Royal Commission into Aged Care Quality and Safety

Interim Report: Neglect

Volume 2
Hearing Overviews and Case Studies

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Introduction

This volume of the Interim Report details some of what we heard in hearings up to and including the hearings held in Darwin and Cairns in July 2019. It also contains the conclusions we have reached about the case studies that have been examined at hearings. This volume is not intended to be a comprehensive record of all evidence received at our public hearings. Some of the evidence has been drawn on in Volume 1. Much of it will be drawn on in our Final Report. Whether or not summarised here, or in Volume 1, we are considering all evidence we have received. This evidence will continue to inform our inquiry.

Hearings

As set out in Volume 1, there are many ways in which the Royal Commission has conducted its inquiries, including through public hearings. This volume contains an outline of some of the evidence received at our public hearings.

By the time this Interim Report is due to be provided to the Governor-General, we will have held 11 public hearings.[1]

By the conclusion of our hearings in Darwin and Cairns in July 2019, we had heard from 197 witnesses. These witnesses included people receiving aged care, family and friends of people receiving care, experts, advocates, researchers, service providers, and representatives from government departments and agencies.

Counsel and Solicitors Assisting the Royal Commission selected witnesses to give evidence based on their connection to the matters being examined in a case study or based on their expertise or experience in connection with the themes being focused on at the particular hearing. In addition, there have been many direct accounts from people about their experiences with aged care. In most cases, providers are not identified in these direct accounts. The purpose of direct accounts is to allow us and the public to bear witness to individuals' experiences. These valuable accounts assist us in understanding a range of issues relevant to our Terms of Reference.

Our Terms of Reference require us to consider appropriate arrangements for evidence and information to be shared by people about their experiences, recognising that some people need special support to share their experiences.[2] In most cases, witnesses have given evidence in person. However, in some cases it has been necessary to take evidence remotely or by pre-recorded video.

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1 Adelaide Hearing 1 (11–13 and 18–22 February 2019), Adelaide Hearing 2 (18–22 March 2019), Sydney Hearing (6–8 and 13–17 May 2019), Broome Hearing (17–19 June 2019), Perth Hearing (24–28 June 2019), Darwin Cairns Hearing (8–12 and 15–17 July 2019), Mildura Hearing (29–31 July 2019), Brisbane Hearing (5–9 August 2019), Melbourne Hearing 1 (9–11 and 13 September 2019), Melbourne Hearing 2 (7–9 and 11 October) and Melbourne Hearing 3 (14–18 October 2019).

2 Letters Patent, 6 December 2019, as amended on 13 September 2019, paragraph (r).

In Volume 1 we explained that, early in the Royal Commission's operation, we decided that each public hearing would focus on particular themes associated with our Terms of Reference.

In addition, Counsel and Solicitors Assisting determined that, where appropriate, case studies would be used to illustrate the themes to be examined at hearings.

Case studies

Case studies that have the potential to expose the themes being explored at a particular hearing are selected for investigation. Solicitors and Counsel Assisting investigate many more case studies than ultimately proceed to examination at public hearings. These investigations are resource-intensive. They involve:

- detailed review of submissions from the public and other information held by the Royal Commission
- interviewing potential witnesses
- issuing notices to relevant entities and comprehensively reviewing the material returned.

Following this process, Counsel and Solicitors Assisting decide which case studies will proceed to examination at a hearing.

To date, case studies at our hearings have focused on the experiences of individuals with particular approved providers of aged care. They have involved some consideration of approved providers' responsibilities and obligations, as well as the regulatory environment within which they operate. It is useful, in this context, to provide a brief explanation of the regulatory environment. More information is available in Background Paper 7 – *Legislative framework for Aged Care Quality and Safety regulation*, available from the Royal Commission's website.

The *Aged Care Act 1997* (Cth) regulates approved providers of aged care. Regardless of the type of aged care, a provider of aged care must be approved under Part 2.1 of the Aged Care Act in order to receive a subsidy for the provision of care.[3] The Secretary of the Australian Department of Health is responsible for the approval of providers and the revocation of approval from providers.

Approved providers have responsibilities and obligations with respect to quality of care, user rights, and accountability.[4] These responsibilities and obligations are set out in the Aged Care Act, the *Quality of Care Principles 2014* (Cth) and the *Accountability Principles 2014* (Cth).

3 *Aged Care Act 1997* (Cth), s 6-1.

4 *Aged Care Act 1997* (Cth), pt 4.1, 4.2 and 4.3.

The case studies have considered various aspects of approved providers' responsibilities and obligations. They have also considered various aspects of aged care complaints, compliance and regulation.

The Aged Care Quality and Safety Commission commenced operation on 1 January 2019. It replaced the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner. The *Aged Care Quality and Safety Commission Act 2018* (Cth) sets out the functions of the Aged Care Quality and Safety Commission. The Commissioner of that Commission is responsible for the consumer engagement, complaints, compliance, regulatory and education functions of the Aged Care Quality and Safety Commission.[5] Many of the accreditation and quality review processes of the Aged Care Quality and Safety Commission are undertaken by quality assessors.[6]

In some case studies, Counsel Assisting have invited us to make findings about substandard care. For the purposes of the case studies considered in this volume, and unless stated otherwise, we have applied the definition of 'substandard care' we used in our approved provider survey:

- care (or complaints about care) which did not meet the relevant quality standards under the *Quality of Care Principles 2014* and other obligations under the Aged Care Act; and
- care (or complaints about care) which, although meeting the relevant quality standards under the Quality of Care Principles and other obligations under the Aged Care Act, was not of a standard that would meet the high standards of quality and safety that the Australian community expects of aged care services.[7]

Leave to appear and post-hearing submissions

In the weeks before public hearings, details of the hearings are announced on the Royal Commission's website. These announcements include details of the scope of matters that will be examined. People or organisations with a direct and substantial interest in matters being examined are invited to apply for leave to appear at the hearing. These applications are considered, with leave usually granted to those who will be called as witnesses or those with an interest in the factual matters being examined in a case study, especially when their interests may be adversely affected.

5 Exhibit 1-38, Adelaide Hearing 1, Statement of Janet Mary Anderson, 4 February 2019, WIT.0023.0001.0001 at [5].

6 Also referred to as regulatory officials: see definition of regulatory official in section 7 of the *Aged Care Quality and Safety Commission Act 2018* (Cth).

7 Service Provider Survey FAQ, https://agedcare.royalcommission.gov.au/submissions/Documents/faq-service-provider-survey.pdf, viewed 11 August 2019.

After most hearings, Counsel Assisting provides written submissions. These written submissions generally concern the case studies. Where Counsel Assisting consider it appropriate, they invite us to make findings about facts and issues arising in those case studies. Counsel Assisting's submissions are provided to parties with leave to appear whose interests are affected by those submissions. Those parties have the opportunity to respond in writing, making submissions in reply. We have considered all of the submissions. Where appropriate, we reach conclusions based on the evidence and submissions before us.

Standard of proof

Hearings of Royal Commissions are conducted differently to trials conducted in courts; they are inquisitorial rather than adversarial in nature. While Royal Commissions are not bound by the rules of evidence, we have been guided by them. We have applied a civil standard of proof. Findings are made and conclusions reached only where we have 'reasonable satisfaction' of the fact or issue in question. We have been guided by the principles discussed by Dixon J in *Briginshaw v Briginshaw*:

> it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular findings are consideration which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal…the nature of the issue necessarily affects the process by which reasonable satisfaction is attained.[8]

While not binding or enforceable, conclusions or findings made by Royal Commissions can have significant impact upon those the subject of them. We have not reached conclusions or made findings lightly. In addition, we expect the Australian Department of Health and the Aged Care Quality and Safety Commission will have regard to the findings we have made and, in appropriate circumstances, take steps to follow up with approved providers.

8 (1938) 60 CLR 336 at 362-3.

1. Adelaide Hearing 1: Perspectives on the Aged Care System

Hearing overview

Introduction

The Royal Commission's first hearing was held in Adelaide, South Australia, on 11 to 13 February and 18 to 22 February 2019. The hearing provided us with scene-setting evidence of the current state of the aged care system and future challenges. The evidence came in the form of oral and written testimony from 28 witnesses, including four witnesses who had direct experience of the aged care system either personally or through a family member.

Key aspects of the hearing were:

- changing demographics of the Australian population and the implications for aged care
- views on the current Australian aged care system from the perspectives of government agencies, representative bodies and people receiving or seeking aged care services
- features of the aged care quality, safety and complaints system
- the nature and meaning of 'quality' and 'safety' within the Australian aged care system.

The evidence at this hearing was wide-ranging. Some of the evidence has been drawn upon in Volume 1 of this Interim Report. It will continue to be drawn upon over the course of our inquiry as well as in our Final Report.

What follows is a brief overview of the hearing.

Demographic changes

It is clear that Australians are living longer in greater numbers than ever before.[1]

1 Exhibit 1-13, Adelaide Hearing 1, AIHW and ABS Graphs, RCD.9999.0004.0001.

We heard from Ms Justine Boland, Program Manager, Health and Disability Branch, Australian Bureau of Statistics, about the increasing proportion of older people in the population. In 2017, approximately 3.8 million or 15% of the Australian population was aged 65 years and over. The Australian Bureau of Statistics projects that in 2066 this will increase to between 8.6 million (21% of the population) and 10.2 million (23% of the population).[2]

The number of people aged 85 years and over in Australia is projected to be between 1.5 million (3.6% of the population) and 2.2 million (4.4% of the population) in 2066.[3]

The proportion of the Aboriginal and Torres Strait Islander populations that are aged 65 and over are considerably smaller than equivalents for the non-Indigenous population, reflecting their higher mortality rate and lower life expectancy. Ms Boland told us that in 2016, the proportion of Aboriginal and Torres Strait Islander people aged 65 and over was 4.8%, compared with 16% for non-Indigenous people.[4]

Ms Sue Elderton, National Policy Manager of Carers Australia, made the point that the increasing proportion of older people in the population will soon reach a 'tipping point' where there are likely to be fewer family carers from younger generations relative to the older population.[5] Aside from the generational imbalance, Ms Elderton said, there is likely to be a decline in the ability or propensity to provide care. She identified factors which influence these trends as:

- the increasing number of women (the traditional providers of family care to the aged) in employment
- the number of families requiring two incomes to support themselves
- families having children later in life than has traditionally been the case, making it harder to care for older parents at the same time as caring for young children
- the rising rate of relationship breakdown and divorces later in life, which impacts on the availability of partners to provide care.[6]

Ms Boland gave evidence about Australian Bureau of Statistics data concerning the dependency ratio for 2018 and the projected data for 2042. The dependency ratio is produced by comparing an estimate of the working age population (aged between 15 and 64 years old) against those outside of that population group.[7] Ms Boland explained that

2 Exhibit 1-6, Adelaide Hearing 1, Statement of Justine Boland, 31 January 2019, WIT.0001.0001.0001 at 0018 [75].

3 Exhibit 1-6, Adelaide Hearing 1, Statement of Justine Boland, 31 January 2019, WIT.0001.0001.0001 at 0019 [76].

4 Exhibit 1-6, Adelaide Hearing 1, Statement of Justine Boland, 31 January 2019, WIT.0001.0001.0001 at 0011 [60(c)].

5 Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T190.13-44; Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0008.

6 Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0008.

7 Transcript, Justine Boland, Adelaide Hearing 1, 12 February 2019 at T115.1-11; Exhibit 1-13, Adelaide Hearing 1, AIHW and ABC Graphs, RCD.9999.0004.0001 at 0002.

based on the Australian Bureau of Statistics' current (2018) and projected (2042) data of the dependency ratio, there is likely to be a lot more people who are reliant on the fiscal base. Currently, there are 52 people for every 48 people who earn. By 2042, there is likely to be 58 people for every 42 people in the working age range.[8]

Views on the current system

Learnings from Oakden

At the opening of this hearing, we heard from Mrs Barbara Spriggs and her son, Mr Clive Spriggs. Mr Robert Spriggs was known to his friends and family as Bob. Bob was Barbara's husband and Clive's father. He was a resident at the Oakden Older Persons Mental Health Service (Oakden) in early 2016.

Oakden was meant to be a facility which provided a supportive environment for older people with complex mental health needs. It was not.

Mrs Spriggs told us about Bob's mistreatment and the effect that had on her and her family. She said that there was a lack of 'dignity, care and respect' for residents at Oakden.[9] Other reports have identified the multitudinous failures that led to Oakden continuing to operate while it provided substandard care.[10]

Mrs Spriggs told us that after her husband suffered mistreatment, it was extremely difficult to make a complaint.[11] She felt that those responsible for Bob's mistreatment had not been held accountable. She said the aged care system lacked accountability.[12]

Mrs Spriggs suggested a number of policy reforms for aged care—especially improved and more effective regulatory oversight and accountability regimes as well as more empathetic staff.[13] She said from the very first moment she went to Oakden, her gut feeling told her that this was not a good place. She had the same gut feeling on her second visit: 'this doesn't feel really good'. Mrs Spriggs was concerned about why no one else had picked up on that feeling.[14] She said:

> So—you know, when accredited people go—the accreditors go out to these places, it's not just about what things have been ticked off, what they've got, what they haven't

8 Transcript, Justine Boland, Adelaide Hearing 1, 12 February 2019 at T115.24-116.26.

9 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T40.39-41.5; Exhibit 1-1, Adelaide Hearing 1, Statement of Barbara Spriggs, 8 February 2019, WIT.0025.0001.0001 [35].

10 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, Carnell and Paterson, October 2017, RCD.9999.0011.1833.

11 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T39.20-34; Exhibit 1-1, Adelaide Hearing 1, Statement of Barbara Spriggs, 8 February 2019, WIT.0025.0001.0001 [19]-[20].

12 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T38.30-39.34; Exhibit 1-1, Adelaide Hearing 1, Statement of Barbara Spriggs, 8 February 2019, WIT.0025.0001.0001 [14]-[20].

13 Exhibit 1-1, Adelaide Hearing 1, Statement of Barbara Spriggs, 8 February 2019, WIT.0025.0001.0001 at 0002-0003 [14]-[20] and 0004 [27].

14 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T41.46-42.14.

> got; people should be going with their gut feeling. And I think if the accreditors are trained correctly, maybe they would pick up on things that are not right, because my gut feeling told me right from the beginning that this is not a good place. And so I have concerns with how—how well our accreditors are and how accountable they are.[15]

Mr Clive Spriggs also explained the changes that he would like to see in the aged care system after his father's mistreatment, especially the use of CCTV and increased training in complex care delivery.[16]

The mistreatment of Bob Spriggs extends to the failure of the system to detect that mistreatment. At the time, Oakden was operating with accreditation from the then Australian Aged Care Quality Agency. The system let Bob down. Failures such as those at Oakden can have catastrophic consequences for residents, including potentially resulting in illness, injury or death.[17]

Views about ageing and older people

Mr Ian Yates AM, the Chief Executive of COTA Australia, told us about the relationship between the design of the aged care sector in Australia and ageism:

> the construction of the aged care sector in Australia, aged care institutions as we know them, has to some degree been an outcome of ageism…and the lack of priority attached to aged care in public policy terms…is pretty unprecedented. That is a function of ageism which is, like sexism and racism, embedded in many ways in which we all interact...
>
> We tend to discount the citizenship of very old people, because they don't have the obvious utility to us that our society frequently values, and that is a really important issue. We have a—not a use-by date, but a best by date attitude to life, rather than assuming that life is something about growing through different stages and phases.[18]

Ms Pat Sparrow, Chief Executive Officer Aged and Community Services Australia, said that a potential barrier to effective implementation of person-centred care in Australia may be cultural and societal approaches to the aged. She said there is a growing public perception that ageing is a negative process. In response, Aged and Community Services Australia is part of the 'EveryAGE Counts' campaign, which promotes the important role older people play in the Australian community.[19]

15 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T42.16-22.

16 Transcript, Clive Spriggs, Adelaide Hearing 1, 11 February 2019 at T43.11-44.14; Exhibit 1-2, Adelaide Hearing 1, Statement of Clive Spriggs, 8 February 2019, WIT.0026.0001.0001 [7]-[19].

17 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, Carnell and Paterson, October 2017, RCD.9999.0011.1833 at 1846.

18 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T90.9-20.

19 Transcript, Patricia Sparrow, Adelaide Hearing 1, 19 February 2019 at T437.20-43.

Ms Claerwen Little, National Director of UnitingCare Australia, emphasised the importance of adopting a rights-based approach when considering how aged care can be improved. She explained that a rights-based approach would uphold choice and dignity within the aged care system in that the rights of older people as they age should be prioritised and a culture of respect should be created.[20]

Ms Little suggested that a person-centred approach is a step towards achieving this because the system would be built around the person and not the other way around.[21] She said, 'I think aged care has become—it's almost like we've kind of—we need to put away our older citizens, that we need to put them into a home and then leave them there.'[22]

Ms Little called for a national conversation about what it means to age:

> The community must embrace the social change that will be upon us in coming decades. Older people are a social group like any other—except that they come with the accumulation of experience and the insight of age. They must be accorded the universal right to live a meaningful life.[23]

Although there has been a recent policy shift toward 'consumer-centred' aged care, we heard that the current aged care system is a product of government control and direction-setting rather than consumer choice. Mr Nicolas Mersiades, Director of Aged Care at Catholic Health Australia, put it succinctly:

> move away from an aged care system which is controlled and managed to the nth degree by the government and instead move to one where we have a genuine aged care service industry where it's the consumer that calls the shots.[24]

Accessing the system

We heard about challenges for people accessing and navigating the aged care system.[25] In particular, this involved people's concerns with My Aged Care.

Mrs Kaye Warrener is 77 years old and is a carer for her 78-year-old husband, Mr Leslie Warrener. Mr Warrener has had a quadruple bypass and has prostate cancer, arthritis, a susceptibility to pneumonia, a tremor in his right hand and cellulitis.[26] Mrs Warrener told us about the challenges she faced seeking aged care support for her husband.

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20 Transcript, Claerwen Little, Adelaide Hearing 1, 20 February 2019 at T487.24-27; Exhibit 1-51, Adelaide Hearing 1, Statement of Claerwen Little, 31 January 2019, WIT.0010.0001.0001 at 0004 [19].

21 Transcript, Claerwen Little, Adelaide Hearing 1, 20 February 2019 at T487.32-33.

22 Transcript, Claerwen Little, Adelaide Hearing 1, 20 February 2019 at T497.36-39.

23 Exhibit 1-51, Adelaide Hearing 1, Statement of Claerwen Little, 31 January 2019, WIT.0010.0001.0001 at 0004 [18] and 0005 [23].

24 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T470.34-37.

25 Transcript, Craig Gear, Adelaide Hearing 1, 12 February 2019 at T140.27-38; Maree McCabe 19 February 2019 at T405.26-T406.2; Kaye Warrener, 21 February 2019 at T596.33-597.32.

26 Exhibit 1-61, Adelaide Hearing 1, Statement of Kaye Warrener, 18 February 2019, KWH.9999.0001.0006 at [8].

She said there was a lack of clarity around where her husband was in the 'queue', poor and confusing communication from My Aged Care, and delays in receiving care.[27]

Ms Maree McCabe, Chief Executive Officer of Dementia Australia, expressed her concern that carers are not able to speak on behalf of a person who seeks to engage with My Aged Care. She said this can make it difficult for them to assist a person who seeks to access My Aged Care.[28]

Mr Craig Gear, Chief Executive Officer Older Persons Advocacy Network, told us of the particular challenges that some members of the community experience when seeking to access aged care:

> when we start to look at some of our more vulnerable Australians and we start to look at people in remote locations or people who may not have that connection to technology, and it is less functional for those people. So if you're talking about remote Aboriginal communities or homeless people or those with mental health issues it does not work well for those and we need a different approach for those types of populations.[29]

Ms Glenys Beauchamp PSM, Secretary of the Australian Department of Health, referred us to the Aged Care Navigator trial. She explained that the Department was looking to have 30 hubs around Australia engage with local areas to help potential aged care recipients access and seek information on the aged care system.[30]

Quality and safety in residential care

Other witnesses at the hearing told us of their concerns about the quality of care and safety in aged care.

Mr Paul Versteege, Policy Manager for the Combined Pensioners and Superannuants Association of NSW Inc, told us of his concerns about the safety of aged care.[31] He said that 'residential aged care recipients have a 1.7% chance of being assaulted by a member of staff'[32] and warned that malnutrition rates amongst people in residential aged care could be as high as 50%.[33] He also identified significant concerns about the quality of clinical care offered in residential aged care facilities.[34]

27 Transcript, Kaye Warrener, Adelaide Hearing 1, 21 February 2019 at T593.26-597.32.

28 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T.410.19-28.

29 Transcript, Craig Gear, Adelaide Hearing 1, 12 February 2019 at T141.2-7.

30 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T329.25-30.

31 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001.

32 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 [39].

33 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 [42].

34 Transcript, Paul Versteege, Adelaide Hearing 1, 12 February 2019 at T162.4-35.

Mr Mersiades told us that residential aged care is not providing meaningful lives for older people.[35]

Mr Yates said that, as a community, we have expected that when people go to residential aged care, somehow all their needs will be looked after by that facility. If that's our expectation, he said, that is not what government is funding.[36]

Mr Matthew Richter, Chief Executive Officer of the Aged Care Guild, had a more positive view. He said that the aged care system meets the current needs of most ageing Australians, although he accepted that there were instances where the system had failed to deliver acceptable levels of care.[37] However, he said the Aged Care Guild did not consider the system sufficiently equipped to meet future needs. He pointed to emerging demographic pressures, which he considered would result in a significant increase in demand for residential aged care services and necessitate an increase in government funding.[38]

Ms Beauchamp also considers that the aged care system broadly meet the needs of older Australians.[39]

Ms Beauchamp drew our attention to the Consumer Experience Reports compiled by the Australian Aged Care Quality Agency.[40] The Consumer Experience Reports relate to residential aged care and in 2018 were based on over 15,000 interviews.[41] Ms Beauchamp emphasised that 98.3% of those interviewed said that they feel 'safe' 'most of the time' or 'always'. This figure includes 17.21% of respondents who said that they feel safe only 'most of the time'. Ms Beauchamp told us that anything less than 100% would not be acceptable.[42]

In relation to an increase in the number of complaints about aged care services, Ms Beauchamp said that this was not because of a decline in the quality of those services. Instead, she claimed that this increase was due to increased public scrutiny on the aged care sector and additional funding being provided for compliance purposes, including having more complaint assessors 'on the ground'.[43]

35 Exhibit 1-50, Adelaide Hearing 1, Statement of Nicolas Mersiades, 31 January 2019, WIT.0011.0001.0001 [5]–[6].

36 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T58.13-15.

37 Exhibit 1-54, Adelaide Hearing 1, Statement of Matthew Richter, 31 January 2019, WIT.0012.0001.0001 [1.1].

38 Exhibit 1-54, Adelaide Hearing 1, Statement of Matthew Richter, 31 January 2019, WIT.0012.0001.0001 [3.2]-[3.3].

39 Exhibit 1-23, Adelaide Hearing 1, Statement of Glenys Beauchamp, 4 February 2019, WIT.0022.0001.0001 at 0027 [116].

40 Exhibit 1-23, Adelaide Hearing 1, Statement of Glenys Beauchamp, 4 February 2019, WIT.0022.0001.0001 at 0027 [111].

41 Exhibit 1-26, Adelaide Hearing 1, What are consumers saying about aged care?, undated, CTH.2000.1000.5400.

42 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T310.42.

43 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T309.12-15.

Home care

There are two primary programs funded by the Australian Government which provide aged care services to people in their own home, the Commonwealth Home Support Programme and Home Care Packages.

All witnesses before the Royal Commission who addressed this topic agreed that enabling older Australians to receive aged care at home is a matter of significant importance.

Ms Louise York, Group Head of the Community Services Group of the Australian Institute of Health and Welfare, and her colleague, Mr Mark Cooper-Stanbury, helped us to put that in context.[44] They told us that aged care services were predominantly provided to people in their own home. In 2016–17, two-thirds of people receiving aged care services received them through the Commonwealth Home Support Programme. People receiving a Home Care Package represented 8% of all people using aged care during the year. Only about 23% of people receiving aged care did so via residential aged care.

Ms York and Mr Cooper-Stanbury said that residential care is much more costly to the Government than home-based care and support. Accordingly, 69% of Government funding for aged care was spent on the 23% of people in residential aged care.[45]

Ms York also stated that the rate of people accessing home care is increasing faster than the rate of people accessing residential care.[46] There seems to be little doubt that demand to access aged care services at home will continue to grow.

As people are staying in their own homes longer, there has been an increase in the acuity of people entering residential care. Acuity is a measure of the care needs of a particular person. This means, Mr Cooper-Stanbury explained, that when people now enter residential care, they are more likely to have complex care needs than they did in the past.[47]

The wait time to access a Home Care Package was a very significant issue at this hearing.

Mrs Warrener told us of the long delay in obtaining the level of care required. Leslie, her husband, was assessed as eligible for a Level 3 Home Care Package on 6 November 2017.[48] On or about 5 February 2019, he was assigned a Level 2 Home Care Package, but was still waiting for a Level 3 Package when Mrs Warrener gave evidence.[49]

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44 Exhibit 1-7, Adelaide Hearing 1, Statement of Louse York, 31 January 2019, WIT.0002.0001.0001.

45 Exhibit 1-4, Adelaide Hearing 1, Statement of Prof John McCallum, 31 January 2019, RCD.9999.0004.0001 at 0009.

46 Transcript, Louise York, Adelaide Hearing 1, 12 February 2019 at T127.4-8.

47 Transcript, Mark Cooper-Stanbury, Adelaide Hearing 1, 12 February 2019 at T127.23-30.

48 Exhibit 1-61, Adelaide Hearing 1, Statement of Kaye Warrener, 18 February 2019, KWH.9999.0001.0006 at [9] and [12]; Transcript, Kaye Warrener, Adelaide Hearing 1, 21 February 2019 at T592.29-32.

49 Exhibit 1-61, Adelaide Hearing 1, Statement of Kaye Warrener, 18 February 2019, KWH.9999.0001.0006 at [16] and [9]; Transcript, Kaye Warrener, Adelaide Hearing 1, 21 February 2019 at T594.1-12.

Mrs Warrener told us that Leslie's health had deteriorated since the assessment yet he was unable to access services that would make a difference to his health.[50]

Professor John McCallum, CEO and Research Director of National Seniors Australia, described the waiting lists for home care as 'profoundly a critical failure'.[51]

Professor McCallum explained that the lack of home care currently results in more people needing to go into residential care and hospitals, which is far more expensive. He described this dichotomy as 'economically irrational' and identified it as an immediate issue to confront.[52]

Mr Yates lamented that a lot more had to be done to understand the composition of the waiting list.[53]

Mr Gear reflected similar views to Mr Yates and Professor McCallum. He told us that Older Persons Advocacy Network hears that waiting times are too long, Packages do not meet people's needs, and supply does not meet demand. The Older Persons Advocacy Network has heard of waiting period of 18 to 24 months.[54]

Mr Versteege was very concerned by the waiting list of over 120,000 people for Home Care Packages.[55] In a survey conducted by Combined Pensioners and Superannuants Association of NSW Inc, 95% of respondents said they wanted to receive care at home.[56] Mr Versteege said that this reflected that people were reluctant to receive residential aged care because of concerns about safety and quality.[57] The combination of delay in distribution of Home Care Packages and residential care not being regarded as sufficiently safe or of sufficient quality represented a serious safety issue in that people were not receiving the level of care needed.[58]

Ms Elderton emphasised the contribution of unpaid carers, including in the home care sector. [59] She referred to a 2015 Deloitte Access Economics Report, which estimated the replacement cost of all informal care in Australia to be $60.3 billion.[60] Ms Elderton thought aged care would comprise a substantial portion of that amount.[61]

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50 Exhibit 1-61, Adelaide Hearing 1, Statement of Kaye Warrener, 18 February 2019, KWH.9999.0001.0006 at [31]; Transcript, Kaye Warrener, Adelaide Hearing 1, 21 February 2019 at T594.25-41.

51 Transcript, Prof John McCallum, Adelaide Hearing 1, 11 February 2019 at T94.3.

52 Transcript, Prof John McCallum, Adelaide Hearing 1, 11 February 2019 at T94.10-16.

53 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T63.38-39.

54 Transcript, Craig Gear, Adelaide Hearing 1, 12 February 2019 at T145.32-39.

55 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 at [15].

56 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 at [26].

57 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 at [27].

58 Transcript, Paul Versteege, Adelaide Hearing 1, 12 February 2019 at T164.34.

59 Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0001.

60 Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0006; Exhibit 1-12, Adelaide Hearing 1, The economic value of informal care in Australia in 2015, June 2015, RCD.9999.0003.0001 at 0022; Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T181.14-19.

61 Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T181.24-30.

Ms Elderton told us that informal carers often step in to provide care because of the long wait times for a Home Care Package.[62] This may mean that the carer is required to give up their own job. This may affect the carer's ability to obtain re-employment as carers are often in their 50s or 60s.[63] She said that caps imposed on the number of Home Care Packages, particularly at higher levels, means the system is not meeting demand.[64]

Other issues were raised about home care.

For instance, Ms Little highlighted particular challenges faced by remote communities. She explained that Home Care Packages in remote communities are often consumed by transport costs due to the distance, leaving fewer funds available for direct services.[65]

Ms Little also told us that Home Care Packages can be difficult to access for the homeless population (particularly older women and single women) who do not have secure accommodation.[66] People from culturally and linguistically diverse backgrounds may also find it difficult to access Home Care Packages due to language barriers.[67]

Ms Elderton mentioned frequent complaints about fees and charges and communication about these charges.[68]

Problems with the delivery of a Home Care Package can have serious consequences. Ms Margaret Harker is 72 years of age and lives independently with the assistance of a Level 4 Home Care Package.[69] Ms Harker requires aged care services following a severe stroke at the age of 64.

Ms Harker emphasised her determination to remain living in her own home and described her efforts to ensure that appropriate physical modifications were made to her home. She described the difficulties she faced when her aged care services provider collapsed in October 2017. After the provider collapsed, Ms Harker received no morning care for two weeks. The collapse had a significant impact on Ms Harker's quality of life and meant she was forced to remain in bed for almost the entire period.[70]

62 Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0005.

63 Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0005; Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T181.39-45.

64 Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0005; Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T189.41-43.

65 Exhibit 1-51, Adelaide Hearing 1, Statement of Claerwen Little, 31 January 2019, WIT.0010.0001.0001 at 0009 [47].

66 Transcript, Claerwen Little, Adelaide Hearing 1, 20 February 2019 at T493.1-8.

67 Transcript, Claerwen Little, Adelaide Hearing 1, 20 February 2019 at T493.11-14.

68 Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0005.

69 Exhibit 1-62, Adelaide Hearing 1, Statement of Margaret Harker, 20 February 2019, WIT.0053.0001.0001 at [3]-[5].

70 Exhibit 1-62, Adelaide Hearing 1, Statement of Margaret Harker, 20 February 2019, WIT.0053.0001.0001 at [129]-[142]; Transcript, Margaret Harker, Adelaide Hearing 1, 21 February 2019 at T610.42-611.3.

Care for people living with dementia

Dementia is a significant health issue affecting about 50% of people in residential aged care. The precise prevalence in the broader community is unclear. The Australian Institute of Health and Welfare estimated there were 376,000 people in Australia living with dementia. That number is projected to grow to 550,000 by 2030.[71] Ms McCabe from Dementia Australia estimated that there are 436,000 Australians currently living with dementia and that by 2056 there will be 1.1 million.[72]

Ms Boland told us about Australian Bureau of Statistics data which shows the number of deaths from dementia, ischaemic heart disease and cerebrovascular disease from 2006 to 2015. The data shows that dementia is becoming a condition which is increasingly likely to be the cause of death, overtaking cerebrovascular disease as a cause of death in around 2012 or 2013.[73]

Dementia is likely to become the leading cause of death for Australians in the 2020s.[74]

Ms McCabe said that getting a diagnosis of dementia can take anything up to three years for older people and seven years for younger people. Ms McCabe drew our attention to the stigma associated with the dementia diagnosis. She said the diagnosis is a profoundly isolating experience for those living with it and for their carers. She described situations where 'family and friends fall away', and that for the person, when they go to the doctor, the doctor starts talking to their carer and not them.[75]

Access to effective aged care is further compromised by failures with My Aged Care. Ms McCabe stated that the staff on the My Aged Care phone line are not dementia trained, and that the advice received from My Aged Care is often inconsistent and poor.[76] Those caring for people living with dementia have similar experiences, with confusing or inaccurate communication received from My Aged Care.[77] Ms McCabe related similar underwhelming experiences with Aged Care Assessment Team (ACAT) assessors at the stage of accessing the aged care system.[78]

71 Australian Institute of Health and Welfare, Australia's health 2018, 2018, Chapter 3.14.

72 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T395.3-13 & T399.13-14.

73 Exhibit 1-6, Adelaide Hearing 1, Statement of Justine Boland, 31 January 2019, WIT.0001.0001.0001 at Exhibit JLB1017, Dementia, CTH.0001.7000.0045.

74 Exhibit 1-13, Adelaide Hearing 1, AIHW and ABS Graphs, RCD.9999.0004.0001 at 0003; Transcript, Justine Boland, Adelaide Hearing 1, 12 February 2019 at T116.32-117.10; Exhibit 1-6, Adelaide Hearing 1, Statement of Justine Boland, 31 January 2019, WIT.0001.0001.0001 at [66(b)].

75 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T398.1-14.

76 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T405.31-T406.2; T406.26-43.

77 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T407.45-T408.17.

78 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T407.24-47.

The impact of dementia on informal carers, and their ability to cope themselves is an issue that is often hidden. Ms McCabe stated it was 'extremely important' that carers in the community are provided adequate support, such as respite care. Ms McCabe said that research shows that carers for people living with dementia have worse health and wellbeing outcomes than carers who care for people with other conditions.[79]

Mr Barrie Anderson told us about his experience caring for someone with dementia. Mr Anderson spoke about the significant changes to his lifestyle and personality which were required to care for his wife, who was living with dementia. He explained that you need to be able to not get angry. You need to become a better communicator and more sensitive.[80]

Mr Anderson told us that dementia care needs to replicate the environment of the home.[81] He said that 'music…really fuels your emotions', but there are difficulties in providing dementia-specific programs which target typically male interests, like a Men's Shed.[82] Mr Anderson also raised the stigma around dementia and said there was a need to raise awareness about the impact of dementia and how the community can better care for people living with dementia.[83]

Physical and chemical restraints

The use of physical and chemical restraints in aged care, especially for people living with dementia, was raised on a number of occasions.

Dr Harry Nespolon, President of the Royal Australian College of General Practitioners, said chemical restraints are in some circumstances appropriate, such as when a patient with dementia is violent towards others.[84] Dr Nespolon told us that psychoactive medications may be given to people with dementia to address psychotic symptoms, rather than as a form of chemical restraint.[85] He said that prescribing medications, including chemical restraints, is a discretionary clinical decision and increased regulation is not an effective solution.[86]

Dr Nespolon considered that the current issue with chemical restraints is the absence of regular review. This means that a person may be on medication for an indefinite period, without its effectiveness being considered.[87]

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79 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T.403.12-T404.13

80 Transcript, Barrie Anderson, Adelaide Hearing 1, 21 February 2019 at T630.31-631.15.

81 Transcript, Barrie Anderson, Adelaide Hearing 1, 21 February 2019 at T631.39-40.

82 Transcript, Barrie Anderson, Adelaide Hearing 1, 21 February 2019 at T633.24-27; Exhibit 1-63, Adelaide Hearing 1, Statement of Barrie Anderson, 15 February 2019, WIT.0030.0001.0001 [52].

83 Exhibit 1-63, Adelaide Hearing 1, Statement of Barrie Anderson, 15 February 2019, WIT.0030.0001.0001 [55]. Transcript, Barrie Anderson, Adelaide Hearing 1, 21 February 2019 at T638.32-47.

84 Transcript, Harry Nespolon, Adelaide Hearing 1, 18 February 2019 at T381.15-33.

85 Transcript, Harry Nespolon, Adelaide Hearing 1, 18 February 2019 at T382.14-18.

86 Transcript, Harry Nespolon, Adelaide Hearing 1, 18 February 2019 at T381.41-45.

87 Transcript, Harry Nespolon, Adelaide Hearing 1, 18 February 2019 at T381.33-39; T382.20-24.

Associate Professor Edward Strivens, President of the Australia and New Zealand Society for Geriatric Medicine, told us that both physical and chemical restraints were often used inappropriately in aged care. In his view there are occasions where they are used in response to 'behavioural and psychological symptoms of dementia', but it is important to realise that these symptoms are often an expression of a person's unmet needs.[88]

According to Associate Professor Strivens, the use of medication should never be a substitute for good quality care. Rather, non-pharmacological management strategies should always be the first step.[89]

Ms McCabe referred us to a 2014 research paper by Associate Professor Peisah and Dr Skladzien to support her assertion that the use of antipsychotic medication to restrain people living with dementia when they are agitated is only effective in 20% of cases.[90]

Ms McCabe called for the development of a multifaceted strategy to reduce chemical and physical restraint use on those living with dementia. This would include education about non-pharmacological intervention and how to access relevant specialists, as well as the need for appropriate staffing numbers and skills mix in care to reduce recourse to both physical and chemical restraints. Dementia Australia's view, she explained, was that psychotropic medications have a role in managing behaviour but only as an option of last resort and in an evidence-based manner.[91]

Ms Beauchamp said the Government and Department's view was that physical and chemical restraints should be used as a last resort. She told us that that the Department would be implementing a formal mechanism for reporting the use of physical restraints.[92] She explained that chemical restraints were also being considered in relation to the mandatory quality indicators, and an exposure draft was in train in relation to this question. The Minister for Health had also convened a committee under the Chief Medical Officer to consider medication mismanagement, but results were not expected for many months.[93]

Other complex care needs

Dementia is not the only care issue for older Australians. Associate Professor Strivens described the complexity of care needs that people face as they age.

88 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T200.33-43; Exhibit 1-14, Adelaide Hearing 1, Statement of Edward Strivens, 28 January 2019, WIT.0021.0001.0001 at 0007 [63].

89 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T201.1-5.

90 Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, 31 January 2019, WIT.0005.0001.0001 at DEH.0001.0001.0006; Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T412.1-21; Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, 31 January 2019, WIT.0005.0001.0001 [28.11]–[28.15].

91 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T413.1-13.

92 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T315.1-33.

93 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T317.22-43

He made the point that each person will have different care needs as they get older. Managing the care needs of older Australians can be 'amongst the most complex the health system has to manage and yet it can be difficult for these people to access the specialist interdisciplinary care that they so desperately need'.[94]

Associate Professor Strivens emphasised that in residential care there needs to be an awareness of the impact that the prescription of multiple medicines can have, such as on the maintenance of adequate hydration.[95] In relation to issues of mental health, he said that around 10% of older Australians have symptoms of depression and anxiety but that rises to up to 50% in residential aged care facilities.[96]

The reason for this increase is said to be the loss of independence and medical comorbidities that are precipitating with an admission to residential aged care.[97] Non-pharmacological, lifestyle and environmental changes have a significant beneficial impact on the mental health of older people.[98]

Management of these complex needs raises issues of skills and training for the aged care workforce.

Skills and training

Professor Deborah Parker from the Australian College of Nurses told us that registered and enrolled nurses are required to meet minimum professional standards, including continuing professional education that is subject to auditing.[99]

Despite these requirements, she said that nurses are not provided enough training in dementia care or in mental health, especially in relation to depression and anxiety.[100] Professor Parker explained that clinical issues can be caused by the variable quality of training that is provided to personal care workers.[101] Attendants handle tasks that nurses may have handled in the past. Professor Parker said that due to the low number of registered nurses that work in aged care facilities, supervision of clinical tasks for personal care workers may not be being carried out by registered nurses but instead by other unregulated workers.[102]

94 Exhibit 1-14, Adelaide Hearing 1, Statement of Edward Strivens, 28 January 2019, WIT.0021.0001.0001.

95 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T213.25-33.

96 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T207.17-21.

97 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T209.32-40.

98 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T 210.10-16.

99 Transcript, Deborah Parker, Adelaide Hearing 1, 13 February 2019 at T223.27-42-T224.26.

100 Transcript, Deborah Parker, Adelaide Hearing 1, 13 February 2019 at T237.11-22.

101 Transcript, Deborah Parker, Adelaide Hearing 1, 13 February 2019 at T227.24-45.

102 Transcript, Deborah Parker, Adelaide Hearing 1, 13 February 2019 at T228.1-6.

Mr Yates said that the current Certificate III and IV courses for aged care workers are insufficient and don't include core components, including in dementia-specific aged care.[103]

Professor McCallum considers that personal care workers have been 'underdone in terms of the VET system and its training and we need better access to training for personal care workers'.[104] His rationale was, in part, that the role of the personal care worker has changed dramatically since the introduction of consumer-directed care. This has resulted in personal care workers often becoming the advocate for the person who is receiving care, including advocating for services outside their own service provider.[105] He said that mandated courses for personal care workers is critical and that these courses should be graded and developed.[106]

Professor McCallum also suggested that the gaps in training of personal care workers could be improved by training for informal carers, training in care planning, personal advocacy to support consumer-directed care, mandated qualifications (including a compulsory unit on dementia), shorter courses, improved on-the-job training and a skills escalator to boost the labour supply in the workforce.[107]

Ms Elderton said that 'sometimes it's people being so rushed off their feet that it's casual neglect'.[108] She also mentioned the importance of improved supports for carers. She noted that currently carers may access counselling, peer support, coaching, training opportunities and financial support from Commonwealth programs, but suggested that these services are not sufficient.[109] She considers training for carers is 'patchy'.[110]

Ms McCabe called for an integrated national approach to dementia education and care.[111]

Lack of integrated care

Another aspect of the delivery of care is the integration between staff at a residential care facility and other health practitioners.

103 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T65.1-16.

104 Transcript, John McCallum, Adelaide Hearing 1, 11 February 2019 at T96.16-17.

105 Transcript, John McCallum, Adelaide Hearing 1, 11 February 2019 at T96.18-26.

106 Transcript, John McCallum, Adelaide Hearing 1, 11 February 2019 at T96.28-30; Exhibit 1-4, Adelaide Hearing 1, Statement of Professor John McCallum, 31 January 2019, WIT.0004.0001.0001 at 0007.

107 Transcript, John McCallum, Adelaide Hearing 1, 11 February 2019 at T96.30-46; Exhibit 1-4, Adelaide Hearing 1, Statement of Professor John McCallum, 31 January 2019, WIT.0004.0001.0001 at 0007.

108 Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T186.33-34.

109 Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T182.10-18; Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, 2 February 2019, WIT.0003.0001.0001 at 0006.

110 Transcript, Susan Elderton, Adelaide Hearing 1, 12 February 2019 at T182.18.

111 Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, 31 January 2019, WIT.0005.0001.0001 [47].

We heard evidence of the lack of integration between the health services that are provided by States and Territories and the aged care system, with the systems described as 'silos'.[112] Ms Sparrow said that 'residential care and the services for older people tend to be planned as if it's a completely separate part of your life and that there's an expectation if you're in aged care that every single need that you have will be met by aged care and, in fact, that's not the case'.[113]

Mr Mersiades considers there is a tendency to see residential care as a 'sort of a standalone health service in its own right'. However, he said residents should have the same access to the wider health system as any other resident of Australia.[114] Mr Versteege made a similar point. He said the aged care system should be integrated with the disability care system, the general healthcare system and the public oral healthcare system.[115]

Palliative care was also identified as a particular issue, highlighting the issues with the interface between State, Territory and Australian Governments in relation to the provision of services to people in residential aged care.[116]

Dr Nespolon explained the obstacles general practitioners can face in providing care in the aged care sector, particularly in residential care facilities. Dr Nespolon said that general practitioners are often unsupported when they visit patients in residential care facilities and it is not unusual to go to the facility, see a patient, write notes and not see a single staff member.[117] Dr Nespolon indicated that poor integration is exacerbated by the lack of information sharing between general practice medical records and residential aged care facility records.[118]

Dr Anthony Bartone, President of the Australian Medical Association, made a number of observations about the interface between residential aged care and the health system and about the administration of medications to residents.

Dr Bartone spoke of a high level of transfer from residential aged care facilities to emergency departments for conditions that could be managed by general practitioners if good clinical handovers and trained nursing staff were available.[119] He also pointed to issues which are deterring doctors from visiting residential aged care facilities, including a lack of access to patient aged care records, difficulties accessing specialist services, limited eHealth technology and a lack of appropriate clinical treatment rooms.[120]

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112 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T217.18

113 Transcript, Patricia Sparrow, Adelaide Hearing 1, 19 February 2019 at T432.22-25.

114 Transcript, Paul Mersiades, Adelaide Hearing 1, 19 February 2019 at T473.26-29.

115 Transcript, Paul Versteege Adelaide Hearing 1, 12 February 2019 at T177.29-42; Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 at 0017 [83].

116 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T82.20-30.

117 Transcript, Harry Nespolon, Adelaide Hearing 1, 18 February 2019 at T385.40-45.

118 Exhibit 1-40, Adelaide Hearing 1, Statement of Dr Harry Nespolon, 25 January 2019, WIT.0016.0001.0001 at 0010.

119 Transcript, Anthony Bartone, Adelaide Hearing 1, 20 February 2019 at T554.30-43; Exhibit 1-56, Adelaide Hearing 1, Amended Statement of Anthony Bartone, 18 February 2019, WIT.0015.0001.0001 at [37].

120 Exhibit 1-56, Adelaide Hearing 1, Amended Statement of Dr Anthony Bartone, 18 February 2019, WIT.0015.0001.0001 at [41].

As well as the lack of an integrated system, the issue of data capture across aged care and health care was raised. Data analytics and information sharing capability need to be strengthened.[121] Ms Beauchamp acknowledged there is a need for improved data between the States and Territories and Australian Government. She described work that is underway to address this issue.[122]

Staffing

A number of witnesses raised the issue of staffing ratios. There were mixed views on whether and how a system of staff ratios could be implemented.

Aged and Community Services Australia did not support staffing ratios, instead preferring staffing needs to be based on the profile of residents.[123]

Along similar lines, Ms Beauchamp considered mandatory staff to patient ratios a 'blunt instrument for a service system which is very diverse, and is also reflecting the diverse nature of the care recipients, and also the diverse nature of the care needs'.[124]

Mr Sean Rooney from Leading Age Services Australia acknowledged the paradox between rising acuity in aged care residents and the reduction in nursing staff. He suggested the way forward is through the work of the workforce taskforce and workforce strategy by looking at the care being provided in a holistic way rather than focusing singly on clinical care. He called for research into this issue.[125]

The Australian Medical Association recommended that a minimum acceptable staffing ratio should be introduced in line with the care needs of residents in residential aged care facilities and to ensure appropriate on-site 24 hour registered nurse availability.[126]

Ms Annie Butler, Federal Secretary of the Australian Nursing and Midwifery Federation (ANMF), told us of repeated studies demonstrating that adequate numbers of registered nurses in each residential aged care facility are required to create the right skill mixes in direct care delivery.[127]

121 Transcript, Deborah Parker, Adelaide Hearing 1, 13 February 2019 at T236.7-43.

122 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T327.13-46.

123 Transcript, Patricia Sparrow, Adelaide Hearing 1, 19 February 2018 at T429.46-T430.1-5.

124 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T338.40-44.

125 Transcript, Sean Rooney, Adelaide Hearing 1, 19 February 2019 at T457.6-17.

126 Exhibit 1-56, Adelaide Hearing 1, Statement of Dr Anthony Bartone, 20 February 2019, WIT.0015.0001.0001 at 0006 [32.3].

127 Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler, 1 February 2019, WIT.0020.0001.0001 at 0004 [29]-[30].

Ms Butler contended that there are no clear obligations on providers about appropriate staff numbers and skills, and suggested that mandatory minimum staffing levels would provide a clear minimum standard for providers.[128] She said that in the acute setting, the implementation of safe mandated minimum staffing would prevent incidents of poor care, improve resident care and cut overall costs.[129]

Ms Butler told us about an ANMF commissioned report, the *National Aged Care Staffing and Skills Mix Project 2016. Meeting residents' care needs: A study of the requirement for nursing and personal care staff.*[130] Ms Butler said that the report provides an evidence-based method to determine the amount of time required for direct and indirect nursing care, and personal care of people in residential care. The report suggests a skills mix of 30% registered nurse, 20% enrolled nurse and 50% personal care worker.[131]

Related to staff ratios is the issue of nursing staff presence in residential aged care facilities, particularly overnight. We heard that the absence of nursing staff overnight can unnecessarily result in residents being transferred to hospital.[132] Dr Bartone highlighted the need for trained nursing staff to improve the quality of medical care in residential care facilities.[133]

Ms Melissa Coad, Executive Projects Coordinator of United Voice, referred to a survey conducted by United Voice's New South Wales branch. This received 128 responses from members working in home care.[134]

Ms Coad explained that the aged care workforce is predominantly older than the average Australian worker, is largely female, is likely to be employed on a part-time or casual basis, and that a number of workers hold more than one job.[135] She said that this is because the wages paid to some of her members does not amount to a 'living wage'.[136]

In addition to these pressures, Ms Coad says that United Voice's members feel stressed and pressured in their day-to-day work, and are not given the time they need to do their job to the best of their ability.[137] Thirty per cent of United Voice survey respondents indicated they undertook unpaid overtime. Nearly half stated that they were not provided with enough time to travel between clients, and 70% reported being rushed.[138]

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128 Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler, 1 February 2019, WIT.0020.0001.0001 at 0005 [34].

129 Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler, 1 February 2019, WIT.0020.0001.0001 at 0006 [39]-[40].

130 Exhibit 1-20, Adelaide Hearing 1, National Aged Care Staffing and Skills Mix Project Report 2016, ANM.0001.0001.3151.

131 Transcript, Annie Butler, Adelaide Hearing 1, 13 February 2019 at T273.28-44.Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler, 1 February 2019, WIT.0020.0001.0001 at 0006 [43].

132 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T584.42-T585.7.

133 Transcript, Anthony Bartone, Adelaide Hearing 1, 20 February 2019 at T548.10-13.

134 Exhibit 1-53, Adelaide Hearing 1, United Voice Home Care Member Survey 2017, UVH.0002.0001.0001.

135 Transcript, Melissa Coad, Adelaide Hearing 1, 20 February 2019 at T506.16-22.

136 Transcript, Melissa Coad, Adelaide Hearing 1, 20 February 2019 at T506.35-42; Exhibit 1-20, Adelaide Hearing 1, Statement of Melissa Coad, 6 February 2019, WIT.0018.0001.0001 at 0008 [49].

137 Transcript, Melissa Coad, Adelaide Hearing 1, 20 February 2019 at T504.31-35; T607.20-22.

138 Exhibit 1-53, Adelaide Hearing 1, United Voice Home Care Member Survey 2017, UVH.0002.0001.0001 at 0006.

Mr Gerard Hayes, National President of the Health Services Union (HSU), described short staffing of facilities as the 'number one' concern of HSU members. He illustrated this concern with an example of one carer on a night shift to look after 25 residents, leaving the carer in an impossible situation to adequately care for each resident.[139] The result, he said, is an aged care workforce which is tired, frustrated and knows that, despite its efforts, there are insufficient resources to adequately provide an appropriate level of care.[140]

Mr Hayes said aged care workers were in a state of 'income insecurity', with many workers on minimum hours contracts. This leaves workers vulnerable to employers reducing their hours.[141] In turn, this vulnerability feeds into the reluctance of workers in the sector to act as whistleblowers if they see something wrong.[142] This has downstream effects for those in care, and it is these people who 'ultimately suffer' if issues are not brought to light.[143]

Mr Hayes summed up issues with staffing in aged care as a 'funding issue' because he considers that funding determines what facilities look like, the staffing levels and how staff are able to engage with the residents.[144] Mr Hayes says there should be some form of minimum staffing standard, but that does not necessarily mean the implementation of staff ratios.[145]

Mr Hayes also spoke to the need to change the 'marketing' of the sector. He called for greater engagement of society as a whole with older people and the sector in order to improve the negative perception of working in the sector.

Mr Yates also raised the remuneration of aged care workers. He noted that unless they are competitively paid, workers will move to alternative industries, such as disability care. Mr Yates supported the recommendations for better remuneration, as well as other recommendations, made by the Aged Care Workforce Taskforce.[146]

Mr Versteege considered that neither the current Aged Care Standards or the Single Aged Care Quality Framework were prescriptive enough in terms of the staffing levels or mix required.[147] He supported the introduction of both mandatory staff ratios and mandatory staff skill mixes.[148]

139 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T579.9-29.

140 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T579.33-42.

141 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T576.42-T577.9

142 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T577.11-20; T577.34-41.

143 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T578.8-18.

144 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T579.4-8.

145 Transcript, Gerard Hayes, Adelaide Hearing 1, 21 February 2019 at T580.9-15.

146 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T65.20-24.

147 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 [56]-[62].

148 Transcript, Paul Versteege, Adelaide Hearing 1, 12 February 2019 at T175.39-176.14.

Mr Mersiades said the answer to workforce issues is not the implementation of minimum staffing ratios but significant upskilling of the workforce. He said that more training was required for palliative and end of life care.[149] He stated that 33% of personal care workers do not hold a Certificate III qualification. He did not consider that minimum staff ratios would take into account the variety of resident needs.[150]

We also heard evidence about the possible registration of personal care workers. This segment of the aged care workforce is currently unregistered.

Mrs Spriggs suggested that if there is wrongdoing by a staff member, this should be documented in a national database so that people who are not suitable to work in aged care are not able to move between employers.[151]

Mr Mersiades supported the registration and credentialing of the unregistered portion of the workforce. Mr Mersiades also noted that improvements needed to be made to the perception of working in the sector and the remuneration available.[152]

Ms Coad also expressed support for an aged care workforce register and pre-employment screening, although she cautioned against this being a 'negative' or 'banned' list rather than a positive system of registration.[153]

Funding and sustainability

Mr Mersiades described the current funding model as an 'outsourced Government model', where the Government regulates most aspects. He said that this model is designed to maximise the Government's capacity to control its budget outlays.[154]

He told us that the current Aged Care Funding Instrument is prone to volatility, with its indexing not keeping up with the market. He considered that Aged Care Funding Instrument fluctuations from year to year are indicative of a flawed system that needs reform.[155]

Mr Mersiades explained that the Aged Care Funding Instrument is not a tool that measures quality of care and there is no calibration between the funding level for personal and nursing care and the achievement of a particular quality of care or quality of life.[156] He said the instrument is a rationing tool to manage costs. It is not a tool which regulates care quality.[157]

149 Exhibit 1-50, Adelaide Hearing 1, Statement of Nicolas Mersiades, 31 January 2019, WIT.0011.0001.0001 [81], [84].

150 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T476.30–477.40.

151 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T40.28-32. See also Transcript, Clive Spriggs, Adelaide Hearing 1, 11 February 2019 at T44.1-2.

152 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T478.10-25.

153 Transcript, Melissa Coad, Adelaide Hearing 1, 20 February 2019 at T513.35-T514.47; T515.13-28.

154 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T465.41-T466.10; Exhibit 1-50, Adelaide Hearing 1, Statement of Nicolas Mersiades, 31 January 2019, WIT.0011.0001.0001 [85], [114].

155 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T468.1-40.

156 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T469.30-47.

157 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T469.36-39.

Mr Mersiades contends that funding assessment should be carried out by an external independent statutory authority rather than by the Australian Department of Health or by providers themselves.[158]

Ms Sparrow told us about funding shortcomings in the current system. She highlighted the approximately 126,000 people waiting for their approved Home Care Package as an example of funding issues in the sector.[159] She told us that Aged and Community Services Australia members report they have capacity to take on more Home Care Packages, but there is insufficient funding for them to do so.[160]

Ms Sparrow also raised a concern that funding has not kept pace with the increasingly complex health needs of people entering residential care.[161]

Mr Versteege was critical of the structure of funding in the aged care system. In his view, the *Aged Care Act 1997* (Cth) was established with the objective of reducing costs to the Australian Government rather than prioritising quality and safety. He considers that there is an undersupply of both residential and home-based aged care services.[162]

Mr Versteege was also critical of the Aged Care Provision Ratio. This is a ratio calculated by the Australian Department of Health to determine how many aged care places there should be. It is currently set at 125 places per 1000 people over 70. Mr Versteege described the Aged Care Provision Ratio as 'smoke and mirrors' because, as the population changes, the ratio means that the number of residential aged care places goes up continuously, allowing the impression that the supply of aged care places is adequate.[163] However, if the initial supply of places is inadequate, then the impression is misleading because the Aged Care Provision Ratio does not fix the issue of the initial undersupply.

Associate Professor Strivens said that interfaces between funding of the health system and the aged care system created difficulties. In his view, a lot of the funding models create artificial divides between State and Commonwealth-funded programs, particularly between State-funded hospital and community programs and Commonwealth-funded home and residential aged care. Associate Professor Strivens said these systems should change so that they drive integration and excellence rather than encouraging silos.[164]

Mr Rooney said that the needs of older Australians were growing faster than the ability of the system to meet those needs, which had been made worse by the Government's

158 Transcript, Nicolas Mersiades, Adelaide Hearing 1, 19 February 2019 at T469.1-25.

159 Transcript, Patricia Sparrow, Adelaide Hearing 1, 19 February 2019 at T419.42-47; Exhibit 1-45, Adelaide Hearing 1, Statement of Patricia Sparrow, 7 February 2019, WIT.0014.0001.0001 [24]–[26].

160 Transcript, Patricia Sparrow, Adelaide Hearing 1, 19 February 2019 at T427.1-25.

161 Transcript, Patricia Sparrow, Adelaide Hearing 1, 19 February 2019 at T420.10-20.

162 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 [14].

163 Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege, 7 February 2019, WIT.0009.0001.0001 [25]; Transcript, Paul Versteege, Adelaide Hearing 1, 12 February 2019 at T169.21-36.

164 Transcript, Edward Strivens, Adelaide Hearing 1, 13 February 2019 at T217.11-18.

freeze on indexation.[165] He referred to reporting by StewartBrown that compared cumulative growth in Aged Care Funding Instrument revenue and direct services costs since September 2014. Mr Rooney stated that the reporting shows 41.4% of residential facilities had an operating loss and 18.9% of residential facilities recorded a cash loss for the September 2018 quarter. Mr Rooney suggested that these percentages would grow during the 2019 financial year. The cumulative growth in Aged Care Funding Instrument funding over time, when compared to the relative direct care costs, shows that the funding provided is insufficient to meet the cost of providing care. Mr Rooney suggested that a similar comparison could be drawn between home care funding and provider cost.[166]

Mr Rooney's gave evidence that, in his view, the Australian Government has failed to act on the recommendations of several reviews, including the *Legislated Review of Aged Care 2017* by David Tune AO PSM that people should be making higher contributions to their aged care, where they are able to.[167] Mr Rooney said there needs to be an agreement with the Government about how much care recipients contribute to their care, when their means permit. The question includes whether means testing should include their home. Mr Rooney suggested consideration of other funding sources, such as a national aged care levy.[168]

Mr Rooney also suggested an independent entity to oversee aged care funding and make recommendations to the Government. He said this would provide greater reassurance about the appropriateness and cost-effectiveness of the aged care funding model.[169]

There are also funding issues faced by remote communities, particularly Aboriginal and Torres Strait Islander communities, under current funding arrangements. Ms Little emphasised that remote communities often receive funding from various sources 'which can create inefficiencies and a siloing of service delivery'.[170]

Ms Little explained that aged care providers in remote communities often cannot access economies of scale, making it costly to build and run facilities.[171] This means that even with government funding, businesses are not always economically viable. If they stop operating, the distance between services increases which makes it even more difficult to access services.[172]

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165 Transcript, Sean Rooney, Adelaide Hearing 1, 19 February 2019 at T453.14-24.

166 Exhibit 1-46, Adelaide Hearing 1, Statement of Sean Rooney, 31 January 2019, WIT.0013.0001.0001 at 0009 [73]; Exhibit 1-47, Adelaide Hearing 1, Second Statement of Sean Rooney, 12 February 2019, WIT.0024.0001.0001 at 0017 [92].

167 Exhibit 1-46, Adelaide Hearing 1, Statement of Sean Rooney, 31 January 2019, WIT.0013.0001.0001 at LAS.0001.0001.0010 [79]. Exhibit 1-35, Adelaide Hearing 1, *Legislated Review of Aged Care 2017*, RCD.9999.0011.0746.

168 Exhibit 1-46, Adelaide Hearing 1, Statement of Sean Rooney, 31 January 2019, WIT.0013.0001.0001 at LAS.0001.0001.0011 [99].

169 Exhibit 1-47, Adelaide Hearing 1, Second Statement of Sean Rooney, 12 February 2019, WIT.0024.0001.0001 at 0017 [107].

170 Transcript, Claerwen Little, Adelaide Hearing 1, 20 February 2019 at T492.10-25; Exhibit 1-51, Adelaide Hearing 1, Statement of Claerwen Little, 31 January 2019, WIT.0010.0001.0001 at 0010 [49].

171 Exhibit 1-51, Adelaide Hearing 1, Statement of Claerwen Little, 31 January 2019, WIT.0010.0001.0001 at 0010 [48].

172 Exhibit 1-51, Adelaide Hearing 1, Statement of Claerwen Little, 31 January 2019, WIT.0010.0001.0001 at 0010 [48].

Ms Beauchamp told us that she believed the budget allocated to the Australian Department of Health for aged care is sufficient for the forward estimates period. However, she acknowledged future challenges with increases in the number of people wanting to remain at home, level of acuity and the level of dementia. The overall numbers of people accessing aged care system will also grow.[173]

Ms Beauchamp suggested the 2011 Productivity Commission Report was a good starting point for considering sustainability issues. She stated that the Department needs to continuously look at the contribution the Australian Government makes to care and support, and the contribution of clients and families to their ongoing care and support. She acknowledged that consideration should be given as to where the funding is channelled, with much of the funding at the moment going to residential aged care. This has remained the case despite a greater proportion of people accessing home care and home support. [174]

Quality and safety regulation and complaints handling

On 1 January 2019, the Australian Aged Care Quality Agency was replaced by the Australian Aged Care Quality and Safety Commission.

We heard that on 1 July 2019 a new Single Quality Framework would commence, unifying the standards that are to apply to many aged care services, be they home care, residential care, flexible care or the care that is provided to some older Aboriginal and Torres Strait Islander people. The Single Quality Framework is now administered by the Commissioner of the Australian Aged Care Quality and Safety Commission.

The evidence provided by Ms Janet Anderson, Australian Aged Care Quality and Safety Commissioner, suggested that the new body had carried over staffing and structures from its predecessor agencies. She said, 'I'm not aware of any significant adjustment in settings between the previous agency and my own, certainly not in the early reaches of the commission's work.'[175] Ms Anderson advised us that she had commissioned a number of reviews of organisational design, regulatory strategy and processes and information sharing processes to determine whether further changes to structure and operations were required to best meet Australian Aged Care Quality and Safety Commission's objectives.[176]

Mr Yates suggested that there needed to be stronger and additional regulatory powers for the Australian Aged Care Quality and Safety Commission, including powers to impose financial penalties and to disqualify individuals.[177]

173 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T291.43-292.2.

174 Transcript, Glenys Beauchamp, Adelaide Hearing 1, 18 February 2019 at T330.43-T331.9.

175 Transcript, Janet Anderson, Adelaide Hearing 1, 18 February 2019 at T357.13-15.

176 Exhibit 1-38, Adelaide Hearing 1, Statement of Janet Anderson, 15 February 2019, WIT.0023.0001.0001 at 0013-0014 [60]-[62].

177 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T53.43-T54.5.

A number of witnesses mentioned the Single Quality Framework. Mr Versteege was critical of both the current accreditation standards and the Single Quality Framework. In his view, assessment standards must be uniform and objective across the sector. The standards must be fair to both the sector and consumers. He considers that the new standards for personal and clinical care, service environments and human resources are unfair to consumers because they lack measurable content.[178] He said the new standards are simply a 'rewrite' of the existing standards, and noted there did not seem to be a change of approach to setting standards.[179]

Professor Parker explained that quality standards in the aged care sector should be measuring indicators as to best practice, not minimum standards.[180]

Mr Versteege and Mr Yates both raised concerns about residential care providers being accredited through a 'tick and flick' approach with assessment of compliance against quality standards being on a pass or fail basis.[181] Mr Yates called for there to be a system of 'star ratings' to enable greater transparency about provider standards and service offerings.[182]

Mr Rooney pointed to a different concern. He told us that a survey of providers had identified a perceived lack of consistency by the Australian Aged Care Quality Agency as being the primary reason for providers' dissatisfaction with the Agency.[183]

Mr Rooney also claimed that quality was a subjective measure, with different interpretations existing across providers, quality assessors, care recipients and families.[184] He suggested that appropriate performance indicators would balance considerations, including:

- variability of interest
- consistency of assessment and data collection by assessors
- reflection of performance improvement or decline in a timely manner
- cost-effectiveness of assessment methods
- eliminating the risk of perverse incentives for performance improvement
- ensuring indicators are fit for the purpose of interpretation and easy to understand.[185]

178 Transcript, Paul Versteege, Adelaide Hearing 1, 12 February 2019 at T172.1-40.

179 Transcript, Paul Versteege, Adelaide Hearing 1, 12 February 2019 at T171.35-47.

180 Transcript, Deborah Parker, Adelaide Hearing 1, 13 February 2019 at T232.5-12; Exhibit 1-15, Adelaide Hearing 1, Statement of Deborah Parker, 31 January 2019, WIT.0017.0001.0001 at 0009.

181 Transcript, Paul Versteege, Adelaide Hearing 1, 12 February 2019 at T169.1-17; Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T73.9-38.

182 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T73.9-38.

183 Exhibit 1-46, Adelaide Hearing 1, Statement of Sean Rooney, 31 January 2019, WIT.0013.0001.0001 at 0011 [89].

184 Exhibit 1-46, Adelaide Hearing 1, Statement of Sean Rooney, 31 January 2019, WIT.0013.0001.0001 at 0018 [154].

185 Exhibit 1-47, Adelaide Hearing 1, Second Statement of Sean Rooney, 12 February 2019, WIT.0024.0001.0001 at 0013 [77(a)-(b)].

Mr Rooney also suggested that performance indicators need to be benchmarked, particularly for factors beyond provider control.[186]

Ms McCabe from Dementia Australia said there should be dementia-specific quality standards in the aged care sector. Care standards for people with dementia needed to be clearly articulated, regulated and monitored.[187] She noted that the Single Quality Framework does not directly address care for dementia.

Concerns were also raised about the regulation of the Commonwealth Home Support Programme and Home Care Packages. Ms Janet Anderson, Australian Aged Care Quality and Safety Commissioner, told us that home care oversight is an area where the Australian Aged Care Quality and Safety Commission needs to do work.[188] According to Ms Anderson, 'I need to accelerate that work because at the moment I'm not convinced that our regulatory gaze in home care is as strong as it needs to be.'[189]

One of the issues drawn to our attention was the challenges associated with making complaints and speaking out about aged care, particularly residential aged care.

Mrs Spriggs spoke of the challenges of speaking out about the quality of care received by her husband. She expressed the view that 'it should have been much easier for me to be listened to and to get answers than it was'.[190] Mrs Spriggs told us that she attempted to get information via the freedom of information process, emphasising the difficulties she had getting answers to questions and having her concerns taken seriously.[191] Mrs Spriggs suggested that there should be 'a clear pathway that an everyday person can follow if they or someone they are caring for experiences a problem'.[192] The Carnell-Paterson *Review of National Aged Care Quality Regulatory Processes* recognised that the fear of reprisals is a very important thing that a proper complaints process has to be able to address.[193]

186 Exhibit 1-47, Adelaide Hearing 1, Second Statement of Sean Rooney, 12 February 2019, WIT.0024.0001.0001 at 0014 [77(c)-(g)].

187 Transcript, Maree McCabe, Adelaide Hearing 1, 19 February 2019 at T410.43-T411.41; Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, 31 January 2019, WIT.0005.0001.0001 [21.1].

188 Transcript, Janet Anderson, Adelaide Hearing 1, 18 February 2019 at T362.39-40.

189 Transcript, Janet Anderson, Adelaide Hearing 1, 18 February 2019 at T362.39-45.

190 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T38.21-23.

191 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T39.23-37.

192 Transcript, Barbara Spriggs, Adelaide Hearing 1, 11 February 2019 at T40.7-10.

193 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, Carnell and Paterson, October 2017, RCD.9999.0011.1833 at 1840 and 1950-1951.

What do 'quality' and 'safety' mean?

In preparing for this hearing, we invited some witnesses to think about the meaning of quality and safety in an aged care context. We summarise some of the responses as follows.

Mr Yates directed us to the National Aged Care Alliance's definition of quality:

> services that are consumer-driven, have a wellness and reablement focus, are affordable for the community and individuals, sustainably provided, and are inclusive of the diversity of older people according to their needs.[194]

Mr Yates defined safety as providing care recipients with appropriate clinical and personal care, and avoiding all possible harm to the care recipient.[195] This involves ensuring respect for the care recipient in the context of their personal circumstances. Mr Yates said the care recipient's perception of their care was important, and that people should find their care positive and constructive. This includes ensuring cultural sensitivity, and recognising varying degrees and types of abilities and disabilities.[196]

Mr Gear drew on the definition used by the World Health Organisation of the key elements and criteria for aged care quality and safety:

a. Safe. Delivering health and aged care that minimises risks and harm to service users, including avoiding preventable ablement reduction, injuries, abuse and neglect, and reducing medical, medication and care related errors.

b. Effective. Providing services based on scientific knowledge and evidence-based guidelines, by appropriately qualified and skilled personnel, to meet, maintain and optimise health and psycho-social outcomes.

c. Timely. Reducing delays in providing and receiving aged care, and delivering the right level aged care, in the right environment, location and duration.

d. Efficient. Delivering health and aged care in a manner that maximizes resource use, avoids waste and provides for sustainability

e. Equitable. Delivering health and aged care that does not differ in availability, accessibility or quality, according to personal characteristics such as gender, race, ethnicity, sexual orientation, cognitive functioning, comorbidities, geographical location or socioeconomic status.

f. People-centred. Providing care that takes into account the preferences, life experiences and aspirations of individual service users and the culture of their community.[197]

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194 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T49.37-50; Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, 31 January 2019, WIT.0006.0001.0001 at 0007 [27] and COT.9999.2222.0003.

195 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T49.16-19; Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, 31 January 2019, WIT.0006.0001.0001 at 0007 [26] and 0008 [28].

196 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T49.24-31; Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, 31 January 2019, WIT.0006.0001.0001 at 0007 [27] and 0008 [28].

197 Exhibit 1-8, Adelaide Hearing 1, Statement of Craig Gear, 31 January 2019, WIT.0007.0001.0001 at 0013 [88].

Ms McCabe said that the concepts of 'quality' and 'safety' are often used interchangeably across aged care policy and program delivery. She said that although the two concepts cannot be entirely separated, in Dementia Australia's analysis the concept of 'safety' relates to a clinical or medical framework, and focuses on such elements as nutrition, hydration, management of wounds and pressure sores, and medication management.

In contrast, she said, the concept of 'quality' relates more to the experience of a person receiving aged care services, and may encompass levels of social engagement and quality of life (as defined by specific indicators). It may also be defined by the mechanisms used to achieve quality outcomes. Both concepts should be underpinned by an inherent culture of respect for ageing and older people.[198]

Ms Sparrow defined safety as the reduction of risk of preventable and unnecessary harm in the provision of aged care services to an acceptable minimum, having regard to current knowledge, resources and context. She said that this broad definition, which includes keeping a person free from all forms of abuse and safety, is a bedrock of quality.[199]

Ms Sparrow told us that quality extends beyond safety and is about the experience the individual has of the service across a range of domains and its impact on their overall quality of life. It is subjective and individualised, influenced by culture, values, personal experience, perceptions and any current or immediate concerns a person may be facing.[200]

We also heard about the importance of:

- a human rights model that respects rights for civility, to be treated well and to have their own needs and aspirations met[201]
- treating people with dignity in respect in their everyday interactions, such as staff respectfully announcing when they are entering the room of a person, or seeking permission where appropriate.[202]

The importance of providing care which prioritises the wants and needs of each individual was clear from the evidence at this hearing.

Mr Yates told us about data collected by COTA Australia which shows that high proportions of care recipients and their families place great importance on staff friendliness (98%), feeling safe and secure (98%), being supported to raise concerns about service and food satisfaction, independence, control of their daily life, and being supported to maintain social relationships and connections with the community. He said that aged care recipients judge an aged care service based on these factors.[203]

198 Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, 31 January 2019, WIT.0005.0001.0001 at 0014 [53]-[56].

199 Exhibit 1-45, Adelaide Hearing 1, Statement of Patricia Sparrow, 7 February 2019, WIT.0014.0001.0001 at 0017 [95(a)].

200 Exhibit 1-45, Adelaide Hearing 1, Statement of Patricia Sparrow, 7 February 2019, WIT.0014.0001.0001 at 0017 [95(b)]

201 Transcript, Claerwen Little, Adelaide Hearing 1, 20 February 2019 at T487.1-5.

202 Transcript, Barrie Anderson, Adelaide Hearing 1, 21 February 2020 at T638.15-22.

203 Transcript, Ian Yates, Adelaide Hearing 1, 11 February 2019 at T50.33-43; Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, 31 January 2019, WIT.0006.0001.0001 at COT.1111.2222.0004 at 0007.

2. Adelaide Hearing 2: Aged Care in the Home

Hearing overview

Introduction

The second hearing, held in Adelaide, South Australia, between 18 and 22 March 2019, was concerned with aged care services provided in a person's home.

The hearing covered:

- the main Australian Government programs available for in-home care and supports: the Commonwealth Home Support Programme and the Home Care Packages Program
- how those programs can be accessed, the available services and funding arrangements, and issues relevant to the quality and safety of care in the home.

These two home care programs provide support and care to about 940,000 Australians.

During this hearing we heard many direct accounts from witnesses who told us about their experiences of the aged care system. We conducted two case studies that illustrated aspects of how providers of home care services are approved and regulated. Our findings and conclusions about these case studies are set out later in this chapter.

We heard oral testimony from 24 witnesses and received written statements from a further four witnesses. There were 103 exhibits received into evidence.

Some of the evidence we received at this hearing has been drawn upon in Volume 1 of this Interim Report. It will continue to be drawn upon over the course of our inquiry as well as in our Final Report. A brief overview of the hearing and the evidence is provided below.

Home care is of central importance for the future of aged care in Australia. It is the mode of care that enables people to live out their lives where they choose to be with a level of independence and social connection to their communities.

Accessing My Aged Care

My Aged Care is the entry point for consumers to access Australian Government-funded aged care services. Departmental witnesses described My Aged Care as comprising a website, contact centre, assessment services and a referral service to connect consumers to care.[1] The call centre, online portal and assessment services are run by separate organisations, funded by the Australian Department of Health through contractual arrangements. We consistently heard that a wide range of older Australians experience difficulties using these services, creating barriers to the effective use of My Aged Care.

Fiona Buffinton, First Assistant Secretary in Home Care Aged Care in the Department of Health, described the My Aged Care service as a referral to a provider, with the provider then offering services. This is particularly used for the Commonwealth Home Support Programme.[2] Ms Buffinton described how assessors can manage a referral to a provider without older people needing to use the My Aged Care website, although we note that this situation may remove choice and control from the older person.[3]

Ms Mary Patetsos (Chief Executive Officer of the Federation of Ethnic Communities Council of Australia Inc), Ms Clare Hargreaves (Manager of Social Policy at the Municipal Association of Victoria) and Mrs Rita Kersnovske (an 80-year-old care recipient) each told us that the modes of communication required for navigating My Aged Care are not suitable for older people who are not confident with online systems or cannot use a mobile phone.[4] To use these modes of communication, older people often have to rely on technology-literate informal carers—daughters, sons, grandchildren, nieces or nephews—to access information about their care. It is difficult for those who do not have this support.

Mr Josef Rack, an 82-year-old care recipient, cannot find his way through the My Aged Care website and rings them instead.[5] Ms Marie Dowling, an 84-year-old care recipient who is legally blind, considers it a major flaw of a system targeted at the older population to have all the information online.[6]

Services provided by My Aged Care are not always accessible for people with hearing or visual impairments, people with communication difficulties, including those brought on through dementia, or people from culturally and linguistically diverse backgrounds.

Mr Paul Sadler, Chief Executive Officer of Presbyterian Aged Care NSW & ACT, emphasised that the online environment could be far more user-friendly. He said letters to consumers would be easier to understand if key information was highlighted. Tailoring the system to address cultural and language issues would assist culturally and linguistically

1 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at [25].

2 Transcript, Fiona Buffinton, Adelaide Hearing 2, 22 March 2019, T1054.5-8.

3 Transcript, Fiona Buffinton, Adelaide Hearing 2, 22 March 2019, T1063.30-34.

4 Exhibit 2-89, Adelaide Hearing 2, Statement of Mary Patetsos, 12 March 2019, WIT.0084.0001.0001 at 0008 [52]; Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at 0015[64.6]; Transcript, Rita Kersnovske, Adelaide Hearing 2, 21 March 2019 at T1005.12-16.

5 Exhibit 2-15, Adelaide Hearing 2, Statement of Josef Rack, 4 March 2019, WIT.0068.0001.0001 at 0004 [28].

6 Exhibit 2-34, Adelaide Hearing 2, Statement of Marie Dowling, 15 March 2019, WIT.0077.0001.0001 at 0009 [54].

diverse communities.[7] Access to services that are suited to LGBTI people is also important. Ms Lynda Henderson, a carer and care recipient, reminded us that as dementia progresses, people may 'become more true to what they had always wanted to be'.[8]

As a consequence of difficulties accessing My Aged Care, some vulnerable clients may be left without aged care supports.[9] It does not appear to us that the current My Aged Care website adequately supports older people to exercise choice and control.

Several witnesses raised concerns about the quality of information provided by My Aged Care.

Ms Ruth Harris, who assisted her mother to try access a Home Care Package, was left with the impression that the My Aged Care call centre staff just read from a screen and deliver set lines.

Ms Raelene Ellis, a carer for her mother, said that she considered My Aged Care, at most times, 'pretty useless'. She suspected that it was a waste of money. She said that apart from referrals to other agencies, it offers very little assistance in terms of actual knowledge about the aged care system.[10]

Ms Marie Dowling said she found the My Aged Care call centre 'horrible', and that she would often get 'the wrong information'.[11] This is consistent with evidence we heard in February 2019 that more than 20% of users considered the My Aged Care call centre did not provide reliable information.[12]

Ms Buffinton gave evidence on how the Department of Health seeks to ensure that My Aged Care is an efficient and effective point of access to the aged care system. She emphasised that My Aged Care is more than just the digital platform. For example, the contact centre receives 1.4 million calls each year. She also explained that improvements to the My Aged Care website were under development and the Department was developing a trial of 'system navigators' to help connect vulnerable groups to services. Ms Buffinton noted that the 'system navigators' were for people who needed additional assistance, such as those who have to contact My Aged Care on their own.[13] The system navigators appear to be a pilot of a local model of referral, and Ms Buffinton described them as increasing the range of information channels for people accessing aged care.[14]

7 Exhibit 2-12, Adelaide Hearing 2, Statement of Paul Sadler, 11 March 2019, WIT.0078.0001.0001 at 0005 [20].

8 Transcript, Lynda Henderson, Adelaide Hearing 2, 18 March 2019 at T681.1-20.

9 Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at 0015 [64.6].

10 Exhibit 2-4, Adelaide Hearing 2, Statement of Raelene Ellis, 12 March 2019, WIT.0083.0001.0001 at 0027 [154].

11 Exhibit 2-34, Adelaide Hearing 2, Statement of Marie Dowling, 15 March 2019, WIT.0077.0001.0001 at 0009 [21].

12 Exhibit 1-23, Adelaide Hearing 1, Statement of Glenys Beauchamp, WIT.0022.0001.0001 at [167-169] and footnote 69.

13 Transcript, Fiona Buffinton, Adelaide Hearing 2, 22 March 2019 at T1065.9-14 and T1065.18-25.

14 Transcript, Fiona Buffinton, Adelaide Hearing 2, 22 March 2019 at T1073.1-8.

As with other areas of aged care, some concern was expressed about the lack of data to guide policy development and reform. Ms Patetsos pointed to a significant data gap in understanding how culturally and linguistically diverse older Australians access, use and experience aged care services. She emphasised that if we are to gain an understanding of these issues, consistent definitions and measures of cultural and linguistically diversity should be developed, together with consistent processes for the collection and analysis of data.[15]

Waiting list for appropriate aged care services in the home

Waiting times to obtain the required level of care at home is a significant issue.

There are four levels available under a Home Care Package, with Level 4 the highest level of care and support. In contrast to the information that is available publicly, the evidence from Ms Buffinton of the Australian Department of Health was that in 2017–18 the average wait time was:

- Level 1: seven months
- Level 2: 13 months
- Level 3: 16 months
- Level 4: 22 months—down from 38 months in 2016–17.[16]

During the 12-month period ending 30 June 2018, a total of 212,857 people appeared in the national prioritisation system for at least some part of the year. Of these people, more than 16,000 died waiting for a Package they never received.[17]

The long wait time for Home Care Packages is simply unacceptable. Older Australians should receive the care they need without unreasonable delay. Delay in providing services goes to the very heart of quality and safety in aged care.

Issues were raised with us about how the assessment process to access home care works. Older Australians in need of entry level support are assessed by the Regional Assessment Services for the Commonwealth Home Support Programme. To access more complex home care through a Home Care Package, an Aged Care Assessment Team, commonly referred to as ACAT, conducts an assessment.[18]

The ACAT assessment determines the level of care a person requires against four levels. They also consider whether a person should be prioritised as 'medium' or 'high'.

15 Exhibit 2-89, Adelaide Hearing 2, Statement of Mary Patetsos, 12 March 2019, WIT.0084.0001.0001 at 0004 [28].

16 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at 63, table 5.

17 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at [76].

18 Known in Victoria as 'Aged Care Assessment Service' or ACAS.

Mr Paul Sadler of Presbyterian Aged Care said that these dual streams for assessment were inefficient and unnecessary.[19] Ms Hargreaves pointed to insufficient communication between My Aged Care and assessment services, leading to 'over-screening' or multiple unnecessary assessments.[20]

Ms Kersnovske and Ms Harris told us about the multiple assessments they were subjected to, and that often the assessment result does not align with the service that may be eventually provided.[21] In describing the desperately short supply of services in rural Queensland, Mrs Kersnovske said:

> I'm not the worst off. There are lots of people worse than me but there seems to be an awareness that there's such a lot of people who are struggling to stay in their own homes. You know, it's really difficult to be—to be expecting neighbours and friends…if you're an independent person, it's really hard to accept help from other people who are just friends and relatives, where there could be a better—a better setup that helps people with—with more help in the home. People—friends and rellies can only do so much.[22]

These are not new concerns. Mr David Tune AO PSM recommended integration of the assessment processes in his 2017 review.[23] The Department of Health has released a discussion paper on integration of assessment, but progress seems to be slow.[24]

Once assessed as eligible for care, the person in need of care must wait for the allocation of a Package. This is due to rationing by the Government of aggregate numbers of Home Care Packages. Many people who have been assessed as needing a high level of care are allocated a lower level Home Care Package as an interim measure.

Ms Ellis told us that despite being assessed as needing a Level 4 Package, her mother had to wait just over 14 months to receive it. During those 14 months, her mother's health deteriorated dramatically, and they 'still only received 4 hours of support a week'.[25]

Ms Anna Hansen, a personal care worker with more than eight years' experience, offered an example. Her client received a Level 2 Package even though she was assessed as needing a Level 4 Package. The care recipient was basically told that she had to wait or a Level 4 recipient to die before she could get a Level 4 Package. Her only other option was to move into residential care.

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19 Transcript, Paul Sadler, Adelaide Hearing 2, 18 March 2019 at T738.13-29.

20 Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at 0024 [115].

21 Exhibit 2-80, Adelaide Hearing 2, Statement of Rita Kersnovske, 13 March 2019, WIT.0088.0001.0001 at [17]-[22]. Transcript, Ruth Harris, Adelaide Hearing 2, 21 March 2019 at T949.45-T949.34.

22 Transcript, Rita Kersnovske, Adelaide Hearing 2, 21 March 2019 at T1009.30-37.

23 Exhibit 1-35, Adelaide Hearing 1, Legislated Review of Aged Care, 2017, RCD.9999.0011.0746, recommendation 27.

24 Australian Department of Health, 'Streamlined Consumer Assessment for Aged care', December 2018, https://consultations.health.gov.au/in-home-aged-care-division/streamlined-consumer-assessments-for-aged-care-ser/, viewed 26 September 2019.

