, it will of course be necessary for the Commission to determine whether the alleged behaviour actually occurred. Once the Commission has made the necessary findings of fact about the behaviour, it can then determine whether the behaviour was unreasonable.

[93] The final element in the s.789FD(1) definition is that the relevant behaviour "*creates a risk to health and safety*". In relation to this element, I respectfully agree with the following analysis of Commissioner Hampton in *Re SB*, which is supported by authorities (cited by the Commissioner) concerning analogous provisions in NSW workplace health and safety legislation:

> "[44] The unreasonable behaviour must also create a risk to health and safety. Therefore there must be a causal link between the behaviour and the risk to health and safety. Cases on causation in other contexts suggest that the behaviour does not have to be the only cause of the risk, provided that it was a substantial cause of the risk viewed in a common sense and practical way. This would seem to be equally applicable here.
>
> [45] A risk to health and safety means the possibility of danger to health and safety, and is not confined to actual danger to health and safety. The ordinary meaning of 'risk' is exposure to the chance of injury or loss. In the sense used in this provision, the risk must also be real and not simply conceptual."

[94] It is clear that it is not necessary for an applicant to demonstrate that he or she has suffered an actual detriment to health or safety - that is, actual illness or injury - in order to demonstrate the necessary risk. However, the existence of such an illness or injury may be relied upon as a manifestation of the necessary risk, provided of course that the requisite causal link to the unreasonable behaviour at work has been established.

[95] Section 789FD(2) is loosely modelled upon provisions in Australian workers' compensation statutes which exclude employers' liability for certain workplace injuries caused by reasonable management action. In the context of s.789FD as a whole, the subsection does not operate as an exclusion as such but only operates (as expressly stated) to avoid doubt, since it is clear that reasonable management action undertaken in a reasonable manner would not constitute unreasonable behaviour under s.789FD(1)(a) in the first place. However it does serve to provide guidance in the interpretation and application of the unreasonable behaviour element of s.789FD(1)(a) in circumstances where an applicant alleges that management action such as

performance management, disciplinary action, allocation of work, restructuring of the workplace and employer directions constitutes bullying. In *Re SB* there is a detailed exegesis of this provision, based on authorities concerning analogous workers' compensation decisions, with which I respectfully agree but which it is not necessary to set out here." (references omitted)

[23] Dr Le believes that she has been bullied at work and has applied for the Commission to make a stop bullying order under section 789FF of the Act.

[24] Where an application has been made under s.789FC of the Act, the Commission has discretion under s.789FF of the Act to make any order it considers appropriate (other than an order requiring payment of a pecuniary amount) to prevent a worker from being bullied at work. Section 789FF of the states as follows:

"**789FF FWC may make orders to stop bullying**

(1) If:

(a) a worker has made an application under section 789FC; and

(b) the FWC is satisfied that:

(i) the worker has been bullied at work by an individual or a group of individuals; and

(ii) there is a risk that the worker will continue to be bullied at work by the individual or group;

then the FWC may make any order it considers appropriate (other than an order requiring payment of a pecuniary amount) to prevent the worker from being bullied at work by the individual or group.

(2) In considering the terms of an order, the FWC must take into account:

(a) if the FWC is aware of any final or interim outcomes arising out of an investigation into the matter that is being, or has been, undertaken by another person or body—those outcomes; and

(b) if the FWC is aware of any procedure available to the worker to resolve grievances or disputes—that procedure; and

(c) if the FWC is aware of any final or interim outcomes arising out of any procedure available to the worker to resolve grievances or disputes—those outcomes; and

(d) any matters that the FWC considers relevant."

[25] Section 789FD(2) prescribes that reasonable management action carried out in a reasonable manner is not bullying at work. The test to be applied is whether the management action was reasonable, not whether it could have been "more reasonable or "more

acceptable".[20] Whilst management action should be procedurally fair and lawful, it does not need to be perfect or ideal to be considered reasonable.[21] The assessment of 'unreasonableness' must arise from the management action itself, not the worker's perception of it.[22]

[26] The Commission can only make orders to stop bullying if it is satisfied that Dr Le has been bullied at work by an individual or a group of individuals; and there is a risk that she will continue to be bullied at work by the individual or group.[23] To obtain those orders Dr Le must establish that she was subject to unreasonable behaviour that was repeated whilst at work and that behaviour created a risk to her health and safety.[24]

[27] It is not in contention that I have jurisdiction to deal with the application.

The Conduct Alleged

[28] Dr Le cited Dr White as the individual whose behaviour was unreasonably creating a risk to her health and safety. Dr Le submits that Dr White's behaviour was repeatedly unreasonable, demeaning and undermining.[25] The specific grounds principally relied upon by Dr Le which she contends constitute unreasonable behaviour by Dr White towards her, are Dr White's behaviour in connection with the following events:

(1) Patient A: Respiratory Patient transferred from the Royal Melbourne Hospital in May 2018.

(2) Patient B: Stroke Patient with a tracheostomy who was transferred from the 'Stroke Ward' to the Rehabilitation Ward on 6 September 2018

(3) Alleged refusal of Dr Le to accept patients into the Rehabilitation Ward and manage discharges from the ward appropriately including particularly;

- Events relating to the patient with terminal prognosis (Patient C) and the patient note entry made by Dr Le in relation to that patient.
- Events relating to the patient with an Acquired Brain Injury (Patient D)
    - Patient reception, management and discharge events

(4) The email from Dr White to Dr Le of 31 October 2018 and the meeting held on 9 December 2018 between Dr Eleftheriou, Debra Hill and Dr Le that followed.

(5) The letter from Dr White to Dr Le of 14 February 2019.

[29] Dr Le contends that the behaviour of Dr White in connection with those matters makes up a pattern of unreasonable behaviour towards Dr Le. Dr Le submits that some of the conduct where her performance has been the subject of criticism by Dr White constitutes unreasonable behaviour. Dr Le also submits it can be accepted she was upset and felt undervalued because of the criticism levelled at her by Dr White and the unwarranted criticism directed towards her plainly constitutes unreasonable behaviour towards her as a worker.[26]

[30] I now turn to the events in relation to each of the instances relied on by Dr Le as conduct by Dr White that she says constitutes bullying type behaviours.

Evidence

Patient A: Respiratory Patient

[31] The background to Patient A and Dr Le's recount of the events is lengthy and go to a number of events surrounding both the referral of the patient to Western Health and the internal management of Patient A's care which largely did not involve Dr White.

[32] Patient A had been admitted to the Royal Melbourne Hospital (RMH) for an elective procedure and suffered a succession of complications post operatively including a stroke. RMH requested a transfer of the patient to the Rehabilitation Ward at Western Health. It is common ground that Dr Ponsford approved the transfer of Patient A from RMH to Western Health.[27]

[33] Dr Le submits Dr Ponsford and the Subacute and Nonacute Assessment and Pathways (SNAP) team held discussions about the patient referral. The referral was then sent to Dr Le and she declined to accept the patient because Patient A required non-invasive ventilation in the form of BiPAP overnight which she says the nursing staff were not familiar to administer at the time of the referral. Dr Le also considered that there were no reasonable grounds that Patient A could do a period of rehabilitation at Sunshine Hospital and then go home.[28] Neither Dr White or Mr Malkoun were aware at that time that Dr Le had been sent and rejected the referral of Patient A.

[34] In her dealings with Patient A, Dr Le sought to achieve outcomes that were supported by some and not others within Western Health. Dr Le experienced a degree of frustration with her peers when it came to making decisions and managing a number of competing and complex matters pertaining to Patient A's care.

<u>Patient A acceptance to Rehabilitation Ward</u>

[35] The then Head of Unit, Dr Ponsford made the decision to accept the transfer of Patient A from the RMH because of reasons which included the family lived closer to the Sunshine Hospital.[29]

[36] Dr White was not involved in the discussions, planning or decision to accept Patient A.[30] Dr White's undisputed evidence is that she was not aware that Dr Le had declined to accept the patient referral at the time.[31]

[37] In her witness statement Dr Le states that she did not know the exact circumstance surrounding the admission of Patient A. Dr Le's oral evidence in cross-examination suggests that at the time she made her statement she was well aware that Dr Ponsford had made the decision to accept Patient A and the reasons as to why he had decided to do so. In fact Dr Le became aware that Dr Ponsford had made the decision after the patient died.[32] Dr Le gave evidence that Dr Ponsford had informed her that they would have adequate staffing and support for the nursing staff to look after Patient A.[33] He had also informed her that he accepted the patient with assurance from the respiratory team that they would provide support.[34]

[38] Dr White's evidence is that she would have expected Dr Le to have asked Dr Ponsford about the critical decision to accept Patient A after the event and during the extensive review of the case that took place sometime after the admission.