25 Exhibit 2-4, Adelaide Hearing 2, Statement of Raelene Ellis, 12 March 2019, WIT.0083.0001.0001 at 0005 [41].

In her written statement, Ms Rosemary Dale, a personal care worker with more than 10 years' experience, said:

> I am aware from conversations I have had with them that most of the clients I see have accepted a lower level Home Care Package, and are still waiting on their Level 4s. These people take a lower level package because they're told their higher package is a few months away, but 2 years later they're still waiting.[26]

At the time she gave evidence, Ms Buffinton accepted that Home Care Packages were not effective. She said there had been an unprecedented increase in demand and that provision had grown from approximately 64,000 Packages in June 2016 to 92,000 Packages in June 2018. The increase in demand followed reforms introduced in February 2017, in particular the move to assign the Package to the care recipient rather than the provider, while still controlling the number of available Packages.

The problem was first identified in 2017. In his *Legislated Review of Aged Car*e, Mr Tune made a number of recommendations associated with addressing the disproportionate wait times and demand, in particular recommending an increase in supply of high level Home Care Packages.[27]

Two years later, the problem has not been resolved. Ms Buffinton estimated that if Home Care Packages were provided to all people on the waiting list, at the level of their assessed need, the annual cost would be approximately $2 billion to $2.5 billion.

A consequence of delays in obtaining the right Home Care Package can be a move into more expensive residential care. After waiting 13 months for a Home Care Package, Ms Ruth Harris and her 92-year-old mother made the decision for Ms Harris's mother to move into a residential aged care facility.[28] Unfortunately, they never received an offer for a Level 3 Package that was apparently sent by mail.[29] No one in the Government followed up.

Ms Hansen told us that waiting times force people into residential care: they can't look after themselves without help, and there's no Home Care Packages available for them.[30] Ms Harris spoke of her strong feelings about the wait times—12 months is 'a long time when you are already very elderly'.[31]

26 Exhibit 2-29, Adelaide Hearing 2, Statement of Rosemary Dale, 6 March 2019, WIT.0079.0001.0001 at 0004 [32].

27 Exhibit 1-35, Adelaide Hearing 1, Legislated Review of Aged Care, 2017, RCD.9999.0011.0746, pp 13, 60-62, recommendations 5, 6 and 7. See also summary table.

28 Exhibit 2-76, Adelaide Hearing 2, Statement of Ruth Harris, 12 March 2019, WIT.0074.0001.0001 at 0004 [35]-[36].

29 Exhibit 2-76, Adelaide Hearing 2, Statement of Ruth Harris, 12 March 2019, WIT.0074.0001.0001 at 0004 [38].

30 Exhibit 2-28, Adelaide Hearing 2, Statement of Anna Hansen, 7 March 2019, WIT.0081.0001.0001 at 0002 [20].

31 Transcript, Ruth Harris, Adelaide Hearing 2, 21 March 2019 at T953.15-20.

Ms Hargreaves pointed to another consequence. She said some care recipients do not move from the Commonwealth Home Support Programme to Home Care Packages because of the long waiting lists. This means Commonwealth Home Support Programme providers service some people with far more complex needs than it is designed and funded for.[32]

Delays while waiting to access a Home Care Package places enormous demands on other people around a care recipient, especially their partners, who tend to be older themselves, and their children. This is a very important issue which we heard needs prompt attention. Informal carers themselves may become ill while supporting an older person to stay at home. The replacement value of informal carers in Australia is estimated at over $60 billion—a cost not borne by the Government.[33]

Government announcements in December 2018[34] and February 2019[35] provided 20,000 additional Home Care Packages. However, Mr Sadler said that 'there's also no question that those figures are quite small when you compare to a total waiting list of 128,000'.[36]

Professor Hjalmar Swerissen of the Grattan Institute and La Trobe University considered it inevitable that when there is more demand than funding, people have to wait for services, service levels for individuals have to be reduced, the cost of services has to be cut, or some combination of these measures gets put in place.[37]

Profession Swerissen said that there is a need for the gateway to be localised and consistent across the country, with a local person who people can go to for assistance.[38]

Professor Swerissen suggested a new model directed at funding individual needs that takes into account a person's 'reasonable and necessary' supports, similar to the National Disability Insurance Scheme.[39] Ms Henderson and Mr Sadler also pointed to the size of packages under the National Disability Insurance Scheme as being much higher and more targeted to individual needs.

32 Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at 0025 [118].

33 Exhibit 1-12, Adelaide Hearing 2, The economic Value of informal care in Australia, 2015, RCD.9999.0003.0001.

34 Exhibit 1-30, Adelaide Hearing 1, the Hon. Greg Hunt MP and the Hon. Ken Wyatt MP, Media Release, 17 December 2018.

35 Exhibit 2-12, Adelaide Hearing 2, Statement of Paul Sadler, 11 March 2019, WIT.0078.0001.0001 at 0007 [34].

36 Transcript, Paul Sadler, Adelaide Hearing 2, 18 March 2019 at T731.35-36.

37 Exhibit 2-86, Adelaide Hearing 2, Statement of Professor Swerissen, 15 March 2019, WIT.0085.0001.0001 at 0003 [12].

38 Transcript, Hal Swerissen, Adelaide Hearing 2, 21 March 2019 at T1039.7-17.

39 Transcript, Hal Swerissen, Adelaide Hearing 2, 21 March 2019 at T1037.39-42.

Role for a system steward

With significant reforms to home-based care in Australia over the past five to 10 years,[40] the system is in a period of transition.[41] We heard that:

- there had been 'very secure and stable' arrangements in home care services following the implementation of the Home and Community Care (HACC) program in 1985[42]
- with concurrent reforms in disability services, and the rollout of the National Disability Insurance Scheme, providers are looking for some ongoing certainty[43]
- an uncertain future risks providers withdrawing from service delivery, leaving older people without essential supports, and with a significant loss of expertise, knowledge and resources to the sector[44]
- the Commonwealth has left some operational gaps in the management of the aged care system.[45]

Commonwealth Home Support Programme providers previously had longstanding engagement in the sector, the majority transferring from the State and Territory Government-run HACC program in 2012.[46] While funding for these providers will continue to July 2022, frequent changes to their contracts have caused them great concern.[47]

We also heard that the current funding arrangements are transactional, and literature shows that transactional approaches have difficulties in transition.[48] There is a perception that the Commonwealth is not ready for an increased marketisation of home care.[49]

With the Australian Government assuming responsibility for the continuum of aged care services, and centralising its administration and regulation, other levels of government have moved away from aged care.[50] Professor Swerissen explained that the Australian Department of Health has not, however, replicated or replaced the local administration and service planning arrangements in each State and Territory, and that this has led to

40 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at [12].

41 Transcript, Hal Swerissen, Adelaide Hearing 2, 21 March 2019 at T1036.38-48.

42 Transcript, Clare Hargreaves, Adelaide Hearing 2, 19 March 2019 at T789.33-36.

43 Transcript, Clare Hargreaves, Adelaide Hearing 2, 19 March 2019 at T790.5.

44 Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at [39].

45 Transcript, Hal Swerissen, Adelaide Hearing 2, 21 March 2019 at T1036.45.

46 Exhibit 2-12, Adelaide Hearing 2, Statement of Paul Sadler, 11 March 2019, WIT.0078.0001.0001 at [21].

47 Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at [50.13].

48 Transcript, Hal Swerissen, Adelaide Hearing 2, 21 March 2019 at T1039.35.

49 Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at [127e].

50 Exhibit 2-86, Adelaide Hearing 2, Statement of Professor Swerissen, 15 March 2019, WIT.0085.0001.0001 at [25].

gaps in service system planning, development and management.[51] Previous assessment arrangements, especially in HACC, also afforded a more localised approach to information and referral.[52] Professor Swerissen said:

> There should be a planning regime that fixes gaps at the local level. This is managing the market—nudging the system in facilitative ways to get it to deliver what it should. The current highly bureaucratic arrangement loses the local relationships and means you deal with people by administrative fiat or transactional arrangements. [53]

Approval of providers of home care

Division 8 of the *Aged Care Act 1997* (Cth) sets out the approval process for a body corporate that seeks to become a provider of Home Care Packages. To be an approved provider, an organisation must be able to demonstrate it is suitable to provide aged care services. Only allowing good quality providers to deliver aged care services is important to the quality and safety of care provided.

The administration of this Division of the Aged Care Act was explained by Mr Graeme Barden, Assistant Secretary, Residential and Flexible Care Branch of the Australian Department of Health, and another Department of Health official who gave evidence under the pseudonym BE.

In her written statement, BE said the number of applications for provider status since 2017 had been relentless and at one point significant numbers of applications were not determined in the standard 90 days allowed for in the Aged Care Act.[54] BE pointed to staffing and training pressures within her team.[55]

According to BE, the standard of applications for approval is not always good and she suggested there was evidence of consultants selling boilerplate applications to prospective providers. Sometimes these boilerplate applications tick all the right boxes for approval, but can still leave doubts in the mind of assessors.

Mr Barden gave evidence that there was a peak period in outstanding applications between about March 2017 and March 2018, owing to a greater than anticipated increase in applications. He said the workload of outstanding applications had since decreased, with only about 60 applications on hand. [56]

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51 Exhibit 2-86, Adelaide Hearing 2, Statement of Professor Swerissen, 15 March 2019, WIT.0085.0001.0001 at [26].

52 Exhibit 2-25, Adelaide Hearing 2, Statement of Clare Hargreaves, 14 March 2019, WIT.0071.0001.0001 at 0013 [53.6].

53 Transcript, Hal Swerissen, Adelaide Hearing 2, 21 March 2019 at T1039.19-22.

54 Exhibit 2-9, Adelaide Hearing 2, Statement of BE, 13 March 2019, WIT.0087.0001.0001 at 0002 [13].

55 Exhibit 2-9, Adelaide Hearing 2, Statement of BE, 13 March 2019, WIT.0087.0001.0001 at 0002 [6].

56 Exhibit 2-78, Adelaide Hearing 2, Statement of Graeme Barden, 20 March 2019, WIT.1066.0001.0001 at [20] and chart 1; Transcript, Graeme Barden, Adelaide Hearing 2, 21 March 2019 at T982.27-28.

Mr Barden accepted that the team of assessors are not meeting the 90-day standard in all cases. He estimated that in the 2018–19 financial year, 10–20 cases were not determined in the 90-day period. He said the Department was in the process of recruiting an additional permanent officer to assess applications.[57]

Fees, charges and transparency

Mr Rack, Ms Henderson and Ms Ellis raised concerns with fees and charges. They thought the administrative fees, which ranged from 35% to 50% of the amount provided for care, were too high.

A broad range of fees was confirmed by Mr Jason Howie of Kincare Health Services Pty Ltd, Mr David Moran and Ms Caroline Ford of Southern Cross Care, Ms Amanda Bowe of Mercy Health, Mr Stephen Judd of HammondCare and Mr Paul Sadler of Presbyterian Aged Care.[58]

Personal care workers also shared the concern about high management fees.[59] Every dollar spent on a management fee is a dollar that is not spent on direct care.

Two other key issues were raised during the hearing: whether the costs charged for individual services (for example, mowing the lawn) were reasonable, and the apparent difficulty of getting information about what fees are charged. Southern Cross Care told us that transparency with respect to fees is an issue across the sector.[60]

The Australian Department of Health does not regulate administrative fees charged by approved providers. They do not know what the actual costs of administering Home Care Packages or Commonwealth Home Support Programme services is or even what a reasonable range of fees may be.[61]

More generally, the hearing exposed that the Department has very little information about how the Home Care Package system operates on the ground, who receives them, and the suite of home care services recipients actually use. The Department does not know, for example, the proportion of funding directed to nursing services, rehabilitation and reablement, nor whether the services are of sufficient quality to make a difference.

Regulation concerning transparency and comparability in home care pricing is an area currently undergoing change. The week before this hearing, the Australian Government

57 Transcript, Graeme Barden, Adelaide Hearing 2, 21 March 2019 at T984.7-11.

58 Exhibit 2-2, Adelaide Hearing 2, Statement of Stephen Judd, 15 March 2019, RCD.0011.0012.0001 at 0002-0004 [18]-[22] and Exhibit 2.13, Adelaide Hearing 2, Statement of David Moran and Caroline Ford, 18 March 2019, RCD.0011.0009.0131 at [5]; Exhibit 2-88, Adelaide Hearing 2, Redacted statement of Amanda Bowe, WIT.0034.0001.0001 at [8]; Exhibit 2-2, Adelaide Hearing 2, Statement of Stephen Judd [18-22] and Exhibit 2.13, Adelaide Hearing 2, Presbyterian Aged Care Home Care Services Price List effective 1 January 2019, RCD.0011.0010.0017.

59 Exhibit 2-29, Adelaide Hearing 2, Statement of Rosemary Dale, 6 March 2019, WIT.0079.0001.0001 at [37].

60 Exhibit 2-23, Adelaide Hearing 2, Statement of David Moran and Caroline Ford of Southern Cross, 18 March 2009, RCD.0011.0009.0137.

61 Transcript, Lisa Studdert/Anthony Speed, Adelaide Hearing 2, 21 March 2019 at T1034.17.

announced that it had finalised new legislation that requires home care providers to publish their pricing information in a new standardised schedule on the My Aged Care website by 1 July 2019.[62] We also acknowledge that some providers voluntarily publish their fee structures online.[63]

Unspent funds

We also heard that funds are going unspent in Home Care Packages and that these amounts are accumulating into the hundreds of millions. The amount estimated at 30 June 2017 was approximately $329 million.[64] Unspent funds are defined as 'the ongoing balance of funds that have not been spent or committed as part of a person's home care package' and may include funds contributed by the Australian Government and the person.[65]

The average Package underspend is approximately $6,720 a year.[66] Those unspent monies are held by approved providers.[67]

Witnesses noted that unspent funds accumulating is one of the consequences of the rigid allocation process for home care.[68] We heard that reasons for care recipients not spending Home Care Package funds included:

- older people putting aside money as a contingency for the proverbial rainy day or a larger expense (for example, purchase of equipment or a home modification, a stint in respite)[69]
- older people having an assessed level that is higher than their actual needs and they choose not to take up clinical care, especially nursing care.[70]

Mr Rack told us that his provider encouraged him to save some of his Package for a rainy day. He now has over $18,000 in accrued Home Care Package funds.[71] Mrs Dowling has done the same and has been able to stockpile funds, even though she is receiving a lower Package than she has been assessed as needing.[72] Mr Moran and Ms Ford from Southern Cross Care said that prior to 2016 it was industry practice to suggest to clients that that the retain 10% of their Package for contingencies.[73]

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62 Australian Department of Health, 'Delivering safety and quality in Australia's aged care system', Media Release, 1 July 2019, https://www.health.gov.au/internet/ministers/publishing.nsf/Content/B52B6B7153144171CA2583C00079A200/$File/KW051.pdf, viewed 26 September 2019.

63 Exhibit 2-2, Adelaide Hearing 2, Statement of Stephen Judd, 15 March 2019, RCD.0011.0012.0001 at [22].

64 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at [53].

65 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at [49].

66 Exhibit 1-50, Adelaide Hearing 1, Statement of Nicolas Mersiades, 31 January 2019, WIT.0011.0001.0001 at 0026 [122.21].

67 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, WIT.0058.0001.0001 at 0018 [53].

68 Transcript, Paul Sadler, Adelaide Hearing 2, 18 March 2019 at T738.45.

69 Transcript, Paul Sadler, Adelaide Hearing 2, 18 March 2019 at T743.35.

70 Transcript, Paul Sadler, Adelaide Hearing 2, 18 March 2019 at T743.45.

71 Exhibit 2-15, Adelaide Hearing 2, Statement of Josef Rack, 4 March 2019, WIT.0068.0001.0001 at 0006 [52].

72 Exhibit 2-34, Adelaide Hearing 2, Statement of Marie Dowling, 15 March 2019, WIT.0077.0001.0001 at 0019 [47].

73 Exhibit 2-23, Adelaide Hearing 2, Statement of David Moran and Caroline Ford, 18 March 2019, RCD.0011.0009.0131[7.6].

Ms Buffinton explained that this was an unexpected outcome.[74] The Australian Department of Health does not give guidance to providers on whether interest may be earnt on packaged care funding and does not require interest to be paid to the Government, if it has been earnt.[75]

Ensuring quality and safety of home care

At the first Adelaide Hearing, Ms Janet Anderson, the Aged Care Quality and Safety Commissioner, told us that she was not at the moment 'convinced that our regulatory gaze in home care is as strong as it needs to be'.[76] She also said that fees and charges were the most common issues raised in complaints.[77] That is consistent with the evidence we heard from care recipients and their representatives in this hearing.

The two case studies conducted as part of this hearing illustrate some concerns about aspects of the regulatory system relating to home care.

Consumer-directed care

From July 2015, Home Care Packages were administered by approved providers on a consumer-directed care basis. This meant that the person receiving home care had a choice, at least in theory, about the services they received from their provider, within their allocated funding. From February 2017, this was further changed so that the funding for Home Care Packages was allocated to the care recipient who could then choose or change providers.

Despite these changes, Professor Swerissen considers that Australian aged care policy does not focus enough on rights and outcomes for older people. He said the Aged Care Act has a strong focus on the provision and quality of care, but its objectives do not specify that care should assist older people to be independent and participate in society.[78]

Informed choice is an important part of consumer-directed care. Ms Patetsos told us that some older people of culturally and linguistically diverse backgrounds do not understand their rights or the way in which home care is funded:

> more often than not, a provider ends up being the party that explains the system to them. By default, that provider then becomes their provider. People who want to access aged care service do not understand that they have a choice in provider.[79]

74 Transcript, Fiona Buffinton, Adelaide Hearing 2, 22 March 2019 at T1089.23-25.

75 Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at [54].

76 Transcript, Janet Anderson, Adelaide Hearing 1, 18 February 2019 at T362.44-45.

77 Exhibit 1.3, Adelaide Hearing 1, Statement of Janet Anderson, 4 February 2019, WIT.0023.0001.0001 at 0248 [103]-[104] and [110].

78 Exhibit 2-86, Adelaide Hearing 2, Statement of Professor Hal Swerissen, 15 March 2019, WIT.0085.0001.0001 at 0002 [8].

79 Exhibit 2-89, Adelaide Hearing 2, Statement of Mary Patetsos, 12 March 2019, WIT.0084.0001.0001 at 0008 [52].

Ms Patetsos also made the point that 'if you are not shown the respect of being given a means of communication', then all your other needs are almost irrelevant because you can't understand what's happening to you.[80]

This issue of rights can be compounded because culturally and linguistically diverse people often find it difficult to exit a service that they are not satisfied with. Ms Patetsos explained that because providers operate in a niche market, the capture of people is strong and that it is common for people to remain with a provider whose services are not meeting their needs.[81]

Workforce

A panel of four home care workers gave evidence: Ms Anna Hansen, Ms Heather Jackson, Ms Sally Warren and Ms Rosemary Dale. Together they have 44 years' experience working in aged care services.

The panel raised a number of concerns about training, safety, time pressures and working conditions. We heard that it is largely up to these lowly paid workers to pay for any additional training they undertake.

Ms Jackson said that, in her observation, the training available to personal care workers has decreased during her time in the aged care workforce. She referred to a move away from face to face sessions to online based training systems, which she considered more of a 'tick and a flick' approach.[82] Ms Hansen told us that in-house training is often not recognised by other employers.[83]

Dementia-specific training is a matter of concern to personal care workers. Ms Warren estimates that approximately 65% of the clients she sees live with some form of dementia. Ms Dale said she has a lot of clients with dementia and some with mental health issues. She put herself through dementia training, which was not required, or provided, by her employer.[84]

Ms Hansen works with many clients living with dementia, but has not received any formal or ongoing training in dementia. Further, while she has Certificate III and IV qualifications, dementia was only a small part of the course content. [85]

The panel also told us of concerns about work health and safety, including visiting people's homes in unfamiliar and uncertain situations at all hours of the day and night.

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80 Transcript, Mary Patetsos, Adelaide Hearing 2, 20 March 2019 at T935.5-7.

81 Exhibit 2-89, Adelaide Hearing 2, Statement of Mary Patetsos, 12 March 2019, WIT.0084.0001.0001 at 0008 [54].

82 Transcript, Heather Jackson, Adelaide Hearing 2, 19 March 2019, T813.25-34; Exhibit 2-27, Adelaide Hearing 2, Statement of Heather Jackson, 7 March 2019, WIT.0080.0001.0003 at [23].

83 Exhibit 2-28, Adelaide Hearing 2, Statement of Anna Hansen, 7 March 2019, WIT.0081.0001.0001 at 0003 [32].

84 Exhibit 2-29, Adelaide Hearing 2, Statement of Rosemary Dale, 6 March 2019, WIT.0079.0001.0001 at [38].

85 Exhibit 2-28, Adelaide Hearing 2, Statement of Anna Hansen, 7 March 2019, WIT.0081.0001.0001 at 0003 [33].

The limited time allocated to a particular care recipient can be a cause of strain and stress for care workers. Ms Jackson said there are instances where she is allocated fifteen minutes to see a client. She told us that she 'is on the time clock and it can be quite distressing for myself trying to get the job done if the person is not quite right that day'.[86] This time pressure impacts on the quality of care that she is able to give.[87]

Other issues raised include the lack of guaranteed working hours, low levels of remuneration and staff retention.[88]

We will hold a hearing to specifically inquire into workforce issues later in 2019.

Case studies

At this hearing we heard two case studies illustrating aspects of how providers of home care services are approved and regulated. Those case studies concerned support for new approved providers, whether the approach to regulation is based on process and documents more than care outcomes, and the effectiveness of regulation.

The case studies also considered the role of administrators and advisers appointed by providers pursuant to sanctions imposed by the Secretary of the Australian Department of Health.

These case studies are of Home Care Package providers, which are approved as aged care providers under the *Aged Care Act 1997* (Cth). The key elements to the oversight of Home Care Package providers appear to be:

- approval as a provider by the Australian Department of Health[89]
- subsequent review by the Aged Care Quality and Safety Commission, possibly in conjunction with a self-assessment against the Home Care Common Standards[90]
- quality reviews conducted by the Aged Care Quality and Safety Commission at least every three years for most providers. The *Aged Care Quality and Safety Commission Rules 2018* require the Commissioner to give written notice specifying the day or days on which the site visit to the provider is to be conducted[91]
- an assessment contact by the Aged Care Quality and Safety Commission, with or without notice[92]

86 Transcript, Heather Jackson, Adelaide Hearing 2, 19 March 2019 at T817.26-33.

87 Transcript, Heather Jackson, Adelaide Hearing 2, 19 March 2019 at 817.35-37.

88 Exhibit 2-28, Adelaide Hearing 2, Statement of Anna Hansen, 7 March 2019, WIT.0081.0001.0001 at 0002 [13] and 0004 [29].

89 Exhibit 2-79, Summary of the Approved Process for Home Care Provider Applicants under the Aged Care Act prepared by the Department of Health, CTH.0001.1000.4975.

90 Transcript, Paul Sadler, Adelaide Hearing 2, 18 March 2019 at T740.37-T741.8; Transcript, BC, Adelaide Hearing 2, 20 March 2019 at T862.41-43.

91 *Aged Care Quality and Safety Commission Rules 2018*, r 53(2).

92 *Aged Care Quality and Safety Commission Rules 2018*, r 65(1).

- serious risk reporting, which can be made from the Aged Care Quality and Safety Commission to the Department of Health[93]
- sanctions, which can be imposed on an approved provider by the Secretary of the Department of Health.[94]

The Australian Department of Health advised us that between 1 July 2015 and 1 July 2019, it sanctioned only six providers of home care.[95]

In both case studies, the approved provider was sanctioned by the Secretary's delegate under Division 67 of the Aged Care Act. The delegate found that there was an immediate and severe risk to the safety, health or wellbeing of care recipients to whom each approved provider was providing care. That finding led to what is referred to as a 'straight to sanctions' decision, which meant the Department of Health was not required to follow certain procedural steps before imposing sanctions.

How to become an approved provider

The Secretary of the Australian Department of Health must approve a person as a provider of aged care if:

- the person makes an application under s 8-2 of the Aged Care Act (by using a form approved by the Secretary)
- the Secretary is satisfied that the applicant is a corporation
- the Secretary is satisfied that the applicant is suitable to provide aged care
- the Secretary is satisfied that none of the applicant's key personnel is a disqualified individual.[96]

In relation to the third dot point, s 8-3 of the Aged Care Act sets out the considerations the Department of Health must take into account when assessing an applicant's suitability. Broadly, these matters include (where relevant):

- the applicant's experience in providing aged care or other relevant forms of care
- the applicant's demonstrated understanding of its responsibilities as a provider
- the systems that the applicant has, or proposes to have, in place to meet its responsibilities
- the applicant's record of financial management, and its methods to ensure sound financial management

93 Transcript, Lisa Studdert, Adelaide Hearing 2, 21 March 2019 at T993.40.

94 Exhibit 2-81, Adelaide Hearing 2, NACCP Decision Point Flowchart, CTH.1000.1015.0227.

95 Information provided to the Royal Commission in response to Notice to Give NTG-0280, CTH.0001.1000.7914 at 7920–7946.

96 Exhibit 2-21, Adelaide Hearing 2, Summary of the approval process for home care provider applicants under the Aged Care Act prepared by the Department of Health, CTH.0001.1000.4974 at 4975 [2] and s 8-1(1) of the *Aged Care Act 1997* (Cth).

- the applicant's conduct as a provider of aged care
- any other matters specified in the Approved Provider principles.[97]

As part of this process, the Secretary of the Department of Health may also consider these matters in relation to any or all key personnel.[98]

What is the framework for reviewing quality and safety compliance and imposing sanctions?

A body corporate that has been approved as a provider of aged care services has responsibilities under the Aged Care Act to provide a minimum quality of care.[99] Prior to 30 June 2019, an approved provider of home care services was required to meet the Home Care Common Standards set out in Schedule 4 to the *Quality of Care Standards 2014* (Cth). After 1 July 2019, they are required to meet the single quality framework in Schedule 2 to the Quality of Care Standards by the *Quality of Care Amendment (Single Quality Framework) Principles 2018* (Cth).

The statutory function of assessing compliance with the home care standards was, between 1 July 2014 and 1 January 2019, performed by the Australian Aged Care Quality Agency.[100] On 1 January 2019, the Australian Aged Care Quality Agency was replaced by the Aged Care Quality and Safety Commission. For present purposes, the Aged Care Quality and Safety Commission now carries out the relevant functions of the former Australian Aged Care Quality Agency as described below.

The legislative framework, as it applied during the period 2017–18 to home care services, was, in summary:

- Any form of contact between the Australian Aged Care Quality Agency and an approved provider for the purposes of assessing performance, assisting with continuous improvement, identifying the need for a quality review, or providing relevant information was an 'assessment contact'.[101] Assessment contacts could be made at any time.[102]
- Following an assessment contact, the Australian Aged Care Quality Agency was required to notify the provider of any areas in which improvements were required to comply with the Home Care Common Standards and any applicable timetable for improvement.[103]

97 No 'other matters' have been specified at the time of writing.

98 Section 8-3(2) of the *Aged Care Act 1997* (Cth).

99 Under Part 2.1 Division 8 of the *Aged Care Act 1997* (Cth) an approved provider has responsibilities under Part 4.1 Division 54 of the Act.

100 *Aged Care Quality Agency Principles 2013* (Cth) (no longer in force).

101 Section 3.14 of the *Quality Agency Principles 2013* (Cth) (no longer in force).

102 *Quality Agency Principles 2013,* ss 3.14 and 3.15.

103 The Home Care Standards are comprised in Division 2 and Schedule 4 of the *Quality of Care Principles 2014*. Also called the Home Care Common Standards.

- In addition, the Australian Aged Care Quality Agency was required by the *Quality Agency Reporting Principles 2013* (Cth) to notify the Secretary of the Australian Department of Health of any non-compliance.
- Having been notified of non-compliance on the part of an approved provider, it was then within the Secretary's discretion to send a notice of non-compliance to that approved provider.[104] A notice had to set out details of the non-compliance, what the Secretary required the approved provider to do to remedy the non-compliance, and what sanctions could be imposed, amongst other matters.
- The Secretary's discretion arose if satisfied that the approved provider had not complied or was not complying with its responsibilities. The provider had 14 days to make submissions to the Secretary.
- Those procedural fairness provisions did not apply if the Secretary was satisfied that because of the approved provider's non-compliance, there was an 'immediate and severe risk' to the safety, health or wellbeing of care recipients to whom the approved provider was providing care.[105] In that situation, the Secretary could proceed 'straight to sanction' without prior notice or any opportunity for the provider to make any submissions addressing the Secretary's concerns or proposed sanctions.
- Under s 3-18 of the *Quality Agency Principles 2013* (Cth), where the Australian Aged Care Quality Agency decided that an approved provider had failed to comply with the Home Care Common Standards, the Chief Executive Officer of the Aged Care Quality Agency was required to decide as soon as practicable whether 'the failure has placed, or may place, the safety, health or wellbeing of a care recipient of the service at serious risk'.

The function of the Australian Aged Care Quality Agency in connection with the mandatory assessment of 'serious risk' contrasts with the function of the Secretary of the Department of Health in the potential assessment of 'immediate and severe risk' as described above. This distinction remains a feature of the legislative framework after 1 January 2019.[106]

While the Australian Aged Care Quality Agency must report a 'serious risk' to the Department of Health, it is a matter for the Secretary of the Department to separately assess whether the Secretary is satisfied there is an 'immediate and severe risk'. The assessment of whether a standard has been breached and, if so, the level of risk, is discharged separately and is not necessarily coordinated between the Australian Aged Care Quality Agency and the Department of Health.[107] Also, it is arguable that 'immediate and severe risk' is a higher standard than 'serious risk'. It is unclear why the two agencies apply different risk standards to the same objective circumstances.

104 Section 67-2 of the *Aged Care Act 1997* (Cth).

105 Section 67-1(2) of the *Aged Care Act 1997* (Cth).

106 Refer s 85 of the *Aged Care Quality and Safety Commission Rules 2018*.

107 For example, Transcript, Lisa Studdert/Anthony Speed, Adelaide Hearing 2, 21 March 2019 at T1029.21-22; Transcript, Glenys Beauchamp, Adelaide Hearing 2, 18 February 2019 at T307.21-23.

The Secretary may impose a sanction in the form of a revocation of approval unless the approved provider appoints an adviser or administrator. Administrators assist a provider to comply with its responsibilities in relation to governance and business operations.[108] By s 66A-4 of the Aged Care Act, the Secretary must provide a report on the aged care service to the administrator or adviser including matters such as review audits and complaints. The provider must provide all relevant information to the administrator or adviser which they require in order to assist the approved provided to comply with its responsibilities.[109]

The two case studies illustrate consider the following three questions:

- Was the timing of approval of each provider relevant in the Secretary's administration of sanctions? If not, is reform required?
- To what extent was the sanction of home care providers connected with the quality and safety of care delivered?
- Were the sanctions appropriate in all the circumstances?

We now turn to the case study of two providers each subject to a 'straight to sanctions' process within a relatively short period after being approved as providers of home care.

BB Pty Ltd remains in the home care market. BD Pty Ltd has left the home care market, although it still provides palliative care.

BB Pty Ltd case study

BB Pty Ltd: how was the procedure for imposing sanctions administered?

This case study was heard in Adelaide on 20 and 21 March 2019. It concerned the experiences of a company and its Director in seeking to become an approved provider, to work with the regulator and respond to sanctions.

The approved provider and its Chief Operating Officer were given pseudonyms, BB Pty Ltd and BA respectively.

The evidence before us consisted of:

- the statement of BA, registered nurse, dated 5 March 2019
- the oral testimony of:
  - BA
  - BE, an officer of the Australian Department of Health

108 Section 66-2(1)(iv) of the *Aged Care Act 1997* (Cth).

109 Section 66A-4(2) of the *Aged Care Act 1997* (Cth). On 17 September 2016, the *Budget Savings (Omnibus) Act 2016* (Cth) repealed former s 66A which had provided for the establishment of administrator and adviser panels including the nomination and approval processes for administrators and advisers.

  - Dr Lisa Studdert, Deputy Secretary, Ageing and Aged Care Group, Australian Department of Health
  - Mr Anthony Speed, Acting Assistant Secretary, Aged Care Compliance Branch, Australian Department of Health
- Exhibit 2-83 chronology of events for each provider the subject of NTP-0016
- Post-hearing written submissions were made by the Australian Government.

BB Pty Ltd became an approved provider on 5 October 2017. Given the approval, BB Pty Ltd must have demonstrated it was suitable to provide aged care and did not have any disqualified individuals as key personnel. Suitability includes demonstrating that the applicant understands its obligations as a provider under Chapter 4 of the Aged Care Act and will be able to meet those obligations.[110]

Prior to applying for approval of BB Pty Ltd as an approved provider, BA requested the Department of Health's assistance in setting up a business to provide Home Care Packages. BA was told the Department does not provide that sort of information.[111]

On 31 May 2018, the Australian Aged Care Quality Agency did an assessment contact with BB Pty Ltd.[112] BA told us that as a result of that contact, BB Pty Ltd put policies and procedures in place within a couple of hours.[113]

On 19 June 2018, the Australian Aged Care Quality Agency provided an assessment contact report to the Department. The Australian Aged Care Quality Agency reported that BB Pty Ltd did not meet 16 of 18 of the expected outcomes of the Home Care Standards reviewed.[114]

On 21 June 2018, the Department notified BB Pty Ltd that sanctions were imposed.[115] This was a straight to sanctions decision based on the Department's assessment that there was an 'immediate and severe risk' to the safety, health or wellbeing of care recipients to whom BB Pty Ltd was providing care.

110 Exhibit 2-11, Adelaide Hearing 2, Guidance for applicants seeking approval to provide Aged Care, CTH.0001.1000.3930 at 3943.

111 Exhibit 2-36, Adelaide Hearing 2, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0002 [7]; Transcript, BA, Adelaide Hearing 2, 20 March 2018 at T912.18-25. The Australian Government has drawn our attention to information or training that is available from the Aged Care Quality and Safety Commission for applicants when applying for home care provider approval. These include: courses and workshops on the new Aged Care Quality Standards; information and resources available on the website including guidance relating to the standards, self-assessment tools and other materials; 'Qassist', a compliance assistance education program. Refer Commonwealth Post-Hearing Submissions, 29 March 2019, RCD.0012.0003.0012 at 0015 [19].

112 Exhibit 2-83, Adelaide Hearing 2, Chronology of events for each provider the subject of NTP-0016, CTH.1000.0002.6095 at 6100 (p6), Item 1.

113 Transcript, BA, Adelaide Hearing 2, 20 March 2019 at T914.10-44; Exhibit 2-36, Adelaide Hearing 2, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0003 [17].

114 Transcript, BA, Adelaide Hearing 2, 20 March 2019 at T914.10-44; Exhibit 2-36, Adelaide Hearing 2, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0003 [17].

115 Exhibit 2-83, Adelaide Hearing 2, Chronology of events for each provider the subject of NTP-0016, CTH.1000.0002.6095 at 6100 (p6), Item 2.

On 6 July 2018, the Australian Aged Care Quality Agency determined that two care recipients from BB Pty Ltd were at 'serious risk'. The Agency sent a serious risk report to the Department that day.[116] That was about 36 days after finding a failure to meet the Home Care Standards and about 15 days after the Department had imposed sanctions. No other relevant communication between the Australian Aged Care Quality Agency and the Department is recorded in the chronology prepared by the Department.[117]

BA did not dispute that BB Pty Ltd's policies and procedures were inadequate.[118] However, she was 'confident that the clinical care was happening all along, and I did not need any assistance with that'.[119] BA said that as far as she knows, BB Pty Ltd's clients were satisfied with the care they were receiving.[120] No clients chose to leave BB Pty Ltd during the period of the sanction.[121]

The Department, in deciding to impose sanctions, was concerned about the failure to comply with the Home Care Standards. The delegate drew particular attention to the failure to have care plans on care recipient files and other shortcomings with record keeping and planning. On the evidence before us, these issues did not immediately concern the quality and safety of care actually delivered.[122] However, the Department considers the absence of care plans and other records to be a care issue.[123] We consider it is entirely appropriate that the regulatory framework includes requirements for record keeping and risk management.

A delegate of the Secretary in the Department of Health was satisfied that BB Pty Ltd was suitable to be a provider of aged care services in October 2017. However, about seven months later, a different delegate of the Secretary decided that non-compliance by BB Pty Ltd represented a serious and immediate risk to two people within its care. We are not confident that the extent of that inconsistency can be explained by the passage of time, given the focus on systems and processes. We return below to the inconsistency between the Australian Aged Care Quality Agency's assessment of risk and the Department's assessment of risk based on the same material as at 21 June 2018.

116 Exhibit 2-83, Adelaide Hearing 2, Chronology of events for each provider the subject of NTP-0016, CTH.1000.0002.6095 at 6100 (p6), Item 4. This was about 36 days after finding a failure to meet the Home Care Standards and about 15 days after sanctions had been imposed by the Department. No other relevant communication between the Agency and Department is recorded in the chronology prepared by the Department.

117 Exhibit 2-83, Adelaide Hearing 2, Chronology of events for each provider the subject of NTP-0016, CTH.1000.0002.6095.

118 Exhibit 2-36, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0003 [17].

119 Exhibit 2-36, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0005 [44]; Transcript, BA, Adelaide Hearing 2, 20 March 2019, T917.5-33.

120 Transcript, BA, Adelaide Hearing 2, 20 March 2019 at T917.5.

121 Transcript, BA, Adelaide Hearing 2, 20 March 2019 at T916.28-29.

122 Exhibit 2-36, Adelaide Hearing 2, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0005 [44]; Transcript, BA, Adelaide Hearing 2, BA, 20 March 2019 at T917.30-33.

123 'Well, the situation where care recipients are not—we are not confident that they are getting care that is appropriate and necessary as—as a care plan would have indicated. And so in some cases the absence of a care plan alone would give us great cause for concern because there is no documentation by which you could verify that a recipient—a client was getting appropriate care.' Transcript, Lisa Studdert/Anthony Speed, Adelaide Hearing 2, 21 March 2019 at T996.21-28.

BB Pty Ltd was required to appoint an administrator and an adviser to assist its return to compliance. BB Pty Ltd had nine Home Care Package clients at this time and an annual turnover of $50,000.[124]

BB Pty Ltd spent nearly $120,000 on the administrator and adviser appointed to comply with the sanction.[125] BA was not given a quote for these services and does not appear to have asked for one. BA was not aware that the costs would be so high when she engaged the administrator and adviser.[126] The Department of Health was not aware of the fees charged by administrators or advisers.[127]

BD Pty Ltd case study

This case study was heard in Adelaide on 20 and 21 March 2019. It also concerned the experiences of a company and its Director in seeking to become an approved provider, to work with the regulator and respond to sanctions.

The approved provider and its Director were given pseudonyms, BD Pty Ltd and BC respectively.

The evidence before us consisted of:

- the statement of BC, a registered nurse, dated 15 March 2019
- the statement of Mr Graeme Barden, dated 20 March 2019
- Exhibit 2-40, a letter from the Australian Department of Health to BC titled 'Application for approval as an approved provider'
- Exhibit 2-83, a chronology of events for each provider the subject of NTP-0016
- Exhibit 2-84, an email exchange between the Australian Aged Care Quality Agency and the Australian Department of Health, dated 7 November 2018
- Exhibit 2-85, an email exchange between an officer of the Australian Department of Health and an officer of the compliance organisation, dated 7 November 2018
- the oral testimony of:
  - BC
  - Graeme Barden, Assistant Secretary, Residential and Flexible Care Branch, Australian Department of Health
  - Dr Lisa Studdert

124 Exhibit 2-36, Adelaide Hearing 2, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0004 [29]; Transcript, BA, Adelaide Hearing 2, 20 March 2019 at T913.24.

125 Exhibit 2-36, Adelaide Hearing 2, Statement of BA, 5 March 2019, WIT.0076.0001.0001 at 0005 [46]; Transcript, BA, Adelaide Hearing 2, 20 March 2019 at T917.47.

126 Transcript, BA, Adelaide Hearing 2, 20 March 2019 at T915.30-36.

127 Transcript, Lisa Studdert/Anthony Speed, Adelaide Hearing 2, 21 March 2019 at T1034.17.

  - Mr Anthony Speed
  - BE, an officer of the Australian Department of Health
- Post-hearing written submissions were made by:
  - the Australian Government
  - Mr Peter Vincent.

BD Pty Ltd became an approved provider in March 2018.[128] BC is a director of BD Pty Ltd. BC is a registered nurse.

Given the approval, BD Pty Ltd must have demonstrated it was suitable to provide aged care and did not have any disqualified individuals as key personnel. Suitability includes demonstrating that the applicant understands its obligations as a provider under Chapter 4 of the Aged Care Act and will be able to meet those obligations.[129]

In fact, before approving BD Pty Ltd to provide aged care services, the Department of Health sought further information about the policies and procedures that would be used to ensure regulatory compliance.[130] BC has tertiary qualifications in nursing and law.[131] She had relevant nursing experience and a particular interest in palliative care.[132] BD Pty Ltd had implemented a practice management system and had developed a policy manual that addressed all aspects of daily operations which was available in hard copy and online through the practice management system.[133] BD Pty Ltd provided a copy of its risk management plan to the Department with its application for approval.[134]

In or about August 2018, BD Pty Ltd agreed to take on palliating clients from Assist Services Pty Ltd, who was subjected to sanctions. Assist Home Services Pty Ltd had sold its business but remained an approved provider.[135]

On 30 October 2018, the Department made a referral to the Australian Aged Care Quality Agency. It was a type 2 referral and was made on the basis that care recipients were to transfer to care provided by BD Pty Ltd.[136]

128 Exhibit 2-83, Adelaide Hearing 2, Chronology of events for each provider the subject of NTP-0016, CTH.1000.0002.6095 at 6098.

129 Exhibit 2-11, Adelaide Hearing 2, Guidance for applicants seeking approval to provide Aged Care, CTH.0001.1000.3930 at 3943.

130 Transcript, Graeme Barden, Adelaide Hearing 2, 21 March 2019 at T970.813.

131 Exhibit 2-58, Adelaide Hearing 2, BD Pty Ltd Application for Approval to Provide Aged Care, 9 August 2017, CTH.1002.1019.6468 at 6471.

132 Transcript, BC, Adelaide Hearing 220 March 2019 at T855.11-22; Exhibit 2-58, Adelaide Hearing 2, BD Pty Ltd Application for Approval to Provide Aged Care, 9 August 2017, CTH.1002.1019.6468 at 6475.

133 Exhibit 2-58, Adelaide Hearing 2, BD Pty Ltd Application for Approval to Provide Aged Care, 9 August 2017, CTH.1002.1019.6468 at 6473.

134 Exhibit 2-58, Adelaide Hearing 2, BD Pty Ltd Application for Approval to Provide Aged Care, 9 August 2017, CTH.1002.1019.6468 at 8490.

135 Exhibit 2-33, Adelaide Hearing 2, Statement of BC, 15 March 2019, WIT.0033.0001.0001 at 0002 [17].

136 Exhibit 2-83, Chronology of events for each provider the subject of NTP-0016, CTH.1000.0002.6095 at 6100.

On 31 October 2018, the Australian Aged Care Quality Agency conducted an assessment contact and prepared an assessment contact report. BD Pty Ltd did not meet nine of the nine expected outcomes of the Home Care Standards reviewed.[137]

The Australian Aged Care Quality Agency required BD Pty Ltd to submit a revised plan for continuous improvement by 30 November 2018, showing how it would meet the standards by 31 January 2019. If compliance was not achieved, the Department was to be notified. The Australian Aged Care Quality Agency was to conduct a quality review in December 2018.[138]

On 7 November 2018, the assessment contact report was given to the Department of Health.[139] The Australian Aged Care Quality Agency did not consider the non-compliance posed a 'serious risk' to any care recipient.

On 8 November 2018, and despite the Australian Aged Care Quality Agency not finding a serious risk on the same information, a delegate of the Secretary of the Department was satisfied that there was 'an immediate and severe risk to the safety, health and wellbeing of the care recipients' and imposed sanctions under a 'straight to sanction' pathway.[140] The delegate decided to revoke BD Pty Ltd's approved provider status unless an administrator and adviser were appointed by BD Pty Ltd and at their expense.[141]

The sanction delegate was concerned by what it described as BD Pty Ltd's complete lack of understanding of its responsibilities as an approved provider.[142] That is at odds with a different delegate's assessment when they approved BD Pty Ltd to provide home care services in March 2018.[143]

BB Pty Ltd had twelve Home Care Package clients at this time.[144]

137 Exhibit 2-45, Adelaide Hearing 2, Australian Aged Care Quality Agency Assessment contact advice, 31 October 2018 CTH.4000.1003.2096 at 2097.

138 Exhibit 2-45, Adelaide Hearing 2, Australian Aged Care Quality Agency Assessment contact advice, 31 October 2018 CTH.4000.1003.2096 at 2097.

139 Exhibit 2-83, Adelaide Hearing 2, Chronology of events for each provider the subject of NTP-0016, CTH.1000.0002.6095 at 6100.

140 Exhibit 2-46, Adelaide Hearing 2, Letter from Department of Health to BD Pty Ltd, 'Sanctions Decision', 8 November 2018, CTH.1002.1002.0055.

141 Section 66-2 of the *Aged Care Act 1997* (Cth) providers for circumstances whereby revocation of an approved provider's approval does not take effect.

142 Exhibit 2-46, Letter from the Department of Health to BD Pty Ltd titled Sanctions Decision, 8 November 2018, CTH.1002.1002.0055 and 0059.

143 Exhibit 2-43, Letter from Department of Health to BD Pty Ltd titled Reconsideration of Deemed Decision to reject Application for Approval as an Approved Provider, 16 March 2018, CTH.1002.1016.1689.

144 Exhibit 2-33, Adelaide Hearing 2, Statement of BC, 15 March 2019, WIT.0033.0001.0001 at 0005 [45].

BD Pty Ltd received an estimate of $165,000 for six months advisory work.[145] BC borrowed money to get through the sanction process. BC was not aware of what other options were available.[146] She felt she had no options and was distressed that she may not be able to keep her promise to a dying care recipient.[147] She was told that other providers paid up to $500,000 for the same service. BC eventually struggled financially and left the home care industry.[148]

Conclusion

To what extent are provider approval processes relevant?

In the case studies, BB Pty Ltd and BD Pty Ltd were approved as suitable to provide aged care by one delegate in the Australian Department of Health only to be sanctioned by another delegate in the Department a mere matter of months later for failures which were primarily about deficiencies in corporate governance. It is difficult to reconcile the two decisions given the adjacent timing.

Senior Counsel Assisting asked Mr Barden whether he thought that the system is working appropriately where a provider is approved in March after consideration of certain articulated matters, and then six months later the Department finds that this particular provider is putting clients at an immediate and severe risk. Mr Barden replied, 'this is a circumstance that I would not expect'.[149]

Mr Barden told us he was responsible for the approved provider section. He said that the approved provider section does talk to the compliance area, but he did not know the specific details that they engage with. He did not know whether the two areas work together to develop a process of approvals that reflects the expectations that the approved provider section would have of particular providers.[150]

The evidence from BE and Mr Barden in the two cases studies raised questions about the rigour of the Department's processes to approve a provider as suitable to provide aged care and the communication flows between the area of the Department responsible for this function and the compliance area responsible for imposing sanctions. The evidence also raises questions about the basis of decision making on similar matters of corporate governance by different areas within the Department and arguably between the Department and the Australian Aged Care Quality Agency.

145 Exhibit 2-49, Adelaide Hearing 2, ACMA Service Proposal, 11 November 2018, THC.0001.0002.0007 at 0009.

146 Exhibit 2-33, Adelaide Hearing 2, Statement of BC, 15 March 2019, WIT.0033.0001.0001 at BC at 0005 [44].

147 Transcript, BC, Adelaide Hearing 2, BC, 20 March 2019 at T874.44-47.

148 Exhibit 2-33, Adelaide Hearing 2, Statement of BC, 15 March 2019, WIT.0033.0001.0001 at 0009 [77].

149 Transcript, Graeme Barden, Adelaide Hearing 2, 21 March 2019 at T974.5-12.

150 Transcript, Graeme Barden, Adelaide Hearing 2, 21 March 2019 at T960.23-31 and T974.20-31.

To what extent was the sanction of home care providers connected with the quality and safety of care delivered?

A significant issue on which each sanction decision turned was the absence of care plans.

There was no evidence before the delegates that people receiving care from BB Pty Ltd or BD Pty Ltd did not receive quality and safe care as a matter of fact. Each provider had a relatively small home care business with nine to 12 home care recipients at the time of sanction.

There is no suggestion, on the evidence before the delegate, that any of BB Pty Ltd's clients raised any concerns with BA about the quality of care received or chose to leave her services.

At the time of the sanction imposed on BD Pty Ltd, it had recently received a transfer of care recipients from a sanctioned provider. The care recipients came to BD Pty Ltd with 'absolutely no paperwork whatsoever'.[151]

The Australian Government submitted that the Department of Health and the Aged Care Quality and Safety Commission (as the successor to the Australian Aged Care Quality Agency) are concerned with adequacy of systems, processes and documentation because of experience. Deficient systems, processes and documentation are risk factors in terms of deficient care, quality and safety.[152] This is a valid point. However, we are left with disquiet over the two cases examined during this hearing.

The reasoning recorded in the sanction decisions involved the following important steps in reasoning. Non-compliance with the record keeping requirements of the Home Care Standards, including the maintenance of care plans, undermined the approved providers' ability to properly provide for care recipients' health, safety and wellbeing. That much may be accepted. Delegates then drew the conclusion that recipients were placed at 'immediate and severe risk'.[153] There was no direct evidence before the delegate of a failure by BB Pty Ltd or BD Pty Ltd to provide safe and quality care to any particular care recipient.

We accept that the delegate decided the issue on information available at the time and that it was unnecessary to find actual harm. So much is plain from the language of the Aged Care Act. However, the statutory test requires that there be both an immediate risk and a severe risk. This is not a disjunctive test. It is not enough that the delegate merely discerns a risk to safety, health and wellbeing.

151 Transcript, BC, Adelaide Hearing 2, 20 March 2019 at T895.14.

152 The Commonwealth refer to Transcript, Dr Lisa Studdert, 21 March 2019, T1027.14-18 and rely on *Saitta Pty Ltd v Secretary, Department of Health and Ageing* [208] AATA 681 at [147].

153 Commonwealth post-hearing submission, 29 March 2019, RCD.0012.0003.0012 at 0026 [69].

This step in reasoning had important consequences, because it led to a 'straight to sanctions' decision. If the 'straight to sanction' pathway had been unavailable, BB Pty Ltd and BD Pty Ltd had a right to procedural fairness. Either or both providers may have been able to put appropriate arrangements in place or explain why the proposed sanctions may have been inappropriate, with reference to matters of fact. Coupled with this, in neither case had the Australian Aged Care Quality Agency notified the approved providers, or the Department of Health, that their non-compliance gave rise to serious risk before the Department decided to impose sanctions.

Appropriate records of care provided and care plans are important. We accept that inadequate systems, processes and documentation can be risk factors. However, we are concerned that those charged with responsibility for oversight and regulation of approved providers may be giving too much weight to the scrutiny of systems and records as a proxy for inferring likely quality and safety outcomes. In the absence of actual measures of the quality of care, the presence of a care plan has become a proxy for quality. This has obvious dangers. The mere presence of paperwork is an inadequate assurance of care delivery. We remember that Ms Anderson, Aged Care Quality and Safety Commissioner, told us in February, 'at the moment I'm not convinced that our regulatory gaze in home care is as strong as it needs to be'.[154]

Were the sanctions appropriate in all the circumstances?

The sanctions imposed on each of BB Pty Ltd and BD Pty Ltd led to significant costs for two small businesses. One of the providers left the aged care sector as a result. Each provider was required to choose and appoint administrators and advisers as a condition of sanction. They spent a large sum, in excess of their annual turnover, on those contractors. Whether to engage administrators and advisors, and the terms on which they did so, was a matter for their own business judgment.

Having found that that there was an immediate and severe risk to the safety, health and wellbeing of the care recipients, it was incumbent on the Australian Department of Health to consider how it should respond with the powers available to it. However, we are not persuaded on the evidence before us that the sanctions imposed were sufficiently responsive to the circumstances and risks.

The two providers had only been approved a relatively short time earlier. When they were approved, the Department was satisfied that both providers were suitable to provide aged care services. That consideration included whether the providers had, or would implement, appropriate policies and procedures. This leaves us with the impression of either an inconsistent approach to approval and subsequent regulation or some other issue with the decision-making process within the Department.

154 Transcript, Janet Anderson, Adelaide Hearing 1, 18 February 2019 at T362.44-45.

Neither provider had an adverse regulatory history. They had not been warned or subject to any prior compliance action.

The approved providers' conduct posed a risk to care recipients, but there was no evidence before the delegates of actual harm. There was some evidence before us that care recipients were happy with the services they received. That is not to say that the Department should only respond to situations causing harm. It is entirely appropriate that the Department is responsive to risks. But it might be expected that a regulator would engage with the recipients of care as part of its processes of determining whether and in what form a sanction might be applied.

At least one of the providers responded very quickly to the concerns and had put forward a folder of evidence of the steps they had taken to the Australian Aged Care Quality Agency before sanctions were imposed. We do not know if that folder was before the sanctions delegate. This willingness to comply with the regulators suggests there was potential, with the right educative and other supports, for that provider to manage itself back to compliance. This may have led to a more efficient and effective outcome for all concerned.

The imposition of sanctions in these circumstances might be regarded as unusual given the small number of home care providers sanctioned by the Department since July 2015.

We consider that a responsive regulator would have weighed these considerations carefully as they all militated against imposing the sanctions that were imposed. The decision to impose the particular sanctions in these circumstances might suggest it is necessary to consider the consistency and predictability of the decision-making processes across approval, accreditation and compliance of providers, the processes by which sanctions are determined and whether an appropriate range of graduated sanctions is available under the Aged Care Act.

3. Sydney Hearing: Residential and Dementia Care

Hearing overview

Introduction

Over eight days, between 6 and 17 May 2019, we held a hearing in Sydney, New South Wales. The subject of the hearing was residential aged care, with a focus on the care of people living with dementia. The key areas examined at the hearing were:

- the perspective and experience of people in residential aged care and people living with dementia, and their family and carers
- quality and safety in residential aged care, particularly for people living with dementia
- the use of restrictive practices in residential aged care
- the extent to which the current aged care system meets the needs of people in residential aged care
- good practice care for people living with dementia, particularly in the context of residential aged care.

We heard oral testimony from 45 witnesses. A total of 693 documents, including 54 witness statements, were received into evidence.

During the course of the hearing, we heard several direct accounts from witnesses who told us about their experiences of the aged care system. From two of those witnesses, we heard their experience of living with dementia.[1] We also conducted a series of case studies, each of which illustrated the challenges and complexities of providing residential aged care.

1 Ms Darryl Melchhart: Transcript, Darryl Melchhart, Sydney Hearing, 6 May 2019 at T1128.30-1146.4; Exhibit 3-3, Sydney Hearing, Statement of Darryl Hilda Melchhart, 27 April 2019, WIT.0013.0001.0001. Ms Merle Mitchell AM: Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1146.25-1150.13; T1161.18-1167.40; Exhibit 3-1, Sydney Hearing, Statement of Merle Valma Mitchell AM, 27 April 2019, WIT.0107.0001.0001; Exhibit 3-5, Sydney Hearing, Video Evidence of Merle Valma Mitchell AM, RCD.9999.037.0001. Mr George Akl: Exhibit 3-4, Sydney Hearing, Statement of George Akl, 29 April 2019, WIT. 0108.0001.0001; Transcript, George Akl, Sydney Hearing, 6 May 2019 at T1151.1-1160.32. Ms Eresha Dilum Dassanayake: Exhibit 3-6, Sydney Hearing, Statement of Eresha Dilum Dassanayake, 1 May 2019, WIT.0109.0001.0001; Transcript, Eresha Dilum Dassanyake, Sydney Hearing, 6 May 2019 at T1168.22-1198.36. Ms Kathryn Nobes: Exhibit 3-28, Sydney Hearing, Statement of Kathryn Nobes, 29 April 2019, WIT.0143.0001.0001; Transcript, Kathryn Nobes, Sydney Hearing, 6 May 2019 at T1415.4-1423.47. Trevor Crosby: Exhibit 3-82, Sydney Hearing, Statement of Trevor Crosby, 8 May 2019, WIT.0142.0001.0001; Transcript, Trevor Crosby, Sydney Hearing, 17 May 2019 at T1918.44-1926.23. Kate Swaffer: Exhibit 3-86, Sydney Hearing, Statement of Kate Swaffer, 16 May 2019, WIT.0127.0001.0001; Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1927.19-1942.15.

We also heard evidence from experts in the field of dementia and residential aged care and from representatives from the Australian Government about its perspective on these areas. In addition, we heard about innovative models of care for people living with dementia in residential settings. We also heard about the use of restraints in aged care and about the Australian Government's response to this.

Several themes arose from the evidence at this hearing. Of these, the need to respect the individuality of those receiving care, no matter their cognitive function and no matter how challenging it is to care for them, emerged clearly.

The evidence at this hearing was vast and complex. Some of the evidence we received at this hearing has been drawn upon in Volume 1 of this Interim Report. It will continue to be drawn upon over the course of our inquiry as well as in our Final Report. A brief overview of the hearing and the evidence is provided below.

Our findings and conclusions about these case studies are set out later in this chapter.

Experience of aged care

The need to respect the individual was clear from the evidence of the first two witnesses, each of whom live in residential aged care. We heard that the transition into residential aged care can be difficult. Providers pay insufficient attention to the impact of this on individuals, including on their dignity, choice and independence.[2] Ms Darryl Melchhart, a 90-year-old resident at an aged care facility, stated that she feels frustration living there. She explained that she has 'a never-ending battle to be seen as a fully competent adult'.[3] Ms Melchhart feels that she has no voice living in residential care.[4]

Tellingly, Ms Merle Mitchell AM, an 84-year-old woman living in residential aged care, said:

> there's just that feeling that this isn't a proper life, and so there is that feeling that the quicker it's all over, the better it is for everybody.[5]

There are challenges in the institutional nature of residential aged care. Ms Mitchell observed that people come in to aged care and are told 'this is your home now'. However, Ms Mitchell said:

> it's not. It's an institution, and it's where you live. But it's not a home, and no matter how many times they tell you, it's still not your home.[6]

2 Exhibit 3-3, Sydney Hearing, Statement of Darryl Hilda Melchhart, 27 April 2019, WIT.0013.0001.0001 at 0003 [8]; Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1148.31-33.

3 Transcript, Darryl Melchhart, Sydney Hearing, 6 May 2019 at T1134.1-3; T1129.22-1130.9; T1131.15-25; Exhibit 3-3, Sydney Hearing, Statement of Darryl Hilda Melchhart, 27 April 2019, WIT.0013.0001.0001 at 0001 [7].

4 Transcript, Darryl Melchhart, 6 May 2019 at T1140.20-46.

5 Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1148.37-39.

6 Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1149.3-5.

Ms Mitchell and Ms Melchhart each described a range of experiences of living in residential aged care. Those experiences ranged from access to medical and dental care, and physiotherapy, to difficulties receiving the correct medication, difficulties with medication management, struggles with appropriate continence care, social isolation, and bland food.[7] They described dismissive attitudes by staff to their experience of intense pain.[8]

Neither Ms Mitchell nor Ms Melchhart felt particularly engaged by the activities made available to them by the facilities in which they live. Ms Melchhart said that there are not enough activities to keep people and their minds occupied.[9] Ms Mitchell said that the people who coordinate lifestyle activities work very hard. She thinks 'too much is expected of them'. She explained that she constantly asks for more challenging activities, only to be told, 'You're the only person who's got the capacity'.[10]

Equity of access to additional services was a feature of both Ms Mitchell's and Ms Melchhart's evidence. Ms Melchhart used to have access to physiotherapy within her care. Now if she wants it, she faces an additional cost.[11] Meanwhile, while Ms Mitchell could afford to pay for additional services such as rehabilitation and physiotherapy, others missed out because they could not afford to pay any more for their care. There are, she said, 'many people who miss out'.[12]

Staffing and care issues

Staffing at residential aged care facilities was a theme throughout the hearing. It arose in both Ms Mitchell's and Ms Melchhart's evidence, each of whom held concerns for the staff working in their respective facilities.

Ms Mitchell told us that there are insufficient staff to support the many residents at her facility, especially at night. Ms Mitchell believes staff ratios would make a big difference.[13] She did not believe the staff had appropriate training to care for her in the way she would hope and expect.[14] Meanwhile, Ms Melchhart was concerned that staff at her facility are overworked and do not have time to engage properly. However, Ms Melchhart said, 'A lot of the people who work at the facility are very nice.'[15]

7 Exhibit 3-3, Sydney Hearing, Statement of Darryl Hilda Melchhart, 27 April 2019, WIT.0013.0001.0001 at 0001 [7], 0003 [13], 0004 [17] and [20].

8 Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1161.32-41.

9 Transcript, Darryl Melchhart, Sydney Hearing 6 May 2019 at T1134.41-42.

10 Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1163.1-10.

11 Transcript, Darryl Melchhart, Sydney Hearing 6 May 2019 at T1145.9-24.

12 Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1166.34-45.

13 Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1161.18-20; T1162.5-15.

14 Transcript, Merle Mitchell, Sydney Hearing, 6 May 2019 at T1162.34-37.

15 Exhibit 3-3, Sydney Hearing, Statement of Darryl Hilda Melchhart, 27 April 2019, WIT.0013.0001.0001 at 0005 [25]-[26].

The difficulties of working in aged care was a central theme in the evidence of Ms Kathryn Nobes, who gave a direct account of her experience as an aged care employee at a facility in New South Wales where she has worked since November 2015.[16] A panel of witnesses of current and former staff of residential aged care facilities drew on their years of experience working in aged care. 'Elizabeth', a registered nurse, Ms Suzanne Wilson and Ms Susan Walton, each assistants in nursing, along with Ms Margaret (Maggie) Bain, a retired diversional therapist, provided us with a range of views and experiences.[17] Some of these experiences were confronting.

Perhaps most confronting of all, Ms Nobes recalled an occasion when a resident at the facility she worked at was killed by another resident.[18] Following this incident, Ms Nobes was diagnosed with post-traumatic stress disorder, which she says was aggravated 'by the manner in which the management of the facility made it difficult for me to talk to the police'.[19]

Ms Nobes believes that the working conditions of care workers has a serious impact on the quality of care that workers are able to provide. Ms Nobes spoke of the challenges of caring for people who live with dementia, including regular assaults on her and her co-workers.[20] She believes that staff working with residents with dementia need more training.[21]

Ms Dilum Dassanayake's mother lives with dementia in residential aged care. She experienced an aged care facility that was not, in her opinion, 'set up to deal with dementia'.[22] Ms Dassanayake recounted the dismissive attitude of staff to her mother:

> On one occasion, the manager said to me in front of my mother 'She's demented, she doesn't understand what we're saying'.[23]

Ms Dassanayake recounted stories of care shortfalls and neglect of her mother which she attributed to the attitude of management and inadequately trained staff.

Professor Elizabeth Beattie, Professor of Aged and Dementia Care in the School of Nursing at the Queensland University of Technology, explained the importance of a person-centred approach to care. For people living with dementia, she explained that there are 'a lot of threats to their personhood'. She added that, 'People living with dementia are no different from us' and that staff need to see the person they are. Professor Beattie accepted that this can be difficult when staff do not care for the same people regularly, or where residents are 'very severely impaired'. She explained that the ability to connect and communicate is very important.[24]

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16 Exhibit 3-28, Sydney Hearing, Statement of Kathryn Jill Nobes, 29 April 2019, WIT.0143.0001.0001 at 0001 [7].

17 Transcript, 'Elizabeth'/Bain/Wilson/Walton, Sydney Hearing, 15 May 2019 at T1676.27-1721.15.

18 Exhibit 3-28, Sydney Hearing, Statement of Kathryn Jill Nobes, 29 April 2019, WIT.0143.0001.0001 at 0001 [8].

19 Exhibit 3-28, Sydney Hearing, Statement of Kathryn Jill Nobes, 29 April 2019, WIT.0143.0001.0001 at 0001 [8].

20 Exhibit 3-28, Sydney Hearing, Statement of Kathryn Jill Nobes, 29 April 2019, WIT.0143.0001.0001 at 0004 [22b].

21 Exhibit 3-28, Sydney Hearing, Statement of Kathryn Jill Nobes, 29 April 2019, WIT.0143.0001.0001 at 0008 [49].

22 Exhibit 3-6, Sydney Hearing, Statement of Eresha Dilum Dassanayake, 1 May 2019, WIT.0109.0001.0001 at 0003 [14].

23 Exhibit 3-6, Sydney Hearing, Statement of Eresha Dilum Dassanayake, 1 May 2019, WIT.0109.0001.0001 at 0003 [14].

24 Transcript, Elizabeth Beattie, Sydney Hearing, 14 May 2019 at T1623.37-1624.17.

Mr George Akl also emphasised the importance of connection and communication in his account of his late father's experience of residential aged care while living with Lewy body dementia.[25] Mr Akl's father was born in Egypt and his first language was Arabic, although he spoke English fluently.[26] His ability to speak English decreased in the year after his diagnosis. Mr Akl explained that when speaking Arabic, his father 'seemed to be a different person, a lot happier, prouder and more alive'.[27] As Mr Akl's father's English decreased, Mr Akl acted as the intermediary between his father and the staff. He was his father's connection to the world of communication.[28]

As his disease progressed, Mr Akl's father became more connected with his culture through language, sounds and food.[29] We have heard repeatedly that sounds, food and culture enliven the minds of people living with dementia.

Mr Akl said it needs to be acknowledged that when it comes to people from culturally and linguistically diverse backgrounds, there is a 'big difference between people whose English is a second language, and native-speakers' and that this divide is 'not really fair'.[30] His father 'had the ability to communicate. There just wasn't a space for him to communicate properly'.[31]

Professor Henry Brodaty AO, Scientia Professor at the Centre for Healthy Brain Ageing at the University of NSW, also emphasised the importance of communication. Professor Brodaty has over 30 years' experience as a psychogeriatrician.[32] He proposed that behaviours of dementia be understood as a means of communication.[33]

Professor Brodaty has spent much of his career in dementia research. He explained that there is not a clear pathway for providing post-diagnosis support for someone diagnosed with dementia.[34]

Diagnosis of dementia

Mr Trevor Crosby and Ms Kate Swaffer each spoke of their experience of being diagnosed with dementia and the support available to them post-diagnosis.

25 Exhibit 3-4, Sydney Hearing, Statement of George Akl, 26 April 2019, WIT.0108.0001.0001.

26 Transcript, George Akl, Sydney Hearing, 6 May 2019 at T1151.44-1152.31.

27 Exhibit 3-4, Sydney Hearing, Statement of George Akl, 26 April 2019, WIT.0108.0001.0001 at 0003 [23].

28 Exhibit 3-4, Sydney Hearing, Statement of George Akl, 26 April 2019, WIT.0108.0001.0001 at 0005 [40].

29 Transcript, George Akl, Sydney Hearing, 6 May 2019 at T1158.20-32.

30 Transcript, George Akl, Sydney Hearing, 6 May 2019 at T1157.35.

31 Transcript, George Akl, Sydney Hearing, 6 May 2019 at T1160.19-20.

32 Exhibit 3-80, Sydney Hearing, Statement of Henry Brodaty, 16 May 2019, WIT.00116.0001.0001.

33 Exhibit 3-80, Sydney Hearing, Statement of Henry Brodaty, 16 May 2019, WIT.00116.0001.0001 at 0008 [38].

34 Transcript, Henry Brodaty, Sydney Hearing, 17 May 2019 at T1886.38-1887.9.

Mr Crosby was diagnosed with Lewy body dementia when he was 65 years old, four years before this hearing.[35] Mr Crosby's diagnosis left him 'dumbfounded'; he 'felt helpless, pathetic'.[36] Mr Crosby experienced a turning point after he and his wife, Jill, participated in a Dementia Australia program called 'Living with Dementia'.[37] However, after the course ended, Mr Crosby felt let down by the lack of ongoing support available for people living with dementia.[38] He joined a peer support program funded by the University of Sydney which aims 'to build up a network of support'.[39]

Mr Crosby said his diagnosis has affected him in many ways and that there is no getting away from it. Dementia is, he said, 'a cruel, ugly killer lurking in the shadows of my life'.[40] However, good things have also come into his life as a result of his diagnosis.[41] Mr Crosby speaks out about dementia. He wants to 'let people know there is no shame in having this diagnosis'.[42]

Ms Swaffer was diagnosed with younger onset dementia when she was 49 years old. She cofounded Dementia Alliance International in January 2014, and is the Chair and Chief Executive Officer of that organisation. Dementia Alliance International provides peer-to-peer support to people living with dementia around the world.[43] When Ms Swaffer co-founded it, her goals were to have an authentic voice, and to 'provide advocacy of, by and for people with dementia'.[44] After her diagnosis, Ms Swaffer was not referred to any support services in South Australia.[45] She explained:

> I was advised to give up work, give up study…To get my end of life affairs in order… everyone around me, basically told me to give up my life and go home and prepare to die.[46]

Mr Glenn Rees, the Chair of Alzheimer's Disease International, argued strongly for post-diagnostic support. He described a person being told, following their diagnosis, to 'get on with their lives' or that 'there's nothing that could be done for them' as 'cruel'.

35 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0001 [7].

36 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0002 [13].

37 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0002 [15].

38 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0002 [17]-[18], 0003 [19].

39 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0003 [24]-[25].

40 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0005 [40].

41 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0005 [41].

42 Exhibit 3-82, Sydney Hearing, Statement of Trevor Douglas Crosby, 8 May 2019, WIT.0142.0001.0001 at 0005 [43].

43 Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1928.1-30; Exhibit 3-84, Statement of Kate Swaffer, 16 May 2019 WIT.0127.0001.0001 at 0009 [68].

44 Exhibit 3-84, Sydney Hearing, Statement of Kate Swaffer, 16 May 2019 WIT.0127.0001.0001 at 0009 [66].

45 Exhibit 3-84, Sydney Hearing, Statement of Kate Swaffer, 16 May 2019 WIT.0127.0001.0001 at 0006-0007 [48]-[49].

46 Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1929.13-20.

Post-diagnosis, he told us, people should be able to go to a dementia coordinator or to a case manager.[47] Mr Rees suggested:

> the adoption of a one-year post diagnosis guarantee of support for the individual with dementia and their informal care partner to receive information on dementia, information on things they can do to manage living with dementia…plan their care and finances and access support and care if needed.[48]

We heard about the stigma associated with the diagnosis of dementia. In Ms Swaffer's experience, stigma surrounding dementia is 'very, very prevalent in the community'.[49] She described dementia as the 'most feared diseased' for Australians over the age of 65 and she partially attributes this to stigma.[50] Connected to this stigma, Ms Swaffer said, is people not wanting to talk to those with dementia about their goals and what they want.[51] She said it is imperative that these conversations occur 'from the time of diagnosis'.[52]

Professor Constance Dimity Pond, Professor of General Practice at the University of Newcastle, spoke of the importance of the timing of diagnosis of dementia. She explained that some people do not want to know whether they have dementia. However, she continued, there are many advantages to knowing, including allowing the person with the diagnosis to make plans for their care while they have the capacity to do so.[53]

At times, Professor Pond told us, it is difficult for general practitioners to diagnose dementia. General practitioners do not generally have 'a full understanding of dementia diagnosis, symptoms and the needs of people living with dementia'.[54] Professor Pond explained that this is in part because doctors in general practice commonly see and manage over 100 different conditions.[55]

Caring for people living with dementia

Associate Professor Stephen Macfarlane, the Head of Clinical Services for the Dementia Centre at HammondCare, estimated that while official prevalence data may suggest the number is lower, as many as 70 per cent of people in residential aged care could be living with dementia.[56] The evidence at this hearing made clear that training about the nature and effects of dementia and how best to care for the increasing number of Australians living with dementia is essential to the provision of quality and safe care.

47 Transcript, Glenn Rees, Sydney Hearing, 13 May 2019 at T1550.18-1551.2.

48 Exhibit 3-40, Sydney Hearing, Statement of Glenn Rees, 28 April 2019, WIT.0126.0001.0001 at 0003 [14].

49 Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1931.8-17.

50 Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1931.45-38.

51 Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1932.1-6.

52 Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1932.10-12.

53 Transcript, Constance Dimity Pond, Sydney Hearing, 14 May 2019 at T1618.4-40.

54 Exhibit 3-48, Sydney Hearing, Statement of Constance Dimity Pond, 6 May 2019, WIT.0118.0001.0001 at 0008 [27].

55 Transcript, Constance Dimity Pond, Sydney Hearing, 14 May 2019 at T1616.3-6.

56 Transcript, Stephen Macfarlane, Sydney Hearing, 15 May 2019 at T1764.20-23.

We heard about the importance of training and experience from a panel of clinicians: Dr Peter Foltyn, Visiting Dental Officer at St Vincent's Hospital Darlinghurst; Associate Professor Lynette Goldberg from the Wicking Dementia Research and Education Centre at the University of Tasmania; and Professors Pond and Beattie.[57] Each of these clinicians are experienced in critical aspects of caring for older Australians living with dementia.

Professor Pond explained that there is a need for an 'in-depth knowledge to identify dementia and it's not simple'.[58] Professor Beattie considered that providing 'optimal nursing care' to people living with dementia 'involves a high degree of skill and training and experience'.[59]

Professor Brodaty does not consider that current education is sufficient for staff caring for people living with dementia. His recommended improvements included a requirement for basic qualifications and on the job training led by a 'nurse champion'. Professor Brodaty stated that changes to the curricula for doctors, nurses and personal care workers should be made to improve the care being provided to people living with dementia.[60]

Dr Foltyn and Associate Professor Goldberg each spoke of the challenges in providing care to those with cognitive decline. Dr Foltyn explained that there is often an expectation that staff will assist those in residential aged care who are incapable of undertaking their own oral care. However, this 'very often just doesn't happen'. This can 'lead to accelerated dental decay'.[61] Associate Professor Goldberg, who is a speech pathologist, explained the risks of dementia to people's ability to eat and drink safely. Those risks include malnutrition, dehydration and aspiration pneumonia.[62]

In addition to hearing about the importance of appropriate clinical, nursing and allied health care, we heard about the importance of the care environment for those living with dementia. This was a particular focus of the evidence of Ms Tamar Krebs and Mr Jonathan Gavshon of Group Homes Australia, Ms Jennifer Lawrence of Brightwater Care Group and Ms Lucy O'Flaherty of Glenview Community Services, who appeared together as a panel to speak about innovative models of care.[63]

The attitudes of those providing care is critically important. Ms O'Flaherty aims 'to recruit for kindness and train for excellence'.[64] In Ms Bain's experience, a good manager will try to ensure that staff bring compassion and empathy to their work.[65] Associate Professor

57 Transcript, Constance Dimity Pond, Sydney Hearing/Beattie/Foltyn/Goldberg, 14 May 2019 at T1607.44-1640.23.

58 Transcript, Constance Dimity Pond, Sydney Hearing, 14 May 2019 at T1616.3-6.

59 Transcript, Elizabeth Beattie, Sydney Hearing, 14 May 2019 at T1619.15-18.

60 Exhibit 3-80, Sydney Hearing, Statement of Henry Brodaty, WIT.0116.0001.0001 at 0013 [66]-[67].

61 Transcript, Peter Foltyn, Sydney Hearing, 14 May 2019 at T1620.1-16.

62 Transcript, Lynette Goldberg, Sydney Hearing, 14 May 2019 at T1622.20-25.

63 Transcript, Tamar/Gavshon/O'Flaherty/Lawrence, Sydney Hearing, 14 May 2019 at T1571.33-1607.10.

64 Transcript, Lucille O'Flaherty, Sydney Hearing, 14 May 2019 at T1585.39-40.

65 Transcript, 'Elizabeth'/Bain/Wilson/Walton, Sydney Hearing, 15 May 2019 at T1700.44-1701.2.

Macfarlane said that to work in aged care and be effective, a person needed to have a passion for caring for older people and an empathy for their needs.[66]

Ms Lawrence stated that training for those caring for people living with dementia should at least address manual handling, maintaining dignity, identifying triggers and symptoms for behaviours, and de-escalation techniques.[67] In-house dementia training is provided at Glenview. Ms O'Flaherty described one aspect of this training, which involved a simulated exercise of what it might be like to experience dementia.[68]

There are challenges in the institutional nature of residential aged care. Environment is a key factor in providing care to people living with dementia.[69] Ms Swaffer said:

> We have taken to thinking it's okay to incarcerate people for getting old or for having dementia…We need to move away from institutions and segregation.[70]

Ms Krebs explained that for people living with dementia, a home-like environment with the smells of a home rather than the smells of an institution is important. Photographs, books or other items from home can assist in providing visual cues.[71]

Mr Rees said that there was a failure to integrate the lessons from other sectors, especially from the National Disability Insurance Scheme, and apply them to aged care.[72] He argued that aged care has a core responsibility to treat people with dementia 'in a humane and open way, and not to segregate them'.[73] Mr Rees observed that 'the voice of the consumer doesn't go through to the [Australian Department of Health]'.[74]

For people living with dementia in residential care, Associate Professor Macfarlane told us, poor design of the physical and social environment is one of the significant systemic causes of substandard care.[75] He explained that shortcomings in the built environment as well as deficits in the social environment, together with the approach of carers to those living with dementia, are some of the common problems encountered by Dementia Support Australia.[76]

66 Transcript, Stephen Macfarlane, Sydney Hearing, 15 May 2019 at T1769.36-39.

67 Exhibit 3-46, Statement of Jennifer Lawrence, 1 May 2019, WIT.0123.0001.0001 at 0003.

68 Transcript, Lucille O'Flaherty, Sydney Hearing, 14 May 2019 at T1585.33-1586.30.

69 Transcript, Tamar Krebs, Sydney Hearing, 14 May 2019 at T1580.46-1581.5.

70 Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1934.45-1935.9.

71 Transcript, Tamar Krebs, Sydney Hearing, 14 May 2019 at T1580.46-1581.5.

72 Transcript, Glenn Rees, Sydney Hearing, 13 May 2019 at T1550.1-8.

73 Transcript, Glenn Rees, Sydney Hearing, 13 May 2019 at T1552.26-29.

74 Transcript, Glenn Rees, Sydney Hearing, 13 May 2019 at T1555.31-46.

75 Exhibit 3-68, Sydney Hearing, Statement of Stephen Robert Macfarlane, 24 April 2019, WIT.0125.0001.0001 at 0017 [77].

76 Transcript, Stephen Macfarlane, Sydney Hearing, 15 May 2019 at T1767.19-24.

Dementia Support Australia delivers government funded services aimed to build sector capacity in supporting people living with dementia who experience behavioural and psychological symptoms of dementia.[77] This includes the Dementia Behaviour Management Advisory Service and the Serious Behaviour Response Team that provide frontline support for carers and organisations caring for people.[78]

Restraint

The case studies at this hearing illustrated that managing behavioural and psychological symptoms of dementia can be a challenge for aged care providers. In addition to the case studies, we heard from Australian experts in research into dementia and into measures taken in residential care in response to behaviours seen as 'challenging'. The use of chemical and physical restraints to manage such behaviours was a very important feature of this hearing.

Ms Wilson and Ms Walton, each assistants in nursing, gave evidence that, in their experience, the use of chemical restraints in aged care facilities was common.[79] Ms Bain, a diversional therapist, spoke of physical restraints. She said that, at one facility in which she had worked, she had seen them used regularly—on a daily basis.[80] 'Elizabeth', a nurse, described chemical restraint, unlike physical restraint, as 'anonymous' so that 'everyone looks fine…they're all clean and tidy and they're not crying out'.[81] She observed that one consequence of the use of chemical restraints was that residents were 'not actually getting the care they need and being treated like a person with needs'.[82] They argued for more staff and better training in how to work with people with dementia.

Dr Juanita Breen (formerly Westbury), a registered pharmacist and senior lecturer in dementia care at the Wicking Dementia Research and Education Centre at the University of Tasmania, told us that the use of psychotropic medication is associated with increased risks of falls and strokes.[83] She said that over-prescribing tended to be caused by pressure from workers in aged care facilities, a false premise that the drugs were effective, little appreciation of their risks, concerns about withdrawal, understaffing and inadequate training. She spoke of a research program she had participated in which aimed to reduce the use of sedatives in aged care facilities.[84]

77 Exhibit 3-68, Sydney Hearing, Statement of Stephen Macfarlane, 24 April 2019, WIT.0125.0001.0001 at 0002 [15] and [17].

78 Exhibit 3-68, Sydney Hearing, Statement of Stephen Macfarlane, 24 April 2019, WIT.0125.0001.0001 at 0004 [24] and 0010 [47].

79 Transcript, Margaret Wilson/Susan Walton, Sydney Hearing, 15 May 2019 at T1708.12-33.

80 Transcript, Margaret Bain, Sydney Hearing, 15 May 2019 at T1711.16-1712.13.

81 Transcript, 'Elizabeth', Sydney Hearing, 15 May 2019 at T1708.6-10.

82 Transcript, 15 May 2019 at T1708.8-10.

83 Exhibit 3-61, Statement of Dr Juanita Westbury, 29 April 2019, WIT.0117.0001.0001 at 0011 [11].

84 Transcript, Juanita Westbury, Sydney Hearing, 15 May 2019 at T1733.29-1735.46.

Dr Breen argued that 'the present Standards are woolly, soothing overtones which sound good in principle but offer no guidance at all on important aspects of care'.[85] She felt that nurses and care workers need to lead cultural change and that guidelines need updating, particularly around consent for chemical restraint.[86]

Associate Professor Macfarlane, who leads the team of Clinical Associates who work with the Severe Behaviour Response Team and the Dementia Behaviour Management Advisory Service,[87] said that, as a general rule, if physical restraints are to be used at all it should only ever be 'an emergency measure that can be justified by the imminent risk of serious harm' to the individual or another.[88] According to Associate Professor Macfarlane, where there is no clinical indication for the prescription of medications that act as chemical restraints, their use is inappropriate.[89] He clearly stated that neither physical nor chemical restraints are appropriate measures to address behaviours associated with dementia, unless there is an emergency where there is a clear and present danger to the person or others. He regards the new restraint Standards as 'deeply flawed'.

Associate Professor Macfarlane's preference is for initial holistic assessment and properly developed care plans which include how the person relates and the care they need to manage their symptoms. These care plans should be updated regularly. Efforts need to be made to address under-recognised pain, deficits in the physical environment, and inadequate discharge summaries.

Associate Professor Macfarlane suggested that better training of staff would give 'the most bang for your buck in terms of appropriate behaviour management and decreasing inappropriate psychotropic polypharmacy'.[90]

Choice and risk

Dignity of risk, the idea that self-determination and the right to take reasonable risks are essential for dignity and self-esteem, has been an ongoing theme throughout the Royal Commission's work. In Sydney we heard how the concept can involve informal discussions about the autonomy of people living with dementia. The issue often arises in paternalistic attempts to make the experiences of these people safer but deny them their own autonomy. We have heard how people living with dementia should not be assumed to be incapable of making decisions about the quality of their life. To a large degree, fears

85 Exhibit 3-62, Sydney Hearing, RCD.9999.0057.0001.

86 Transcript, Juanita Westbury, Sydney Hearing, 15 May 2019 at T1739.34-1740.7.

87 Exhibit 3-68, Sydney Hearing, Statement of Stephen Robert Macfarlane, 24 April 2019, WIT.0125.0001.0001 at 0001 [8].

88 Exhibit 3-68, Sydney Hearing, Statement of Stephen Robert Macfarlane, 24 April 2019, WIT.0125.0001.0001 at 0026 [131].

89 Exhibit 3-68, Sydney Hearing, Statement of Stephen Robert Macfarlane, 24 April 2019, WIT.0125.0001.0001 at 0025 [126]-[130].

90 Transcript, Stephen Macfarlane, Sydney Hearing, 15 May 2019 at T1771.1-3.

about the person making such decisions stem from the stigma attaching to the disease. A person living with dementia may enjoy life more, and their living experience may be enriched, by being able to go for a walk, to eat a certain food or drink a certain drink, even though there may be risk involved.