[39] On 22 May 2018 Patient A was transferred to the Rehabilitation Ward at Sunshine and admitted as Dr Jayaratne patient.[35] Dr Le's evidence is that there were some initial delays in receiving all of Patient A's care needs.[36]

[40] On Wednesday 23 May 2018 the Rehabilitation Registrar corresponded with RMH to obtain care details for the patient including the applicable settings for the BiPAP machine.

[41] Dr Le's returned to work on 24 May 2018. Patient A had been stable for about 36 hours after her arrival however she deteriorated around lunchtime and became hypoxic and drowsy. The events that followed were a Medical Emergency Team (MET) call attended by the Registrar, Dr Le and an intensive care unit (ICU) liaison nurse. The Respiratory Registrar also attended to assist with Patient A's management. Dr Le's evidence is the initial assessment was that Patient A should be moved to the Respiratory Ward. Patient A was not moved because a later evaluation found that the value on the blood gas had not changed since the patient's admission.[37] There were subsequently three more MET calls throughout the day and into the evening because of the way Patient A was presenting.[38]

[42] There was a decision made to move Patient A to an acute ward. Dr Le made a call to the Operations Manager who she says agreed with the decision however she could not find an acute unit which was prepared to accept Patient A.

[43] Dr Le attempted to contact the Head of the Respiratory Unit who was unable to be reached due to being in transit. She then proceeded to engage with the General Medical Consultant and the ICU Registrar.

The phone call

[44] The chain of events leading up to the phone call are largely undisputed. Dr Le had formed the view that the Rehabilitation Ward was not sufficiently staffed or experienced enough to manage Patient A and therefore Patient A had to be transferred. On the evening of 24 May 2018 around 5:15pm Dr Le called Dr White to request assistance in having Patient A transferred to a different ward.[39] Dr White was in her car with her children at the time of the call.

[45] Dr Le's evidence is that Dr White did not ask for her opinion in the matter and instead asked to speak to the Respiratory Registrar. The evidence below does not support Dr Le's recollection of the events. Dr White had sought responses from Dr Le about clinical observation of the patient's condition. Dr Le says she was not party to the discussion that took place between Dr Hordern, Respiratory Registrar and Dr White. When Dr Hordern handed back the phone, Dr White informed Dr Le that based on the blood gases she could not advocate for the patient to be moved to the acute ward.

[46] After considering the evidence of Dr White, Dr Le's recollection of the events shifted. She recalled Dr White asking her about the patient's blood gas level and how the patients' chest sounded before she asked to speak to Dr Hordern who she had heard in the

background.[40] Dr White spoke to Dr Hordern, before the phone was handed back to Dr Le. A brief discussion occurred between Dr Le and Dr White. Dr Le requested that Dr White help her have the patient moved and informed her that she had "contacted many other consultant asking for them to accept the patient to be moved to a ward, but they refusing."[41] Dr Le was unable to persuade Dr White to move Patient A to the Respiratory Ward.

[47] Dr White's evidence is that when Dr Le telephoned her she seemed very stressed and she had formed the impression that her stress was making it difficult to present the clinical issues clearly to her. Dr White's evidence is that Dr Le was speaking quickly and was not making much sense and given her seniority she expected Dr Le to have been much calmer even when dealing with difficult patient situations.[42]

[48] Dr White says she asked Dr Le a series of questions in order to make a decision as to the request Dr Le had made to have the patient transferred, Dr Le's tone changed and she became frustrated and angry. Dr White's evidence is that Dr Le was unable to provide answers to the questions and medical details she was requesting from her.[43] Dr White's evidence is that Dr Le was unable to give her an accurate and coherent idea of the patient clinical status in terms of either the current clinical status in a way Dr White could be clear about.[44] Dr White says she asked Dr Le who else was present and Dr Le informed her that Dr Hordern was there. Dr White asked to be put onto Dr Hordern who subsequently provided her with a different assessment of the Patient's medical condition than that provided by Dr Le and he was of the opinion that the patient's condition had not deteriorated sufficiently to justify a transfer to the Respiratory Ward.[45] Dr White's recollection of Dr Hordern's assessment of the patient is consistent with his notes in the patient records in which he states that there was "no evidence of respiratory compromise" and there was "no need for acute admission".[46]

[49] Subsequent to the phone conversation between Dr Le and Dr White, Dr White participated in a number of phone calls to discuss Patient A's care and around 8:00pm for a number of reasons the decision was made to move Patient A to the Respiratory Ward.[47] Dr White's evidence is that she had informed Dr Le that she would make further inquiries however Dr Le denies that this occurred. Dr Le's evidence is that she is not clear on who made the decision to transfer the patient nor is she aware of any discussions Dr White may have had with other management about Patient A's transfer.[48]

[50] Dr White followed up with Dr Le later that evening at around 8:00pm and inquired as to what had happened with the patient. Dr Le let Dr White know that the patient was about to be transferred to the Respiratory Ward.[49] Dr Le's evidence is that she had not been made aware about any discussions taking place in the background that would have facilitated the transfer of Patient A nor was she aware who had made the decision to enact the transfer.[50]

[51] Dr White's evidence is that the next day she requested the Respiratory Consultant, Dr Mark Lavercombe review what had happened and she sought his professional opinion. Dr Lavercombe informed Dr White that the patient's condition had not changed since the previous evening. Dr Lavercombe was not convinced that there was any change to the patients baseline however he had agreed to transfer the patient for a more prolonged assessment and to ensure stability.[51]

[52] Dr Le's evidence is that she was anxious, but she wasn't panicking and that at the time she was not so incapacitated as to make a decision about the patients care.[52] During the discussion Dr Le asked Dr White to assist with having the patient transferred to a different

ward. She explained that she had contacted a number of other Consultants asking them to accept the patient however her requests had been refused.[53] Dr Le was frustrated because in her professional opinion she had formed the view that the patient was at risk because the nurses were not capable of looking after Patient A's care needs.

[53] Dr Le's evidence is that Dr White had not given her the opportunity to explain this and instead opted to seek the opinion of the Respiratory Registrar who in her opinion did not know the capabilities of the nursing staff on the ward.[54] She argued that the Registrar had earlier in the day formed a different view to the one he ultimately recorded in the patient notes however this argument is not supported by any evidence. Dr Le gave evidence that the view the Registrar expressed at around 12:30pm that day was prior to the Registrar reviewing the blood gases.[55]

[54] Although there were some difference of opinions amongst those who were responsible for the patients care Dr Le concedes that the Respiratory Registrar has more experience in respiratory medicine than she has and the Registrar ultimately formed the view that the patient did not need to be transferred at that point in time.

[55] Patient A's condition deteriorated over the following days and some days later Patient A died from complications that were not associated with the Rehabilitation Unit.[56]

[56] Subsequently Dr Le attended the Intensive Care Units (ICU) mortality and morbidity (M&M) meeting. Generally, the purpose of a M&M meeting is to consider the circumstances of particular cases and what lessons could be learnt so as to improve future practices.[57]

Rehabilitation M&M Meeting

[57] Dr Le attended the ICU M&M meeting, Dr White was not present at the meeting.[58] Dr Le says questions were raised as to how the patient had come to be transferred to Western Health's Rehabilitation Unit. Dr Le was unable to answer those questions.[59]

[58] A Rehabilitation Unit M&M meeting was held some time later. Dr Ponsford chaired the meeting and Dr Le, Dr White and Mr Malkoun were all in attendance at that meeting. Patient A was discussed during the course of the meeting.[60]

[59] During the meeting a Registrar who was not involved in the case management of Patient A presented an independent view of the patient case management. Dr White provided information that she had spoken with a number of colleagues within the hospital, including the Respiratory Consultant and it was agreed that the patient's cause of death was an aspiration she had developed after her departure from the Rehabilitation Ward.

[60] Dr Le's evidence is that Dr White had stated that she had maintained the view that the patient could have remained on the Rehabilitation Ward however Dr Le had panicked because she was not physician trained.[61] Dr Le's evidence is that she considered the comments to be inappropriate and demeaning, and without reasonable foundation.

[61] Dr White denies making the comments alleged by Dr Le. Dr White's evidence is that the meeting is a multidiscipline meeting and there were a lot of people expressing their views and that she was not the only person participating in the conversation.[62] Dr White's evidence is that the conversation was around where it was best that patients such as Patient B should be

managed, the discussion about the differences in training and the different skills and experience between rehabilitation physicians and more acutely trained respiratory physicians was in that context.[63] Dr White's evidence is that she said that "the specialist medical training for Rehabilitation Consultants is different to that of Respiratory Physicians, and because of that we may need to call on the expertise of the Respiratory Consultants to manage particular patients in the future if need be."[64] Dr White suggested that the Rehabilitation Ward should upskill to be able to deal with patients like Patient A.

[62] Mr Malkoun's evidence is that Dr White did not state during the meeting that Dr Le had "panicked" because she was "not physician trained".[65]

[63] There was some discussion about the likelihood that the Rehabilitation Ward would experience more patients like Patient A and that it might be good for the Rehabilitation Ward to look at upskilling so that they could comfortably deal with such patients. Dr White's evidence is that the Rehabilitation Consultant had proposed some innovative concepts about a "shared care model" however Dr Le argued that similar patients should not come to her ward.