Professor Joseph Ibrahim, the Head of Health Law and Ageing Research at Monash University, spoke of the dilemma in the balance between 'paternalism and a person's right to autonomy'.[91] He emphasised the challenges of providing proper care to older people, including people living with dementia, while affording them choices as to how to live the remainder of their lives, including the important principle of 'dignity of risk'.[92] Professor Ibrahim argued that people do not enter residential aged care to 'be cocooned'. He explained that fundamental to being a person is to have autonomy and the ability to choose what to do with your life.[93] He explained:

> We've got to confront the reality of an older person in residential care with dementia and multiple disabilities who requires help to get through the day is still a person who has rights and they have the right to choose what they want to do, and they don't need to justify it to anyone. Our responsibility is to be reasonable in supporting them for their wish.[94]

Professor Ibrahim said that residents are grown-ups who can make their own decisions and that the duty of care ought to be supporting residents in their autonomy.[95]

Picking up on the point of risk and choice, Mr Gavshon said focusing on the choice rather than getting 'overburdened or over-focussed on the risk' is critical.[96]

Both Mr Rees and Ms Swaffer raised human rights considerations in the face of the aged care system's treatment of people who are living with dementia.[97]

91 Transcript, Joseph Ibrahim, Sydney Hearing, 16 May 2019 at T1784.19-20.

92 Transcript, Joseph Ibrahim, Sydney Hearing, 16 May 2019 at T1787.29-1790.28.

93 Transcript, Joseph Ibrahim, Sydney Hearing, 16 May 2019 at T1789.15-22.

94 Transcript, Joseph Ibrahim, Sydney Hearing, 16 May 2019 at T1805.34-44.

95 Transcript, Joseph Ibrahim, Sydney Hearing, 16 May 2019 at T1806.1-20.

96 Transcript, Jonathan Gavshon, Sydney Hearing, 14 May 2019 at T1600.43-45.

97 Exhibit 3-40, Sydney Hearing, Statement of Glenn Rees, 28 April 2019, WIT.0126.0001.0001 at 0005 [25], 0008 [44]-[45], 0013 [69], 0016 [81]; Transcript, Kate Swaffer, Sydney Hearing, 17 May 2019 at T1937.40-1940.47; Exhibit 3-84, Sydney Hearing, Statement of Kate Swaffer, 16 May 2019, WIT.0127.0001.0001.

Australian Government response

The evidence in the hearing suggests there may be linkages between inadequate knowledge about the needs of people living with dementia and resort to restrictive practices in aged care settings, comprising both physical restraint and inappropriate use of medicines.

We heard evidence on aspects of these issues from three witnesses from the Australian Department of Health and one witness from the Aged Care Quality and Safety Commission.[98]

The evidence from these witnesses outlined the Australian Government's dementia care policy, the process of development of recent amendments to the *Quality of Care Principles 2014* (Cth) concerning the use of restrictive practices, and the Aged Care Quality and Safety Commission's approach to monitoring compliance by approved providers with standards relating to the care for people living with dementia.[99]

The new amendments were prepared in urgent circumstances. On 17 January 2019, in response to media reports of restrictive practices in residential aged care, the Minister for Senior Australians and Aged Care issued a media release announcing better regulation relating to restrictive practices in residential aged care.[100] The Minister did not receive any formal recommendations from the Department about how such regulation might be strengthened before making this announcement.[101] On 24 January 2019, the Minister requested that the Chief Medical Officer, Professor Brendan Murphy, and the Department of Health convene a clinical advisory committee on the issue of restrictive practices in residential aged care to provide options 'as soon as possible'.[102] That committee was convened in February and March 2019. Over the same period, Assistant Secretary Amy Laffan of the Department of Health convened an industry key stakeholder group.[103] Following these steps, on 2 April 2019, the Minister made an instrument which inserted a new Part 4A in the Quality of Care Principles, with effect from 1 July 2019.[104]

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98 Dr Brendan Murphy, Australian Government Chief Medical Officer: Exhibit 3-55, Sydney Hearing, Statement of Brendan Francis Murphy, 14 April 2019, WIT.0129.0001.0001. Amy Laffan, Assistant Secretary, Aged Care Quality and Regulatory Reform Branch: Exhibit 3-78, Sydney Hearing, Statement of Amy Elizabeth Laffan, 18 April 2019, WIT.0105.0001.0001. Josephine Mond, Assistant Secretary, Dementia and Support Ageing Branch, Residential and Flexible Aged Care Division: Exhibit 3-79, Sydney Hearing, Statement of Josephine Mond, 18 April 2019, WIT.0144.0001.0001. Christina Bolger, Executive Director, Regulatory Policy and Performance, Aged Care Quality and Safety Commission: Exhibit 3-75, Sydney Hearing, Statement of Christina Mary Bolger, 18 April 2019, WIT.0106.0001.0001.

99 See also Transcript, Brendan Murphy, Sydney Hearing, 14 May 2019 at T1641.27-1671.46; Transcript, Christina Bolger, Sydney Hearing, 16 May 2019 at T1810.26-1836.30; Transcript, Amy Laffan, Sydney Hearing, 16 May 2019 at T1837.1-1868.20; Transcript, Josephine Mond, Sydney Hearing, 16 May 2019 at T1868.40-1881.22.

100 Exhibit 1-28, Adelaide Hearing 1, RCD.9999.0011.2033.

101 Transcript, Amy Laffan, Sydney Hearing, 16 May 2019 at T1848.40-43.

102 Exhibit 3-55, Sydney Hearing, Statement of Brendan Francis Murphy, 24 April 2019, WIT.0129.0001.0001 at 0002-0003 [9].

103 Exhibit 3-55, Sydney Hearing, Statement of Brendan Francis Murphy, 24 April 2019, WIT.0129.0001.0001 at 0002-0003 [9]-[11]; Exhibit 3-78, Sydney Hearing, Statement of Amy Elizabeth Laffan, 18 April 2019, WIT.0105.0001.0001 at 0008-0011 [45]-[51].

104 Added by the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth).

Senior Counsel Assisting asked the government witnesses about perceived shortcomings in the new provisions, including the workability of the definition of 'chemical restraint' and the laxity of the new provisions on the issue of consent relating to prescription of psychotropics and review of their use.[105]

Professor Murphy explained that the new provisions are not intended to impose on aged care providers any obligation to obtain or document the obtaining of consent for chemical restraint of or on behalf of a care recipient. He added that prescribing was a matter for which the relevant medical practitioner is responsible.[106]

Ms Laffan assessed the new provisions as having 'no more than minor impacts'.[107] Ms Laffan said that she does not expect a material reduction in rates of prescription of psychotropics as a result of the amendments.[108]

In Ms Laffan's oral evidence, she explained that her view of the scope of the definition of 'physical restraint' in the new provisions is such that any limitation on freedom of movement, including the use of keypad-secured doors, will be a physical restraint.[109] If this is correct, Ms Laffan accepted that there could be a change to the operations of many approved providers' operations.[110]

Christina Bolger, Executive Director, Regulatory Policy and Performance, Aged Care Quality and Safety Commission, said that while the Aged Care Quality and Safety Commission has authority to monitor the Aged Care Quality Standards, it would refer information to the Department of Health if the new provisions were not being met. Ms Bolger said that at present, the Aged Care Quality and Safety Commission could not technically monitor compliance with the 2019 Principles.[111] Ms Bolger said that the Aged Care Quality and Safety Commission's assessors cannot tell from observing residents who is being given psychotropics, and they do not review a sufficient number of medication records to form an accurate view of the use of psychotropic agents in any particular residential aged care facility.[112]

105 Transcript, Brendan Murphy, Sydney Hearing, 14 May 2019 at T1667.32-1668.47; T1669.33-1671.35.

106 Transcript, Brendan Murphy, Sydney Hearing, 14 May 2019 at T1663.29-43 and T1664.15-29.

107 Transcript, Amy Laffan, Sydney Hearing, 16 May 2019 at T1864.8-16; Exhibit 3-2, Sydney Hearing, General Tender Bundle, tab 113, CTH.1007.1006.4547.

108 Transcript, Amy Laffan, Sydney Hearing, 16 May 2019 at T1857.28-32.

109 Transcript, Amy Laffan, Sydney Hearing, 16 May 2019 at T1854.36-1855.6.

110 Transcript, Amy Laffan, Sydney Hearing, 16 May 2019 at T1857.32-1858.47.

111 Transcript, Christina Bolger, Sydney Hearing, 16 May 2019 at T1830.34-1831.21.

112 Transcript, Christina Bolger, Sydney Hearing, 16 May 2019 at T1817.45-1818-10; T1820.22-38.

Case studies

Introduction

At the Sydney Hearing the Royal Commission heard four case studies, each of which illustrated the challenges and complexities of providing residential aged care. Those case studies concerned claims of substandard residential care made by close relatives of four residents at different facilities:

- the experiences of Mr Terance Reeves during a period of residential respite care at Garden View Aged Care
- the experiences of a woman given the pseudonym CO at Brian King Gardens, a facility operated by Anglicare
- the experiences of a woman given the pseudonym CA at Oberon Village, a facility operated by Columbia Nursing Homes
- the experiences of a woman given the pseudonym DE at a facility in Willoughby operated by Bupa Aged Care Australia.

At the beginning of the hearing, Senior Counsel Assisting indicated that he would provide a set of written submissions for each case study setting out the findings he would invite the Commissioners to make. Parties with leave to appear at the hearing affected by those findings were given the opportunity to respond in writing to Counsel Assisting's submissions.

Senior Counsel Assisting explained that the evidence on which the case studies would fall to be determined would be the documents tendered in each case study and the oral evidence that was heard in that case study. The evidence under consideration in each case study would not extend to any other observations made by witnesses later in the hearing.

During the course of the hearing, Counsel Assisting referred to 'scenarios' that had been prepared and were put to experts later in the hearing. Of the evidence given by those experts in relation to the 'scenarios', Senior Counsel Assisting explained in his closing remarks:

> For the purposes of raising issues for expert comment, we, the counsel assisting team, prepared four scenarios comprising assumptions reflecting the issues which we saw as arising from each of the case studies that had been heard. Those scenarios did not name the approved providers.
>
> They were provided to the experts who gave evidence this week. None of the opinions expressed by the witnesses on those scenarios will be relied upon in any way to invite findings to be made in the case studies themselves. The scenarios were put to the witnesses to prompt observations about issues which appear to arise in relation to dementia and residential care. Commissioners, I refer again to the four case studies

> you heard. To be clear, we do not propose to rely on any of the opinions expressed by experts in relation to the scenarios for the purposes of your findings in the case studies. We ask you, Commissioners, not to take any such observations into account when you come to make your findings in the case studies in due course.[113]

In our role as Commissioners, we have adhered to the course proposed by Senior Counsel Assisting in his closing remarks. In coming to the conclusions and reaching the findings that follow, we have not had regard to any observations made by experts or other witnesses about the scenarios.

Garden View case study

Introduction

The Royal Commission examined the experience of Mr Terance (Terry) Reeves at the Garden View Nursing Home (Garden View) in Merrylands, New South Wales. Garden View is operated by Garden View Aged Care Pty Ltd (Garden View Aged Care). Garden View Aged Care has 72 allocated places.[114] As at 30 June 2018, there were 70 residents, 58 of whom had a diagnosis of dementia.[115]

The evidence before the Royal Commission consisted of:

- the statement of Lillian Reeves, Mr Reeves's wife, dated 26 April 2019[116]
- the statement of Michelle Lauren McCulla, Mr Reeves's daughter, dated 23 April 2019[117]
- the statement of Natalie Sonya Smith, Mr Reeves's daughter, dated 26 April 2019,[118] and a supplementary statement of Ms Smith, dated 3 May 2019[119]
- the statement of Jayanthi Kannan, a registered nurse at Garden View, dated 26 April 2019[120]

113 Transcript, Sydney Hearing, 17 May 2019 at T1945.27-40.

114 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 92, KLL.001.001.0006; Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 95, KLL.001.001.0061.

115 Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, 2 May 2019, WIT.0137.0001.0001 at 0009 [59].

116 Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001.

117 Exhibit 3-9, Sydney Hearing, Sydney Hearing, Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001.

118 Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 26 April 2019, WIT.0147.001.0001.

119 Exhibit 3-11, Sydney Hearing, Supplementary statement of Natalie Sonya Smith, 3 May 2019, WIT.0147.0002.0001.

120 Exhibit 3-12, Sydney Hearing, Statement of Jayanthi Kannan, 26 April 2019, WIT.0139.0001.0001.

- the statement of Kee Ling Lau, the Director of Nursing at Garden View, dated 2 May 2019,[121] and a supplementary statement of Ms Lau, dated 6 May 2019[122]
- the statement of Dr Miles Burkitt, a general practitioner who attended on Mr Reeves at Garden View, dated 29 April 2019[123]
- the statement of Dr Kenneth Wong, a general practitioner who attended on Mr Reeves at Garden View, dated 1 May 2019[124]
- the oral testimony of those seven witnesses
- the tender bundle for this case study, which consists of 103 documents[125]
- two letters containing correspondence between the Co-Solicitor Assisting the Royal Commission and Sparke Helmore Lawyers, dated 2 May 2019 and 6 May 2019.[126]

Garden View Aged Care and its employees Ms Lau and Ms Kannan, along with Dr Wong, Dr Burkitt and Mr Reeves's family, were each granted leave to appear at the public hearing and were represented by counsel and solicitors.

In accordance with the directions we made on 30 May 2019, Counsel Assisting provided written submissions setting out the findings they consider should be made arising from this case study.[127] In response to those submissions, the Royal Commission received submissions from Garden View, Drs Wong and Burkitt, and Mr Reeves's family.[128] Garden View also provided submissions in response to the submissions of Mr Reeves's family.[129]

It is necessary to address, from the outset, certain submissions made by Garden View Aged Care.[130]

121 Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, 2 May 2019, WIT.0137.0001.0001.

122 Exhibit 3-16, Sydney Hearing, Supplementary statement of Kee Ling Lau, 6 May 2019, RCD.0011.0024.0001.

123 Exhibit 3-13, Sydney Hearing, Statement of Dr Miles Burkitt, 29 April 2019, WIT.0146.0001.0001.

124 Exhibit 3-14, Sydney Hearing, Statement of Dr Kenneth Wong, 1 May 2019, WIT.0145.0001.0001.

125 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle.

126 Exhibit 3-17, Sydney Hearing, RCD.9999.0041.0001; Exhibit 3-18, Sydney Hearing, RCD.9999.0042.0001.

127 Sydney Hearing, Submissions of Counsel Assisting, 31 May 2019, RCD.0012.0004.0033.

128 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308; Sydney Hearing, Submissions on behalf of Dr Miles Burkitt and Dr Kenneth Wong, 11 June 2019, RCD.0012.0007.0001; Sydney Hearing, Submissions of Reeves family, 7 June 2019, RCD.0012.0007.0051.

129 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Reeves family, undated, GVN.001.002.0236.

130 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308; Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Reeves family, undated, GVN.001.002.0326.

Garden View Aged Care raised various concerns about procedural matters that arose in relation to the Sydney Hearing. Specifically that:

- It was denied procedural fairness by reason of not having received notice of allegations made against it in the terms used in Counsel Assisting's opening address.[131]
- It was denied procedural fairness concerning statements made and evidence elicited outside the hearing of the case study on 6 and 7 May 2019.[132]
- Notwithstanding that the case study was closed on 7 May 2019 and its counsel excused from further attendance, Counsel Assisting later 'reopened' the case study without notice, calling 'purportedly relevant witnesses' and adducing 'evidence bearing adverse matters and allegations', occasioning procedural unfairness.[133]
- It had not been served with a copy of the Reeves family submission dated 7 June 2019 but had found this document itself on the online Court Book, and this was 'yet another example of those assisting the [Royal] Commission failing to afford procedural fairness to Garden View'.[134]
- Counsel Assisting appeared 'unable to bring an open mind'.[135]
- There was a reasonable apprehension of bias on our part.[136]

Garden View Aged Care submitted that:

- we should exclude from our consideration and any subsequent publication any direct or indirect reference to Garden View emanating from the expert and policy panels
- we should not adopt the findings advocated by Counsel Assisting in submissions dated 31 May 2019 in particular that Mr Reeves was mistreated and was the victim of deconditioning caused by the use of physical restraints
- we should (or perhaps could) otherwise make no adverse findings against Garden View Aged Care.[137]

131 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0313 [16].

132 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0309-0311 [7]-[13].

133 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0311 [13a].

134 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0326 at 0326 [1]-[2].

135 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0312 [14].

136 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0311 [13b].

137 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0309 [5a]-[5c].

At the outset, we note that the first of Garden View Aged Care's proposals outlined above—that in making findings in this case study we should exclude from consideration any evidence from the expert and policy panels—is consistent with the course advanced by Senior Counsel Assisting in his closing address.[138] We have adhered to that course.

We have considered Garden View Aged Care's submissions carefully. We consider that, having reviewed the procedural steps that have been taken as a whole, Garden View Aged Care has been given fair notice of the issues that adversely affect its interests and has had a fair opportunity to present evidence and make submissions on those issues.

We conclude that Garden View Aged Care has not been denied procedural fairness in relation to the questions arising for our determination in the case study, and do not consider that any reasonable apprehension of bias arises. We do not consider we are precluded from making findings in the case study that might be regarded as adverse to Garden View Aged Care.

Background

Mr Reeves was born in 1946.[139] On 18 October 1974, Mr Reeves married his wife, Lillian.[140] Together they have three children, Michelle McCulla, Natalie Smith and Ian Reeves.[141]

Mr Reeves worked for 40 years as a technician with Telstra. He took a redundancy to 'start a simpler life' and joined Mrs Reeves working at Kings Safety Wear. In October 2009, they both retired. They had a dream to travel Australia.[142]

In 2010, Mr Reeves was diagnosed with Alzheimer's disease.[143] In the first three years after his diagnosis, things were good. Mr and Mrs Reeves did a lot of travelling—they had to 'hurry it along'.[144]

Mrs Reeves told us that about five years after his diagnosis, Mr Reeves's ability to function significantly declined.[145] He remained in the two-storey family home in the care of Mrs Reeves.[146] Mr Reeves came to be reliant on his wife and family for assistance.[147]

From 1 May 2018 to 7July 2018, Mr Reeves stayed at Garden View as a residential respite care recipient.

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138 Transcript, Sydney Hearing, 17 May 2019 at T1945.27-40.

139 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0001 [5].

140 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0001 [6].

141 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1202.21-35 and T1203.39-47

142 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0001 [7].

143 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0001 [8].

144 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1203.17-19.

145 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1203.19-20.

146 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1203.28-37.

147 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0001 [9].

Assessment for respite care

In February 2018, Mrs Reeves was making plans to travel overseas with her sister and brother-in-law. She needed to place Mr Reeves in residential respite care in order to go. Mrs Reeves had not had a break during the many years she had been caring for Mr Reeves at home. She thought respite would be a good opportunity for Mr Reeves to have a break from her and for her to have a break.[148]

On 21 February 2018, Mr Reeves was assessed by an aged care assessment team (ACAT).[149] The ACAT assessment report recorded that there was 'evidence of significant carer stress and the need for some residential respite'.[150]

Mr Reeves's ACAT assessment report recorded Mr Reeves's medical conditions as advanced Alzheimer's disease, depression and hypercholesteraemia.[151] Mr Reeves was assessed as:

> independent in mobility, transfers and toileting, but otherwise is dependent on Lillian for all activities of daily living and independent activities of daily living.[152]

According to the assessment, Mr Reeves's significant cognitive decline meant that 'he was unable to complete a sentence, hold a conversation or provide information'. Mr Reeves experienced some aggressive incidents and wandering behaviour, day and night reversal, and weight loss and reduced appetite.[153]

Mr Reeves was recommended as eligible for a high-priority Level 4 Home Care Package, permanent residential care and respite care at a high level. If either permanent or respite residential care were to be considered, the assessment determined that Mr Reeves needed 'the skills and contained environment of a specialized dementia unit'.[154]

In March 2018, Mrs Reeves started making arrangements for Mr Reeves to enter respite care. Mrs Reeves made contact with Garden View. She arranged for about two months of residential respite care for Mr Reeves from 1 May to 30 June 2018.[155]

148 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1206.21-25.

149 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 7, CTH.4001.0004.6799.

150 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 7, CTH.4001.0004.6799 at 6800.

151 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 7, CTH.4001.0004.6799 at 6799.

152 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 7, CTH.4001.0004.6799 at 6800.

153 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 7, CTH.4001.0004.6799 at 6780-6801.

154 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 7, CTH.4001.0004.6799 at 6801.

155 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 13, GVN.0001.0001.1268.

This was a difficult decision for Mrs Reeves and her family. She was concerned about how Mr Reeves would cope.[156] Mrs Reeves planned to go overseas at the end of May after an interim period of some weeks after Mr Reeves' admission to allow him to settle in.[157] Ms McCulla, Ms Smith and Mr Ian Reeves agreed with Mrs Reeves that they would visit their father regularly.[158]

Admission to Garden View

Mrs Reeves and Ms Smith brought Mr Reeves to Garden View on 1 May 2018. He was admitted to residential respite care.[159]

The Royal Commission did not hear any comprehensive expert evidence about Mr Reeves's clinical condition at the time of his entry into Garden View.

Mrs Reeves and Ms McCulla each gave evidence that by the six-month period before May 2018, Mr Reeves needed help showering, dressing and eating.[160] But he could still use the toilet himself, talk with his family to some degree and make cups of tea.[161] He was mobile, walking and navigating the stairs at home without assistance.[162] He did not shuffle and had never fallen.[163]

On or about 15 March 2018, Mrs Reeves answered questions from staff at Garden View about Mr Reeves's care needs. Some of her responses were written in a 'Database Admission Form'.[164]

We accept both Mrs Reeves's and Ms McCulla's evidence about Mr Reeves's care needs in the six months prior to May 2018. Subject to what we say below, we accept that the Database Admission Form is also broadly accurate.

The Database Admission form recorded Mr Reeves as being occasionally 'incontinent of urine, incontinent of faeces'.[165] Mrs Reeves gave evidence that those references are incorrect.[166] Mrs Reeves said that Mr Reeves did not 'go in being incontinent'. She

156 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1207.18-32.

157 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1207.9-16; Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0001 [9].

158 Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0002 [14].

159 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0002 [12].

160 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1204.14-26; Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0001 [7]. Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0001 [9].

161 Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0001 [6]-[7]; Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1203-1204.

162 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0001 [9].

163 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1215.1-13.

164 Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0001 [8]; ranscript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1207.9-16.

165 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 9, GVN.0001.0001.0146 at 0148.

166 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1210.29-42.

believes it is something 'they've put down themselves'. Mr Reeves did, she explained, need reminding about where the toilet was.[167] However, once he was there 'he would take care of himself and it was fine'.[168]

On balance, we consider the description of Mr Reeves as occasionally incontinent to be reasonable. We do not consider he could otherwise be fairly described as 'incontinent'.

The Database Admission Form also recorded that Mr Reeves was 'on depressant medication'.[169] Again, Mrs Reeves gave evidence that this is incorrect. She said Mr Reeves had never been on antidepressants.[170] We accept Mrs Reeves's evidence about this. There is no evidence to suggest Mr Reeves was taking any antidepressant medication.

At the time of Mr Reeves's admission on 1 May 2018, his only regular medication was 24mg of Galantamine at night. This was recorded on Mr Reeves's admission notes by Dr Kenneth Wong, Garden View's visiting medical practitioner.[171] Mr Reeves was taking Galantamine to address the progression of his dementia.[172]

On 1 May 2018, Dr Wong assessed Mr Reeves as requiring 'normal nursing care'.[173] Dr Wong told us that Mr Reeves's mobility was good.[174] We accept this evidence.

It was recorded on Mr Reeves's progress notes, also on 1 May 2018, 'that he tends to wander around'.[175] Yet no behavioural issues were noted on the 1 May 2018 respite care plan and assessment form for Mr Reeves.[176] Ms Kee Ling Lau, a registered nurse and the Director of Nursing at Garden View, gave evidence that they should have been.[177] We agree.

Behaviour management strategies should have been noted in Mr Reeves's care plan at the time of his admission. We are concerned by this omission, which suggests that staff at Garden View might not have been as prepared as they could have been to address Mr Reeves's care needs relating to behaviours associated with his dementia.

167 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1210.29-42.

168 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1204.30-36.

169 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 9, GVN.0001.0001.0146 at 0149.

170 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1210.45-1211.1.

171 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 65, GVN.0001.0001.0648 at 0648.

172 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1204.40-41.

173 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 65, GVN.0001.0001.0648 at 0648.

174 Transcript, Kenneth Wong, Sydney Hearing, 7 May 2019 at T1295.16-18.

175 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0278.

176 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 13, GVN.0001.0001.1268 at 1269.

177 Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, 2 May 2019, WIT.0137.0001.0001 at 0012 [78].

Physical restraints and the use of risperidone

Mr Reeves's progress notes record that he was very unsettled from the outset and remained so during his time at Garden View. He wandered at night unless diverted by nursing staff, then was drowsy during the day as a result of day-night reversal.[178]

Use of restraints on Mr Reeves

The primary issue in this case study was the use of physical restraints on Mr Reeves while he was at Garden View. The question of consent to the use of the antipsychotic medication risperidone is also in issue.

Garden View Aged Care's policy manual, which was in place at the time Mr Reeves was in Garden View's care, provides a definition of physical restraint:

> 'Physical restraint' is the intentional restriction of a person's voluntary movement or behaviour by the use of a device or physical force for behavioural purposes. Restraints may include lap belts, table tops, bed rails, water chairs and tub chairs that are difficult to get out of.[179]

Risperidone prior to Garden View

Risperidone is an antipsychotic medication with various side effects including potential drowsiness and risk of falls.[180]

Mrs Reeves gave evidence about Mr Reeves's experience with risperidone in the period before he was admitted to Garden View.

She told us that she had a prescription for Risperdal, a form of risperidone. She gave it to Mr Reeves on one or two occasions when he was upset, but found it made him 'quite drowsy'. Mrs Reeves did not 'think it worked too well for him'. On one occasion she gave him a full tablet. She said he was 'almost unconscious' afterwards so she 'never did that again'.[181] She told her daughters about this.[182]

Mrs Reeves's evidence was that she did not tell Garden View that she sometimes gave Mr Reeves half a tablet of risperidone if he was upset.[183] However, there is a note in Mr Reeve's progress notes made on the evening of 1 May 2018 which suggests otherwise.

178 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278; Transcript, Dr Kenneth Wong, Sydney Hearing, 7 May 2019 at T1297.24-34.

179 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1236.

180 Transcript, Miles Burkitt, Sydney Hearing, 7 May 2019 at T1288.3-32.

181 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1205.15-43.

182 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1206.9-16.

183 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1212.44-47.

The registered nurse on duty that night was Ms Jayanthi Kannan. At 10pm on 1 May 2018, Ms Kannan made a note in Mr Reeves's progress notes.[184] The note said:

> Resident remains awake & wandering. Received phone call from wife and daughter. Wife informed the above. Wife said at home when he is really restless she gives Risperidone 5mg ½ tab tds. Written in LMO's book to r/v. Staff brought him out to the nurse's station as resident doesn't like to stay in his room.
> J Kannan (RN).[185]

There is a dispute about who Ms Kannan spoke with that night. Ms Kannan believes that she spoke with Mrs Reeves. Ms McCulla says she spoke with a nurse at Garden View that night. Mrs Reeves said she did not.

Ms McCulla gave evidence that she made a telephone call to Garden View on the evening of 1 May 2018 to check how her father was 'settling in on his first night'.[186] She said she spoke with a nurse who told her that her father was unsettled.[187]

Ms McCulla told us that the nurse asked whether her father had ever been given anything to settle his nerves. Ms McCulla said she told the nurse her father had previously been given half a tablet of risperidone, 'but it did not sit well with' him.[188] Ms McCulla continued:

> It didn't sit well with him, and as a family we had discussed that we didn't ever want to do that again. So to recommend that as a treatment in a home, absolutely would never have happened.[189]

Ms McCulla said that she was at her home with her family when she made the call to Garden View. It is Ms McCulla's evidence that she was not on the phone with her mother.[190]

Ms McCulla's evidence about the telephone call with Garden View was clear.

Senior Counsel Assisting asked Mrs Reeves about this matter. She said did not have any communication with Garden View after she and Ms Smith left Garden View that day. Her evidence that she did not tell staff at Garden View that she sometimes gave Mr Reeves half a tablet of risperidone when he was upset was clear. She said that she never gave consent in any form for Garden View to administer any risperidone to Mr Reeves.[191]

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184 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1263.16-18.

185 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0278.

186 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0002 [16]; Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1229.14-1230.25.

187 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0002 [16]; Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1229.14-24.

188 Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1229.14-21.

189 Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1230.10-12.

190 Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1230.14-25.

191 Transcript, Lillian Reeves, Sydney Hearing, 6 May 2019 at T1212.34-1213.23.

Ms Kannan also gave evidence. She believes that it was Mrs Reeves that she spoke with on the evening of 1 May 2018.

Senior Counsel Assisting put it to Ms Kannan that she mistook who she was speaking with and that the person she actually spoke with was one of Mr Reeves's daughters. Ms Kannan did not accept this. She believed there was a call from Mrs Reeves.[192] However, she did not have a clear recollection of the telephone call.[193]

Garden View Aged Care submitted that Mrs Reeves's recollection is likely to be incorrect and Ms Kannan's record in the progress notes is correct. Garden View Aged Care further submitted that the reference in those notes to Mr Reeves's wife and daughter might refer to two different telephone calls.

Mrs Reeves's evidence about these matters was clear and we accept it. Ms McCulla's evidence was similarly clear. We also accept her account.

On the evening of 1 May 2018, Ms McCulla spoke with the registered nurse on duty and told her that her mother had given Mr Reeves risperidone on occasions when he was very upset. She did not give consent for Garden View to administer risperidone.

The most likely explanation for the conflict between the evidence of Mrs Reeves and Ms McCulla on the one hand and Ms Kannan's entry in the progress notes on the other is that Ms Kannan's belief that she had spoken with Mr Reeves's wife (in addition to his daughter) that evening was mistaken. Ms Kannan's own account was that she did not have a clear recollection.[194] In reaching this conclusion, we do not suggest that Ms Kannan made a deliberate misrecording in her notes.

On the same evening, Ms Kannan wrote in an 'LMO communication book' to the visiting local medical officer (or LMO) that Mr Reeves was unsettled and wandering a lot and that 'wife said she give his Risperidone (0.)5mg ½ tab TDS (PRN) pls sign NIM'.[195] Certain text on the note was struck through with horizontal lines. The note, showing the horizontal lines, reads as follows:

> 1.5.18 Terance Reeves – unsettled, wandering ++
> Wife said she give him Risperidone 5mg [sic]
> ~~½ tab tds (PRN) wife given consent to chart~~
> ~~(Reg) Risperidone ½ tab (nocte) +~~ ½ tab tds (PRN)
> Pls sign ~~NIM~~[196]

192 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1263.29-45.

193 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1264.5-7; T1264.44-1265.1.

194 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1264.5-7; T1264.44-1265.1.

195 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 88, GVN.0001.0002.0286 at 0286; Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1265.34-1267.39.

196 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 88, GVN.001.002.0286 at 0286.

Ms Kannan explained that NIM stands for 'nurse initiated medication'.[197] She also explained that TDS stands for 'three times a day'.[198] PRN is an abbreviation of the Latin term *pro re nata*, meaning 'as needed'.

We understand that Ms Kannan's note in the LMO communication book is a request for the local medical officer to prescribe risperidone to Mr Reeves on an as needed basis, with the registered nurse having authority to decide when the medication is needed.[199]

The text that was struck through with horizontal lines in the note includes a statement that Mr Reeves's wife had consented to the charting of risperidone for regular administration 'nocte', meaning 'at night'.

Ms Kannan could not recall why she had written the text and why it appeared struck through with horizontal lines.[200] Senior Counsel Assisting suggested to Ms Kannan that she wrote the words, then thought she had made a mistake and crossed them out. Ms Kannan could not recall if this was the case.[201] To the extent that Garden View Aged Care submitted that this suggestion was not put to Ms Kannan, we reject that submission.[202]

No other explanation was advanced in the evidence before us, although a number of other potential explanations were advanced in post-hearing submissions by Dr Burkitt and Dr Wong, Garden View's local medical officers. They submitted that the state of the evidence is not sufficiently clear as to when the words were struck through. Garden View Aged Care submitted that it has not been established when and why the words were struck through with a horizontal line.

Senior Counsel Assisting submitted that we should find that it is most likely that Ms Kannan wrote the note in the LMO communication book after the phone call, realised that she had made a mistake because they did not reflect the content of the phone call, and so crossed them out. The Reeves family supported this finding.

However, the evidence is insufficiently clear for us to make that finding and we decline to do so. We accept the submissions of Drs Wong and Burkitt and of Garden View Aged Care in this regard.

We return to this issue of the struck through text when we come to events on 7 May 2018.

197 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1267.18-20.

198 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1264.38-40.

199 Transcript, Miles Burkitt, Sydney Hearing, 7 May 2019 at T1285.3-18.

200 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 88, GVN.0001.0002.0286 at 0286; Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1265.29-1267.29.

201 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at 1266.45-1267.1.

202 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0322 [40c].

Supervision of Mr Reeves and the East Wing

For several days following his admission, staff at Garden View provided close supervision over Mr Reeves. Such supervision included 1:1 care when he was unsettled. On 3 May 2018, progress notes by Ms Kannan record that Mr Reeves needed 1:1 care, and that he stayed at the nurses' station 'as he likes the company of other people'.[203]

On 4 May 2018, progress notes by Ms Kannan record that Mr Reeves was offered colouring-in books and a magazine, spat his dinner time medication out, and had a continence 'pad in situ'.[204]

Also on 4 May 2018, Garden View commenced a 'red alert' monitoring chart for Mr Reeves, which recorded that he was in East Wing from 13:30 to 18:30.[205] Garden View uses a red alert monitoring chart for residents who wander a lot.[206]

The East Wing is a secure area at Garden View for people living with dementia.[207] Since about 2000, Garden View has used the East Wing as a close monitoring unit for people living with advanced dementia. It has a maximum capacity of 12 residents.[208] During the period from late May to early July 2018, there were about six to eight residents there (other than Mr Reeves), all save one of whom were either bedridden or restrained.[209]

On 5 May 2018, progress notes by Ms Kannan record that Mr Reeves was, after being unsettled, being closely monitored, and was sitting in the nurses' station.[210]

From this point, it seems that Mr Reeves spent more and more time in the East Wing.

The Reeves family submitted that Garden View unlawfully confined Mr Reeves by placing him in the East Wing without necessary authorisations from a person able to consent.[211] This issue was not explored during the hearing of the case study. We decline to make a finding that Mr Reeves was unlawfully detained.

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203 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0279.

204 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0279.

205 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 67, GVN.0001.0001.0868 at 0870.

206 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1268.46-1269.12.

207 Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, 2 May 2019, WIT.0137.0001.0001 at 0007 [43].

208 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1308.23-40.

209 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0004 [38], disputed by Ms Lau on the basis of information from staff which, to the best of her recollection, was that only Mr Reeves was restrained: Transcript Kee Ling Lau, 7 May 2019 at T1309.3-5. Ms McCulla's direct evidence should be preferred.

210 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0279 at 0280.

211 Sydney Hearing, Submissions of Reeves family in reply to submissions of Counsel Assisting, 7 June 2019, RCD.0012.0007.0051 at 0051 [2]-[3].

First 'charting' of risperidone at Garden View

No risperidone accompanied Mr Reeves on his admission to Garden View.[212]

Mr Reeves's medical notes from 7 May 2018 record that he was 'wandering a great deal' and 'generally unsettled'. The notes further record 'Risperidone 0.5mg ½ TDS PRN NIM'.[213] Mr Reeves's prescriber order sheet records that Dr Burkitt 'charted' Mr Reeves half a tablet of 0.5mg risperidone three times a day as required for 'Behaviour/Unsettled'.[214]

About this, Dr Burkitt stated:

> I was advised at the time by the duty RN that the Resident had already been prescribed this by the Resident's doctor prior to arriving at the Garden View Nursing Home. However I was aware that this particular medication did not accompany him when he arrived at the facility. The circumstances surrounding the prescribing of this medication was that the Duty RN advised me that the Resident was extremely agitated, confused and wandering extensively. As I was advised that he was on Risperidone on a PRN basis at home, I determined that the medication was relevant to the prevailing situation and so I charted it.[215]

Dr Burkitt went on to state that he 'considered the re-charting of this existing medication would be worth a trial'.[216] The question of whether Dr Burkitt obtained appropriate consent to prescribe risperidone to Mr Reeves is in issue.

Part 5 of the *Guardianship Act 1987* (NSW) requires the informed consent of an individual's 'person responsible' in relation to the prescription and administration of a medication such as risperidone. Such consent cannot be implied. Ms McCulla told us that throughout the period Mr Reeves was at Garden View, Mrs Reeves was Mr Reeves's guardian.[217] In their submissions, Dr Burkitt and Dr Wong called into question the factual and legal basis to support a conclusion that Mrs Reeves was Mr Reeves's guardian.[218] However, we accept Ms McCulla's evidence that Mrs Reeves was Mr Reeves's guardian. Mrs Reeves, as Mr Reeves's guardian, was his 'person responsible'.

The prescription and administration of risperidone is medical treatment and major treatment for the purposes of Part 5 of the Guardianship Act, it being the administration of a restricted substance for the purposes of affecting the central nervous system within reg 10(1)(e) of the *Guardianship Regulation 2016* (NSW).

212 Exhibit 3-13, Sydney Hearing, Statement of Dr Miles Burkitt, 29 April 2019, WIT.0146.0001.0001 at 0002 [11].

213 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 65, GVN.0001.0001.0648 at 0649.

214 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 69, GVN.0001.0001.1260 at 1262.

215 Exhibit 3-13, Sydney Hearing, Statement of Dr Miles Burkitt, 29 April 2019, WIT.0146.0001.0001 at 0002 [11].

216 Exhibit 3-13, Sydney Hearing, Statement of Dr Miles Burkitt, 29 April 2019, WIT.0146.0001.0001 at 0003 [17].

217 Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1227.42-1228.1.

218 Sydney Hearing, Submissions on behalf of Dr Miles Burkitt and Dr Kenneth Wong, 11 June 2019, RCD.0012.0007.0001 at 0002-0003 [6]-[9].

Before risperidone can be prescribed and administered, consent in writing from the person responsible must be sought.[219] A request for consent must be accompanied by information specifying the condition requiring treatment, alternative courses of treatment for the condition, the general nature and effect of the treatments, the degree and nature of significant risks, and the reasons for the proposed treatment.[220]

Dr Burkitt did not seek consent from Mr Reeves's 'person responsible' before making this prescription. Dr Burkitt said he interpreted what was recorded in the LMO communication book on 1 May 2018 as consent.[221]

It is on this issue that the question of the timing of the striking through with a horizontal line of the words 'wife's consent' in the LMO communication book assumes some importance.

We accept that if the words were not struck through at the time Dr Burkitt decided to prescribe risperidone, it could have been understood that he had the express consent of Mrs Reeves to prescribe and administer risperidone to Mr Reeves.

Dr Burkitt, Dr Wong and Garden View Aged Care submit that we cannot be satisfied that the words were struck through before Dr Burkitt decided to prescribe risperidone on 7 May 2018.

We accept that it is possible that at the time Dr Burkitt decided to prescribe risperidone, the words 'wife's consent' appeared.

However, it is clear from the evidence before us that the information recorded by Ms Kannan in LMO communication book contained two significant errors. The first error is relates to the identity of the family member who had referred to risperidone. The second error relates to the substance of what had been said. These errors resulted in Mr Reeves being prescribed risperidone without the consent of the person responsible.

As we have said above, Ms McCulla did not provide consent, implied or otherwise, to the prescription or administration of risperidone. Instead, she simply advised that her mother had given Mr Reeves risperidone on occasions when he was very upset.

Consent to administration of psychotropic treatment by residential aged care facility cannot be implied or inferred from the mere fact that a family member may have had a prescription to administer that psychotropic treatment. These are two very different things. The question whether the 'person responsible' wishes to extend such authority to the residential aged care facility will depend on a range of factors, including the degree of familiarity that facility has with the person receiving care and the degree of trust the person responsible feels toward the nursing staff of the facility.

219 *Guardianship Regulation 2016* (NSW), regs 12(2) and 13(2).

220 *Guardianship Act 1987* (NSW), s 40(2).

221 Transcript, Miles Burkitt, Sydney Hearing, 7 May 2019 at T1286.18-19.

We do not accept the suggestion that seemed to be made by Ms Lau in her evidence that consent could be implied from the telephone conversation which took place on 1 May 2019 between Ms Kannan and Ms McCulla.[222] We also do not accept Dr Burkitt's and Dr Wong's submissions on this point, which were to similar effect.[223]

Ms Kannan's note of the conversation in the progress notes does not evidence informed consent in accordance with the Guardianship Act for the prescription of risperidone.

We find that risperidone was prescribed to Mr Reeves without informed consent having first been obtained in accordance with the Guardianship Act. Following this prescription, risperidone was administered to Mr Reeves on a number of occasions without consent.

The failure to obtain informed consent is not attributable to Dr Burkitt in circumstances where we accept that the words 'wife's consent' may have appeared in the LMO communication book at the time he decided to prescribe risperidone and we have no way of knowing when those words were struck through.

That there is no clear answer about when the words 'wife's consent' were struck through in the LMO communication book underscores the unsatisfactory nature of the mode of communication and record keeping adopted in this case.

Dr Burkitt's evidence was that antipsychotic medications like risperidone have significant side effects. Those side effects include involuntary movements, drowsiness, and propensity to fall. It is important to obtain informed consent to the prescription of it.[224]

The mode of communication adopted between Garden View and Dr Burkitt did not reflect the importance of the subject matter. Dr Burkitt suggested in his evidence that the methodology of striking out contents of the LMO communication book reflects a bad process and that if this practice was to occur, it should have been accompanied by clear notations showing who had done so, why and when.[225] We agree.

Physical restraints at Garden View

Garden View used physical restraints on some of its residents from time to time prior to Mr Reeves's admission on 1 May 2018. An assessment contact report of a visit by the Australian Aged Care Quality Agency from 22 January 2016 records an example:

> Staff interviews identified four care recipients require physical restraint which is monitored and recorded. Restraint authorisations are signed by medical officers and care recipients' nominated persons responsible. The home's policy states restraint authorisations need to be reviewed by the medical officers within a timeframe of

222 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1319.24-46.

223 Sydney Hearing, Submissions on behalf of Dr Miles Burkitt and Dr Kenneth Wong, 11 June 2019, RCD.0012.0007.0001 at 0014-0015 [57]-[58] and 0018 [71], [74].

224 Transcript, Miles Burkitt, Sydney Hearing, 7 May 2019 at T1288.3-33, 43-46.

225 Transcript, Miles Burkitt, Sydney Hearing, 7 May 2019 at T1287.1-9.

> 12 weeks. We reviewed three care recipients restraint documentation and identified they had not been signed by the medical officer within 12 weeks. The deputy director of nursing informed us they would review the home's systems to ensure restraint authorisations were current and reviewed in line with the home's policies.[226]

Ms Lau's evidence confirmed that Garden View employed physical restraints on some residents. She said that in 2017 Garden View experienced an escalation in the number of residents with what she referred to as 'challenging behaviour', leading to a peak number which Ms Lau could not recall. Ms Lau also said that from time to time about seven to nine residents were subjected to restraints.[227]

On 1 March 2017, Garden View's Clinical Nurse Educator sent an email to staff, including Ms Lau and Ms Kannan, stating 'Here are a few updates, please read carefully'. The email set out five numbered points and invited recipients to contact the author, Kim or Han if they required further information.[228] The reference to 'Kim' was a reference to Ms Lau.[229] Point 1 in the email said:

> 1. The residents in the central lounge if need to be restrained, please sitting [sic] them near the glass door side, it doesn't look nice when the visitors walk in and see resident been [sic] restrained.[230]

On 21 March 2017, Ms Lau forwarded the email, making specific reference to the email's attachments.[231]

Ms Lau denied having been aware of the content of point 1 of the 1 March 2017 email. She said that if she had been aware of it, she would have corrected it to ensure that residents under restraint were left in a visible location because, she said, 'when the residents are under restraint, they need to be supervised'.[232]

Senior Counsel Assisting put it to Ms Lau that it was likely that the clinical nurse educator raised the contents of point 1 with Ms Lau before sending the email. Ms Lau did not accept this.[233] Senior Counsel Assisting also put it to Ms Lau that she was supportive of the direction to move residents under restraint out of sight because she did not want to give the impression that there were too many residents under restraint at Garden View. Ms Lau did not accept this.[234]

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226 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 1, CTH.4001.0002.9898 at 9905.

227 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1304.22-31.

228 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 2, CTH.4001.1001.0442.

229 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1307.7-13.

230 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 2, CTH.4001.1001.0442.

231 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 2, CTH.4001.1001.0442.

232 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1305.32-42.

233 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1307.19-32.

234 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1308.6-21.

Ms Lau's evidence about these matters was unconvincing. We do not accept it. It is implausible that she was unaware of the contents of point 1 of the email of 1 March 2017, particularly in circumstances where she later forwarded the email.

First use of physical restraints on Mr Reeves

In the period May to July 2018, the written policy of Garden View concerning the use of restraints was that they could be used only as a last resort and with the written authorisation of both the resident's medical practitioner and the authorised representative of the resident.[235]

When Ms McCulla visited her father on 8 May 2018, she found him physically restrained by what she described as a 'blue restraint/lap belt'.[236]

Progress notes written by Ms Kannan later that day stated that Mr Reeves had shown disruptive behaviour, including naked intrusion into other rooms, was 'aggressive and put his fist in the air' and that staff walked him back to his room.[237]

On that day, staff used the word 'aggressive' when explaining the use of the restraints to Ms McCulla. When Ms McCulla asked whether this meant that Mr Reeves had tried to hit someone, she was told 'no, he was yelling to stop it and he wasn't cooperating'.[238]

There was no authorisation of any kind in place for physical restraint to be applied to Mr Reeves, and no record of this use of restraint was made in a restraint chart, progress notes, or any other record produced by Garden View to the Royal Commission.

Garden View Aged Care submitted that Mr Reeves's restraint was justified by an emergency and that Garden View was in the process of moving to the reduction and elimination of the use of restraints, represented by a change in its policy on 11 July 2018.[239]

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235 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1232 and 1236-7.

236 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0003 [24]; Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1231.29-1232.10. We note that Garden View Aged Care's submissions, GVN.0001.002.0308 at 0313 [17] and footnote 8, and Ms Lau's first statement (Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, 2 May 2019, WIT.0137.0001.0001 at 0009 [56]) refer to a serious risk decision made by the Aged Care Quality and Safety Commission, which is Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 58, CTH.1006.1001.0056. In this decision, the Quality and Safety Commission stated (at 0058) that a pelvic restraint and not a lap belt had been applied to Mr Reeves. For present purposes, it does not matter whether the type of restraint applied was more correctly to be described as a pelvic restraint or a lap restraint, or if a combination of the two was applied over the period of Mr Reeves' respite. The effect of both was to restrain him to his chair by a device in immediate contact with his body.

237 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0279 at 0281.

238 Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1231.29-1232.10.

239 Sydney Hearing, Submissions of Garden View Aged Care Pty Limited in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0320 [39](b).

There are references in the progress notes to Mr Reeves being restless and at various times during the day having entered other rooms, having urinated on the floor, having removed his clothes, and having been 'aggressive' and putting his fist up in the air. Ms Kannan recalled some of these notes as she read through them.[240]

We do not accept that these circumstances described in the notes and by Ms Kannan amounted to an 'emergency' justifying physical restraint under the policies then in place at Garden View.

We do not accept that there was an emergency of any kind, and certainly not one sufficient to justify physical restraint by lap or pelvic belt.

During the previous week, when Mr Reeves had been unsettled after his arrival, Garden View had provided 1:1 care to him without the need to resort to restraint. Further, Garden View did not seek the intervention of Dementia Behaviour Management Advisory Service or the Severe Behaviour Response Team on 8 May 2018, or at any other point.[241]

Ms Lau stated that Garden View 'resolved to pursue a goal of a no-restraints facility'. She said training was provided to staff about restraint free environments on 11, 12 and 13 July 2018.[242]

It is clear that Garden View's resolution came too late for Mr Reeves. It evidently did not prevent the use of restraints on him on 8 May 2018 and on the majority of the remaining days he spent at Garden View thereafter.

After Ms McCulla found Mr Reeves restrained on 8 May 2018, she had a discussion with a female staff member about restraints. These matters were recounted in her statement.[243] Her statement was provided to Garden View Aged Care before Ms Kannan's and Ms Lau's statements were provided to the Royal Commission.

Ms Kannan was on duty on the afternoon shift at Garden View on 8 May 2018.[244] Neither she nor Ms Lau responded in their statements to Ms McCulla's statement about Mr Reeves being restrained on 8 May 2018.

Senior Counsel Assisting put it to Ms Kannan during her oral evidence that Mr Reeves had been restrained on 8 May 2018 and that it appeared from Ms McCulla's evidence that Ms Kannan had known about this on the day. Ms Kannan accepted that Mr Reeves had been restrained, but said that 'nurses' had done this without her approval and she reported it to 'management'.[245]

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240 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1270.22-41.

241 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1316.25-44.

242 Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, dated 2 May 2019, WIT.0137.0001.0001 at 0007 [40].

243 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0003 [24]-[27].

244 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1270.15-1271.13.

245 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1270.39-45; T1271.10-13; or assistants in nursing, see Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0320 [39](b)(i).

Senior Counsel Assisting asked Ms Lau about this. She said that listening to Ms Kannan's evidence was the first she had heard of it.[246]

The evidence from Ms Kannan and Ms Lau on this point is concerning: no report of the application of physical restraints without prior consent or authorisation by the registered nurse on duty ever reached the director of nursing, Ms Lau.

Continued use of physical restraints on Mr Reeves

Physical restraints continued to be used on Mr Reeves during his time at Garden View.

On 8 May 2018, risperidone was administered at 19:00 with no effect.[247] Risperidone was administered to Mr Reeves on an as needed basis on several more of the days that followed.[248]

There is evidence that physical restraints were applied to Mr Reeves on at least one other occasion before any form of consent was given by Mrs Reeves.

On 11 May 2018, Ms Smith visited her father and found him restrained by a lap belt, which Ms Smith removed.[249] She said a nurse approached her and said, 'I need to talk to you, we have some forms for you or your Mum to sign.'[250] Ms Smith told the nurse she 'would deal with the forms at the end of the visit'.[251]

When Ms Smith was leaving that day, a nurse gave her a form authorising physical restraint. Ms Smith said that the nurse told her she had to sign the form and that restraint would only be used for short periods. Ms Smith did not feel comfortable signing the form. She took it home and telephoned her mother about it.[252]

On 12 May 2018, Ms Smith and Mrs Reeves met and spoke at length about the issue of the restraint authorisation form. It is unclear whether Ms Smith handed over the form she had brought from Garden View the previous day. She did not see Mrs Reeves sign any form.[253]

246 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1317.16-30.

247 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0281.

248 On 9 May 2018 at 15:15, on 10 May 2018 twice, at 07:30 and 21:45, and on 15 May 2018 at 12:30. See Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0282-0283.

249 Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 26 April 2019, WIT.0147.0001.0001 at 0001-0002 [10].

250 Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 26 April 2019, WIT.0147.0001.0001 at 0002 [10]; Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0003 [29].

251 Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 26 April 2019, WIT.0147.0001.0001 at 0002 [10].

252 Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 26 April 2019, WIT.0147.0001.0001 at 0002 [11]-[16]; Exhibit 3-11, Sydney Hearing, Supplementary Statement of Natalie Sonya Smith, 3 May 2019, WIT.0147.0002.0001 at 0001 [4].

253 Exhibit 3-11, Sydney Hearing, Supplementary Statement of Natalie Sonya Smith, 3 May 2019, WIT.0147.0002.0001 at 0001 [4]; Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1214.14-43.

On 13 May 2018, Mrs Reeves attended Garden View before leaving for her overseas trip. She gave evidence that she spoke with the registered nurse on duty, who gave her a form to authorise physical restraint and went through it with her.[254]

Mrs Reeves gave evidence that the registered nurse told her that restraint would be applied only as a last resort for Mr Reeves's safety, such as during handovers and mealtimes, and for no more than 30 minutes.[255]

Mrs Reeves said she then signed the form, initially in the wrong place and then in the correct place, but omitted to fill in the field identifying her relationship to Mr Reeves. Mrs Reeves gave evidence that the nurse signed her own name as witness and dated it, and then said 'I will just fill in this relationship', referring to the relationship section of the form and that she would put in 'wife'. To this, Mrs Reeves said 'fine'. The nurse then took the form away.[256] The form stated:

> Restraints in any form are not recommended. However, sometimes residents can exhibit behaviour that may place them at risk and harm. In that event chemical, environmental or physical restraint may be necessary. This form is only to be completed and signed if all other methods of protecting the resident have been tried and failed. The authorisation will be reviewed by the LMO at predetermined intervals of not more than twelve weeks.[257]

The form of restraint ticked on the form was 'belt/lap restraint', the reason was 'danger to self and others', and the conditions were that it would be applied 'Under the supervision and recommendation of Registered Nurse'.[258]

Ms Kannan was the registered nurse on duty from 2.30pm on 13 May 2018. She does not remember speaking with Mrs Reeves and does not think she gave her the form.[259]

Ms Kannan did not recall the discussion she had with Mrs Reeves on this occasion and did not believe that she would have said things attributed to her by Mrs Reeves's account.[260]

Garden View Aged Care submitted that a miscommunication or misunderstanding must have occurred, possibly as a result of information provided by Ms Smith to Mrs Reeves.[261]

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254 Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0002 [16]-[17]; Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1215.29-1218.6.

255 Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0002 [16]-[17]; Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1215.34-1218.6.

256 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1217.42-1218.6.

257 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 21, GVN.0001.0001.1270.

258 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 21, GVN.0001.0001.1270.

259 Exhibit 3-12, Sydney Hearing, Statement of Jayanthi Kannan dated 26 April 2019, WIT.0139.0001.0001 at 0003 [12].

260 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1271.36-1272.21.

261 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0319 [38].

We accept Mrs Reeves's account. Mrs Reeves gave clear evidence about the conversation whereas Ms Kannan did not recall the event at all.[262] Further, Mrs Reeves's account is consistent with the documentary evidence. Ms Kannan's handwriting appears where she signed as witness to Mrs Reeves signing the form, and where the word 'wife' appears alongside Mrs Reeves's signature on the form.[263]

As set out above, the relevant written policy of Garden View provided that restraint would be applied as a 'last resort'.[264] Garden View had not at this time, nor did it at any time, seek advice from the Dementia Behaviour Management Advisory Service (DBMAS) or intervention by a Severe Behaviour Response Team in relation to the care of Mr Reeves.[265] The rostering policy of the facility permitted further staff to be put on during a shift if needed for special reasons, but Ms Lau explained in her evidence that 1:1 care was only affordable for a limited time of around 4.5 hours per resident per day.[266]

Garden View Aged Care submitted that we cannot be satisfied that restraint was applied on each and every occasion to Mr Reeves in breach of the policy of Garden View to apply physical restraint only as a last resort, and that to take that view would be to 'entirely misunderstand the working environment of those within an aged care facility'.[267] We reject this submission.

The fact that Garden View did not, at any time, seek assistance from DBMAS or a Severe Behaviour Response Team alone leads us to conclude that on each and every occasion Garden View applied restraints to Mr Reeves, they were not applied as a 'last resort'. Further, and in any event, the extent and frequency with which restraints were applied, a point we address in detail below, constitutes a course of conduct which could not be described as consistent with restraints being applied as a 'last resort'.

Mr Reeves was physically restrained on multiple days between 14 and 28 May 2018. It is not possible to establish the frequency and duration of periods of restraint, because no restraint chart was provided in response to the notice from the Royal Commission for any date prior to 28 May 2018.[268] Ms McCulla gave evidence that a staff member of Garden View later told her that earlier restraint records had been lost.[269] We accept that this is probably what occurred.

262 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1273.16-27.

263 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1272.32-35.

264 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1232.

265 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1316.25-44.

266 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1315.28-30; T1316.20-23.

267 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0319 [39].

268 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0283-0284; Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0004 [33] and [36]; Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 26 April 2019, WIT.0147.0001.0001 at 0002 [17].

269 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0004 [34].

On 14 May 2018, Mr Reeves's progress notes and red alert monitoring chart record that Mr Reeves was restrained in the dining room.[270] Ms McCulla's husband visited on this day and found Mr Reeves restrained in the East Wing.[271]

On 15 May 2018, Dr Wong was informed by senior nursing staff that they were concerned about the continued wellbeing of Mr Reeves, that he was not settling into his new environment, that he was wandering around the nursing home and getting agitated with staff, and that he appeared to be in some distress at these times.[272] The nursing staff informed Dr Wong that the low dose of Risperidone was not effectively managing his distress, his wandering or his behaviour and that the wandering was creating a risk of falling.[273]

Dr Wong gave evidence that he observed Mr Reeves and could see that he was walking along the corridor in a confused state. Dr Wong tried to speak with Mr Reeves but Mr Reeves was too confused to engage.[274] Dr Wong determined that it was in Mr Reeves's best interests and for the sake of safety that his Risperidone dose was increased and that he have a belt restraint applied when the nursing staff formed the view that it was required.[275]

Dr Wong explained that he assumed that it would only be used as a last resort. When Senior Counsel Assisting asked him explain what this meant, Dr Wong accepted that 1:1 care could have been used to prevent falls risk to Mr Reeves without applying restraints.[276]

Dr Wong did not discuss any limitation on the period of time for which a belt restraint could be applied.[277] Dr Wong prescribed risperidone 0.5mg as a regular medication to be taken at night on the basis of information from nursing staff to the effect that Mr Reeves had heightened confusion and agitation in the evening, and signed a note in Mr Reeves's medical notes that he authorised belt restraint.[278]

Dr Wong prescribed the increased regular dose of Risperidone without seeking or obtaining any consent from an authorised representative or family member.[279] There was no communication by staff of Garden View with a family member about the change in dosage of Risperidone.[280] In considering whether Dr Wong should have done more, we note he was a visiting doctor, not a member of staff of Garden View.

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270 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0283; Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 67, GVN.0001.0001.0868 at 0876.

271 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0004 [35].

272 Exhibit 3-14, Sydney Hearing, Statement of Dr Kenneth Wong, 1 May 2019, WIT.0145.0001.0001 at 0002 [M].

273 Exhibit 3-14, Sydney Hearing, Statement of Dr Kenneth Wong, 1 May 2019, WIT.0145.0001.0001 at 0002 [N].

274 Transcript, Kenneth Wong, Sydney Hearing, 7 May 2019 at T1297.24-28.

275 Exhibit 3-14, Sydney Hearing, Statement of Dr Kenneth Wong, 1 May 2019, WIT.0145.0001.0001 at 0002 [O].

276 Transcript, Kenneth Wong, Sydney Hearing, 7 May 2019 at T1300.11-24.

277 Transcript, Kenneth Wong, Sydney Hearing, 7 May 2019 at T1299.6-16, T1300.1-3.

278 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 65, GVN.0001.0001.0648 at 0649.

279 Transcript, Kenneth Wong, Sydney Hearing, 7 May 2019 at T1302.1-8.

280 Transcript, Natalie Sonya Smith, Sydney Hearing, 7 May 2019 at T1256.34-45.

Dr Burkitt gave evidence about the potential significance of cumulative doses of medications such as risperidone. When Senior Counsel Assisting took Dr Burkitt to the entry in the LMO communication book which referred to prescribing risperidone on both an as needed basis (PRN) and a regular dose, he said that he would not have prescribed both a PRN and regular dose, or not 'straightaway'. He said:

> DR BURKITT: Well, quite frankly I wouldn't have done it.
>
> MR GRAY: Okay. And why is that?
>
> DR BURKITT: Well, because these sorts of medications are really last resort medications, and you don't go flying into it straightaway. Half a tablet, which is .25 milligrams which is not quite what that message says there, but that's what it obviously meant, is to be given at the last resort. And to try and settle the resident down, it's important to take him for a walk, take him out to the garden, reassure him, toilet him, give some interaction with the local nursing home community, get the – the recreational officer to participate in having some activities done which would tend to even—even with quite severely demented people, sometimes it can settle them down.
>
> MR GRAY: And another reason is that these antipsychotic drugs such as risperidone have side effects; that's right, isn't it?
>
> DR BURKITT: Mmm.
>
> MR GRAY: What do they include?
>
> DR BURKITT: Well, there's quite a lot listed but I think in the context of where we are with this drowsiness and propensity to fall is very important, but there are other – there's quite a big list of side effects. I can't go into all of them here.
>
> MR GRAY: No.
>
> DR BURKITT: But there are a lot and some of them include involuntary movements and involuntary posture and things like that which is a problem.
>
> MR GRAY: And is it generally well known in the body of general practitioners that there is drowsiness and falls from risperidone?
>
> DR BURKITT: It is. It is, yes.[281]

Dr Wong knew that risperidone was associated with increased risks of falls. Senior Counsel Assisting suggested that it was illogical for Dr Wong to prescribe a lap belt restraint in light of falls risk at the same time as increased and regular risperidone. Dr Wong denied any lack of logic by explaining that the increased regular dose of risperidone was to be taken at night, when it might help Mr Reeves to sleep, in turn

281 Transcript, Miles Burkitt, Sydney Hearing, 7 May 2019 at T1287.46-1288.32

addressing Mr Reeves's drowsiness during the day.[282] So much may be accepted as a matter of Dr Wong's clinical judgement.

However, the fact remains that Dr Wong did not obtain consent for the regular dosage of risperidone. Nor did he turn his mind to obtaining it. Rather, he made certain assumptions, which he explained as follows:

> MR GRAY: Yes, on 15 May, or at any time before 15 May, did you turn your mind to the obtaining of informed consent from an authorised representative of Mr Reeves for prescribing him .5 milligrams risperidone nocte on a regular basis.
>
> DR WONG: The simple answer is no, I did not, but I made a couple of assumptions. One, it was previously prescribed already by Dr Burkitt and, second, the nursing – nursing staff inform me that the patient was already on it before he came to nursing home.
>
> MR GRAY: But you were informed that Mr Reeves was only on half a tablet of .5 milligrams - - -
>
> DR WONG: That's correct.
>
> MR GRAY: - - - PRN which means .25 milligrams risperidone PRN, and it's a different matter, I suggest to you, to prescribe risperidone on a regular basis, be it in the daytime or nocte, it's a different matter requiring informed consent for that matter. What do you say to that?
>
> DR WONG: That is your opinion and I got different opinion from that. I say – I already explain my answer. I gave it at night-time in the hope that he may get some sleep and hopefully he may reverse his sleeping pattern, and I hoped that would happen.[283]

Dr Wong and Dr Burkitt submitted that Dr Wong might have considered that the note in the LMO communication book of 1 May 2018 constituted consent.[284] But Dr Wong's evidence, set out above, leaves no room for this suggestion.

Dr Burkitt and Dr Wong submitted that there is no requirement under the Guardianship Act that consent needs to be obtained for every incremental adjustment of medication for which consent has already been obtained. They further submitted that there was implied consent apparent to Dr Wong on the basis that Dr Burkitt has prescribed it already and that, according to the nursing staff, 'the patient was already on it before him came to [the] nursing home'.[285]

282 Transcript, Kenneth Wong, Sydney Hearing, 7 May 2019 at T1297.20-34.

283 Transcript, Kenneth Wong, Sydney Hearing, 7 May 2019 at T1302.1-23.

284 Sydney Hearing, Submissions on behalf of Dr Burkitt and Dr Wong, 11 June 2019, RCD.0012.0007.0001 at 0021 [84].

285 Sydney Hearing, Submissions on behalf of Dr Burkitt and Dr Wong, 11 June 2019, RCD.0012.0007.0001 at 0021 [84].

We consider it significant that Dr Wong was informed that Mr Reeves was on a 0.25mg dose of risperidone as needed, and that he decided to prescribe a higher, regular dose.

Dr Wong and Dr Burkitt submitted to the effect that the Guardianship Act does not require additional consent for every incremental adjustment of medication for which consent has already been obtained. This may be correct, at least in certain circumstances.

However, based on the facts before us, it is our view that Dr Wong should have turned his mind to the question of obtaining informed consent for the prescribing of a regular 0.5mg dose of risperidone given that he had been informed that the status quo was 0.25mg to be administered as needed.

That Dr Wong had a clinical justification for prescribing a regular dose at night is not an answer to this. Clinical justification is not the same as consent.

As Senior Counsel Assisting suggested, it was a different matter for Mr Reeves to be prescribed a regular dose of risperidone as opposed to on an as needed dose. Separate informed consent was therefore required.

We do not accept the submissions on behalf of Dr Burkitt and Dr Wong on this point. The regular dosage of 0.5mg risperidone to be administered at night was prescribed on 15 May 2018 without consent.

The Reeves family submitted that Garden View 'procured the prescription of Risperidone for Mr Reeves and administered it to him not as a form of medical treatment, but as a form of chemical restraint', referring to the purpose of the Risperidone being to stop Mr Reeves 'wandering' and being disruptive in the perception of staff.[286] This issue was not explored with the relevant witnesses during the hearing of the case study. We decline to make the findings sought by the Reeves family.

Restraint chart

As we have already mentioned, there is no available restraint chart for the first 20 days from 8 May 2018, the point at which it is known that physical restraints were first used on Mr Reeves.[287] However, there is a chart covering the period 28 May 2018 to 7 July 2018. The chart was completed by assistants in nursing under the general supervision of a registered nurse.[288]

286 Sydney Hearing, Submissions of Reeves family, 7 June 2019, RCD.0012.0007.0051 at 0052, [4].

287 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1274.7-11.

288 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 61, CTH.4001.0004.6767; Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1324.31-1325.21.

Assistants in nursing completed the entries in those charts at the end of their shifts on the basis of their best recollection.[289] Garden View Aged Care relied on Ms Lau's supplementary statement in support of its submission that 'generally the restraint charts are not reliable'.[290] We do not accept that submission.

We find that over the 41 days for which restraint charts are available, they document that Mr Reeves was restrained on 39 days, in blocks of time varying from about 30 minutes to two hours at a time. The aggregate periods of physical restraint applied to Mr Reeves as charted in the 41 days covered by Garden View's restraint chart amount to more than six hours on at least 25 days, more than nine hours on 15 days, and more than 13 hours on five days.[291]

Ms Lau identified three occasions (the night of 30-31 May, a 30-minute period on 6 June, and 'long periods' during the night preceding 12 June) when progress notes refer to Mr Reeves being on a lounge on which Ms Lau stated he could not have been restrained.[292] These three occasions affected the reliability of four of the entries in the restraint chart. In addition, Ms Lau's supplementary statement refers to two other entries which she contends are inconsistent with records of a physiotherapy appointment and a record in progress notes that Mr Reeves was in a 'tub chair'.[293]

We accept that there is doubt as to whether Mr Reeves was restrained by lap belt during the periods identified by Ms Lau. However, accepting this does not lead us to conclude that the restraint chart is generally unreliable.

In light of the evidence that assistants in nursing generally completed charts of this kind at the end of their shifts, some inaccuracies might be expected. In general, however, the extent of time recorded in the entries each shift is likely to be approximately correct.

Assistants in nursing would have had no reason to exaggerate the times they record. Even if all six entries identified by Ms Lau are partially unreliable, the aggregate periods of physical restraint applied to Mr Reeves as charted in the 41 days covered by Garden View's restraint chart are unjustifiably long.

289 Transcript, Jayanthi Kannan, Sydney Hearing, 7 May 2019 at T1274.26-34; Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1324.31-33.

290 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0321 [39](c).

291 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 61, CTH.4001.0004.6767.

292 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1328.46-1329.33.

293 Exhibit 3-16, Supplementary statement of Kee Ling Lau, 6 May 2019, RCD.0011.0024.0001 at 0002-0003 [6]; Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1328.46-1332.41.

Garden View's policy on restraints

Ms Lau gave evidence that a policy manual in place at the time Mr Reeves was in Garden View's care provided 'some guidance on the use of restraints'.[294] The policy manual is in evidence before us. It states that physical restraints 'can only be used as a last resort where all other means to keep [residents] safe have failed'.[295] It goes on:

> Garden View Nursing Home strives to facilitate the dignity and autonomy of its residents to enhance their quality of life and to maximise their safety and independence. Garden View Nursing Home maintains that this can be achieved through the provision of a least restrictive environment, and therefore does not use physical or chemical restraint except in circumstances where all other alternatives have been determined as ineffective and/or inappropriate.[296]

The manual sets out the protocol for the use of restraints.[297] In particular, each resident is to be assessed on admission for behaviours that may pose a risk of injury or misadventure to themselves or others. Any identified behaviours will be discussed with the person responsible and the medical practitioner. Finally, it states:

> In the event that all possible strategies to minimise the risk of injury to self and/or others and/or misadventure are proven to be ineffective and/or inappropriate and a decision is made to use restraint as a management strategy then:
>
> - Written authorization for restraint will be obtained from the resident's medical practitioner utilising Restraint Authorisation Form.
> - Written agreement for the use of restraint will be obtained from the Person(s) Responsible utilising the Restraint Authorisation Form.[298]

The manual states that authorisations and agreements to use restraint should detail the reason for the restraint, the circumstance in which restrains may be used and the type of restraint.[299]

Garden View's use of physical restraints on Mr Reeves as documented in the restraint chart was in breach of its own policy on the use of restraints.

In her oral evidence, Ms Lau initially stated that there was no breach of Garden View's policy on the use of restraints, because 'the policy says that he can be restrained under emergency basis, but then it is very hard to demonstrate what is emergency basis'.[300]

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294 Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, 2 May 2019, WIT.0137.0001.0001 at 0009 [114].

295 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1232.

296 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1236.

297 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1237-1238.

298 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1237.

299 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 5, GVN.0001.0001.1175 at 1237.

300 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1310.1-3.

We do not accept that any emergency occurred on the evidence before us. In this respect, we refer to our findings about the use of restraint on Mr Reeves on 8 May 2018, above. We find that Garden View did breach its own policy, because on every occasion it was applied to Mr Reeves, physical restraint was not applied as a last resort.

Ms Lau, later in her evidence, accepted that Garden View did not do everything that it could have done to investigate other options for managing Mr Reeves's behaviours before imposing physical restraints on him, in that it did not seek advice from DBMAS for Mr Reeves and did not seek the intervention of the Severe Behaviour Response Teams for Mr Reeves.[301]

Further, another way in which Garden View could have done more before resorting to physical restraint would have been to commence a behaviour monitoring chart, as part of a systematic assessment of Mr Reeves's behaviours and what might be done to prevent them and look after him better. However, Garden View only commenced this on 20 May 2018, by which date restraints were already being used on Mr Reeves.[302]

In addition, on the occasions on which restraint was applied to Mr Reeves before 15 May 2018, it was applied without the authorisations required by Garden View's policy being in place—namely, without the consent of Mrs Reeves and the authorisation of an LMO, in this case Dr Wong. Ms Lau accepted that if Mr Reeves was restrained before authorisation in any form had been given, then that would be a breach of Garden View's policy.[303] Mrs Reeves provided authorisation on 13 May 2018, and Dr Wong did so on 15 May 2018. However, Mr Reeves was subjected to physical restraint in the form of a lap belt on at least two prior occasions: 8 May and 11 May 2018.[304]

It follows that Garden View breached its own policies. These breaches resulted in periods of physical restraint which could never be justified.

Ms Lau in effect agreed that aggregate daily periods of restraint of the magnitude recorded on many days in the restraint chart, detailed below, could not be justified.[305] However, she disputed the reliability of the restraint chart. As we have already said, we find that the restraint chart is generally reliable in providing the approximate periods of time for which Mr Reeves was restrained.

It is clear from what we have said above that Garden View did not follow its policy on the use of restraints in the provision of care to Mr Reeves.

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301 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1317.8-14.

302 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1322.33-46.

303 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1317.16-1318.25.

304 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0003 [24]; Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1231.29-1232.10; Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 3 May 2019, WIT.0147.0001.0001 at 0001 [10]; Transcript, Natalie Sonya Smith, Sydney Hearing, 7 May 2019 at T1251.23-1253.11.

305 Transcript, King Lee Lau, Sydney Hearing, 7 May 2019 at T1311.20-1312.1.

Deterioration in Mr Reeves's condition

On 16 May 2018, the progress notes again recorded that Mr Reeves was physically restrained.[306] On this day, Ms McCulla visited and found Mr Reeves restrained and in wet clothes.[307]

On 16 May 2018, Mr Reeves's regular dose of 0.5mg of risperidone at night commenced.[308] Mr Reeves refused to take this medication on 17 May 2018. It was administered to him on 18, 19 and 20 May 2018.[309] These administrations were without consent.

On 20 May 2018, Garden View commenced a behaviour monitoring chart for Mr Reeves.[310]

On 21 May 2018, Mr Reeves had a fall.[311] No further risperidone was administered to Mr Reeves after this fall.[312]

It is possible that Mr Reeves had another fall on 23 May 2018, when he was found crawling on the floor. Garden View did not notify any family members of this.[313]

On 28 May 2018, Dr Burkitt ceased both the as needed and regular night time prescriptions of risperidone in light of the falls Mr Reeves had had.[314]

From 28 May 2018, on every day except two (21 June 2018 and 6 July 2018) until Mr Reeves left Garden View on 7 July 2018, he was physically restrained for periods of between 30 minutes and two hours at a time, in aggregate daily periods varying from several hours to 13 or 14 hours.[315] He was generally restrained during the day because he was falling asleep; he was generally restrained during the night because he was restless and wandering.[316] For much of the time, this took place in the East Wing.[317]

306 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0284.

307 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0004-0009 [36]-[49].

308 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 66, GVN.0001.0001.0833 at 0835.

309 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 66, GVN.0001.0001.0833 at 0835.

310 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 62, GVN.0001.0004.6809.

311 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 70, GVN.0001.0001.1263 at 1263-1264.

312 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 66, GVN.0001.0001.0833 at 0835, 0837.

313 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0284-0285; Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1323.22-1324.9.

314 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 69, GVN.0001.0001.1260 at 1262; tab 65, GVN.0001.0001.0648 at 0649; Exhibit 3-13, Sydney Hearing, Statement of Dr Miles Burkitt, 29 April 2019, WIT.0146.0001.0001 at 0002 [12], [16].

315 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 61, CTH.4001.0004.6767.

316 Transcript, Kee Ling Lau, Sydney Hearing, 7 May 2019 at T1311.15-18.

317 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 64, GVN.0001.0001.0278 at 0283-0284; Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0004 [33] and [36]; Exhibit 3-10, Sydney Hearing, Statement of Natalie Sonya Smith, 26 April 2019, WIT.0147.0001.0001 at 0002 [17].

On 1 June 2018, Mr Reeves had a fall which was recorded on CCTV and documented.[318] He sustained an injury to his head and appeared to have pain in his shoulder.[319]

On the night of 1 June 2018, Temazepam was prescribed with the consent of Ms Smith to help Mr Reeves sleep.[320] It was commenced at 10mg to be taken at night. On 18 June 2018, the Temazepam prescription was increased to 20mg to be taken at night (2 x 10mg tablets), with Ms Smith's consent.[321]

Both Senior Counsel Assisting and the Reeves family invited us to find that the restraint applied to Mr Reeves was 'mistreatment' and that it resulted in deconditioning of Mr Reeves, rendering him incontinent and less mobile.

Garden View Aged Care, Dr Burkitt and Dr Wong opposed any such findings. They submitted that in light of the seriousness of the allegation of mistreatment, highly probative evidence would be required in order to make such a finding.[322] They suggested that there is no probative basis for a finding of deconditioning in the absence of expert clinical evidence establishing the 'baseline' condition of Mr Reeves on his admission to Garden View, establishing his condition on discharge, and identifying the causes of his functional decline in a way that excludes other potential causal factors such as the progression of his Alzheimer's disease, changes to his environment and routine and other matters, including the potential effect of different medications.

We decline to make a finding that the restraint of Mr Reeves was 'mistreatment'. That expression has different connotations in different contexts, and might be misunderstood as connoting the deliberate infliction of harm. The deliberate infliction of harm to Mr Reeves was not suggested during the case study. We are satisfied, however, that the application of restraints to Mr Reeves was substandard care.

There was some lay and opinion evidence to suggest a deconditioning effect.

Ms McCulla considered that, as time went on, Mr Reeves became dependent on someone to assist him walking, and that the long days spent restrained in his chair had affected his ability to walk unassisted.[323] Ms McCulla's opinions on these matters may be correct, but in the absence of expert clinical evidence we cannot rely on them to make the findings sought.

318 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 70, GVN.0001.0001.1263 at 1265-1266.

319 Transcript, Michelle Lauren McCulla, Sydney Hearing, 7 May 2019 at T1240.33-46.

320 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 69, GVN.0001.0001.1260 at 1260; Transcript, Natalie Sonya Smith, Sydney Hearing, 7 May 2019 at T1258.28-32.

321 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 69, GVN.0001.0001.1260 at 1260; Transcript, Natalie Sonya Smith, Sydney Hearing, 7 May 2019 at T1258.46-1260.6.

322 Sydney Hearing, Submissions of Garden View Aged Care in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0314 [22], citing *Briginshaw v Briginshaw* (1938) 60 CLR 336.

323 Exhibit 3-9, Sydney Hearing, Statement of Michelle Lauren McCulla, 23 April 2019, WIT.0097.0001.0001 at 0010 [88].

We decline to make a finding that the application of physical restraint caused Mr Reeves to be deconditioned. While there is insufficient evidence for us to make a finding that the application of restraints caused Mr Reeves to be deconditioned, consistent with the Aged Care Quality and Safety Commission's serious risk decision dated 5 March 2019,[324] we are satisfied that the application of the restraints posed a serious risk to Mr Reeves's health, safety and wellbeing.

The Aged Care Quality and Safety Commission conducted a review audit of Garden View from 17 to 22 January 2019.[325] A delegate of the Aged Care Quality and Safety Commissioner made a serious risk decision against Garden View on 5 March 2019.[326] The Review Audit found that Garden View did not meet 34 of the 44 expected outcomes in the Accreditation Standards, including expected outcome 2.13, relating to behaviour management.

The Aged Care Quality and Safety Commission said that Garden View's failure to comply with expected outcome 2.13 had:

> placed Mr Terance Reeve's safety, health or wellbeing at serious risk by failing to manage his challenging behaviours through repeatedly physically restraining him for extended periods of time in an extreme form of restraint, restricting his choice to move freely around the home.
>
> Failure to do so has been to the detriment of Mr Reeves safety, dignity and quality of life.[327]

Garden View Aged Care submitted that by 23 May 2019 it was no longer non-compliant with expected outcome 2.13. It submitted that it was confident that its remaining non-compliances would be resolved within a short time.[328] Garden View Aged Care made the point that the Aged Care Quality and Safety Commission's finding had gone no further than finding that Mr Reeves was placed at serious risk, and was not a finding that he had been mistreated or had suffered harm. On this basis, Garden View Aged Care submitted that Senior Counsel Assisting's submissions that Mr Reeves had been mistreated during his respite at Garden View and had been deconditioned by the restraint applied to him were at odds with the work done by the Aged Care Quality and Safety Commission.

As we have explained in our detailed findings above, consistently with the conclusion sought by Garden View Aged Care, we are not satisfied on the evidence before us that staff of Garden View mistreated Mr Reeves or that the periods of physical restraint applied to Mr Reeves actually caused or contributed to deconditioning.

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324 Exhibit 3-7, Sydney Hearing, Garden View Tender Bundle, tab 58, CTH.1006.1001.0056.

325 Exhibit 3-7, Sydney Hearing, Garden View Case Study Tender Bundle, tab 56, CTH.1006.1001.1006.

326 Exhibit 3-15, Sydney Hearing, Statement of Kee Ling Lau, 2 May 2019, WIT.0137.0001.0001 at 0008-0009 [49]-[56].

327 Exhibit 3-7, Sydney Hearing, Garden View Case Study Tender Bundle, tab 58, CTH.1006.1001.1056 at 1058.

328 Sydney Hearing, Submissions of Garden View Aged Care Pty Limited in response to submissions of Counsel Assisting, 14 June 2019, GVN.001.002.0308 at 0308 [3].

On the other hand, consistently with the conclusions reached by the Aged Care Quality and Safety Commission in March 2019, we are satisfied that staff of Garden View applied physical restraint to Mr Reeves for extended periods of time. This involved affixing a lap belt or pelvic restraint to Mr Reeves, securing him to his chair over 30 minute to two-hour periods at a time, which in the aggregate amounted to multiple hours of restraint per day, virtually every day over a period of about 46 days. This was unjustified and represented substandard care that put Mr Reeves's health, safety and wellbeing at serious risk.

Mr Reeves leaves Garden View

On 7 July 2018, Mrs Reeves removed Mr Reeves from Garden View. According to her observations at the time, which we accept, he was incontinent, unable to talk and unable to walk without assistance.[329]

Mrs Reeves gave evidence of a partial recovery by Mr Reeves in the weeks after his discharge from Garden View. We accept Mrs Reeves's evidence that, at the time of her giving evidence, Mr Reeves had regained mobility but remained unable to speak and was incontinent.[330]

Mrs Reeves was diagnosed with a form of blood cancer. She is no longer able to care for Mr Reeves at home. He now lives in permanent care. Of the facility Mr Reeves now lives in, Mrs Reeves said:

> The facility is wonderful. They don't restrain. They don't medicate. He's free to walk around the halls. He walks a lot. He's allowed to walk out in the gardens. They supervise. He's had no falls. He walks very well.[331]

However, Mrs Reeves went on:

> But he never came back 100 per cent after being at Garden View; never came back.[332]

Brian King Gardens case study

Introduction

The Royal Commission examined the experiences of Mrs CO at the residential aged care facility Brian King Gardens in north-west Sydney, New South Wales, which since July 2016 has been operated by Anglicare.

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329 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1221.10-16; Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0002 [20].

330 Exhibit 3-8, Sydney Hearing, Statement of Lillian Reeves, 26 April 2019, WIT.0141.0001.0001 at 0002 [23]; Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1221.28-36.

331 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1221.28-30.

332 Transcript, Lillian Sonya Reeves, Sydney Hearing, 6 May 2019 at T1221.30-31.

The evidence before the Royal Commission consisted of:

- the statement of DM, Mrs CO's daughter, dated 17 April 2019[333]
- the statement of DL, Mrs CO's daughter, dated 26 April 2019[334]
- three statements of Richard Farmilo, the Residential Manager of Brian King Gardens, dated 26 April 2019, 2 May 2019 and 10 May 2019[335]
- the statement of Amy Tinley, the Care Manager of Brian King Gardens, dated 9 May 2019[336]
- the statement of Cheryl Lee, the Clinical Speech Pathologist of Brian King Gardens, dated 26 April 2019[337]
- the statement of Dr Margaret Ann Ginger, general practitioner, dated 2 May 2019[338]
- the oral testimony of those six witnesses
- the statement of Anglicare, dated 7 May 2019[339]
- Anglican Community Services response to the Royal Commission request for information, dated 7 January 2019[340]
- the tender bundle for this case study, which consists of 129 documents.[341]

Brian King Gardens and each of Mr Farmilo, Ms Tinley, Ms Lee and Dr Ginger were granted leave to appear at the public hearing and were represented by counsel and solicitors.

In accordance with the directions we made on 31 May 2019, Counsel Assisting provided written submissions setting out the findings they consider should be made arising from this case study.[342] In response to those submissions, the Royal Commission received submissions from Brian King Gardens and on behalf of Dr Ginger.[343]

333 Exhibit 3-20, Sydney Hearing, Statement of DM, 17 April 2019, WIT.0099.0001.0001.

334 Exhibit 3-21, Sydney Hearing, Statement of DL, 18 April 2019, WIT.0136.0001.0001.

335 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001; Exhibit 3-23, Sydney Hearing, Statement of Richard Farmilo, 2 May 2019, WIT.0154.0001.0001; Exhibit 3-83, Sydney Hearing, Second Supplementary Statement of Richard Farmilo, 10 May 2019, RCD.0011.0025.0001.

336 Exhibit 3-44, Sydney Hearing, Statement of Amy Tinley, 9 May 2019, WIT.0164.0001.0001.

337 Exhibit 3-26, Sydney Hearing, Statement of Cheryl Lee, 26 April 2019, WIT.0131.0001.0001.

338 Exhibit 3-27, Sydney Hearing, Statement of Dr Margaret Ann Ginger, 2 May 2019, WIT.0155.0001.0001.

339 Exhibit 3-24, Sydney Hearing, Statement of Anglicare, 7 May 2019, WIT.0165.0001.0001.

340 Exhibit 3-25, Sydney Hearing, Anglican Community Services response to Royal Commission's request for information, 7 January 2019, SUB.0001.0012.3856.

341 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle.

342 Sydney Hearing, Submissions of Counsel Assisting the Royal Commission, 31 May 2019, RCD.0012.0006.0001.

343 Sydney Hearing, Submissions for Anglican Community Services, 14 June 2019, RCD.0012.0008.0001; Sydney Hearing, Submissions on behalf of Dr Ginger, 11 June 2019, RCD.0012.0007.0042.

Background

Mrs CO was born in England in 1934. She and her husband travelled to Australia in December 1959 and had four children. In December 2010 Mrs CO was diagnosed with dementia.[344]

On 1 February 2013, Mrs CO was admitted to Brian King Gardens in north-west Sydney for respite care and on 22 February 2013 she was admitted as a permanent resident.[345]

Brian King Gardens was operated by Anglican Retirement Villages until July 2016 when Anglican Retirement Villages and the Council of the Sydney Anglican Home Mission Society merged their separate businesses to form Anglicare in July 2016.[346] Anglicare continue to operate Brian King Gardens.[347]

Following Mrs CO's admission to Brian King Gardens, a number of assessments were carried out. These included an oral and dental assessment on 22 February 2013, which led to the development of an oral and dental management plan.[348] An extended care plan was developed on 21 May 2013.[349]

July 2016 complaint (skin cream / stocking)

On 12 July 2016, Mrs CO's daughter, Ms DL, took her mother away from Brian King Gardens for four nights. During this trip, Ms DL noticed that her mother had been given a medicated skin cream belonging to another resident.