[64] Dr Le's evidence is that during the meeting Dr White did not invite her to make any comments on any of the matters raised pertaining to Patient A.[66]

Patient B: Stroke Patient with a tracheostomy

[65] Patient B is a neurology patient who had a tracheostomy and was referred to the Subacute and Nonacute Assessment and Pathways (SNAP) team for consideration for transfer to the Rehabilitation Ward.[67] The SNAP team assesses the criteria that needs to be met before a patient will be accepted onto the Rehabilitation Ward.

[66] Dr Le first started considering the transfer of Patient B on either 21 or 22 August 2018.[68] Dr Le received an email from the Tracheostomy Physiotherapist about Patient B on 24 August 2018 requesting a meeting.[69] On Sunday 26 August 2018 Dr Le sent an email to the SNAP Clinical Nurse Coordinator (CNC) and Dr Jayaratne with a copy to Dr White and others. In her email she outlined her concerns and requested clarification regarding the patient's treatment plan, care needs and the level of training and support that the Rehabilitation team would need to safely care for Patient B before she could be transferred to the Rehabilitation Ward. Dr Le says she did not receive a response from the SNAP CNC regarding the patient progress or her concerns raised.[70]

[67] On 31 August 2020 Dr Jayaratne reviewed the case and wrote a plan to be completed prior to Patient B's transfer.

[68] Dr Le received an email that was forwarded by Dr Jayaratne on 4 September 2020. In the email the neurologist requested assistance from the Respiratory team to be involved in the patient care if Patient B was to be transferred to the Rehabilitation Ward. Dr Le says there had been no follow-up or response from the Respiratory team regarding the neurologist's request.[71]

[69] On 4 September 2018 Dr White was copied into an email from Dr Sung seeking assistance with moving Patient B from the acute stroke ward to Rehabilitation because the Rehabilitation team wanted a Respiratory team member to physically review the patient once a week on the Rehabilitation Ward rather than on an as needs basis. Dr White's evidence is

that it is unusual for a specialist to have to email Managers to enquire about delays to patient transfers and the usual key performance indicator (KPI) from referral to transfer is 24 hours. Her evidence is that Patient B was complex and it was expected that it would take a little longer however the delay had been two weeks.[72] Dr White responded letting Dr Sung know that she had only just become aware of the issue and the matter was likely to be resolved the next day.[73]

[70] On 6 September 2018 Dr Le went to the acute neurology ward to review the patient, it was at this time she became aware that the patient was being transferred to the Rehabilitation Ward.[74] Dr Le's evidence is that she was concerned that the patient would be transferred in circumstances where neither herself or Dr Jayaratne, the Rehabilitation Registrar or the nursing staff were aware that the patient was being admitted. Dr Le says the ward was not prepared to care for the patient due to the staffing and equipment.[75]

[71] Mr Malkoun's evidence is that Dr Le's statement that the Rehabilitation Ward was unprepared for the admission of the patient was "simply untrue". Mr Malkoun refers to the SNAP note which provide that Dr Jayaratne was consulted about Patient B on 31 August 2018 and 4 September 2018 prior to the transfer on 6 September 2018.[76]

[72] Mr Malkoun's evidence is that he had personally spoken to the Nurse Unit Manager about Patient B's arrival on 6 September 2018.[77] Prior to Patient B's arrival Mr Malkoun held discussions with both the SNAP Manager and the Operations Manager about the concerns raised relating to Patient B's arrival.[78] Mr Malkoun gave evidence that he was assured during those discussions that they would receive the equipment required.[79] Mr Malkoun's evidence is that he had authorised additional staffing and had discussions about sourcing equipment from the ward Patient B was leaving. Mr Malkoun says the equipment was sourced very quickly. Dr Le acknowledges that Mr Malkoun approved for extra staff to be on the ward, her evidence was that he did that after it was decided the patient would be moved.[80]

[73] Patient B was transferred to the Rehabilitation Ward on 6 September 2018. Dr White's evidence is that this occurred after a multidisciplinary team meeting confirmed that the patient was improving and was awaiting rehabilitation.[81]

[74] When Patient B arrived on the Rehabilitation Ward there was a delay in obtaining the relevant equipment. The equipment had been left behind on the acute ward and someone from the Rehabilitation Ward had to go back up and collect the patient's equipment a short time after. The patient was however transferred with no adverse incident occurring however Dr Le says that was not without a "lot of stress and a lot of scrambling in the last minute" before the patient arrived.[82]

[75] Dr Le's evidence is that on 7 September 2018 she received a phone call from Dr Jayaratne requesting that she agree to look after the patient. Later that day Dr Le called Dr White to express her concerns regarding the lack of communication between the SNAP clinician and the Rehabilitation Ward which she says had led to unnecessary stress on the ward for the nursing staff and potentially compromised patient care and safety.[83]

The Phone Call 7 September 2018

[76] On 7 September 2018 Dr Le and Dr White had a phone conversation about Patient B. In summary Dr Le's evidence is that she raised a number of concerns about Patient B's

transfer including that staff had not been given advance notice and critical equipment for the patient had not been arranged for the patient's arrival. Dr Le raised her concerns in the context that, even though there had been no adverse incident and, although a delay, they had obtained the necessary equipment, she believed there could have been a significant adverse outcome.[84] Dr Le raised her concerns that the ward had not had enough time to prepare for the patients arrival.[85]

[77] Dr White responded stating that she didn't understand why Dr Le was stressed because there had been no medical issues with the patient so far and that there was no problem with organising the equipment and that the subacute division has never been given advance notice of patients being admitted so why does the Rehabilitation Ward have to be given advance notice.[86]

[78] Dr Le's concerns at the time was that there were communications issues between SNAP and the ward.[87] Dr Le's evidence is that she said "Don't you think that it is unfair to make that statement while the patient has special care needs and it is vital to know in advance so that we can prepare for her admission". Dr Le says that at this stage of the conversation she had become quite upset and was in tears. Dr Le's evidence is that she told Dr White that she felt embarrassed every time she rang her with an issue she would end up in tears.[88] Dr Le's evidence is that she made the following comment:

> "I do not want to call you to be in tears and distress like this, but I am not happy that my concerns have never been acknowledged and always being pushed back by you as if I am over-reacting and asking for special treatment compared to everyone else".[89] (sic)

[79] Dr White's evidence is that during the phone call from Dr Le on the evening of 7 September 2018 she sought to understand why Dr Le was calling about a patient that was not under her direct supervision. Dr White's evidence is that Dr Le was in tears from the moment she answered the phone. Dr White says she questioned Dr Le to gain an understanding of why she was so distressed. She informed Dr Le that the nursing staff and Dr Jayaratne had been provided with two weeks' notice of the transfer. Dr White had formed the view that Dr Le seemed offended because she was not given notice of the patients transfer. Dr White also gave evidence that she was not "pushing back" on Dr Le, she was asking question to establish the reason for her distress and concerns about Patient B.

[80] Dr White's evidence is that she was concerned for Dr Le and had at no time during the call behaved inappropriately towards Dr Le.

[81] Dr White responded that it was late on a Friday night and they agreed to finish the conversation and that they would meet to discuss a potential solution.

[82] Dr White's evidence is that when patients are admitted to the Rehabilitation Ward, medical practitioners and nursing staff are to comply with the Western Health Rehabilitation Referral Assessment Principles (the Principles) and the Western Health Procedure Transfer and Direct Admission to Continuing Care Services (Transfer and Direct Admission Procedure).[90]

[83] Dr White's evidence is that once the criteria is met it is expected that the patient will be transferred and there is no requirement for the Rehabilitation Ward to receive written or formal notice that the criteria has been met or that a patient will be transferred to the

Rehabilitation Ward at a particular time on a particular day. She submits that this is how the hospital system works.[91] Dr White's evidence is that a list setting out the patients who are waiting to get into the Rehabilitation Ward is produced by the SNAP team and that list is used to allocate vacant beds in the Ward as and when they become available. The Nurse in Charge of the Rehabilitation Ward will be given verbal notice by SNAP as to who is coming onto their ward on the day prior to transfer and sometimes on the day they are transferred.[92]

Meeting 18 September 2018

[84] On 18 September 2018 Dr Le attended a meeting with Dr White and Mr Malkoun. Dr Le had become upset and tearful during the meeting. Dr Le says she raised concerns about the lack of communication and the lack of clinical handover between SNAP and the Rehabilitation team. She raised concerns about a particular individual that she had previously complained about to the SNAP Manager without achieving any improvements. Dr Le expressed her disappointment in the lack of appreciation for the increasingly difficult and challenging work conditions and the achievements that the Rehabilitation staff had delivered over the year. She also discussed the increasing number of admissions of patients that had no capacity to participate in an active rehabilitation program. Dr Le says she gave examples of patients that should not have been admitted to the Rehabilitation Ward and responded to Dr Malkoun's questions as to where they should have been admitted.