Ms DL subsequently made a complaint to Brian King Gardens about a lack of communication among staff resulting in Mrs CO not being packed for the trip, that Mrs CO only had one pair of pressure stockings that were ripped and in need of replacement, and that her mother had been provided with the medication of another resident.[350] The complaint was dealt with internally on the same day by Margaret Westwood, ACFI (Aged Care Funding Instrument) Coordinator, Margaret Westwood.[351]

On 13 July 2016, Ms DL met with the Service and Administration Coordinator Angela Muller and another member of staff.[352] Ms DL received an apology. The issue of the pressure stockings seems to have been resolved on the basis that Brian King Gardens would purchase three stockings for Mrs CO.[353] At this meeting, Ms DL raised the issue of

344 Exhibit 3-20, Sydney Hearing, Statement of DM, 17 April 2019, WIT.0099.0001.0001 at [6].

345 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at 0007 [23], 0012 [40].

346 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at 0004 [13].

347 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at 0004 [13].

348 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at 0011 [34](l) and (m).

349 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at 0011 [35]; Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 93, ANC.0001.0009.0001.

350 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 15, ANC.0001.0006.3683 at 3684.

351 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 15, ANC.0001.0006.3683.

352 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 16, ANC.0001.0006.3705 at 3706.

353 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 16 ANC.0001.0006.3705 at 3706.

her mother's significant weight gain, an increase of 30 kilograms over three years, and her resulting shortness of breath. Ms DL indicated that she and Ms DM would like Mrs CO's general health reviewed.[354]

In their submissions, Anglicare acknowledged that in providing another resident's medication to Mrs CO, Brian King Gardens failed to provide Mrs CO care that was person-centred or in compliance with Anglicare's own standards.

November 2017 ACFI Assessment

On 20 October 2017 one of the Brian King Gardens physiotherapists sent an email to the Facility Manager of Brian King Gardens Mr Richard Farmilo, seeking confirmation that Mr Farmilo had asked about Mrs CO's pain treatments that morning.[355] The physiotherapist wrote that Mrs CO was not receiving physiotherapy treatment and asked if she needed to be reviewed for pain treatment.[356]

Mr Farmilo responded by email, confirming that he had asked about Mrs CO. He wrote that Mrs CO is 'currently LHH [low, high, high] in ACFI. Her ADL's [Activities of Daily Living] will go up, however we don't want her CHC [Complex Health Care] to drop, hence the need for pain management'.[357] He went on to write '[a]ll I ask is that you review her again for pain management. For the H is remain, she will need to be on the new 4B, receive a HP and also the TED's [thromboembolic deterrent stockings]. However this depends on your pain assessment and any interventions you recommend'.[358]

In his oral evidence, Mr Farmilo explained that the conversation with the physiotherapist on 20 October 2017 would have occurred in a daily handover meeting that morning, and that he asked the question about the need for pain treatment in response to the changing care needs of Mrs CO.[359]

Counsel Assisting put to Mr Farmilo that he sent the email on 20 October 2017 because of an impending ACFI assessment, and not because of the changing needs of Mrs CO.[360] The implication of the question was that Mr Farmilo's focus was on increasing the funding Brian King Gardens would receive if Mrs CO's ACFI rating was increased and not on the care needs of Mrs CO. Mr Farmilo denied this. He gave evidence that the ACFI submission would have been made in response to changing care needs, including reports by Mrs CO of increased pain.[361]

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354 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 16, ANC.0001.0006.3705 at 3706.

355 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 36, ANC.0001.0001.2025.

356 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 36, ANC.0001.0001.2025.

357 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 36, ANC.0001.0001.2025.

358 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 36, ANC.0001.0001.2025.

359 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1387.5-40.

360 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1388.32-33.

361 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1388.32-33; Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at [45](g)(ix).

During his examination, Counsel Assisting took Mr Farmilo to a number of emails concerning the ACFI assessments of Mrs CO and other residents.[362] In one of these emails sent on 3 November 2017, Mr Farmilo asked the ACFI Coordinator Ms Bartrop '[w]hat needs to change to make [Mrs CO] an H in ADL's or is this not possible?'[363] Ms Bartrop responded that she didn't 'think a high in ADLS was possible' before setting out what care assistance is required for a high in ADLs.[364]

The email correspondence before the Royal Commission suggests that Mr Farmilo's focus was on getting the highest possible ACFI score to receive the highest level of funding possible for the care provided to Mrs CO. Counsel Assisting put this to Mr Farmilo a number of times. Mr Farmilo consistently rejected these assertions. Mr Farmilo maintained that Mrs CO's changing care needs was the driving factor behind any change to the ACFI assessment.

We are not satisfied that there is sufficient evidence to support a finding that in acting the way he did, Mr Farmilo was motivated by receiving higher ACFI funding rather than Mrs CO's changing care needs. In coming to this conclusion, we have had regard to the evidence of Mr Farmilo provided in his second supplementary statement that Brian King Gardens had not, as of 10 May 2019, been the subject of ACFI downgrade by the Australian Department of Health since 2013.[365] We will consider whether the current ACFI system incentivises approved providers to overstate the care needs of their residents in order to receive a greater level of funding as part of our broader work on funding in the aged care system.

Dental care

An Anglican Retirement Village Dental Care Plan dated 28 June 2016 notes that Mrs CO had a high risk of dental decay and required assistance to clean her teeth and remove her upper partial denture every night.[366] According to a letter Mr Farmilo wrote to Ms DL on 27 November 2016, this directive was written up, a sign advising of the directive was placed in Mrs CO's room and the information was discussed at a handover meeting between registered nurses and care staff.[367]

On 1 November 2016 Mrs CO saw her dentist Dr Lindsay for an examination. Dr Lindsay prepared a note of the examination for Brian King Gardens, in which she wrote that she believed that Mrs CO's dentures had not been removed or cleaned for a number of weeks, or more, and that this had caused significant decay in four months.[368]

362 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1380-94.

363 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 40, ANC.0001.0006.4106 at 4107.

364 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 40, ANC.0001.0006.4106 at 4108.

365 Exhibit 3-83, Sydney Hearing, Second Supplementary Statement of Richard Farmilo, 10 May 2019, RCD.0011.0025.0001 at 0002 [7].

366 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 19, ANC.0001.0004.1781.

367 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 20, ANC.0001.0005.0755.

368 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 13, ANC.0001.0004.1769 at 1770.

At a meeting with Mr Farmilo on 21 November 2016, Ms DM outlined how disappointed the family was with the care provided to Mrs CO and asked what action would be taken to rectify the problem.[369]

On 28 November 2016, Mr Farmilo sent an email to Ms DL and Ms DM, attaching a letter dated 27 November 2016 regarding the investigation that was undertaken into Mrs CO's oral care at Brian King Gardens.[370] The investigation involved Mr Farmilo meeting individually with the registered nurses and care staff involved in Mrs CO's care, visiting Mrs CO's room and reviewing her dental care plans and oral care directives.[371]

In this letter Mr Farmilo apologised for the 'several breakdowns' and wrote that he had 'put in place strategies to prevent any future occurrences'.[372] The several breakdowns included that staff were unaware of the directives and were not following the instructions. In his letter of 27 November 2016, Mr Farmilo said that a reason for staff not following the care directives was due to Mrs CO becoming agitated, resistive and preventing staff from removing her dentures when they attempted to do so.[373]

Both Ms DL and Ms DM gave evidence that Mrs CO was never resistive when it came to her teeth, and disagreed with Mr Farmilo's assertion that Mrs CO was resistive to oral care.[374] The iCare notes, while not a complete record, do not make any reference to Mrs CO being resistive to oral care prior to 1 November 2016.

In his statement to the Royal Commission, Mr Farmilo acknowledged that Mrs CO's oral care directives were not consistently followed in the second half of 2016.[375]

On 29 November 2016 Mrs CO attended the dentist and had two decayed teeth extracted.[376] In her statement, Ms DM wrote that her sister attended this appointment, held her mother's hand and watched her mother 'quietly sob as her teeth were extracted'.[377]

Notwithstanding the evidence of Ms DL and Ms DM and the lack of evidence of any resistance to oral care in the iCare notes, Anglicare submitted that one of the reasons Mrs CO's oral care directives were not consistently followed was likely due to some resistance to care on behalf of Mrs CO. We do not accept this submission for the following reasons.

369 Exhibit 3-20, Sydney Hearing, Statement of DM, 17 April 2019, WIT.0099.0001.0001 at 0006 [47].

370 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 20, ANC.0001.0005.0755.

371 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at 0026 [60].

372 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 20, ANC.0001.0005.0755.

373 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 20, ANC.0001.0005.0755.

374 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1350.1-35.

375 Exhibit 3-22, Sydney Hearing, Statement of Richard Farmilo, 26 April 2019, WIT.0130.0001.0001 at 0029-0030 [62]-[66].

376 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 71, ANC.0001.0004.1360 at 1460-1461.

377 Exhibit 3-21, Sydney Hearing, Statement of DM, 18 April 2019, WIT.0099.0001.0001 at 0005 [43].

First, we accept the evidence of Ms DL and Ms DM, about which they were not challenged, concerning the approach to oral health by their mother and the priority that it had been for her during her life.

Second, we note the evidence that Mrs CO had been in Brian King Gardens since 2013 and there is no suggestion of her being resistive to oral care in that time. Further, resistance was not reported to the registered nurses and was not communicated to the family. There is no evidence as to what, if any, interventions Brian King Gardens implemented to address Mrs CO's resistance to care.

Third, we observe that there was no deterioration of her teeth according to consecutive dental care plans before June 2016.[378] This was despite Mrs CO having a high risk of decay owing to a dry mouth, as Dr Lindsay warned on 28 June 2016. Until then, the record shows a high standard of oral care being provided by the facility. This is borne out by the re-accreditation audit report of July 2015.[379]

We are satisfied that Mrs CO's oral and dental care in the second half of 2016, and related communication with the family, fell well short of an appropriate standard. The care staff at Brian King Gardens did not consistently follow the care directives, and as at 1 November 2016 Mrs CO's dentures had not been removed or cleaned for a number of weeks or more. This failure contributed to the significant tooth decay experienced by Mrs CO and caused distress to Mrs CO and her family.

Podiatry care

Following her admission to Brian King Gardens and while Mrs CO was classified as a low care resident, Ms DL and Ms DM took responsibility for booking and paying for Mrs CO's podiatry appointments.[380] However, when Mrs CO's classification was later changed to a 'high care' resident, Brian King Gardens took responsibility for booking and managing Mrs CO's podiatry appointments.[381]

In February 2017, Ms DL and Ms DM discussed the fact that their mother was complaining of sore feet and was limping.[382] Ms DL took off her mother's pressure stockings and saw that her toenails were very long, and thought that they had not been cut for months.[383]

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378 In 2014 it was noted that Mrs CO had partial upper dentures and required supervision and standby assistance with oral hygiene and that in the case of she had '*no tooth decay or broken teeth or roots*' Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 4, ANC.0001.0004.1779. In June 2015 there was no substantive change in Mrs CO's teeth from the previous year; Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 9, ANC.0001.0004.1773.

379 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 10, CTH.4001.0003.9521 at 9536 for outcome 2.15.

380 Exhibit 3-20, Sydney Hearing, Statement of DM, 17 April 2019, WIT.0099.0001.0001 at 0004 [35].

381 Exhibit 3-20, Sydney Hearing, Statement of DM, 17 April 2019, WIT.0099.0001.0001 at 0004 [35].

382 Exhibit 3-20, Sydney Hearing, Statement of DM, 17 April 2019, WIT.0099.0001.0001 at 0004 [36].

383 Exhibit 3-20, Sydney Hearing, Statement of DM, 17 April 2019, WIT.0099.0001.0001 at 0004 [35].

On 6 March 2017, Ms DM sent a letter of complaint about Mrs CO's toenails. Ms DM observed that when Ms DL investigated, she saw that the toenails were overgrown and digging in.[384] A photo attached to the email showed the seriously neglected state of Mrs CO's toenails.[385] Mr Farmilo responded by email, writing that he would look into the matter.[386]

On 6 March 2017, Mr Farmilo wrote to the podiatry service. He pointed out that according to the iCare records, although Mrs CO was seen regularly for podiatry until 11 August 2016, she was not seen again until February 2017.[387] The podiatrist replied to the effect that after seeing Mrs CO on 11 August, an appointment was made for 20 September which Mrs CO did not attend.[388] He wrote that thereafter Mrs CO 'slipped off' his 'radar' and that he 'may have forgotten to chase her up again'.[389] He apologised and wrote that he would ensure that she received podiatry care every six weeks.[390]

On 7 March 2017, Mr Farmilo responded to Ms DM and Ms DL and explained what had happened.[391]

We are satisfied that the staff of Brian King Gardens failed to:

- provide podiatry care for Mrs Co between 11 August 2016 and February 2017
- observe, or to report, the overgrown state to Mrs CO's toenails during routine showering and general care in 2016
- investigate or arrange a podiatry visit for Mrs CO despite her complaining of pain in her feet.

In this respect, we are satisfied that the care provided by Brian King Gardens to Mrs CO fell below the standard that might reasonably be expected. This caused considerable pain and discomfort to Mrs CO. The failure of staff to identify from their daily care the state of Mrs CO's toenails, including in circumstances where she was limping, is of particular concern.

Prescription of mirtazapine

On 4 July 2018, Mrs CO's General Practitioner, Dr Margaret Ginger, attended Brian King Gardens and heard from the Care Manager, Ms Amy Tinley, that there had been a report from one of the pastoral care workers that Mrs CO was distressed and crying over the loss of her baby son years before.[392]

384 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 26, ANC.0001.0001.0651.

385 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 26, ANC.0001.0001.0651.

386 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 28, ANC.0001.0005.1186.

387 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 27, ANC.0001.0001.0663 at 0664.

388 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 27, ANC.0001.0001.0663.

389 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 27, ANC.0001.0001.0663.

390 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 27, ANC.0001.0001.0663.

391 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 31, ANC.0001.0005.1195.

392 Exhibit 3-27, Sydney Hearing, Statement of Dr Margaret Ann Ginger, 2 May 2019, WIT.0155.0001.0001 at 0001 [3]. See also Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 71, ANC.0001.0004.1360 at 1532-33.

Dr Ginger saw Mrs CO and concluded that she was agitated, distressed and was showing 'signs of being depressed'.[393] Dr Ginger prescribed 45 mg of the anti-depressant mirtazapine to be taken at night.[394] The administration of mirtazapine commenced on 6 July 2018.

In Dr Ginger's oral evidence, she agreed that as of 4 July 2018 she had discussed Mrs CO with Ms Tinley on numerous occasions.[395] Dr Ginger was aware that Mrs CO had a history of wandering, had anxiety and cried quite a lot. At that point in time, Mrs CO had not been diagnosed with depression but had only showed signs of suffering from it.[396]

In an episode of wandering, on 24 June 2018, Mrs CO was reported missing at 12.15pm. CCTV footage showed her leaving the building at 11.58am and police were notified at 2.15pm.[397] At 3.10pm, one of her daughters found Mrs CO outside but within the grounds of the facility, trapped between a brick wall and some fencing.[398]

Following this episode, there was a subsequent discussion between Ms Tinley and Mrs CO's daughter, Ms DL, where the issues of Mrs CO being agitated and wandering were discussed. According to Ms DL, Ms Tinley said that Mrs CO was often found crying and distressed.[399] Ms Tinley suggested that if Mrs CO continued that way she would probably have to go into the secure facility inside Brian King Gardens, known as Everglade.[400]

Ms Tinley gave evidence that at this time Mrs CO's grief was really distressing and that the interventions that previously settled Mrs CO were no longer working.[401] These interventions included spending one-on-one time with Mrs CO, outside walks, doll therapy, and music and group activities.[402] Further interventions, such as engaging Anglicare's internal dementia support program or the Australian Government's Dementia Behaviour Management Advisory Service (DBMAS), were not attempted.[403] Ms Tinley did, however, accept that when the usual interventions stopped working, these further interventions should have been tried.[404]

Although prescribed on 4 July, the drug Axit was not administered until the evening of 6 July. Axit is a brand name of the tetracyclic anti-depressant mirtazapine. Mirtazapine is indicated for major depression.

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393 Exhibit 3-27, Sydney Hearing, Statement of Dr Margaret Ann Ginger, 2 May 2019, WIT.0155.0001.0001 at 0001 [3].

394 Exhibit 3-27, Sydney Hearing, Statement of Dr Margaret Ann Ginger, 2 May 2019, WIT.0155.0001.0001 at 0001 [3].

395 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1405.3-28.

396 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1405-3.

397 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 71, ANC.0001.0004.1360 at 1530-1.

398 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1351.1-11.

399 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1352.30-37.

400 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1352.41.

401 Exhibit 3-44, Sydney Hearing, Statement of Amy Tinley, 9 May 2019, WIT.0164.0001.0001 at 0005 [14].

402 Exhibit 3-44, Sydney Hearing, Statement of Amy Tinley, 9 May 2019, WIT.0164.0001.0001 at 0005 [14].

403 Exhibit 3-44, Sydney Hearing, Statement of Amy Tinley, 9 May 2019, WIT.0164.0001.0001 at 0005 [15].

404 Exhibit 3-44, Sydney Hearing, Statement of Amy Tinley, 9 May 2019, WIT.0164.0001.0001 at 0005 [15].

According to the 2013 edition of the *Australian Medicines Handbook*, published by the Pharmaceutical Society of Australia and the Royal Australian College of General Practitioners, anti-depressants should begin with a low dose, increasing gradually over two to four weeks and that although the full antidepressant effect may take six to eight weeks, improvement is often seen within one to three weeks.[405]

In the case of the elderly, according to the handbook, medical practitioners should 'consider a lower starting dose with a more gradual increase' to minimise the effect of adverse effects. It goes on to say that 'mirtazapine and sertraline seem ineffective in people with dementia and depression and convincing evidence of benefit of other anti-depressants is lacking'. The handbook states that 60mg is the maximum dose for adults, with the starting dose 15mg, 'increasing gradually to 30–45mg at night'.[406] Common side effects include 'increased appetite, weight gain, sedation, weakness and peripheral oedema'.[407]

To largely the same effect, the Clinical Practice Guidelines and Principles of Care for People with Dementia, published in February 2016 by the NHMRC, would also seem to suggest that mirtazapine was not the appropriate response to Mrs CO's situation at that time. For example recommendations 86 and 88 are in these terms:

> 86. People with dementia who experience agitation should be offered a trial of selective serotonin reuptake inhibitor (SSRI) antidepressants (the strongest evidence for effectiveness exists for citalopram) if non-pharmacological treatments are inappropriate or have failed. Review with evaluation of efficacy and consideration of de-prescribing should occur after two months. The need for adherence, time to onset of action and risk of withdrawal effects and possible side effects should be explained at the start of treatment.
>
> 88. The role of antidepressants in the treatment of depression in people with dementia is uncertain. Larger trials conducted in people with dementia have not shown benefit (in group data) for antidepressants for treatment of depression per se. Nevertheless, it is considered that those with a pre-existing history of major depression (prior to developing dementia) who develop a co-morbid major depression should be treated in the usual way.[408]

405 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 117, RCD.9999.0035.0003 at 0004.

406 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 117, RCD.9999.0035.0003 at 0006.

407 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 117, RCD.9999.0035.0003 at 0006.

408 Exhibit 3-2, Sydney Hearing, General Tender Bundle, tab 14, RCD.9999.0031.0002 at 0017-0018 [16]-[17]. See also recommendations 79, 80 and 84; Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 128, RCD.9999.0036.0001; tab 129, RCD.9999.0036.0003.

Dr Ginger took a different view at the time she prescribed. Her evidence was that she used mirtazapine because it is both an anti-depressant and anti-anxiety medication and it tends to help patients settle.[409] By the time of the hearing in May 2019, she said that she was not happy with her prescription of mirtazapine on that occasion.[410]

On 11 July 2018, Mrs CO's 84th birthday, Dr Ginger lowered the dose of mirtazapine to 30mg after nursing staff advised her that Mrs CO had become increasingly drowsy over the last week.[411] The circumstances that preceded that decision were of some concern at the time, and were captured in both the clinical notes that were in evidence and the oral evidence given at the hearing by Ms DM and Dr Ginger.

In the case of Ms DM, we note that she visited her mother that morning with two of Mrs CO's grandchildren to celebrate her birthday because that was the time when her mother was 'usually pretty sprightly'.[412]

Ms DM said that her mother was fast asleep, fully dressed on her bed and that they could not wake her.[413] She was told by a nurse that her mother was very sleepy and as a result went to the café to allow her to finish what they thought was a 'nanna nap'. When they came back 45 minutes later, she was still 'out to it'.[414]

That evidence is borne out by a contemporaneous note from the care supervisor at 12.17pm in largely the same terms.[415] A later note made at 2pm by one of the nurses suggests that staff were concerned about Mrs CO. It noted that although she was not responding to verbal command, she did respond to pain and that it was not possible to check her pupils as Mrs CO was not opening her eyes. Dr Ginger was notified and attended Mrs CO. The notes state that she would review Mrs CO's medication.[416]

Dr Ginger's notes refer to Mrs CO having a long period of being unresponsive but noted that by 2.22pm she was responsive and talking. Dr Ginger made the entry '?? TIA', which referred to a transient ischaemic attack or mini-stroke. She noted she had discussed the situation with one of the daughters, and that it was not necessary for Mrs CO to be hospitalised. Her note concluded with the following statement: 'Would suggest we reduce avanza dose as she apparently has been increasingly drowsy over the week.'[417]

409 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1408.19.

410 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1412.42.

411 Exhibit 3-27, Sydney Hearing, Statement of Dr Margaret Ann Ginger, 2 May 2019, WIT.0155.0001.0001 at 0001 [4].

412 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1355.11-12.

413 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1355.16-19.

414 Transcript, DL/DM, Sydney Hearing, 8 May 2019, 1355.41-42.

415 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 71, ANC.0001.0004.1360 at 1533.

416 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 71, ANC.0001.0004.1360 at 1533.

417 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 71, ANC.0001.0004.1360 at 1533.

Consent

The evidence clearly demonstrates that Mrs CO lacked the capacity to consent to a medical treatment involving the prescription of a psychotropic drug.

The evidence also indicates that until 9 July 2018, when Mrs DL spoke to someone from Brian King Gardens, no consent was obtained for the treatment.

We find that consent was prima facie necessary because the administration of mirtazapine concerned a restricted substance that would, quite obviously, affect the central nervous system of Mrs CO.[418] We find, therefore, that the prescription of mirtazapine was a major treatment for the purposes of Part 5 of the *Guardianship Act 1987* (NSW). Further, regulations 12(2) and 13(2) of the *Guardianship Regulations 2016* (NSW), together with s 40(2) of the Guardianship Act governed the form and extent of that consent. We find that under s 36(1) of the Guardianship Act, Ms DL and Ms DM were the only persons capable of giving consent for such treatment in the absence of an order for the treatment by the Guardianship Tribunal or there was a need, as a matter of urgency, to prevent Mrs CO from continuing to suffer significant distress.

Clearly, consent had not been obtained from Mrs CO's daughters when the Mirtazapine was first administered on 6 July 2018.[419]

Submissions made on behalf of Dr Ginger argued that it is not clear from the Guardianship Act who is responsible for obtaining consent where medication is prescribed and administered in a nursing home.

The Guardianship Act does not specify who should seek consent, focussing rather on who is capable of giving it,[420] the form in which the request for consent is to be made and the way in which it is to be given.[421]

Further, it is an offence under s 35 of the Guardianship Act for treatment to which Part 5 applies to be 'carried out' on a patient without consent being given.

In her statement, Mrs Tinley wrote that when Dr Ginger was seeing Mrs CO on 4 July 2019, she and Dr Ginger attempted unsuccessfully to call Ms DL to discuss Mrs CO's emotional state and the proposed change to her medication.[422] In her oral evidence, Ms Tinley said that she and Dr Ginger did not discuss the issue of consent before the prescription of the mirtazapine, adding that it was not part of her role to 'gain consent' for the medication.[423]

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418 See reg 10(1)(e) of the *Guardianship Regulations 2016* (NSW).

419 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1354.7-9.

420 See s 36 and Part 5 Divisions 3 and 4 of the *Guardianship Act 1987* (NSW).

421 See s 40 of the *Guardianship Act 1987* (NSW) and regs 12(2) and (3) of the *Guardianship Regulations 2016* (NSW).

422 Exhibit 3-44, Sydney Hearing, Statement of Amy Tinley, 9 May 2019, WIT.0164.0001.0001 at 0006 [19]; Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1407.12-16; Exhibit 3-23, Sydney Hearing, Statement of Richard Farmilo, 2 May 2019, WIT.0154.0001.0001 at 0005 [19].

423 Transcript, Amy Tinley, Sydney Hearing, 13 May 2019 at T1563-31.

Mr Farmilo gave evidence that the family's consent was obtained on 9 July 2018 when Ms Tinley spoke with Ms DL.[424] Ms DL says she received a call from Ms Tinley in July 2018 and provided her consent for the prescription of Mirtazapine to help with Mrs CO's anxiety and agitation.[425] Ms DL gave evidence that Ms Tinley did not discuss with her the dosage or potential side effects of the Mirtazapine prescription during this conversation.[426]

Mirtazapine has significant side effects, including increased appetite, weight gain, sedation, weakness and peripheral oedema.[427] Ms DL gave evidence that the side effects of the medication were not discussed with her.[428]

Ms Tinley and Mr Farmilo both said there were no procedural guidelines in place at Brian King Gardens to deal with the obtaining of consent in such circumstances.[429] Mr Farmilo gave evidence that Anglicare was currently developing a number of new policies, including one regarding capacity and consent.[430] In his evidence, Mr Farmilo agreed that the treating doctor is required to consult with a person who is able to make decisions relating to medical treatment on behalf of a resident before a treatment is agreed upon. He gave evidence that this is what normally happens at Brian King Gardens.[431]

Counsel Assisting submitted that written consent for this treatment was required pursuant to Part 5 of the Guardianship Act and that the 45mg dosage was inappropriate and not clinically warranted.

Anglicare submitted that consent was not required for the treatment because Dr Ginger considered it to be necessary as a matter of urgency to prevent Mrs CO continuing to suffer significant distress—and, therefore, that consent was not required pursuant to s 37(1)(c) of the Guardianship Act. Alternatively, Anglicare submitted that consent was not required under the Guardianship Act as the prescription of Mirtazapine is not a 'major medical treatment' pursuant to cl 10 of the Guardianship Regulation.

An immediate problem with the necessity or urgency submission of Anglicare is that if the charting of Mirtazapine was so urgent, there is no explanation as to why it took until the evening of 6 July for the drug to be administered.

Further, other than for Dr Ginger's evidence that she prescribed the drug because she 'just thought it was necessary to commence the medication for her',[432] the evidence of Ms Tinley and Dr Ginger would not seem to have embraced any notion that consent was

424 Exhibit 3-23, Sydney Hearing, Statement of Richard Farmilo, 2 May 2019, WIT.0154.0001.0001 at 0005 [19].

425 Exhibit 3-21, Sydney Hearing, Statement of DL, 18 April 2019, WIT.0136.0001.0001 at 0002 [14].

426 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1353-44.

427 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 117, RCD.9999.0035.0006.

428 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1354.7-9.

429 Transcript, Amy Tinley, Sydney Hearing, 13 May 2019 at T1563-37; Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1365.7-18.

430 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1365.41-46.

431 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1365.7-18.

432 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1407.25.

not required because of any pressing urgency or necessity. On their evidence, they never addressed themselves to the question of consent or discussed or recorded the matter as being one involving circumstances of the kind which s 37 applied. Dr Ginger assumed that it would have been administered that day,[433] but there is no evidence that she followed up the matter the following day. When asked why she prescribed mirtazapine on 4 July, her evidence was, which we accept:

> From the reports of the pastoral carer she was again crying and – and very upset. She was having memories back of her baby son and—and the—the dying of that baby son and that's very distressing for a patient with dementia because they can't really—they think it's very real at the time. And she had also had previous episodes where she was crying constantly, when they asked—the staff were asking her why are you crying, she couldn't remember why she was crying but she was upset. She was agitated. ….So at that stage I—I did—I didn't want to leave my patient distressed and in a distressed condition.[434]

Dr Ginger also agree that an antidepressant prescription would have little effect on the depressive symptoms for a period of days and sometimes a week of two.[435] Following that decision, Dr Ginger and Ms Tinley tried to contact the daughters several times.[436] This suggests that they wanted to raise the issue of consent with them. Ms Tinley made a note on iCare that as late as 9 July 2018 she was still trying to call Ms DL to talk about the move to Everglades and 'new medications', although the entries were not framed in terms of seeking consent *per se*.[437]

Ms DL's evidence about a conversation that she had at 4pm on 9 July suggests that the prescription was still regarded as requiring consent. She said that when she spoke to the person from Brian King Gardens she heard that her mother was reliving childhood memories of abuse and that she was:

> continuing to be very agitated, crying, and she was wandering a lot more and the nurses were finding this difficult for them. And they suggested that she goes on medication.[438]

When Counsel Assisting asked whether she agreed with that, she said:

> I—yes, I—I did give my consent for that to be used, but I had no idea actually what it was.[439]

433 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1407.35.

434 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1406.40-46.

435 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1406.20-25.

436 Transcript, Margaret Ann Ginger, Sydney Hearing, 8 May 2019 at T1407-15.

437 Exhibit 3-19, Sydney Hearing, Brian King Gardens Tender Bundle, tab 71, ANC.0001.0004.1360 at 1533.

438 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1353.33-36.

439 Transcript, DL/DM, Sydney Hearing, 8 May 2019 at T1353.44-45.

If the need to prescribe and administer mirtazapine was so urgent on 4 July that consent could be dispensed with, it is hard to reconcile that with the delay in the actual prescription of the drug.

Further, the iCare records did not record, as Mr Farmilo conceded, any update on Mrs CO's condition on 5 or 6 July to suggest that her condition was worsening.[440] It is equally troubling that there is no note on iCare concerning Mrs CO's progress at all between 4 and 9 July 2018.

Coupled with the fact that, as Mr Farmilo conceded, the drug could have been obtained and administered faster than it took to administer in this case, [441] there is little evidence to support the submission that the medical practitioner carrying out or supervising the treatment considered it necessary, as a matter of urgency, to prevent the patient from suffering or continuing to suffer significant pain or distress for the purposes of s 37(1)(c) of the Guardianship Act.

We are, however, concerned that mirtazapine, a drug with potentially serious side effects, was prescribed and administered to Mrs CO without the consent of her family members. While Brian King Gardens did obtain consent from Mrs CO's daughter, Ms DL, three days after mirtazapine was first administered, it is concerning that Ms DL gave evidence that the side effects of mirtazapine were not discussed with her.

Oberon Village case study

Introduction

The Royal Commission examined the experiences of Mrs CA at the Columbia Oberon Village Aged Care (Oberon Village) at Oberon, New South Wales, which is operated by Columbia and Australian Hospital Administration Pty Ltd (Columbia).

The evidence before the Royal Commission consisted of:

- the statement of Ms DF, Mrs CA's daughter, dated 17 April 2019[442]
- the statement of Cheryl O'Connell, registered nurse at Oberon Village, dated 24 April 2019[443]
- the statement of Marian Anderson, General Manager of Operations at Oberon Village, dated 24 April 2019[444]

440 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1378.15.

441 Transcript, Richard Farmilo, Sydney Hearing, 8 May 2019 at T1377.43.

442 Exhibit 3-32, Sydney Hearing, Statement of Ms DF, 17 April 2019, WIT.0102.0001.0001.

443 Exhibit 3-30, Sydney Hearing, Statement of Ms Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001.

444 Exhibit 3-33, Sydney Hearing, Statement of Ms Marian Anderson, 24 April 2019, WIT.0135.0002.0001.

- the oral testimony of Ms DD and Ms Anderson
- the tender bundle for this case study, which consists of 84 documents.[445]

Columbia was granted leave to appear at the public hearing and was represented by counsel and solicitors.

In accordance with the directions we made on 30 May 2019, Counsel Assisting provided written submissions setting out the findings they consider should be made arising from this case study. In response to those submissions, the Royal Commission received submissions from Columbia.[446]

Oberon Village is a 70-bed residential aged care facility operated by Columbia Nursing Homes Pty Ltd. Oberon Village is located about 180 kilometres west of Sydney.

Columbia provided numerous documents to us in answer to a notice to produce documents. Senior Counsel Assisting tendered several of those documents at the hearing.

At the outset of this case study, Senior Counsel Assisting explained that:

> Depending on the make-up of the population of a particular facility or an area within a particular facility such as a wing, there's a tension between the imperative of dignity of risk and freedom of movement on the one hand, and direct impacts on the physical safety of residents on the other.[447]

This case study illustrated this point. It also illustrated the range of perspectives of those affected by incidents of the kind experienced by Mrs CA. Senior Counsel Assisting continued:

> Family of residents who come to sustain injuries in incidents of this kind have a perspective that must be heard. But it's also important to consider the perspective of management and the difficulties management faces and how they grapple with the difficult issues that are raised.[448]

It is against this background that we have considered the experience of Mrs CA at Oberon Village.

Background

Mrs CA was born on 5 June 1936. She was 82 years old at the time of the Sydney Hearing.[449] Mrs CA is married with five daughters and two sons.[450] Mrs CA was diagnosed

445 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle.

446 Sydney Hearing, Submissions of Columbia Aged Care, 7 June 2019, RCD.0012.0007.0036.

447 Transcript, Sydney Hearing, 8 May 2019 at T1429.6-9.

448 Transcript, 8 May 2019 at T1429.12-15.

449 Transcript, DF, Sydney Hearing, 8 May 2019 at T1434.47.

450 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0001 [5].

with Alzheimer's disease in or around 2010.[451] She lived at home with her husband until May 2018.[452]

Ms DF explained that while Mrs CA was at home, she and her sisters helped care for their mother. They assisted with showering, cleaning up and providing meals.[453]

Mrs CA was unable to look after herself from around October 2017. Ms DF stated that Mrs CA 'could walk but she needed to be fed, showered, dressed and wear incontinence pads'.[454] Mrs CA could not speak.[455] On occasion, Mrs CA would 'lash out' at her husband.[456] She had a history of 'wandering'.[457]

In May 2018, Mrs CA's husband had knee replacement surgery.[458] When Mrs CA's family became aware that this surgery was necessary, they made arrangements to place Mrs CA into residential respite care.[459]

This was a difficult decision for the family. As Ms DF explained:

> Dad did not want to put Mum in care, but we saw this as a good opportunity to take the first step towards permanent care. With Dad having had surgery, we were able to get her into respite care. By that stage my sister [DG] had quit her job and was getting called out to their house every second day to help with things.[460]

On 16 May 2018, Mrs CA entered Oberon Village on a respite basis.[461] She was admitted to a dementia-specific unit of the facility.[462] Ms DF said that Mrs CA seemed 'pretty happy' at Oberon. There was 'a nice lounge room and [Mrs CA's] room was lovely'.[463] Ms DF stated that the staff there were lovely to Mrs CA.[464] However, the two incidents explored in the case study were, according to Ms DF, 'really bad'.[465]

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451 Transcript, DF, Sydney Hearing, 8 May 2019 at T1435.9; Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0001 [5].

452 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0001 [5].

453 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0001 [5].

454 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0001 [6].

455 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0001 [7].

456 Transcript, DF, Sydney Hearing, 8 May 2019 at T1435.19-24.

457 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0003 [15]-[16].

458 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0002 [8].

459 Transcript, DF, Sydney Hearing, 8 May 2019 at T1435.45-1436.6.

460 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0002 [8].

461 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 32, CAC.0001.0010.0094 at 0098.

462 Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0002 [9].

463 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0002 [9].

464 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0005 [30].

465 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0005 [30].

Compliance with the Accreditation Standards

Prior to Mrs CA's admission to the dementia unit at Oberon Village, the service at the facility had attracted the attention of the Australian Aged Care Quality Agency.

On 18 January 2018, the Quality Agency conducted an unannounced contact assessment visit at Oberon Village.[466] From 6 February 2018 to 23 February 2018, the Quality Agency conducted a review audit against the 44 expected outcomes of the Accreditation Standards.[467]

On 27 March 2018, a delegate of the Secretary of the Australian Department of Health issued a notice of non-compliance to Columbia Nursing Homes.[468]

The notice of non-compliance recorded that Oberon Village had not met certain of the expected outcomes in the Accreditation Standards. In particular, the notice recorded that Oberon Village had not met expected outcome 2.13 (behavioural management). That expected outcome stated that 'the needs of care recipients with challenging behaviours are managed effectively'.[469]

On 16 May 2018, around the time of Mrs CA's admission to Oberon Village, the Quality Agency found that, with one exception relating to information systems, all instances of non-compliance had been resolved.[470]

The dementia unit

During Mrs CA's stay at Oberon Village, there were 27 residents with a diagnosis of dementia. Twelve of these residents, including Mrs CA, resided in the dementia unit.[471] There were two empty beds.[472]

Ms O'Connell stated that in June 2018, for the 12 residents then staying in the dementia unit, there was one assistant in nursing and one enrolled nurse rostered to work.[473] She stated that the registered nurse on duty would attend the dementia unit to 'monitor the residents'.[474] Other staff, including an in-house dementia advisor, would also attend the unit from time-to-time.[475]

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466 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 10, CTH.1006.1000.0010.

467 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 11, CTH.4001.0005.2260; tab 12, CTH.4001.0005.1620.

468 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 21, CTH.1006.1000.0302.

469 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 21, CTH.1006.1000.0302 at 0308.

470 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 31, CTH.1006.1000.0148.

471 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0007 [44]; Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0008 [52].

472 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0007 [44].

473 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0002 [15] and 0007 [44].

474 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0007 [44]-[45].

475 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0005 [29]; Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0009 [53].

Columbia Nursing Homes provided a floor plan of the dementia unit at Oberon Village to us.[476]

The floor plan shows that the dementia unit had 14 beds for residents. Ten were single rooms. There were two rooms with two beds. Each of these rooms was accessed by a door off a central hallway.

The dementia unit had a communal space. This space was used as a dining room and a sitting room. A nurses' station / quiet room (the nurses' station) was adjacent to the communal space.[477]

Ms DF's statement included an observation that the nurses' station did not have glass windows allowing supervision of the residents and that, even with the door open, there was only a partial view of the communal area and the garden and no line of sight from the nurses' station down the corridor of the central hallway to the residents' rooms.[478] The floor plan showed a small window pane in the door between the nurses' station and the communal area. Ms DF said that even if there was some glass, this permitted only a partial view of the communal space and the ends of the hallway could not be seen.[479] The floor plan is consistent with Ms DF's evidence that the ends of the hallway and doorways to rooms off those areas of the hallway could not be seen from the nurses' station and we accept it.

Ms O'Connell and Ms Anderson explained that closed circuit television cameras monitored all common areas at Oberon Village. This footage was livestreamed to a monitor in the nurses' station. The cameras did not monitor residents' rooms.[480] Ms O'Connell stated that the nurses' station is 'designed to assist the care staff on duty, not to be their primary location'.[481] We accept this, but also note and accept Ms DF's evidence that she had seen both of the two staff on duty in the room at the same time.[482]

Under the procedures in place for the dementia unit, care staff checked residents every 30 minutes. However, Ms O'Connell told us that observations might occur more frequently due to ordinary staff movement.[483] Columbia Nursing Homes submitted that it believes that the supervision of residents at Oberon Village through nursing, other staff, and closed circuit television monitoring 'was appropriate and in compliance with aged care legislation'.[484]

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476 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 84, CAC.0005.0001.0001.

477 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0003 [20]. See also Transcript, DF, Sydney Hearing, 8 May 2019 at T1443.40-1444.7.

478 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0005 [30]; Transcript, DF, Sydney Hearing, 8 May 2019 at T1444.29-1445.2. See also Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 84, CAC.0005.0001.0001.

479 Transcript, DF, Sydney Hearing, 8 May 2019 at T1444.13-14.

480 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0015 [104]; Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0007 [43], 0011 [65]-[66] and 0013 [73].

481 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0015 [108].

482 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0015 [108].

483 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0006 [34] and 0008 [54]. See also Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1456.38-1457.10.

484 Sydney Hearing, Submissions of Columbia Aged Care, RCD.0012.0007.0036 at 0037 [17].

Mrs CA was allocated room 2, which was located at one end of the central hall way.[485] We were told that she regularly 'wandered' about the unit. She would enter other residents' rooms and pick up their belongings.[486]

The room next door to Mrs CA's room was room 4. This room was occupied by a female resident, Mrs CC.[487]

Room 1, across the hallway from Mrs CA's room, was occupied by a male resident, Mr CB.[488] During the day, he generally spent his time outside his room. The door to his room was usually locked.[489]

Mrs CC was involved in an incident with Mrs CA on 22 June 2018. Mr CB was involved in an incident with Mrs CA on 27 June 2018. We return to these incidents below.

Reportable Assaults Register

In the 11 months before the incident concerning Mrs CA on 22 June 2018, Mrs CC was recorded in Oberon Village's 'Reportable Assaults (Sexual and Physical) Register' as having been suspected of assaulting, or alleged to have assaulted, other residents on five occasions.[490] Those 'assaults' were recorded on 28 July 2017, 23 January 2018, 15 February 2018, 11 May 2018 and 17 May 2018.

During a Quality Agency site visit on 13 February 2018, the Quality Agency recorded that Oberon Village referred Mrs CC to the Dementia Behaviour Management Advisory Service on 12 January 2018. However, the Quality Agency noted that the Dementia Behaviour Management Advisory Service's recommendations had not been incorporated into Mrs CC's care plan. The Quality Agency also noted that staff working with Mrs CC did not have access to the Dementia Behaviour Management Advisory Service report.[491]

During a further Quality Agency visit on 15 May 2018, the Quality Agency recorded that Mrs CC's 'challenging behaviour' had improved. The Quality Agency noted that a behaviour assessment for Mrs CC was completed on 9 April 2018.[492]

485 Transcript, DF, Sydney Hearing, 8 May 2019 at T1442.37-1443.15.

486 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0003 [16]; Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0005 [30].

487 Transcript, DF, Sydney Hearing, 8 May 2019 at T1443.17-24.

488 Transcript, DF, Sydney Hearing, 8 May 2019 at T1443.26-38.

489 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1456.18-21; Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0002 [13]; Transcript, DF, Sydney Hearing, 8 May 2019 at T1442.27.

490 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001 at 0005-0007.

491 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 14, CTH.1006.1000.0078 at 0090.

492 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 30, CTH.1006.1000.0121 at 0138 and 0139.

In the 15 months before the incident concerning Mrs CA on 27 June 2018, Mr CB was recorded in Oberon Village's reportable assaults register as having been suspected of assaulting, or alleged to have assaulted, other residents on three occasions.[493] Those 'assaults' were recorded on 4 April 2017, 9 May 2017 and 8 November 2017.

Ms Anderson gave evidence that after each of the incidents concerning Mrs CC and Mr CB, there was follow up by staff at Oberon Village on the measures relating to their conduct.[494]

As Counsel Assisting submitted, this follow-up evidently did not prevent further incidents occurring.[495] When asked why there had been repeated incidents, Ms Anderson's evidence was to the effect that both Mrs CC and Mr CB, as people living with dementia, could show unpredictable behaviour for which triggers are unexpected and spontaneous.[496] Ms Anderson explained that Oberon Village's policies promoted minimal use of physical and chemical restraints. They were to be used only as a last resort.[497]

Columbia Nursing Homes submitted that while Counsel Assisting's observation about follow-up not preventing further incidents is factually correct, it 'should not be regarded in a pejorative way'.[498] This is because, Columbia Nursing Homes submitted, once a decision was taken 'to prefer resident dignity' over the use of restraints, 'there is a risk that there will be interactions between residents from time to time'.[499] We accept this submission at a general level. However, it raises the obvious point that great consideration is needed in managing the mix of residents in particular areas of a facility. On the evidence before us, we are unable to reach a conclusion about whether anything more could reasonably have been done to mitigate the risk of incidents involving Mr CB or Mrs CC and other residents of the dementia wing, including Mrs CA.

Mrs CA herself was recorded in Oberon Village's assaults register. She was suspected of having assaulted, or alleged to have assaulted, a staff member on 3 June 2018.[500] While this matter was not explored in detail at the hearing, it is illustrative of the challenges in behaviour management faced by Oberon Village.

493 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001 at 0004-0007.

494 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1450.5-1453.18.

495 Sydney Hearing, Submissions of Counsel Assisting, RCD.0012.0004.0025 at 0027-0028 [14], [17].

496 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1453.27.

497 Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0012 [70]-[71], 0014-0015 [81]-[86].

498 Sydney Hearing, Submissions of Columbia Aged Care, RCD.0012.0007.0036 at 0038 [22].

499 Sydney Hearing, Submissions of Columbia Aged Care, RCD.0012.0007.0036 at 0038 [22].

500 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001 at 0006.

Incidents concerning Mrs CA

An extended care plan for Mrs CA was finalised on 31 May 2018, two weeks after her admission to Oberon Village. The care plan explained some of Mrs CA's behaviours:

> [Mrs CA] shadows staff members caring for her and/or other residents. When this happens staff are to reassure [Mrs CA] and provide her with diversionary activity such as dusting. [Mrs CA] is intrusive at times and will enter other residents' rooms and handle and remove other residents' belongings causing distress to others and at times exposing herself to risk for injuries takes things that do not belong to her. When this occurs staff are to monitor for comfort or other needs such as toileting, thirst, hunger, pain etc. and address same. Staff are to reorientate [Mrs CA] to her room and her belongings.
>
> When [Mrs CA] displays intrusive wandering Staff are to redirect [Mrs CA] to familar [sic] surroundings and reorientate her to her bedroom/dinning [sic] room where necessary [sic]. Staff to encourage the residents famiy [sic] to personalise her bedroom to create a sense of belonging and familiarity. Staff are to provide [Mrs CA] with purposeful activities to provide physical and social stimulation and ensure boredom is not a trigger for behaviours. When [Mrs CA] displays pacing behaviour staff are to monitor for evidence of pain (i.e. rubbing, grimacing, guarding, flinching moaning or other vocalisations etc) and report any concerns to the RN for further assessment and management. When [Mrs CA] displays sleep disturbances staff are to assist her with toileting, monitor for pain and provide her with a snack and warm drink.[501]

Three behaviour assessments were prepared for Mrs CA while she was at Oberon Village.[502] The first of those assessments was commenced on 1 June 2018 and completed on 5 June 2018.[503] It recorded that Mrs CA may take items that do not belong to her.

22 June incident

At approximately 3.00pm on 22 June 2018, Mrs CA and Mrs CC were unaccompanied by staff for a short time in the communal area. Mrs CA 'attempted to remove [Mrs CC's] clean clothing from her hands'.[504] There was then an altercation between the two of them and Mrs CC hit Mrs CA on the face.[505] Mrs CA sustained a cut to her mouth.[506]

501 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 38, CAC.0001.0009.0003 at 0014-0016.

502 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 50, CAC.0001.0010.0613; tab 56, CAC.0001.0010.0590; tab 60, CAC.0001.0010.0592.

503 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 50, CAC.0001.0010.0613.

504 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 53, CAC.0001.0008.0016; Transcript, DF, Sydney Hearing, 8 May 2019 at T1437.10-17.

505 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 53, CAC.0001.0008.0016; Transcript, DF, Sydney Hearing, 8 May 2019 at T1437.10-17.

506 Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0006 [39]; Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0002 [10]-[12].

The critical incident report for this incident records that each of Mrs CA's and Mrs CC's families were contacted.[507] As we have set out above, Oberon Village contacted the Dementia Behaviour Management Advisory Service after this incident. The critical incident report records that the advisory service confirmed 'interventions are appropriate for residents' condition'.[508]

A second behaviour assessment was recorded to have been completed for Mrs CA at 3.34pm on 22 June 2018. This was half an hour after the incident involving Mrs CA and Mrs CC.[509] This assessment does not refer to that incident and is substantially the same as Mrs CA's first behaviour assessment.[510]

Ms Anderson was not present at the time of this incident. It was not reported to her at the time. She gave evidence to us based on a review of the documents that had been completed by staff at Oberon at the time of this incident.[511]

Ms Anderson did not know whether the second assessment was completed as a result of the incident involving Mrs CA and Mrs CC.[512] She said the assessment was by the 'in-house dementia adviser'. The Dementia Behaviour Management Advisory Service was also contacted. Ms Anderson said they were aware of the strategies 'and agreed they were sufficient'.[513] This is consistent with the notation on the critical incident report that the advisory service had been contacted and had confirmed that the interventions were appropriate.

A third behaviour assessment was completed for Mrs CA on 25 June 2018.[514] This assessment included some additional information about the behaviours displayed by Mrs CA.[515] It also included additional guidance about behaviour management interventions recommended for Mrs CA.[516]

Again, the in-house dementia advisor made this assessment. Ms Anderson explained that some of the strategies for managing Mrs CA's behaviour remained the same as those in the previous assessments. Ms Anderson noted that the Dementia Behaviour Management Advisory Service had been consulted. She expected Oberon Village 'would go with' expert advice from that service.[517]

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507 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 53, CAC.0001.0008.0016.

508 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 53, CAC.0001.0008.0016.

509 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 56, CAC.0001.0010.0590.

510 See Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1457.37-1458.26.

511 Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0006 [34].

512 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1457.44-1458.1.

513 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1458.11-26.

514 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 60, CAC.0001.0010.0592.

515 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 60, CAC.0001.0010.0592.

516 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 60, CAC.0001.0010.0592 at 0593.

517 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1458.28-1459.24.

27 June incident

At around 8.15 pm on 27 June 2018, there was a second incident involving Mrs CA. Records about this incident were prepared by staff at Oberon Village and provided to us.[518]

Early on the evening of 27 June, Mrs CA was assisted to bed for the night. A short time later, Mrs CA 'wandered' out of her room and was walking down the corridor.[519] It is not entirely clear whether staff directed, escorted, partially directed or partially escorted Mrs CA from the communal area to her room. What is clear is that she was then left unaccompanied.[520] At this time, there were two staff on duty in the dementia unit.[521]

At some time between 7.59pm and 8.10pm that evening, Mrs CA entered Mr CB's room while Mr CB was in it.[522] Ms Anderson said that Mrs CA and Mr CB were not under 'immediate supervision' at the time.[523]

While Mrs CA was in Mr CB's room, Mrs CA's head and body made forceful contact with the floor. Mrs CA said that Mr CB pushed her. Mr CB said that Mrs CA fell and he pulled her into the corridor to get help.[524]

At approximately 8.10pm, an assistant in nursing on duty that night saw Mr CB dragging Mrs CA out of his room by her arms into the hallway.[525] Mrs CA was bleeding heavily from her head.[526]

Staff on duty that night did not see the events in Mr CB's room. Closed circuit television camera footage did not assist in revealing what had happened.[527]

Attempts were made to contact a registered nurse on duty. At about 8.15pm, a nurse, Ms O'Connell, arrived from another floor.[528]

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518 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 61, CAC.0001.0008.0003; tab 62, CAC.0001.0002.0088; tab 63, CAC.0002.0007.0378.

519 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0002 [13] and 0003 [15]; Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 63, CAC.0002.0007.0378.

520 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 63, CAC.0002.0007.0378; Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0008 [58].

521 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 0007 [47].

522 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 63, CAC.0002.0007.0378.

523 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1459.26-30.

524 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 62, CAC.0001.0002.0088 and tab 65, CAC.0001.0008.0002.

525 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 62, CAC.0001.0002.0088 and tab 63, CAC.0002.0007.0378. See also Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0007 [43].

526 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 49, CAC.0001.0010.0044 at 0046; tab 62, CAC.0001.0002.0088.

527 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 62, CAC.0001.0002.0088 and tab 65, CAC.0001.0008.0002.

528 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 62, CAC.0001.0002.0088.

Ms O'Connell stated that she immediately assessed Mrs CA. She observed a five centimetre laceration on Mrs CA's head. The laceration was bleeding heavily. She applied pressure to the wound, which stopped bleeding after approximately five minutes.[529] Ms O'Connell stated that after assessing Mrs CA she called an ambulance to transfer Mrs CA to hospital.[530]

At approximately 8.25pm, staff contacted the families of Mrs CA and Mr CB about the incident.[531] Staff also reported the incident to the police, who attended the facility at 9.30pm.[532] The police later decided not to take the matter further.[533]

It is not possible for us to form a conclusion about whether Mrs CA was hit or pushed by Mr CB that night or whether she fell. However, it is clear from what follows that she sustained significant injuries as a consequence of what happened that night.

Admission to hospital

Following the incident on 27 June 2018, Mrs CA was admitted to two hospitals.

On the evening of 27 June 2018, Mrs CA was taken by ambulance to the first hospital for 'further investigation and treatment'.[534]

Ms DF recounted what her sister told her about Mrs CA's appearance and what happened at the first hospital.[535] There was a lot of blood on the right side of Mrs CA's head but she did not 'seem too bad'.[536] The first hospital wanted to take some X-rays. However, the radiographer was not available for another two days. In the meantime, the hospital proposed to return Mrs CA to Oberon Village. The family refused. They wanted Mrs CA to remain in hospital.[537]

On 29 June 2018, the radiographer was unavailable. Ms DF said that Mrs CA 'looked close to death'.[538] Mrs CA was transferred to a second, larger hospital. Staff at the second hospital 'saw the visible haematoma on [Mrs CA's] head'. They recommended a CT

529 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 00013-14 [95]-[96].

530 Exhibit 3-30, Sydney Hearing, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at 00013-14 [97]; see also Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 49, CAC.0001.0010.0044 at 0046.

531 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 61, CAC.0001.0008.0003; tab 49, CAC.0001.0010.0044 at 0046.

532 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 61, CAC.0001.0008.0003

533 Exhibit 3-33, Sydney Hearing, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at 0007 [47].

534 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 49, CAC.0001.0010.0044 at 0046.

535 Transcript, DF, Sydney Hearing, 8 May 2019 at T1438.12-1439.19; Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0003 [21]-[22].

536 Transcript, DF, Sydney Hearing, 8 May 2019 at T1438.41-43.

537 Transcript, DF, Sydney Hearing, 8 May 2019 at T1438.43-45; Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0003 [21].

538 Transcript, DF, Sydney Hearing, 8 May 2019 at T1439.8-19; Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0003 [22].

scan.[539] Those scans showed, Ms DF said, that Mrs CA had a bleed on her brain, as well as a fractured left clavicle and a fractured pelvic rami.[540] Notwithstanding the absence of medical or hospital records about Mrs CA's injuries,[541] we accept Ms DF's evidence about the nature of these injuries.

Mrs CA stayed in the medical ward of the second hospital for three and a half weeks.[542] Ms DF stated that during this time it fell to her and her sisters to be Mrs CA's voice.[543] Ms DF believed the hospital's aim was to send Mrs CA back to an aged care facility. She and her sisters wanted Mrs CA to be able to walk before she left hospital.[544]

Ms DA stated that it seemed to her that hospital staff did not know how to care for someone living with dementia. Ms DF explained:

> They didn't realise Mum could not talk or that she could not feed herself. If I, or another family member, were not in attendance, I don't think Mum would have been changed, given fluid or food. I also am not sure she would have been given pain relief.[545]

Ms DF and her sisters pushed for Mrs CA to move to the rehabilitation ward.[546] Once there, Ms DF stated, Mrs CA was refused physiotherapy when the physiotherapist realised Mrs CA could not speak. Mrs CA was on the rehabilitation ward for a few days before the family was told that Mrs CA's application for rehabilitation was not approved because of Mrs CA's inability to communicate.[547] Once the family was told this, they decided it was time to move Mrs CA to an aged care facility.[548]

Mrs CA's new facility

After Mrs CA was transferred to hospital on 29 June 2018, Ms DF started looking for emergency care for Mrs CA. She secured a place at another aged care facility.[549] After Mrs CA left the rehabilitation ward, she moved to that facility, where she remained at the time of the hearing.[550]

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539 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0003 [22].

540 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0003 [22]; Transcript, DF, Sydney Hearing, 8 May 2019 at T1439.8-19.

541 Sydney Hearing, Submissions of Columbia Aged Care, RCD.0012.0007.0036 at 0039 [30].

542 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [26] and [28].

543 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [23].

544 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [23].

545 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [24].

546 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [26].

547 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [27]-[28]; Transcript, DF, Sydney Hearing, 8 May 2019 at T1441.12-41.

548 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [28]

549 Transcript, DF, Sydney Hearing, 8 May 2019 at T1441.43-1442.9.

550 Transcript, DF, Sydney Hearing, 8 May 2019 at T1441.43-1442.9; Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [29].

Ms DF explained that this facility was not the first preference for Mrs CA. However, she said that now that Mrs CA is there, her family 'are really happy':

> The staff there are brilliant and have bent over backwards. Mum is now immobile so her wandering isn't an issue. She sits in a chair or in bed. We haven't had any incidents.[551]

Mrs CA is now chairbound or bedbound. She does not talk at all.[552]

Oberon Village's reporting of 'assaults'

Between 10 July 2015 and 6 February 2019, there were 82 assaults recorded in Oberon Village's reportable assault register.[553] Of the 82 incidents in the reportable assaults register, 10 were reported to the Australian Department of Health. The remaining incidents were not reported because they involved one or more residents with 'cognitive impairment'.

Ms Anderson explained that the register maintained by Oberon Village records not only reportable and non-reportable assaults, but also allegations of resident assaults on staff.[554] Columbia Nursing Homes submitted that 'there is no obligation on Oberon Village to maintain such a comprehensive register'.[555] However, we consider that it is good practice.

The 'assaults' by Mrs CC and Mr CB on other residents recorded in Oberon Village's reportable assaults register before June 2018 were alleged or suspected 'reportable assaults'.[556] Those alleged or suspected reportable assaults were not reported by staff at Oberon Village to police and the Department of Health. Nor were they required to be.[557]

Subsection 63.1AA(3) of the *Aged Care Act 1997* (Cth) provides that the obligation to report does not apply 'in the circumstances…specified in the Accountability Principles'. Approved providers are responsible for complying with the requirements of those principles. Subsection 53(1) of the *Accountability Principles 2014* (Cth) specifies circumstances for the purposes of s 63.1AA(3) of the Aged Care Act. In particular, an approved provider is not required to report an alleged or suspected reportable assault if the alleged or suspected assault was committed by a care recipient who had previously been assessed as suffering from a cognitive or mental impairment and in respect of whom the approved provider has since put in place and made a record of arrangements for management of their behaviour.

551 Exhibit 3-32, Sydney Hearing, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at 0004 [29].

552 Transcript, DF, Sydney Hearing, 8 May 2019 at T1442.20-30.

553 Exhibit 3-29, Sydney Hearing, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001.

554 Transcript, Marian Anderson, Sydney Hearing, 8 May 2019 at T1455.6-7.

555 Sydney Hearing, Submissions of Columbia Aged Care, RCD.0012.0007.0036 at 0039 [33].

556 See s 63.1AA of the *Aged Care Act 1997* (Cth).

557 See s 63.1AA(2) of the *Aged Care Act 1997* (Cth).

It appears from the entries in the right hand column of Oberon Village's reportable assaults register that alleged or suspected reportable assaults by Mrs CC and Mr CB were not reported to police and the Department of Health on the basis that the requirements of s 53(1) of the Accountability Principles were met.

Evidence was not put before the Royal Commission about what Columbia Nursing Homes did to meet the requirements of s 53(1) of the Accountability Principles in respect of entries in the register relating to alleged or suspected assaults by Mrs CC or Mr CB before June 2018. However, Columbia Nursing Homes submitted that in its view the requirements of the Accountability Principles were met.[558] We accept this submission.

Nevertheless, whatever was done to meet those requirements, it did not prevent the incidents involving Mrs CA on 22 and 27 June 2018. Questions also remain about the adequacy of the requirements themselves.

Accommodating people with behaviours associated with dementia

Finally, this case study illustrated the challenges providers of aged care face when accommodating people who live with behaviours associated with dementia.

Counsel Assisting submitted that:

> Residents with a history of aggressive behaviours, such as Mrs CC and Mr CB, should, where possible, be placed in rooms that are in the line of sight of a staff outpost. Residents with a history of intrusive behaviour, such as Mrs CA, should not be placed in rooms nearby rooms occupied by residents who have a history of suspected or alleged aggressive behaviour, especially in a location where the entries to such rooms are not in clear line of sight of staff.[559]

Columbia Nursing Homes accepted that room placement could impact interactions between residents. However, it submitted that there is no evidence before the Royal Commission to support the above submission of Counsel Assisting. Columbia Nursing Homes submitted that:

> Due to the inherent unpredictability of dementia which can manifest in aggressive behaviour, Columbia does not believe placing residents with a 'history of aggressive behaviour' within line of sight and away from those with intrusive behaviour would necessarily prevent harm coming to any resident.[560]

Everyone has a right to feel safe where they live, to have privacy and to have freedom of movement. The issue of how best to accommodate people living with behaviours associated with dementia is complex. We will return to this matter during the course of our inquiry.

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558 Sydney Hearing, Submissions of Columbia Aged Care, RCD.0012.0007.0036 at 0039 [35].

559 Sydney Hearing, Submissions of Counsel Assisting, RCD.0012.0004.0025 at 0032 [39].

560 Sydney Hearing, Submissions of Columbia Aged Care, RCD.0012.0007.0036 at 0041 [44].

Bupa Willoughby case study

Introduction

The Royal Commission examined the experience of Mrs DE at Bupa Aged Care Willoughby (Bupa Willoughby) following her discharge from hospital in July 2017. Bupa Willoughby is an aged care facility located in Sydney. It is operated by Bupa Aged Care Australia Pty Ltd (Bupa).

The evidence before the Royal Commission consisted of:

- the statement of Ms DI, Ms DE's daughter, dated 17 April 2019[561]
- the statement of Ms DJ, Ms DE's daughter, dated 12 May 2019[562]
- the statement of Timothy Ross, Bupa Medical Services Director, dated 26 April 2019[563]
- the statement of Maureen Berry, Bupa Executive Clinical Advisor, dated 1 May 2019[564]
- the oral testimony of Ms DI, Ms DJ and Ms Berry
- the tender bundle for this case study, which consists of 175 documents.[565]

Bupa was granted leave to appear at the public hearing and was represented by counsel and solicitors.

In accordance with the directions we made on 30 May 2019, Counsel Assisting provided written submissions setting out the findings they consider should be made arising from this case study. In response to those submissions, we received submissions from Bupa.[566]

We heard oral evidence from Mrs DE's daughters, Ms DI and Ms DJ, who each gave evidence to the Royal Commission to the effect that the standard of care provided to their mother fell below their expectations.

We also heard oral evidence from Ms Maureen Berry. Ms Berry is an experienced registered nurse currently in her 46th year of practice.[567] During the relevant period, Ms Berry was Chief Operating Officer of Bupa.[568] She was not involved in the direct care of Mrs DE, and she gave evidence based on a review of the relevant documents.[569]

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561 Exhibit 3-35, Sydney Hearing, Statement of Ms DI, 17 April 2019, WIT.0101.0001.0001.

562 Exhibit 3-36, Sydney Hearing, Statement of Ms DI, 12 May 2019, WIT.0190.0001.0001.

563 Exhibit 3-37, Sydney Hearing, Statement of Mr Timothy James Ross, 26 April 2019, WIT.0148.0001.0001.

564 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001.

565 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle.

566 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060.

567 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0001 [7].

568 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0001 [5].

569 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0002 [9].

Bupa submitted that Counsel Assisting did not make any recommendations to us as to the findings that could be made against Bupa in this case study.[570] We do not accept this submission. It is clear from the language of Counsel Assisting's submissions that they make conclusions of fact and certain allegations, and that they invite us to make findings in line with those conclusions.

In circumstances where we have not made findings beyond the matters raised in Counsel Assisting's submissions, we have not considered it necessary to invite further submissions from Bupa.

In determining whether to make findings in line with the conclusions set out throughout Counsel Assisting's submissions, we have had regard to the evidence before us in this case study. We have also had regard to the matters raised in the written submissions made on behalf of Bupa.

Counsel Assisting made various submissions that the care provided to Mrs DE was, in certain regards, 'substandard'. Bupa submitted that the term 'substandard' and interchangeable phrases, such as 'gap in care', 'serious failure of care' and 'below the standards expected of aged care providers', were not defined in Counsel Assisting's submissions. Nor were those terms, Bupa submitted, defined in the evidence led during the hearing of this case study, including during Ms Berry's oral evidence.[571] Bupa set out its understanding of the definition of substandard care as:

a. care (or complaints about care) which did not meet the relevant quality standards under the *Quality of Care Principles 2014* and other obligations under the Aged Care Act; and

b. care (or complaints about care) which, although meeting the relevant quality standards under the Quality of Care Principles and other obligations under the Aged Care Act, was not of a standard that would meet the high standards of uality and safety that the Australian community expects of aged care services.[572]

This definition is consistent with the definition of 'substandard care' provided in our guidance about the service provider survey.[573] This is the definition the Royal Commission applies in considering instances or possible instances of alleged substandard care.

In addition, Bupa submitted that it has had regard to its own policies and procedures about such matters. Those policies and procedures define 'incident' as an 'event or circumstance which could have led (or did lead) to unintended harm, loss or damage to a person'. Bupa submitted that the application of these definitions would capture cases falling below community expectations.[574]

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570 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0061 [6]

571 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0062 [7].

572 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0062 [8].

573 Service Provider Survey FAQ, https://agedcare.royalcommission.gov.au/submissions/Documents/faq-service-provider-survey.pdf, viewed 11 August 2019.

574 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at [10].

In considering the matters raised in this case study, we have adopted and applied Bupa's understanding of the definition of substandard care.

Background

Mrs DE was born in 1947 in Germany.[575] Mrs DE had two daughters, Ms DI and Ms DJ. Mrs DE died in Willoughby on 15 August 2017 at 70 years of age.[576]

In late 2016, Mrs DE's daughters observed her to be experiencing some memory loss and forgetfulness as well as a small amount of confusion. They put it down to Mrs DE getting older.[577] However, in February 2017 Mrs DE had a fall at home and was taken to Royal North Shore Hospital. She was a patient there for several weeks.[578]

Ms DI explained that the doctors thought Mrs DE may have had a stroke or seizure.[579] She was prescribed an anti-seizure medication, Epilim.[580] Ms DI said this seemed to improve her mother's condition, bringing her 'back to good health and improved cognitive state'.[581]

Mrs DE had a history of cancer. She was diagnosed with lung cancer in 2002 and with two brain tumours the following year.[582] Mrs DE was treated with radiotherapy on her brain and lungs. In 2004, Mrs DE was in remission. She was 'considered to be a miracle by her oncologist'.[583]

Ms DI explained that tests were conducted during Mrs DE's hospital stay and doctors concluded that Mrs DE's cognitive and physical condition was a result of her cancer treatment. In short, Mrs DE's 'brain was beginning to "melt"'.[584] Despite this, Ms DI told us that while her mother was in hospital and undergoing testing:

> she was still very mobile and happy. She would laugh with the nurses. She was still very much her old self.[585]

At this time both Ms DI and Ms DJ had young babies. Their mother coming to stay with either of them once she was discharged from hospital was not an option. They decided to look into respite care for Mrs DE with the idea that she would 'get better and then return to her apartment to live on her own again'.[586]

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575 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0001 [5].

576 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 78, BPA.001.127.0191.

577 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0001 [9].

578 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [10]

579 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [12].

580 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [12], [13].

581 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [12].

582 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0001 [8].

583 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0001 [8].

584 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [12].

585 Transcript, DI, Sydney Hearing, 13 May 2019 at T1468.36-38.

586 Transcript, DI, Sydney Hearing, 13 May 2019 at T1468.43-1469.2.

In mid to late February 2017, while Mrs DE was still in hospital, she was assessed by an Aged Care Assessment Team (ACAT).[587]

On 3 March 2017, Mrs DE was approved for high care residential respite, permanent residential care and a Level 4 Home Care Package. Mrs DE's ACAT assessment recorded the care needs of Mrs DE. These care needs included an air mattress for pressure area care.[588]

Ms DI said that her mother was 'adamant she did not want to enter respite or aged care', so she and her sister arranged in-home support for their mother. When Mrs DE returned home from hospital, assistance was in place.[589]

Ms DI and Ms DJ had concerns about how able Mrs DE was to look after herself. They were keeping a close eye on her. It looked like Mrs DE's cognition might be declining further.[590]

Two or three days after Mrs DE left hospital, Ms DI and Ms DJ realised that she could not be alone. She could not walk around her apartment unassisted, and 'she was confused and spaced out'. The hospital could not keep Mrs DE long term, so Ms DI and Ms DJ started looking for residential respite care for her.[591]

Mrs DE joined Ms DJ on a tour of an aged care facility. Early on in the tour she left, saying she did not want to stay there and was not in need of aged care.[592]

Mrs DE continued to live at home with assistance in place as arranged by Ms DI and Ms DJ.

26 May 2017 hospitalisation

On 26 May 2017, Mrs DE had a fall at home. She returned to Royal North Shore Hospital by ambulance with a badly fractured right humerus.[593] Mrs DE remained in hospital until 6 July 2017.[594]

During her hospital stay, Mrs DE's cognitive condition declined and her health deteriorated. Her communication became limited. She was reliant on assistance and was bedridden.[595]

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587 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [14].

588 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1502.19-33; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 168, BPA.036.002.9382 at 9383.

589 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [14].

590 Transcript, DI, Sydney Hearing, 13 May 2019 at T1469.41-47.

591 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [15].

592 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [15].

593 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0002 [16]-[17]; Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0001 [7].

594 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 50, BPA.001.127.0212.

595 Transcript, DI, Sydney Hearing, 13 May 2019 at T1470.13-24; Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0001 [8].

Mrs DE would often complain in hospital 'about pain or discomfort from her bed sores, fractured arm or arthritic knee'.[596] Ms DJ observed that as Mrs DE lost her ability to speak, it was more difficult to tell what was wrong. However, there were times when she would moan, grimace and point to communicate that she was in pain.[597] Ms DI said that while her mother could not necessarily tell her where the pain was or the extent of the pain, 'you could tell that something was really bothering her'.[598] Ms DI said that when Mrs DE needed to be turned because of her pressure injuries:

> it was really distressing. We would usually leave the room because she would be howling and moaning and she was very, very upset.[599]

When Mrs DE was admitted to hospital she was alert but confused.[600] By the end of her stay she was 'essentially immobile and required assistance with most activities'.[601]

Mrs DE was discharged from hospital to Bupa Willoughby on 6 July 2017.[602]

Admission to Bupa Willoughby

On 2 June 2017, about a month before Mrs DE's admission, Ms DJ spoke with a representative of Bupa Willoughby on the telephone about Mrs DE's care needs and the services that Bupa Willoughby could provide.[603] Ms DJ understood from this discussion that Bupa Willoughby would provide Mrs DE with the level of assistance that she needed.[604]

Ms DI told us that she and her sister spent a fair bit of time talking with the Care Manager at Bupa Willoughby about not only their mother's physical and cognitive condition but also her needs, wants and personality. They felt comfortable that Bupa Willoughby knew 'the full extent' of their mother's condition.[605] Ms DI explained that she and her sister:

> spent a lot of time...sharing that information and making sure we felt 1000 per cent comfortable that they fully understood what Mum needed in the absence of us being able to provide that care for her at home.[606]

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596 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0001 [9]; Transcript, DI, Sydney Hearing, 13 May 2019 at T1471.7-16.

597 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0001 [9].

598 Transcript, DI, Sydney Hearing, 13 May 2019 at T1471.11-14.

599 Transcript, DI, Sydney Hearing, 13 May 2019 at T1471.7-11.

600 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 50, BPA.001.127.0212.

601 Transcript, DI, Sydney Hearing, 13 May 2019 at T1470.13-24; Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001.0001 at 0001 [8].

602 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 50, BPA.001.127.0212 at 0213.

603 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [11].

604 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [11]; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 44, BPA.001.153.0016.

605 Transcript, DI, Sydney Hearing, 13 May 2019 at T1471.28-46.

606 Transcript, DI, Sydney Hearing, 13 May 2019 at T1471.28-46.

Initially, Mrs DE was admitted to Bupa Willoughby on a respite basis. Her daughters expected that this would likely evolve into a permanent placement.[607]

At the time Mrs DE was admitted to Bupa Willoughby, Ms DJ met with the Care Manager and discussed a number of Mrs DE's health issues, including her general physical incapacity, bed sores, arthritis, requirements for assistance with feeding, her cognitive incapacity, and her reliance on hearing aids and glasses. Ms DJ also told the Care Manager that she held enduring power of attorney for her mother.[608]

Mrs DJ's 'Bupa Willoughby Extra Services Resident and Accommodation Agreement – Respite' confirmed that Ms DJ was Mrs DE's power of attorney, next of kin and primary contact, and that Ms DI was the alternative contact.[609]

6 July 2017 hospital discharge referral

A hospital discharge referral was prepared for Mrs DE by Royal North Shore Hospital, dated 6 July 2017. It recorded Mrs DE's condition and care needs at the time of her discharge to Bupa Willoughby.[610]

In preparing her statement to us, Ms Berry reviewed the file held by Bupa in relation to Mrs DE. Mrs DE's 6 July hospital discharge referral was contained in that file.[611]

From her review of the discharge referral, Ms Berry noted several matters, including the following:

- Mrs DE had a comminuted fracture of the head of her right humerus, which is a very serious fracture. This was Mrs DE's principal diagnosis at hospital.[612]
- Mrs DE was experiencing other active problems, including malnutrition, urinary retention and cognitive decline.[613]
- Mrs DE's health history included cancer, low grade cognitive impairment and hyperlipidaemia. A neuropsychological assessment demonstrated that Mrs DE had a lack of capacity for decision making.[614]

607 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [12].

608 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [13].

609 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 51, BPA.001.127.0150; tab 173, BPA.041.002.0329.

610 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 50, BPA.001.127.0212 at 0213.

611 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0006 [19].

612 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0006 [21a].

613 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0006 [21b].

614 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0006 [21c].

- Mrs DE's condition had declined since her seizure in February 2017. She had a history of excessive alcohol intake but no longer drank. She required a 4 wheel walker. She had decreased communication. No clear cause of the cognitive decline had been found.[615]
- The results of a blood test showed that Mrs DE had a high white cell count and high C-reactive protein, which together indicated that she had an infection.[616]

The discharge summary also revealed that:

- Mrs DE required 'lots of encouragement for oral intake and supervision during meals'[617]
- Mrs DE's urinary retention was managed with an indwelling catheter[618]
- Mrs DE was at risk of pressure areas.[619]

At the hearing there was some question about whether and when the discharge referral was available to Bupa Willoughby staff, with Ms Berry saying it was 'not clear whether this discharge document was provided to staff at Bupa Willoughby…prior to, or upon, [DE's] arrival'.[620] She told us this was because the copy on the file did not have a date stamp indicating when it was received.[621]

However, Bupa accepted in its submissions that:

> in advance of Mrs DE being admitted to Bupa Willoughby, and on the day of Mrs DE's admission, the matters that were identified in the 6 July Discharge Referral were known to staff at Bupa Willoughby.[622]

It is clear from Mrs DE's nursing progress notes that this was the case.[623] Bupa Willoughby was aware of the matters contained in Mrs DE's 6 July discharge referral at the time of her admission.

615 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0007 [21d].

616 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0007 [21e].

617 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 50, BPA.001.127.0212 at 0214.

618 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 50, BPA.001.127.0212 at 0214.

619 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 50, BPA.001.127.0212 at 0215.

620 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0006 [19].

621 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0006 [19]; Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1504.16.

622 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0071 [42].

623 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0296.

Mrs DE's interim care plan

A number of documents were created by Bupa staff on the day Mrs DE was admitted. These included an 'Interim Care Plan' and a 'Diet Analysis'.[624]

The interim care plan was prepared for Mrs DE by a registered nurse at Bupa Willoughby.[625] Ms Berry made several observations about the interim care plan, including that it:

- specified that Mrs DE wore her glasses are at all times[626]
- identified that Mrs DE had excoriation on her groin and required repositioning and pressure area care every four hours[627]
- specified that Mrs DE required 'full assistance' with meals and drinks, which meant that a staff member would need to be with Mrs DE for her meals and to bring the food to her mouth (without forcing her to eat food) if she was unable to do so.[628]

In her statement and in oral evidence to us, Ms Berry acknowledged that there were gaps in the interim care plan, including:

- that the box for 'physically aggressive/assault' was not ticked and no notes were made in this section[629]
- it did not mention Mrs DE's cognitive decline and it should have[630]
- it did not mention that Mrs DE required bilateral hearing aids[631]
- it failed to specify that Mrs DE required extra encouragement and supervision with eating.[632]

We will return to Mrs DE's interim care plan and the issue of whether it was updated below.

Diet analysis

On 6 July 2017 a Diet Analysis was completed for Mrs DE. It included an indication that she needed full assistance with her meals, but that (with the exception of an allergy to fish) her diet and fluids were normal.[633]

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624 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 53, BPA.001.127.0255; tab 171, BPA.041.002.0247.

625 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 53, BPA.001.127.0255.

626 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0010 [30j], [31d]; Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1509.42-T1510.08.

627 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0009 [30e]; Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1509.5-20

628 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0010 [30h].

629 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0010 [31a].

630 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1508.42-1509.3.

631 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0010 [30j], [31d]; Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1509.42-1510.08.

632 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1509.35-40.

633 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, Tab 171, BPA.041.002.0247_E.

Hospitalisation on 7 July 2017

On 7 July 2017, Mrs DE was transferred by ambulance to Royal North Shore Hospital.[634] She was at Bupa Willoughby for less than 36 hours.[635]

According to the discharge referral following this hospitalisation (18 July discharge referral), Mrs DE was readmitted with aspiration pneumonia 'post discharge to Bupa Willoughby'.[636] Bupa Willoughby had referred her to hospital due to 'fevers, tachycardia, decreased urine output and decreased level of consciousness'. Paramedics had found Mrs DE with unchewed food and medications in her mouth.[637]

Bupa Willoughby was aware that Mrs DE required full assistance with eating and that her care needs included close supervision during meals. There is nothing before us to suggest that Bupa Willoughby did not provide assistance and supervision to Mrs DE during meals in the period from her admission on 6 July to her transfer to hospital on 7 July. Mrs DE's progress notes record that she was supervised and assisted with meals and medication during this time.[638] However, the quality of that assistance and supervision is open to doubt, given that Mrs DE was found with unchewed food and medication in her mouth on 7 July immediately after leaving the care of Bupa Willoughby.

Ms Berry stated that she 'expected someone would have cleared [Mrs DE's] mouth, provided she would allow it'.[639] She told us that if staff were unsure whether Mrs DE had cleared her mouth they should have 'reported it and kept her in an upright position'.[640] Senior Counsel Assisting put it to Ms Berry that if this did not happen, it was an instance of substandard care. She responded that it was 'an instance of failure to follow good safe practices'.[641]

Ms Berry accepted that unchewed food and medicine in Mrs DE's mouth indicated that the care provided to Mrs DE 'was not of an acceptable standard and represented gaps in care delivery'.[642] She also accepted that in relation to the clearing of Mrs DE's mouth, the care provided was substandard.[643]

634 Transcript, DI, Sydney Hearing, 13 May 2019 at T1472.12-20.

635 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0295-0296.

636 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 67, BPA.001.127.0197 at 0197.

637 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 67, BPA.001.127.0197 at 0197.

638 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0295-0296.

639 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0019 [73c].

640 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1512.42-43.

641 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1515.7-10.

642 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1513.17-1514.1.

643 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1513.17-1514.1.

Bupa accepted, in its submissions, that the failure to clear Mrs DE's mouth could have led to harm, loss or damage to Mrs DE and in that sense was an instance of substandard care.[644] It is clear to us that the care provided to Mrs DE, when it came to ensuring she had cleared her mouth, was substandard.

Bupa went on to submit that there is no evidence upon which we can conclude that such a failure led to harm, loss or damage to Mrs DE in that it was not the cause of her aspiration pneumonia.[645]

We have not been invited to and do not propose to make any findings about the cause of Mrs DE's aspiration pneumonia. We accept that when Mrs DE was admitted to Bupa Willoughby she had signs of an infection.

Mrs DE remained in hospital for 11 days.[646] Ms DI said that she noticed further decline in her mother during this period.[647] She was not sure whether Mrs DE comprehended what was happening or what was being said to her.[648]

Ms DJ recalled that at some stage during this period she had a conference with a doctor, social worker and hospital registrar about palliative care for her mother.[649] Ms DJ did not recall the specifics of this conversation other than it was 'about counselling and support services that may be available, rather than any plans or direction' about Mrs DE's final days.[650]

Over the course of 7 and 8 July 2017, a resuscitation plan was created for Mrs DE by medical staff at Royal North Shore Hospital.[651] The plan records that CPR is not to be performed in the event of cardiopulmonary arrest on the basis that Mrs DE's condition was such that CPR was 'likely to result in negligible clinical benefit'.[652]

The existence of this resuscitation plan assumes some relevance when it comes to the steps taken by Bupa Willoughby in relation to Mrs DE's care. We will return to it below.

18 July 2017 return to Bupa Willoughby

Mrs DE was transferred back to Bupa Willoughby on 18 July 2017.[653]

644 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0079 [75].

645 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0079 [75].

646 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [14].

647 Transcript, DI, Sydney Hearing, 13 May 2019 at T1472.27-30.

648 Transcript, DI, Sydney Hearing, 13 May 2019 at T1472.27-34.

649 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [15].

650 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [15].

651 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 56, BPA.001.127.0250.

652 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 56, BPA.001.127.0250.

653 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [16].

At the time of Mrs DE's return to Bupa Willoughby, she was bed bound and unable to move her limbs.[654] She was essentially unable to communicate verbally.[655] Ms DI also doubted whether her mother could communicate that she was in pain.[656] It is clear that Mrs DE had experienced acute cognitive decline.[657]

On 20 July 2017, Ms DJ signed an 'Extra Services Resident and Accommodation Agreement' with Bupa.[658] This time, the agreement was for residential rather than respite care.

Again, Bupa was informed that Ms DJ was the power of attorney and primary contact for DE and Ms DI was the secondary contact.[659]

Mrs DE's care needs post-discharge

The speech pathology branch of Royal North Shore Hospital prepared a speech pathology discharge handover for Mrs DE. It was dated 18 July 2017 and sent to Bupa Willoughby by fax the same day.[660] There is no question that it was received by Bupa Willoughby, with Mrs DE's Nursing Progress Notes recording:

> Received speech pathology report from hospital (RNSH) Pt is on Dysphagic diet / mildly thickened fluid. CM will book speech path.[661]

The speech pathology handover gave details about Mrs DE's diagnosis of dysphagia, further cognitive and functional decline, and detailed instructions about feeding based on speech pathology advice.[662] The handover included assessments that Mrs DE 'requires verbal and physical prompts to open her mouth to spoon/straw' and 'had difficulty manipulating solids'. It included recommendations 'SOFT DYSPHAGIA diet and MILDLY THICK FLUIDS with assistance' and to monitor Mrs DE for signs of aspiration or penetration, for coughing, for a wet gurgly voice with oral intake, and for reduced chest health.[663] A direction was given for Mrs DE to be referred to a speech pathologist.[664]

654 Transcript, DI, Sydney Hearing, 13 May 2019 at T1473.14-26.

655 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1530.9-10.

656 Transcript, DI, Sydney Hearing, 13 May 2019 at T1473.4-7.

657 Transcript, DI, Sydney Hearing, 13 May 2019 at T1472.27-34; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 67, BPA.001.127.0197 at 0202.

658 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 62, BPA.001.127.0109.

659 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [16]; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 62, BPA.001.127.0109 at 0110.

660 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 59, BPA.001.153.0034 at 0034.

661 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0296.

662 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 59, BPA.001.153.0034 at 0036.

663 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 59, BPA.001.153.0034; tab 67, BPA.001.127.0197.

664 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 59, BPA.001.153.0034; tab 67, BPA.001.127.0197.

The 18 July hospital discharge referral reflects the matters outlined in the speech pathology handover. It included identical instructions to monitor Mrs DE for signs of aspiration and about the need for her to be referred to a speech pathologist. It contained additional details about the decline in Mrs DE's condition and a recommendation that Mrs DE be referred to physiotherapy.[665]

Ms Berry gave evidence that the copy of 18 July hospital discharge referral found on file was received by Bupa Willoughby one week after Mrs DE's readmission, on 25 July 2017.[666] However, it is clear from Mrs DE's 'Medical and Allied Health Notes' that this discharge referral was received by Bupa Willoughby by no later than 19 July 2018.[667]

Care documentation not promptly updated by Bupa Willoughby

Mrs DE's interim care plan was not updated to reflect the speech pathology handover about the care Mrs DE needed to manage her dysphagia, risk of aspiration and risk of choking.

With the exception of a handwritten note about wound management made on 13 August 2017, there is nothing before us to suggest that Mrs DE's interim care plan was updated or replaced with a more comprehensive care plan during Mrs DE's time at Bupa Willoughby.[668]

Ms Berry explained that a care plan could take several weeks to develop and an interim plan is appropriate before then.[669]

Bupa submitted that while the interim care plan itself was not updated, a comprehensive care plan would ordinarily take a month to complete. Bupa went on to submit that steps to complete such a plan were in fact taken, and documented, prior to Mrs DE's death.[670] We accept this.

However, if it is not practical to prepare a comprehensive care plan in a timely manner, it is clearly essential that interim care plans are immediately updated upon re-admission in light of hospital discharge information about care needs.

Ms Berry agreed that a replacement interim care plan should have been prepared in circumstances where Mrs DE's health condition had materially deteriorated.[671]

665 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 67, BPA.001.0127.0197 at 0201.

666 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0011 [38].

667 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0221.

668 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1508.16-45.

669 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0003 [11b], [31] and [73a].

670 Sydney Hearing, Submissions of Bupa Aged Care Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0073 [54].

671 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1516.6-14.

We find that there was a breach of Bupa's work instructions for care planning and dysphagia management when it came to Mrs DE's care, by reason of the failure to update or replace Mrs DE's interim care plan.[672]

Ms Berry stated that 'Bupa Willoughby staff departed from the work instructions and policy documents in respect of Mrs DE'. In particular:

> There was limited documentation of the care planning for [DE]. This was inconsistent with the documentation requirements as outlined in WI Res 03.2 Care Planning and WI Res-4.3.5 Dysphagia management. The key issue in relation to this is that the interim care plan was not updated on [DE's] return from the RNS in relation to her care needs to manage her dysphagia and risk of aspiration or choking.[673]

At the time of Mrs DE's return to Bupa Willoughby on 18 July 2017, or in the few days following, the documents directing the care needs of Mrs DE should have been updated or replaced to reflect the changes in Mrs DE's care needs, including the deterioration in her condition and the matters contained in the speech pathology handover. They were not.

On 18 July 2017, Bupa Willoughby staff completed a nutrition and hydration assessment for Mrs DE.[674] The document reflects, in part, the speech pathology handover. However, it fails to reflect the level of care and supervision that was instructed, particularly in relation to monitoring for aspiration risk.[675] There is no evidence that the diet analysis dated 6 July 2017 was updated promptly upon Mrs DE's readmission. The next version of Mrs DE's diet analysis (in which Mrs DE's diet has been changed to smooth pureed meals and mildly thick fluids) was dated 27 July 2017.[676]

Ms Berry gave evidence that there is an expectation that staff would follow the Bupa dysphagia management work instruction, which she described as being similar to the speech pathology handover.[677] Ms Berry agreed that the expectation that staff will follow policy is no excuse for not including detailed instructions in assessments and care plans.[678]

On 26 July 2017, Mrs DE was assessed by a speech pathologist.[679] The speech pathologist's assessment is recorded in Mrs DE's Allied Health notes.[680] The speech pathologist recorded her impression that Mrs DE had moderate to severe oropharyngeal dysphagia.[681] The speech pathologist recommended that Mrs DE have 'full assistance

672 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 48, BPA.046.016.6236; tab 20, BPA.013.036.1010.

673 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0019 [73a].

674 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 107, BPA.041.002.0243.

675 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1518.18-1519.16.

676 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 71, BPA.007.001.8471; Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0016 [53b].

677 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1519.14-23.

678 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1519.25-30.

679 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0223-0225.

680 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0224.

681 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0224.

with all oral intake' and that an 'upright posture' with correct positioning being essential.[682] Mrs DE was to be monitored carefully for clinical signs of aspiration.[683]

The speech pathologist's recommendations are also contained in a handwritten note described as 'safe swallowing tips'.[684] Ms Berry said the speech pathologist had:

> clearly written them for placement in the room where Mrs DE was being fed for the purpose of staff and family, and they are consistent with the work instruction on dysphagia management.[685]

Ms DI was with her mother during the speech pathologist's assessment.[686] She recalled that the speech pathologist wrote up some handwritten notes and put them up behind her mother's bed.[687]

It is likely, based on this evidence, that the 'safe swallowing tips' prepared by the speech pathologist were on display in the room where Mrs DE was fed from 26 July 2017.

However, even after this assessment on 26 July 2017, Mrs DE's interim care plan was not updated to incorporate the speech pathologist's recommendations.[688]

On 27 July 2017, nine days after her return to Bupa Willoughby, Mrs DE was assessed by a physiotherapist.[689] Ms Berry said that this assessment 'was conducted later than expected given [DE's] condition'.[690] The physiotherapist did not assess Mrs DE's respiratory status. This was a breach of Bupa's policy about assessments of this kind.[691]

The failure to do a respiratory assessment was, at least in part, a result of the failure to update Mrs DE's interim care plan with both the speech pathology handover from Royal North Shore Hospital and the speech pathologist's recommendations following her assessment on 26 July 2017.[692]

682 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0225.

683 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0225.

684 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 68, BPA.036.002.5165.

685 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1532.28-42.

686 Transcript, DI, Sydney Hearing, 13 May 2019 at T1475.11-25.

687 Transcript, DI, Sydney Hearing, 13 May 2019 at T1475.11-25.

688 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1516.33-37.

689 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 70, BPA.007.001.8399 at 8403.

690 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1516.27-31; Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0019 [73b].

691 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 70, BPA.007.001.8399; tab 2, BPA.007.001.8399; Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1516.27-31; Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0019 [73b].

692 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1516.27-31.

Ms Berry accepted that the failure to update or replace Mrs DE's interim care plan had material consequences for the standard of care provided to Mrs DE. Namely, the physiotherapist failed to address Mrs DE's respiratory status.[693]

This failure led to Mrs DE losing the potential benefit of physiotherapy for respiratory issues. We are not able to say whether or not Mrs DE's health actually suffered as a result by comparison to what her health would have been if the physiotherapist had addressed her respiratory issues, but this is possible.

Further, although we are not able to say whether Mrs DE's nutritional intake was actually affected, it is possible that the absence of a care plan that reflected the matters contained in the speech pathology handover and the speech pathologist's recommendations contributed to Mrs DE not getting the optimal nutritional intake she otherwise would have received.[694]

Bupa accepted that the documentation maintained by the staff at Bupa Willoughby in relation to Mrs DE's care was generally not of the standard expected of Bupa staff, and was not prepared in a manner that was consistent with Bupa's policies, procedures and processes. This was, they submitted, unacceptable in a clinical setting. We agree.

Bupa submitted that while particular gaps in documentation did not in fact lead to harm, loss or damage to Mrs DE, they could have led to harm and fall within the definition of substandard care adopted by Bupa in its submissions.[695] We agree that they could have led to harm, and that they were instances of substandard care. We cannot make any finding whether they did or did not cause harm.

Care provided between 18 July and 14 August 2017

Assistance with feeding and adequate nutrition

Between 18 July and 14 August 2017, Mrs DE was unable to feed herself. She was dependent on others for assistance.[696]

Ms DI understood that staff at Bupa Willoughby were assisting her mother to eat. Or, as she told us, that was what they were telling her.[697]

693 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1516.1-37.

694 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1519.30-36.

695 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0065 [22].

696 Transcript, DI, Sydney Hearing, 13 May 2019 at T1473.14-26.

697 Transcript, DI, Sydney Hearing, 13 May 2019 at T1473.14-26.

Ms DI stated that on most occasions when she visited Mrs DE, she found a tray of cold food next to her. The tray would be full of food and it appeared that she had not eaten any of her meal. Or that she had only eaten very little.[698] Ms DI recounted a conversation she had with a nurse when she, Ms DJ and Mrs DE's sister, Ms DK, were visiting Mrs DE:

> On one occasion when we were visiting (and Mum's sister [DK] was visiting as well), a nurse came into the room and collected Mum's full tray of food. On this occasion [DK] asked 'why are you taking her tray when she hasn't eaten anything?' and the nurse said to us 'She's not hungry. She doesn't eat. She's not hungry' and proceeded to scrape the entire contents of her meal into the bin and walk away. [DK] replied 'Of course she isn't telling you this, she can't hear you, and she cannot speak/communicate'. The nurse clearly shrugged off this comment and went about her business…[699]

From this interaction, Ms DI became concerned that staff were not taking the time to assist her mother with eating.[700] She believed they were putting food in front of Mrs DE, 'then returning later to collect the untouched meal and throw it in the bin'.[701]

Ms DI gave evidence that on occasions where time was spent with Mrs DE to encourage her to eat, or when food that Mrs DE enjoyed was provided to her, she could be encouraged to eat food.[702] Around 2 August 2017, Mrs DE's sister visited Mrs DE every day for a week, and during these visits assisted with feeding. Ms DI observed that Mrs DE 'really perked up over that week' and that she 'was looking more full in the face and alive and a lot healthier'.[703]

The concerns about the assistance being given to Mrs DE with her eating prompted Ms DJ, Ms DI and Ms DK to request a meeting with Bupa Willoughby. The request was made on around 2 August 2017.[704] The meeting, a family conference, took place on 10 August 2017 and was attended by Ms DJ and Ms DI.[705] Ms DK and Bupa Willoughby's general practitioner were also there.[706]

698 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0004 [27].

699 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0004 [27].

700 Transcript, DI, Sydney Hearing, 13 May 2019 at T1474.8-30.

701 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0004 [28]; Transcript, DI, Sydney Hearing, 13 May 2019 at T1473.27-1474.30.

702 Transcript, DI, Sydney Hearing, 13 May 2019 at T1473.47-1474.1.

703 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0005 [29].

704 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0005 [29].

705 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0003 [18].

706 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0301.

At this conference, Ms DJ explained, they discussed Mrs DE's care and a visit by a palliative care nurse the previous day.[707] The 'nursing retrospective report' on the family conference in Mrs DE's progress notes state:

> reassured the family of care team assisting [DE] with fluids & nutrition, although [DE's] sister insisted that staff weren't 'feeding [DE]'. [The care manager] advised [DE's] sister that no force feeding to take place under any circumstances.[708]

Following the family conference, 'Daily Food Intake Records' were completed for Mrs DE on 11, 12 and 13 August 2017.[709] These records detailed the food and beverages consumed by Mrs DE on these days.[710] There are no 'Daily Food Intake Records' for Mrs DE for 14 and 15 August 2017.

However, a further nutrition and hydration assessment was completed for Mrs DE on 15 August 2017. It recorded Mrs DE's dietary needs and the level of assistance she required with eating. On this occasion, the documentation prepared by Bupa Willoughby was consistent with Royal North Shore Hospital's speech pathology handover of 18 July 2018. This assessment recorded that Mrs DE was at risk of malnutrition. It stated that she had a poor appetite and lacked motivation.[711] However, this was too late to be of use, because Mrs DE died later that day.[712]

In the period from when Mrs DE returned to Bupa Willoughby and her death, it is clear that she was observed to have a poor appetite and refused to eat on occasions. This much is recorded in her progress notes.[713]

The notations in Mrs DE's progress notes do not cover each meal time between 18 July and 15 August 2017. Nor do they contain any detail about the level of assistance provided to Mrs DE during mealtimes.[714]

Counsel Assisting submitted that it can be concluded from the evidence that, for the majority of her stay, Mrs DE did not receive adequate assistance from Bupa with feeding and drinking.

Bupa submitted that no conclusions can be drawn from the frequency of the entries in the progress notes because records are not required for every meal.

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707 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0003 [18].

708 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0301.

709 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 166, BPA.001.145.0003.

710 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 166, BPA.001.145.0003.

711 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 80, BPA.001.153.0023.

712 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 78, BPA.001.127.0191.

713 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295. The relevant entries are identified in Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at [96].

714 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295. The relevant entries are identified in the Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0025 [96].

We decline to make the finding sought by Counsel Assisting. Bupa Willoughby's records and the available evidence more generally does not permit us to conclude that for the majority of her stay Mrs DE did not receive adequate assistance. However, it is clear from Ms DI's and Ms DJ's evidence that the level of assistance they observed was insufficient in light of Mrs DE's needs and did not accord with the assessment and recommendations of the speech pathologist on 18 July 2017. We are satisfied that the care provided to Mrs DE to meet her nutritional needs, as observed by Ms DI and Ms DJ, was substandard. Further, there is grave cause for concern from what was said by the nurse on that occasion that Mrs DE's nutritional needs might have been neglected in a similar way on other occasions, but we cannot be sure of this.

The management of Mrs DE's hearing aids and glasses, discussed below, may also have been an issue when it came to Mrs DE's food intake.[715]

Hearing aids and glasses

Ms DI told us that Mrs DE was quite 'hard of hearing' and needed her glasses to see:

> She couldn't do anything without her glasses…She had hearing aids that she needed to wear all the time in both ears…They were essential to her sense of knowing where she was and being able to communicate and understand people around her.[716]

These aids were critical to her, particularly as someone with cognitive decline experiencing communication difficulties.

Bupa Willoughby was aware that Mrs DE was reliant on bilateral hearing aids and glasses. This information was recorded in Mrs DE's March 2017 Aged Care Assessment Team (ACAT) assessment.[717] The ACAT assessment was received by Bupa Willoughby on or around 19 June 2017, before Mrs DE's first admission to Bupa Willoughby.[718]

Mrs DE's reliance on hearing aids was not recorded in her interim care plan.[719] Ms Berry described this as omission of a material piece of information that would have directed care rather than a gap in care.[720]

Bupa accepted that the failure to record Mrs DE's hearing aids in the interim care plan was an omission of a material piece of information that would have directed Mrs DE's care.[721] Bupa does not accept that the failure to record Mrs DE's hearing aid in the interim care plan was a gap in care such that substandard care was provided to Mrs DE.[722]

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715 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1519.38-44.

716 Transcript, DI, Sydney Hearing, 13 May 2019 at T1475.43-1476.5.

717 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 168, BPA.036.002.9382 at 9384.

718 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 34, BPA.036.002.9381.

719 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1502.45-T1503.1; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 53, BPA.001.127.0255.

720 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1510.41-44.

721 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0088 [106].

722 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0088 [106].

Ms DI told us that during Mrs DE's time at Bupa Willoughby, Mrs DE's glasses went missing. Her hearing aids were very frequently lost. When they were found, they often had flat batteries or simply were not placed in Mrs DE's ears.[723] Ms DI explained that this was frustrating and upsetting because she knew that without her hearing aids Mrs DE 'would not be able to communicate with the nurses, doctors' or visitors.[724]

Ms Berry accepted that for a person with cognitive decline, such as Mrs DE, communication issues would be compounded by the deprival of hearing aids and glasses. She agreed that a person in this state would be more likely to feel bewildered, confused and distracted and less likely to be able to communicate and follow tasks.[725]

Bupa submitted that the progress notes 'do not record any bewilderment, confusion or distraction, inability to communicate or increased agitation' connected to Mrs DE's use of hearing aids or glasses.[726] This does not excuse instances where Mrs DE did not have the benefit of access to and use of her hearing aids and glasses.

Bupa submitted that the failure to record Mrs DE's need for hearing aids in the interim care plan does not indicate that staff were unaware of Mrs DE's use of hearing aids. We accept that staff had access to documents that would have informed them of Mrs DE's need for hearing aids. However, had Mrs DE's use of hearing aids been recorded in the interim care plan, there would be no doubt of staff's awareness. They would have been clearly on notice about her needs in this regard.

The omission of reference to Mrs DE's hearing aids in the interim care plan most likely contributed to her not having the benefit of their provision and use to the extent she should have.

It is reasonable to expect that Mrs DE would have access to and use of both her glasses and her hearing aids generally and particularly at all meals. This was especially important in light of the assessment by the speech pathologist on 18 July 2017 that Mrs DE needed verbal and physical prompts to assist her to eat and drink. That Mrs DE's glasses and hearing aids would often go missing and that her hearing aids often had flat batteries or were not placed in her ears was a failure to meet the level of care Ms DI and Ms DJ expected for their mother generally, and particularly at mealtimes.

723 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0005 [31], [32]; Transcript, DI, Sydney Hearing, 13 May 2019 at T1475.41-T1477.16.

724 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0005 [31].

725 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1510.1-44.

726 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0089 [107].

Pressure injuries

Mrs DE's ACAT assessment recorded that she needed an air mattress for pressure area care and her 6 July hospital discharge recorded that she was at risk of pressure areas.[727] Bupa Willoughby was aware of both of these matters from the time of Mrs DE's initial admission to Bupa Willoughby.

Mrs DE's interim care plan recorded that she needed repositioning and pressure area care every four hours over a 24 hour period. It was clear that Mrs DE was at risk in relation to her skin integrity in that she had a pre-existing excoriation on her groin.[728]

A Braden Risk Assessment was completed for Mrs DE.[729] The record of the assessment is undated and there is no reference to it in either of Mrs DE's progress notes or her medical and allied health notes. Bupa submits that it is likely that the assessment was completed at some point after Mrs DE returned to Bupa Willoughby on 18 July 2017 and 22 July 2017, when a skin integrity assessment was completed. The skin integrity assessment refers to Mrs DE's Braden Risk Assessment result of eight.[730]

We accept this is the most likely date-range in which the Braden Risk Assessment was completed. However, once again, the poor state of records in relation to Mrs DE's care make it difficult to say precisely when the Braden Risk Assessment was conducted.

The purpose of a Braden Risk Assessment is to determine someone's level of risk of developing pressure injuries.[731] Braden Risk Assessments are completed to identify the kinds of interventions that are necessary and how often they should be performed.[732]

Mrs DE's Braden Risk Assessment result of eight placed her at 'high risk' of developing pressure injuries.[733]

Bupa's policy for people at high risk was for more frequent repositioning than the four hours recorded in Mrs DE's interim care plan.[734] Ms Berry explained that repositioning 'up to every two hours' may have been required.[735]

727 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1502.19-33; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 168, BPA.036.002.9382 at 9383; tab 50, BPA.001.127.0212 at 0215.

728 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 53, BPA.001.127.0255.

729 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 155, BPA.001.153.0026.

730 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 175, BPA.041.002.0241_E.

731 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1522.16-27.

732 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1523.11-15.

733 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 155, BPA.001.153.0026.

734 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1523.25-28.

735 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1523.25-28.

Mrs DE's skin integrity risk assessment records that Mrs DE required repositioning every one to two hours.[736] Mrs DE's interim care plan was not updated to reflect this. Ms Berry conceded that this constituted a gap in documentation.[737]

There is nothing in Bupa's records to indicate that Mrs DE was provided with the air mattress specified in her ACAT assessment. Ms Berry would have expected that if an air mattress was provided, it would have been recorded in Bupa's records.[738] Ms DI could not recall whether Mrs DE had access to an air mattress.[739]

Bupa submitted that it is not clear, one way or another, whether an air mattress was provided to Mrs DE. We accept that it is not clear. We cannot be sure whether Mrs DE's skin integrity was actually impacted by the absence of an air mattress (or, if one was provided at some point in time, when any such impact might have ceased). However, the poor record keeping of Bupa Willoughby in this regard was unsatisfactory and gave rise to risk to Mrs DE, in that she might not have had the benefit of a required intervention.

On 13 August 2017 an open pressure injury was noticed on Mrs DE's left buttock.[740] A handwritten note on the back of Mrs DE's interim care plan notes this.[741] This notation is the only amendment that was made to Mrs DE's interim care plan during her time at Bupa Willoughby.

Bupa Willoughby produced a photograph which shows a pressure injury.[742] The Royal Commission has not published this photograph, although it is before us in evidence.

The pressure injury is approximately four centimetres long by three centimetres wide. In Ms Berry's words, 'It would have been helpful for a ruler to be used as per the work instruction'.[743]

Although the photograph is undated, it can be inferred that it is a photograph of Mrs DE taken on 13 August 2017 when the pressure injury on her right buttock was detected.[744] According to the notation on Mrs DE's interim care plan, wound management was commenced upon discovery of this injury.[745]

Ms Berry explained that the photograph showed 'evidence of healed pressure injuries'.

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736 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 155, BPA.001.153.0026; tab 175, BPA.041.002.0241_E.

737 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1522.16-1523.36.

738 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1502.34-43.

739 Transcript, DI, Sydney Hearing, 13 May 2019 at T1477.38-40.

740 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1502.45-1503.1; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 53, BPA.001.127.0255 at 0256.

741 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1502.45-T1503.1; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 53, BPA.001.127.0255 at 0256.

742 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 172, ATU.0001.0001.0381_E.

743 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1524.18-41.

744 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1524.38-41.

745 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 53, BPA.001.127.0255.

Ms Berry said that the pressure area 'would have been reddened for some time' and:

> when staff were providing personal care, such as washing [Mrs DE]—not necessarily turning, but washing—they would have had an opportunity to view all of her skin and see what the condition was…and they would have noted that it was becoming red and should have raised the alarm to the registered nurse.[746]

Mrs Berry said further that:

> [Mrs DE] already had a number of pressure area sores that were—that had occurred to her while she was in hospital. And they appeared to have healed, but this is very new skin and it's very easy for the new skin, with a minimum amount of pressure, to start to deteriorate again.[747]

There is an entry in Mrs DE's progress notes on 13 August 2017 which states:[748]

> Carer reported about the pressure sore on left buttocks, dressing applied, commenced on wound management and [pressure area care].

There is no documented record of what, if any, pressure injury care Bupa was providing Mrs DE before 13 August.

Counsel Assisting has submitted that the entry in Mrs DE's progress notes on 13 August 2017 suggests that no wound management or pressure area care was provided before this date. Ms Berry disagreed with this suggestion when Senior Counsel Assisting put it to her.[749]

Bupa relied on the work instruction relevant to progress notes to demonstrate that it was not expected that staff would have recorded every instance of pressure care and repositioning.[750] The stated purpose of that work instruction is to ensure a 'resident's responses to care and other events that are not regarded as regular or expected outcomes' are recorded.[751] Repositioning and pressure area care were, Bupa submitted, interventions that 'were a regular and expected occurrence in the day to day care that was provided to Mrs DE'.[752]

Mrs DE's medical and allied health notes record that on 9 August 2017, Bupa Willoughby staff reported to a registered nurse with the Greenwich Community Palliative Care Team (a team external to Bupa) that Mrs DE was 'in pain on turning and when performing

746 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1524.18-1525.15.

747 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1525.24-27.

748 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0302 (entry at 13:30 on 13 August 2017).

749 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1525.40-45.

750 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0095 [131]; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 18, BPA.012.003.4595.

751 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 18, BPA.012.003.4595 at 4595.

752 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0095 [131].

personal care' and that there was a pressure area on Mrs DE's left buttock.[753] Pain relief was prescribed by the palliative care team.[754]

Bupa submitted that this, together with Ms Berry's evidence that she would expect reddening for some time before developing to a stage where the skin becomes broken, and the progress notes from 13 August 2017, demonstrates that Bupa Willoughby acted consistently with Bupa's work instructions on progress reporting and pressure area management.[755]

We accept that it is likely that Mrs DE was receiving some form of pressure area care prior to 13 August 2017. However, there is insufficient evidence to allow us to draw conclusions about the nature or frequency of the care being provided. Again, the absence of satisfactory record keeping presents the risk that Mrs DE was not receiving required interventions.

Pain management

Mrs DE was a resident of Bupa for a period of four weeks before her death on the evening of 15 August 2017. During this time, Mrs DE had a number of painful conditions, including arthritis, a recovering broken humerus, and nascent pressure area issues which presented as an injury on 13 August 2017.[756] As already noted, upon Mrs DE's re-admission to Bupa Willoughby on 18 July 2017 she had suffered a significant cognitive decline. She was essentially unable to communicate verbally.[757]

Reviewed in that light, it is concerning that Mrs DE's progress notes made at 10.10am on 18 July 2017, the date she returned to Bupa Willoughby, record:

> Rt BIB Rt transport @930hrs Rt alert and confused @ times. ***Rt screaming ? reason. Nil c/o pain or discomfort when asked.*** Obs refused by Rt initially but allowed. BP – 130/86, T-36.9, SPO2 97%, RR -19, DR – 100bpm, NOK informed about Pt is with (BUPA) us now. Medication changes as per discharge summary.[758] [emphasis added]

We are satisfied that, at this stage, it is likely that Mrs DE was essentially unable to communicate verbally and had experienced significant cognitive decline, so asking her whether she was in pain or discomfort was an inadequate approach to Mrs DE's pain management needs.

753 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0226.

754 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0226.

755 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0095-0096 [132]-[134]; Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1524.18-T1525.15; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0302 (entry at 13:30 on 13 August 2017).

756 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1529.41-44; T1523.38-45.

757 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1530.9-10.

758 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0296.

Mrs Berry agreed that when admitted to Bupa Willoughby for the second time, Mrs DE was essentially unable to communicate verbally and was therefore indicated for application of the Abbey Pain Scale.[759]

The Abbey Pain Scale is used to determine if someone is in pain when they are unable to verbally communicate.

An Abbey Pain Scale Assessment was in place for Mrs DE in the period 18 to 22 July 2017.[760] Ms Berry accepted that it was not updated after 22 July 2017 and it should have been.[761]

Ms Berry agreed that Bupa Willoughby nursing staff should have continued to administer the Abbey Pain Scale on at least a daily basis for Mrs DE.[762]

Ms Berry accepted that in the absence of Abby Pain Scale assessments in the period 23 July until 11 August 2017, when a Norspan patch was applied to Mrs DE, it was not possible to make a proper assessment of Mrs DE's pain. In the context of Ms Berry's examination about these matters, she accepted that there was a serious failure in the care provided to Mrs DE by Bupa Willoughby.[763] We are satisfied that Ms Berry's acceptance of these propositions was correct and make findings accordingly.

Bupa submitted that despite an Abbey Pain Assessment not being conducted in this period, Mrs DE's progress notes and Medical and Allied Health notes indicate that staff at Bupa Willoughby were monitoring and managing Mrs DE's pain in the period 23 July and 11 August 2017.[764] We accept that staff were taking steps to monitor and manage Mrs DE's pain when they detected it, but we repeat our finding that it was a serious failure in Mrs DE's care for Bupa Willoughby not to continue the administration of the Abbey Pain Scale, and that it was not possible to make a proper assessment of Mrs DE's pain without doing so.

Communication with family, advance care and palliative care planning

Both at the time Mrs DE was first admitted to Bupa Willoughby, on 6 July 2017, and at the time of her return, on 20 July 2017, Bupa Willoughby was aware that Ms DJ was Mrs DE's power of attorney, next of kin and primary contact.[765]

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759 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1530.9-13.

760 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 65, Abbey Pain Scale, 22 July 2017, BPA.007.001.8910.

761 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1530.15-24.

762 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1530.15-24.

763 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1530.15-46.

764 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0097 [139].

765 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [13], [16]; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 62, BPA.001.127.0109.

Advance Care Directive

Ms DI gave evidence that when Mrs DE was admitted to Bupa Willoughby on 6 July 2017, she did not have an Advance Care Directive in place.[766] We accept this evidence.

It is unclear if Bupa Willoughby was told of Mrs DE's lack of Advance Care Directive on 6 July 2017.

Mrs DE was re-admitted to Royal North Shore Hospital on 7 July 2017. On this occasion, a resuscitation plan was created for her.[767] The plan records that CPR is not to be performed in the event of cardiopulmonary arrest on the basis that Mrs DE's condition was such that CPR was 'likely to result in negligible clinical benefit'.[768]

On 23 July 2017, an 'admission database assessment' form was completed for Mrs DE.[769] That form records that Mrs DE had end of life wishes and an Advance Care Directive in place.

Bupa submitted that the resuscitation plan prepared at Royal North Shore Hospital was a form of Advance Care Directive.[770] This was, Bupa submitted, in line with Bupa's policy and procedure about Advance Care Directives.[771] We accept this.

At the time Mrs DE was first admitted to Bupa Willoughby on 6 July 2017 she did not have an Advance Care Directive in place. However, we make no finding that Bupa Willoughby was aware, or ought to have been aware, of this omission at that time.

Palliative care

Mrs DE's 18 July hospital discharge referral records that in relation to palliative care planning, a family conference was held at which 'the family agreed to palliative care input and community link in'.[772] Ms DJ remembered this conference but did not recall that it was about any plans or directions about Mrs DE's final days.[773]

766 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0003 [18].

767 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 56, BPA.001.127.0250.

768 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 56, BPA.001.127.0250.

769 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 66, BPA.001.154.0001 at 0006.

770 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0072 [46].

771 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 16, BPA.049.005.9147.

772 Transcript, DI, Sydney Hearing, 13 May 2019 at T1472.27-34; Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 67, BPA.001.127.0197 at 0198.

773 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [15].

On 9 August 2017, a specialist palliative nurse from Greenwich Hospital attended Mrs DE and drafted a 'palliative care journey'.[774] Bupa Willoughby did not give prior notice of this visit to Ms DI and Ms DJ.[775] Ms DJ found out about the visit after her aunt, who was visiting Mrs DE at the time, called her that evening.[776] Ms DJ stated:

> If I had known [the appointment was happening], I would have wanted to be present so that I could have input into Mum's plan to make sure it was in line with what I thought Mum would have wanted. I would have also liked to be able to ask questions so that I could understand the state of mum's health at that time and what to expect in Mum's last days.[777]

The palliative nurse recommended certain pain relief medication for Mrs DE, including a Norspan patch and Endone as needed. She also recommended end of life care medications as needed: Morphine for pain; Midazolam for agitation or restlessness; and Metoclopramide for nausea.[778] These medications were charted on 11 August 2017, and the Norspan patch was applied to Mrs DE.[779]

The palliative care nurse's visit was discussed at a family conference held at Bupa Willoughby on 10 August 2017.[780] The 'nursing retrospective report' records that Mrs DE's family was disappointed at not having been 'notified of palliative care approach'. It continues:

> advised the family that plans were all written on discharge summary letter from the hospital which should have been discussed with the [next of kin] prior to discharge. Cleared the misunderstanding.[781]

Ms DI and Ms DJ were dissatisfied with the level of information they were receiving from Bupa Willoughby. Ms DJ explained that she and Ms DI:

> wanted to understand what had happened at the palliative care nurse's visit. We felt very confused and out of the loop.[782]

They did not know that a palliative care plan had been drafted for their mother. Ms DI said that had they not called for the family conference, they would not have known that such a plan had been drafted.[783] Ms DJ and Ms DI were given a copy at the family conference.[784]

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774 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [17].

775 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [17]; Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0006 [37].

776 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [17].

777 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0002 [17].

778 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 161, BPA.001.127.0220 at 0226.

779 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 163, BPA.001.127.0257 at 0265-0270.

780 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0300-0301.

781 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 160, BPA.001.127.0295 at 0300-0301.

782 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0003 [18].

783 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0006 [37].

784 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0003 [18].

When Ms DI and Ms DJ asked whether Mrs DE should be transferred to hospital if she got sick in the future, they were told that it was not recommended due to Mrs DE's frailty and the likelihood that doing so would cause distress. They were told that Mrs DE would be kept medicated and comfortable at Bupa Willoughby.[785]

Ms Berry acknowledged, in her statement to us, that in her view:

> the staff in the Bupa home did not communicate effectively with DE's family about her health, ongoing clinical and non-clinical care needs, and the family's expectations of DE's palliative care once she returned from the Royal North Shore Hospital on 18 July 2017.[786]

Ms Berry accepted that the failure by Bupa Willoughby to coordinate a meeting between the palliative care nurse and Ms DI and Ms DJ was a shortcoming in communication and in preparing the family for what was about to happen.[787]

She also accepted that in the context of end of life care it is critical to include authorised representatives from the family in planning. It is critical because the accepted clinical approach to clinical care encompasses not only the person who is dying, but also their family.[788]

The National Health and Medical Research Council's 'Guidelines for a Palliative Approach in Residential Aged Care' addresses the importance of involving family members in the palliative care process through forums such as family conferences.[789] The guidelines indicate that one feature of such conferences is that help should be provided to family members on what to expect.[790]

Ms Berry explained that, in her experience, the assessment of Mrs DE by the palliative care team on 9 August 2017 indicated that Mrs DE's 'condition was rapidly deteriorating'. This should have, she stated, 'triggered the need to prepare [Mrs DE's] family for what was ahead'. She would have expected there to be regular contact with Mrs DE's family to update them about Mrs DE. The documents indicated to Ms Berry that there were 'breakdowns in communication'.[791]

785 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0003 [18].

786 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0003 [11c].

787 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1527.37-1528.8.

788 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1526.17-32.

789 Exhibit 3-39, Sydney Hearing, Guideline for a Palliative Approach in Residential Aged Care, approved by the National Health and Medical Research Council, May 2016, RCD.9999.0049.0016 at 0159.

790 Transcript, Maureen Berry, Sydney Hearing, 13 May 2019 at T1526.34-1527.9.

791 Exhibit 3-38, Sydney Hearing, Statement of Ms Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0018 [66], [67].

In its submissions to us, Bupa conceded that Mrs DE's family was not communicated with in the manner they should have been. Staff at Bupa Willoughby:

> did not do enough to communicate with Mrs DE's family about her deterioration (and comfort them) during the final days of Mrs DE's life.[792]

Bupa apologised for the unintended harm and ongoing distress to Ms DJ and Ms DI caused by this failure in communication.[793]

Bupa Willoughby's approach to communication with Ms DJ and Ms DI in relation to Mrs DE's ongoing care requirements was unacceptable. It fell below the level of communication to be expected from aged care providers. The lack of consultation regarding Mrs DE's ongoing health is of particular concern given the neurological assessment demonstrating that Mrs DE had a lack of capacity for decision making.[794]

Bupa Willoughby's approach to the involvement of Ms DJ and Ms DI in palliative care planning process was unacceptable. It fell below the standards expected of aged care providers in this regard, including a failure to meet the Palliative Approach in Residential Aged Care Guidelines.

Events of 15 August 2017

Mrs DE died at Bupa Willoughby on 15 August 2017.

Ms DI and Ms DJ each gave clear accounts of their experiences of Mrs DE's final day.

At about 1pm on 15 August 2017, Ms DI arrived at Bupa Willoughby to visit her mother 'as normal'. She found her mother in a chair asleep and unattended. Ms DI noticed that Mrs DE's 'breathing was rapid and that her chest sounded rattly'.[795]

Ms DI knew something was wrong. She asked staff to check on Mrs DE. A nurse moved Mrs DE to her room and gave her oxygen. Ms DI had to leave to pick up her daughter.[796] Staff told Ms DI that they would keep an eye on Mrs DE. The nurse said, 'It should be fine.'[797]

792 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0100 [155]-[157].

793 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0100 [157].

794 Exhibit 3-34, Sydney Hearing, Bupa Willoughby Case Study Tender Bundle, tab 67, BPA.001.0127.0197.

795 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0007 [40], [41].

796 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0007 [41].

797 Transcript, DI, Sydney Hearing, 13 May 2019 at T1479.40.

At about 6.00pm that day a nurse on duty called Ms DI. Ms DI struggled to understand what the nurse was saying. It seemed to Ms DI that the nurse did not speak English very well. Straight away the nurse asked Ms DI whether she wanted Bupa Willoughby to call an ambulance for her mother.[798] Ms DI asked the nurse for an update on Mrs DE's condition. The nurse replied 'could be pneumonia. I don't know'.[799] Ms DI said the nurse did not give her 'any idea of [Mrs DE's] condition, symptoms or whether she had declined, her level of consciousness'.[800]

Ms DI was confused. She did not know what was going on. She did not feel capable of making a decision based on what she considered to be a lack of information.[801]

Ms DI called Ms DJ and told her their mother 'was not doing well'. She called again later and said that Bupa Willoughby had called to ask whether or not to send Mrs DE to hospital. Ms DJ was shocked. First, she stated, they had no information about why Mrs DE needed to go to hospital. Second, they had been told less than a week before that transferring Mrs DE to hospital 'would only cause [Mrs DE] distress'.[802]

Ms DI and Ms DJ arrived at Bupa at approximately 7.15pm.[803] Ms DJ gave the following account of what happened:

> 20. [DI] and I drove to Bupa Willoughby together. When I arrived, I could hear Mum's breathing 20 metres down the corridor, it was so loud. When I got into the room I could see that her breathing was very laboured, and she looked uncomfortable. There was no one around to help my Mum. I felt quite panicked at this stage, my sister and I were taking turns running around looking for someone and staying with Mum. This went on for at least 30 minutes before we could find someone to help us.
>
> 21. Even when we were able to find people, we felt they did not know how to handle the situation. I recall that there was a male nurse [DN] and a female [DO] staff member on duty that night. They did not speak very good English and it was difficult to communicate with them, in particular [DO]. When we asked for help the female nurse told me 'we're busy, we'll get there when we can'. When the staff members came to Mum's room they did not do much. They would adjust the oxygen tank and then disappear for another 30 minutes.

798 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0007 [42].

799 Transcript, DI, Sydney Hearing, 13 May 2019 at T1480.18-19.

800 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0007 [42].

801 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0007 [42].

802 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0003 [19].

803 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0007 [43].

> 22. We had a print out of the palliative care nurse's medication plan. We got out that piece of paper and showed it to one of the nurses. If felt like we were begging them to give Mum the medication listed on that plan. Eventually they did give Mum something, although it seemed to me that they had not even considered giving her drugs before we asked.
>
> 23. Over the course of the night we attempted to call the palliative care nurse directly at Greenwich Hospital. She found Mum's file and spent a lot of time talking to us. She was the only person that night that spoke to us about what was happening and what to expect.[804]

At about 9.30pm that evening, the after-hours general practitioner attended Mrs DE. It was not the doctor Mrs DE usually saw. Ms DI described this attendance:

> At about 9:30 pm the GP arrived to come and see Mum (this was not the regular GP that saw Mum as part of Bupa Willoughby from what we could gather he was from an out of hours doctors service). He looked at Mum, checked a few things as far as her breathing and chest, then said something under his breath to the nurse and then walked out. He was in the room for all of about 90 seconds. [DJ] called the GP back and said 'Hold on, can you please tell us what is going on?' He replied 'This is not my area of expertise'. He gave us no other indication as to Mum's condition, what was happening, if or how she was declining, what to expect. We were completely in the dark. Once he'd left the room [DJ] and I looked at each other in disbelief and felt helpless.[805]

Mrs DE died at 10.45pm.[806]

Ms Berry gave evidence about the care provided to Mrs DE on 15 August 2017. This evidence was based on her review of the available documents. Her review caused her to reach the conclusion that the clinical care provided to Mrs DE over the course of 15 August was adequate.[807]

Bupa submitted that we should accept Ms Berry's opinion about the adequacy of the clinical care provided to Mrs DE. It would not, Bupa submitted, be appropriate to find otherwise in circumstances where Ms Berry was a nurse of some 46 years' experience, 10 of which were in aged care.[808]

Bupa submitted that the clinical care provided to Mrs DE, and, in particular, the management of her 'pain and discomfort while she was palliating, was appropriate to her particular needs and condition'.[809]

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804 Exhibit 3-36, Sydney Hearing, Statement of DJ, 12 May 2019, WIT.0190.0001.0001 at 0003 [20]-[23].

805 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0008 [48].

806 Exhibit 3-35, Sydney Hearing, Statement of DI, 17 April 2019, WIT.0101.0001.0001 at 0007 [43].

807 Exhibit 3-38, Sydney Hearing, Statement of Maureen Mary Berry, 1 May 2019, WIT.0148.0002.0001 at 0029 [103]. 808 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0103 [163].

809 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0066 [26].

There is insufficient evidence before us to allow us to conclude that the clinical care provided to Mrs DE on 15 August was adequate. We make no finding on this issue.

Ms DI and Ms DJ gave clear evidence of their experience of their mother's final hours. We accept this evidence in its entirety. It is clear from the evidence of Ms DI and Ms DJ that the frequency, duration and nature of their interactions with Bupa Willoughby staff did not meet the standards of support and empathy of care that they were reasonably entitled to expect for Mrs DE.

Bupa accepted that staff at Bupa Willoughby did not communicate effectively with Ms DJ and Ms DI. Staff did not do enough to communicate with Ms DI and Ms DJ about Mrs DE's deterioration. As Bupa has accepted, they did not 'do enough to comfort them through the final hours of Mrs DE's life'.[810] Ms Berry described the communication during those final hours as 'completely inappropriate'. We agree. Not only was it inappropriate. It was substandard.

Conclusion

Bupa contends that during Mrs DE's time at Bupa Willoughby, there was no substandard care that did in fact lead to any harm, loss or damage to her.[811]

We are unable to make a finding either way on the question whether substandard care of Mrs DE on the part of Bupa Willoughby led to harm to Mrs DE, or loss or damage.

However, as identified in the above findings, we are satisfied that Bupa Willoughby's care of Mrs DE was substandard with regard to:

- its assistance and supervision of her eating on 7 July 2017
- its failure to incorporate in a timely way the recommendations of the speech pathologist on her re-admission on 18 July 2017 with regard to the form of her diet and assistance at mealtimes
- its failure to incorporate the recommendations of the hospital regarding the need for a physiotherapist to assess respiratory issue for Mrs DE
- its level of assistance with her eating on at least one occasion witnessed by Ms DI and Ms DJ
- its management of Mrs DE's hearing and visual aids generally and particularly at mealtimes
- its pain management of Mrs DE between 22 July and 11 August 2017.

810 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0065 [24].

811 Sydney Hearing, Submissions of Bupa Aged Care Australia Pty Ltd, 14 June 2019, RCD.0012.0008.0060 at 0066 [26].

There were additional instances of unsatisfactory record keeping in relation to pressure area care.

While we cannot be sure that these failings had an actual adverse outcome on Mrs DE's health, they all clearly had that potential and carried that risk.

The evidence before us suggests that, whether or not actual harm was suffered by Mrs DE from these failings was essentially a matter of chance, and that the practices of Bupa Willoughby were inadequate to prevent or mitigate any such harm.

In addition, the level of communication and support extended by Bupa Willoughby to Ms DI and Ms DJ regarding Mrs DE's end of life was unsatisfactory and amounted to substandard care of them.

4. Broome Hearing: Aged Care in Remote Areas

Hearing overview

Introduction

Over three days, between 17 and 19 June 2019, we held a hearing in Broome, Western Australia. The subject of the hearing was aged care in remote areas, with a focus on the unique needs of Aboriginal and Torres Strait Islander people when it comes to aged care services. The key areas examined at the hearing were:

- the nature and scope of aged care services for Aboriginal and Torres Strait Islander people living in remote areas
- the diverse aged care needs of Aboriginal and Torres Strait Islander people
- the many different locations at which care is delivered
- the barriers to accessing aged care services for people living in remote areas
- the challenges of maintaining an adequately skilled and culturally appropriate workforce.

We heard oral testimony from 16 witnesses. Ninety-nine documents, including 15 witness statements, were received into evidence.

The perspective and experience of people accessing aged care in remote areas, and that of their family members and carers, was an important feature of this hearing. In addition, we received evidence from Aboriginal and Torres Strait Islander leaders in the field of aged care. Aged care and primary health providers also gave evidence.

The evidence at this hearing was powerful. It revealed the many challenges in delivering aged care in remote and very remote settings. It also revealed some of the inequity of access faced by people receiving care in these areas.

Some of the evidence from this hearing has been drawn upon in Volume 1 of this Interim Report. It will continue to be drawn upon over the course of our inquiry as well as in our Final Report. A brief overview of the hearing and the evidence is provided below.

The focus of the hearing was the delivery of aged care in remote and very remote locations and, in in particular, to Aboriginal and Torres Strait Islander people. We heard about how aged care is being delivered, through various models, at multiple remote and very remote locations in Western Australia, Queensland, South Australia, the Northern Territory and the inhabited external territories.

There are challenges to the delivery of care in all of these areas. At the same time, however, there are individuals and providers operating across remote and very remote locations who are very committed to providing culturally safe, quality aged care services.

Culturally safe care

The delivery of culturally safe care to Aboriginal and Torres Strait Islander people was a principal focus of this hearing. We heard numerous perspectives. What was clear from these perspectives is that it is the person receiving care who determines whether care is culturally safe. Mr Graham Aitken, a Yankunytjatjara descendent and Chief Executive Officer of Aboriginal Community Services, explained:

> In our eyes, the judge of what culturally safe is the individual. We will speak to the Elder about what they need for us to be culturally safe, appropriate, or—or whatever. It's an individual conversation and it's a respect that we treat everyone as an individual and with dignity and to us it's what cultural safety is all about.[1]

Community care

Community care is delivered in many remote communities. Services delivered in remote communities are often delivered through community care centres. These centres provide services to older people in the community through Home Care Packages and the Commonwealth Home Support Programme.

We heard about this model of care being delivered in circumstances where there is no access to residential care in the local community.

Bidyadanga is a remote Aboriginal Community, around 200 kilometres from Broome and 2071 kilometres from Perth. It has a population of approximately 750 people from five language groups: Karajarri, Juwaliny, Mangala, Nyungamarta and Yulpartja.[2] It is the largest remote Aboriginal community in Western Australia.

Witnesses from the community of Bidyadanga told us about the delivery of aged care there. There is no residential aged care facility in Bidyadanga. The only aged care services in the community are offered at the Bidyadanga HACC Centre.[3] Home Care Packages and Commonwealth Home Support Programme funding is provided to Kimberley Aged and Community Services, which then has an agreement with the Bidyadanga Community Corporation for the HACC Centre to provide the services.[4] Kimberley Aged and

1 Transcript, Graham Aitken, Broome Hearing, 17 June 2019 at T2072.17-21.

2 Exhibit 4-2, Broome Hearing, Statement of Faye Dean, 5 June 2019, WIT.1142.0001.0001 at 0002 [7], [9].

3 Exhibit 4-2, Broome Hearing, Statement of Faye Dean, 5 June 2019, WIT.1142.0001.0001 at 0002 [10], 0003 [20].

4 Exhibit 4-2, Broome Hearing, Statement of Faye Dean, 5 June 2019, WIT.1142.0001.0001 at 0007 [52]; Transcript, Faye Dean, Broome Hearing, 17 June 2019 at T1969.33.

Community Services works 'in partnership with Aboriginal communities to provide aged care services to Aboriginal people who live in remote communities'.[5]

The Bidyadanga HACC Centre provides a range of services within the community of Bidyadanga. Those services include picking up people from their homes and collecting their washing in the morning, providing breakfast and assistance with showering, as well as helping members of the community through activities such as physical exercises, shopping, washing, facilitating trips to Broome or fishing spots, and providing assistance with financial and Centrelink matters.[6] The youngest person receiving care at the HACC Centre is aged in their mid-forties and the oldest is ninety years old.[7]

Ms Faye Dean and Mr Ryan Hammond work at the Bidyadanga HACC Centre. They gave evidence together about the HACC Centre and their work there.

Ms Faye Dean is a Karajarri Elder.[8] She is currently a community care supervisor at the HACC Centre.[9] Mr Ryan Hammond is a senior support worker at the HACC Centre.[10] Ms Dean identified him as the person who could take over running the centre if she was unable to do so.[11]

Miss Madeleine Jadai, a 55-year-old Mangala woman, gave evidence about her experience as a carer in Bidyadanga.[12] Miss Jadai previously worked at the community's school.[13] However, she has significant caring responsibilities. Miss Jadai cares for the children and grandchildren of a sister who died in a car accident and for her sister, Betty Barney.[14] The focus of Miss Jadai's evidence was her experience caring for Ms Barney, who lives with dementia, receives aged care services and is about 62 years old.[15]

Miss Jadai is 'able to take a break' when Ms Barney visits the Bidyadanga HACC Centre.[16] Ms Barney goes to the centre most days.[17] Miss Jadai considers Ms Barney to be well looked after there.[18] Sometimes Miss Jadai helps out at the HACC Centre.[19]

5 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2019.42-44.
6 Transcript, Faye Dean, Broome Hearing, 17 June 2019 at T1970.1-40
7 Transcript, Faye Dean, Broome Hearing, 17 June 2019 at T1971.5-17.
8 Transcript, Faye Dean, Broome Hearing, 17 June 2019 at T1974.47.
9 Transcript, Faye Dean, Broome Hearing, 17 June 2019 at T1969.4.
10 Exhibit 4-2, Broome Hearing, Statement of Faye Dean, 5 June 2019, WIT.1142.0001.0001 at 0002 [13].
11 Transcript, Ryan Hammond, Broome Hearing, 17 June 2019 at T1975.6.
12 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1986.42-1988.6.
13 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1990.17.
14 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1986.8; T1987.9-10.
15 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1986.43-44.
16 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1987.34.
17 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1990.42-46.
18 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1987.32.
19 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1990.26.

Aboriginal Elders and Community Care Services operates Aboriginal Community Services in South Australia.[20] Mr Aitken explained that Aboriginal Community Services has grown since its incorporation. It started as the Aboriginal Elders Village north of Adelaide and as a small HACC program.[21] It now provides care to close to 600 people across South Australia, including to over 200 people living in remote communities in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands.[22] Mr Aitken's family are Yankunytjatjara people.[23]

Mr Aitken explained that his organisation has 'the great privilege of delivering supports and services to a number of Elders'. Mr Aitken said it is hard to define what an Elder is. But, he said, it is 'about respect', not necessarily age.[24]

The model of care delivered by Aboriginal Community Services across the APY Lands is similar to that delivered by the Bidyadanga HACC Centre. Mr Aitken explained that in each community in which they deliver services, there is a community centre that operates as a base from which aged care services are provided.[25] The centres provide breakfast and lunch, pick up washing and take it back to people in the community.[26] People come to the centre for breakfast.[27] Lunch is taken to people's homes or wherever else they might be.[28]

Some care is delivered through centres or directly in people's homes as the need arises. Ms Ruth Crawford, Manager, Aged and Community Services, Western Australian Country Health Service – Kimberley, explained that in her experience there is often a clear preference for the former as people do not want other people from the community coming into their house and invading their privacy.[29] Mr Aitken gave similar evidence, explaining that delivering care to the home can be a challenge for a range of reasons, including overcrowding.[30]

Availability of care

We heard that if residential care or residential respite is required for someone in Bidyadanga they must travel about 200 kilometres to Broome or over 300 kilometres to Derby.[31] Miss Jadai also explained that the absence of respite services in Bidyadanga

20 Exhibit 4-8, Broome Hearing, Statement of Graham Aitken, 3 June 2019, WIT.1134.0001.0001 at 0001 [3].

21 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2065.40-42.

22 Exhibit 4-8, Broome Hearing, Statement of Graham Aitken, 3 June 2019, WIT.1134.0001.0001 at 0002 [7], [9].

23 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2064.42.

24 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2065.14-21.

25 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2068.8-9.

26 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2068.37-39.

27 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2068.13-16.

28 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2068.17-19; T2068.35-37.

29 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2098.41-2099.5.

30 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2068.17-19; T2068.44-47.

31 Transcript, Broome Hearing, Madeleine Jadai, 17 June 2019 at T1993.1-3.

meant that she had to take Ms Barney with her on a long trip to the desert for a funeral that she was required to attend, with the result that Ms Barney became sick and required antibiotics.[32]

Availability of aged care services is limited in remote and very remote locations. Access to residential aged care is even more limited. Few providers operate in remote and very remote areas and those that do are overwhelmingly from the not-for-profit sector. We heard from not-for-profit providers operating across remote and very remote locations across Australia, including:

- UnitingCare Queensland, which runs an extensive aged care services across Queensland and the Northern Territory through Australian Regional and Remote Community Services (ARRCS)[33]
- Uniting Church Homes, which trades as 'Juniper – A Uniting Church Community' (Juniper) and operates a range of services across Western Australia, including in the Kimberley region[34]
- Southern Cross Care (WA) Inc., which delivers services in Western Australia, including at Germanus Kent House and Bran Nue Dae Community Centre in Broome[35]
- Aboriginal Elders and Community Care Services, which operates Aboriginal Community Services in South Australia, providing services across the APY Lands.[36]

Vast distances often need to be travelled to access services from or to provide services in remote and very remote areas in Australia. For example, Ms Tamra Bridges said that to get to ARRCS's Docker River facility, 90% of staff are required to fly to Alice Springs and then to Yulara, from where they take the 'bush bus', travelling three hours on a dirt road. Given the distances involved, staff work on a rotating roster of ten weeks on and two weeks off.[37]

Ms Crawford explained that Kimberley Aged and Community Services' clients are spread across the Kimberley in communities that are commonly difficult to access in the wet season.[38]

We heard that the cost of food, transport and staff force providers in these areas to operate at a loss. Mr Craig Barke, the Chief Executive Officer of UnitingCare Queensland, explained the cost of providing services increases the more remote locations become.[39]

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32 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1987.40-46.

33 Transcript, Craig Barke, Broome Hearing, 17 June 2019 at T2004.41-43.

34 Exhibit 4-12, Broome Hearing, Statement of Michael Preece, 13 June 2019, WIT.0256.0001.0001 at 0002 [8]-[13].

35 Exhibit 4-11, Broome Hearing, Statement of Rejane Le Grange, 6 June 2019, WIT.0212.0001.0001 at 0001 [4], [5].

36 Exhibit 4-8, Broome Hearing, Statement of Graham Aitken, 3 June 2019, WIT.1134.0001.0001 at 0001-0002 [3], [7], [9].

37 Transcript, Tamra Bridges, Broome Hearing, 17 June 2019 at T2012.28-45.

38 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2094.15-30.

39 Transcript, Craig Barke, Broome Hearing, 17 June 2019 at T2018.24.

Different funding arrangements present challenges for providers operating in remote and very remote locations.[40] Mr Aitken explained that there were no National Disability Insurance Scheme services in the APY lands, so they provide meals for people with disability.[41] He is:

> just not convinced that the NDIS and the individualised funding model, whilst I totally believe in, you know, choice and control of individualised budgets, from an operational point of view and a financial point of view, I don't quite see that it will be financially viable for us to step into that space just yet.[42]

Mr Aitken said that block funding provided through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program helps them with their finances.[43]

Ms Ruth Crawford described the effects of administering multiple sources of funding, with each program having its own requirements for reporting. These requirements can affect service delivery.[44]

Dr Michael Preece, Executive Director Operations at Juniper, stated that Juniper is essentially required to use its aged care operations in Perth to cross-subsidise the aged care services that it provides to Aboriginal and Torres Strait Islander people across the Kimberley.[45]

In many cases, medical services support communities where residential care is not available.

Dr Kate Fox is a general practitioner who lives in Broome.[46] She is employed three days a week by the Kimberley Aboriginal Medical Services and two days a week by the Broome Regional Aboriginal Medical Service.[47] Kimberley Aboriginal Medical Services is a regional Aboriginal Community Controlled Health Organisation (ACCHO) that oversees independent member ACCHOs and provides primary health care to five remote communities across the Kimberley. The Bidyadanga Health Centre is one of the ACCHOs that Kimberley Aboriginal Medical Services oversees.[48]

Dr Fox travels by small plane to provide medical services at the Bidyadanga Health Centre.[49] Dr Fox described some of the difficulties that older people in Bidyadanga face in attending the clinic, including access to transport, communication and establishing trust

40 Transcript, Michael Preece, Broome Hearing, 18 June 2019 at T2146.39-2147.38.

41 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2070.1-5.

42 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2070.5-8.

43 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2076.14-27.

44 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2100.10-36.

45 Exhibit 4-12, Broome Hearing, Statement of Michael Preece, 13 June 2019, WIT.0256.0001.0001 at 0004 [26].

46 Transcript, Kate Fox, Broome Hearing, 19 June 2019 at T2155.24.

47 Exhibit 4-13, Broome Hearing, Statement of Dr Kate Suzanne Fox, WIT.1145.0001.0001 at 0001 [3].

48 Transcript, Kate Fox, Broome Hearing, 19 June 2019 at T2157.38-40; Exhibit 4-13, Broome Hearing, Statement of Kate Suzanne Fox, WIT.1145.0001.0001 at 0002 [8]-[9].

49 Transcript, Kate Fox, Broome Hearing, 19 June 2019 at T2157.32.

with clinic staff.[50] Dr Fox considers Bidyadanga would benefit from a home and community care service with access to a clinical nurse specialist with training in aged care, and, ideally, with renal training.[51]

The Chief Executive Officer of the Royal Flying Doctor Service of Australia, Dr Martin Laverty, explained that while the service is not an aged care provider, it provides primary and other health services to older Australians in remote and very remote locations. These services include emergency air retrieval, outreach and telehealth medical, nursing, dental, mental, and allied health care, and patient transport.[52] The Royal Flying Doctor Service fills a number of the significant gaps that exist in primary health coverage of remote and very remote Australia.

Dr Laverty explained that primary care and aged care are interdependent. He said that avoidable hospital admissions for Aboriginal people across the Kimberley are three times the national average and in the Northern Territory four times.[53] He said:

> where your primary care is failing, you are going to have greater call on aged care services for older Australians and when they enter their acuity will be higher such that they will require a higher level of support. Again, to the interdependence between primary care and the aged care system.[54]

Barriers

The barriers to access to aged care services in remote and very remote areas, particularly to Aboriginal and Torres Strait Islander people, cannot be underestimated.

Ms Roslyn Malay, a Yurriyangem Taam Kija woman from Wadamun, Co-Chair of the Aboriginal and Torres Strait Islander Australian Association of Gerontology Ageing Advisory Group, and Project Officer and Researcher at the University of Western Australia Centre for Health and Ageing, gave evidence.[55] She is an expert in the 'complex social, environmental and cultural issues' that 'affect and influence the health and wellbeing of Aboriginal and Torres Strait Islander people in the Kimberley'.[56] Ms Malay explained:

> Location and distance to access services is a huge barrier. Rural and remote service providers have greater challenges, particularly with the cost of service provision, workforce and access to professional services. Very remote communities can be located hundreds of kilometres from a small town centre such as Balgo Community to Halls Creek.[57]

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50 Transcript, Kate Fox, Broome Hearing, 19 June 2019 at T2160.13-25.

51 Transcript, Kate Fox, Broome Hearing, 19 June 2019 at T2164.21-24.

52 Exhibit 4-7, Broome Hearing, Statement of Martin Laverty, 22 May 2019, WIT.0157.0001.0001 at 0002 [12].

53 Transcript, Martin Laverty, Broome Hearing, 18 June 2019 at T2055.26-42.

54 Transcript, Martin Laverty, Broome Hearing, 18 June 2019 at T2055.45-2056.3.

55 Exhibit 4-15, Broome Hearing, Statement of Roslyn Malay, 2 June 2019, WIT.0174.0001.0001 at 0001 [4]-[5]; Transcript, Broome Hearing, Roslyn Malay, 19 June 2019 at T2171.10-15.

56 Exhibit 4-15, Broome Hearing, Statement of Roslyn Malay, 2 June 2019, WIT.0174.0001.0001 at 0001 [5].

57 Exhibit 4-15, Broome Hearing, Statement of Roslyn Malay, 2 June 2019, WIT.0174.0001.0001 at 0003 [15].

Barriers extend from the remoteness of locations and absence of transport, to language and a lack of cultural awareness.[58]

Working in partnership with local communities has proven to be successful. We heard examples of this from Mr Aitken, Ms Crawford and from Professor Leon Flicker AO, who pioneered a partnership in the Looma community. Ms Bridges described the partnership with communities as being:

> critical to understanding the needs of the people we care for and providing them with dignity and deep respect as they age.[59]

As Professor Flicker observed, where the care provided is not culturally safe, Aboriginal and Torres Strait Islander people will be reluctant to take it up and may in some cases refuse care. Ms Crawford neatly summarised the challenge when she said:

if you don't have the trust of the communities…the communities…won't let you visit; they won't listen to you when you go, and they—they don't want to work together with you. So having trust of people in the communities is really important.[60]

Trust is, Ms Crawford agreed, very much the underlying foundation for a partnership model of care.[61]

Dr Fox emphasised the importance of building trust:

> it's really important to build relationships of trust, and I think, you know, trust is important in any therapeutic doctor/patient relationship but it's the next level when it's a white doctor and an Aboriginal patient, and I think that's due to the impact of—you know, historical impacts of colonisation and–and–and past discriminatory government policies and, you know, marginalisation of, you know, marginalisation, essentially there was exclusion of Aboriginal people from western—from white western health services. So—and those past discriminatory policies have engendered this transgenerational distrust in white people and white health services…
>
> it honestly takes a lot of time and I think that's where continuity of care builds into it because you need to have time with patients to build up that trust, and I often spend a lot of my time in consultations just getting to know a person, talking about things that I—that we that I know about them or, you know, talking about the footy or the Dockers and doing that before I can—and you know, often over multiple consults before I can even look at potentially addressing some of those complex chronic health needs.[62]

58 Exhibit 4-15, Broome Hearing, Statement of Roslyn Malay, 2 June 2019, WIT.0174.0001.0001 at 0003 [16].

59 Exhibit 4-5, Broome Hearing, Statement of Tamra Bridges, 31 May 2019, WIT.0166.0001.0001 at 0003 [23].

60 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2096.39-42.

61 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2096.32-41.

62 Transcript, Kate Fox, Broome Hearing, 19 June 2019 at T2162.35-2163.9.

Ms Yvonne Grosser is an Aboriginal woman from Quairading in Western Australia, raised in Perth, and an enrolled nurse.[63] She described her experience working in residential aged care in Broome. Ms Grosser explained that although she is an Aboriginal woman, the fact that she was not from the local community was a barrier for her. She explained how it took time for her to earn the confidence and acceptance of Aboriginal residents. For her, developing 'confidence required taking the time to learn their background and culture'.[64]

Language was another barrier to providing care to Aboriginal people. Ms Grosser explained that she speaks only English, while some of the residents she cared for in Broome only spoke Aboriginal languages.[65] Ms Grosser explained that she would communicate with some of the Aboriginal residents via hand signals and eye and head movements that she was taught by her Elders growing up. Although from a different part of Western Australia, she found that many of these signals were the same in Broome.[66]

Ms Crawford explained that people from culturally and linguistically diverse backgrounds have access to interpreters for free as part of their Home Care Packages. However, Aboriginal and Torres Strait Islander people do not have access to a comparable free interpreting service. Ms Crawford explained that in the case of Kimberley Aged and Community Services' clients:

> the money has to come out of either the package or most commonly we take it out of our administration money because it's very, very difficult if you've got to charge one client for two or three hours at $88 for half an hour; they don't have much money left.[67]

The evidence about the importance of and the connection to Country for Aboriginal and Torres Strait Islander people was overwhelming and undeniable.

Miss Jadai said that Aboriginal people need to maintain their attachment to community and Country.[68] Ms Grosser described people in an aged care facility away from Country as 'quite sad people. You could see that their heart is sad'.[69] Being on Country is 'healing'.[70] Ms Curnow explained:

> Aboriginal and Torres Strait Islander people innately trust in their culture…their languages…it may from the outside seem easier for, you know, to go down a western lifestyle and live that way, but it—there's not that trust in that way of living. If we do rely totally on a western way of living, we will lose our way of hunting and our way of gaining our own food security, our way of living together, of knowing who our—

63 Exhibit 4-3, Broome Hearing, Statement of Yvonne Grosser, 12 June 2019, WIT.1144.0001.0001 at 0001 [4]-[5].

64 Exhibit 4-3, Broome Hearing, Statement of Yvonne Grosser, 12 June 2019, WIT.1144.0001.0001 at 0002 [16].

65 Transcript, Yvonne Grosser, Broome Hearing, 17 June 2019 at T1997.12.

66 Transcript, Yvonne Grosser, Broome Hearing, 17 June 2019 at T1997.27-28; Exhibit 4-3, Broome Hearing, Statement of Yvonne Grosser, 12 June 2019, WIT.1144.0001.0001 at 0002 [15].

67 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T22016.4-8.

68 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1988.5.

69 Transcript, Yvonne Grosser, Broome Hearing, 17 June 2019 at T1999.5-8.

70 Transcript, Yvonne Grosser, Broome Hearing, 17 June 2019 at T1999.5.

> our collective cultural insurance is, you know, how our families look after each other. We can't be isolated from each other, you know, which is what a western culture sort of like…[71]

Ms Belinda Robinson, Residential Manager of Juniper Ngamang Bawoona and Juniper Numbala Nunga, explained that the flexibility of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program allows Juniper to 'be a bit more open with…attending to the cultural needs' of residents at facilities that attract that funding, including taking them on Country. However, Aged Care Funding Instrument funding, which she described as 'very clinical care based', does not allow this flexibility at facilities under that funding arrangement.[72]

Barriers also extend to the effect of past policies. We heard that the trauma suffered by members of the Stolen Generations, as a consequence of forcible removal and isolation from homes, family, culture and Country, is a significant issue that continues to impact members of the Stolen Generations and their families.[73] Ms Bridges put it this way:

> For many Aboriginal and Torres Strait Islander people, there is a distrust of institutions and a reluctance to enter care. This distrust results from the history of marginalisation, racism and mistreatment of Aboriginal and Torres Strait Islander people, including forced removal of people from Country. The theme here is the need for 'connection' for an Aboriginal and Torres Strait Islander person; connection not only to people but also to every facet of Country and how they are integral to, and inseparable from, that existence. Connection is central to a person's identity, sense of self and purposeful life. Much distrust has come from the intentional and incidental, breaking of that connection by non-Indigenous people, services and government.[74]

Ms Crawford said that residential aged care is sometimes seen by Aboriginal and Torres Strait Islander people 'as the place to go to die, so they do not want to go'.[75] Ms Malay reinforced this, saying older Aboriginal and Torres Strait Islander people have told her their views on residential aged care:

> what they're saying about the residential care is pretty much a death sentence to them. It's not where they want to end up. They prefer to stay on Country, to be able to continue their leadership in the role that they play in the community. And that they don't—that they don't want to end up in aged care…They would rather stay on Country and to die…[76]

We heard that not only do barriers affect access to care by Aboriginal and Torres Strait Islander people, they also affect participation in the aged care workforce by

71 Transcript, Venessa Curnow, Broome Hearing, 19 June 2019 at T2185.37-47.

72 Transcript, Belinda Robinson, Broome Hearing, 18 June 2019 at T2121.40-44.

73 Transcript, Graham Aitken, Broome Hearing, 18 June 2019 at T2085.43-2086.2; Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2093.42-45.

74 Exhibit 4-5, Broome Hearing, Statement of Tamra Bridges, 31 May 2019, WIT.0166.0001.0001 at 0009 [66].

75 Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2109.20-21.

76 Transcript, Roslyn Malay, Broome Hearing, 19 June 2019 at T2173.36-46.

Aboriginal and Torres Strait Islander people. Ms Malay said that racism is a barrier to entering the workforce:

> we need current leadership in the sector to promote cultural safety, first, by working collaboratively with local Aboriginal traditional owners—owner groups to improve—to increase the two-way sharing. We need cultural leadership in the sector to promote cultural safety, firstly, by working together. We need employers to understand and respect Aboriginal employers' obligations such as attending sorry business and law business.[77]

Mr Aitken explained the importance of understanding these matters. It is important that he is flexible in the way he manages their services because often staff will need to be absent for family or cultural reasons. If he did not allow flexibility, Elders would 'voice their disappointment'. Making provision so that Aboriginal and Torres Strait Islander staff can honour their traditions is 'part of being culturally safe'.[78]

Ms Venessa Curnow is an Ait Koedal and Sumu woman and Executive Director of Aboriginal and Torres Strait Islander Health at the Torres and Cape Hospital and Health Service.[79] She explained that employing Aboriginal and Torres Strait Islander people would assist with the delivery of culturally safe care. Ms Curnow has worked for many years in Aboriginal and Torres Strait Islander aged care services. She encourages employment of Aboriginal and Torres Strait Islander people, in particular those who are informal carers—unpaid carers and family members:

> So that's just part of our operating, you know, we understand that they've got that skill set, that you can't teach people as well. You can teach an Aboriginal and Torres Strait Islander person about mainstream caring, how to lift people, how to turn people, you know, what type of medications to give and when, but it's harder to teach a non-Indigenous person cross-cultural skill sets because that's the kind of things that you learn over a long period of time and cross-cultural—cultural safety is at the—the—one end of the continuum. You start off at cultural competence awareness and then move on to cultural competence and then hopefully over time people can get to cultural safety, but it's a skill set that's built up over a long period of time.[80]

Conclusion

The importance of Elders in Aboriginal and Torres Strait Islander communities emerged clearly throughout this hearing. There are many issues that affect the delivery of aged care services to older Aboriginal and Torres Strait Islander people living in remote and very remote locations. At the heart of these issues, however, is respect for Elders and older people. It is clear from those who gave evidence at this hearing that this respect drives the desire to care for older Aboriginal and Torres Strait Islander people.

77 Transcript, Roslyn Malay, Broome Hearing, 19 June 2019 at T2174.23-30.

78 Transcript, Graham Aitken, Broome Hearing, 17 June 2019 at T2080.6-27.

79 Transcript, Venessa Curnow, Broome Hearing, 19 June 2019 at T2179.41.

80 Transcript, Venessa Curnow, Broome Hearing, 19 June 2019 at T2187.16-46.

When asked what made her people happy, Miss Jadai answered:

> Being around families and being together, especially our Elders. They've given so much to us, you know, and showing us Country and teach us the right way, so it's time to give—give them back something.[81]

Ms Curnow said that:

> Country is central to who we are and what we do and it also encompasses us as well because then on Country we've got Aboriginal and Torres Strait Islander individuals and then we've got our family which is our broader networks and community. And then what encompasses all of us is Country so it's central to each of us as individuals, but as a whole it encompasses us all as well and keeps us safe, feeds us, gives us shelter, and even has a spiritual aspect as well around a place of belonging and feeling and having feelings.
>
> …
>
> So our connection to Country is not as a physical resource; it is partly as a physical resource, yes, we know we need to get food. We know we need shelter and sorts of things, but at the same time we have a story about an animal and we have—so we end up with a spiritual connection and a belonging to an animal or a place. We have a story about a place, we have a song about a place, we have a dance about a place, we have artwork about places, and it's all around Country and our connections to Country.[82]

Ms Dean said the most important thing to understand is:

> Elders are our future, our culture. And that's who we learn off, our—our Elders.[83]

81 Transcript, Madeleine Jadai, Broome Hearing, 17 June 2019 at T1988.13-15.

82 Transcript, Venessa Curnow, Broome Hearing, 19 June 2019 at T2184.36-2185.16.

83 Transcript, Faye Dean, Broome Hearing, 17 June 2019 at T1983.21-22.

5. Perth Hearing: Person-centred Care

Hearing overview

Introduction

Over five days, between 24 and 28 June 2019, we held a hearing in Perth, Western Australia. The focus of the hearing was person-centred care and palliative care. The main areas examined at the hearing were:

- how aged care services can be provided in a way which is person-centred, including care which values the identity, experience and autonomy of the person accessing care and promotes their choice and control over services provided
- the factors that influence whether aged care services are delivered in a person-centred manner, including:
  - the relationships between the person accessing care, people providing support (including family and other members of the community) and the service provider
  - broader societal attitudes towards older people
- the perspective and experience of people who access aged care, including the ways in which aged care services are, or are not, person-centred
- good practice care models for providing person-centred aged care
- the role of advance care planning to support the provision of quality aged care services
- the extent to which people using aged care services are able to access palliative care
- the quality of palliative care services available to people using aged care services.

We heard oral testimony from 30 witnesses. There were 510 documents, including 39 witness statements, received into evidence.

During this hearing, a range of experts, service providers and people who have worked in aged care gave us their views on the importance of a person-centred or a relationship-focused approach to aged care and to palliative care in an aged care setting. We also heard accounts from people who care or have cared for a loved one.

The importance of a person-centred or relationship-focussed approach to aged care and to palliative care in aged care was further illustrated by two case studies. Our findings and conclusions about these case studies are set out later in this chapter.

Some of the evidence we received at this hearing has been drawn upon in Volume 1 of this Interim Report. It will continue to be drawn upon over the course of our inquiry as well as in our Final Report. A brief overview of the hearing and the evidence is provided below.

It is clear from the evidence both at the Perth Hearing and across our work that societal attitudes inform the delivery of aged care. The importance of relationships in delivering person-centred care emerged clearly. Organisational leadership plays a critical role both in fostering relationships and in the attitudes that inform the delivery of aged care.

Early in the hearing, we heard that person-centred care is a philosophy of care, not a model of care. Often, this distinction is confused.[1]

While there are varied definitions, in general person-centred care is a philosophy of care that respects, and responds to, the preferences, needs and values of people receiving care and those who care for them.[2]

Importance of relationships

The hearing revealed the importance of relationships to person-centred care. Understanding the individual who is receiving care is critical. The relationship between the person in care, their loved ones and the facility is also critical, as is understanding and attending to the particular person's needs, holistically and not limited to clinical care. Several witnesses at this hearing made this clear.

We heard how important it is for staff to know well the person receiving care well. This is facilitated by maintaining consistent staffing so that they can build familiarity and a genuine relationship with the older person.[3]

Ms Patti Houston is a personal care worker. She drew on the work of English social psychologist and dementia expert Professor Tom Kitwood to describe person-centred care as involving 'working with people and their families to find the best ways' to provide care.[4] To her, person-centred care involves:

> looking at the person as a whole, not just they need to be in a room, they need to be washed and cleaned. We need to be actually filling their needs as human beings.[5]

1 Transcript, Jason Burton, Perth Hearing, 25 June 2019 at T2406.20-26.

2 Exhibit 5-6, Perth Hearing, Statement of Karn Nelson, WIT.0207.0001.0001 at 0031 [123].

3 Transcript, Bryan Lipmann, Perth Hearing, 26 June 2019 at T2467.16; Transcript, Kate Rice, Perth Hearing, 26 June 2019 at T2466.30-39.

4 Transcript, Patti Houston, Perth Hearing, 26 June 2019 at T2517.1-20.

5 Transcript, Patti Houston, Perth Hearing, 26 June 2019 at T2517.1-20.

The importance of this approach was illustrated by the evidence of Mr Anthony O'Donnell, an 85-year-old resident at an aged care facility. He emphasised the need for carers to understand what residents want as individuals.[6] He found that, by contrast, his care revolves around the completion of tasks.[7] Mr O'Donnell described actual care as 'connecting with residents in order to see to their needs' and interacting 'with them as people'.[8] Mr O'Donnell recognised the effect of this arrangement on both those receiving care and those delivering it:

> And once the resident immediately is satisfied, it's off to the next most urgent task or call, leaving the parties neither satisfied nor fulfilled.[9]

Dr Lisa Trigg, Assistant Director of Research, Data and Intelligence at Social Care Wales, emphasised that it is important that those people providing care understand they are 'not doing to' but instead 'doing with' those to whom they deliver care.[10]

We heard there is a lack of authenticity in relationships that are not equal and have a task focus. Mr Jason Burton, the Head of Dementia Practice and Innovation at Alzheimer's Western Australia (Alzheimer's WA), said that when the success of a carer's outcome is measured by whether they complete the relevant task, with no consideration for how the care recipient feels, 'a social malignancy' is created, particularly for those living with dementia.[11]

Mr Burton said that 'personhood is absolutely critical'.[12] The environment round those being cared for needs to respond to the person and give them what they need otherwise the person is diminished as a person.[13]

The two case studies at this hearing illustrated what can happen when relationships between loved ones and providers break down. The Japara Mitcham case study demonstrated the effects of the disintegration of the relationship between family members and providers. The Alkira Gardens case study illustrated the importance of relationships between providers, care recipients and their families.

By way of contrast, we also heard about the benefits for all involved when the relationships between providers, care recipients and their families are working well. Mr Kevin Chester and a witness given a pseudonym, Ms EA, each care for a loved one who lives with dementia. They spoke positively of their experiences with aged care services for their loved ones.

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6 Transcript, Anthony O'Donnell, Perth Hearing, 25 June 2019 at T2482.18-19.

7 Transcript, Anthony O'Donnell, Perth Hearing, 25 June 2019 at T2478.20-21.

8 Transcript, Anthony O'Donnell, Perth Hearing, 25 June 2019 at T2478.22-24

9 Transcript, Anthony O'Donnell, Perth Hearing, 25 June 2019 at T2478.24-26.

10 Transcript, Lisa Trigg, Perth Hearing, 28 June 2019 at T2802.6.

11 Transcript, Jason Burton, Perth Hearing, 25 June 2019 at T2404.43-2405.5.

12 Transcript, Jason Burton, Perth Hearing, 25 June 2019 at T2405.14.

13 Transcript, Jason Burton, Perth Hearing, 25 June 2019 at T2405.14-19.

Ms EA's partner, Ms EB, lives with younger onset Alzheimer's disease.[14] Since her diagnosis in 2010, Ms EB has received various aged care services from Alzheimer's WA.[15] She has participated in a range of programs offered by them, including a support group at Mary Chester House for people with dementia.[16]

Ms EA said that building constructive relationships is critical to providing quality care.[17] She said it is important to continue trying to connect with a person, especially as conditions like Alzheimer's disease cause them to change and withdraw.[18] Ms EA credited Ms EB's agreement to attend Mary Chester House to Ms EB's close relationship with her support worker, founded in a mutual appreciation for animals and nature.[19] Ms EA considered that she and Alzheimer's WA were partners in Ms EB's care.[20] She stressed the importance of person-centred care for people with living dementia and their families, explaining person-centred care as:

> to know the person behind the dementia and then to engage them as far as possible in day-to-day life that is rewarding, that normalises their life and that keeps them engaged in the world as they deal with their dementia.[21]

At Mary Chester House, staff made Ms EA and Ms EB feel welcome. They took care and time to greet them when they arrived, showing Ms EB photographs of her and Ms EA participating in activities, and offering coffee. Ms EA went on:

> It is certainly difficult and time consuming to give people a lot of one-on-one time when there are 12 to 14 clients at once and limited resources. Just these small things and taking a minute or two to sit down and talk with someone is so important to most of us when we are needing reassurance in a world that is so complex and so confusing.[22]

Mr Chester's wife, Marie, lives at the Whiddon Largs residential aged care facility at Maitland, New South Wales. Mr Chester lives in an independent living unit in the same complex.[23] Mr Chester gave evidence together with Ms Carolyn (Carol) Jubb. Ms Jubb is a leisure and lifestyle officer at the facility and Mrs Chester's 'buddy'.[24]

14 Transcript, EA, Perth Hearing, 25 June 2019 at T2418.33.

15 Transcript, EA, Perth Hearing, 25 June 2019 at T2418.38-39.

16 Transcript, EA, Perth Hearing, 25 June 2019 at T2419.33-35.

17 Transcript, EA, Perth Hearing, 25 June 2019 at T2423.32.

18 Transcript, EA, Perth Hearing, 25 June 2019 at T2423.33-34.

19 Transcript, EA, Perth Hearing, 25 June 2019 at T2423.34-37.

20 Transcript, EA, Perth Hearing, 25 June 2019 at T2424.4; T2425.11-12.

21 Transcript, EA, Perth Hearing, 25 June 2019 at T2426.22-26.

22 Transcript, EA, Perth Hearing, 25 June 2019 at T2423.39-2424.2.

23 Transcript, Kevin Chester, Perth Hearing, 25 June 2019, T2440.36, T2443.3-4, T2442.46.

24 Transcript, Carolyn Jubb, Perth Hearing, 25 June 2019 at T2439.36-44; Exhibit 5-17, Perth Hearing, Statement of Kevin Charles Chester, 3 June 2019, WIT.1137.0001.0001 at 0002 [14], [17].

Mr Chester is invited to be a part of, and help the staff with, Marie's care.[25] He feels welcomed to go into the facility, which makes it very easy for him to 'spend time with Marie, and to be close to her and be involved with whatever is going on'.[26] It is very important to him and Mrs Chester that he comes every day and they can spend time together.[27] They are, he said, 'separate, but never apart'.[28]

Ms Jubb had training in relationship-based care and described it as being:

> about coming together as a family and being able to relate to each other as a friend rather than just a—a person that you have to care for. It's about really looking after them more as an individual and learning about what they like and what they don't like...[29]

Ms Jubb described staff at the Whiddon Largs facility as 'all together as a family' and said that they 'help each other out more', which creates a friendly atmosphere.[30] There is teamwork and less segregation between staff in various roles than might be typically found in residential aged care. Ms Jubb considered herself to be supported by the other staff at the facility.[31]

The Chief Executive Officer of the Whiddon Group, Mr Chris Mamarelis, explained that 'relationships are central' to what they do at Whiddon: 'The core premise is to form deeper and richer relationships between the care recipient and the caregiver.'[32] He explained that relationship-based care requires consistent rostering. At Whiddon, they ask 'staff to commit themselves to a certain number of shifts'. This promotes familiarity and the development of relationships.[33]

The term 'person-centred care' is not one that Mr Bryan Lipmann AM, the founder and Chief Executive Officer of Wintringham, was familiar with until he was asked to give evidence at the hearing.[34] In his evidence he focused on the substance rather than a label. He described the approach to care of homeless and formerly homeless people at Wintringham as:

> treating people how you would like to be treated, or put it a slightly different way, how would you like your parent or your grandparent treated. And so it's a matter of getting to know the person and spending time with them.[35]

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25 Exhibit 5-17, Perth Hearing, Statement of Kevin Charles Chester, WIT.1137.0001.0001 at 0006 [44], [46]; Transcript, Kevin Chester, Perth Hearing at 25 June 2019 at T2448.3-12.

26 Transcript, Kevin Chester, Perth Hearing, 25 June 2019 at T2450.42-45.

27 Transcript, Kevin Chester, Perth Hearing, 25 June 2019 at T2450.45-47.

28 Transcript, Kevin Chester, Perth Hearing, 25 June 2019 at T2451.24, 41-42.

29 Transcript, Carolyn Jubb, Perth Hearing, 25 June 2019 at T2449.26-30; Exhibit 5-17, Perth Hearing, Statement of Kevin Charles Chester, 3 June 2019, WIT.1137.0001.0001 at 0003 [26].

30 Transcript, Carolyn Jubb, Perth Hearing, 25 June 2019 at T2448.31-36.

31 Transcript, Carolyn Jubb, Perth Hearing, 25 June 2019 at T2450.6-8.

32 Transcript, Chris Mamarelis, Perth Hearing, 25 June 2019 at T2427.43; T2430.29-38.

33 Transcript, Chris Mamarelis, Perth Hearing, 25 June 2019 at T2430.44-47.

34 Transcript, Bryan Lipmann, Perth Hearing, 25 June 2019 at T2462.44-46.

35 Transcript, Bryan Lipmann, Perth Hearing, 25 June 2019 at T2462.44-2463.7.

Mr Lipmann argued that you need to help people out by creating a physical environment that enables them to interact, do what they want to do, and be joyful.[36]

Wintringham has high levels of staff loyalty in its work providing care to the homeless or people at risk of homelessness. Mr Lipmann explained that consistency of staff is 'terribly important' in providing care.[37]

Ms Emma Murphy works as an 'agency nurse' in aged care. Some weeks she can have five shifts in the one facility. In other weeks she has five shifts each at different facilities. She said it can be 'quite overwhelming' looking after people she's not familiar with. To assist with this:

> after handover I make it my duty to go around and see everyone, see what sort of needs they have that aren't necessarily documented. Everyone in aged care is at a different level of care so I think it is really important to understand the needs they have.[38]

Mr Matthew Moore, the General Manager of Aged and Disability Services at the Institute for Urban Indigenous Health, explained that the Institute offers an integrated model of care. Funding available to them allows 'services that actually wrap around the client'; it is not just an 'isolated aged care service'.[39] In delivering person-centred care to Aboriginal and Torres Strait Islander people, Mr Moore said they 'put the person in the centre of their holistic needs'.[40]

It is important for providers to understand the individuals receiving care. It is also necessary for people to understand the wishes of their loved ones. Dr Craig Sinclair, of the Centre of Excellence in Population Ageing Research at the University of New South Wales, explained the importance of advance care planning and supported decision making. He outlined the role advance care planning can play for loved ones: 'part of it is starting a conversation that often hasn't been held within the family'.[41] Dr Sinclair said that an assumption inherent in advance care planning is that 'we all want to make our own decisions and anticipate a future and make decisions for the future'.[42] This assumption, he explained, can result in discussions being framed in a narrow way with a focus on decline in capacity and death, 'rather than what you want to live well'.[43] Measures need to be put in place 'that enable a person to preserve their identity'.[44]

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36 Transcript, Bryan Lipmann, Perth Hearing, 25 June 2019 at T2460.24-2461.21.