[85] Mr Malkoun's evidence is that for some time he had been receiving feedback from staff, including Operations Managers, SNAP clinicians and educators who had approached him with concerns about Dr Le's patient care and decision making including, her lack of senior leadership, concerns with senior medical decision making and that decisions were not made with consultation, length of stay for patients in the rehabilitation ward, resistance and reluctance to accept patients into the rehabilitation unit despite bed availability and lack of collaboration with external staff to the unit. Mr Malkoun gave evidence that he raised these issues with Dr Le during the meeting and gave specific examples however she was not open to discussing the issues.[93]

[86] Mr Malkoun's evidence is that during the meeting Dr Le did not say much and she was struggling not to cry and was holding back tears. Mr Malkoun says that Dr Le was crying and had trouble speaking during the meeting. Mr Malkoun gave evidence that they discussed a number of concerns about Dr Le's practices however she refused to accept there were any issues in the Rehabilitation unit or with her practice. Mr Malkoun advised Dr Le that there had been a change in management in SNAP and he would set up a meeting between Rehabilitation Consultants and Nurse Manager and SNAP to discuss the issues raised.[94]

[87] Dr White's evidence is that they explained to Dr Le that the hospital needs to expedite transfers to subacute beds as soon as any particular patient no longer needed to be in an acute bed. They also explained that this type of transfer was something that would often occur on the day and was a normal everyday part of life working in the Sunshine Hospital.[95] They discussed Patient B and in response to Dr Le's concerns about communication from other teams Dr Le was asked what she had done to improve communication between her own ward and other staff in the hospital. Dr White's evidence is that Dr Le was not able to outline any steps she had taken to address these issues.[96]

[88] Dr Whites evidence is that they raised the issue that Dr Le had a tendency to be negative when receiving patients with any complexity on to the Rehabilitation ward and in multidisciplinary meetings. Dr White's evidence is that Dr Le did not take this well. Dr White's evidence is she said that the negativity was not helpful, particularly when Dr Le would express those negative thoughts to SNAP team members, the nurses and other staff members. Dr White's evidence is that they informed Dr Le that there was an expectation that Consultants were leaders of the team and it is their job to address any issues that arise in a positive and constructive way that would model professional behaviours to more junior staff. Dr White denies saying to Dr Le that she was responsible for the poor morale on the Rehabilitation Ward.[97]

[89] Dr White's evidence is that she reminded Dr Le that the Rehabilitation Ward has the most medical full time equivalent (FTE) of all the subacute wards in Sunshine Hospital and she was asked to reflect on some of the issues raised during the meeting. Dr White says due to the evident level of Dr Le's distress during the meeting she asked whether everything was ok outside of work and whether she needed extra support or wanted some time off. Dr Le said she didn't want to take time off as she was not likely to be relaxed on time off and she likes being at work.

[90] Dr Le has acknowledged that when Patient B had arrived on the ward she was medically stable and there were no adverse outcomes. However, Dr Le denies that Dr White and Mr Malkoun raised any concerns outlined above about her performance.[98]

Patient C

Events relating to the patient with terminal prognosis (Patient C) and the patient note entry made by Dr Le in relation to that patient.

[91] In or around early October Dr Le had three empty beds in the Rehabilitation Ward. The SNAP team reviewed three patients for potential admission to the Rehabilitation Ward. Each of the patients was assessed as suitable to leave their acute wards.

[92] Dr Le also reviewed the patients for potential admission however she decided that none of the patients were suitable for admission despite the SNAP team assessment and that there were no other suitable beds available for them at Western Health at the time.

[93] The three patients were ultimately received by the Rehabilitation Ward. One of the patients was a young patient who was initially admitted to the Sunshine Hospital oncology ward (Patient C).

[94] On 9 October 2018 the Manager of the SNAP team informed Dr White she had been having issues with Dr Le accepting patients and provided Dr White with a copy of an entry Dr Le had placed into Patient C's notes.

[95] Dr Le made the following entry into Patient C's clinical notes:

> "[Discussions with] SNAP Manager and despite my concerns of [patient] lack of participation/behaviour & complex/unrealistic expectation from patients & [oncology] team apparently we have no options but have to accept him from bed management point of view."[99]

[96] Dr White considered the entry in the patients clinical records inappropriate because it would highly likely be prejudicial to the patients ultimate care because it creates an immediate sense of negativity amongst the other members of the medical team and suggests that a particular patient should not be receiving care on their ward. Her evidence is that it is not an entry that concerns the patient's medical needs in any way and to write about a disagreement with a colleague regarding a patient transfer in the notes appears prejudicial and unprofessional.

[97] Dr Le's evidence is that she was justified in making the notes given her recommendations in Patient C's case. Dr Le's evidence is that she was being ignored by the SNAP team, they did not follow through with anything that she recommended and then they would tell her that she had to accept the patient even though there was a lack of follow up on her recommendations.[100]

[98] Dr Le met with Dr White on 11 October 2018. Dr Le says they met in the corridor and she raised concerns she held about the cohort of patients that they were expected to accept into the Rehabilitation Ward with no clear diagnoses, prognoses or rehabilitation goals.[101] In her oral evidence Dr Le concedes that they met in the corridor and they went into a meeting room.[102]

[99] Dr White's recollection is that she met with Dr Le to discuss the entry she had made on a Patient C's clinical notes. Dr White took Dr Le into a spare meeting room to have a private discussion. In any case they met, and the discussion did occur.

[100] Dr White informed Dr Le that it had come to her attention that there had been a difference of opinions with the Manager of the SNAP team and that it was not appropriate to write about those disagreements in patient notes as it comes across as being unprofessional.

[101] Dr Le says in response to being told the notes were unprofessional she told Dr White that the entry in the patient notes was her genuinely held clinical opinion. Dr Le says that Dr White instructed her not to document her opinion in the patient history and that she was expected to fill empty beds.[103]

[102] Dr Le's evidence is that she does not believe that it was reasonable for Dr White to assert that the making of the entry was unprofessional and to simply give her the direction not to do so. Dr Le's evidence is that Dr White did not refer to any authoritative statement in support of her direction or invite any discussion of the matter.[104]

[103] Dr Le says she tried to direct the discussion towards the concerns she had initially raised being that patients were being accepted from other wards who were not properly classified as rehabilitation patients and the acceptance of patients from other health services however Dr White was not willing to discuss those matters.[105]

[104] Dr White's evidence is that she was concerned because Dr Le did not seem to have an appreciation of what was appropriate to include in patient clinical records. Dr White's evidence is that she told Dr Le that "we don't write what we feel in a patient's clinical notes. These notes are for direct clinical opinions about patient care". Amongst other things Dr White told Dr Le it is not a clinical opinion to write about another Manager.[106]

[105] Dr White's evidence is that it seemed to her that Dr Le wanted to argue about everything she had said and she did not have time for a lengthy discussion about each individual matter. She instead told Dr Le that she understood her concerns but the point of the discussion was to discuss the entries in the clinical notes. Dr White says she then left the meeting room.[107]

31 October 2018 Email Correspondence from Dr White to Dr Le

[106] In light of the difficulties Dr White was experiencing with Dr Le she sought advice from Ms Debra Hill, Manager of Employee Relations and Business Partnerships. Ms Hill's evidence is that Dr White informed her that Dr Le was pushing back on a lot of different things and the pressure on the Rehabilitation Ward and other staff was increasing.

[107] Ms Hill's evidence is that Dr White informed her that she had attempted to speak to Dr Le about these issues and provided examples of Dr Le refusing to take patients and not having discharge plans in place. Dr White informed her that Dr Le was not listening to her and not respecting her decision making and the seniority of her role as Head of Unit and she had also made inappropriate notes in a patient's records.[108]

[108] With the assistance of Ms Hill, Dr White sent an email setting out her expectations of her continuing behaviour in writing. Dr White sought assistance from the Human Resources Department in drafting the correspondence. One could say Dr White was setting some ground rules.

[109] On 31 October 2018 Dr White sent the email to Dr Le in which she writes:

> "We have spoken on two occasions where we discussed some issues related to our expectations of you in your role as a Consultant Rehabilitation specialist at Western Health (WH).
>
> I was concerned about your response as I felt that you were struggling to reflect on the changes expected of you and had some difficulty taking feedback provided."

[110] Dr White goes on to detail a number of her concerns being:

(a) The entry into Patient C's clinical notes,
(b) Negativity and staff morale,
(c) Dr Le expressing that large numbers of patients in the emergency department as not her concern.[109]

[111] Dr White then sets out her expectations before concluding that she is happy to discuss the concerns raised and that she is available to help solve problems on the ground for individual patients if needed. Dr White states:

> "As previously discussed, if you feel there is any way that WH or myself can support you more in your role, then please feel free to discuss this with me as we are willing to help.
>
> I really hope that we can see some changes in your approach to the above issues, however, if any are repeated formal disciplinary processes may need to be

> commenced. I do hope we can continue to work together in a collaborative and positive manner."[110]

[112] Dr White's evidence is that as the Clinical Director she was entitled to raise any concerns she had about the way Dr Le was conducting her medical practice in the Division for which Dr White was ultimately responsible.

[113] Dr Le took issue with the email and her evidence is that Dr White's email fails to identify the two occasions she had spoken to Dr Le that were referred to in the email.

[114] In respect of the patient notes Dr Le continues to hold the belief that they were not inappropriate and she was simply recording her professional opinion.

[115] Dr Le responded to the points outlined in Dr Whites email on 1 November 2018. Dr Le also took issue with the second concern and says she was not aware that it had at any time been asserted that she was responsible for the poor moral in the Rehabilitation Unit. Dr Le was not sure if Dr White was implying that she was responsible for staff on the ward not having the skill to deal with complex patients who have acute care needs or being willing to develop them. Dr Le says if that was the case then there were many assumptions built into the allegation Dr White had made and it was completely inappropriate for her to do so. On the third matter raised in Dr Whites email, Dr Le says the view attributed to her does not reflect Dr Le's views expressed to Dr White accurately.

[116] The implication of the email and the way it was communicated to Dr Le was that Dr Le understood it to mean that she was not performing her role properly and not acting consistently with her obligations as a Consultant Specialist at Western Health. Dr Le says there were no reasonable grounds for Dr White to have formed such a view and the conclusions were reached without a fair inquiry or consideration of the facts. Dr Le read the email to mean that Dr White had formed a concluded view that Dr Le was not performing her role in a manner that was consistent with her obligations. Dr Le considers it to be unreasonable that Dr White sent the email detailing her concerns and expectations without conducting an inquiry into whether the relevant facts and circumstances justified the conclusions expressed.[111] Dr Le regards the behaviour of Dr White in sending the email to be intimidating and unreasonable and sending the email was an instance of bullying conduct by Dr White.

Patient D: Acquired Brain Injury Patient

[117] In December 2018 Patient D, a young male who had acquired a brain injury (ABI) and severe cognitive impairment after a large tumour resection was admitted to the Rehabilitation Ward. Patient D's brain injury meant that he was given a life expectancy of approximately 12 months. Patient D was on the Rehabilitation Ward for 2 months without a confirmed discharge plan in place.

[118] Patient D had severe cognitive impairment, displayed behaviours including agitation, aggression and absconding and this was exacerbated by his repeated requests to be discharged from the hospital.[112] Patient D was independent in all of his basic personal needs, but his escalating behaviours were increasingly difficult to manage. Dr White says this was in part related to his lengthy stay on the Rehabilitation Ward.[113]

[119] Patient D's parents were appointed his legal guardians by VCAT. Dr Le says that they were caring but elderly parents who were concerned for their own safety when they were around him. Dr Le's evidence is that Patient D's case was complicated because there was no clear treatment plan when he was transferred to the Rehabilitation Ward. Dr Le's evidence is that prior to Patient D being transferred to the Rehabilitation Ward he was nursed one on one due to what could be summarised as his high risk behaviours. Patient D had absconded from the Rehabilitation Ward on multiple occasions and Dr Le says he should have been managed in the specialised Acquired Brain Injury Unit (ABI) rehabilitation service.

[120] Dr Le's evidence is that she had several discussions with the patient's parents about moving him to Western Health's state wide inpatient ABI rehabilitation services however they did not give their consent due to the location of those services and because at that stage the neurosurgical and oncology team did not have a clear diagnosis or prognosis for him. Dr Le says Patient D's parents were under the impression that he only had a few months to live and was not a candidate for treatment.

[121] Dr White's evidence is that to the extent that Patient D should have been transferred to a specialised acquired brain injury rehabilitation facility, it was Dr Le's responsibility to action any transfer of that kind. Dr Le had taken no steps to facilitate any such transfer.[114]

The phone conversation 18 December 2018

[122] The events leading up to the 18 December 2018 phone call are as follows. On 13 December 2018 Dr white sent an email to Dr Le to see Patient D. Dr Le responded thanking Dr White and outlining the circumstances involving the parents and her immediate concerns.

[123] On 14 December 2018 Dr White reviewed the patient.

[124] Dr White's evidence is on 17 December 2018 she received a telephone call from the Operations Manager of the Rehabilitation Ward. During the call he raised his concerns about the high number of patients on the Rehabilitation Ward with no clear discharge plans and multiple patients with a lengthy stay period. Dr White's evidence is she then contacted both Rehabilitation Consultants and asked if she could discuss their cases.

[125] On 18 December 2018 Dr Le called Dr White. Dr Le and Dr White gave somewhat different accounts of the phone call. However, what is not in contention is that Dr White asked about the discharge plans to see what she could do to help reduce the length of stay before they commenced discussing the patients. Dr White's evidence is that Dr Le did not seem happy with Dr White and was not particularly forthcoming during the telephone call.

[126] Dr Le's evidence is that during their discussion about Patient D, Dr White told her she could not advocate for him to be placed in an aged care facility and that he should be discharged to a Supportive Residential Services (SRS) as he wishes. Dr Le says she accepted Dr White's comments.[115] Dr White denies that she made those comments.

[127] Dr Le also stated that Dr White disagreed with the use of Olanzepine prn on Patient D when he would attempt to leave the ward due to the risk of sedation and aspiration.[116] Dr White's evidence is that she had never stated that Dr Le couldn't use olanzapine, she was attempting to have a more nuanced conversation about the risks and benefits of chemical restraints in the context of discussing Patient D.[117]

[128] Dr White says she questioned Dr Le about Patient D's discharge plan. Dr Le explained the next step would be to refer him to the Community Based Disorders Assessment and Treatment Services (CBDATS) at the Royal Talbot for an assessment and advice about an appropriate discharge destination. Dr Le advised Dr White that this would take weeks to months.[118] Dr White voiced her concerns about the plan which involved the patient, after an already lengthy stay, spending weeks to months further on the ward. [119]

[129] Dr White's evidence is that Dr Le argued with her repeatedly about Patient D's placement. Dr White says that despite Dr Le admitting that some of her patients were no longer receiving rehabilitation therapy and did not need to be on the ward she would not listen to any advice or directives that she might give about discharge planning for her patients.

[130] Dr Le says Dr White suggested they should consider discharging Patient D to an SRS and in reply Dr Le told her that they had already explored that option and his parents had declined due to the risks of absconding from an SRS facility. Dr Le says Dr White stated that they didn't have to explain all of the risks to the family.[120]

[131] Dr White denies that she made such a statement and would never advocate for a medical practitioner not to explain potential risks to patient's guardians. Dr White's evidence is that Dr Le's own plan was to send Patient D to an SRS and the parents had looked at one facility and declined saying it was in poor condition. Dr White's evidence is that it is Dr Le's role to guide the parents to look at the least restrictive options for the patient.[121]

[132] During the call Dr Le discussed a stroke patient who had been on the Rehabilitation ward for two weeks. Dr Le referred to the Australasian Rehabilitation Outcomes Centre (AROC) benchmarking document informing Dr White that the document outlines the average length of stay for certain diagnoses and the severity of the condition. Dr Le's evidence is that she said that the document was used in the case conferences as a reference document for patient's length of stay.

[133] The AROC was established by the Australasian Faculty of Rehabilitation Medicine of the Royal College of Physicians, and managed by the Australian Health Services Research Institute at the University of Wollongong. Dr White's evidence is the AROC document is not a data set that is meant to be used the way that Dr Le suggests. Her evidence is that it is not a clinical guideline or standard produced by any medical association. The document simply identifies the average length of stay at different hospitals for different patient groups.

[134] Dr Le then sought assistance from AMA Victoria before sending an email to the Chief Medical Officer Paul Eleftheriou requesting he intervene.