37 Transcript, Bryan Lipmann, Perth Hearing, 25 June 2019 at T2467.16.

38 Transcript, Emma Murphy, Perth Hearing, 26 June 2019 at T2519.29-33.

39 Transcript, Matthew Moore, Perth Hearing, 26 June 2019 at T2574.26-38.

40 Transcript, Matthew Moore, Perth Hearing, 26 June 2019 at T2575.14.

41 Transcript, Craig Sinclair, Perth Hearing, 26 June 2019 at T2609.26-27.

42 Transcript, Craig Sinclair, Perth Hearing, 26 June 2019 at T2607.41-42.

43 Transcript, Craig Sinclair, Perth Hearing, 26 June 2019 at T2608.4-11.

44 Transcript, Craig Sinclair, Perth Hearing, 26 June 2019 at T2608.15-20.

Leadership, culture and staffing

The evidence at this hearing was clear that organisational leadership and culture is critical to the delivery of person-centred care. A commitment to adhering to the philosophy of person-centred care comes from the top of an organisation and filters down. Mr Mamarelis put it this way:

> As CEO, I'm responsible for every aged care resident that we care for. I'm responsible for every home care client that we visit. I'm responsible for every retirement village resident as well. So as CEO, my focus and my leadership is very important in the organisation in setting the tone and setting the culture. As CEO, it has been really important, given the cultural shift, that we have to take to empower our people and give them licence to start thinking in this different context and to take them on that journey with us.[45]

Mr Mamarelis said he reassures team members that the approach they take at Whiddon 'is okay'. He provides staff with resources. He also works closely with the board, keeping them informed of progress.[46]

Dr Lisa Trigg was compelling on the importance of leadership. She contrasted the position of Mr Mamarelis with that of Mr Andrew Sudholz, one of the founders and the Chief Executive Office of Japara Healthcare Limited.[47] During his evidence as part of the Japara Mitcham case study, Mr Sudholz referred to a resident and relative meeting in mid-2016, about which he said:

> there were a number of people who were very abusive, very aggressive towards me, shouted me down, and showed little respect to me as the CEO of a big organisation. And I found that disappointing, and I was quite distraught about that.[48]

Mr Sudholz's position, Dr Trigg said, 'absolutely encapsulated where you can go wrong in aged care'.[49] Dr Trigg continued:

> I feel slightly uncomfortable picking an individual, but I think that really sums up what the issue is, that if you don't believe those people, not just the residents, but their families, the—the people who work there every day, whether it be in the kitchen or the laundry or, you know, registered nurses, then you—you kind of missed the point.[50]

45 Transcript, Chris Mamarelis, Perth Hearing, 25 June 2019 at T2431.31-37.

46 Transcript, Chris Mamarelis, Perth Hearing, 25 June 2019 at T2431.39-44.

47 Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2367.24-31.

48 Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2391.39-43.

49 Transcript, Lisa Trigg, Perth Hearing, 28 June 2019 at T2800.12.

50 Transcript, Lisa Trigg, Perth Hearing, 28 June 2019 at T2800.29-33.

Japara said in submissions that:

> Properly understood, Mr Sudholz is not by this evidence suggesting that he was the most important person in the room or otherwise attempting to apportion blame in any response to a complaint. Rather, he is expressing disappointment and distress that, by virtue of the conduct of certain individuals, a resident and relative meeting that he had attended was not productive.[51]

Mr Burton explained the importance of leadership and culture. He put it this way:

> person-centred care…can only exist if the organisational culture of person-centredness is in place. Practitioners will do their very best to be as person-centred as they can, but if they're working in a care culture and a care environment of their organisation that doesn't support it, it's extremely difficult to sustain it. I think part of what we see in the high staff turnover we have in aged care is people just disenfranchised…the majority of people working in aged care generally, and especially in dementia care, are very caring, compassionate, inspirational, passionate people who want to do the best for their clients, and they're looking for care environments that will allow them to do that.[52]

Mr Burton continued:

> at the heart of person-centred care is culture. It's the culture of the organisation, it's the culture of the leaders, it's the behaviour of the leaders in the organisation. Without that, care staff will find it very difficult to actually implement person-centred care at the coalface.[53]

It is clear from the evidence before us that the attitudes of those who lead organisations affect all levels of operation, including those working to them, and fundamentally influence the quality of aged care and the dignity and respect displayed towards older people.

A panel of aged care workers gave clear evidence that people working in the sector want a care environment that supports them to provide person-centred care. Each of the workers spoke about their desire to deliver care that made lives better.[54]

Ms Anna Urwin, a physiotherapist who previously worked in aged care, gave evidence in a panel with others who have worked in aged care. Her experience working in aged care prompted her to question how someone receiving care can 'expect to have any sense of independence or improvement in quality of life' when they do not have a 'sense of choice' in what they do throughout the day or about the treatment that they are given.[55]

51 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [78].

52 Transcript, Jason Burton, Perth Hearing, 25 June 2019 at T2412.20.

53 Transcript, Jason Burton, Perth Hearing, 25 June 2019 at T2415.36-39.

54 Transcript, Urwin/Murphy/Whitford/Houston, Perth Hearing, 26 June 2019 at T2511.10-2539.12.

55 Transcript, Anna Urwin, Perth Hearing, 26 June 2019 at T2524.31-35.

Mr Lipmann gave some credit for the staff longevity at Wintringham to leadership. In his role as Chief Executive Officer, he reinforces to his staff that they are 'special people doing special work' helping those otherwise 'rejected by the aged care industry'.[56]

Dr Trigg explained the importance of staff in this context:

> to deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported.[57]

Having staff with the right attributes is a component of delivering person-centred care. Mr Burton explained that if staff with the right attributes are not attracted and retained by an organisation, then delivering this kind of care is not possible.[58] Mr Burton said the attribute he looks for is 'warmth in a person' and the ability to ask questions about the individual and try to understand them.[59]

Ms Kate Rice gave evidence together with Mr Lipmann. She is the manager of one of Wintringham's residential aged care facilities.[60] She has worked with Wintringham for 18 years.[61] Ms Rice described a clear benefit of having long-term staff: they know the people they care for. She said 'we're actually interested'. The long-term retention of staff has assisted with the development of relationships with residents over a period of time.[62]

Ms Rice involves herself in the recruitment of staff, whether it be recruitment of someone to work in the kitchen, a cleaner, care or nursing staff. She seeks to identify people with an 'interest and commitment to older people'.[63] A lot of people who apply for jobs at Wintringham do not have experience working with homeless people. Some of those applicants give answers during their interviews that reveal respect for older people. These applicants 'jump out' as potentially good staff members.[64]

It was clear from Ms Rice that what is important is attitude and commitment; people can be trained to give good care. She said that it is the right attitude and commitment that is important—you can train people in the provision of care.[65] In her words:

> I'm excited about working in aged care. I love it. So I think if I love it, I want to find other people who are equally as excited as me.[66]

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56 Exhibit 5-19, Perth Hearing, Statement of Bryan David Lipmann AM, 11 June 2019, WIT.1135.0001.0001 at 0003 [18]; Transcript, Brian Lipmann, Perth Hearing, 25 June 2019, T2453.29-20; T2465.45-2566.13.

57 Transcript, Lisa Trigg, Perth Hearing, 28 June 2019 at T2801.43-44.

58 Transcript, Jason Burton, Perth Hearing 25 June 2019 at T2409.21-25.

59 Transcript, Jason Burton, Perth Hearing 25 June 2019 at T2409.25-38.

60 Exhibit 5-18, Perth Hearing, Statement of Kate Rice, 14 June 2019, WIT.1136.0001.0001 [3]; Transcript, Lipmann/Rice, Perth Hearing, 25 June 2019, T2452.35-2471.29.

61 Exhibit 5-18, Perth Hearing, Statement of Kate Rice, 14 June 2019, WIT.1136.0001.0001 [6].

62 Transcript, Kate Rice, Perth Hearing, 25 June 2019 at T2466.23-2467.2.

63 Transcript, Kate Rice, Perth Hearing, 25 June 2019 at T2465.8-13.

64 Transcript, Kate Rice, Perth Hearing, 25 June 2019 at T2465.13-15.

65 Transcript, Kate Rice, Perth Hearing, 25 June 2019 at T2465.21-26.

66 Transcript, Kate Rice, Perth Hearing, 25 June 2019 at T2465.38-40.

However, there are challenges in finding the right staff. Ms Gaye Whitford is a registered nurse who works as an aged care coordinator in regional South Australia. She described the difficulty she has recruiting staff in a rural setting. She faces very limited resources, minimal staffing and a small volunteer base. Access to allied health workers and geriatricians is difficult. Funding is also a problem.[67]

Risk and safety

The tension between the right of those receiving care to exercise personal autonomy and their safety has been a constant theme at our hearings. The tension between risk and safety was examined at this hearing in the context of person-centred care.

It was demonstrated that it is possible to allow for dignity of risk in a balanced way. Mr Mamarelis told us if a 95-year-old woman wanted to ride a Harley Davidson, they would make that happen.[68] Mr Lipmann spoke of a woman in her eighties who wanted to get a tattoo.[69] Not all steps to balance dignity of risk and safety need to be as novel as these examples.

Ms Murphy gave an example where the risk was not balanced. She spoke of a married couple living in the same residential aged care facility, both of whom have dementia:

> The wife has late stage dementia. So she has a tendency to abscond or wander, so she resides in a secure wing of the facility. And her husband, who also has dementia but is not as cognitively declined as she is, resides in a separate area of the facility, and so he often becomes confused and would like to go and see his wife, asks when can I go and see her. So because of restrictive restraint policies in aged care, he cannot reside in the same wing as her because he doesn't have the tendency to wander. So he will come to the nurses and ask to be escorted to see her. He's allocated one hour twice a day to see his wife and he will come and ask us many times a day to come and see her, and often due to time constraints we have to let him know that he has already seen her twice today, he has to wait until tomorrow, or it's not his time yet. Or sometimes staff might be busy and he might only be able to see her once a day.[70]

This experience is in stark contrast to that of Mr and Mrs Chester described above.

It is clear from the evidence at this hearing that providers can choose to manage the balance between risk and safety in a way that prioritises personal autonomy and increases choice and control for those receiving care.

67 Transcript, Gaye Whitford, Perth Hearing, 26 June 2019 at T2518.8-18.

68 Transcript, Chris Mamarelis, Perth Hearing, 25 June 2019 at T2435.39-41.

69 Transcript, Bryan Lipmann, Perth Hearing, 25 June 2019 at T2464.3-17.

70 Transcript, Emma Murphy, Perth Hearing, 26 June 2019 at T2519.41-2520.6.

Dr Sinclair explained the benefits of supported decision making. An approach that 'boils down to an understanding that we develop and maintain our capacity for autonomous decision-making in the context of relationship'. There is, he continued, a 'spectrum of decision-making abilities…even as cognition declines'.[71]

Palliative care

In addition to an examination of person-centred care in aged care generally, the Perth Hearing focused on person-centred care in the context of palliative care in aged care. We heard of the particular importance of such care being person-centred.

Mr Joshua Cohen, a palliative care nurse practitioner, explained that the most important aspects of palliative care in aged care are adapting the care to the individual and the family, and keeping the care recipient at the centre of that care. However, pain management in residential care is often difficult because of the care setting and the absence of staff knowledge in how to manage the medications and the pain.[72] Training is also essential.[73]

Ms Dale Fisher, the Chief Executive Officer of Silver Chain, described Silver Chain's model of person-centred palliative care:

> Philosophically, we believe it's really important that we transfer the power and control of care to the person affected, and clearly the family as well are important in that definition.[74]

Ms Fisher said that 'death is a part of the life cycle' and that 'socially and culturally' conversations are not had about it.[75] She maintained that 'as a society we need to talk about death more'.[76]

We also heard evidence from a panel of palliative care experts: Dr Jane Fischer, Board Chair for Palliative Care Australia and palliative medical specialist; Professor Jennifer Tieman, Director of the Research Centre in Palliative Care, Death and Dying at Flinders University; and Dr Elizabeth Reymond, Deputy Director, Metro South Palliative Care Service and Director Brisbane South Palliative Care Collaborative. They said that ensuring people die well is critical to older people's quality of life in their last moments.

71 Transcript, Craig Sinclair, Perth Hearing, 26 June 2019 at T2605.29-38.

72 Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2690.24-29.

73 Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2717.10-30.

74 Transcript, Dale Fisher, Perth Hearing, 26 June 2019 at T2558.9-11.

75 Transcript, Dale Fisher, Perth Hearing, 26 June 2019 at T2566.45-47.

76 Transcript, Dale Fisher, Perth Hearing, 26 June 2019 at T2566.45-47.

Dr Fischer explained the need for palliative care to be holistic. In Dr Fischer's opinion, a 'truly holistic' person-centred approach to palliative care requires a team approach. In addition to management of people's physical symptoms, other important considerations in giving palliative care include people's psychosocial and social issues, cultural beliefs, financial issues and other matters.[77]

At a broad policy level, Professor Tieman said:

> We must anticipate the impact of population changes, societal changes and policy reform so that we can future proof whatever decisions we are making about palliative care provision and we need to make sure that person-centredness permeates all planning at all levels, policy, service design, consumer engagement and planning and evaluation, and that will be the test of us actually being person-centred.[78]

Dr Reymond described a 'palliative care crisis'.[79] She gave evidence about the need to normalise dying in what she described as our 'death denying society'.[80] Dr Reymond explained that where death is expected it:

> can be planned for in a proactive way, so that as needs emerge from people… you can proactively plan for them, and that can increase both the quality of life and quality of death.[81]

The Alkira Gardens case study illustrated the desperate circumstances families can find themselves in when the system fails: acting as advocates for their loved ones in their final days instead of choosing how to spend the time that they have left together.

Societal attitudes

Inextricably linked to all of these concepts is the question of whether Australia has a national culture of respect for ageing and older people. Attitudes towards ageing and older people can affect the care that is provided to them.

The Age Discrimination Commissioner, Dr Kay Patterson AO, referred to the 'scourge of elder abuse and ageism that we see in our community'.[82] She said 'ageism can be described as "discrimination against people based on their age, manifested through negative stereotypes and perceptions"'.[83] Dr Patterson considers that there needs to be a deep change in education to inform how people view older people because this influences the way they then treat older people.[84]

77 Transcript, Jane Fischer, Perth Hearing, 27 June 2019 at T2758.43-2756.3.

78 Transcript, Jennifer Tieman, Perth Hearing, 27 June 2019 at T2778.4-8.

79 Transcript, Elizabeth Reymond, Perth Hearing, 27 June 2019 at T2778.17-18.

80 Exhibit 5-39, Perth Hearing, Statement of Dr Elizabeth Reymond, 30 May 2019, WIT.0187.0001.0001 at 0015 [71].

81 Transcript, Elizabeth Reymond, Perth Hearing, 27 June 2019 at T2756.25-27.

82 Transcript, Kay Patterson, Perth Hearing, 26 June 2019 at T2541.35-36.

83 Exhibit 5-26, Perth Hearing, Statement of Dr Kay Patterson, 14 June 2019, WIT.0247.0001.0001 at 0006 [17].

84 Transcript, Kay Patterson, Perth Hearing, 26 June 2019 at T2541.28-34.

It is clear that the beliefs people hold about the ability, capacity and needs of older people can lead to assumptions that a person is incapable of making decisions for themselves or does not want to pursue meaningful activity and personal growth. In turn, this can lead to the balance between autonomy and protection being skewed, so that older people's wishes are not respected.

Dr Mike Rungie, a Director of the Centre for Modern Ageing, explained that negative beliefs about older people can lead to complacency and a lack of innovation in aged care. He thinks ageism is a real problem in which older people:

> get positioned in a place where the world thinks it's okay to stick you in an aged care facility without trying really hard to see whether we could keep you at home with a package, and the world thinks it's all right for you to be doing nothing all day and bored and that you ought to be able to cope with that…[85]

Ms Houston, a personal care worker, called for a complete cultural change to aged care in Australia and for a shift to valuing older people. She said it should not be a matter of:

> Well, we'll just stick them over there where we can't see them and we won't worry about that because it's all a bit yucky when people get old and, you know, they're just not themselves any more.[86]

The need for education to create deep change in community attitudes towards older people was emphasised.

The late Senator Bernard Cooney put it this way in his submission to us:

> The real values of a society as distinct from its stated claims, can be measured by the way in which its most vulnerable members, and that certainly includes those in aged care facilities, are treated. Not much empathy is needed to appreciate that it is hard to retain a sense of personal dignity when little by little individual autonomy is lost. Viewed against this standard, our failures are apparent.[87]

85 Transcript, Mike Rungie, Perth Hearing, 26 June 2019 at T2597.37-2598.2.

86 Transcript, Patti Houston, Perth Hearing, 26 June 2019 at T2535.47-2536.12.

87 Exhibit 5-7, Perth Hearing, General Tender Bundle, tab 67, AWF.001.00519 at _0002.

Case studies

Japara Mitcham case study

Introduction

The Royal Commission examined the experiences of Mr Clarence Hausler at the Mitcham Residential Aged Facility (Japara Mitcham) at Mitcham, South Australia, which since 2014 has been operated by Japara Healthcare Limited (Japara).

The evidence before the Royal Commission consisted of:

- the statement of Noleen Hausler, Mr Hausler's daughter, dated 29 May 2019[88]
- the statement of Racheal Musico, the former Facility Manager at Japara Mitcham, dated 12 June 2019[89]
- the statement of Diane Jones, Japara's Quality Manager, dated 12 June 2019[90]
- the statement of Julie Reed, the former Executive Director of Aged Care Services at Japara, dated 12 June 2019[91]
- the statement of Andrew Sudholz, Japara's Chief Executive Officer, dated 13 June 2019[92]
- the statement of Stuart Woodley, the Group Quality Manager at Japara, dated 23 June 2019[93]
- the oral testimony of those six witnesses
- the statement of TL, a Quality Manager at Japara, who was not called to give oral evidence, dated 28 June 2019[94]
- the statement of Kimberley Keevers, who worked as a Quality Manager at Japara, who was not called to give oral evidence, dated 28 June 2019[95]
- the tender bundle for this case study, which consisted of 275 documents.[96]

88 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001.

89 Exhibit 5-10, Perth Hearing, Statement of Rachael Anne Musico, 12 June 2019, WIT.0231.0001.0001.

90 Exhibit 5-11, Perth Hearing, Statement of Diane Jones, 12 June 2019, WIT.0230.0001.0001.

91 Exhibit 5-12, Perth Hearing, Statement of Julie Elizabeth Reed, 12 June 2019, WIT.0228.0001.0001.

92 Exhibit 5-13, Perth Hearing, Statement of Mark Andrew Sudholz, 13 June 2019, WIT.0229.0001.0001.

93 Exhibit 5-21, Perth Hearing, Statement of Stuart Randall Woodley, 23 June 2019, WIT.0272.0001.0001.

94 Exhibit 5-42, Perth Hearing, Statement of TL, 28 June 2019, WIT.0276.0001.0001.

95 Exhibit 5-41, Perth Hearing, Statement of Kimberley Keevers, 28 June 2019, WIT.0276.0001.0001.

96 Exhibit 5-8, Perth Hearing, Mitcham General Tender Bundle.

Japara and each of Ms Musico, Ms Jones, Ms Reed, Mr Woodley and Mr Sudholz were granted leave to appear at the public hearing and were represented by counsel and solicitors. Senior counsel for Japara did not make any application to cross-examine any of the witnesses called.

In accordance with the directions we made on 28 June 2019, Counsel Assisting provided written submissions setting out the findings they consider should be made arising from this case study. In response to those submissions, the Royal Commission received submissions from Japara.[97]

Mr Clarence Hausler

The late Mr Clarence Hausler was born in 1926. He grew up on a family farm in Morgan, South Australia. He married Betty in 1954 and they had five children, one of whom is Ms Noleen Hausler. Mr Hausler worked for much of his life as an orchardist on the same farm on which he grew up. He loved his community and was the Chairman of the Morgan Lions Club. Mr Hausler enjoyed restoring paddleboats on the Murray River and was a keen fisherman.[98]

In about 1991, Mr Hausler developed dementia. At about the same time, he was diagnosed with type 2 diabetes and depression.[99]

For about 10 years, Mr Hausler's wife Betty cared for him at home.[100] After she unexpectedly passed away in July 2001, the decision was made, primarily by Ms Hausler, that he should enter residential care.[101] He was incontinent, had restricted cognition and could not live safely alone due to his risk of falling.[102]

In July 2002, after 12 months in a residential facility at Barmera, near Morgan, Mr Hausler moved to the Mitcham Residential Aged Facility.[103] This was because the country facility was too far away for Ms Hausler to visit regularly from Adelaide. Mr Hausler was initially not very happy to move from the country but accepted that the move was in his best interest.[104]

97 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001; Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001.

98 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0002 [6]–[15].

99 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0002 [16].

100 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0002 [17].

101 Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2224.4.

102 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0003 [26].

103 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0003-0004 [30].

104 Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2224.28; Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0004 [33].

For the first 12 years of Mr Hausler's residence, the facility at Mitcham was operated by Whelan Care. Mr Hausler received good quality care during this period.[105] Ms Hausler had a positive relationship with the Mitcham facility and its staff during this time. Ms Hausler held Mr Hausler's power of attorney and was the main family visitor.[106] She accepted responsibility for Mr Hausler personally and financially to ensure that he was cared for.[107]

Japara Mitcham

In August 2014, Japara acquired the Mitcham Residential Aged Facility.[108] Japara is the parent entity of a complex corporate entity.[109] Japara Aged Care Services Pty Ltd, a Japara subsidiary, was the approved provider under the *Aged Care Act 1997* (Cth).[110] Japara is one of the largest approved providers delivering aged care services in Australia and has approximately 8200 shareholders.[111] It operates 49 residential aged care facilities across New South Wales, Victoria, Queensland, South Australia, and Tasmania. Japara has approximately 4000 residents and 5500 staff.[112] Compared with many of its other facilities, Japara's Mitcham facility is relatively small, with 38 beds.[113] More than 99% of Japara's revenue is derived from residential aged care services, including respite care;[114] 73% is derived from Commonwealth funding.[115] In 2017–18, Japara recorded a total net profit after tax of $23,327,000.[116] In 2017–18, Japara received $262,981,000 in Australian Government funding.[117]

Mistreatment of Mr Hausler at Mitcham

From early January to August 2015, Ms Hausler observed a deterioration in her father's demeanour. He seemed unhappy.[118] She began to develop serious concerns about his safety and wellbeing, and about the quality of care he was receiving at Japara Mitcham.[119] She had suspicions about one of the male staff because Mr Hausler seemed concerned

105 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0004 [36], 0005 [40].

106 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0003 [25], 0004 [34].

107 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0003 [29].

108 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0006 [48]; Exhibit 5-12, Perth Hearing, Statement of Julie Elizabeth Reed, 12 June 2019, WIT.0228.0001.0001 at 0004 [22].

109 Exhibit 5-13, Perth Hearing, Statement of Mark Andrew Sudholz, 13 June 2019, WIT.0229.0001.0001 at 0002 [9].

110 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 258, SUB.0001.0036.1147.

111 Exhibit 5-13, Perth Hearing, Statement of Mark Andrew Sudholz, 13 June 2019, WIT.0229.0001.0001 at 0002 [9].

112 Exhibit 5-13, Perth Hearing, Statement of Mark Andrew Sudholz, 13 June 2019, WIT.0229.0001.0001 at 0001 [7]; Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2368.6-15.

113 Exhibit 5-10, Perth Hearing, Statement of Rachael Anne Musico, 12 June 2019, WIT.0231.0001.0001 at 0002 [8].

114 Exhibit 5-13, Perth Hearing, Statement of Mark Andrew Sudholz, 13 June 2019, WIT.0229.0001.0001 at 0002 [12].

115 Japara Healthcare Limited. (2018) *Japara Annual Report 2018*, 14. Available at: http://japara2018japa1246.onlineicr.com (viewed on 4 July 2019).

116 Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2368.46.

117 Japara Healthcare Limited. (2018) *Japara Annual Report 2018*, 42. Available at: http://japara2018japa1246.onlineicr.com (viewed on 4 July 2019).

118 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0009 [73].

119 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0008 [66].

when he was around.[120] When Ms Hausler asked her father directly whether anyone was hurting or roughly handling him during treatment and care, his usual non-verbal cues were 'guarded' as if he did not want to tell her. Her father's usual relaxed posture changed to being curled up in a foetal or protective position.[121]

On 31 August 2015, Ms Hausler surreptitiously installed a covert video camera in Mr Hausler's bedroom.[122] The camera footage that was recorded shows the following events:

- on 31 August 2015, former Japara employee, Mr Corey Lucas, assaulted Mr Hausler[123]
- on 1 September 2015, agency nurse Ms Kiranjeet Kaur used excessive force against Mr Hausler while she was feeding him (Agency Nurse incident)[124]
- on 9 September 2015, Mr Lucas again assaulted Mr Hausler.[125]

Japara's internal communication about the Agency Nurse incident

On 3 September 2015, having watched the camera footage, Ms Hausler delivered a letter of complaint about the Agency Nurse incident to a registered nurse at Japara Mitcham. The letter stated in part:

> Whilst feeding Dad she repositioned him (by herself) by wrenching his right arm to pull him back to an upright position as he had slumped to his left with his head dropped forward into the bedding.
>
> To rearrange his pillow under his head she jerked his head sideways to put the pillow behind his head then pushed his head back using the palm of her hand on his forehead to hyperextend his head…She then continued to feed Dad.[126] [Emphasis added]

Japara responded to Ms Hausler's letter on 5 September 2015.[127]

Email correspondence provided to the Royal Commission shows that on 3 September 2015, Ms Keevers, Home Commissioning Manager and former Quality Manager, sent an email to Ms Julie Reed, former Executive Director of Aged Care Services, which

120 Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2231.37-40.

121 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0009 [73]; Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2231.26-30.

122 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0009 [75]-[77].

123 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 26, NOL.0001.0002.0001.

124 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 27, NOL.0001.0002.0002.

125 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 28, NOL.0001.0002.0004.

126 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 39, JAH.0001.0003.2494.

127 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 40, JAH.0001.0003.2496.

attached a draft of that letter.[128] In her email to Ms Reed, Ms Keevers told her superior that, 'I have dated it the 5th - so it looks like we thought about it seriously'.[129]

In her statement to the Royal Commission, Ms Keevers states that she put the date of 5 September on her draft letter because she intended to speak with the agency in question and Ms Reed on 4 September, before a written response could be provided to Ms Hausler.[130]

Senior Counsel Assisting asked both Mr Sudholz, Japara's Chief Executive Officer, and Ms Reed about the use of the phrase 'so it looks like we thought about it seriously' in Ms Keevers' email. Mr Sudholz said that he was not the author and he could not answer the question.[131] Ms Reed said 'it was an unfortunate turn of phrase'.[132] Senior Counsel Assisting suggested to Ms Reed that Ms Keevers wanted to give Ms Hausler a false impression. Ms Reed disagreed.[133] When asked whether she could offer an alternative explanation for what was written, Ms Reed indicated that she could not speak about Ms Keevers' intention but 'I know she would not mean that'.[134]

Counsel Assisting submitted that the plain meaning of 'so it looks like' is to create a false impression. Counsel Assisting submitted that if it was the case that Ms Keevers dated the letter 5 September because she needed to undertake other tasks first, there would be no need to use the phrase.[135]

Japara submitted that Counsel Assisting's submissions in this regard should be rejected. It argued that the phrase was used 'as part of a short hand over note to a colleague'.[136] Japara submitted that the evidence of Ms Keevers and Ms Reed was that the letter was to be dated 5 September to allow for further investigation to occur and that the email from Ms Keevers needed to be considered in its full context.[137] We do not accept this submission.

We find that Ms Keevers used the phrase 'so it looks like we thought about it seriously' in accordance with its plain meaning. Considering the email in its full context, including the subsequent written evidence from Ms Keevers and the written and oral evidence of Ms Reed, we cannot see any other explanation for the use of the phrase. After considering Japara's submissions and the supporting materials, it is clear to us that the letter was post-dated to create a false impression that Japara Mitcham had taken Ms Hausler's allegation seriously.

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128 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 38, JAH.0001.0003.2493.

129 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 38, JAH.0001.0003.2493.

130 Exhibit 5-41, Perth Hearing, Statement of Kimberley Keevers, 28 June 2019, WIT.0276.0001.0001 at 0002-0003 [9].

131 Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2372.20-22.

132 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2334.15-22.

133 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2334.43-2335.19.

134 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2335.21-25.

135 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [40].

136 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [20].

137 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [17]-[21]; Exhibit 5-41, Perth Hearing, Statement of Kimberley Keevers, 28 June 2019, WIT.0276.0001.0001 at 0002-0003 [9]-[10]; Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2335.14-32.

'Investigation' into the Agency Nurse incident by Japara Mitcham

Ms Reed gave evidence about an internal Japara investigation after Ms Hausler delivered her complaint of 3 September 2015.

Ms Reed told us that on 4 September 2015 she spoke to an individual identified by the pseudonym 'TL', a Quality Manager at Japara, as part of her investigation into the Agency Nurse incident. Ms Reed said TL spoke with Ms Hausler.[138] Ms Reed said of the conversation she claims occurred between TL and Ms Hausler, 'that was the investigation, really'.[139] Ms Reed said that based on the conversation with TL, she was satisfied that the conduct disclosed in Ms Hausler's letter was not a 'reportable assault' within the meaning of s 63-1AA of the Aged Care Act.[140]

In her oral evidence, Ms Hausler denied speaking to TL.[141]

TL provided a statement to the Royal Commission which addressed the purported conversation between herself and Ms Hausler.[142] TL has no recollection of having a conversation with Ms Hausler on 4 September 2015. TL's statement did not address whether or not she spoke to Ms Reed on 4 September 2015 about Ms Hausler.

Ms Hausler followed up with Japara about the Agency Nurse incident and was informed that she had no right to contact the nursing agency in question and that the matter was to be resolved by normal protocols.[143] Japara Mitcham did not otherwise engage with Ms Hausler or Mr Hausler about the Agency Nurse incident.[144]

Japara submitted that we should find that TL spoke with Ms Hausler on 4 September 2015.[145] According to Japara, the importance of the conversation between TL and Ms Hausler to Ms Reed's decision making weighs in favour of the conversation having taken place.[146] Japara submitted that we should find that Japara did 'treat seriously and investigate' the Agency Nurse incident.[147]

Ms Hausler's evidence that she did not talk to TL about her written complaint was clear, credible and was not subject to any challenge. By contrast, Ms Reed's evidence is unsupported by any document recording the content of any conversation between Ms TL

138 Transcript, Julie Reed, Perth Hearing, 25 June 2019 at T2349.7-27.

139 Transcript, Julie Reed, Perth Hearing, 25 June 2019 at T2349.27.

140 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2332.41; T2336.21-2337.26.

141 Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2237.10-20.

142 Exhibit 5-42, Perth Hearing, Statement of TL, 28 June 2019, WIT.0276.0001.0001 at 0002 [6]-[10].

143 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0011 [90].

144 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0011 [90].

145 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [25].

146 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [25].

147 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [27].

and Ms Hausler. Ms Hausler's evidence that the conversation with Ms TL did not occur is to be preferred.

We find that Ms TL did not discuss the Agency Nurse incident with Ms Hausler; nor did Japara investigate the Agency Nurse incident on 3–5 September 2015, or at all.

Decision not to report Agency Nurse incident at time of incident

Section 63-1AA of the Aged Care Act sets out the responsibilities of an approved provider of residential care relating to an allegation or suspicion of a 'reportable assault'. The definition of 'reportable assault' includes unreasonable use of force.[148] An approved provider is required to report an allegation or suspicion of a reportable assault to the Australian Department of Health and to police as soon as reasonably practicable and within 24 hours.[149]

On 27 November 2015, Japara made a report under s 63-1AA of the Aged Care Act to the Department of Health about the Agency Nurse incident which had occurred on 1 September 2015.[150] Japara made that report at the request of the Aged Care Complaints Scheme (SA office)[151] after Ms Hausler had lodged a complaint with the scheme about her father's care at Japara Mitcham on 24 November 2015.[152]

Japara did not report the Agency Nurse incident at the time they received it because Ms Reed formed the view that the event was not to be reported.[153] In her oral evidence, Ms Reed said she stands by the decision not to report the allegation.[154] Ms Reed said that she understood that the facility has the 'right' to investigate and then make a decision as to whether it ought to be reported.[155]

Japara submitted that because of an apparent discrepancy between what Ms Hausler told the registered nurse on 3 September 2015 and what Ms Hausler wrote in her letter, it was necessary for Ms Reed to properly understand the allegation before deciding whether the conduct met the description of a reportable assault. Japara submitted that Ms Reed's decision not to report was 'reasonable in light of the information available to her'.[156]

Counsel Assisting submitted that the duty to report is enlivened on the date on which the allegation is received. It is common ground that Japara received the Agency Nurse incident on 3 September 2015.[157]

148 See definition of 'reportable assault' contained in s 63-1AA(9) of the *Aged Care Act 1997* (Cth).

149 See s 63-1AA(9) of the *Aged Care Act 1997* (Cth).

150 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 61, JAH.0001.0003.5591.

151 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 248, JAH.0001.0005.7532 at 7559.

152 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 37, NOL.0001.0003.0024.

153 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2332.43-2333.1.

154 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2333.1.

155 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2329.34.

156 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [33].

157 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [32].

The conclusion that the allegation was a 'reportable assault' as defined by the Aged Care Act is supported by all of the evidence.[158] The Aged Care Act does not provide a discretion not to report where an entity with reporting obligations considers that the allegation lacks credibility, or is inaccurately expressed. When Ms Hausler said that Ms Kaur's conduct included 'wrenching' Mr Hausler by the arm, and that Ms Kaur had 'jerked', 'pushed' and 'hyperextended' Mr Hausler, it was clear that she was making an allegation that Ms Kaur had used unreasonable force. From that time, Japara had an obligation to report the Agency Nurse incident. In the circumstances where, as we have found, Ms Reed did not investigate the Agency Nurse incident, her failure to report was not reasonable.

Having received an allegation of use of unreasonable force on 3 September 2015 from Ms Hausler, Japara failed in its duty to report the allegation as required by s 63-1AA(2) of the Aged Care Act. Until 26 November 2015, the internal decision at Japara, taken at the behest of Ms Reed, was that no report of the Agency Nurse incident to the Department of Health was required. The report of the Agency Nurse incident by Japara to the Department on 27 November 2015 was nearly three months late.

Reporting of Agency Nurse incident on 27 November 2015

Ms Rachael Musico, former Facility Manager, completed a Japara internal form titled 'ACSAG Information to the Department – Compulsory Reporting of Assault Form', which formed part of Japara's report under s 63-1AA of the Aged Care Act.[159]

Ms Musico recorded the date of the incident was entered on the form as 26 November 2015 rather than 1 September 2015.[160]

Counsel Assisting questioned Ms Musico about this. Ms Musico agreed that the Agency Nurse incident had occurred on 1 September 2015.[161] Counsel Assisting asked why she didn't record 1 September 2015 on the form as the date of the incident. Ms Musico stated that '26 November was when we were informed by the department to lodge a compulsory report'.[162] Ms Musico did not consider this to be incorrect information.[163]

Counsel Assisting submitted that Ms Musico's evidence about the accuracy of the report appears to relate to the fact that Ms Musico also attached Ms Hausler's complaint letter dated 3 September 2015 to the form and that Ms Musico's position is that the form and its attachments could be read as providing a complete picture.[164]

158 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [65].

159 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 61, JAH.0001.0003.5591.

160 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 61, JAH.0001.0003.5591.

161 Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2271.34.

162 Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2271.39-40.

163 Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2272.4.

164 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [62]; Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2271.20-30.

Counsel Assisting submitted that it was open for us to find that the report made by Japara of the Agency Nurse incident was over two and a half months late and that Japara failed to properly report the Agency Nurse incident. Counsel Assisting said it was open to us to find that the date of the incident was incorrectly reported by Japara.[165]

Japara submitted that Ms Musico did not seek to mislead the Department of Health by stating that the date of the incident was 26 November 2015. The evidence from Ms Musico and Ms Jones was that the form submitted to the Department recorded 'the date that Japara became aware of a reportable assault, noting that up to that point Japara's understanding was that the agency nurse incident was not reportable'.[166]

Counsel Assisting and Japara appear to agree that the report of the Agency Nurse incident in November 2015 was inaccurate. Ms Reed was required to report the Agency Nurse incident when Ms Hausler provided the handwritten letter to Japara on 3 September 2015. It follows that by reporting the Agency Nurse incident on 16 November 2015, Japara failed to properly report that allegation. The form that Ms Musico completed did not accurately describe the date of the Agency Nurse incident. In circumstances where Ms Musico included the 3 September 2015 letter from Ms Hausler in her correspondence with the Department of Health, we do not conclude that Ms Musico sought to mislead the Department by recording the date of the incident in the way that she did.

Emergency Paramedic Service contact number

On 2 February 2017, Ms Hausler lodged a complaint with the Aged Care Complaints Commissioner about the care provided to her father at Japara Mitcham.[167] In the complaint, Ms Hausler expressed concerns about several aspects of her father's care.

One of Ms Hausler's complaints investigated by the Aged Care Complaints Commissioner concerned the failure by an employee at Japara Mitcham to locate the contact details for the Extended Care Paramedic on 11 December 2016 (Issue 5).[168]

On 9 February 2017, the Aged Care Complaints Commissioner wrote to Japara Mitcham seeking a written response about Ms Hausler's complaints, including Issue 5.

On 20 February 2017, Mr Woodley, Group Quality Manager, sent Ms Musico and Ms Jones a draft of a proposed response to the Aged Care Complaints Commissioner. The proposed response stated (in part):

> The Extended Care Paramedic phone number is on the home's list of contact numbers (see attached).

165 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [64], [68], [103(d)].

166 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [37].

167 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 251, JAH.0101.0003.00115.

168 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 251, JAH.0101.0003.00115 at 00116.

> Do we have evidence that it was listed somewhere on the day?
>
> If not add it to the contact list now. We are only saying that it IS on the list not WAS.[169]

On 20 February 2017, Mr Woodley sent a response to the Aged Care Complaints Commissioner in the terms of his draft response.[170]

Ms Musico gave evidence that Mr Woodley was asking her in his email to add the Extended Care Paramedic number to the contact list on 20 February 2017.[171] Ms Musico could not recall specifically what was recorded on the list on 11 December 2015.[172] She agreed that staff could not find the number on 11 December 2015.[173] When asked by Counsel Assisting whether it was 'incomplete' for Mr Woodley to say in his letter to the Aged Care Complaints Commissioner that the number 'is' in the contact list, without referring to the circumstances in which the request arose, Ms Musico said that she could not recall.[174]

Documentary evidence was produced to the Royal Commission about the Aged Care Complaints Commissioner's investigations concerning Issue 5, including further investigations conducted after Japara's response of 20 February 2017.[175]

Counsel Assisting submitted that these documents demonstrate that on 20 February 2017 Mr Woodley provided a response to the Aged Care Complaints Commissioner that was intentionally incomplete.[176] In support of that submission, Counsel Assisting referred to:

- correspondence from the Aged Care Complaints Commissioner to Japara dated 1 March 2017 in which the Aged Care Complaints Commissioner sought further information about why the contact number was not accessible on the day[177]
- internal Japara correspondence involving Mr Woodley following the Aged Care Complaints Commissioner's request for further information of 1 March 2017[178]
- Mr Woodley's response to the Aged Care Complaints Commissioner's request of 1 March 2017, which Counsel Assisting submitted was 'deliberately vague' on the issue of whether the contact number was available to the staff member on the day in question.[179]

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169 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 144, JAH.0001.0006.2895-2896 (emphasis in original).

170 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 150, JAH.0001.0006.2950.

171 Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2275.46.

172 Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2276.14.

173 Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2276.24.

174 Transcript, Rachael Musico, Perth Hearing, 24 June 2019 at T2276.29.

175 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 267, JAH.0001.0006.2645; tab 268, JAH.0001.0006.2716; tab 269, JAH.0001.0006.3098; tab 270, JAH.0001.0006.3111; tab 271, JAH.0001.0006.3214; tab 272, JAH.0001.0006.3228; tab 273, JAH.0001.0006.3423.

176 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [77].

177 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 269, JAH.0001.0006.3098.

178 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 270, JAH.0001.0006.3111; tab 271, JAH.0001.0006.3214.

179 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 272, JAH.0001.0006.3228.

Japara submitted that we should not make the findings sought by Counsel Assisting. It acknowledged, as did Mr Woodley in his oral evidence,[180] that the answer he gave was not complete.[181] Japara submitted that the Royal Commission should rely upon the evidence of Mr Woodley that the answer he provided was a direct response to a request made by the Aged Care Complaints Commission in a phone call.[182]

Mr Woodley's explanation of the response he sent on 20 February 2017 is hard to accept in light of the documentary evidence. It is clear that the Aged Care Complaints Commissioner considered the response of 20 February 2017 to be inadequate because it did not address the issue of whether the number was available on 11 December 2015.[183] Internal correspondence within Japara reveals that the answer given was constructed to minimise damage to Japara.[184] The ultimate response sent by Mr Woodley was intentionally vague on the issue of whether the phone number was available on 11 December 2015.[185] None of this is consistent with Mr Woodley's position that the incomplete response he provided had been sought by the Aged Care Complaints Commissioner.

We find that Mr Woodley's answer to the Aged Care Complaints Commissioner of 20 February 2017 was intentionally incomplete and was calculated to avoid providing information to the Aged Care Complaints Commissioner that was damaging to Japara.

Whether the care of Mr Hausler was person-centred

As noted in the introduction to this chapter, the theme of the Perth Hearing was 'person-centred care'. Japara witnesses gave evidence about the meaning of 'person-centred care'.[186] Mr Sudholz gave evidence to the effect that person-centred care requires staff to work in partnership with residents, their family members and representatives.[187] Ms Reed, Ms Jones and Ms Musico agreed in their written statements that relationships between staff, residents and relatives are important.[188]

Ms Hausler gave evidence that after the assaults on Mr Hausler by Mr Lucas, her relationship with the Japara staff 'deteriorated significantly'.[189]

180 Transcript, Perth Hearing, Stuart Woodley, 26 June 2019 at T2503.24-31.

181 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [41].

182 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [41].

183 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 269, JAH.0001.0006.3098.

184 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 270, JAH.0001.0006.3111; tab 271, JAH.0001.0006.3214.

185 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 272, JAH.0001.0006.3228.

186 Exhibit 5-12, Perth Hearing, Statement of Julie Elizabeth Reed, 12 June 2019, WIT.0228.0001.0001 at 0005-0009 [28]-[49]; Exhibit 5-11, Perth Hearing, Statement of Diane Jones, 12 June 2019, WIT.0230.0001.0001 at 0003-0005 [15]-[26]; Exhibit 5-10, Perth Hearing, Statement of Rachael Anne Musico, 12 June 2019, WIT.0231.0001.0001 at 0002-0006 [13]-[31].

187 Exhibit 5-13, Perth Hearing, Statement of Mark Andrew Sudholz, 13 June 2019, WIT.0229.0001.0001 at 0004 [20].

188 Exhibit 5-12, Perth Hearing, Statement of Julie Elizabeth Reed, 12 June 2019, WIT.0228.0001.0001 at 0005-0009 [28]-[49]; Exhibit 5-11, Perth Hearing, Statement of Diane Jones, 12 June 2019, WIT.0230.0001.0001 at 0003-0005 [15]-[26]; Exhibit 5-10, Perth Hearing, Statement of Rachael Anne Musico, 12 June 2019, WIT.0231.0001.0001 at 0002-0006 [13]-[31].

189 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0026 [193].

The Royal Commission received evidence about key events which occurred after the assaults against Ms Hausler's father and which affected Ms Hausler's relationship with the staff at Japara Mitcham.

In around November 2015, Ms Hausler commenced weekly meetings with Japara staff.[190] Ms Hausler gave evidence that initially these weekly meetings assisted in rebuilding relationships.[191]

Events involving Ms Reed

On 10 September 2015 (the day after the assault by Corey Lucas against Mr Hausler), Ms Reed informed Ms Hausler that filming people covertly was illegal and not acceptable.[192] Ms Reed gave evidence that she did not consider this communication to be insensitive to Ms Hausler.[193]

On 9 November 2015, Ms Reed sent an email to Ms Hausler in response to her question about whether Japara had a camera policy. In her email, Ms Reed advised Ms Hausler that it had been explained to her on numerous occasions that by covertly filming in a resident's room, she would be seriously breaching multiple pieces of legislation.[194]

On 9 December 2015, Ms Reed sent a letter to Ms Hausler. The letter advised (among other things) that it was unlawful for Ms Hausler to conduct surveillance without the permission of staff.[195]

In her oral evidence, Ms Reed agreed that this letter was unhelpful in the context of the weekly meetings that were occurring and the attempts to rebuild the relationship with Ms Hausler.[196]

SACAT hearing

In March 2016, an application by Ms Hausler for guardianship of Mr Hausler was listed before the South Australian Civil and Administrative Tribunal (SACAT).[197] Japara briefed counsel to attend the SACAT hearing on instruction from Ms Reed.[198] Ms Reed had a

190 Exhibit 5-11, Perth Hearing, Statement of Diane Jones, 12 June 2019, WIT.0230.0001.0001 at 0007-0008 [40]; Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2248.11; Transcript, Perth Hearing, Diane Jones, 24 June 2019 at T2295.34.

191 Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2248.39.

192 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 44, JAH.0001.0003.2531 at 2532.

193 Transcript, Julie Reed, Perth Hearing, 24 June 2019 at T2354.39.

194 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 177, JAH.0004.0001.0461.

195 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 72, JAH.0001.0003.5818.

196 Transcript, Julie Reed, Perth Hearing, 25 June 2019 at T2358.4-9.

197 Exhibit 5-9, Perth Hearing, Statement of Noleen Joy Hausler, 29 May 2019, WIT.1124.0001.0001 at 0027 [204]; Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2252.32.

198 Transcript, Julie Reed, Perth Hearing, 25 June 2019 at T2364.17-19.

concern about whether Ms Hausler getting 'special powers' might help her get a video camera back in Mr Hausler's room.[199]

Ms Hausler was not given notice that Japara would be appearing at the SACAT hearing, or that Japara would contest the application.[200]

Derogatory comments about Ms Hausler

On 13 July 2016, a meeting with lawyers was held in Glenelg. Ms Hausler and Mr Sudholz both attended the meeting.[201] A record of the meeting notes that staff at Japara referred to Ms Hausler as 'the smiling assassin'.[202]

In her oral evidence, Ms Jones recalled Ms Hausler being called names by carers at Japara.[203]

Counsel Assisting submitted that Mr Hausler had a special relationship with Ms Hausler, which was essential to his receiving high quality, person-centred care. Counsel Assisting said that the relationship between Japara and Ms Hausler was important because of Mr Hausler's care needs and the problems he had experienced, including being a victim of a criminal assault by a Japara staff member. This meant that Ms Hausler was in the best position to understand her father's care needs. Counsel Assisting submitted that Japara caused the deterioration of this relationship, particularly through the actions of Ms Reed in key events. This included Ms Reed sending the November 2015 email, sending the December 2015 letter, her actions in relation to the SACAT hearing and her failure to manage the relationships between staff and Ms Hausler, including failing to prevent staff from calling Ms Hausler a 'smiling assassin'.[204]

Japara submitted to the Royal Commission that the findings sought by Counsel Assisting were not open.[205] Japara submitted that it reported the assault by Corey Lucas immediately and took action to ensure Mr Hausler's welfare.[206] Staff at Mitcham were 'informed of the incident in general terms' at a staff meeting and subsequent training.[207] Japara suggested that it offered considerable support to Ms Hausler following the assault, including making counselling available and establishing regular meetings between Ms Hausler and staff.[208]

199 Transcript, Julie Reed, Perth Hearing, 25 June 2019 at T2366.1-5.

200 Transcript, Noleen Hausler, Perth Hearing, 24 June 2019 at T2252.42–2253.36.

201 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 193, JAH.0001.0004.4589.

202 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 193, JAH.0001.0004.4589 at 4590.

203 Transcript, Perth Hearing, Diane Jones, 24 June 2019 at T2298.44.

204 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [99].

205 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [75].

206 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [49]-[50].

207 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [51].

208 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [52]-[53].

Japara acknowledged that there was a difference in the interactions by Ms Musico and Ms Jones with Ms Hausler compared with those by Ms Reed. Japara submitted that Ms Reed's interactions arose whenever an issue required the consideration of senior management, which explained why those interactions were more formal and took place without the benefit of face-to-face discussion.[209] Japara submitted that when Ms Reed told Ms Hausler on 10 September 2015 she had acted illegally in placing the camera in her father's room, she had not overlooked how Ms Hausler must have been feeling that day.[210]

In relation to the email on 9 November 2015 and the letter of 9 December 2015, Japara accepts that the 'tone and content of the correspondence sent to Ms Hausler could have been improved'.[211] However, it claims that it is not surprising that such correspondence emphasised the legalities of the issues.[212]

In relation to Japara's decision to inform staff at the Mitcham facility about the assault of Mr Hausler by Mr Lucas, Japara submitted that staff were sufficiently aware of the 9 September 2015 assault and, therefore, that Ms Reed's decision to inform staff directly about what had happened was appropriate.[213]

Japara rejected Counsel Assisting's suggestion that there was a downfall in the relationship between Ms Hausler and Japara by July 2016, relying upon the existence of meetings between Ms Hausler, Ms Musico and Ms Jones.[214] Japara also submitted that the decision to send legal representatives to SACAT was justified over a concern that Ms Hausler was seeking increased powers in relation to her father's care.[215] Japara submitted that this was done 'in the interests of Mr Hausler'.[216]

It is clear to us that Japara did not adopt a person-centred approach or a relationship-centred approach in its dealings with Mr Hausler or Ms Hauser. Japara did not place the interests of Ms Hausler at the centre of its interactions with the Hausler family. Japara's submissions do not explain why Ms Hausler was not told that Japara would be sending legal representatives to the SACAT hearing. The Royal Commission accepts the submission of Counsel Assisting that the reason Japara did not tell Ms Hausler was because the hearing at SACAT formed part of a larger 'battle' between Japara and Ms Hausler over the care of her father.[217]

In doing so, Japara overlooked the care of Mr Hausler. There was a total failure by Japara to provide Mr Hausler with relationship-centred care and person-centred care.

209 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [57].

210 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [58].

211 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [66].

212 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [66].

213 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [70].

214 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [71].

215 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [73].

216 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [73].

217 Perth Hearing, Submissions of Counsel Assisting – Mitcham Case Study, 5 July 2019, RCD.0012.0010.0001 at [100].

Systemic issues

Counsel Assisting submitted that the documentary, written and oral evidence before us reveals certain concerns about the culture of Japara and raises the issue of systemic deficiencies or failures.

Japara made submissions resisting a finding about any cultural concerns.[218] Counsel Assisting did not seek any specific findings arising out the Perth Hearing in relation to these issues. Accordingly, we do not make any such findings.

However, while not making findings about any possible systemic deficiencies in Japara, we note with concern what was demonstrated about Japara during the course of the hearing. Dr Lisa Trigg, who has conducted extensive research into relationship-centred care,[219] was seriously concerned by the evidence given by Japara's CEO, Mr Sudholz. In particular, Dr Trigg was struck by Mr Sudholz's description of a meeting he attended at Mitcham, about which he said:

> I think it was mid-2016, we had a resident and a relative meeting that I was attending, and in that meeting, there were a number of people who were very abusive, very aggressive towards me, shouted me down and showed little respect to me as the CEO of a big organisation, and I found that disappointing, and I was quite distraught about that.[220]

Dr Trigg quoted this evidence from Mr Sudholz, before telling us:

> For me, that's the problem. …[Y]ou're not the most important person in the room, and if you don't recognise that the most important people in the room are the residents and the relatives and the people who work with them every day, then you have completely missed the point.[221]

We agree with Dr Trigg's assessment of Mr Sudholz's evidence. Mr Sudholz also showed no concern about three reported allegations of assault in relation to one resident at a single facility in a short period of time.[222] In correspondence, Mr Sudholz called Ms Hausler 'vexatious'.[223] Mr Sudholz did not display any awareness of the specifics of any of the alleged assaults which the Royal Commission was told had been happening in Japara's other facilities.[224] He made no reference in his evidence to a need by Japara's board for greater scrutiny of allegations of assault, or even improved transparency of reporting of abuse to the board. Mr Sudholz was belligerent in his ignorance of these serious events.

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218 Perth Hearing, Submissions of Japara – Mitcham Case Study, 12 July 2019, RCD.0012.0011.0001 at [76].

219 Exhibit 5-40, Perth Hearing, Statement of Dr Lisa Trigg, 4 June 2019, WIT.0156.0001.0001.

220 Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2391.39-43; Transcript, Lisa Trigg, Perth Hearing, 28 June 2019 at T2800.6.

221 Transcript, Lisa Trigg, Perth Hearing, 28 June 2019 at T2800.17.

222 Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2384.6.

223 Exhibit 5-8, Perth Hearing, Mitcham General tender bundle, tab 128, JAH.0001.0005.6370.

224 Transcript, Andrew Sudholz, Perth Hearing, 25 June 2019 at T2387.1.

Conclusion

What happened to Clarence Hausler at Japara Mitcham should never have occurred. He was the subject of a series of degrading assaults when he should have been allowed to enjoy the last years of his life in peace. He and his daughter, who was the most significant support in his life, should have been allowed to continue their close and special relationship. However, beyond the indignity and criminality of the assaults committed against her father, Ms Hausler had to contend with an organisation determined to avoid accountability for its actions.

Alkira Gardens case study

Introduction

The Royal Commission examined the experiences of Mr Vincent Paranthoiene at Alkira Gardens in the Sutherland Shire of New South Wales. Alkira Gardens is operated by the Sisters of Our Lady China Health Care Proprietary Limited (OLC). In addition to Mr Paranthoiene's care broadly, this case study focused on the adequacy and quality of palliative care provided by Alkira Gardens to Mr Paranthoiene between 18 September and 3 October 2017 as well as aspects of his care prior to that period.

The evidence before the Royal Commission consisted of:

- the statement of Ms Shannon Ruddock, Mr Paranthoiene's daughter, dated 31 May 2019[225]
- the statements of Mr Joshua Cohen, a nurse practitioner from Calvary Hospital (Calvary) who visited Mr Paranthoiene at Alkira Gardens, dated 29 May 2019 and 6 June 2019[226]
- the statements of Mr John Leong, the Compliance and Development Manager of OLC, dated 14 June 2019 and 25 June 2019 [227]
- the oral testimony of those three witnesses
- the tender bundle for this case study, which consisted of 166 documents.[228]

Mr Leong had no direct knowledge of the circumstances of Mr Paranthoiene's care. His evidence was based on his review of the clinical records. He informed the Royal Commission that, of the 13 nursing staff who cared for Mr Paranthoiene, only two remained employed by OLC.[229]

225 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001.

226 Exhibit 5-33, Perth Hearing, Statement of Joshua Cohen, 29 May 2019, WIT.0179.0001.0001 and Exhibit 5-34, Perth Hearing, Statement of Joshua Cohen, 6 June 2019, WIT.0225.0001.0001.

227 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 and Exhibit 5-35, Perth Hearing, Statement of John Leong, 25 June 2019, WIT.0244.0002.0001.

228 Exhibit 5-31, Perth Hearing, Alkira Gardens Case Study Tender Bundle.

229 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0005 [40].

Alkira Gardens was granted leave to appear at the public hearing and was represented by counsel and solicitors. No applications were made by counsel for Alkira Gardens to cross-examine any of the witnesses called.

In accordance with the directions we made on 28 June 2019, Counsel Assisting provided written submissions setting out the findings they consider should be made arising from this case study. In response to those submissions, the Royal Commission received submissions from Alkira Gardens.[230]

Mr Vincent Paranthoiene

Vincent Paranthoiene was born in September 1936 in Sutherland, New South Wales.[231] He was the eldest child of four and had a tough upbringing. He was responsible for his younger siblings from a young age.[232] He had a diverse career, working at various points in his life as an abalone diver and a plumber's assistant. Later, he volunteered as a community bus driver.[233]

Mr Parathoiene always had a love of the water. He raised three children: one son and two daughters. One of his daughters, Ms Shannon Ruddock, recalls that she would regularly engage in water activities with her late father while she was growing up; he would dive for abalone while she would snorkel beside him.[234]

Mr Paranthoiene was happily married for 35 years. His wife was diagnosed with terminal breast cancer in 1998 and died in 2006. Mr Paranthoiene was devastated by her death.[235] He moved to Sydney to live with one of his daughters and her family.[236] Eventually he moved into an apartment building in Sydney where all of the residents were over 55 years old.[237]

In January 2017, Mr Paranthoiene had a stroke. Up to this time, he had been fit and healthy and had lived without assistance. Because he was living by himself, he remained in his unit for two days before anyone found him. He was taken to hospital and while there he fell and broke his ribs.[238]

Mr Paranthoiene was discharged from hospital and, after a brief stay at a private facility, entered residential aged care at Alkira Gardens on 20 April 2017.[239] Ms Ruddock said that it was very difficult to make a decision about where her father should be placed

230 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001.

231 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0001 [5].

232 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0001-0002 [8]-[9].

233 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0002 [10]-[11].

234 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0002 [12].

235 Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2628.4.

236 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0002 [15].

237 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0002 [16].

238 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0002 [16-20].

239 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0003.

and, after a period of 'blindly' looking for facilities, they settled on the Catholic facility, Alkira Gardens.[240] At this time, Mr Paranthoiene was aged 80 years.[241]

The Sisters of Our Lady of China Health Care

OLC commenced operation on 1 January 1984. Since 2004, OLC shifted from a single facility operator with 71 beds to a multi-facility operator with five facilities totalling 475 beds in and around Sydney, New South Wales. Alkira Gardens opened on 1 June 2015.[242]

Ms Ruddock contacted the Royal Commission by a public submission because she was concerned that Mr Paranthoiene had not received adequate palliative care while residing at Alkira Gardens.[243]

Mr Paranthoiene's malignant spindle cell sarcoma

In July 2017, Ms Ruddock noticed that her father had developed a large lump on his chest near where he had previously broken his ribs.[244] This was originally misdiagnosed in August 2017 as a haematoma, although the misdiagnosis was not the subject of criticism in the submissions of Counsel Assisting.[245]

On 3 September 2017, Ms Ruddock and her sister took their father out for a family lunch for Father's Day. Ms Ruddock had not seen her father for approximately three weeks and saw a noticeable decline in his presentation at this time. She described her father as yellow and having lost a lot of weight, delirious and gravely ill. She thought he was dying.[246]

On 4 September 2017, Ms Ruddock took Mr Paranthoiene to the emergency department of a hospital, where he was admitted.[247] Further scans of Mr Paranthoiene's chest and a biopsy at hospital led to him being diagnosed with an advanced malignant spindle cell tumour and he was given a poor prognosis.[248] He was referred to the Community Palliative Care Team at Calvary Hospital in preparation for his discharge back to Alkira Gardens. Mr Paranthoiene returned to Alkira Gardens on 18 September 2017. The hospital's Discharge Referral Note was sent to Alkira Gardens.[249]

240 Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2630.41-47, T2631.1-10.

241 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [1].

242 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0001-0002 [9]-[10], [19].

243 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [2].

244 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0003 [30].

245 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [6].

246 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0005 [47].

247 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0005 [52].

248 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0006 [58]-[59].

249 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0007 [69]; Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 23, SHA.0002.0001.0005; tab 24, SLC.0001.0002.3574.

The discharge note set out Mr Paranthoiene's prescribed analgesia for pain relief.[250] The analgesia medications were Oxycontin 25mg BD (twice daily), Lyrica 25mg BD (twice daily) and Endone 5mg q2hr PRN (every two hours as needed).[251]

The evidence was that the Oxycontin and Lyrica were 'baseline' medications to be taken by Mr Paranthoiene every day and the Endone was an as-needed medication for 'breakthrough pain', that is, pain that he experienced even while taking the baseline medications.[252]

Ms Ruddock described her experience of Alkira Garden's inability to care for her father after he returned from hospital on 18 September 2017 until 3 October 2017. She was concerned that her father's needs, particularly his pain management and relief, were not adequately managed by Alkira Gardens during this time.[253] Ms Ruddock explained that she felt that the staff at Alkira Gardens were not able to look after her father.[254]

Mr Cohen, a nurse practitioner from Calvary Hospital and specialist in palliative care, consulted Mr Paranthoiene at Alkira Gardens on 20 and 27 September 2017.[255] During those consultations, Mr Cohen considered options to manage Mr Paranthoiene's pain. Mr Cohen had no independent recollection of attending Mr Paranthoiene or meeting with or having discussions with Mr Paranthoiene or Ms Ruddock. In his evidence, Mr Cohen relied upon the notes that he took at the time.[256]

At the relevant time, Mr Cohen was a transitional nurse practitioner and was not yet endorsed.[257] This meant that Mr Cohen was unable to prescribe medication for Mr Paranthoiene. Rather, Mr Cohen provided recommendations and guidance on pain medication and pain management to Mr Paranthoiene's general practitioner.[258] Mr Paranthoiene's general practitioner then attended on him and prescribed and charted pain medication.

Mr Paranthoiene was taken to Sutherland Hospital on 3 October 2017 following a fall at Alkira Gardens.[259] On 6 October 2017 he was transferred to Calvary Hospital.[260]

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250 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 23, SHA.0002.0001.0005 at 0006; SLC.0001.0002.3574 at 3575.

251 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 23, SHA.0002.0001.0005 at 0006; Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 24, SLC.0001.0002.3574 at 3575; Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2691.13-33; T2705.1-7.

252 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0007-0008; Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2691.13-30.

253 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0013-0014.

254 Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2660.1-5; T2661.1-30.

255 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 28, SLC.0001.0001.3737; tab 29, SLC.0001.0001.3739; tab 34, SLC.0001.0001.5307; tab 35, SLC.0001.0001.5308.

256 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 104, LCM.0002.0002.0001; Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2680.12-13.

257 Joshua Cohen is now an endorsed nurse practitioner.

258 Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2697.14-16.

259 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0015 [134]-[136].

260 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0015 [142].

After Mr Paranthoiene spent some time at Calvary, Ms Ruddock was told that her father needed to return to Alkira Gardens because he had not entered the 'active dying' phase.[261] Based on her earlier experience, Ms Ruddock was very concerned that Alkira Gardens could not provide adequate palliative care for her father and she did not want him to return there.[262] Ms Ruddock told the Royal Commission that she and her sister 'begged' Calvary for their father to be able to stay there.[263]

The day before Mr Paranthoiene was due to return to Alkira Gardens, Ms Ruddock received a letter from the Department of Health advising that Alkira Gardens had been sanctioned on the grounds of serious concerns regarding the health, safety and wellbeing of residents.[264] Ms Ruddock informed Calvary. Due to the sanctioning, as well as Mr Paranthoiene's subsequent clinical deterioration, Mr Paranthoiene was allowed to stay at the hospital until he died on 16 November 2017.[265]

Provision of palliative care by Alkira Gardens between 18 September and 3 October 2017 and adequacy of records

While Mr Paranthoiene was a resident at Alkira Gardens, OLC had a Palliative Care Policy, a Pain Management Policy and a Pain Management Guideline.[266]

The permanent residential agreement between Mr Paranthoiene and Alkira Gardens also provided that Alkira Gardens would establish and supervise a complex pain management or palliative care program.[267]

There were no clinical progress notes about the care of Mr Paranthoiene on 26 and 27 August 2017 or for the period 29 August to 2 September 2017. When questioned about these gaps by Counsel Assisting, Mr Leong was unable to explain why there were no progress notes for these dates.[268]

Further, there were also no records of any pain assessments being conducted by Alkira Gardens in respect of Mr Paranthoiene's pain on 23, 25 and 30 September and 1, 2 and 3 October 2017.

Mr Leong couldn't explain the absence of any record of pain assessment on 23 September 2017 when questioned about it by Counsel Assisting.[269]

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261 Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2658.19-32.

262 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0016 [145]-[150].

263 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0016 [149]; Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2660.1-4; T2661.1-30.

264 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 39, SHA.0002.0001.0013; Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2660.10-17.

265 Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2660.30-42, T2662.36-47; T2663.1-4.

266 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 161, SLC.0001.0009.0216; tab 165, SLC.0001.0010.0002; tab 164, SLC.0001.0010.0001.

267 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 12, SLC.0001.0002.3807 at 3839.

268 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2743.28-44.

269 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2731.23-24.

There were no pain assessments of Mr Paranthoiene from 30 September to 3 October 2017. When questioned by Counsel Assisting, Mr Leong agreed that he couldn't say what was happening on those dates.[270] Mr Leong also agreed that on some occasions Alkira Gardens' staff kept inadequate records of Mr Paranthoiene's pain.[271]

When questioned by Counsel Assisting, Mr Leong agreed that the treatment of Mr Paranthoiene from 18 September to 3 October 2017 was inadequate but stated that Alkira Gardens did provide pain analgesia.[272]

There was no specific document that set out Mr Paranthoiene's palliative care needs.[273] In her evidence, Ms Ruddock described the Discharge Note dated 18 September 2017 as a palliative care plan. She also referred to the reviews conducted by Mr Cohen on 20 and 27 September 2017. Mr Cohen didn't recall there being a palliative care plan or an advanced care plan in Mr Paranthoiene's case.[274]

Mr Leong agreed that there was no specific palliative care plan for Mr Paranthoiene.[275]

Mr Cohen's evidence stressed the importance of documentation and he explained that records of pain assessments were important because they enabled him to consider what pain relief was required.[276]

Counsel Assisting submitted that:

- Alkira Gardens did not keep adequate records of Mr Paranthoiene's care, including progress notes or a palliative care plan throughout the time he resided at Alkira Gardens[277]
- in the absence of records of pain assessments being conducted by Alkira Gardens on 23, 25 and 30 September and 1, 2 and 3 October 2017, it can be inferred that no pain assessments were conducted on those days[278]
- having regard to all the circumstances, Alkira Gardens failed to provide either adequate or quality palliative care to Mr Paranthoiene between 18 September and 3 October 2017.[279]

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270 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2734.8-14.

271 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2735.1-4

272 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2735.38-39.

273 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2739.17-47; T2740.1.

274 Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2695.32.

275 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2739.17-18.

276 Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2693.42-47.

277 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [41], [42], [46], [49a].

278 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [41]-[45], [49b].

279 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [49c].

In response, OLC submitted that it was not put on notice by the Royal Commission that submissions would be made in relation to matters relating to record keeping during the period prior to 18 September 2017.[280] OLC submitted that Counsel Assisting had told the Royal Commission that the focus of the submissions would be on the period 18 September 2017 to 3 October 2017.[281]

OLC's position in relation to the inferences that can be drawn from the records is difficult to accept. The denial of natural justice said to arise is difficult to understand. OLC claims they were not on notice that submissions might be made by Counsel Assisting on topics outside of the period 18 September 2017 to 3 October 2017. However, questions were asked of Mr Leong about events falling outside this period.[282] Mr Leong's statement addressed issues falling outside this narrow date range.[283] OLC was represented by counsel at the hearing. No objection was taken to the questions asked by Counsel Assisting where they went outside the period 18 September to 3 October 2017. There is no suggestion in OLC's submissions that there is additional relevant material which is not before the Royal Commission. OLC did not submit that it had not been provided with the material to which Counsel Assisting referred in their submissions. In any event, OLC has had the opportunity to provide its own submissions to the Royal Commission responding to the allegations made by Counsel Assisting and was provided with all of the material upon which those submissions were based.

We reject OLC's suggest that our making findings in relation to record keeping outside of the period to 18 September 2017 to 3 October 2017 would be a breach of natural justice.

On the substantive issues, OLC's position in relation to the adequacy of its record keeping is confusing. Mr Leong admitted that he had no explanation for why documents which ought to have been prepared did not appear in Mr Paranthoiene's file.[284] In its written submissions, OLC admitted that it is possible that Mr Paranthoiene was in pain and his pain status was not recorded due to inadequate record keeping.[285] We consider that there is more than sufficient evidence to substantiate the findings that Counsel Assisting has asked us to make.

Alkira Gardens kept inadequate records of Mr Paranthoiene's care between 20 April and 3 October 2017. It can be inferred from the absence of any records for the assessment of Mr Paranthoiene's pain on 23 September, 25 September, 30 September, 1 October, 2 October and 3 October 2017 that there were no pain assessments of Vincent Paranthoiene on those dates. Alkira Gardens failed to provide either adequate or quality palliative care to Mr Paranthoiene between 18 September and 3 October 2017.

280 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [22.2].

281 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [17].

282 For example, Transcript, John Leong, Perth Hearing, 27 June 2019 at T2743.20-44.

283 For example, Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0007.

284 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2743.42-44.

285 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [98].

Availability of pain medications at Alkira Gardens

As noted above, Mr Paranthoiene returned to Alkira Gardens on the afternoon of 18 September 2017. The records indicated that he was discharged from hospital with a small amount of pain medication: Endone 5mg, Lyrica 25mg and Oxycontin 20mg.[286] Mr Paranthoiene was prescribed Oxycontin 25mg. The staff of Alkira Gardens were unable to administer a dosage of Oxycontin 25mg because only Oxycontin 20mg was available, which was ultimately administered to Mr Paranthoiene. Further, the pharmacy was closed.[287] Although an urgent order could be faxed to the pharmacy in some circumstances,[288] this did not occur at the time. Mr Leong could not explain why the pharmacy was not contacted by phone.[289]

Alkira Gardens did not receive 25mg Oxycontin and 25mg Lyrica until 20 September 2017. Two days passed after Mr Paranthoiene's return to Alkira Gardens before Alkira Gardens held the required prescription medication to manage his serious pain.[290]

At the relevant time, Alkira Gardens did not hold an imprest stock of medications, including those prescribed for Mr Paranthoiene. Nor did Alkira Gardens hold a Schedule 8 licence under the *Poisons and Therapeutic Goods Regulation 2008* (NSW). Legislative changes mean that Alkira Gardens is now able to hold such medications.[291]

Counsel Assisting submitted that in circumstances where Alkira Gardens could not hold imprest stock, it should not have received Mr Paranthoiene as a palliative care resident. This was because Alkira Gardens was not practically able to deliver adequate palliative care services because it did not hold a stock of relevant medication and nor was it able to take steps to ensure a supply of relevant medication.[292]

OLC accepted that residential aged care service providers need to have arrangements for the speedy supply of prescription medication.[293]

However, OLC submitted that due to the arrival of Mr Paranthoiene late in the afternoon on 18 September 2017, it was not possible to arrange for a general practitioner to attend and issue a prescription in time for it to be filled that day and it would be unreasonable to expect them to be able to do so.[294] It also submitted that there was no clinical deficiency in

286 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0009 [84].

287 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0009 [85].

288 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0010 [90].

289 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2742.4-5.

290 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2741.44-46.

291 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0009 [81].

292 Perth Hearing, Submissions of Counsel Assisting – Alkira Gardens Case Study, 5 July 2019, RCD.0012.0009.0001 at [54].

293 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [64].

294 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [65]-[84].

the failure to arrange the supply of Oxycontin because Endone was supplied in its place.[295] We do not accept these submissions.

OLC's submissions on this topic do not directly engage with the findings that Counsel Assisting has asked us to make. OLC submitted that it would have been unreasonable to arrange a supply of the Oxycontin on 18 September 2017.[296] It does not say that it would have been unreasonable to take steps to arrange a supply on 19 September 2017. The only step that Alkira Gardens took on 18 September 2017 was to fax the discharge summary to the local general practitioner that evening.[297] It did not inform the general practitioner that an early attendance was required due to the inadequate supply of Oxycontin. Alkira Gardens did not communicate to Mr Paranthoiene's family that the medication provided by the hospital did not match his prescription. Mr Leong conceded that he could not explain why the facility did not contact the pharmacy.[298]

Alkira Gardens was unable to hold a stock of relevant medication. Being aware of this, Alkira Gardens failed to take steps to ensure the immediate and reasonable supply of Mr Paranthoiene's relevant prescription medication when he was discharged from hospital on 18 September 2017.

Alkira Gardens lacked the physical and organisational capacity to provide Mr Paranthoiene with either adequate or quality palliative care, specifically prescription pain medication, between 18 September and 3 October 2017.

Communication and relationship between Mr Paranthoiene's family and Alkira Gardens

Ms Ruddock told us that she had various interactions with Alkira Gardens between 18 September and 3 October 2017. On 18 September 2017, Ms Ruddock and her sister had a meeting with Alkira Gardens' facility manager and deputy facility manager.[299] At the meeting, Ms Ruddock and her sister complained that Alkira Gardens hadn't noticed Mr Paranthoiene's clinical decline. Ms Ruddock said that she asked Alkira Gardens if they could care for Mr Paranthoiene as a palliative patient and they said that they could.[300] Mr Leong explained that in preparation to give evidence, he had spoken to the deputy facility manager at Alkira Gardens, who had characterised this meeting as a family conference to discuss Mr Paranthoiene's return to Alkira Gardens.[301] It is the policy of Alkira Gardens to make a record of all family conferences, and of all complaints.

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295 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [81].

296 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [65]-[73].

297 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 20, SLC.0001.0002.3666 at 3667.

298 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2749.37-39.

299 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0009-0010 [79]-88]; Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0008 [73]; Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2639.46-47, T2640.1.

300 Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2643.32-35; Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0009 [82]-[85].

301 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0008 [73].

Despite this, there is no record of this meeting.

Ms Ruddock stated that on 19 September 2017 she suggested to Alkira Gardens that a sign be placed on Mr Paranthoiene's door to explain that 'he was a palliative resident and needed regular pain assessments' because she 'had not been told exactly how' Alkira Gardens was going to manage her father's palliative care needs.[302] Ms Ruddock was told that such a sign could not be placed on her father's door.[303] Ms Ruddock felt:

> very uncomfortable that my father, a complex palliative patient, would be placed on a large ward without any understanding of how his needs would be communicated to staff.[304]

On 27 September 2017, Ms Ruddock was present for Mr Cohen's review of Mr Paranthoiene, along with the nursing team staff at Alkira Gardens.[305] In this meeting, Ms Ruddock 'became very concerned' that the staff at Alkira Gardens could not properly care for Mr Paranthoiene.[306]

In her evidence, Ms Ruddock described her concern for her father not receiving Endone unless she asked for it from staff.[307] There are no records of any discussions between Alkira Gardens and Ms Ruddock about Mr Paranthoiene's pain relief. Mr Leong gave evidence that if there had been any such discussion, he would expect that the discussion would have been recorded.[308]

Mr Cohen gave evidence about the importance of relationships between care recipients, their families and residential aged care facilities.[309]

Ms Ruddock explained that she felt she had to advocate for her father's care because it was not being provided by Alkira Gardens.[310] Due to this, Ms Ruddock was not able to enjoy time with her father in his final months and weeks because she was preoccupied with ensuring her father received appropriate and humane care.[311] Upon discovering that Mr Paranthoiene could remain at Calvary Hospital to die on around 9 November 2017, Ms Ruddock was relieved. She told us that she felt like she had been 'in a battle' with OLC and she just wanted to end her relationship with Alkira Gardens so she could focus on caring for her father.[312]

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302 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0010 [94].

303 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0010 [95].

304 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0011 [96].

305 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 104, LCM.0002.0002.0001 at 0009.

306 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0013 [117].

307 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0011 [102]; Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2649.32-44.

308 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2742.42.

309 Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2694.36-44.

310 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0014 [133].

311 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0017 [159].

312 Transcript, Shannon Ruddock, Perth Hearing, 27 June 2019 at T2663.14-23.

Counsel Assisting submitted that Alkira Gardens' failure to maintain a relationship with Ms Ruddock undermined the quality of palliative care provided to Mr Paranthoiene.

OLC submitted that it would be a denial of procedural fairness for us to make findings about the relationship between Alkira Gardens and Ms Ruddock prior to 18 September 2017.[313] As stated above, we do not consider that making findings about events occurring prior to 18 September 2017 constitutes a denial of procedural fairness where OLC has had an adequate opportunity to respond to the findings that Counsel Assisting has proposed we make.

OLC otherwise concedes that it did not adequately manage the relationship with Ms Ruddock. However, OLC submitted that:

> Alkira Gardens did not manage the relationship with Ms Ruddock well and in that regard, it did not provide her with the support she deserved and needed. Her evidence of her experience demonstrates this.
>
> And the consequence of this failure by Alkira Gardens is that Ms Ruddock's time and emotional energy was focussed on the lack of care she believed he was getting, rather than supporting her father and enjoying her time with him during the period at Alkira Gardens from 18 September 2018 to 3 October 2017…
>
> Importantly also, despite the failures in relation to Ms Ruddock, the totality of the evidence shows that the care actually received by Mr Paranthoiene was of an appropriate standard. There are no legitimate substantial shortcomings in the actual care provided to Mr Paranthoiene that are established on the evidence given to the Commission.[314]

This submission suggests that the distress caused to Ms Ruddock is not a 'legitimate substantial shortcoming' or part of the 'actual care' provided to Mr Paranthoiene. We consider that the submission shows a failure to recognise the importance of relationships between providers and family members to quality aged care. Ms Ruddock was one of the most important people to her father in his final days. Ensuring that she was in a position to provide loving support to her father should have been a priority for Alkira Gardens. Providing quality care to Mr Paranthoiene should have included supporting and fostering a positive relationship with Ms Ruddock.

Alkira Gardens inadequately communicated with Mr Paranthoiene and his family about the provision of palliative care by Alkira Gardens to Mr Paranthoiene between 18 September and 3 October 2017. Alkira Gardens failed to maintain a relationship with Ms Ruddock in relation to her father's care. This lack of relationship undermined the quality of palliative care provided by Alkira Gardens to Mr Paranthoiene.

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313 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [17]-[22].

314 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [139]-[140], [142].

Staffing at Alkira Gardens

Of the 13 registered nurses involved in the care of Mr Paranthoiene, one was an agency staff member and 12 others were employed by Alkira Gardens. As noted above, out of those 12 employee nurses, 10 have resigned and only two remained employed at Alkira Gardens at the time of the Perth Hearing.[315] As a consequence of the sanctions imposed by the Department of Health on Alkira Gardens in October 2017, Alkira Gardens increased the hours worked by registered nurses at Alkira Gardens by 23.5 hours per day.[316] The sanctions were based on the findings of an audit carried out by the Australian Aged Care Quality Agency.

Mr Leong agreed that there were not enough staff working at Alkira Gardens at the time Mr Paranthoiene was a resident.[317]

OLC submitted that it does not follow from the findings of the Australian Aged Care Quality Authority that Alkira Gardens did not have enough staff to provide an adequate standard of care to Mr Paranthoiene. It submitted that there is no probative evidence that the deficient staffing levels found to exist by the regulator affected Mr Paranthoiene's care. OLC also relies upon what it says is the absence of a specific complaint about staffing levels by Ms Ruddock.[318]

To the extent that OLC seeks to rely on Ms Ruddock not specifically complaining about staffing levels in her evidence, we reject that submission. Ms Ruddock's evidence on this point is as follows:

> My concerns are that there were not enough staff at Alkira to care for residents such as my father with complex needs, and the staff that were there were not trained to provide appropriate palliative care, including how to administer PRN medications.[319]

In addition, Ms Ruddock drew unfavourable comparisons to the staffing levels at Calvary hospital,[320] recalled another person asking questions about the ratios of staff at Alkira Gardens at the family and residents' meeting following the sanction,[321] and sought to supplement the staff at Alkira Gardens by hiring her own private nurse.[322] She argued for a rigorous form of accreditation before an aged care facility could provide palliative care and said that it was inhumane to move palliating people between aged care and hospital.[323]

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315 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2746.18-21; Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0005 [40]-[41].

316 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0017 [119]; Transcript, John Leong, Perth Hearing, 27 June 2019 at T2747.15.

317 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2744.15.

318 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [110]-[116].

319 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0018 [170].

320 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0016 [147].

321 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0017 [162].

322 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0017 [163].

323 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0018 [171]-[172].

In addition, Mr Leong's own evidence was that the levels of staff were inadequate when Mr Paranthoiene was a resident there.[324] The evidence from Mr Cohen was that providing palliative care to Mr Paranthoiene would require a staff member to check his pain levels every two hours.[325] The suggestion from OLC is that the Royal Commission should accept that while there were not enough staff at the facility overall, there were nonetheless enough to provide quality palliative care to Mr Paranthoiene. We do not accept this distinction.

There were not enough suitably qualified staff working at Alkira Gardens between 18 September 2017 and 3 October 2017 to provide an adequate standard of care for Mr Paranthoiene.

Wound care

On 24 September 2017, Alkira Gardens noticed redness and a pressure sore developing on Mr Paranthoiene's sacrum.[326] Alkira Gardens noticed that Mr Paranthoiene had a red mark that might develop into a pressure wound and told Ms Ruddock that a special mattress had been put on her father's bed to try and prevent pressure wounds.[327]

There is no further mention of this issue in the records until 1 October 2017.[328] On that day, Ms Ruddock was advised by a staff member of Alkira Gardens that the pressure wound had started to open up, that the general practitioner had been called and that he had put Mr Paranthoiene on a bacterial antibiotic as precaution.[329] The wound was clearly serious.[330]

Mr Leong accepted that a registered nurse ought to have checked the dressing area each day. Mr Leong was unable to explain why the wound was not identified earlier than 1 October 2017.[331] He gave evidence that Alkira Gardens' wound care policy required the wound to be checked within five days, but that did not occur. He accepted that Mr Paranthoiene's wound was not treated in accordance with the policy.[332]

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324 Transcript, John Leong, Perth Hearing, 27 June 2019 at T2744.15; T2747.9.

325 Transcript, Joshua Cohen, Perth Hearing, 27 June 2019 at T2693.10.

326 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0015 [103]; Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 30, SLC.0001.0002.3670 at 3671.

327 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0012 [105].

328 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 31, SLC.0001.0001.3531; tab 36, SLC.0001.0002.3534.

329 Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, 31 May 2019, WIT.1132.0001.0001 at 0014 [130]; Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0015 [107]-[109].

330 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 89, SLC.0001.0002.3533.

331 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0015 [108].

332 Exhibit 5-35, Perth Hearing, Statement of John Leong, 25 June 2019, WIT.0244.0002.0001 at 0003 [18].

An audit conducted in October 2017 by the Australian Aged Care Quality Agency cited Mr Parathoiene's wound care in its finding that Alkira Gardens had not met the standard for skin care.[333] The same audit concluded that the home 'did not have sufficient appropriately skilled staff to ensure that services were delivered in accordance with the accreditation standards'.[334]

In relation to wound care, OLC submitted that the documentary evidence before us does not support the findings sought by Counsel Assisting.[335] OLC also submitted that no evidence was adduced which suggested that the care provided by Alkira Gardens led to the development or any worsening of the wound.[336] The submissions are silent on Mr Leong's own admission of the failure to follow Alkira Gardens own policies in relation to the wound and the findings of the Australian Aged Care Quality Agency.

Relying on the concession by Mr Leong that the wound was not properly managed and on the findings of the Australian Aged Care Quality Agency, we conclude that Alkira Gardens failed appropriately and adequately to care for Mr Paranthoiene's sacrum wound between its appearance on 24 September 2017 and his admission to hospital on 3 October 2017.

Management of falls

When Mr Paranthoiene moved to Alkira Gardens in April 2017, the Resident Interim Care Plan prepared by OLC noted that he was considered low falls risk.[337] This record is in contrast to the My Aged Care support plan conducted a month previously, which recorded Mr Paranthoiene as high falls risk.[338] On 19 September 2017, the physiotherapy records stated that Mr Paranthoiene was high falls risk.[339]

Between 18 September and 3 October 2017, Mr Paranthoiene had seven falls at Alkira Gardens.[340] Most of those falls were unwitnessed. The records available indicate that Mr Paranthoiene's general practitioner was informed following each fall and an incident form was completed after each fall.[341]

333 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 38, SLC.0001.0002.3258 at 3290.

334 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 38, SLC.0001.0002.3258 at 3267-3275.

335 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [118]-[127].

336 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [128].

337 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 67, SLC.0001.0002.3626.

338 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 2, SHA.0002.0001.0002.

339 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 25, SLC.0001.0002.3668.

340 Exhibit 5-36, Perth Hearing, Statement of John Leong, 14 June 2019, WIT.0244.0001.0001 at 0013-0014 [99]; Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 25, SLC.0001.0002.3668; tab 30, SLC.0001.0002.3670; tab 33, SLC.0001.0002.3672; tab 82, SLC.0001.0002.3546.

341 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 105, SLC.0001.0002.3554; tab 108, SLC.0001.0002.3542; tab 109, SLC.0001.0002.3541; tab 112, SLC.0001.0002.3549; tab 115, SLC.0001.0002.3548; tab 116, SLC.0001.0002.3547; tab 117, SLC.0001.0002.3537.

The audit conducted in October 2017 by the Australian Aged Care Quality Agency cited Mr Paranthoiene's case in its finding that Alkira Gardens had not met the standard for mobility, dexterity and rehabilitation.[342]

In its submissions, OLC sought to traverse the findings made by the Australian Aged Care Quality Agency which it had previously accepted. OLC suggested that it does not further the needs of this Royal Commission's Letters Patent to make findings in relation to matters which have already been addressed by a regulatory body.[343] We note in this regard that our Letters Patent expressly state that we are not required to inquire into a particular matter to the extent that we are satisfied that the matter has been 'sufficiently and appropriately dealt with by another…investigation'.[344]

OLC submitted that the approach taken by Alkira Gardens in relation to falls was a 'very diligent and careful response' and that there is no evidence that any more could have been done to prevent the falls.[345]

The evidence before us, in the form of the findings of the Australian Aged Care Quality Agency, is that more could and should have been done in relation to Mr Paranthoiene's falls.[346] Alkira Gardens failed adequately to manage Mr Paranthoiene's falls risk between 18 September and 3 October 2017.

Conclusion

The care that Mr Vincent Paranthoiene received at Alkira Gardens is a matter of great concern to this Royal Commission. Ms Ruddock's bravery in telling us her story is commendable. In so doing, she has exposed serious gaps in the palliative care provided to older Australians.

342 Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 38, Review Audit Assessment Report, 23 October 2017, SLC.0001.0002.3258 at 3293-3296.

343 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [136].

344 *Letters Patent*, 6 December 2018 as amended on 13 September 2019.

345 Perth Hearing, Submissions of Sisters of Our Lady of China – Alkira Gardens Case Study, 12 July 2019, RCD.0012.0012.0001 at [131]-[132].

346 After referring to five residents who had sustained falls, including Mr Paranthoiene, the Agency concluded that 'none of the above incidents have been investigated or appropriate falls prevention strategies implemented to minimize the risk of recurrence': Exhibit 5-31, Perth Hearing, Alkira Gardens General Tender Bundle, tab 38, Review Audit Assessment Report, 23 October 2017, SLC.0001.0002.3258 at 3293–3296.

6. Darwin and Cairns Hearing: Clinical Care and Access to Aged Care

Hearing overview

Introduction

The Royal Commission held a hearing in Darwin, Northern Territory, from 8 to 12 July 2019, and in Cairns, Queensland, from 15 to 17 July 2019. The focus of the hearing was on the quality of aged care. The key areas examined at the hearing were:

- aspects of care in residential, home and flexible aged care programs, including:
  - accessibility and availability
  - wound, medication and pain management
  - food, nutrition and hydration
  - continence care
  - mobility and falls
  - social supports
- rural and regional issues for service delivery of aged care
- quality of life for people receiving aged care.

In Darwin, there was an additional focus on the delivery of care in the Northern Territory, including to Aboriginal and Torres Strait Islander people.

The Royal Commission heard oral testimony from 52 witnesses. There were 2062 documents, including 58 witness statements, received into evidence.

During this hearing, the Royal Commission heard from a range of experts, service providers and people who have worked in aged care. People who care or have cared for a loved one gave accounts of their experiences. The interconnected nature of various aspects of care was further illustrated by three case studies. Our findings and conclusions about these case studies are set out later in this chapter.

Some of the evidence we received at this hearing has been drawn upon in Volume 1 of this Interim Report. It will continue to be drawn upon over the course of our inquiry as well as in our Final Report. A brief overview of the hearing and the evidence is provided below.

The evidence at this hearing made clear the interrelation between various aspects of care: failings in one area of care can affect other areas. These areas of care relate to both clinical and personal care as well as the quality of life of those receiving care.

Over the course of the hearing, a range of clinical and other experts gave evidence that illustrated the interconnection between the various domains of care and their effect on quality of life.

Delivery of care in the Northern Territory

Over the course of the hearing in Darwin, we received evidence about aged care in the Northern Territory.[1] The evidence in Darwin about the stark challenges faced by Aboriginal and Torres Strait Islander older people living in the Northern Territory was powerful. The challenges of poverty, food insecurity, difficulties accessing services, lack of culturally safe and secure services, and the distance from services stood out. The importance of connection to Country was also highlighted.

Since March 2018, Ms Mildred Numamurdirdi, an Elder and traditional owner from Numbulwar, has lived in residential aged care in Darwin, which is 800 kilometres away from her home.[2] The nearest residential aged care facility to Numbulwar is in Katherine, five or six hours' drive away.[3]

Ms Numamurdirdi was supported to give evidence to the Royal Commission by her doctor, Dr Meredith Hansen-Knarhoi, a general practitioner with Danila Dilba Health Service.[4] Danila Dilba Health Service is an Aboriginal community-controlled organisation that provides primary health care and community services in Darwin and the surrounding areas.[5]

Dr Hansen-Knarhoi explained that it has been quite difficult for Ms Numamurdirdi to maintain contact with her family in Numbulwar.[6] It took some months to arrange a mobile telephone for Ms Numamurdirdi.[7] Despite 'exploring options', it has not been possible for Ms Numamurdirdi to return to Numbulwar.[8]

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1 In addition to the evidence received in the hearing, in June 2019 we received a written submission from the Northern Territory Council of Social Service (NTCOSS), which set out information relating to the care needs of Territorians, challenges relating to aged care provision in the Northern Territory, service deficits, cost of service, and the special needs of Aboriginal and Torres Strait Islander people in the Northern Territory: *NTCOSS Submission to the Royal Commission into Aged Care Quality and Safety*, June 2019, AWF.600.01146 (also available at https://mk0ntcoss2rx2i6x3dbk.kinstacdn.com/wp-content/uploads/2019/07/NTCOSS-ACRC-Submission-FINAL.pdf).

2 Transcript, Meredith Hansen-Knarhoi, Darwin Hearing, 8 July 2019 at T2848.11-40.

3 Transcript, Meredith Hansen-Knarhoi, Darwin Hearing, 8 July 2019 at T2848.30-34.

4 Transcript, Meredith Hansen-Knarhoi, Darwin Hearing, 8 July 2019 at T2847.21-2853.21.

5 Exhibit 6-6, Darwin and Cairns Hearing, Statement of Olga Havnen, 4 July 2019, WIT.0263.0001.0001 at 0002 [12]; Transcript, Olga Havnen, Darwin Hearing, 8 July 2019 at T2877.42-2878.2.

6 Transcript, Meredith Hansen-Knarhoi, Darwin Hearing, 8 July 2019 at T2849.6-9.

7 Transcript, Meredith Hansen-Knarhoi, Darwin Hearing, 8 July 2019 at T2849.9-10.

8 Transcript, Meredith Hansen-Knarhoi, Darwin Hearing, 8 July 2019 at T2849.1-4.

In a video statement to the Royal Commission, Ms Numamurdirdi described how she felt living away from her family and Country:

> My heart is crying because I far away from my family. Yes. Because if I pass away here, I've got my spirit, my culture, my ceremony way back home at home and my family, they don't want that way, because we've got everything there in the home. And if we pass away, culture there, our spirit. That is my family, because I'm the eldest out of my family and that's my mother land Numbulwar.[9]

It was made clear to us that being away from Country has a profound effect on older Aboriginal and Torres Strait Islander people. In addition to the effect on the individual, Elders and older people being away from Country can have profound consequences for their families and their communities, indeed on the broader Australian community, because of the cultural knowledge Elders and older people hold. Ms Sarah Brown, Chief Executive Officer of Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation (Purple House), explained it this way:

> I don't think you can underplay the importance—we've got senior—senior people with the cultural knowledge of particular bits of land of Australia that has been passed on to them, and they're away from their Country. If they don't get an opportunity to return to teach their kids and their grandkids their cultural heritage, it's lost not only for those families but the whole community. And the whole of Australia loses that knowledge.[10]

Community aged care can support people to remain on Country and in their communities.

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council (Aboriginal Corporation) supports older people to continue to live on Country across the NPY region of the Northern Territory, South Australia and Western Australia.[11] Ms Kim McRae is the Tjungu team manager, looking after aged care, disability and respite services at NPY Women's Council. She explained that ensuring the basic necessities of living are provided to older people is important in supporting them to remain on Country in their communities.[12] She said:

> Nutrition and making sure people are getting regular meals. That can be a big issue for a range of reasons. Some of it is about the fact that poverty is a huge issue out on communities. Most people are dependent on Centrelink benefits. There is an obligation to share and support your family, and sometimes the end result of all of those things can mean that old people aren't getting enough to eat because they're making sure their grandkids are eating before they're looking after themselves. So making sure that people get access to the meals program, that they are getting regular nutritious food can make a huge difference to someone's life.

9 Exhibit 6-1, Darwin and Cairns Hearing, General Tender Bundle, tab 64, RCD.9999.0093.0001; Transcript, Meredith Hansen-Knarhoi, Darwin Hearing, 8 July 2019 at T2851.11-18.

10 Transcript, Sarah Brown, Darwin Hearing, 8 July 2019 at T2870.37-42.

11 Transcript, Kim McRae, Darwin Hearing, 8 July 2019 at T2856.32-39.

12 Transcript, Kim McRae, Darwin Hearing, 8 July 2019 at T2856.21-26; T2863.36-2864.3.

> Also being able to access laundry services…because most people don't have a washing machine in their house. So being able to wash bedding, blankets, clothing, particularly if incontinence is an issue is really important in terms of maintaining people's health. So those sort of really basic supports are very, very important to ensure that people can continue to live on Country.[13]

Aboriginal and Torres Strait Islander people in the Northern Territory, and across the rest of Australia, live with a range of complex health issues. These issues, including high rates of diabetes and renal failure, were highlighted at this hearing.[14]

Professor Geoffrey Sussman, Clinical Wound Consultant at Austin Health in Melbourne and President of the Asia Pacific Association for Diabetic Limb Problems, explained that remoteness and difficulty in accessing treatment creates a 'major issue' with diabetes in Aboriginal and Torres Strait Islander communities in the Northern Territory.[15] He described the rate of amputations he encounters as a 'shocking reflection on us as a community'.[16]

Ms Olga Havnen, a Western Arrente descendent and Chief Executive Officer of Danila Dilba, voiced frustration at the situation:

> The point I really want to emphasize is that Aboriginal people have by far the most complex health conditions, complex level of needs and who actually receive the least level of service, and these things are not new. We have talked about it for decades as Donna and Dr Boffa have said. You know, we have done a lot of the research. I simply do not understand how we can still face such inequity. And I get it that, you know, there are competing economic and other sort of priorities but it's like when the hell do Aboriginal people's needs get met.[17]

Danila Dilba and the Central Australian Aboriginal Congress explained the need for greater transparency and information sharing between the primary health care networks and community aged care and Home Care Package services to ensure people receive the services they need.[18]

Dr John Boffa, the Chief Medical Officer for Public Health of the Central Australia Aboriginal Congress, spoke of the decline in community nursing that resulted from the nationalisation of aged care and jurisdictional tensions around responsibility for nursing. He said it is well established that home visits from nurses to older people with multiple chronic diseases prevents hospitalisation.[19]

13 Transcript, Kim McRae, Darwin Hearing, 8 July 2019 at T2863.36-2864.3.

14 Transcript, Kim McRae, Darwin Hearing, 8 July 2019 at T2863.24-31.

15 Transcript, Geoffrey Sussman, Darwin Hearing, 11 July 2019 at T3343.6-27.

16 Transcript, Geoffrey Sussman, Darwin Hearing, 11 July 2019 at T3343.29-32.

17 Transcript, Olga Havnen, Darwin Hearing, 8 July 2019 at T2899.30-37.

18 Transcript, Boffa/Ah Chee/Havnen/Giles, Darwin Hearing, 8 July 2019 at T2896.25-2898.20.

19 Transcript, John Boffa, Darwin Hearing, 8 July 2019 at T2901.1-2902.13.

Bundjalung woman and Chief Executive Officer of the Central Australia Aboriginal Congress, Ms Donna Ah Chee, described Aboriginal people with high clinical needs waiting for long periods before receiving the services they are eligible for.[20] These wait times are not unique to Central Australia.[21]

In addition to providing a range of other services, Larrakia Nation Aboriginal Corporation is an approved provider of aged care services and also delivers services under the Commonwealth Home Support Programme.[22]

Ms Michelle McCall, Aged and Disability Program Manager at the Corporation, explained that as part of its Commonwealth Home Support Programme services, Larrakia Nation provides assistance through what was previously known as the Commonwealth Assistance with Care and Housing for the Aged program to those 'living rough' on Larrakia land. Through this program, the Corporation provides intensive case management services until a service provider can provide services.[23]

However, Larrakia Nation said it turns away about 30 people a month from its Commonwealth Home Support Programme services because of the limited number of places and resources.[24]

Ms Sharai Johnson, Larrakia descendent and Aged Care Coordinator at Larrakia Nation, spoke of delays in access to Level 3 and Level 4 Home Care Packages in Darwin. Typically, she said, the wait is 18 months from the date of assessment until the provision of services. However, Larrakia Nation had one client who had waited 28 months. In Ms Johnson's experience, some people 'rapidly decline in health' while waiting; others have died.[25]

Ms Michelle McKay, Chief Operating Officer of the Northern Territory Government Top End Health Service, described the impact of waiting lists for high level Home Care Packages on the hospital system. The impact of waiting lists is compounded by difficulties accessing residential aged care: 'It can often be the case that individuals in this situation actually need to be in hospital because it is the only place able to care for their high level needs.'[26]

In addition, there was evidence that clinical and personal care needs are not being met in some residential aged care settings in the Northern Territory, and that residents' quality of life is suffering. Dr Sarah Giles of Danila Dilba spoke of difficulties with management plans

20 Exhibit 6-5, Darwin and Cairns Hearing, Statement of Ms Donna Ah Chee concurred in by Dr Boffa, 4 July 2019, WIT.0265.0001.0001 at 0008 [36].

21 However, NTCOSS submits that the Northern Territory has a greater proportion of lower level Home Care Packages than all other jurisdictions: *NTCOSS Submission to the Royal Commission into Aged Care Quality and Safety* June 2019 AWF.600.01146 at page 7, citing M Lowe and P Coffey, 'Effect of an ageing population on services for the elderly in the Northern Territory', *Australian Health Review*, 2019, Vol 43, pp 73–74.

22 Exhibit 6-34, Darwin and Cairns Hearing, Statement of Anne Elise Morgan, 9 July 2019, WIT.0255.0001.0001 at 0007 [34].

23 Transcript, Michelle McCall, Darwin Hearing, 12 July 2019 at T3420.10-31.

24 Exhibit 6-34, Darwin and Cairns Hearing, Statement of Anne Elise Morgan, 9 July 2019, WIT.0255.0001.0001 at 0008 [41].

25 Transcript, Sharai Johnson, Darwin Hearing, 12 July 2019 at T3422.40-3423.31.

26 Transcript, Michelle McKay, Darwin Hearing, 8 July 2019 at T2917.4-11.

in areas of allied health. She gave an example of a resident being unable to access an ophthalmologist for assessment for potentially preventable diminishing vision because it was deemed necessary that they first see an optometrist. The expense of first seeing an optometrist was, however, too great. For at least two months, the individual affected had not been able to access care to allow their management plan to progress.[27]

Larrakia Nation explained that residential aged care is not appropriate for some people. A large number of their clients have been affected by the Stolen Generations and resist entry to residential aged care to avoid being re-institutionalised.[28]

As is the case elsewhere in Australia, there are staffing and workforce challenges in the Northern Territory. The importance of increasing the Aboriginal and Torres Strait Islander workforce and improving other people's knowledge of culture and working in appropriate ways were emphasised.

The panel of witnesses from Danila Dilba and Central Australia Aboriginal Congress discussed the need for better use of interpreters, cultural workers, and mandated cross-cultural safety training in aged care facilities.[29] Purple House works 'Malparara Way', which is 'non-Aboriginal staff working with local Aboriginal people who have the expertise in language and culture'.[30]

Ms McCall explained that Larrakia Nation is 'bucking the trend' when it comes to their workforce.[31] Ms Anna Morgan, the Independent Non-Member Director, said that in the last three years staffing levels have doubled.[32] Larrakia Nation is attracting young staff members, including young male staff members. There was a deliberate strategy on the part of the Larrakia Nation to attract 'young and Indigenous' workers. Part of the strategy, Ms McCall explained, was to look for passion. They are 'selling aged care for helping the Elders…you're making a difference to the quality of people's lives'.[33] Ms Sharai Johnson spoke of the rewarding nature of the work:

> What makes it so rewarding is that you know that you're impacting—you're having a positive impact on each individual's life, daily life, their daily living, and if you can be that one person to make that change on a daily basis, then that's a wonderful outcome, not only for my personal satisfaction, my professional development, and giving that back to the community, giving that back to the workforce and also mentoring younger staff members, just the younger generation in general, showing them that aged care is—it's a great place to be. It is a wonderful place to be. It is so rewarding, and you know what? You just keep going every day.[34]

27 Transcript, Sarah Giles, Darwin Hearing, 8 July 2019 at T2888.33-2889.25.

28 Exhibit 6-34, Darwin and Cairns Hearing, Statement of Anne Elise Morgan, 9 July 2019, WIT.0255.0001.0001 at 0008 [44].

29 Transcript, Boffa/Ah Chee/Havnen/Giles, Darwin Hearing, 8 July 2019 at T2890.19-2892.42.

30 Transcript, Kim McRae, Darwin Hearing, 12 July 2019 at T2859.11-15.

31 Transcript, Michelle McCall, Darwin Hearing, 12 July 2019 at T3424.11-41.

32 Transcript, Anna Morgan, Darwin Hearing, 12 July 2019 at T3419.18-21.

33 Transcript, Michelle McCall, Darwin Hearing, 12 July 2019 at T3424.11-41.

34 Transcript, Sharai Johnson, Darwin Hearing, 12 July 2019 at T3425.34-41.

Quality of care and quality of life

Some matters confronting the delivery of care in the Northern Territory are common across the country. There was a particular focus at this hearing on the interaction between the quality of personal and clinical care and quality of life.

Quality of care

At this hearing we heard that safety is central to quality care. It is clear that an absence of safety can lead to poor outcomes.

Unsafe care can be overt, such as the startling account given by Ms Lisa Backhouse of her mother's experience in aged care. She described finding her mother 'in pain, agitated, lying half out of bed and soaking in urine' while the care workers were chatting in the nurse's office.[35] Concerned about the level of care her mother was receiving, Ms Backhouse moved her to a different facility, only to be told that her mother had been assaulted twice in the new facility.[36] Ms Backhouse's distress was clear as she explained that she had moved her mother to 'guarantee her safety and instead delivered her further into harm's way'.[37] To ensure her mother's safety, Ms Backhouse sought permission to install a motion-activated surveillance camera in her mother's room.[38]

Ms FA described the distressing experience of discovering her father falling from his bed with half of his body on the floor, in his nightgown, a bib and 'foul-smelling pants which looked to be very full of urine'.[39]

Absences of safety also include failure to undertake clinical assessments, failure to provide expert clinical care when needed, or the delivery of inappropriate care.

It is clear from the evidence at this hearing that assessment of people receiving care plays an important role in ensuring appropriate care is provided. Many of the clinical experts involved in the hearing called for individualised assessments of older people across multiple clinical domains at the point of entry into care.

Associate Professor Michael Murray, the President of the Continence Foundation of Australia, emphasised the importance of continence assessments to assist in understanding the nature of a continence-related problem.[40] Dr Joan Ostaszkiewicz, Research Fellow at Deakin University in the Centre for Quality and Patient Safety Research, has clinical and academic expertise in the management of incontinence in frail older people.[41] She explained that in the aged care context, continence information is collected

35 Transcript, Lisa Backhouse, Darwin Hearing, 11 July 2019 at T3199.38-40.

36 Transcript, Lisa Backhouse, Darwin Hearing, 11 July 2019 at T3198.21-3200.36.

37 Transcript, Lisa Backhouse, Darwin Hearing, 11 July 2019 at T3200.37-38.

38 Transcript, Lisa Backhouse, Darwin Hearing, 11 July 2019 at T3200.41-43.

39 Transcript, [FA], Cairns Hearing, 17 July 2019 at T3777.30-38.

40 Transcript, Michael Murray, Darwin Hearing, 11 July 2019 at T3277.1-17.

41 Transcript, Joan Ostaskiewicz, Darwin Hearing, 11 July 2019 at T3273.24-27.

for the purposes of the Aged Care Funding Instrument. However, she explained, the information collected is insufficient to inform clinical care, which defeats the purpose.[42]

In the context of falls, Dr Frances Batchelor of the National Ageing Research Institute explained that these assessments should be ongoing and dynamic, particularly as people's conditions change.[43]

Assessment of the medication people are using is also important. Dr Janet Sluggett, from Monash University's Faculty of Pharmacy and Pharmaceutical Sciences, proposed that pharmacists be brought closer to the point of care to identify medication-related problems, to help resolve those problems and to help prevent future medication-related problems from occurring.[44]

The intersection of risk factors across domains was central to this hearing. For example, we heard that nutrition can impact strength, falls risk and wound healing, medications can impact continence and falls risk, and incontinence can impact skin integrity. Errors or omissions in one domain may have implications in many others.

Dr Sluggett explained that the use of medication can have 'unintended or harmful effects' which contribute to increased risk of falls, worsen or cause urinary incontinence, increased infection, unintended weight loss, and could undermine sound diabetes management.[45]

Professor Johanna Westbrook, Professor of Health Informatics and Patient Safety and Director of the Centre for Health Systems and Safety Research at Macquarie University, described a study undertaken by her team which identified that general practitioners may be making medication decisions on records with an average of 10 discrepancies per resident compared with the aged care facility record.[46] She explained:

> In general, the greatest proportion of those discrepancies related to…omissions in the general practice record, so that changes…which appeared in the aged care facility record did not appear in the general practice record.[47]

More generally, Professor Westbrook outlined how data analytics of medication information could support better care and help identify anomalous prescribing practices.[48] In relation to general clinical data, Professor Westbrook told us that aged care providers are already collecting a large amount of important clinical data but that it is not necessarily recorded in a useful and accessible way: aged care is 'data rich but information poor'.[49] Professor

42 Transcript, Joan Ostaszkiewicz, Darwin Hearing, 11 July 2019 at T3279.7-45.

43 Transcript, Frances Batchelor, Cairns Hearing, 16 July 2019 at T3722.27-44.

44 Transcript, Janet Sluggett, Darwin Hearing, 12 July 2019 at T3383.1-8.

45 Exhibit 6-32, Darwin and Cairns Hearing, Statement of Janet Sluggett, 27 June 2019, WIT.0251.0001.0001 at 0003-0011.

46 Transcript, Johanna Westbrook, Darwin Hearing, 11 July 2019 at T3242.46-3243.11.

47 Transcript, Johanna Westbrook, Darwin Hearing, 11 July 2019 at T3242.46-3243.11.

48 Exhibit 6-22, Darwin and Cairns Hearing, Statement of Johanna Westbrook, 3 June 2019, WIT.0196.0001.0001 at 0004 [14]-[17].

49 Exhibit 6-22, Darwin and Cairns Hearing, Statement of Johanna Westbrook, 3 June 2019, WIT.0196.0001.0001 at 0003 [13].

Westbrook explained that if certain steps were taken, a wealth of clinical performance data would be available for ongoing monitoring and analysis, enabling the quick identification of areas for improvement.[50] We intend to give further consideration to these proposals and related issues.

Wounds are another area that requires ongoing assessment and management. Professor Geoffrey Sussman and Ms Hayley Ryan, Board Director of Wounds Australia, emphasised the importance of prevention of pressure injuries.[51] Ms Ryan explained that it is not uncommon for her to see a resident with a skin tear as a result of something as seemingly straightforward as brushing across their bedsheets.[52] Professor Sussman explained that good quality emollients can be used to prevent skin tears.[53]

Ms Catherine Sharp, a registered nurse with experience in wound management, said she is often called when wounds are 'so far gone' they will not heal. She said prevention 'would be much easier'.[54] Such was the experience of Mrs Santoro, examined in the Assisi Centre case study.

Prevention also arose as a theme in the areas of continence and falls management.

There are multiple causes of incontinence, but access to a toilet is key to helping avoid incontinence. Incontinence prevention can be staff-intensive when assisting people to use the toilet, and so staff find the pragmatic solution: to let older people use incontinence pads. We have heard considerable evidence of this practice throughout many of our hearings.

Associate Professor Michael Murray explained that it is 'the fundamental nature of human dignity and lived experience' to avoid incontinence 'on each and as many occasions as you possibly can'.[55]

Dr Joan Ostaszkiewicz spoke of the indiscriminate use of continence pads 'creating a situation of incontinence', resulting in what she termed 'socially engineered incontinence'.[56] Dr Ostaszkiewicz said:

> there's broad scale lack of awareness of incontinence as a problem and its causes, and that leads to people accepting it to be a problem of old age…which is just not the case.[57]

50 Exhibit 6-22, Darwin and Cairns Hearing, Statement of Johanna Westbrook, 3 June 2019, WIT.0196.0001.0001 at 0009-0011 [34]-[37] (medication management), 0011-0013 [38]-[45] (pressure injuries), 0015-0017 [51]-[63] (generally), and 0024 [79]-[81]; Transcript, Johanna Westbrook, Darwin Hearing, 11 July 2019 at T3250.42-3253.8.

51 Transcript, Ryan/Sussman, Darwin Hearing, 11 July 2019 at T3330.9-24.

52 Transcript, Hayley Ryan, Darwin Hearing, 11 July 2019 at T3331.35-41.

53 Transcript, Geoffrey Sussman, Darwin Hearing, 11 July 2019 at T3331.10-11.

54 Transcript, Catherine Sharp, Darwin Hearing, 11 July 2019 at T3300.24-3301.1.

55 Transcript, Michael Murray, Darwin Hearing, 11 July 2019 at T3281.26-28.

56 Transcript, Joan Ostaskiewicz, Darwin Hearing, 11 July 2019 at T3293.24-3294.1.

57 Transcript, Joan Ostaszkiewicz, Darwin Hearing, 11 July 2019 at T3277.41-44.

Dr Ostaszkiewicz expressed concern that the manufacturers of continence products were providing education and, in doing so, were often promoting the use of incontinence products (such as pads) over preventative strategies.[58]

Ms Hayley Ryan similarly noted the adverse impact of wound product suppliers providing training at aged care facilities.[59]

Several clinical experts spoke of the benefits of multidisciplinary approaches to the management of care.

Associate Professor Peter Gonski explained the benefits of a multidisciplinary team at the acute end of the care spectrum, noting his 'flying squad' has geriatricians, a registrar, and nurse practitioners.[60] The flying squad also has a role in educating staff at facilities. Associate Professor Gonski explained that the flying squad is only at a facility for a short period and then it is 'up to the aged care facility to run with that treatment'.[61]

Ms Catherine Maloney from Services for Australian Rural and Remote Allied Health considered that people receiving aged care services should have access to multidisciplinary teams, including allied health professionals. She called for the wider use of allied health assistants and telehealth services where there was limited access to allied health professionals, such as in a rural and regional context.[62]

Dr Frances Batchelor explained that highly trained allied health professionals such as physiotherapists, occupational therapists and dietitians play a key role. Dr Batchelor said there was potential to consider the role of allied health assistants, but expressed some caution in that regard.[63]

Professor Geoffrey Sussman outlined the range of factors that can affect the ability of wounds to heal. Again, the need for a multidisciplinary approach was clear:

> No wound patient has just one simple problem because there are so many underlying intrinsic or extrinsic factors. The medication they're on, the things they're using in their diet, they're smoking, there are so many things that can impact on the ability to heal and so by having a broader church of people looking at the patient, it means that you can very quickly assess the problem and get to the nub of what you need to do to intervene. So it is very much multidisciplinary.[64]

58 Transcript, Joan Ostaskiewicz, Darwin Hearing, 11 July 2019 at T3287.46-3289.9.

59 Transcript, Hayley Ryan, Darwin Hearing, 11 July 2019 at T3339.4-9.

60 Transcript, Peter Gonski, Darwin Hearing, 11 July 2019 at T3222.38-44.

61 Transcript, Peter Gonski, Darwin Hearing, 11 July 2019 at T3226.35-40.

62 Transcript, Catherine Maloney, Darwin Hearing, 12 July 2019 at T3408.44-3409.4.

63 Transcript, Frances Batchelor, Cairns Hearing, 16 July 2019 at T3727.6-15.

64 Transcript, Geoffrey Sussman, Darwin Hearing, 11 July 2019 at T3340.33-39.

Associate Professor Murray described the need to help take steps to manage continence. He listed a range of measures that involve a variety of disciplines: medication reviews, appropriate physiotherapy, appropriate occupational therapy with necessary devices and aids, access to doors that are easy to open and appropriate management of diet.[65]

Diet and nutrition

Diet, nutrition and food are important to both quality of care and quality of life.

Dr Sandra Iuliano, Senior Research Fellow at the Department of Medicine at the University of Melbourne, Mr Robert Hunt, Chief Executive Officer of the Dietitians Association of Australia, and Ms Sharon Lawrence, Commonwealth Home Support Programme Accredited Practising Dietitian, each made clear that malnutrition can have dire consequences for an older person's health.[66]

The Dietitians Association of Australia gave evidence that there is a 'completely unacceptable' level of malnutrition among older Australians, with 8% of older people living in the community and between 22% and 50% living in residential care estimated to be malnourished.[67]

Mr Robert Hunt spoke of a scoping project commissioned by the Dietitians Association on the Development of Nutrition and Menu Planning Standards for Residential Aged Care Facilities in Australia and New Zealand. He said that that work revealed that there are no standards or 'central repository' of guidance about appropriate nutrition in residential aged care.[68]

Dr Sandra Iuliano described the issues concerning adequacy of nutrition as a systemic problem in residential care.[69] Dr Iuliano's research has identified barriers to adequate and nutritious food in residential aged care facilities as including a lack of education, food budgets, lack of flexibility in food ordering and menu choice and a lack of proper documentation of menus and recipes.[70] There is a lack of education about these matters among food service staff. These staff, Dr Iuliano said, are doing the best they can but need more and better education about the nutritional needs of older people.[71]

65 Transcript, Michael Murray, Darwin Hearing, 11 July 2019 at T3288.25-3289.5.

66 Transcript, Iuliano/Hunt/Lawrence, Cairns Hearing, 16 July 2019 at T3648.9-3676.10.

67 Exhibit 6-48, Statement of Robert Hunt and Sharon Lawrence on behalf of the Dietitians Association of Australia, 20 June 2019, WIT.0205.0001.0001 at 0011 [53].

68 Transcript, Robert Hunt, Cairns Hearing, 16 July 2019 at T3662.43-3663.6.

69 Transcript, Sandra Iuliano, Cairns Hearing, 16 July 2019 at T3658.41.

70 Exhibit 6-47, Statement of Sandra Iuliano, 28 June 2019, WIT.0251.0001.0001 at 0005-0006 [21].

71 Transcript, Sandra Iuliano, Cairns Hearing, 16 July 2019 at T3658.41-3659.3.

Ms Jo-Ann Lovegrove told us that her father, who lives in residential aged care in Darwin, requires assistance with eating and could typically take a long time to eat a meal. Because of the time it takes him to finish a meal, food is sometimes taken away because staff think he is full but he is not.[72] Dr Iuliano explained that more time needs to be spent assisting residents to eat. She emphasised that while the literature showed that residents need 'half an hour [of physical assistance with eating] to achieve adequate intake', there needs to be a focus on improving 'the whole eating experience'.[73]

Ms Sharon Lawrence explained that unintended weight loss in older people can increase the risk of infection, impair the body's ability to repair wounds, decrease muscle mass and affect the ability to sit and to eat. It can lead to increased risk of pneumonia and, in the very worst cases, multiple organ failure. Dehydration, she said, can mimic changes in cognitive status.[74] Ms Lawrence said that while the first line of intervention in managing malnutrition is ensuring food is nutritious, additional interventions can be used, such as 'speech pathologists to assess chewing and swallowing' and dentists 'to look at dentition issues'.[75]

Ms Adrienne Lewis of the South Australian Dental Service explained that 'in terms of quality of life, there are multiple problems with poor oral health'. She said poor oral health can impact on chewing, food choices and sense of taste.[76]

Ms Lindy Twyford, Mr Timothy Deverell and Mr Nicholas Hall spoke about their experiences working in food services in aged care. Neither Mr Deverell nor Mr Hall considered that the commercial cookery qualifications they hold prepared them to work in aged care. Specifically, there was no focus on the nutrition needs of older people. Ms Twyford said that she received ongoing training relevant to the needs of older people through the facility where she works.[77]

Budgets within aged care facilities for food vary. Mr Deverell explained that budgets could range from $14 to $17 per day per resident to as low as $6.50 to $7 per day per resident.[78] Higher budgets allow for the provision of fresh food with better cuts of meat and quality vegetables. By contrast, lower budgets involved more processed food, lower protein, and secondary cuts of meat.[79]

Ms Maggie Beer AM, cook and founder of the Maggie Beer Foundation, considered a budget of $10.50 per person per day to be the minimum to produce good quality food and nutrition outcomes in aged care.[80] Ms Beer said that this budget will only be sufficient

72 Transcript, Jo-Ann Lovegrove, Darwin Hearing, 12 July 2019 at T3357.4-7.

73 Transcript, Sandra Iuliano, Cairns Hearing, 16 July 2019 at T3664.1-24.

74 Transcript, Sharon Lawrence, Cairns Hearing, 16 July 2019 at T3657.1-35.

75 Transcript, Sharon Lawrence, Cairns Hearing, 16 July 2019 at T3664.4-16.

76 Transcript, Adrienne Lewis, Cairns Hearing, 16 July 2019 at T3682.9-13.

77 Transcript, Twyford/Deverell/Hall, Cairns Hearing, 16 July 2019 at T3610.40-3611.22.

78 Transcript, Deverell, Cairns Hearing, 16 July 2019 at T3612.21-23.

79 Transcript, Timothy Deverell, Cairns Hearing, 16 July 2019 at T3612.28-3613.3.

80 Transcript, Maggie Beer, Cairns Hearing, 16 July 2019 at T3633.20-30.

when the facility adopts a holistic approach to food, uses food grown in its gardens and the kitchen is run by an educated passionate cook or chef.[81] Ms Beer said to be a cook or a chef in aged care is complex.[82]

The Maggie Beer Foundation provides immersive masterclasses, including sessions with dietitians and nutritionists, to cooks and chefs in aged care.[83] Ms Beer emphasised that food needs to be appetising and appealing for residents to want to eat.[84] Her evidence emphasised the centrality of food to a person's quality of life.

Quality of life

Quality of life is a central tenet of care. Experts across multiple clinical disciplines all referred to quality of life as an aspect of, perhaps the most important aspect of, care. Professor Westbrook considered that maintaining and improving quality of life is one of the most important outcomes that we should aspire to in aged care.[85] She identified how data can be collected using available instruments measuring aspects quality of life, opening the potential for analysis of the performance of aged care providers and identification of areas for improvement in aged care delivery relating to quality of life.[86] Professor Westbrook referred to the positive impact on the wellbeing of participants in a study using instruments of this kind due to the engagement and empowerment of aged recipients in the process.[87]

Ms Lisa Backhouse expressed it this way:

> Growing old should be a dignified experience where self-respect can be maintained. The next generation must have confidence that their basic physical, psychological and human needs will be met and hopefully exceeded when they are at their most vulnerable.
>
> The current situation is heartbreaking at best, criminal at worst. When we look back in years to come, much like the orphanages of yesteryear, this will be our country's greatest shame.[88]

Ms Sally Hopkins, Executive Director of Eden in Oz & NZ, described the 'Eden Alternative', calling for a paradigm shift in the culture of aged care so that there is a move away from the institutional model of aged care to one that is directed by the person.[89]

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81 Transcript, Maggie Beer, Cairns Hearing, 16 July 2019 at T3633.20-3634.10.

82 Transcript, Maggie Beer, Cairns Hearing, 16 July 2019 at T3634.46-47.

83 Transcript, Maggie Beer, Cairns Hearing, 16 July 2019 at T3634.30-41.

84 Transcript, Maggie Beer, Cairns Hearing, 16 July 2019 at T3637.35-3638.2.

85 Transcript, Johanna Westbrook, Darwin Hearing, 11 July 2019 at T3260.36-48; Exhibit 6-22, Darwin and Cairns Hearing, Statement of Johanna Westbrook, 3 June 2019, WIT.0196.0001.0001 at 0018-0023 [65]-[78].

86 Professor Westbrook referred in particular in this regard to the work of Professor Julie Ratcliffe of Flinders University in relation to quality of life measurement in the context of health economics: Exhibit 6-23, Darwin and Cairns Hearing, Supplementary statement of Johanna Westbrook, 11 July 2019, WIT.0196.0002.0001.

87 Transcript, Johanna Westbrook, Darwin Hearing, 11 July 2019 at T3261.25-3262.20.

88 Transcript, Lisa Backhouse, Darwin Hearing, 11 July 2019 at T3205.37-44.

89 Transcript, Sally Hopkins, Darwin Hearing, 11 July 2019 at T3307.16-3310.24.

Ms Natasha Chadwick, Chief Executive Office and founder of NewDirection Bellmere, spoke about the relationship-based focus at Bellmere. She explained that at NewDirection, people do not 'live in a facility, they live in a community'.[90] Ms Chadwick stated that improving quality of life 'is at the heart' of what they seek to achieve at Bellmere.[91]

Ms Lisa Jones is a House Companion leader at Bellmere. She had decided to leave her previous role in aged care because the environment had started to affect her negatively. When she saw a position advertised at Bellmere, the values described by Bellmere, including community, respect, individuality and relationships, aligned with hers and so she thought she 'would give [aged care] one last chance'.[92]

Ms Elsie Scott, a resident at Bellmere, said she looked at a number of aged care facilities before settling on Bellmere, which she described as 'light years ahead'. She was 'looking for something that was one-on-one and really caring…personal'.[93]

While clinical experts agreed that quality of life is important to quality of care, we heard evidence about the tensions that exist in practice. For example, there is a perception that the provision of acute care in a residential setting might detract from an appropriately homelike environment. However, Ms Angela Raguz, a registered nurse and General Manager of residential care at HammondCare, said 'that doesn't mean that good clinical care cannot be delivered in a domestic and familiar environment'.[94]

As noted, Associate Professor Gonski described his flying squad providing acute care in residential aged care settings. He described residential aged care facilities as reluctant at first but said that ultimately they embraced the delivery of more clinically complex services in residential aged care with the support of a hospital-based team.[95]

HammondCare benefits from flying squads.[96] Ms Raguz agreed with Associate Professor Gonski's description of the educational and training benefits provided by the flying squads.[97] She explained the benefits of providing expertise to 'frontline care staff who are empowered'.[98]

90 Transcript, Natasha Chadwick, Cairns Hearing, 17 July 2019 at T3751.1-7.

91 Exhibit 6-53, Darwin and Cairns Hearing, Statement of Natasha Chadwick, 17 June 2019, WIT.0172.0001.0001 at 0002 [16].

92 Transcript, Lisa Jones, Cairns Hearing, 17 July 2019 at T3736.6-3737.28.

93 Transcript, Elsie Scott, Cairns Hearing, 17 July 2019 at T3734.45-3746.10.

94 Transcript, Angela Raguz, Cairns Hearing, 17 July 2019 at T3803.15-35.

95 Transcript, Peter Gonski, Darwin Hearing, 11 July 2019 at T3219.1-21.

96 Transcript, Angela Raguz, Cairns Hearing, 17 July 2019 at T3796.7-10.

97 Transcript, Angela Raguz, Cairns Hearing, 17 July 2019 at T3804.4-14.

98 Transcript, Angela Raguz, Cairns Hearing, 17 July 2019 at T3804.23-27.

Ms Raguz described the value of configuring services in small clusters in order to strengthen relationships and enhance familiarity:

> I believe that relationship-focused care delivers good clinical care and good clinical results. I believe that knowing and understanding that person and then being able to tailor that care to meet those needs…comes from relationship as much as it comes from having clinical expertise. And it's bringing all of those ingredients, if you like, together and doing that effectively with a model that has…evidence behind it to say it works and it improves quality of life. It's really important to have all of those ingredients in place so you can provide good clinical care in a home for people.
>
> …
>
> People would prefer to stay in their own home surrounded by people that they love and who they trust. If we aren't able to provide that care for people in their own home any longer, how do you extrapolate that model to provide it within a residential aged care setting? And that is through the domestic and familiar model.[99]

However, Dr Jennifer Abbey, a registered nurse and clinical consultant, disagreed with this view. She said a homelike environment 'was totally unsuitable for at least 50 per cent of residents'. Dr Abbey suggested that as people's care needs increase, 'the whole thing falls apart'.[100] Dr Drew Dwyer, a nursing gerontologist, agreed with Dr Abbey's comments, noting that people are 'going to reach an end stage at some point'.[101] This evidence calls for a better understanding of the expectations of aged care and the limitations of clinical care in an aged care environment, which includes elements of hospital, hotel and home.

Dr Drew Dwyer, Dr Jennifer Abbey and Ms Sandy Green, a nurse practitioner, called for an increased emphasis on clinical training and skills, clinical governance, and recognition of the role of the registered nurse and nurse practitioner. Ms Green described some of the challenges she has faced in helping people—not only families, but also doctors and other health professions—understand the role of the nurse practitioner.[102]

Conclusion

It is clear from the evidence at this hearing that quality care has multiple dimensions, including: safety; clinical and personal care; and quality of life, including cultural, socio-economic and geographical factors.

Further, from the frequency and gravity of accounts of substandard care, the relevant failures appear to be systemic and to arise from aspects of the framework for the provision of aged care in Australia. This is despite the undoubted commitment and care offered by the overwhelming majority of those working in the sector.

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99 Transcript, Angela Raguz, Cairns Hearing, 17 July 2019 at T3803.34-3809.2.

100 Transcript, Jennifer Abbey, Cairns Hearing, 17 July 2019 at T3805.20-21; T3806.18-23.

101 Transcript, Drew Dwyer, Cairns Hearing, 17 July 2019 at T3806.25.

102 Transcript, Sandy Green, Cairns Hearing, 17 July 2019 at T3794.17-3795.24.

Aged care providers in rural and regional locations face particular challenges in providing quality care, including access to skilled workers and specialist care. These issues are further complicated by cultural factors, poverty, and lack of access to services.

Case studies

IRT William Beach Gardens case study

Introduction

The Royal Commission examined the experience of Ms Shirley Doris Fowler (Ms Fowler) as a resident at IRT William Beach Gardens (IRT WBG). IRT WBG is an aged care facility located in Kanahooka, New South Wales. This facility is, and was during the relevant period, operated by Illawarra Retirement Trust, an approved provider of residential aged care under the *Aged Care Act 1997* (Cth). As at 30 June 2018, there were 152 residents.[103]

The evidence before the Royal Commission consisted of:

- the statement of Lyndall Helen Fowler (Lyndall), Ms Fowler's daughter, dated 20 June 2019[104]
- the statement of Kristy Taylor, Care Manager at IRT WBG, dated 28 June 2019[105]
- the statement of Sophoronia Briguglio, Business Manager for IRT Group's Illawarra aged care centres, dated 28 June 2019[106]
- the oral testimony of those three witnesses
- the tender bundle for this case study, which consists of 1156 documents[107]
- the statements of Dr Robert Keith Bird of Dapto Healthcare Pty Ltd, Ms Fowler's usual general practitioner.[108]

IRT WBG and Dr Bird were both granted leave to appear and were legally represented at the hearing.

103 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1151, SUB.0001.0069.1455 at 1458.

104 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001.

105 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001.

106 Exhibit 6-12, Darwin and Cairns Hearing, Statement of Sophoronia Briguglio, 28 June 2019, WIT.0259.0002.0001.

107 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle.

108 Exhibit 6-14, Darwin and Cairns Hearing, Statement of Dr Robert Keith Bird, 27 June 2019, WIT.0271.0001.0001; Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001.

Senior Counsel Assisting submitted that there is no suggestion of deliberate wrong doing by IRT WBG.[109] However, Senior Counsel Assisting submitted that IRT WBG was insufficiently proactive in managing the following issues experienced by Ms Fowler during her time with IRT WBG:

- the development of contractures
- the development of pressure sores
- haematoma
- weight loss, diet and nutrition management
- quality of life.

While IRT WBG does not seek to suggest that the care provided to Ms Fowler was always perfect or could not be improved, IRT WBG submitted that, overwhelmingly, Ms Fowler's care was of an appropriate quality and standard.[110]

IRT WBG submitted that, since the events discussed in this case study, it has implemented new training and procedures relevant to concerns raised by Senior Counsel Assisting. IRT WGB say that some of these improvements were implemented prior to the announcement of the Royal Commission, and others were implemented throughout IRT WBG's participation in the Royal Commission.[111]

Background

Ms Fowler was born in 1927. At the time of this case study, she was 92 years old. Ms Fowler began demonstrating memory problems around 2005. At this time, she was living independently in the Adelaide Hills. Her memory gradually deteriorated over several years, leading to social isolation, difficulty with self-care and the inability to manage her household finances.[112]

Ms Fowler's condition declined markedly following two falls in 2008 and 2010, causing a right broken hip and fractured neck of her left femur.[113]

After an Aged Care Assessment Team assessment in 2010, Ms Fowler was admitted to an aged care facility in the Adelaide Hills where she resided from December 2010 to July 2013.[114]

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109 Transcript, Darwin and Cairns Hearing, 9 July 2019 at T2927.32-33; Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001.

110 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0001 [4].

111 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0001 [5].

112 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [12].

113 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [13]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2938.11-38.

114 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [14]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2939.18-22.

In June 2013, Lyndall moved from South Australia to Wollongong in New South Wales. As Ms Fowler's power of attorney,[115] Lyndall and her siblings decided that Ms Fowler would move to live in residential care near Lyndall.[116]

Lyndall was trained as a registered nurse at the Royal Adelaide Hospital in the early 1970s. She has a certificate of nursing, a Diploma of Applied Science in Community Nursing, awarded in 1978, and a Graduate Diploma in Education, awarded in 1988. Lyndall retired when her mother required more dedicated care and support in residential care.[117]

Admission to IRT WBG

Ms Fowler was first admitted to IRT WBG in July 2013 and continued to live there at the time of the case study.[118] When she was first admitted to IRT WBG, she had progressed Alzheimer's disease and was placed in a secure ward at IRT WBG known as Flinders West.[119]

At the time of admission, Lyndall filled out several admission forms and discussed details of Ms Fowler's medical conditions and personal preferences with IRT WBG's staff. Lyndall was the primary contact for Ms Fowler. Lyndall told staff that she wanted to be informed about all aspects of her mother's care.[120] At this time, Ms Fowler had some difficulty communicating (although was able to do so), was relatively mobile and was able to feed herself.[121]

At the time of writing, Ms Fowler has end stage dementia. She is nonverbal, unable to respond to questions or directions, immobile and unable to feed or toilet herself.[122] Her Alzheimer's has progressed to the point that she cannot move any part of her own body except her eyes.[123] IRT WBG submitted this 'progression of Mrs Fowler's Alzheimer's disease is directly relevant to the care she has received while a resident at IRT WBG and some of the complications which have arisen in providing care to Ms Fowler'.[124]

115 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [17]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2939.28-29.

116 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [15]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2939.43-2940.02.

117 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2936.25-28; Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0001-0002 [5]-[8].

118 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0003 [20].

119 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [16]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2940.20-26.

120 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [17].

121 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0003 [20].

122 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0002 [11].

123 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2937.01-04.

124 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0002 [6].

Care Information Procedures at IRT WBG

In response to notices from the Royal Commission, IRT WBG provided documents relevant to Ms Fowler's care at IRT WBG, including a vast number of clinical care documents that were extracted from the Leecare Platinum clinical IT system (Platinum).[125]

IRT WBG has used Platinum since 2015.[126] Platinum is a clinical record and management software product with a range of capabilities, including the ability to keep records relevant to care needs and to monitor matters such as resident details, daily records, assessments, care plans, care valuations, and weights and vital sign observations.[127]

Upon admission, a resident is assessed by a register nurse and/or a Care Manager. A care plan is prepared for that resident. Ms Taylor describes a care plan as a 'living' document which is updated on an as needs basis to reflect changing care needs and preferences:[128]

> They are used to direct and guide the care provided to each individual. Each time an RN completes an assessment for a resident in relation to a particular area of care, the Platinum system will update the care plan so that the document reflects the most current care needs and directions for care of the resident.[129]

Upon commencement of a shift, care staff go through a verbal handover where an update is provided along with a printout of each resident's 'vital information', also known as a 'handover sheet'. This update contains the information that appears on a resident's front page of their Platinum profile.[130] Care staff can access the fuller suite of information held on Platinum (in relation to a particular resident) on a desktop computer.[131]

IRT WBG explained that the Platinum system is a 'live' care management system which has the primary focus of enabling care providers to quickly and efficiently understand a resident's most up to date information.[132] IRT WBG compared the Platinum system to an online news website, where 'the front page will be regularly updated with the latest alerts'.[133]

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125 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, 9 July 2019.

126 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2976.26.

127 Exhibit 6-12, Darwin and Cairns Hearing, Statement of Sophoronia Briguglio, 28 June 2019, WIT.0259.0002.0001 at 0014-0017 [81]-[87].

128 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0004-0005 [28].

129 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0005 [29].

130 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2977.1-10.

131 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2977.8-9; For a further explanation regarding the IRT WBG procedures and processes with respect to recording and exchange of relevant care information see Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0004-0008 [25]-[45]; Exhibit 6-12, Darwin and Cairns Hearing, Statement of Sophoronia Briguglio, 28 June 2019, WIT.0259.0002.0001 at 0014-0017 [81]-[88]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1155, RCD.9999.0104.0001.

132 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1155, RCD.9999.0104.0001 at 0001.

133 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1155, RCD.9999.0104.0001 at 0002.

In practice, a staff member will usually write a list of care tasks and observations they have made throughout their day on a piece of paper, and then towards the end of their shift will document what they have done at the computer.[134]

IRT WBG submitted that 'the system does not appear to care providers in the same way as records that were extracted and presented to the [Royal] Commission. Counsel Assisting's reliance on printed, historical records has resulted in some incorrect conclusions being reached'.[135]

On this point, Solicitors Assisting wrote to IRT WBG's legal representation on 4 July 2019, in advance of the hearing, asking:

> Further to the response already provided to item 8 of NTG-0259, please describe how the care records entered into IRT WBG's Leecare Solutions care delivery management software are displayed to staff providing care to residents, including to external contractors or visiting GPs.
>
> If the manner in which the care records are displayed is different to how the records have been produced to the Royal Commission, please explain how the records are differently displayed.[136]

In a response provided on 5 July 2019, IRT WBG produced a number of screenshots of the Platinum system as it appears to care staff and external providers.[137] IRT WBG offered Counsel Assisting the opportunity to view a live demonstration of the system.[138]

While we consider that Counsel Assisting's reliance on printed records may have resulted in some initial confusion leading up to the hearing, Counsel Assisting and IRT WBG have taken all reasonable steps to ensure that the Platinum system was understood in practice. We have no concerns that this has any material impact on the findings set out below.

134 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2977.46–2978.03.

135 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0003 [15].

136 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1155, RCD.9999.0104.0001 at 0001.

137 Home Page, IRT.0001.0075.0002; Resident Home Page, IRT.0001.0075.0011; Progress Notes, IRT.0001.0075.0010; Live Care Plan, IRT.0001.0075.0015; Wound Care Plan, IRT.0001.0075.0011; Nutritional Assessment Update View, IRT.0001.0075.0003; Nutritional Assessment View, IRT.0001.0075.0006 and IRT.0001.0075.0007; Doctor & Health Specialist Visit Record – Live View, IRT.0001.0075.0001.

138 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1155, RCD.9999.0104.0001 at 0001.

Access to external health consultants

In her statement, Ms Briguglio identified a number of policies and general processes relevant to IRT WBG residents' access to allied health professionals.[139]

These policies include an IRT document entitled 'Other Health and Related Services Policy'.[140] Relevantly, that policy provides:

> IRT respects the rights of residents and clients to be consulted and referred to other appropriate external health specialists and services including complimentary [*sic*] therapies of their choice, that are not provided by IRT, in accordance with their needs and preferences.
>
> All preference regarding external health services and alternative treatment or therapies including complementary therapies will be assessed, documented and evaluated in consultation with the resident/client and medical practitioner where appropriate.
>
> Management and staff will consult with and provide appropriate information to each resident/client and/or their representative in consultation with the residents'/clients' medical practitioner. Residents/clients and/or their representatives will be informed if they are responsible to meet the cost associated with the external service.[141]

Ms Taylor identified that this policy applied at the relevant time in this case study (mid-2016 onward). Ms Taylor's evidence was that it is the responsibility of the registered nurses at IRT WBG to identify whether it is appropriate to obtain other health and related services for residents.[142]

Ms Briguglio stated that 'IRT WBG seeks to facilitate access to allied health professionals for all residents as and when clinically indicated, and at the request of residents or their representatives'.[143] In her oral evidence, Ms Briguglio explained that if a resident is assessed as requiring physiotherapy that IRT WBG is not claiming an Aged Care Funding Instrument (ACFI) payment for, there are no budget constraints on the approval of that expense and IRT WBG would bear the cost.[144] Ms Briguglio's evidence was that outside annual physiotherapy reviews and regular 3-month reviews addressing the safety of transfers of residents with mobility issues, assessments by physiotherapists would only occur on a referral from the clinical management of IRT WBG.[145]

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139 Exhibit 6-12, Darwin and Cairns Hearing, Statement of Sophoronia Briguglio, 28 June 2019, WIT.0259.0002.0001 at 0005-0007 [27]-[39].

140 Exhibit 6-12, Darwin and Cairns Hearing, Statement of Sophoronia Briguglio, 28 June 2019, WIT.0259.0002.0001 at 0005 [27].

141 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 908, IRT.0001.0066.0004 at 0005.

142 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2973.3-24.

143 Exhibit 6-12, Darwin and Cairns Hearing, Statement of Sophoronia Briguglio, 28 June 2019, WIT.0259.0002.0001 at 0005 [28].

144 Transcript, Sophoronia Briguglio, Darwin Hearing, 9 July 2019 at T3026.19-3027.47.

145 Transcript, Sophoronia Briguglio, Darwin Hearing, 9 July 2019 at T3024.12-3025.17.

Palliative care

On 13 May 2016, Lyndall met with Dr Bird to have a discussion about the future care for Ms Fowler. In his supplementary statement, Dr Bird outlined that, as a result of that discussion, Lyndall decided that 'Ms Fowler should receive no more active treatment, no matter the issues that arose, and that she should commence palliative care' [emphasis added].[146]

The contemporaneous progress notes produced by Dapto Healthcare Pty Ltd and annexed to the statement of Dr Bird,[147] record that on 13 May 2016 Dr Bird had a long discussion with Lyndall regarding Ms Fowler. The notes state: 'agreement no aggressive treatmwent [sic] and no further investigations re her blood film' [emphasis added].[148]

There might be a material difference between 'no more active treatment' and 'no aggressive treatment' in this context. In noting this potential difference, in no way are we suggesting that Dr Bird has deliberately mischaracterised the decision or agreement reached; merely that the written record of what was agreed uses different language from what he recalls, and their respective meanings are open to different interpretations.

Dr Bird says that 'once a decision of this kind has been made, every time a patient shows signs of illness, a decision has to be made whether or not to put the patient through the discomfort of investigations, when it has already been decided to not treat the possible illnesses identified in the investigations'.[149] In light of the written record that the agreement was for no 'aggressive' treatment, the words 'it has already been decided to not treat the possible illnesses' may be too broad. However, it is unnecessary to reach a conclusion on this point.

Advance Care Directive

On 7 December 2016, Lyndall signed an 'Advance Care Directive' as Ms Fowler's enduring power of attorney. Dr Bird also signed this document. In this document, Lyndall agreed to the following:

- if Ms Fowler had a cardiac arrest, Lyndall wanted 'no cardio pulmonary resuscitation'
- if Ms Fowler needed treatment, Lyndall wanted 'palliative level' of care 'and antibiotics'

146 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0005-0006; Darwin and Cairns Hearing, Written Submissions of Counsel Assisting the Royal Commission into Aged Care Quality and Safety, 24 July 2019, RCD.0012.0015.0001 at 0028 [103].

147 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0006.

148 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1153, DHC.0002.0001.0169 at 0169_014.

149 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0005 [8(c)]; Darwin and Cairns Hearing, Written Submissions of Dr Bird in reply, 31 July 2019, RCD.0012.0016.0001 at 0002 [5].

- if Ms Fowler needed to be fed, Lyndall wanted 'oral only'
- 'Not for hospital transfer without family consultation.'[150]

'Palliative level of care' is defined within this Advance Care Directive as aiming 'to keep you free from pain and discomfort as much as is possible. Any treatments or investigations will only be for pain relief and to ease your discomfort'.[151]

Referral to Palliative Care in 2017

On 13 April 2017, a registered nurse from IRT WBG informed Lyndall about a 'link' with the palliative care team, and discussed getting a referral from Dr Bird the following week.[152]

The notes of a review by a general practitioner from Dapto Healthcare on 26 April 2017, record 'general deterioration—nil specific symptoms that currently require pall care'.[153]

On 26 May 2017, 'in consultation with Lyndall and Ms Fowler's GP, it was decided a palliative care approach would be taken, such that there was a referral to the community palliative care team'.[154] IRT WGB submitted that at this point Ms Fowler was 'placed under a specific end stage palliative care directive', citing in support a letter from Dr Bird's practice Dapto Healthcare to a community palliative health service dated 26 May 2017 and certain other documents. [155] However, neither the letter (which is a referral but notes that Ms Fowler remains under the care of her general practitioner) nor any of the other cited documents are properly to be described as 'end stage palliative care directives'.[156] Ms Taylor's oral evidence on this topic, which we will address below, was not consistent with IRT's submission. The evidence on precisely what was agreed in mid-2017 as constituting the relevant palliative approach for Ms Fowler was imprecise and uncertain, and we consider this likely reflects the state of communications at the time. This is very concerning. We are unable to accept IRT's submission that Ms Fowler was placed under a specific end stage palliative care directive in or about May 2017.

150 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 166, IRT.0001.0002.2591 at 2594.

151 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 166, IRT.0001.0002.2591 at 2592.

152 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 759, IRT.0001.0002.9576 at 9641.

153 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 759, IRT.0001.0002.9576 at 9632.

154 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0003 [22]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1134, DHC.0002.0001.0183.

155 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1138, DHC.0002.0001.0183.

156 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0002-0003 [10], 0016 [60]; tab 1013, IRT.0001.0069.0541; tab 1017, IRT.0001.0069.0563; tab 68, IRT.0001.0002.0692; tab 62, IRT.0001.0002.0650; tab 1138, DHC.0002.0001.0183.

Lyndall approved a palliative approach, but says that the information and education provided around this important topic was inadequate:

> I am aware that there are guidelines regarding palliative care in residential facilities and am concerned that these guidelines are not understood or implemented. I have asked repeatedly whether these guidelines are in use at William Beach Gardens but have never been given an answer.[157]

Lyndall gave evidence that she understood palliative care to mean that the 'approach to her care should be about trying to give her some quality of life and—and really spending time'. Lyndall stated that 'a row of patients lined up in front of a television set doesn't seem like patient-centred care to me'.[158] We accept Lyndall's evidence of her understanding at the time and the lack of adequate information provision to her on this topic.

Palliative Care Policy at IRT WBG

The Palliative Care Policy at IRT WBG states that 'palliative care is care provided for all people of all ages who have a life limiting illness, with no prospect of a cure and for whom the primary treatment goal is comfort and quality of life'.[159]

This policy defines three graduating tiers of palliative care:

i. A palliative approach: the primary goal of a palliative approach is to improve the resident's/client's level of comfort and function, and to address their psychological, spiritual and social needs.

ii. Specialised palliative service provision: this form of palliative care involves referral to a specialised palliative team or health care practitioner … however this does not replace a palliative approach but rather augments it with focused, intermittent, specific input as required.

iii. Terminal care: this form of palliative care is appropriate when the resident is in the final days or weeks of life and care decisions may need to be reviewed more frequently. Goals are more sharply focused on the resident's physical, emotional and spiritual comfort, and support for the family.[160]

Ms Taylor confirmed that this was the policy that applied in the relevant time period, from mid-2016 to the time she gave evidence.[161]

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157 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0011 [103].

158 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2958.29–2959.04.

159 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 773, IRT.0001.0003.0952 at 0955; Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2973.40-2974.10.

160 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 773, IRT.0001.0003.0952 at 0955.

161 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2973.40–2974.10.

Ms Taylor also agreed that in the period around May 2017, when palliative care was being discussed and agreed upon for Ms Fowler, it was the first form of palliative care, the lowest tier ('a palliative approach') that was decided upon.[162]

IRT WBG said that the aim of palliative care is to 'enhance quality of life, rather than to seek to treat or cure'. IRT WBG submitted that their care of Ms Fowler during her palliative stages should be viewed in this context.'[163] So much may be accepted, but we are left with concerns that there may have been different expectations about Ms Fowler's day to day care between Lyndall, IRT WBG and Dr Bird as a result of imprecision and uncertainty as to what had been agreed.

Contractures

During 2016, Ms Fowler began demonstrating signs of decline in her overall health, including a series of 'non-responsive' episodes when she could not be woken, had several episodes of reduced levels of consciousness,[164] and showed signs of heightened falls risk.[165] From January to October 2016, Ms Fowler suffered a series of falls.[166] Despite these falls, as at 24 August 2016 she was able to independently move around the facility with the supervision of staff.[167]

On 15 October 2016, Ms Fowler had a further fall. She was transferred to hospital the following day after Lyndall reported to IRT WBG staff that Ms Fowler was 'not her normal' self.[168] Ms Fowler was recorded as being in pain when standing on her feet and she was having difficulty bearing weight.[169]

162 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2974.23–2974.27.

163 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0003 [12].

164 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2946.18-22.

165 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0003 [21]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 926, IRT.0001.0068.0070 at 0073, 0076, 0082; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2946.11-34.

166 Falls recorded on 25 January 2016, 22 June 2016, 7 July 2016, 14 July 2016, 17 July 2016, 19 August 2016, 15 September 2016, 5 October 2016 and 10 October 2016 (Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0003 [22]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 168, IRT.0001.0002.2714_E; tab 1076, DHC.0002.0001.0003; tab 929, IRT.0001.0068.0141; tab 930, IRT.0001.0068.0143; tab 931, IRT.0001.0068.0145; tab 763, IRT.0001.0003.0289 at 0393; tab 932, IRT.0001.0068.0147; tab 933, IRT.0001.0068.0149; tab 934, IRT.0001.0068.0151).

167 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0388.

168 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0344; Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0003 [23].

169 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0343.

On 17 October 2016, Ms Fowler was discharged back to IRT WBG.[170] Lyndall described that after this episode, 'my mother deteriorated significantly. She would draw her legs up when she was lying down as if she was in pain. Her mobility decreased, she had a strange gait, could not walk properly, and she had difficulty using cutlery'.[171]

From this time, Ms Fowler was placed in a mobile chair where she was seated most of the day and was otherwise bedridden.[172] Ms Fowler began crossing her legs against each other when she was in a sitting position,[173] and when in bed she would curl into the foetal position.[174]

Hospital discharge summary

When Ms Fowler was discharged from hospital to IRT WBG on 17 October 2016, the hospital discharge summary recorded a discharge plan suggesting that Ms Fowler be reviewed by a physiotherapist for strength and mobility optimisation.[175] A record of a physiotherapy assessment on the next day, 18 October 2016, notes (amongst other things) that while Ms Fowler was able to move from sitting to standing with full assistance of the physiotherapist, she was not able to continue to stand without assistance.[176]

Counsel Assisting proposed a finding that Ms Fowler should have been clinically assessed as requiring a referral to a physiotherapist for a review concerned with Ms Fowler's reablement, including putting stretches or other passive exercises in place, and that IRT WBG failed to do so and failed to ensure that the physiotherapy assessments conducted in October and December 2016 addressed this need.

Specific assessments were conducted in relation to Ms Fowler's range of movement and limb strength.[177] On the basis of these records, IRT WBG submitted that it is 'clear that Ms Fowler was, in fact, reviewed by her physiotherapist for the purposes of strength and mobility'.[178] The assessment included measuring strength and mobility. However, this is not the same as a review for strength and mobility *optimisation*, which was the recommendation made in the hospital discharge plan. To review for strength and mobility *optimisation* means to review for potential interventions to improve or maintain strength and mobility to the extent possible, not merely assessing strength and mobility. IRT WBG

170 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 214, IRT.0001.0002.3118.

171 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0003 [24].

172 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 0004 [28], 0006 [55]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0340-0342; tab 1118, DCH.0002.0001.0129 at 0130.

173 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0333-0334.

174 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0021 [97].

175 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1118, DHC.0002.0001.0129.

176 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 923, IRT.0001.0068.0026.

177 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 923, IRT.0001.0068.0026 at 0028.

178 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0006 [26].

also submitted that the physiotherapist discussed 'treatment' with Lyndall, citing an entry in the progress notes on 18 October 2016, but there is no suggestion in that entry of discussion of any treatment. [179]

Senior Counsel Assisting submitted that Ms Taylor accepted that the referral to the physiotherapist should have included a recommendation to review for strength and mobility optimisation, and the assessment did not include any recommendations for strength and mobility optimisation such as exercises. Rather, the assessment was concerned with the status of Ms Fowler's mobility and the safety of transfers.[180] This meant that, in spite of the recommendation in the hospital discharge summary about strength and mobility optimisation for Ms Fowler, the documentation available to care staff did not flag the need for exercises, a point that Ms Taylor accepted was unsatisfactory.[181]

IRT WBG criticised Senior Counsel Assisting's questioning of Ms Taylor on this point, submitting that his questions were qualified by the words 'apart from a limb strength test'. IRT WBG suggested that this qualification left aside a key element of the assessment and 'demonstrates a lack of understanding of the assessment provided. It further caused confusion and uncertainty in Ms Taylor's response on physiotherapy assessments given the obvious contradiction in the question'.[182] This exchange between Senior Counsel Assisting, Mr Peter Gray QC, and Ms Taylor went as follows:

> MR GRAY: And the discharge report specifically referred to involvement for strength and mobility optimisation. So shouldn't it have been the purpose of the referral to obtain from the physio thorough examination of how to improve Shirley's strength and mobility, particularly in her legs? Would you agree with that?
>
> MS TAYLOR: Yes.
>
> MR GRAY: Now, the physiotherapy assessment was performed and we have a record of it at tab 923. And in the physiotherapy assessment there doesn't appear to be – have you seen this document recently in preparation for your evidence?
>
> MS TAYLOR: I believe I would have read it, but I've read a lot of documents.
>
> MR GRAY: Yes. It's 18 October 2016. I've been through it a couple of times. I don't see any recommendations for exercises, whether self-initiated, assisted, passive, from whatever to – choose whatever description you want, I don't see that in this document. Would you like the operator to flick through it and for you to identify anything that might allude to exercises?
>
> MS TAYLOR: Yes, if you don't mind.

179 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0006 [25]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0337.

180 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019, T3001.29-3002.16.

181 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019, T3002.37-3003.05.

182 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0006 [27].

MR GRAY: Yes. Operator, could you please just follow Ms Taylor's instructions? It's nothing on that page, is there?

MS TAYLOR: No.

MR GRAY: What about the next page? There's a lot of detail on exactly the topic you drew to the Commissioner's attention. That is, safety of transfers?

MS TAYLOR: Yes.

MR GRAY: But that seems to be the focus – apart from a limb strength test, there isn't actually anything about optimising mobility and strength. Do you agree with that?

MS TAYLOR: Yes. I agree with that.[183]

We accept that in the final exchange extracted above, Ms Taylor responded to a question which put to one side the limb strength test. We therefore need to consider and if possible form our own view as to whether the limb strength test section of the physiotherapy assessment could reasonably be described as being about optimising mobility and strength. That part of the physiotherapy assessment stated:

LIMB STRENGTH

Muscle Strength Grading	3. Full ROM against gravity
Left Arm:	
Satisfactory Strength for function/care needs?	Yes
Right Arm:	
Satisfactory Strength for function/care needs?	Yes
Left Leg:	
Satisfactory Strength for function/care needs?	Yes
Right Leg:	
Satisfactory Strength for function/care needs?	Yes[184]

Clearly, and on its face, this part of the assessment was an assessment of existing strength and included nothing that could be described as a review for *optimising* strength or mobility, through exercises or any other intervention.

IRT WBG submitted that in conducting functional assessments, physiotherapists must consider matters which are relevant to strength / mobility. It is a physiotherapist's role to recommend 'treatment plans to assist with mobility (and address risk related to immobility) following these assessments. Where appropriate, such treatments may

183 Transcript, Kristy Taylor, Darwin Hearing, 9 May 2019, T3001.29-3002.17.

184 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 923, IRT.0001.0068.0026 at 0028.

include exercises'.[185] IRT WBG said that they reasonably expect 'that treating healthcare practitioners who review residents in relation to a lack of mobility, would consider the risk of contractures and, where applicable, recommend appropriate treatments'.[186]

We find that IRT WBG failed to ensure that the physiotherapy assessments addressed Ms Fowler's need for review for mobility and strength optimisation. For example, IRT WGB should have ensured that the physiotherapist assess whether regular exercises could be put in place for Ms Fowler. The effect of IRT WBG's submissions unduly seeks to impose an exclusive responsibility in this regard on the physiotherapist, rather than accepting responsibility for ensuring implementation of the recommendations in the hospital discharge report. We do not accept IRT WBG's submissions in this regard.

Detection of contractures

General practitioner notes from a review of Ms Fowler on 19 October 2016 indicate that Ms Fowler had a significant deterioration in mental and physical capacity, and was refusing to stand.[187]

Ms Taylor gave evidence that in addition to an annual 'full comprehensive' assessment by a physiotherapist, IRT WBG had a standard quarterly physiotherapy assessment for all residents, including Ms Fowler. However, Ms Taylor stated that during these 3-monthly assessments, the physiotherapist was 'just reviewing the mobility status of the resident to make sure that we are mobilising that resident safely' and that matters such as reablement, prevention of contractures, and exercises would be assessed on a referral basis.[188]

Ms Fowler was again reviewed by a treating physiotherapist for a Functional Assessment on 24 October 2016,[189] 25 October 2016,[190] 29 October 2016,[191] 9 November 2016,[192] 10 November 2016[193] and 30 November 2016.[194] Each of these reviews notes that Ms Fowler is not able to mobilise independently.[195] IRT WGB submitted that these reviews were conducted on a referral basis and were not part of IRT WBG's standard quarterly assessment reviews.[196]

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185 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0007 [29].

186 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0007 [30].

187 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0335.

188 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2986.1-45.

189 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 138, IRT.0001.0002.2216.

190 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 139, IRT.0001.0002.2219.

191 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 140, IRT.0001.0002.2222.

192 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 924, IRT.0001.0068.0038.

193 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 134, IRT.0001.0002.2198.

194 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 143, IRT.0001.0002.2234.

195 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0006-0007 [28].

196 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0006-0007 [28].

On 3 November 2016, a Skin Assessment was completed by a registered nurse of IRT WBG. Amongst other things, the Assessment directs staff to reposition Ms Fowler every two hours, requires the daily application of emollients and notes the use of an airbed.[197]

By 17 November 2016, as Ms Fowler was then immobile, she was moved to a different unit within IRT WBG known as the Nebo Cottage.[198] Around this time, she was provided with an air chair.[199]

Lyndall believes that around late 2016 and early 2017, Ms Fowler developed contractures in her legs.[200] However, IRT WBG submitted that 'there is no documented evidence of contractures having developed in Ms Fowler's legs until April 2017, including no documented discussion or concern raised by Lyndall'.[201]

Lyndall reported to IRT WGB on 10 April 2017 that Ms Fowler had developed contractures. At the same time, Lyndall complained of the slumped position Ms Fowler was left in her chair and queried whether there had been a physio review and exercises for Ms Fowler when left in her chair.[202]

Prevention and treatment of contractures falls under the IRT policies for general Clinical Care[203] and Mobility Dexterity and Rehabilitation.[204]

Ms Taylor's statement included evidence that contractures are uncommon and that Ms Fowler's contractures were unusually severe.[205] Ms Taylor's statement referred to the importance of prevention.[206] Ms Taylor's statement referred to various attempted

197 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0320, 0321; tab 204, IRT.0001.0002.3066; tab 1069, IRT.0001.0002.1883.

198 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0317; Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0004 [29].

199 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0317.

200 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0006 [55]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tenderbundle, tab 920, IRT.0001.0068.0001 at 0002; Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0021 [97].

201 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0010 [40].

202 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 759, IRT.0001.0002.9576 at 9643; tab 860, IRT.0001.0022.4604.

203 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0020 [89]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tenderbundle, tab 792, IRT.0001.0003.1954.

204 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0020 [89]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tenderbundle, tab 777, IRT.0001.0003.1002.

205 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0020 [90].

206 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0020 [91].

interventions which, on scrutiny of the documents cited, all occurred in or after late 2017.[207] Ms Taylor also commented that in spite of these interventions, the onset of Ms Fowler's contractures was rapid.[208] However, the evidence suggests that Ms Fowler's contractures had at least begun to develop well before this period. Ms Taylor's statement did not refer to any interventions before April 2017, which is when Lyndall identified that Ms Fowler had developed contractures and raised this with IRT WBG.

In her oral evidence, Ms Taylor accepted that the risk of contractures should be identified when it is observed that a resident is assuming a particular position and not changing from that position and/or continuing to return to that position. Ms Taylor's evidence was that care staff should observe whether a resident is returning to such a position and report this to the Team Leader or the on duty registered nurse to then seek physiotherapy review, and so this depends on the training of the direct care staff to be alert for the issue.[209] This is unsurprising: there was no registered nurse dedicated to any particular area within IRT WBG. Rather, a floating registered nurse was available across the facility at all times, with additional registered nurses available at various other times outside the night shift.[210]

In her oral evidence, Ms Taylor accepted that it was inappropriate that staff of IRT WBG had not identified that Ms Fowler had developed contractures, agreeing that not every resident has a qualified nurse as a regular visitor and advocate for a relative.[211]

Senior Counsel Assisting put to Ms Taylor that no physiotherapist assessment / plan had been conducted for Ms Fowler between 13 December 2016 and 3 August 2017.[212] Ms Taylor accepted that it was inappropriate that no physiotherapist assessment / plan had been conducted for Ms Fowler between 13 December 2016 and 3 August 2017. Her evidence in this regard was as follows:

> MR GRAY: Yes. So in respect of the period between December 2016 and August 2017, this was a period in which Ms Shirley Fowler had (a) she had already become immobile before that, but (b) during this period she was showing increasing signs of
>
> assuming a particular position - - -
>
> MS TAYLOR: Yes.
>
> MR GRAY: - - - whether in a chair or in bed. Do you agree with that?

207 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0020-0021 [93]-[96].

208 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0021 [97].

209 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2982.44-2983.19, T2984.01-15.

210 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2979.32–2980.31. For specific times of registered nurse rostering, see Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0011 [43]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1156, RCD.9999.0104.0009 at 0025.

211 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3012.15-3013.19

212 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3007.41-43.

MS TAYLOR: Yes, I agree with that.

MR GRAY: I suggest to you that that indicated the need for some sort of further physiotherapy assessment. As soon as that occurred direct care staff should have escalated that to an RN and an RN should have sought a physio referral. What do you say to that?

MS TAYLOR: Yes, I say that's correct.

MR GRAY: All right. So the fact that there was this gap of eight months or so was not appropriate care, in your view?

MS TAYLOR: No.

MR GRAY: No, it wasn't appropriate?

MS TAYLOR: No, it wasn't.[213]

We note that there were two 'functional assessments' conducted in March 2017, [214] and that each of them has a section titled 'Transfers' that states the requirements for assistance with particular kinds of transfers. Each one notes '[s]ee Physio assessment for specific functional ability details', but does not attach any further assessment. It is unclear whether any fresh assessment was conducted at these times, or whether this refers to a pre-existing physiotherapy assessment. They also include sections titled 'Mobility' and 'Movement in Bed', both of which also state requirements for assistance. There is no mention of anything relating to assessment for interventions to prevent deterioration in mobility.

Counsel Assisting submitted that IRT WBG failed to detect the development of the contractures. Had IRT WBG detected the contractures, they should have raised this with the physiotherapists.

IRT WBG submitted that Counsel Assisting's view that it is necessary for IRT WBG to specifically bring matters relevant to mobility (including contractures) to the physiotherapist's attention is a view that does not recognise the role, expertise and training of physiotherapists: 'As a registered healthcare professional, a physiotherapist would be expected to comment on such matters if they were present';[215] 'These registered healthcare practitioners are experts in risks associated with immobility and were in a position to identify the risk of contractures, identify developing contractures, and to recommend appropriate preventative measures and treatments.'[216] IRT WBG

213 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3008.6-31.

214 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 135, IRT.0001.0002.2202; tab 136, IRT.0001.0002.2209.

215 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0007 [31].

216 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0011 [45].

said that it is IRT WBG's standard practice to have 'quarterly assessment reviews' by physiotherapists, and IRT WBG also relies on the functional assessments which were performed.

IRT WBG's submissions tend to de-emphasise the importance of Ms Taylor's evidence, summarised above. As mentioned above, Ms Taylor accepted that the quarterly reviews were directed to issues concerning the safety of transfers. On their face, it appears that the functional assessments available for Ms Fowler, so far as they relate to mobility, were for a similar purpose. Ms Taylor also accepted that staff of IRT WBG should observe whether a resident is tending to assume a particular physical position and report this to the Team Leader or on duty registered nurse to then seek physiotherapy review. While we accept that it would reasonably be expected that a physiotherapist would detect the onset of contractures, the physiotherapist may not be as well placed as the staff of IRT WBG to identify warning signs of risk of contractures, such as a resident falling into a habit of assuming a particular position on a daily basis. Given that IRT WBG care staff are on the floor day in and day out, and consistently with Ms Taylor's evidence, we find that IRT WBG staff should be on the lookout for changes in mobility and that these changes should be documented in the records for potential referral to physiotherapists.

Ms Fowler gave evidence that 'the facility has not shown any initiative to acquire guidance on how to prevent or minimise my mother's contractures'.[217] We accept this evidence.

It is reasonable to expect that IRT WBG care staff should have noticed changes in Ms Fowler's physical posture when IRT WBG care staff were observing and attending to the personal care of Ms Fowler—for example, when changing an incontinence aid or when transferring Ms Fowler in a sling. We find that IRT WBG, in failing to detect the onset of Ms Fowler's contractures, failing to raise this with the physiotherapists and failing to document this in its records, failed to provide appropriate care to Ms Fowler. It is not sufficient to rely on the fact that physiotherapists saw Ms Fowler from time to time over the relevant period. In accordance with its policies, the onus was on IRT WBG to make a specific referral.

Ms Taylor was not aware whether direct care staff were specifically trained to follow these steps in late 2016 or in 2017, although training in this regard has occurred since that time, in 2018, and is ongoing.[218]

In light of Ms Taylor's roles at IRT WBG and her lack of awareness of any such training, we find it likely that there was no such specific training in 2016-2017.

217 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0007 [59].

218 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2984.12-43.

Passive exercises

In the event that concerns about immobility are referred to a physiotherapist, IRT WGB said that it would then be expected that the physiotherapist would review the resident to determine risks of contractures and seek to put in place treatment plans to reduce the risk of contractures developing, such as regular 'range of movement' exercises.[219]

Based on the records produced by IRT WBG, Ms Fowler was not referred to a physiotherapist for this purpose in the relevant period of late 2016 to April 2017. Ms Fowler was not referred to a physiotherapist until August 2017. As already noted, Ms Taylor accepted that there was a gap in the conduct of physiotherapy assessments between December 2016 and August 2017, and that this was not appropriate care of Ms Fowler.[220]

IRT WGB's witnesses accepted that a physiotherapy review concerned with Ms Fowler's reablement, including putting stretches or other passive exercises in place in an effort to limit the development of contractures, could only occur on a referral basis.[221] Physiotherapists would do this where there is a referral from the IRT WBG staff responsible for management of care.[222] Ms Taylor's evidence was that a physiotherapist would only assess a resident regarding contractures on a referral from staff of IRT WBG.[223] As there is no evidence of such referral, we find that there was no physiotherapist assessment conducted for that purpose.

While the Royal Commission did not hear any expert evidence about the effectiveness or otherwise of passive exercises in preventing contractures, Ms Taylor accepted that it is proper nursing practice to assist residents who have immobility issues to move their limbs—exercise their limbs—as a measure that might prevent contractures.[224]

From 15 October 2016 to late 2017, IRT WGB's records do not include any evidence of intervention such as assisted stretching exercises or range of motion exercises included in Ms Fowler's Care Plan. The lack of documentation identifying any such exercises is consistent with there having been no referral to a physiotherapist to address the risk of contractures in that period. Ms Taylor said there was a 'gap in the documentation keeping regarding that'.[225] Ms Taylor accepted that it was very important that Ms Fowler should have received exercises to prevent contractures, and she accepted that the documentation did not show any evidence of exercises being provided at any time before 10 April 2017,

219 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1156, RCD.9999.0104.0009 at 0027.

220 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3008.06-31.

221 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2986.25-35; Transcript, Sophoronia Briguglio, Darwin Hearing, 9 July 2019 at T3024.17-3025.31.

222 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2986.31-45; Transcript, Sophoronia Briguglio, Darwin Hearing, 9 July 2019 at T3024.17-3025.31.

223 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2986.31-40.

224 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2983.33-40.

225 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2982.11-16.

when Lyndall detected the contractures. Ms Taylor accepted that she was not giving any evidence to suggest that any exercises had been provided to Ms Fowler.[226]

Ms Fowler was again reviewed by a physiotherapist on a referral basis on 13 December 2016. On the basis of the evidence before the Royal Commission, it appears that the treating physiotherapist did not recommend that Ms Fowler be provided with any specific form of exercise regime at this time.[227]

Between the commencement of December 2016 and April 2017, IRT WBG submitted that treating physiotherapists assessed Ms Fowler on a further five occasions, relying on the two Functional Assessments conducted in March we have already mentioned.[228] She also received regular physiotherapist administered massages for pain management during this period.[229] As already mentioned, we do not consider there to be evidence of an assessment directed to mitigating the risks of further deterioration in Ms Fowler's mobility and in particular the risks of developing contractures in this period.

In October 2017, Lyndall and the treating physiotherapist met for a care evaluation meeting to discuss repositioning and contracture management.[230] The progress note indicates that, at that time, exercises had been provided.[231] Ms Taylor accepted that up to that point in time there is nothing in the documents to suggest exercises had been provided.[232]

Counsel Assisting submitted that, in light of that evidence, there is not merely a gap in documentation. Rather, the existing documentation demonstrates that Ms Fowler's need for mobility and strength optimisation from 17 October 2016 was effectively ignored, and it should readily be inferred that they were not met with any exercise regimen.

IRT WBG refer to a care evaluation entry made on 21 April 2017, which says that Lyndall was informed that Ms Fowler 'received passive exercises and massaging on a regular basis and she [Lyndall] was very happy with this'.[233]

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226 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3006.22-3007.01.

227 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0008-0009 [36]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 963, IRT.0001.0069.0131.

228 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0009 [37]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 963, IRT.0001.0069.0131; tab 145, IRT.0001.0002.2241; tab 146, IRT.0001.0002.2244; tab 135, IRT.0001.0002.2202; tab 136, IRT.0001.0002.2209.

229 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0009 [38]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 100, IRT.0001.0002.2034; Exhibit 6-8, Darwin and Cairns Hearing, tab 102, IRT.0001.0002.2051.

230 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0020-0021 [93]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 761, IRT.0001.0003.0001 at 0083.

231 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 761, IRT.0001.0003.0001 at 0083.

232 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2982.18-22.

233 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3013.21-30; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 68, IRT.0001.0002.0692.

During the period October 2016 to April 2017, Ms Fowler received massages approximately twice per week.[234] IRT WBG submitted that these treatments involved stimulation of muscles and limbs and are the kind of passive exercises which might be recommended for persons at risk of contractures.[235]

Even if Ms Fowler was receiving exercises, IRT WBG submitted that her cognitive impairment and resistance to staff served as barriers to some potential therapies.[236]

We do not accept that these twice-weekly massages can be seen as a substitute to regular passive exercises. There is no evidence before us that relatively infrequent massages would perform the same function. Further, if Ms Fowler had been receiving physiotherapist-directed exercises to address the risk of contractures, then we would expect this to be documented in the records of IRT WBG. We find that it is unlikely Ms Fowler was receiving any regular exercise regimen prior to 10 April 2017.

Pressure injuries

Preventative measures

The Royal Commission heard from a number of experts who emphasised that implementation of preventative measures is a key to wound management, and preferable to reactive treatment of pressure injuries.[237] IRT WBG agrees with this view, and submitted that throughout Ms Fowler's time at IRT WBG, they have been 'proactive in assessing Ms Fowler's risk of pressure injuries and implementing preventative measures to minimise her risk of developing such injuries'.[238]

It is IRT WBG's practice that 'skin integrity care plans must be reviewed at least annually, or more frequently if there is a change in the resident's clinical needs or as the result of an incident'.[239] Each skin assessment for Ms Fowler has involved an assessment against the Norton Scale, a 'clinically accepted assessment tool to identify persons at risk of the development of pressure injuries'.[240] 'Norton Scale scores range between 5 and 20, with a lower score indicating higher levels of risk for pressure injury development.'[241]

234 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1029, IRT.0001.0071.0001.

235 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0009-0010 [38].

236 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0008 [35].

237 Transcript, Catherine Sharp, Darwin and Cairns Hearing, 11 July 2019 at T3301.01-47; Transcript, Hayley Ryan, Darwin and Cairns Hearing, 11 July 2019 at T3330.09-15; Transcript, Geoffrey Sussman, Darwin and Cairns Hearing, 11 July 2019 at T3330.17-37.

238 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0014 [52].

239 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0014 [53].