18 December 2018 meeting

[135] On 11 November 2018 Dr Eleftheriou received an email from Dr Le in which Dr Le made complaints about a number of perceived issues that were occurring in the Rehabilitation Ward.[122] In her email Dr Le refers to a number of "disrespectful and unacceptable behaviours" that had allegedly occurred. Dr Le refers to each of the events set out above and that she had received a threatening email from Dr White.[123]

[136] Dr Eleftheriou met with Dr White and discussed the contents of Dr Le's email. Dr Eleftheriou reassured Dr White that the email she had sent to Dr Le was reasonable and in keeping with the minimum standards all health services expect of their senior medical staff. Dr Eleftheriou's evidence is that Dr White was demonstrating sound clinical leadership by discussing key clinical matters like patient flow and access, appropriate discharge and referrals.[124]

[137] Dr Eleftheriou obtained Dr's White's consent to attend a meeting with himself and Dr Le to discuss and resolve the issues raised by Dr Le. On 12 November 2018 Dr Eleftheriou responded to Dr Le's email suggesting the same.[125] Dr Le responded requesting that her representative from the Australian Medical Association (AMA) be present at the meeting.[126] Dr Eleftheriou consulted with Human Resources on the issue and arranged for a meeting to take place on 18 December 2020.[127]

[138] Ms Hill discussed the background to the matter with Dr Eleftheriou prior to the meeting so that he could prepare. On 18 December 2018 Dr Le and her AMA representative met with the Dr Eleftheriou and Ms Hill.[128] Dr Eleftheriou and Ms Hill gave evidence that Dr Le cried throughout the meeting and expressed that the email received from Dr White who she viewed was not a specialist in the field and from whom she had received direct criticism over her decision making was upsetting. Amongst other things Dr Le expressed her concerns about the Rehabilitation Ward being used as a dumping ground for patients, Dr White referring to her as not being physician trained and that she did not feel valued and felt undermined.[129] Ms Hill had formed the view that the issued Dr White had raised and written to Dr Le about were appropriate to raise and that the October email was reasonable management action.[130]

[139] Dr Eleftheriou's evidence is the conduct Dr Le described was not bullying conduct and he did not agree with the characterisation of Dr White's behaviour in that way, and says he repeatedly explained to Dr Le that it was Dr Whites role to enquire about patient discharge plans and to set out relevant expectations of the Consultants under her supervision as Clinical Director.[131] Dr Eleftheriou's evidence is that Dr Le refused to acknowledge that Dr White was simply trying to carry out her responsibilities as a diligent head of unit and in his view Dr Le failed to demonstrate appropriate insight into the issues and her own performance or show any willingness to compromise or try to understand Dr White's perspective.[132]

[140] Dr Le's account of the meeting is that Western Health representatives expressed a view that there were communication issues with herself and Dr White.[133] Dr Eleftheriou gave evidence that when he referred to communication issues he was referring to the fact that Dr Le was refusing to listen to or speak to Dr White, which was most concerning to him as Dr White was Dr Le's Manager and Dr Le's desired outcome from the meeting was to have no contact or communication with Dr White. Dr Eleftheriou held the view that Dr White had at all times acted appropriately in her dealings with Dr Le.[134]

[141] Dr Eleftheriou raised the idea of an independent mediator in an attempt to resolve any communication issues. Dr Eleftheriou's evidence is that Dr Le made it clear she didn't want to be in the same room as Dr White.

[142] Dr Eleftheriou corresponded with Dr Le's representative by email and a proposal was put forward by the representative on 21 December 2018 detailing how the matters raised by Dr Le should be approached. Dr Eleftheriou had concerns about the proposal as it did not address his concerns that Dr Le does not like to receive negative feedback.

[143] On 9 January 2019 Dr Le emailed Dr Eleftheriou seeking a response to the proposal put forward by her representative before she commenced a five week period of leave.[135] Dr Le's evidence is that she also sought help and counselling from the Victorian Doctor's Health Program as she had decided that the psychological impact on her dealings with Dr White were too much to manage on her own.[136]

[144] Dr Eleftheriou replied on 10 January 2019 to advise that he was still "working on" a response. Whilst considering the proposal Dr Eleftheriou had discussions with Human Resources and Dr White and he was alerted to a patient safety issue relating to Dr Le.

[145] A response was ultimately provided from Ms Hill to Dr Le's representative on 29 January 2019. The email noted that:

(a) The expectations set out by Dr White in her email dated 31 October 2018 in relation to Dr Le were not unreasonable;
(b) Western Health supports Dr White in her role as Clinical Services Director; and
(c) Ms Hill and Dr Eleftheriou had made inquiries about patient safety issues that needed to be addressed formally with Dr Le.[137]

<u>The performance letter</u>

[146] Ms Hill assisted Dr White in preparing a performance letter. There was some delay in the preparation of the letter due to the Christmas period and leave arrangements.

[147] Dr Le returned to work on the 19 February 2019. Dr Le's evidence is that Dr White approached and handed her the letter without comment. The letter directed her to attend a performance meeting on 28 February 2019 with Dr White and a Human Resource Representative. The letter advised Dr Le that Dr White was following up from her informal discussions held over a number of months pertaining to her expectations of Dr Le in her role at Western Health. The letter sets out that Dr White is concerned that Dr Le is having some difficulty reflecting on the changes expected of her and had difficulty receiving feedback. The letter goes on to state that Dr White intends to discuss areas of Dr Le's performance that need improvement and offer support and training that may assist her in reaching the required performance level. The letter contained Dr Whites concerns and expectations of Dr Le and some information about resources available to Dr Le.[138]

[148] Dr Le submits that the letter provided insufficient details about the alleged underperformance issues for her to respond, nor did the letter provide details of the alleged patient safety issues that required immediate remedy. After receiving the letter Dr Le commenced sick leave on 21 February 2019. Dr Le has not returned to work.

Conclusions

[149] Before I deal with my specific finding's I make the following observations. When determining if Dr Le has been bullied at work, in this matter I am required to consider the particular behaviours exhibited by Dr White towards Dr Le. It is not necessary for me to make findings about the appropriateness of the medical decisions of either Dr White, Dr Le or any other practitioner who gave evidence in this matter.

[150] Dr White is responsible for the clinical management of the entirety of the Aged Care, Cancer and Rehabilitation Division which includes the Rehabilitation Unit Dr Le works in. Dr White is more senior in her employment hierarchy to Dr Le. Dr Le reports to Dr White and Dr White has the ultimate responsibility for the function of the Rehabilitation Unit. Dr Le takes issue with Dr White being appointed to her position. Dr Le struggles to accept that she reports to Dr White; this is partly due to the fact that she has formed the view that the Rehabilitation Unit should be run by a Rehabilitation Physician.[139]

[151] Dr Le accepts that rehabilitation medicine is changing, the demographic is changing, patients are getting older and more complex and there is more in-home care for less complex patients.[140] However her actions when it comes to patient acceptance do not reflect her understanding.

[152] Although Dr Le reports to Dr White it does not mean that Dr Le is not responsible or cannot be held accountable for her decisions as a practitioner. Quite the contrary, as a medical practitioner every decision Dr Le makes about patient treatment she is accountable for. Therefore, it stands to reason that Dr Le is concerned that any negative inferences about her performance may have adverse consequences in a professional sense.

[153] Dr Le unreasonably held the view that Dr White dismissed issues or concerns of importance concerning patient management. If Dr White did not agree with Dr Le she took those disagreements personally and not professionally. It was argued the actions of Dr White in dismissing Dr Le's professional opinion on patient care, patient admissions and other matters pertaining to the operation of the Rehabilitation Ward was demeaning and left Dr Le feeling unappreciated and undervalued. Dr White did not dismiss Dr Le's opinions and views, she chose to discern between the information provided to her and elected to make a decision of her own choosing as a Manager.

[154] Dr Le holds the view that she is highly competent and that the criticism levelled at her by Dr White was not justifiable and those criticisms were not made on the basis of facts, therefore it was unreasonable in all of the circumstances.

[155] The evidence in these proceedings suggests otherwise. There are a number of instances where Dr White was justified in raising her concerns with Dr Le, however Dr Le refused to engage in discussions with Dr White in a professional manner after having already formed an earlier view that Dr White did not respect her opinions. Quite frankly the situation became quite absurd considering Dr Le's and Dr Whites professional status.

[156] At the time Patient A had been admitted Dr Le had already formed some views as to the relationship between herself and Dr White. It is clear from the evidence that Dr Le had formed the view that Dr White was not a Rehabilitation Specialist and did not respect the

professional opinion of Dr Le. Having formed this view it is clear any engagement that took place between Dr Le and Dr White was subsequently affected by Dr Le's preconceptions.

[157] Dr Le's recount of the circumstances surrounding the admission of Patient A indicates that she had experienced some difficulties overall with both Patient A's care and the internal hospital management between the different wards. Having formed the view that Dr White did not respect her professional opinion, it is conceivable that Dr Le may have been experiencing difficulties explaining the clinical situation to Dr White.

[158] Whilst I make no findings in this matter about the medical competencies or management of the patients, I make the following observation about the evidence presented. Dr Le presented as a compassionate practitioner singly focussed on patient care and she had formed the view that some of the patients should not have been admitted to the ward and when they were Dr Le felt that the patient care was being compromised. Dr Le became somewhat frustrated at hospital managements internal politics in patient care and she was often unable to achieve the outcomes she sought. Dr Le sort to shift the blame for this on Dr White.

[159] Dr Le considers herself to be an expert in her field and believes she has the knowledge of the capabilities of the nurses within her unit that others didn't understand, she has an expectation that her peers recognise her skills, knowledge and experience. I make this observation not as a criticism of Dr Le, however the combination of events combined with Dr Le's expectations led to some of the frustration Dr Le had experienced in managing the competing interests that often arose between Dr Le and the Hospital.

Patient A

[160] It has been inferred that I should draw a negative inference from the absence of evidence from Dr Hordern. It is not necessary for me to do so, the authenticity of Dr Hordern's patient notes were not contested.[141] In making my decision I consider a finding that Dr Le was frustrated and anxious which was Dr Le's own evidence is sufficient to draw the conclusions I have set out below.

[161] Even though Patient A wasn't Dr Le's patient it was evident that Dr Le had formed the view that the patient needed to be transferred for the reasons set out above. Dr Le had been dealing with a number of obstacles regarding her desire to have Patient A transferred and I accept that she was frustrated by the time she spoke to Dr White on the phone on 24 May 2018. Dr Le also became anxious whilst speaking to Dr White.

[162] Dr White reasonably held the expectation that Dr Le should have been able to communicate a clinical assessment of the patient in a clear and concise manner. I accept that Dr Le was unable to do so. I do note however that Dr White as her Manager made no attempt to assist or aide Dr Le in being able to deliver the information she required to make an assessment of the situation, this was in part because of Dr White's expectations of Dr Le as a professional. Dr White, as was her right, instead requested to speak to another practitioner in order to obtain the information she required to make an informed assessment.

[163] This was done in Dr Le's presence which resulted in Dr Le taking offence. Dr Le was offended that Dr White had elected to not support Dr Le's request and instead chose the opinion of the Respiratory Doctor over Dr Le's. Dr Le was of the opinion that the Respiratory

Doctor did not understand the nurses skill and the needs of the patient. Dr Le was left feeling embarrassed, undervalued and unappreciated and she formed the view Dr White did not value her professional opinion. Quite frankly this is where the problems began. Dr Le's conduct in the events described from that day forward were motivated by her perceptions of Dr White's actions and motives, this ultimately had an effect on Dr Le's response and reactions in any future dealings with Dr White. I make this observation for reasons that will become apparent below.

[164] Dr Le did not get the response she desired from Dr White and unfairly categorises Dr White's singular interaction with her as unreasonable conduct. What Dr Le fails to understand is that Dr White was doing her job, her decision was based on a clinical assessment and at no time do I consider her conduct to have been unreasonable in the context of the circumstances.

[165] When considering Dr White's actions in the context of the circumstances I do not consider them to be of a bullying nature. Dr White was trying to form an assessment of the situation in a timely manner and had every right to seek the views of the Respiratory Specialist or any other practitioner that she thought was relevant to consult with in the circumstances. However, I make the following observations for the benefit of the parties. Dr White was acutely aware that Dr Le was anxious when talking to her. In an ideal situation it would have been prudent of Dr White to have followed up with Dr Le immediately after the event to discuss the situation and resolve any perceived issues. Had she done so the problem may have been resolved there and then and not left to fester as it did. I say this because Dr White says she was concerned about Dr Le's welfare however she chose to do nothing about addressing those concerns until the meeting that took place some months later.

[166] The evidence suggests that Dr White did not ignore Dr Le's concerns about Patient A. I accept that Dr White did tell Dr Le that she would look into the matter and Dr White proceeded to go about performing her duties expediently making a number of phone calls to evaluate those concerns and address the circumstances surrounding Patient A's care. Whilst I acknowledge Patient A wasn't on Dr Le's bed card and in fact was the responsibility of Dr Jayaratne, given her invested interest in the circumstance it would have been prudent for Dr White to have at least informed Dr Le that she had in fact followed up on her concerns.

[167] I do not find the actions of Dr White to have been unreasonable in the context of the surrounding circumstances therefore her actions cannot be described as bullying type behaviours.

Rehabilitation meeting

[168] It is common ground that the M&M Meeting was to *facilitate discussion* (emphasis added) about lessons learned and are not designed to attribute blame to any particular person. It had been discussed during the meeting that it had been determined that the deterioration of Patient A's condition and the circumstances that led to the death of Patient A were not attributable to anything that occurred in the management of Patient A on the Rehabilitation Ward.

[169] I accept that Dr White made comments during the meeting as to the differences in skill and experience between rehabilitation physicians and more acutely trained respiratory physicians in the context of the discussion that had taken place. The context of Dr White's discussion was how the Rehabilitation Unit would have to work together with Respiratory

Consultants and Registrars in the future in similar circumstances like the ones with Patient A.[142] This was supported by the evidence of Mr Malkoun.

[170] Dr Le alleges that Dr White had said in the meeting that she had *"panicked because she was not physician trained"*. I have considered the evidence and I accept the evidence of Dr White and Mr Malkoun being that those were not the actual words spoken. Given Dr Le's strongly held views about Dr White it is conceivable that Dr Le took the comments made by Dr White to be directed towards her.

[171] Dr Le also makes the allegation that Dr White did not invite her to share her view on Patient A. It has already been established that the M&M meetings involve discussions from the attendees. Dr Le also gave evidence that she had discussed the circumstances involving Patient A.[143] If Dr Le as a professional had a view that she wished to express it is apparent given the nature of the meeting that she did not need an invitation from Dr White to do so.

[172] Bullying can often involve subtle actions, that is the person who is behaving unreasonably can often target the recipient in ways that are less obvious and without considering the conduct in the context of the overall circumstances the behaviours can at times seem perfectly reasonable. It is for those reasons I have carefully considered the comments made by Dr White in the M&M meeting in the overall context of the preceding circumstances.

[173] In the context of the events leading up to the M&M meeting in this case, the purpose of the M&M meeting and Dr White's desire for changes to occur, I do not consider her conduct in that meeting to have been unreasonable in all of the circumstances.

[174] I also make the following observation. I do not in the circumstances consider it to be a case of Dr Le fabricating allegations. Observing the order in which the events occurred and the observations by Dr White, Mr Malkoun and Dr Eleftheriou made about Dr Le's emotional state in conjunction with Dr Le's own admissions, I have formed the view that given Dr Le's previous experience with Dr White in dealing with her concerns about Patient A, including the phone call on 24 May 2018, it is reasonable to conclude that Dr Le perceived Dr White's comments being directed towards her. If I am wrong about this I still do not consider in the context of the events that occurred Dr White's conduct at the M&M meeting to be unreasonable.

7 September 2018 Phone call

[175] Dr Le was concerned during the phone call about the length of notice they would receive on the ward for incoming patients. Dr Le concedes that no other ward at the hospital received advance notice of patients being transferred to the ward.

[176] There is nothing in the evidence that leads me to consider the conduct of Dr White during the call to be either unprofessional or unreasonable. Dr White simply told Dr Le that she didn't understand why she was so upset about the circumstances and proceeded to explain why she didn't agree with Dr Le. It is evident in the language Dr Le uses that if Dr White didn't agree with Dr Le on a given subject then Dr Le would perceive Dr White as being unreasonable. It is at this point that I agree with the submissions of the Respondent being that Dr Le does not take kindly to having her views disagreed with and she is unwilling to receive feedback that doesn't fit with her own view.

18 September 2018 Meeting

[177] I accept that after taking a phone call from Dr Le, due to the level of distress shown by Dr Le during that phone call Dr White arranged a meeting with Dr Le to discuss her concerns. It was not the first time Dr Le had been upset or distressed and unable to control her emotions during clinical phone calls.

[178] Dr Le attended a meeting on 18 September 2018 with Mr Malkoun and Dr White. Mr Malkoun gives an account of the meeting which suggests that Dr Le was visibly upset at the commencement of the meeting. Mr Malkoun saw the meeting as an opportunity to raise a number of concerns about Dr Le's demeanour and lack of understanding of the circumstances surrounding the transfer of Patient B as well as a number of concerns he had previously held. Both Dr White and Mr Malkoun proceeded to address their concerns for a period of approximately 90 minutes.

[179] If I was to accept Dr Le's evidence as to the events that took place at the meeting on 18 September 2018, it would appear that she raised a number of concerns that were discussed however there were no issues about her performance raised by Dr White in any of the circumstances discussed. I found this to be quite extraordinary. Either Dr White was being too subtle in her approach to dealing with her concerns or Dr Le was either completely oblivious or ignorant of the fact that she could possibly be attributing to the situation she had found herself in. Based on the evidence and material before me I find it to be the latter.

[180] The only criticism I make of Dr White is, knowing that Dr Le had exhibited signs of distress and had become anxious in the proceeding period leading up to the meeting it would have been prudent for Dr White and Mr Malkoun to initially conduct a welfare check on Dr Le before arranging a meeting to discuss the concerns they held about her performance.

Patient Note

[181] I found the circumstances of Dr Le's complaint in this instance to be where the matter becomes somewhat absurd. Here we have grown professionals whose relationship has come to the point where the details of those relationships are now being entered into patient records and instead of acknowledging the true underlying circumstances, the argument turns to whether or not those records constitute a clinical note.

[182] I do not, in the context of the bullying application given the circumstances in which the entry into the patient records occurred need to determine whether or not that record was a "clinical opinion". The parties can wrap this issue up in whatever technical argument they wish however the reality is it was made out of Dr Le's frustration with a member from the SNAP team.

[183] There is no dispute that Dr Le made the entry she did into the patients records. What concerns me most about this incident is not whether the note constitutes a clinical record or not, but rather Dr Le's motives for making the note which were also at the heart of Dr Whites' concerns. Dr Le was frustrated with the SNAP team and that they had not adhered to her recommendations. Dr Le and a member of the SNAP team had had a difference of opinion and instead of dealing with it in a professional manner Dr Le decided to document her opinion on the patient's medical records.

[184] Dr Le's motives for writing the notes were totally unprofessional and it is my view that she demonstrated an inability to address her issues with the SNAP team in a professional and considered manner. Dr White is correct and was well within her rights to raise her concerns with Dr Le.

[185] Given the context in which the notes were written Dr White's conduct towards Dr Le was reasonable management action. Dr White as the Manager was within her right to caution Dr Le about such conduct and there was nothing unreasonable about Dr White's behaviour in this instance.

Email 31 October 2018 and meeting held on 9 December 2018

[186] Dr Le's contention is that the behaviour towards Dr Le in connection with the 31 October email and the events in the 9 December 2018 meeting should be found to constitute unreasonable behaviour towards Dr Le.

[187] Dr White's email to Dr Le on 31 October 2018 simply highlighted a number of difficulties relating to Dr Le's behaviour that she had been dealing with over a period of time and her expectations of Dr Le. The evidence suggests that Dr White had sought and taken advice from others in trying to manage the circumstances without them having to escalate to the level they eventually did.

[188] Dr Le takes issue with Dr White not specifying on which two occasions they had discussed Dr White's concerns and expectations. The evidence deduced during the hearing suggests that it should have been blatantly obvious to Dr Le when she had met with Dr White where those concerns were discussed. However, Dr Le only seems to be able to acknowledge the issues she has raised on those occasions. This again supports Dr White's evidence that Dr Le had little or no insight to her conduct and how her conduct was affecting her relationships with others.

[189] Given my findings above in those circumstances I did not find Dr White's email to Dr Le to be a departure from what would be reasonable human resource management practices. Dr White's email was perfectly in keeping with her responsibilities as the Clinical Services Director.

[190] I do however level some criticism at Dr Eleftheriou's management of the matter. I did not find his approach to be impartial, nor did it go anyway to assisting in resolving the matter. Dr Eleftheriou had been informed by Dr White that she had been having issues with Dr Le's behaviour and upon receiving her complaint he took no steps to meet with Dr Le to discuss the details of her complaint and investigate impartially. Whilst I do not consider that there would have been a different outcome had he approached Dr Le's complaint in a different manner, it was still incumbent on him to ensure an unbiased approach affording Dr Le procedural fairness and natural justice.

[191] Given my findings above it was reasonable in the circumstances for Dr White to invite Dr Le to attend the informal performance discussion so as to resolve the ongoing situation that was becoming untenable.

[192] None of the conduct complained about by Dr Le is bullying in my view. The instances requiring Dr White to make discretionary decisions are within her role and even though she at times had not acquiesced to Dr Le's requests, this does not constitute bullying.

[193] There has been nothing heavy handed or unreasonable about Dr White's approach to managing the issues that have arisen with Dr Le's behaviours.

[194] Given my findings in this matter, there is no basis to consider the making of orders as contemplated by s.789FF of the Act. Accordingly, this application must be dismissed and an Order[144] to that effect will be issued.

COMMISSIONER

Appearances:

B. Mueller Special Counsel for Dr Le
M. Minucci of Counsel for Western Health and Dr White

Hearing details:

2020.
Melbourne:
February 19, 20.
May 18 (by telephone).

Final written submissions:

Applicant: 19 March 2020
Respondent: 8 April 2020
Applicant reply: 17 April 2020

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[1] AE429332

[2] Exhibit A1, p3

[3] Exhibit JS1, p2

[4] Ibid, p3

[5] Ibid, p2 & Exhibit A1, p7
[6] Transcript PN240
[7] Exhibit R2, p12
[8] Exhibit JS1, p5
[9] Ibid, p4
[10] Exhibit R2, p7 -10 and Exhibit R3, p22
[11] Exhibit R2, p6
[12] Exhibit R5, p4
[13] Exhibit R2, p9
[14] Exhibit A1, p52
[15] Exhibit A5, p4
[16] Exhibit A2, p13
[17] [2016] FWC 2308 at [13]
[18] Section 789FC of the Act
[19] [2015] FWC 775
[20] *Bropho v Human Rights & Equal Opportunity Commission* (2004) 135 FCR 105 at [79]
[21] See *Department of Education & Training v Sinclair* [2005] NSWCA465, *Von Stieglitz and Comcare* [2010] AATA 263 at [67]
[22] *Ms SB* [2014] FWC 2104 at [51]
[23] Section 789FF of the Act
[24] *Ms SB* [2014] FWC 2104
[25] Exhibit A1, p50
[26] Exhibit A5, p12
[27] Transcript PN397; Exhibit R5, p31 and ExhibitR3, p44(b)
[28] Exhibit A1, p54
[29] Transcript PN397
[30] Exhibit R3, p44
[31] Exhibit A3, p44(c)
[32] Transcript PN 401
[33] Ibid PN 400-405
[34] Ibid PN404
[35] Exhibit A1, p55(f)
[36] Ibid, p55(g)&(h)
[37] Ibid, p58
[38] Ibid, p59
[39] Transcript PN1267
[40] Ibid PN491-492
[41] Ibid PN 501
[42] Exhibit R3, p47
[43] Transcript PN1165; Exhibit R2, p49
[44] Transcript PN1166
[45] Exhibit R3, p51
[46] Ibid, CW-4
[47] Exhibit A1, p65; Exhibit R3, p56 and Transcript PN1346
[48] Transcript PN546
[49] Exhibit A2, p6(b)
[50] Transcript, PN546

[51] Exhibit R3, p58
[52] Transcript PN475
[53] Ibid PN501
[54] Ibid PN504
[55] Ibid PN531
[56] Exhibit A1, p69; Transcript PN552-554
[57] Exhibit A1, p70; Exhibit R3, p63
[58] Exhibit A1, p71; Exhibit R3, p59
[59] Exhibit A1, p74
[60] Exhibit R5, p39
[61] Exhibit A1, p82
[62] Transcript PN1448
[63] Ibid PN1445
[64] Exhibit R3, p64
[65] Transcript PN2221; Exhibit R5, p41
[66] Exhibit A1, p87
[67] Ibid, p89
[68] Transcript PN602
[69] Ibid PN600
[70] Exhibit A1, p91-92
[71] Ibid, p92
[72] Exhibit R3, p75
[73] Ibid, CW-9
[74] Exhibit A1, p93
[75] Ibid, p94
[76] Exhibit R5, LM-12
[77] Transcript PN2256-2261
[78] Ibid PN2262
[79] Ibid PN2275
[80] Ibid PN637
[81] Exhibit R3, p77
[82] Transcript PN620
[83] Exhibit A1, p98
[84] Transcript PN664
[85] Ibid PN672
[86] Exhibit A1, p98-102
[87] Transcript PN674
[88] Ibid PN676
[89] Exhibit A1, p103
[90] Exhibit R3, p74
[91] Ibid, p70
[92] Ibid, p72
[93] Exhibit R5, p53-55
[94] Ibid, p54-58
[95] Exhibit R3, p94
[96] Ibid, p96
[97] Ibid, p97

[98] Transcript PN702-714
[99] Exhibit R3, CW-10
[100] Transcript PN829
[101] Exhibit A1, p112
[102] Transcript PN831
[103] Exhibit A1, p113
[104] Ibid, p117
[105] Ibid, p118
[106] Exhibit R3, p121
[107] Ibid, p125
[108] Exhibit R6, p7-9
[109] Exhibit R3, CW-12
[110] Ibid, CW-11
[111] Exhibit A1, p23-129
[112] Ibid, p135; Exhibit R3, p136
[113] Exhibit R3, p136
[114] Ibid, p137
[115] Exhibit A1, p154
[116] Ibid, 156
[117] Exhibit R3, p148
[118] Exhibit A1, p161
[119] Exhibit R3, p149
[120] Exhibit A1, p154-164
[121] Exhibit R3, p149-151
[122] Exhibit R4, p14
[123] Exhibit A1, NL-4
[124] Exhibit R4, p16
[125] Ibid, p17
[126] Ibid, p18
[127] Ibid, p19
[128] Exhibit A1, p168
[129] Exhibit R6, p20
[130] Ibid, p20-21
[131] Exhibit R4, p24
[132] Ibid, p25
[133] Exhibit A1, p169
[134] Exhibit R4, p30
[135] Exhibit A1, p170
[136] Ibid, p171
[137] Exhibit R4, p43 and PE-13
[138] Exhibit A1, NL-6
[139] Transcript PN359
[140] Ibid PN370-375
[141] Ibid PN523-524
[142] Ibid PN569
[143] Ibid PN561
[144] PR723297