240 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0014 [53]; Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0015 [69]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 203, IRT.0001.0002.3064.

241 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0014 [53].

Ms Fowler has been regularly provided with skin assessments, including 12 skin assessments completed in the period 15 October 2016 to March 2018.[242] Over the period of these assessments, Ms Fowler's Norton Scale score deteriorated as follows:

- July 2016, Norton Scale score of 14. Ms Fowler was recorded as able to reposition herself. Measures to support skin integrity included twice daily application of sorbolene cream.[243]
- 29 October 2016, Norton Scale score of 9. Ms Fowler is provided an air mattress as a pressure relieving device. Ms Fowler is repositioned by staff every four hours. Measures to support skin integrity included twice daily application of sorbolene cream.[244]
- 14 November 2016, Norton Scale score of 8. Ms Fowler is immobile, repositioning requirements increased to every 2 hours (along with the use of the air mattress and emollient applications).[245]
- 25 April 2017, Norton Scale score of 6. The skin assessment notes 'that staff should conduct regular skin inspections for signs of redness' and includes additional instructions to staff to ensure regular repositioning, including moving Ms Fowler between her air chair and air mattress.[246]
- 5 June 2017, Norton Scale score of 6.[247]

242 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0015 [54]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 209, IRT.0001.0002.3076; tab 208, IRT.0001.0002.3074; tab 207, IRT.0001.0002.3072; tab 205, IRT.0001.0002.3068; tab 204, IRT.0001.0002.3066; tab 202, IRT.0001.0002.3062; tab 201, IRT.0001.0002.3060; tab 200, IRT.0001.0002.3058; tab 198, IRT.0001.0002.3049; tab 194, IRT.0001.0002.3038; tab 192, IRT.0001.0002.3033; tab 190, IRT.0001.0002.3028.

243 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0015 [55]; Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0015 [69]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 203, IRT.0001.0002.3064.

244 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0015-0016 [56]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 202, IRT.0001.0002.3062.

245 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0016 [57]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 190, IRT.0001.0002.3028.

246 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0016 [59]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 200, IRT.0001.0002.3058.

247 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0017 [61]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 208, IRT.0001.0002.3074.

Two pressure injuries

IRT WBG said that 'the preventative measures and management processes outlined above were provided to Ms Fowler'[248] and that these measures are 'consistent with best practice interventions and processes for prevention of pressure injuries'.[249] Despite these preventative measures, around the middle of 2017 two pressure areas developed under Ms Fowler's feet. The first pressure area was located around the bunion area on the left side of her right foot and started as a small red mark.[250] The second developed on the outer side of her left foot.[251] Lyndall remembers that she noticed the marks when assisting with some aspect of Ms Fowler's care.[252]

By around July to September of 2017, the area on the right foot bunion area had broken down and become a pressure injury with exudate.[253] By August 2017, the left foot had become swollen, with an infected ulcer.[254]

By November 2017, an ulcer on the right foot had developed, which was very deep with necrotic areas.[255]

From December 2017, Ms Fowler became bed bound because it was impossible to position her in a chair without pressure on the ulcer on her right foot.[256] Lyndall believes that as the ulcer was so deep, it also damaged the ligaments or tendons of the big toe on her right foot.[257] IRT WBG notes there is no clinical evidence to support this claim.[258]

It took until late 2018 for the ulcer on the right foot to heal.[259]

248 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0016 [58].

249 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0017 [62].

250 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 756, IRT.0001.0002.9534 at 9545; tab 761, IRT.0001.0003.0001 at 0158-0159.

251 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 756, IRT.0001.0002.9534 at 9546; tab 761, IRT.0001.0003.0001 at 0172-0173.

252 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2964.19-24; Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0004 [31].

253 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0004 [32].

254 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0004 [33].

255 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0004 [33].

256 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [40].

257 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [40].

258 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0019 [72].

259 See Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [40].

The second pressure area on the outer side of Ms Fowler's left foot mostly healed by around June 2018,[260] and was completely healed by August 2018.[261] Lyndall's view is that it did not take as long to heal partly because the position of the lesion meant it was not subject to as much pressure.[262]

IRT WGB submitted that Ms Fowler was undergoing 'end of life' palliative care at the time of the initial pressure injuries. She had also started demonstrating symptoms of cachexia (an inability to properly absorb nutrition).[263] This can have an impact on wound development and healing.[264]

Ms Fowler's treatment was further complicated by the fact that some of her wounds were 'infected with MRSA (methicillin-resistant staphylococcus aureus)'.[265]

New pressure area identified by Lyndall

On 18 March 2018, Lyndall noticed that Ms Fowler's left foot was looking at risk of developing a pressure injury and sent an email of complaint to IRT WGB.[266] Clinical records created later that night record for the first time a reddened pressure area on the bunion area of Ms Fowler's left foot.[267]

With respect to a picture of the pressure area which had been displayed during the hearing,[268] Ms Taylor agreed that the monitoring by IRT WBG staff must have failed in some way for that pressure area to have deteriorated to that point without being noticed by staff.[269]

260 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 485, IRT.0001.0002.6210.

261 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 461, IRT.0001.0002.5947.

262 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [41].

263 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0017 [64]; Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0016 [75]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 761, IRT.0001.0003.0001 at 0031, 0038, 0072, 0095, 0130, 0131, 0135, 0137, 0141, 0153, 0156, 0163.

264 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0017 [64]; Transcript, Geoffrey Sussman, Darwin and Cairns Hearing, 11 July 2019 at T3330.30-34; Transcript, Hayley Ryan, Darwin and Cairns Hearing, 11 July 2019 at T3329.05-10.

265 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0018 [65]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1021, IRT.0001.0069.0585 at 0587, 0588, 0592, 0594; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2964.45-47.

266 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 29, IRT.0001.0002.0220 at 0223.

267 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 498, IRT.0001.0002.6343.

268 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1050, LFO.0001.0001.0003.

269 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3018.03-07.

On 19 March 2018, Lyndall attended IRT WBG and spoke to nurses regarding the new pressure area on Ms Fowler's left foot. It looked to Lyndall like another pressure area that might break down.[270] After identifying the new pressure area, Lyndall advocated for the use of interventions to prevent the area rupturing:[271]

> I took immediate action to research possible treatment options, invest in aids and advocate their use with the Care Manager. I employed a seamstress to make foam foot protectors and had a pair of sheepskin boots made to measure. William Beach Gardens also bought foot protectors that could be used for protecting other pressure areas on the body.[272]

IRT WBG contends 'that such booties are not designed to prevent pressure areas, but rather are for comfort of deteriorating residents'.[273]

However, the pressure injury healed within a few weeks. With these interventions, the pressure area that was developing resolved without becoming an open injury.[274] Lyndall gave evidence that 'this illustrated to me that pressure sores can be prevented with appropriate care and aids'.[275]

Counsel Assisting submitted that we should find that IRT WBG was insufficiently proactive in managing Ms Fowler's risk of developing pressure injuries at all material times from late 2016 (when Ms Fowler became immobile) until at least March 2018, giving rise to a serious risk to Ms Fowler.[276]

IRT WBG submitted that there is no evidence before the Royal Commission to support a finding that Ms Fowler was at serious risk as a result of the preventative measures provided by IRT WBG.[277]

We find that the successful interventions demonstrated by Lyndall show that, with appropriate interventions and some proactivity of pressure area care, pressure injuries on Ms Fowler's feet are not inevitable and can be avoided. This raises questions about whether the very serious pressure injuries suffered by Mr Fowler on her feet from July 2017 to late 2018 might have been preventable, if they had been detected as pressure areas earlier.

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270 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [42].

271 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 29, IRT.0001.0002.0220 at 0223.

272 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [43]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1055, LFO.0001.0001.0019.

273 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0021 [80].

274 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [44].

275 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0005 [44].

276 Darwin and Cairns Hearing, Submissions of Counsel Assisting, 24 July 2019, RCD.0012.0015.0001 at 0016 [56a].

277 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0021 [79].

However, in the absence of clinical expert evidence, we decline to make a finding that those injuries could have been avoided or that IRT WBG was insufficiently proactive in managing Ms Fowler's risk of developing pressure injuries in2017.

As to the occasion in March 2018, when Lyndall identified that there was a further pressure area developing on Ms Fowler's left foot, Counsel Assisting submitted that there was a failure of pressure area monitoring for Ms Fowler by staff of IRT WBG in failing to identify this for themselves.[278]

IRT WBG acknowledges that Lyndall identified a pressure area developing on Ms Fowler's left foot, but they do not 'agree that the identification of this area by Lyndall demonstrates a lack of proactive steps taken by IRT WBG'.[279] This is because as there were numerous skin assessments completed for Ms Fowler, it is clear that IRT WBG was proactive in identifying and managing Ms Fowler's risk of developing pressure injuries in the relevant period.[280]

IRT WBG submitted that pressure areas may develop very rapidly (some can develop within half an hour), and therefore 'it is not reasonable to conclude that the area had necessarily been left unnoticed by care staff'.[281] We accept this. We also note IRT's submission that, after this pressure area was identified by Lyndall, IRT WBG said they made enquiries of its care staff 'who confirmed that there was no sign of any pressure area developing on the previous day'.[282]

IRT WBG submitted that although not expected or required, Lyndall is actively involved in the care of her mother.[283] Lyndall undertakes activities including helping Ms Fowler dress, changing her socks, and assisting with her hygiene. It is in these circumstances that IRT WBG's submitted that Lyndall identified the pressure area: 'It is reasonable to assume that, had IRT WBG staff been attending to these tasks as they ordinarily would, staff would have identified the area'.[284]

We accept that Lyndall played a vital role in the care for Ms Fowler, and it was in these circumstances that she identified the pressure injury before staff at IRT WBG. However, we do not find that this necessarily demonstrates a failing on the part of IRT WBG.

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278 Transcript, Kristy Taylor, Darwin Hearing, 9 May 2019, T3018.03-07.

279 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0018 [68].

280 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0021 [78].

281 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0019 [70]; Transcript, Catherine Sharp, Darwin and Cairns Hearing, 11 July 2019 at T3301.21-27; Transcript, Sussman, Darwin and Cairns Hearing, 11 July 2019 at T3330.39-41; T3330.45-3331.04; Transcript, Hayley Ryan, Darwin and Cairns Hearing, 11 July 2019 at T3330.41-47; T3331.01-05.

282 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0019 [70].

283 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0019 [69].

284 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0019 [69].

Wound charts

In accordance with IRT WBG policies and procedures, each time a pressure injury was identified, it was reported in the clinical notes, the registered nurse on duty was notified, Lyndall was notified, a skin assessment was conducted, the skin integrity care plan was updated and a wound management plan was prepared.[285]

IRT WBG has provided more than 500 wound charts to the Royal Commission as part of this case study. IRT WBG explained that this is because 'for a period of time, Ms Fowler was receiving daily or near daily specific care for her wounds, with charts being updated every time Ms Fowler's wounds were attended to'.[286] Consistent with Wound Australia guidelines, each wound chart includes (and requires the care staff to update):

- a picture diagram showing the location of each wound and its severity
- a photo of each wound (and, if applicable, historical photos)
- a description of each wound including the position and the current length and width of the wound, STAR classification and odour details (if any)
- a description of the skin surrounding each wound including erythema and exudate type
- interventions, including how regularly the wound dressings should be changed
- details of the wound healing status (for example, granulating, sloughy).[287]

IRT WBG submitted that 'a review of a sample of Ms Fowler's records demonstrates that care providers were reviewing and updating these details (including width and length) as expected'.[288]

Senior Counsel Assisting raised a number of issues with these records, including:

- they do not describe particular injuries using consistent descriptions
- they are not ordered sequentially for each injury
- they are not accompanied by tape measurements
- they are not taken from a consistent angle or in consistent lighting.[289]

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285 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0018 [66]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 225, IRT.0001.0002.3332; tab 228, IRT.0001.0002.3344; tab 239, IRT.0001.0002.3416; tab 246, IRT.0001.0002.3468; tab 209, IRT.0001.0002.3076; tab 205, IRT.0001.0002.3068; tab 198, IRT.0001.0002.3049; tab 192, IRT.0001.0002.3033.

286 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0022-0023 [87].

287 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0022-0023 [87].

288 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0022-0023 [87].

289 Darwin and Cairns Hearing, Submissions of Counsel Assisting, 24 July 2019, RCD.0012.0015.0001 at 0014 [50].

Ms Taylor accepted that the wound charts in relation to Ms Fowler's pressure injuries were unsatisfactory for these reasons. Ms Taylor stated that IRT WBG has since improved its wound charts. When Senior Counsel Assisting suggested that the confusing nature of the wound charts presented a serious risk to Ms Fowler because different clinicians would be unable to understand the progression of a particular injury, Ms Taylor said that often the same registered nurse was attending to the injuries, but she also said 'yes' and acknowledged that at the time the injuries were 'difficult to track'.[290]

IRT WBG 'acknowledges that its record keeping practices with respect to wound charts as they existed in 2017 could have been improved'.[291] IRT WBG has since implemented improvements so that all wound photographs are labelled with the applicable wound ID (rather than a description of the location), and all photographs are to be taken with the same digital camera, using the same light source, and ideally depicted in the same relative position as the previous photograph.[292] IRT WBG notes that it is not always possible to take photographs of wounds in an entirely consistent manner. IRT WBG 'would not expect RNs to place a resident in a position which causes pain or discomfort for the resident in order to take a photograph'.[293]

Counsel Assisting submitted that we should find that the wound charts kept by IRT WBG of Ms Fowler's pressure injuries were confusing and presented a serious risk that she would not receive proper care.

We find that the issues outlined by Counsel Assisting in relation to the wound charts have the potential to raise confusion about which photograph relates to which injury, and about the progression of the particular injury. IRT WBG acknowledge that the photographs did not include tapes for measurement and were not always taken with the same lighting and positioning but submitted that this did not expose Ms Fowler to serious risk.[294]

While Ms Taylor conceded that the wound charts were unsatisfactory, IRT WBG submitted that there is no evidence which supports a link between any purported deficiencies in the wound charts and the care delivered to Ms Fowler as less than appropriate.[295]

While there is no clear evidence that the former presentation of wound charts presented a serious risk to Ms Fowler, we find that, consistent with Ms Taylor's evidence, the wound charts were not optimal. In the event of breakdowns in continuity of wound care, this could have presented some degree of risk that wound care might be less than optimal.

290 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3018.15-3019.02.

291 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0021 [81].

292 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0021 [81(a)-(b)].

293 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0022 [82].

294 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0024-0025 [93].

295 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0022 [85].

In relation to the use of photographs of wounds, Lyndall gave the following evidence:

> While RNs took photographs of wounds, I felt that they were not always taking a proactive role in utilising those images in clinical care and management of the wound. Normal practice would be to compare the wound with the most recent image at every dressing to assess progress and assess whether different interventions are needed. On occasion I would ask RNs for their assessment and was often told that they may not have seen the wound for weeks. I deduced from this that the RNs were not always making use of images in clinical management.[296]

IRT WBG does not agree with Lyndall that registered nurses were not looking at the most recent photos of Ms Fowler's wounds.[297] As previously described, the Platinum system automatically updates the record, so that the most recent information is presented to care staff. IRT WBG submitted that 'RNs working in real time would have the photograph in front of them in recording their progress notes, such that it is hard to see how wound photos could not have been considered'.[298] There is no evidence before us to suggest that any registered nurse failed to understand wound charts or follow the care plan set out in the wound chart.[299] We accept the submissions of IRT WBG in this regard.

Further, we heard that, since 2017, IRT WBG has improved the wound chart process by:

- improving the guidance documentation for processes in wound care management, including that incident reports are to be completed for all pressure injuries.
- providing further training on wound management and care over the last 12 months, including training by external providers for registered nurses and team leaders.
- continuing with its non-registered nurse care staff to provide additional training for identification of red areas that have the potential to develop into pressure injuries.[300]

296 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0004 [36].

297 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0024 [90].

298 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0023-0024 [88]-[90].

299 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0022 [85].

300 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0025 [94(a)-(c)]; Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0019 [86].

Haematoma

On 9 September 2018, IRT WBG care staff identified a skin tear and haematoma under Ms Fowler's left knee while bathing her.[301] Upon staff noticing the haematoma, they recorded it in an incident report,[302] the haematoma was escalated to an registered nurse for review[303] and Lyndall was notified.[304]

In her witness statement, Lyndall describes that initially the staff could not explain to her what caused the haematoma, but that they had told her that there had been bleeding found after her bath.[305] In a series of three emails from 26 September 2018 to 2 October 2018 addressed to IRT WBG staff, Lyndall suggests that the equipment used by staff to transfer Ms Fowler from her bed caused the haematoma, and the tear was caused by her right toenail positioning due to her contractures.[306] IRT WBG submitted that there is no definitive evidence before the Royal Commission to support that opinion.[307]

On 2 October 2018, in response to Lyndall's emails, IRT WBG staff wrote 'the haematoma was caused by the pressure of blood vessels from Shirley's legs the way they are contracture. The haematoma would have caused the skin tear when it burst do [sic] to staff having repositioned Shirley'.[308]

The Royal Commission has heard that older persons with fragile skin may sustain tears from very minor movements, including simply by brushing across their bedsheets.[309]

Lyndall describes actively pursuing the issue with staff and looking into the equipment used to bath her mother.[310] Lyndall formed the opinion that the injury was most likely caused by the type of sling used to transfer Ms Fowler.[311] Around September 2018,

301 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 762, IRT.0001.0003.0175 at 0238-0239.

302 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 937, IRT.0001.0068.0161.

303 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 762, IRT.0001.0003.0175 at 0238-0239.

304 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 762, IRT.0001.0003.0175 at 0239.

305 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0007 [62].

306 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0007 [61]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 865, IRT.0001.0022.4637 at 4639.

307 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at [98].

308 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 865, IRT.0001.0022.4637 at 4638.

309 Transcript, Hayley Ryan, Darwin and Cairns Hearing, 11 July 2019 at T3331.35-41.

310 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0007 [63]

311 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0007 [63].

Lyndall consulted an external occupational therapist, who provided information about an appropriate alternative type of sling, known as a cradle sling.[312]

IRT WBG submitted that where a physiotherapist considers that a sling may no longer be appropriate for a resident, they communicate this to IRT WBG as part of the regular Functional Assessment review process.[313] The sling in question had been determined as appropriate. At Ms Fowler's Functional Assessment on 8 August 2018[314] and her Physiotherapy Assessment on 13 August 2018,[315] there was no such communication to suggest otherwise.[316]

After a successful trial, a cradle sling was purchased by IRT WBG.[317] IRT WBG submitted that this 'was done in a spirit of collaboration with Lyndall, not because of any identified clinical concern with the existing sling'.[318] However, Lyndall's evidence in relation to this matter was that 'once again, this was an issue that I feel I had to notice for it to be addressed and shows a lack of awareness of appropriate aids and equipment'.[319] IRT WBG said there is no evidence before the Royal Commission to support this claim.[320]

Counsel Assisting submitted that we should find that IRT WBG was insufficiently proactive in identifying the cause of Ms Fowler's haematoma and preventing further harm. IRT WBG said that 'there are no additional steps that IRT WBG could reasonably have taken, noting also that Counsel Assisting has not highlighted any inappropriate acts or omissions on the part of IRT WBG, nor referenced alternative best practice processes that were not followed'.[321]

The evidence is insufficient for us to make a finding that IRT WBG was insufficiently proactive in identifying the cause of the haematoma, and we decline to do so in the absence of expert clinical evidence. However, we do accept that Lyndall's explanation as to the cause of the haematoma and skin tear is reasonable, and we note that a safe and appropriate sling was obtained by IRT WBG after Lyndall intervened.

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312 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0007 [65].

313 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0026 [98]-[99].

314 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 149, IRT.0001.0002.2255.

315 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 938, IRT.0001.0068.0163.

316 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0026 [99].

317 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [66]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 34, IRT.0001.0002.0251 at 0254.

318 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0026 [101].

319 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [67].

320 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0026 [100].

321 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0027 [102].

Diet, nutrition and weight loss

Diet and nutrition are matters which Lyndall has described as being an 'ongoing problem during my mother's time at William Beach Gardens requiring constant advocacy'.[322]

Accommodating intolerances

Ms Fowler is allergic to colour 102 (tartrazine) and has a lactose intolerance.[323]

Upon admission to the facility, Lyndall provided IRT WBG with information regarding Ms Fowler's food intolerances.[324] IRT WBG undertook a nutrition assessment, and then created a nutrition care plan.[325] Ms Fowler's allergens and intolerances were made known to staff through her diet and nutrition care plan, vital information page and documentation kept in the kitchen which lists residents' food preferences, allergens and intolerances.[326]

Despite this, Lyndall described witnessing Ms Fowler being given food containing lactose on multiple occasions in the first year of residence.[327] Ms Taylor gave evidence that, 'I have identified a small number of instances where, through human error, Ms Fowler was inadvertently provided with food that contained lactose'.[328] IRT WBG concedes that, on some occasions, 'the record keeping with respect to these meals could be improved'.[329]

Food at IRT WBG is arranged through a central kitchen. IRT WBG has also provided lactose-free milk, yoghurt, cream and custard which has been purchased separately by the Hospitality Manager from the supermarket.[330]

322 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [68].

323 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [69].

324 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0025 [114].

325 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0025 [114]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tenderbundle, tab 1032, IRT.0001.0071.0026.

326 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0025 [115].

327 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [71].

328 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0026-0027 [122(a)].

329 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0027 [104].

330 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0009 [82]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tenderbundle, tab 863, IRT.0001.0022.4619; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2960.16-25.

Lyndall observed that most weeks there are minimal lactose free alternatives offered on the IRT weekly menu.[331] Alternatives are often in the form of something more processed or insubstantial, such as canned baked beans or a garden salad.[332] Lyndall does not think that lactose-free diets are of the level one would expect.[333] In reply, IRT WBG said that they have provided the Royal Commission with a large volume of samples of its regular menus for residents: 'These include lactose free options such as Barramundi with Sesame Soy, Rice Noddle [sic] with Pork & Prawn, Lamb with Tomato & Vegetables (among many others).[334]

However, Lyndall explained

> Well, it—the menu would show lactose free, and this has happened over the last year. So it has been ordered and is on the menu, but then when—it wouldn't be provided or, particularly, in those pureed meals or textured meal options. So it definitely would have been ordered, but when the staff checked, it wouldn't—wasn't there.[335]

Lyndall described that to ensure Ms Fowler receives adequate nutrition, and because Lyndall enjoys cooking, she prepares lactose-free soups and other meal alternatives to take to Ms Fowler.[336] IRT WBG said they encourage families to be actively involved in the care of their loved ones.[337] In this regard, they were happy to work closely with Lyndall with respect to Lyndall providing particular meals for Ms Fowler.[338]

Ms Taylor conceded that Ms Fowler was given lactose on occasion. We find this to be unacceptable, and a failure by IRT WBG to keep adequate records or procedures in place to prevent Ms Fowler being inadvertently provided with food containing lactose.

Provision of finger food

On Ms Fowler's admission to IRT WBG, she was relatively independent in feeding herself, although records show that sometimes she refused food or to sit at mealtimes.[339] IRT WBG submitted that 'in accordance with IRT WBG's commitment to maintaining independence

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331 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [71].

332 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [72]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2961.13-19.

333 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0009 [83].

334 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0029 [110]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 26, IRT.0001.0002.0190; tab 1156, RCD.9999.0104.0009 at 0021-0024.

335 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2961.35-39.

336 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008 [73]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2960.16-25.

337 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0027 [124], 0028 [130], 0028 [133].

338 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0027 [123], 0027 [125].

339 Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0025-0026 [117]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 989, IRT.0001.0069.0380 at 0380, 0382, 0384-0387; tab 992, IRT.0001.0069.0404.

and dignity of residents to the greatest extent possible, from 2013 to 2016 Ms Fowler fed herself without assistance from staff, although she was closely monitored'.[340]

When Ms Fowler was able to feed herself, she was very shaky. This would often cause her to spill her food, especially where the meal was liquid.[341] Lyndall described that she would often find Ms Fowler 'wearing clothes that were covered in food, apparently having being in that state from breakfast time'.[342]

IRT WBG recognises that as a result of encouraging residents, including Ms Fowler, who are slowly losing their cognitive ability and manual dexterity to feed themselves, there is always the possibility of food spillage. However, in IRT WBG's view, the principles of dignity of risk and consumer choice dictate that it is preferable to accept that spills may occur on occasion, rather than have otherwise independent persons being fed by care staff.[343]

However, on several occasions Lyndall made requests to IRT WBG for the provision of more finger food.[344] Lyndall has sought greater provision of high-quality finger foods to help residents 'maintain independence and retain some dignity'.[345] While there is always fresh fruit available for residents, the provision of finger food was not something Lyndall felt that IRT WBG adequately addressed.[346] As a result, around the time Ms Fowler moved into the Nebo Unit, Lyndall was providing some of the finger food for Ms Fowler herself. Lyndall was bringing in finger foods such as quality party pies, sausage rolls and chicken pieces.[347]

In oral evidence, Ms Taylor agreed that from looking at the food chart it is difficult to ascertain whether Ms Fowler was receiving the finger foods, due to poor documentation.[348]

We accept that it is a possibility that providing finger foods to Ms Fowler could have resulted in less spills on her clothing and increased dignity.

340 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0029 [111].

341 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008-0009 [76].

342 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008-0009 [76]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 810, IRT.0001.0022.4038; tab 811, IRT.0001.0022.4039; tab 812, IRT.0001.0022.4040; tab 813, IRT.0001.0022.4041; tab 874, IRT.0001.0041.3451; tab 875, IRT.0001.0041.3452; tab 876, IRT.0001.0041.3453; tab 877, IRT.0001.0041.3454.

343 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0029-0030 [112].

344 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 874, IRT.0001.0041.3451; tab 879, IRT.0001.0041.3495 at 3498; tab 993, IRT.0001.0069.0409 at 0415; tab 759, IRT.0001.0002.9576 at 9635.

345 Exhibit 6-9, Darwin and Cairns Hearing, Statement of Lyndall Helen Fowler as amended, 20 June 2019, WIT.0103.0001.0001 at 0008-0009 [75]-[78]; Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2961.13-14, T2946.04-09.

346 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2945.45–2956.02.

347 Transcript, Lyndall Fowler, Darwin Hearing, 9 July 2019 at T2946.04-09.

348 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2992.30-36.

Inaccurate food and fluid charts

Counsel Assisting submitted that the food and fluid intake charts kept by IRT WBG staff are incomplete and unreliable.[349] An aspect of this issue was raised by the dietitian in the Dietitian Review (see below). It was also raised by Lyndall on a number of occasions, including during a telephone call with Ms Taylor on 11 May 2016.[350] The progress note of this call records that Lyndall raises concerns that Ms Fowler continues to lose weight despite the dietitian's recommendations and the additional snacks and food Lyndall has provided: 'from looking at her food chart it is difficult to ascertain whether [Ms Fowler] is receiving the finger foods and additional food additives due to poor documentation.[351]

During the hearing, Senior Counsel Assisting took Ms Taylor to an example of inconsistencies between the progress notes and the food and liquid charts on 9 May 2017. On this occasion, the progress notes stated that Ms Fowler had refused her meal despite numerous attempts by staff, while the food and liquid chart contained an entry to the effect that Ms Fowler ate a sausage roll for dinner that evening.[352] IRT WBG submitted that Ms Fowler 'initially refused her meal, but eventually ate a sausage roll, salad and fruit. IRT WBG are able to reach this conclusion because the electronic system displays the data described above'.[353]

IRT WBG contends that Senior Counsel Assisting's concerns and reliance on food intake records is 'the product of misunderstanding as to how those records present electronically on the Platinum system, as compared to how the information is presented in the documents extracted from the Platinum system and produced to the Commission'.[354] They say:

> the presentation of the records in the form produced to the Commission does not include data such as which member of staff updated the food and fluid chart, and the time that the chart was updated. This lack of data and the unusual presentation likely confused Ms Taylor when she was asked to consider hard copy records by Counsel Assisting during the hearing on 9 July 2019.[355]

Counsel Assisting submitted that we should find that IRT WBG failed to keep proper records of Ms Fowler's food consumption.

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349 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 99, IRT.0001.0002.1962; tab 97, IRT.0001.0002.1886; tab 98, IRT.0001.0002.1923.

350 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 993, IRT.0001.0069.0409 at 0415.

351 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 993, IRT.0001.0069.0409 at 0415.

352 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2995.21–2996.04; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 97, IRT.0001.0002.1886 at 1887; tab 759, IRT.0001.0002.9576 at 9622.

353 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034-0035 [134].

354 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034 [133].

355 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034-0035 [134].

IRT WBG acknowledges that certain aspects of its record keeping with respect to the recording of actual intake of food could have been improved.[356] But the actual care provided 'demonstrates that overall IRT WBG did have in place appropriate procedures to monitor, record and manage Ms Fowler's weight and nutrition in consultation with Ms Fowler's GP'.[357] Further:

> IRT WBG contends that the evidence before the Commission clearly shows that IRT WBG provided Ms Fowler with nutritious and appropriate foods, took care to ensure that she was fed, regularly weighed Ms Fowler and consistently liaised with her GP and Lyndall in relation to her weight. When viewed in this context Ms Fowler was not at any serious risk as the result of the care provided to her by IRT WBG.[358]

In light of these difficulties in relation to the accurate portrayal of records within Platinum, we do not make any findings in relation to the documentation of food intake.

Food budget

IRT WBG submitted that the food options provided to Ms Fowler were in accordance with its standard practice. This submission is supported by the fact that the food budget at IRT WBG is above the industry standard,[359] and exceeds what was described to the Royal Commission by Ms Maggie Beer and other experts on 16 July 2019.[360]

For the period 2016–2019, IRT WBG's average daily spend for food per resident was approximately $16.80.[361] IRT WBG submitted that this figure does not include the cost of any nutritional supplements which are given to residents.[362]

In her oral evidence, Ms Taylor said that 'the supplements need to be charted by the GP before we commence the supplements'.[363]

It is evident on Ms Fowler's medication chart that supplements Dr Bird prescribed supplements on 7 June 2017.[364] As with other medication, this would tend to suggest that the nutritional supplements were provided at the additional expense of the resident.

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356 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034 [130].

357 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0035 [137].

358 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0035 [138].

359 Transcript, Sandra Iuliano, Darwin and Cairns Hearing, 16 July 2019 at T3673.10-24.

360 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0028-0029 [108].

361 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1156, RCD.9999.0104.0009 at 0023-0024.

362 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0029 [109].

363 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2990.11-14, T2989.35-40.

364 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1083, DHC.0002.0001.0041 at 0044.

Dietitian review and weight parameters

In oral evidence, Ms Taylor stated that when a resident is admitted, they are weighed by IRT WBG staff and their weight range parameters are set by staff in the range of two kilograms above and two kilos below their admission weight.[365] After weight is measured by staff on admission, the General Practitioner will then review the weight record and set the weight range parameters that they deem acceptable.[366]

In relation to the setting of weights parameters, the Royal Commission asked Dr Bird:

> From 15 April 2015, have you:
>
> - set and made amendments from time to time; and/or
> - by arrangement with IRT WBG been responsible for setting and making amendments to the parameters of Ms Fowler's weight in Ms Fowler's Leecare Solutions Weight and Vital Signs electronic form maintained by IRT WBG in its Information technology systems?

In response, Dr Bird's gave evidence as follows:

> I do not have an independent recollection of setting or adjusting Ms Fowler's weight parameters. My usual practice would be to reset the weight parameters as the need arose, as would other medical and nursing staff who were treating her. Staff at WBG have advised me that they are unable to identify any dates that weight parameters may have been changed in the Leecare system, or by whom, as the system does not retain the earlier entries.
>
> Weight parameters are able to be changed by the medical staff and by Registered Nurses as stated by Ms Taylor in her evidence. Ms Taylor sets the initial parameters upon an admission of a patient as 2kgs above and below the admission weight.[367]

Dr Bird explained that general practitioners visiting IRT WBG have access to the 'Weight and Vital' section of Platinum,[368] and any changes to parameters would be done in the presence of a member of the nursing staff at the time of consultation and orally conveyed to that person as well as adjusted in the Platinum system.[369] IRT staff are alerted if the weight goes out of the parameters set by the General Practitioner.[370]

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365 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2988.11–2989.04.

366 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2998.7-26; Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0001-0002 [3].

367 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0002-0003 [4(a)-(b)].

368 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0001-0002 [3]; Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2998.07-26.

369 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0003 [5].

370 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2998.07-26.

Ms Taylor gave evidence that any changes to the parameters for Ms Fowler's weight would be made by a general practitioner or an registered nurse.[371]

On 15 April 2015 a document entitled 'Nutrition Assessment' was prepared.[372] The document notes that the 'goal/expected outcome' is that Ms Fowler 'will not lose more than two kilograms in one month'.[373]

By February 2016, Ms Fowler weighed 57.12kg.[374] On 18 March 2016 and 22 April 2016, Ms Fowler was assessed by a geriatrician in relation to her weight loss and the falls identified earlier.[375] In a facsimile to Dr Bird dated 26 April 2016, the geriatrician noted that Ms Fowler's 'weight loss is multifactorial, probably related to her UTIs as well as her difficulty in sitting through some meals'. The geriatrician suggested that 'a dietitian review would be helpful.'[376]

In April 2016, Ms Fowler was referred for review by a dietitian.[377] On 7 May 2016, Ms Fowler attended a dietitian, accompanied by Lyndall.[378] The review by the dietitian (Dietitian Review), set out in the IRT WBG progress notes, includes the following observations and recommendations:

- that Ms Fowler's weight was 57.82kg, and the healthy weight range for her height was 63kg to 78kg; it was recommended that her weight 'should go up to at least 65kg'
- that there were 'Obvious signs of muscle wasting especially upper body indicative of protein malnutrition'
- that Lyndall brought in food and also took Ms Fowler out for meals. However, the IRT WBG 'food records do not reflect the additional foods that her daughter brings in for the staff to boost her meals with. I have to assume they are not given routinely. I make this assumption as energy intake without taking into account these extra foods is reflected by how her weight is responding'
- that protein intake was to be boosted by the provision of Resource Fruit Beverage with lunch and dinner and 1 Ensure Two CAL preferably as 50ml four times daily

371 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3009.01-09.

372 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1001, IRT.0001.0069.0481.

373 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1001, IRT.0001.0069.0481 at 0481.

374 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1006, IRT.0001.0069.0513 at 0515.

375 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1104, DHC.0002.0001.0102.

376 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1104, DHC.0002.0001.0102 at 0104.

377 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 993, IRT.0001.0069.0409 at 0410-0411.

378 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 993, IRT.0001.0069.0409 at 0412-0414.

- that energy was to be boosted by:
  - adding a heaped teaspoon of coconut oil and another of honey to Ms Fowler's porridge
  - adding peanut butter or nut paste to toast for breakfast as well as the jam or honey
  - providing more substantial snacks such as muffins, frittata, ½ sandwiches.[379]

Dr Bird gave evidence that:

> Ms Fowler's weight was monitored mainly by the nursing staff at WBG. If there were any concerns with her weight, it was brought to my attention either by those nurses, or by Lyndall, then I would review the weight charts myself.[380]

IRT WBG agreed that the general practitioner is the medical link to care provided to residents, and that care centres should work with treating general practitioners in relation to any care provided to residents.[381]

Ms Taylor gave evidence that the Dietitian Review would be referred to the general practitioner, who could prescribe the supplements, and IRT WBG staff would implement the recommendations other than the supplements.[382] In accordance with the Dietitian Review, there are numerous records referencing that substantial snacks were provided to Ms Fowler, including coconut oil being added to porridge, muffins and frittata.[383]

Dr Bird reviewed Ms Fowler at his clinic and recommended that the food suggestions from the dietitian be maintained.[384] However, there is no detail recorded in relation to the weight gain parameters recommended by the dietitian.[385]

379 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 993, IRT.0001.0069.0409 at 0412-0414.

380 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0001-0002 [3].

381 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0030-0031 [116]; Transcript, Peter Gonski, Darwin and Cairns Hearing, 11 July 2019 at T3230.18-20.

382 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2989.35-2990.14.

383 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0031 [119]; Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0026 [119], 0026 [121]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 993, IRT.0001.0069.0409 at 0415; tab 99, IRT.0001.0002.1962; tab 991, IRT.0001.0069.0395 at 0396-0398, 0400, 0401; tab 997, IRT.0001.0069.0445 at 0445, 0450, 0452, 0457; tab 998, IRT.0001.0069.0458 at 0459, 0461, 0463-0466; tab 999, IRT.0001.0069.0468 at 0468, 0470, 0471, 0473-0475; tab 1000, IRT.0001.0069.0476 at 0476, 0478, 0479.

384 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 993, IRT.0001.0069.0409 at 0415.

385 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0030-0031 [116].

IRT WBG acknowledges that 'certain aspects of its record keeping with respect to the setting of weight parameters and also the recording of actual intake of food could have been improved'.[386] IRT WBG has since implemented the following continuous improvement measures in relation to its nutritional record keeping and escalation procedures:

- following a dietitian review, the Care Manager personally reviews the recommendations with respect to the resident, updates the resident's vital information in the Platinum system and adds the resident to the general practitioner list for charting their directives
- the clinical nurse educator delivered a toolbox talk on nutrition and hydration to care staff
- registered nurses conduct a daily review of food and fluid charts and, where they identify inadequate documentation, they address that with the relevant staff member.[387]

Staff have undertaken further education specific to record keeping, and Ms Taylor confirms that from the beginning of 2018 she was confident that documentation had improved.[388]

As detailed above, Counsel Assisting submitted that the dietitian's advice recommending that Ms Fowler gain weight was not documented by IRT WBG in the Nutrition Assessment as it should have been. We accept that submission and find that from the time of the Dietitian Review, the Nutrition Assessments and Dietary Details should have been, but were not, updated by IRT WBG to adequately reflect the outcomes of the Dietitian Review.

Further, it is unclear on the evidence what parameters were set for Ms Fowler's weight. Following the Dietitian Review, a succession of Nutrition Assessments occurred. However, in each and every one of them, the nutrition goal remained that Ms Fowler will 'not lose more than 2 kg in one month'.[389] IRT WBG 'acknowledges that the documentation of Ms Fowler's GP's decision on whether or not to implement the weight gain target recommended by the dietitian could be improved'.[390]

It is apparent is that the Nutrition Assessment was not updated to reflect the Dietitian Review or any other recommendations in relation to weight, and accordingly that the Care Plan was not updated with important information as it should have been.[391]

386 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034 [130].

387 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2999.40-47, T3000.01-03; Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034 [130(a)-(c)].

388 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2993.33-44; Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034 [131].

389 For example, Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 178, IRT.0001.0002.2865.

390 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0031 [118].

391 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2974.29-47; T2975.45-2976.04.

IRT WBG also record specific dietary needs in a document entitled 'Dietary Details'. Following the Dietitian Review in May 2016, the next Dietary Details report was completed on 2 July 2016.[392] We find that the details of the Dietitian Review, and in particular the recommendations relating to food to boost energy, are not reflected in this document as they should have been.[393]

In oral evidence, Ms Taylor agreed that the failure to amend the weight to better reflect the recommendation by the dietitian that Ms Fowler needs to gain weight, is inconsistent with proper process and seems to be an error.[394] Ms Taylor agreed further that this is an error that could cause real risk because the staff who are acting on the nutritional assessment might not appreciate that the dietitian had recommended that the resident needs to increase her weight, not merely maintain it within the loss of a further two kilograms.[395]

However, while IRT WBG recognises better documentation could have been maintained, it submitted that there:

> is no evidence before the [Royal] Commission which suggests that these record keeping issues in any way adversely impacted Ms Fowler's weight or overall condition or were at a level where they could have done so. Equally, there is no suggestion or evidence that any other steps would have resulted in a different (improved) outcome for Ms Fowler.[396]

We consider that IRT WBG's failures to incorporate dietitian recommendations into care planning documentation, including weight monitoring, could well have had concrete adverse impacts for Ms Fowler's health and wellbeing. While we accept that we cannot make a finding on the evidence before us that there was an actual impact of this kind, we are concerned that IRT WBG's submission tends to underestimate the gravity of these issues and the risk its failings presented to Ms Fowler. In particular, we disagree with the submission that the failings were not 'at a level' where they could have impacted on Ms Fowler's weight or overall condition.

Dr Bird gave evidence that in reviewing the Dietician Review, 'he would agree with the overall report' and that he agrees 'with the introduction of the supplements as specified in the report'.[397] Dr Bird prescribed supplements on or about 7 June 2017, more than a year after the Dietitian Review.[398]

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392 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 116, IRT.0001.0002.2115.

393 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2991.34-46.

394 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2991.06-16.

395 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2991.18-24.

396 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0034 [132].

397 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0004 [8(a)].

398 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1083, DHC.0002.0001.0041 at 0044.

Further decline and significant weight loss

During the period March 2016 to September 2016, Ms Fowler's weight remained stable at approximately 57kg.[399] However, after a material decline and hospitalisation following a fall in October 2016,[400] Ms Fowler sustained significant weight loss.[401] As at 25 October 2016, Ms Fowler's weight was approximately 3kg lower than her last weigh-in on 20 September 2016.[402] In a written submission, IRT WBG stated:

> IRT WBG recognises that this was a material weight loss, however this must be seen in the context of the decline in Ms Fowler's overall condition, including the multiple incidents she experienced during that month including her hospitalisations.[403]

Dr Bird says this significant weight loss occurred at a time that Ms Fowler 'had deteriorated to the point where there was a significantly diminished quality of life and a conservative, comfort focussed approach to care to be taken'.[404]

By 25 October 2016, Ms Fowler's weight was 54.09kg.[405] Ms Fowler had sustained a weight loss of more than 3kg in about one month, having weighted 57.26kg at her last weigh on 20 September 2016.[406]

On 26 October 2016, progress notes reflect a direction by an registered nurse to care staff to 'please re-weigh – outside of range' and the direction is given 'notify RN if weight remains outside of range.'[407] A reweigh occurred on 28 October 2016, again showing that Ms Fowler's weight was 54.09kg.[408]

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399 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1006, IRT.0001.0069.0513.

400 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289.

401 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1006, IRT.0001.0069.0513; Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2999.

402 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0031-0032 [120]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 222, IRT.0001.0002.3177.

403 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0031-0032 [120].

404 Darwin and Cairns Hearing, Written Submissions of Dr Bird in reply, 31 July 2019, RCD.0012.0016.0001 at 0002 [6]; Exhibit 6-11, Darwin and Cairns Hearing, Statement of Kristy Lee Taylor as amended, 28 June 2019, WIT.0259.0001.0001 at 0004 [23].

405 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1006, IRT.0001.0069.0513 at 0515.

406 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1006, IRT.0001.0069.0513 at 0515.

407 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0330.

408 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1006, IRT.0001.0069.0513 at 0515.

At the hearing, Senior Counsel Assisting, Mr Gray QC, put the following to Ms Taylor:

> There really has been a drop in weight. There doesn't appear to be follow-up action apart from re-weighing. There doesn't appear to be some practical outcome in terms of trying to address this loss of weight with some different intervention or an assessment by a dietitian or anything of that kind. Are you able to comment on that? [409]

In response, Ms Taylor explained new processes IRT WBG implemented in relation to clinical care, including weekly weighs, food charts, adjustments to diet, and referral to a dietitian and general practitioner.[410] These processes came into place in 2018.[411]

At Ms Fowler's regular weigh-in in December 2016, as her weight had not returned to her September 2016 levels (around 57kg), she was referred to her general practitioner for review.[412] Ms Fowler's general practitioner reviewed her on 4 January 2017 and concluded that her weight was stable.[413] Dr Bird did not provide IRT WBG with any changes to her then current nutrition or treatment plan.[414]

From January 2017 to April 2017, Ms Fowler was being weighed on an approximately weekly basis to monitor her for further weight loss.[415] Her weight was relatively stable until March 2017, when it again started declining.[416]

In response to questions about Ms Fowler's weight loss, Dr Bird gave evidence that:

> Dementia Australia on their website highlights the problems with eating. 'It is common for people in the later stages of dementia to lose a considerable amount of weight. People may forget how to eat or drink, or may not recognise the food they are given.'[417]

409 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2999.34.

410 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2999.40-47.

411 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T3000.03.

412 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0032 [121]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0289.

413 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0032 [121]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 763, IRT.0001.0003.0289 at 0289.

414 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0032 [121]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 759, IRT.0001.0002.9576 at 9672; Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0007 [10(a)].

415 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0032 [122]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1006, IRT.0001.0069.0513 at 0514.

416 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0032 [122].

417 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0004-0005 [8(b)].

IRT WBG 'agrees with the evidence given by Ms Fowler's GP referencing the Dementia Australia website…This was consistent with Ms Fowler's condition in late 2016 and 2017'.[418]

However, what Dr Bird's submission does not include is the remainder of the quote from the Dementia Australia website:

> Providing nutrition supplements may need to be considered. If a person has swallowing difficulties, or is not consuming food or drink over a significant period of time and their health is affected, nutrition supplements may be considered for consumption other than by mouth.[419]

According to Dr Bird:

> A key factor in the care of Ms Fowler occurred on 13 May 2016. On that day I met with Lyndall and we had a very frank discussion about future care for Ms Fowler and what our care aims should be, going forward. As a result of that discussion, Lyndall made the decision, as Ms Fowler's next of kin, that Ms Fowler should receive no more active treatment, no matter the issues that arose, and that she should commence palliative care. Once a decision like this has been made, a decision needs to be made each time a patient shows signs of illness, as to whether or not to put the patient through the discomfort of investigations, when a decision has already been made not to treat the possible illnesses that the investigations uncover.[420]

Dr Bird says palliation was the predominant factor that applied to all of the decisions concerning Ms Fowler's care after this conversation on 13 May 2016: 'This did not mean that weight monitoring completely fell away, but it did mean that the clinical purpose of such actions significantly changed.'[421]

IRT WBG agrees, saying that this 'further decline in weight correlates with Lyndall's discussions with Ms Fowler's GP to the effect that Ms Fowler was palliating in April 2017'.[422] IRT WBG submitted that this is also consistent with Lyndall's 'understanding of her mother's condition, with progress notes from June 2017 noting that Lyndall did not require a dietitian review for her mother because Lyndall understood weight loss was

418 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0033 [125]-[126].

419 Dementia Australia n.d., 'The later stages of dementia', https://www.dementia.org.au/about-dementia/carers/later-stages-of-dementia, viewed on 9 August 2019.

420 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0005-0006 [8(c)].

421 Darwin and Cairns Hearing, Written Submissions of Dr Bird in reply, 31 July 2019, RCD.0012.0016.0001 at 0002 [7].

422 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0032 [123]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1153, DHC.0002.0001.0169.

part of the dying process'.[423] According to Dr Bird, 'Ms Fowler's charted weight history at the relevant times is unremarkable for a person with her generally declining condition.'[424]

Relationship between pressure injuries and nutrition

Around the middle of 2017, two pressure injuries developed on Ms Fowler's feet.[425] These pressure injuries did not heal until 2018.[426] The Royal Commission heard evidence that pressure injuries are excruciatingly painful.[427]

As Ms Taylor accepted in her oral evidence, significant weight loss could have a very adverse effect on the strength of the person in question, their ability to fight infection, their ability to recover from injury, and their proneness to illness.[428]

The Royal Commission also heard expert evidence that residents are more likely to get pressure sores if they are malnourished. Two reasons for this are because:

- the wound stays longer, due to the inability to heal and resist infection
- as residents start to lose weight, they have less padding. This results in greater pressure on the skin.[429]

In such circumstances, monitoring weight may have had direct clinical relevance to the pain and discomfort Ms Fowler experienced as a result of the pressure injuries, and would be the expected approach under the Advance Care Directive agreement between Lyndall and Dr Bird signed in December 2016 that states 'any treatments or investigations will only be for pain relief and to ease [Ms Fowler's] discomfort'.[430]

However, in an email to IRT WBG dated 29 June 2017, Lyndall wrote as follows:

> I accept that my mother is dying and certainly do not want any extraordinary intervention to prolong her life but the care being provided does not appear to match the gravity of her deterioration in my view.
>
> Last night when it was obvious from observation that Shirley had lost more weight I asked to see the RN and found that her weight had dropped from 47+kg to 45+kg on 19/6 and 43.6kg 27/6 (I acknowledge that accreditation was underway at the

423 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0033 [127]; Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 759, IRT.0001.0002.9576 at 9578.

424 Darwin and Cairns Hearing, Written Submissions of Dr Bird in reply, 31 July 2019, RCD.0012.0016.0001 at 0001-0002 [4].

425 Darwin and Cairns Hearing, Written Submissions of Counsel Assisting the Royal Commission into Aged Care Quality and Safety, 24 July 2019, RCD.0012.0015.0001 at 0012 [41].

426 Darwin and Cairns Hearing, Written Submissions of Counsel Assisting the Royal Commission into Aged Care Quality and Safety, 24 July 2019, RCD.0012.0015.0001 at 0013 [45]-[46].

427 Transcript, Catherine Anne Sharp, Darwin and Cairns Hearing, 11 July 2019 at T3300.23-32.

428 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2987.35-2988.03.

429 Transcript, Sandra Iuliano, Darwin and Cairns Hearing, 16 July 2019 at T3656.23-36.

430 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 166, IRT.0001.0002.2591 at 2592.

> time of the first weight). I am extremely upset that I had to raise the issue and make suggestions about offering fluids more often and specific recording of Resource Supplement consumption as it is not clear if she has been having it 3 times a day as ordered…
>
> What is the point of all the weighing if no action results from a significant weight loss?…I would have thought at this stage as much as 1kg weight loss could be something that might flag a need to offer fluids more often or reduce meals and offer small amounts of food more often.[431]

On 5 July 2017, less than a week after the date of this email, weekly weighs were ceased.[432]

The National Aged Care Mandatory Quality Indicator Program

In oral evidence, Ms Taylor agreed that significant weight loss, be it described as three kilograms in a month or three successive months of weight reduction, can have a very adverse effect on the person who has suffered the weight loss, including on their strength, ability to fight infection, ability to recover from injury and how prone they are to illness generally.[433] Ms Taylor agreed it is a very serious issue and needs to be monitored carefully.[434]

The National Aged Care Mandatory Quality Indicator Program Manual 1.0 (the Manual), which came into effect on 1 July 2019, defines palliative care as:

> Palliative care is an approach that improves the quality of life of care recipients and their families facing problems associated with life-threatening illness, through prevention and relief of suffering by early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual issues.[435]

The Manual defines end of life (terminal) care as:

> A form of palliative care that is appropriate when the care recipient is in the final weeks or days of life.[436]

Ms Taylor agreed in evidence that in the period around May 2017, Ms Fowler was in receipt of the lower tier of palliative care.[437]

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431 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 27, IRT.0001.0002.0204.

432 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1066, DHC.0001.0001.0043 at 0059.

433 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2987.35-2988.05.

434 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2988.07-09.

435 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0008.

436 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0008.

437 Transcript, Kristy Taylor, Darwin Hearing, 9 July 2019 at T2974.23-27.

For the purposes of section 26(a) of the *Accountability Principles 2014* (Cth), the Manual specifies that 'all aged care recipients must be assessed for unplanned weight loss' except for 'care recipients receiving end-of-life palliative care'.[438] The manual defines unplanned weight loss as:

> where there is no written strategy and ongoing record relating to planned weight loss for the care recipient.[439]

For the purposes of section 26(b) of the Accountability Principles, the Manual specifies that:

> Approved providers must compile or otherwise derive from these measurements and assessments the following information:
>
> - The total number of care recipients who experienced a significant unplanned weight loss for the quarter.
> - The total number of care recipients who experienced consecutive unplanned weight loss for the quarter.[440]

The Manual describes significant weight loss as:

> Significant weight loss is unplanned weight loss equal to or greater than three kilograms over a three-month period. This result is determined by comparing the care recipient's weight at the last weigh this quarter (three-month period) with their weight at the last weight last quarter. Both these weights must be available to provide this result.[441]

The Manual describes consecutive unplanned weight loss as:

> Consecutive unplanned weight loss is unplanned weight loss of any amount every month over three consecutive months of the quarter. This can only be determined if the care recipient is weighed on all three occasions.[442]

In accordance with the Manual, the information collected under the Quality Indicator Program must be given to the Secretary of the Australian Department of Health.[443]

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438 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0022.

439 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0020.

440 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0022.

441 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0021.

442 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0021.

443 Section 26 of the *Accountability Principles 2014* (Cth).

The program requires reporting of unexpected weight loss where a resident is palliative, which was the case for Ms Fowler. As the Manual highlights:

> **Important note**
>
> - Any unplanned and unexpected weight loss should be investigated promptly and appropriate treatment commenced.
> - If a care recipient cannot be weighed, it is still good practice to monitor them using alternative means such as mid-arm or calf circumference. This ensures changes are identified and appropriate strategies put in place.[444]

IRT WBG submitted that the aim of palliative care is to 'enhance quality of life, rather than to seek to treat or cure. IRT WBG's care of Ms Fowler during her palliative stages should be viewed in this context'.[445] IRT WBG submitted that:

> it had in place appropriate processes and procedures for monitoring and managing Ms Fowler's weight, diet and nutrition. The evidence before the Commission … demonstrate that Ms Fowler's weight and nutrition were regularly monitored, proactive steps were taken with respect to maintaining her weight, quality food was provided, and issues with respect to her weight and nutrition were communicated with Lyndall and Ms Fowler's treating GP.[446]

Dr Bird submitted that, 'There is nothing in the evidence that supports any findings of a lack of rigour by [him] in respect of Ms Fowler's weight. Rather, the evidence shows a pragmatic approach to weight management of a palliated patient with advanced care needs and a generally declining condition.'[447]

Dr Bird gave evidence that 'weighing Ms Fowler involves a lengthy process with many staff and is uncomfortable for Ms Fowler. The weighing involved Ms Fowler being put in a sling to be weighed'.[448] At this stage, Dr Bird says that Ms Fowler was in a terminal state.[449]

444 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 1152, RCD.9999.0106.0001 at 0023.

445 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0003 [12].

446 Darwin and Cairns Hearing, Written Submissions of IRT William Beach Gardens in reply, 31 July 2019, RCD.0012.0018.0001 at 0033 [129].

447 Darwin and Cairns Hearing, Written Submissions of Dr Bird in reply, 31 July 2019, RCD.0012.0016.0001 at 0003 [9].

448 Exhibit 6-14, Darwin and Cairns Hearing, Supplementary Statement of Dr Robert Keith Bird, 22 July 2019, WIT.0249.0001.0001 at 0008 [11].

449 Darwin and Cairns Hearing, Written Submissions of Dr Bird in reply, 31 July 2019, RCD.0012.0016.0001 at 0002-0003 [8].

However, as highlighted in the Manual (see above), we find that there are alternative options to overcome this logistical difficulty. Lyndall also noted that Ms Fowler's weight loss was 'obvious from observation'.[450]

Had the National Aged Care Mandatory Quality Indicator Program been in effect during the relevant period (mid–2016 to late–2017), we find that the level of weight loss experienced by Ms Fowler would have been captured by the mandatory reporting of data.

We find that IRT WBG, in conjunction with Dr Bird, should have identified Ms Fowler's weight loss as a matter for concern and action, and treated it accordingly. It is apparent from the evidence that there has been a lack of rigour in the practices adopted by IRT WBG and Dr Bird in terms of monitoring Ms Fowler's weight and taking appropriate steps where issues with weight loss were identified.

Assisi Aged Care Centre case study

Introduction

The Royal Commission considered the experiences of the late Mrs Annunziata Santoro in residential aged care at Assisi Aged Care Centre (Assisi Centre). Assisi Centre is located in Rosanna in Melbourne, Victoria, and is owned and operated by Assisi Centre Ltd (Assisi).

The evidence before the Royal Commission consisted of:

- the statement of Anamaria ('Anna') Ng, Mrs Santoro's daughter[451]
- the statement of Dr Eric Tiong Yew Tay, the general practitioner for Mrs Santoro[452]
- the statements of Paul Cohen, Interim Chief Executive Officer of Assisi[453]
- the statement of Donato Smarrelli, the Chair of the Board of Directors of Assisi[454]
- the oral testimony of those four witnesses
- the tender bundle for this case study, which consists of 460 documents.[455]

Counsel Assisting examined each witness at the Darwin Hearing on 10 July 2019. Dr Tay and Assisi were granted leave to appear. Dr Tay and his legal representative were present throughout the hearing but did not seek leave to examine any of the witnesses. Assisi and its representatives were also present throughout the hearing. Counsel for Assisi sought and was granted leave to examine Dr Tay, but otherwise did not seek to ask questions of any other witness.

450 Exhibit 6-8, Darwin and Cairns Hearing, IRT William Beach Gardens tender bundle, tab 27, IRT.0001.0002.0204.

451 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001.

452 Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001.

453 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001; Exhibit 6-18, Darwin and Cairns Hearing, Supplementary Statement of Paul Cohen, 7 July 2019, WIT.0258.0002.0001.

454 Exhibit 6-19, Darwin and Cairns Hearing, Statement of Donato Smarrelli, 7 July 2019, WIT.0288.0001.0001.

455 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle.

Neither of the witnesses from Assisi had any direct involvement in, or personal knowledge of, the provision of care to Mrs Santoro.[456] Mr Cohen, who was apparently put forward by Assisi as its main witness of fact, was not employed at Assisi at the time of events relating to Mrs Santoro.[457]

In accordance with directions that we made on 12 July 2019, Counsel Assisting made written submissions setting out, among other things, findings proposed by Counsel Assisting for this case study.[458] In response, legal representatives for Assisi and Dr Tay respectively provided the Royal Commission with written submissions.[459] Assisi's representatives then made supplementary submissions, largely in reply to Dr Tay's submissions.[460] The Royal Commission also received correspondence from a nurse manager from Assisi dated 26 July 2019.[461] Ms Ng did not make written submissions.

Assisi and Dr Tay did not dispute that we should make some of the findings proposed by Counsel Assisting. We refer further below to matters in respect of which there was disagreement between Counsel Assisting and one or more parties with leave to appear.

Mrs Annunziata Santoro

Mrs Santoro was born in Italy in 1924 and grew up there before migrating to Australia in 1956.[462] After settling in Australia, Mrs Santoro married her husband when she was 40 years old. Together they raised a family, including their daughter, Ms Ng.[463]

In about 2008, Mrs Santoro came to live with Ms Ng and her family.[464] Ms Ng was Mrs Santoro's primary carer at this time. Mrs Santoro had a number of medical conditions, including type 2 diabetes, macular degeneration, arthritis and arrhythmia.[465] Mrs Santoro was assessed for a Home Care Package and received some care at home. Eventually, however, as her mother's care needs increased, Ms Ng made the decision to move her mother into residential aged care because the Home Care Package did not provide for additional care of Mrs Santoro at home.[466]

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456 See Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 244, RCD.0010.0001.0101; Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3137.3-3138.21.

457 See, for example, Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3139.6-3140.15.

458 Submissions of Counsel Assisting the Royal Commission: Assisi Centre Limited (Assisi) Case Study, 24 July 2019, RCD.0012.0014.0001.

459 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002; Submissions of Dr Tay in reply to submissions of Counsel Assisting, 1 August 2019, RCD.0012.0019.0003.

460 Supplementary Submissions of Assisi in reply to submissions of Counsel Assisting, 9 August 2019, RCD.0012.0022.0002.

461 Letter to the Royal Commission, 26 July 2019, AWF.600.01113.0001; Chronology of Events – Mrs Santoro, 26 July 2019, AWF.600.01113.0002.

462 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0001 [5]-[6].

463 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001.

464 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0002 [8]-[9]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3049.35-37.

465 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0002 [9]-[10].

466 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0002 [11]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3049.41-43.

On 15 June 2017, Mrs Santoro moved into residential aged care at Assisi Centre. At that time, Mrs Santoro was 93 years of age and was mobile and in reasonable health for her age.[467] She preferred to speak Italian and was not particularly proficient in English.[468]

Early days at Assisi Centre

On first entering Assisi Centre, Mrs Santoro lived in the 'low care' unit called St Anthony's.[469] She was visited by her daughter, Ms Ng, and two of her sons on a regular basis.[470] Initially, Ms Ng visited her mother around twice a week for an hour or so, but by April 2018 she was spending more time with her mother.[471] At all relevant times, Ms Ng held medical power of attorney for Mrs Santoro.

Around the time that Mrs Santoro entered Assisi Centre, care staff were aware of her medical conditions and, in particular, her diabetes. Those conditions were recorded in the records held by Assisi for her.[472] It was only after she entered residential aged care that Mrs Santoro was formally diagnosed with dementia.[473] Staff had from the time of her arrival at Assisi Centre also classified Mrs Santoro as a high falls risk.[474]

Mrs Santoro had some difficulties adjusting to her new living environment at Assisi Centre.[475] She did not want to live in residential aged care. Ms Ng felt that staff only gave her and her mother limited emotional support at this time.[476]

To help her mother adjust to life at Assisi Centre, Ms Ng made a 'social story' for Mrs Santoro in March 2018.[477] It was in the form of a photograph album and was designed to help Mrs Santoro understand who she was and who the people around her were. Ms Ng found that going through the album helped to settle her mother.[478]

Ms Ng gave evidence that, although she encouraged staff to look at the album with her mother, particularly when her mother was upset, she never once saw them do so.[479] She said that she often found the album packed away in her mother's drawers when she visited her.

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467 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003 [15].

468 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3052.32-36.

469 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003 [16].

470 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3064.4-3064.36.

471 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3064.4-22; Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0009 [51].

472 See, for example, Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 17, ACL.500.0001.2606.

473 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3050.15-22.

474 See, for example, Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 11, ACL.500.0001.3618.

475 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003 [17].

476 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3052.7-12 and T3054.15-27.

477 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003 [17].

478 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003 [18].

479 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003 [18]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3056.31-45.

Mr Cohen, Interim Chief Executive Officer of Assisi, gave evidence that, according to his review of Assisi's records, the 'social story' photo album was only used on three occasions between 28 June 2018 and 14 August 2018 and was then 'inaccessible' until it was found by Ms Ng nearly five weeks later on 20 September 2018.[480] He accepted that the lack of use of this therapeutic tool did not 'meet an appropriate standard or Ms Ng's expectations'.[481]

Counsel Assisting submitted that, having regard to the evidence of Ms Ng and Mr Cohen, Assisi staff made little, if any, use of the 'social story' photograph album prepared by Ms Ng for Mrs Santoro.[482] We agree and find accordingly.[483]

Ms Ng also prepared a one-page document for Assisi staff that provided a snapshot of her mother, including her likes and dislikes, and put it up in her mother's room.[484] Ms Ng's evidence was that Assisi staff did not seem to take much interest in this document.[485]

Counsel Assisting submitted that, on the basis of the available evidence, we should find that Assisi staff did not make use of available means to properly manage Mrs Santoro's agitation and other behaviour associated with dementia.[486] In reply, Assisi submitted that there is a lack of evidence before the Royal Commission about other activities undertaken at Assisi Centre to manage behaviour related to dementia generally or, in particular, in Mrs Santoro's case.[487] So much may be accepted. Having regard to the lack of use of the 'social story' prepared for Mrs Santoro by her daughter, however, we find that Assisi staff did not make use of all available means to properly manage Mrs Santoro's agitation and other behaviour associated with dementia.

Hospital admissions in November 2017 and March and April 2018

When Ms Ng visited her mother in the afternoon on 12 November 2017, she observed her mother was clammy and complaining of thirst.[488] Given her mother's diabetes, Ms Ng asked a nurse working at Assisi Centre to check her mother's blood sugar levels. The measurement was very high.[489]

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480 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003 [18]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3056.9-18.

481 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0038 [208].

482 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92a].

483 Assisi accepts that such a finding is "available on the evidence". See Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [93].

484 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0003-0004 [19]; Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 211, AMN.0001.0001.0002.

485 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3056.1-9.

486 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92b].

487 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [27].

488 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0004 [25].

489 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0004 [25].

The next morning, the nurse manager on duty in St Anthony's unit called Ms Ng to inform her that her mother had a chest infection and that her mother's general practitioner, who had seen her that morning, had recommended that the nurse manager merely observe Mrs Santoro rather than call an ambulance.[490]

After that telephone call with the nurse manager, Ms Ng went to Assisi Centre and insisted that staff call an ambulance to take her mother to hospital. Later that day, her mother was admitted to Austin Health, where she was diagnosed with pneumonia. She remained there until returning to Assisi Centre on 21 November 2017.[491]

On 19 March 2018, Mrs Santoro suffered an unwitnessed fall at Assisi Centre and was found on the floor in her room by Assisi staff.[492] As a result of the fall, she sustained three fractures, a sacral fracture, a pubic rami fracture and an acetabular fracture. She was again admitted to Austin Health and remained there until she returned to Assisi Centre on 5 April 2018.

On 9 April 2018, a locum nurse observed Mrs Santoro to have a very high heart rate. She was subsequently taken by ambulance to another hospital. She was diagnosed at the hospital with asymptomatic tachycardia secondary to an untreated urinary tract infection.[493] While in hospital, she fell from bed. As a result of that fall, she was closely supervised for the remainder of her time in hospital. She returned to Assisi Centre on 16 April 2018.

New general practitioner

By November 2017, Ms Ng was not satisfied with her mother's general practitioner.[494] At that time, she requested that Assisi staff make arrangements for a new general practitioner to attend to her mother. In late 2017, the then nurse manager at St Anthony's recommended Dr Eric Tay from Andrew Place Clinic. According to Ms Ng, she agreed with this recommendation and understood that her mother would be seen by Dr Tay. She gave evidence that she followed up with Assisi staff on a number of occasions about her request that her mother see Dr Tay instead of her previous doctor. Her mother was not seen by Dr Tay until 26 April 2018.[495]

490 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0004-0005 [26].

491 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0005 [27].

492 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0007 [37].

493 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0007 [38].

494 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3058.18-3059.6. See also Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0004-0005 [26], 0006 [32] and 0007 [35].

495 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0004-0005 [26], 0006 [32] and 0007 [35]-[36].

Counsel Assisting submitted that Assisi staff failed to make arrangements to change, in accordance with Ms Ng's requests, Ms Santoro's general practitioner within a reasonable time.[496] Assisi says in reply that such a finding should not be made as the selection and engagement of an appropriately skilled general practitioner is ultimately a matter for a resident or their representative.[497] Assisi further submitted that, in any event, its staff provided timely assistance to Ms Ng to identify an alternative practitioner and appropriate contact and follow-up was undertaken by Assisi when requested.[498] We do not make any finding about the adequacy or otherwise of assistance given by Assisi in relation to Mrs Santoro's change of general practitioner. There is insufficient evidence to do so.

Dr Tay was Mrs Santoro's general practitioner from 26 April 2018 until around 23 October 2018, shortly before her death.[499] During that time, he consulted her at Assisi Centre on 17 occasions. He ordinarily attended Assisi Centre fortnightly on a Thursday, but would otherwise attend on Mrs Santoro specifically when he considered it necessary to do so.[500] Two of his general practitioner colleagues at Andrew Place Clinic saw Mrs Santoro when Dr Tay was on leave between 15 September 2018 and 8 October 2018.[501]

At all times while consulting Mrs Santoro, Dr Tay was aware that, by reason of her dementia, she did not have capacity to give consent to medical treatment and that Ms Ng held a medical power of attorney for her mother and was the person from whom he would obtain such consent.[502] Dr Tay was also aware at all times of Mrs Santoro's other medical conditions, including diabetes, chronic pain syndrome and low blood pressure.[503]

Although Dr Tay professed in his oral evidence at the hearing on 10 July 2019 to appreciate the importance of good record-keeping to ensure proper medical treatment and continuity of care,[504] his records of his treatment of Mrs Santoro were overall of a poor standard.[505] Dr Tay accepted that, in respect of some events pertaining to his treatment of Mrs Santoro, he had not kept any records at all.[506]

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496 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92c].

497 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [29-[30]. See also item 2.7 of Part 2 of Sch 1 to the *Quality of Care Principles 2014* (Cth).

498 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [31]-[33].

499 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3083.45-3084.12; Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0002 [7].

500 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3084.21-38.

501 Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0002 [7]; Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3084.46-3085.14.

502 Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0010 [63.3]; Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3085.16-43.

503 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3089.38-3090.5 and T3092.30-33.

504 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3085.45-3086.14.

505 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3089.1-17 and T3126.10-13. See also Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0009 [63.2].

506 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3089.19-24 and T3103.29-3104.1. See also, for example, Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0008 [56] and 0009 [61].

His records were also kept in two separate systems, one managed by Andrew Place Clinic and the other by Assisi.[507] Nursing and care staff at Assisi Centre were unable to look at the records managed by Andrew Place Clinic. Dr Tay accepted that, ideally, his records should have been accessible in both systems.[508]

Counsel Assisting submitted that, on the evidence before the Royal Commission, the following findings should be made about record-keeping by Dr Tay and communication between Assisi staff and Dr Tay:

a. Dr Tay's record-keeping in relation to his care for Mrs Santoro was generally poor[509]

b. poor record-keeping by Dr Tay compromised the quality of clinical care delivered to Mrs Santoro[510]

c. Dr Tay should have, but did not, duplicate his clinical records for Mrs Santoro at Andrew Place Clinic and Assisi Centre[511]

d. failure by Dr Tay to duplicate his clinical records for Mrs Santoro compromised the quality of clinical care delivered to her[512]

e. there was a significant lack of effective communication between Dr Tay and Assisi staff about the management of Mrs Santoro's care[513]

f. lack of effective communication related to, among other things, management of Mrs Santoro's wounds from 17 July 2018 onwards[514]

g. by that lack of effective communication, Dr Tay and Assisi staff compromised the quality and safety of care delivered to Mrs Santoro.[515]

Assisi agreed that it is open to make the proposed findings set out at subparagraphs (a) to (d) above.[516] Assisi does not accept that, insofar as they relate to Assisi, the proposed findings at subparagraphs (e) to (g) should be made.[517] Assisi says that its staff were entitled to assume that Dr Tay, as Mrs Santoro's treating general practitioner with access to Assisi's electronic records, would keep himself up to date with relevant entries and reports and would record any relevant instruction to nursing staff and other Assisi staff.[518]

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507 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3086.16-19; Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0003 [12]; Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 246, DET.0001.0001.0001 and tab 169, ACL.500.0001.0609.

508 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3088.6-40.

509 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92l].

510 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92m].

511 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92n].

512 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92o].

513 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92p].

514 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92q].

515 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92r].

516 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [99].

517 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [100].

518 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [34c].

Dr Tay does not dispute that the proposed findings at subparagraphs (a) and (c) should be made. However, he argues that there is no evidence to permit the making of findings of the kind proposed by Counsel Assisting at subparagraphs (b) and (d) to (g).[519] Dr Tay submitted that the evidence does not support a finding that his standard of record-keeping or communication of information to Assisi staff compromised the quality and safety of care delivered to Mrs Santoro.[520]

We find that Dr Tay's record-keeping in relation to his care for Mrs Santoro was generally poor and that he should have duplicated, but did not duplicate, his clinical records for Mrs Santoro at Andrew Place Clinic and Assisi Centre. We note his evidence that he has sought to improve his record-keeping in more recent times.[521]

We also find that Dr Tay's poor record-keeping and his failure to duplicate his clinical records compromised the quality of clinical care delivered to Mrs Santoro. We do not consider such a finding to be controversial. Good care depends on good communication between the people responsible for delivering that care. Poor record-keeping compromises the communication between those people. It was not possible for Dr Tay to speak with every single other person who had a role in the provision of care to Mrs Santoro. Nor could he reasonably rely on information being relayed to every such other person. The failure to keep adequate records in respect of Mrs Santoro meant that other people were not properly kept abreast of his assessment and conclusions about her medical conditions and their treatment. In that way, Mrs Santoro's quality of clinical care was compromised.

We also find that there was a lack of effective communication between Dr Tay and Assisi staff about the management of Mrs Santoro's care. On our assessment, both Dr Tay and Assisi staff share responsibility for that shortcoming. Some specific instances of that lack of effective communication are set out below. In particular, there was a clear lack of effective communication about management of Mrs Santoro's wounds from 17 July 2018 onwards. Again, we find that, by that lack of effective communication about the provision of care to Mrs Santoro, the quality and safety of care delivered to Mrs Santoro was compromised.

Weight loss and poor record-keeping about weight and nutrition

On 12 May 2018, Mrs Santoro was weighed by Assisi staff and found to have lost around 5½ kilograms since her weight had last been recorded at Assisi on 12 March 2018.[522] Her weight loss over that time, from 54.5kg to 48.9kg, represented about 10% of her total body weight.[523]

519 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [53.2] and [53.3].

520 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [53.3].

521 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3123.33-3124.5.

522 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 301, ACL.500.0001.4272.

523 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0020 [110].

Although Mrs Santoro was then given dietary supplements by Assisi staff,[524] her weight was not subsequently monitored on a regular basis. Mr Cohen accepted that the failure by Assisi staff to take weekly measurements of Mrs Santoro's weight while she was on dietary supplements contravened Assisi's policy.[525] It was also poor clinical practice.

Records about Mrs Santoro's weight loss, the possible reasons for it and the effectiveness of supplements were inadequate.[526] Aside from omitting information, they were also internally inconsistent and ambiguous. We find that poor record-keeping about Mrs Santoro's weight loss compromised the delivery of quality care to Mrs Santoro.

One example is Dr Tay's initial 'comprehensive assessment' of Mrs Santoro on 11 May 2018, in which he had regard to out-of-date and inaccurate weight records kept by Assisi. It is evident that he had regard to the weight records taken by Assisi staff on 12 March 2018. Without up-to-date and accurate weight records for Mrs Santoro, Dr Tay's assessment could not accurately reflect her condition and her care needs. Dr Tay gave evidence that he was not alerted to Mrs Santoro's weight loss by Assisi staff.[527] He said that, if he had been aware of it, he would have made inquiries about her diet and nutrition. Dr Tay otherwise agreed that an older person's weight loss, if caused by inadequate nutrition, could affect other aspects of the person's clinical care.[528] He agreed that it could increase the risk of falls and adversely affect healing of wounds. We accept this evidence of Dr Tay. It is consistent with expert evidence given to the Royal Commission.[529]

It was not until October 2018 that Mrs Santoro's family were told of her significant weight loss between March and May 2018.[530] Given that Ms Ng at all times held medical power of attorney for Mrs Santoro and was regularly visiting her, Assisi staff should have brought the weight loss to her attention at or around the time of first observing it.

Counsel Assisting submitted that Assisi did not keep adequate clinical records about Mrs Santoro's weight and its management[531] and that the records about Mrs Santoro's weight suggest staff failed to monitor on a regular basis the effectiveness of dietary supplements.[532] In reply, Assisi says that, save for occasions when she was hospitalised, Mrs Santoro was weighed monthly and her weight declined as a result of that hospitalisation. Assisi nonetheless concedes that it did not weigh Mrs Santoro in accordance with its

524 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0042 [208].

525 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0042 [208].

526 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 214, AMN.0002.0001.0007 at 0027-0030.

527 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3095.1-3096.15; Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0009 [63.1].

528 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3096.27-43.

529 Exhibit 6-30, Darwin and Cairns Hearing, Statement of Professor Geoff Sussman and Ms Hayley Ryan, WIT.0257.0001.0001 at 0014 [58]-[59]; Transcript, Frances Batchelor, Darwin Hearing, 16 July 2019 at T3723.45-3724.21.

530 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0013 [72]-[73]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3069.23-3070.8.

531 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92d].

532 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92e].

Nutrition and Hydration Policy or as indicated by her condition and accepts that the findings sought by Counsel Assisting are appropriate.[533] We also consider, on the evidence before the Royal Commission, that those findings should be made.

Falls in June 2018 and July 2018 and subsequent hospitalisation

At all times from Mrs Santoro's entry on 15 June 2017, Assisi staff had known that she was at a high risk of falls. However, no low bed or floor bed was obtained for her until 20 April 2018.[534] By then, Ms Ng had had to ask for such a bed to be provided.[535] In June and July 2018, Mrs Santoro had a series of falls at Assisi Centre.[536] As a result of those falls, Mrs Santoro sustained various injuries and was transferred to hospital on a number of occasions. The most significant fall resulted in a broken right hip on 12 July 2018, for which she was hospitalised at Austin Health. Assisi maintains that its staff's response to each of Mrs Santoro's falls was appropriate and cannot be said to be inadequate.[537] We agree.

On or around 14 July 2018, Mrs Santoro's hip was operated on. On 17 July 2018, Mrs Santoro was discharged back to Assisi Centre.[538] On or around that date, Assisi received a discharge document from Austin Health dated 17 July 2018, which relevantly stated that:

- the surgical wound on her right hip should be reviewed by her general practitioner two weeks after the surgery
- she had a pressure injury on her right heel that required aquacel dressing.[539]

Assisi staff did not show this document to Dr Tay or anyone else and Dr Tay was not told of its contents.[540] In evidence to the Royal Commission, Dr Tay accepted that, even though he was aware of Mrs Santoro's discharge from hospital around 17 July 2018, he never asked Assisi staff or the hospital for a copy of the hospital's discharge documentation.[541] Nor did he ask anyone for information about the hospital's directions for Mrs Santoro's care post-discharge.

533 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [37]-[38].

534 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0008 [45].

535 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0007-0008 [40]-[43].

536 See, for instance, Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0010 [57]-[58].

537 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [44].

538 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 232, ACL.001.0004.0252; Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 233, ACL.001.0004.0259.

539 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 233, ACL.001.0004.0259.

540 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3105.29-32. Ms Ng also was not given the discharge document or told of its contents. See Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3064.38-45.

541 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3105.34-3106.40.

Assisi submitted that the Austin Health discharge summary was included in Mrs Santoro's clinical file at Assisi, summarised by nursing staff in the electronic record and accessible by Dr Tay.[542] In his evidence, Dr Tay admitted that the lack of any follow-up by him to obtain this document, or at least the information in it, represented a 'failing' on his part.[543] In addition to that failing, he did not take steps to access Assisi's progress notes for Mrs Santoro, which he could have done, to ascertain the hospital's directions for her post-discharge care.[544] He generally conceded that, in his management of patients at Assisi Centre, it would have been preferable for him to access progress notes *and* speak to nursing staff, but he often only did the latter.[545]

Hip wound infection and further hospitalisation in August 2018

On Mrs Santoro's return to Assisi on 17 July 2018, Assisi care staff recorded that Dr Tay would review the wound a fortnight after the operation.[546] That review was therefore due to take place on or around 27 July 2018. The review was to involve consideration of removal, or directions for removal, of surgical staples from the wound. That task was capable of being undertaken at Assisi Centre.

Dr Tay saw Mrs Santoro at Assisi Centre on 19 July 2018 and 2 August 2018.[547] He did not remove or direct the removal of the surgical staples on either of those occasions. He did not physically examine her hip wound on either occasion. His notes for the consultation on 19 July 2018 do not refer to her discharge from hospital, her broken hip or the existence of any surgical staples at the site of her hip operation.[548] The notes also do not refer to any pressure injury on Mrs Santoro's right heel. Instead, the notes only comment on administration of anti-psychotropic medication.

Dr Tay's notes for the consultation on 2 August 2018 also only refer to administration of Oxazepam and an increased dosage of Quetiapine.[549] In his oral evidence before the Royal Commission, Dr Tay stated that, on 2 August 2018, Assisi staff did not mention Mrs Santoro's hip wound to him, so 'I did not think of it'.[550]

542 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [48].

543 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3105.45-3106.17.

544 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3106.42-3107.13.

545 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3127.41-3128.20.

546 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 234, ACL.500.0001.3780 at 3782.

547 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3109.34-41 and T3114.13-25; Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0005 [32] and [36].

548 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 246, DET.0001.0001.0001 at 0007. See also Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3108.38-3109.8.

549 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 246, DET.0001.0001.0001 at 0008.

550 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3114.13-25.

The wound from Mrs Santoro's hip surgery became infected and that infection led to her return to the Austin Health's emergency department for treatment, including removal of the staples, on 6 August 2018.[551] In his evidence, Dr Tay conceded that, if he had attended to her hip wound earlier and monitored it for infection, the need for Mrs Santoro to go to hospital could have been avoided.[552] In this regard, we find that Dr Tay failed in his responsibility for the proper management of Mrs Santoro's hip wound after her discharge from hospital.

Assisi records otherwise referred to a telephone conversation between Dr Tay and Assisi staff on 26 July 2018 (that is, in the period between Dr Tay's two consultations on 19 July 2018 and 2 August 2018).[553] According to that record, an Assisi staff member told Dr Tay that the surgical staples were not ready for removal at that time. Dr Tay gave evidence that he could not recall that conversation.[554]

Counsel Assisting submitted that:

a. Dr Tay should have sought information from Assisi staff or Austin Health about post-discharge directions from Austin Health for the management of Mrs Santoro's hip wound[555]

b. if Dr Tay had attended to Mrs Santoro's hip wound earlier and monitored it more closely for infection, the need for her to return to hospital on 6 August 2018 could have been avoided[556]

c. Assisi staff should have given Dr Tay information about post-discharge directions from Austin Health for the management of Mrs Santoro's hip wound and the pressure injury on her right heel[557]

d. Assisi staff did not take adequate and timely steps to prevent and manage the infection of Mrs Santoro's hip wound and to remove the surgical staples[558]

e. both Dr Tay and Assisi staff failed in their responsibility for the proper management of Mrs Santoro's hip wound after her discharge from hospital on 17 July 2018.[559]

551 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0011 [59]-[60].

552 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3116.10-13.

553 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 194, ACL.501.0001.0131 at 0132.

554 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3114.27-3115.25.

555 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92s].

556 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92t].

557 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92u].

558 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92v].

559 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92w].

In reply, Assisi conceded that the proposed findings at subparagraphs (a) and (b) above are consistent with the evidence before the Royal Commission, but otherwise says that the proposed findings at subparagraphs (c) to (e) are inconsistent with that evidence and should not be made in respect of Assisi.[560] Assisi submitted that the Austin Health discharge directions were summarised in the electronic file of Mrs Santoro and therefore accessible to Dr Tay.[561] Further, Assisi submitted that staff attempted to contact Dr Tay on 4 August 2018 and subsequently about redness at the wound site but were unable to make contact with him.[562]

Dr Tay submitted that the proposed findings at subparagraphs (b) and (e) above are not supported by the evidence. He submitted that any shortcoming in his proper management of the wound relates solely to his failure to seek information on post-discharge directions and not in any way to his management of the wound.[563] We do not regard those two matters as separate and distinct from one another in the way that Dr Tay suggests. Dr Tay does not otherwise dispute the findings proposed by Counsel Assisting about the proper management of Mrs Santoro's hip wound.

While a lack of communication from Assisi staff is obviously undesirable, we find that there is no reasonable excuse for Dr Tay's failure to examine and attend to Mrs Santoro's hip wound on 2 August 2018. Dr Tay conceded as much in his oral evidence.[564]

We also find that Assisi staff failed in their responsibility for the proper management of Mrs Santoro's hip wound after her discharge from hospital. They did not take adequate and timely steps to prevent and manage the infection in her hip wound. They also failed to communicate regularly and effectively with Dr Tay about the precise nature of the post-discharge management of that wound and the removal of surgical staples from it. As Mr Cohen acknowledged, the circumstances at Assisi leading to Mrs Santoro's re-admission to hospital with the infected wound were 'a departure from policy and an expected standard of care'.[565] He considered that, even if Dr Tay did not remove the staples, Assisi nursing staff could and should have done so.[566]

560 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [101]-[102].

561 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [48].

562 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [53]-[54].

563 Submissions of Dr Tay in reply to submissions of Counsel Assisting, 1 August 2019, RCD.0012.0019.0003 at [53.5].

564 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3115.27-3116.13.

565 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0041 [208]; Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3150.29-3151.22.

566 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3152.6-9.

In these circumstances, we consider that, on balance, most of the findings sought by Counsel Assisting and set out above should be made. On the basis of the evidence before the Royal Commission, we find that:

- Dr Tay should have sought information from Assisi staff or Austin Health about post-discharge directions from Austin Health for the management of Mrs Santoro's hip wound
- if Dr Tay had attended to Mrs Santoro's hip wound earlier and monitored it more closely for infection, the need for her to return to hospital on 6 August 2018 could have been avoided
- Assisi staff should have directly told Dr Tay about post-discharge directions from Austin Health for the management of Mrs Santoro's hip wound and the pressure injury on her right heel
- Assisi staff did not take sufficient steps to prevent and manage the infection of Mrs Santoro's hip wound and to remove the surgical staples
- both Dr Tay and Assisi staff failed in their responsibility for the proper management of Mrs Santoro's hip wound after her discharge from hospital on 17 July 2018.

Pain management

Dr Tay was aware from the commencement of his treatment of Mrs Santoro that she had been diagnosed with chronic pain syndrome.[567] He accepted in his oral evidence that, as a consequence, he was at all times also aware of the need to carefully manage Mrs Santoro's pain.[568] Soon after commencing as Mrs Santoro's general practitioner, he reduced her dosage of painkillers delivered by Norspan opioid patch.[569]

In his evidence, Dr Tay accepted that it was necessary to carefully monitor and review the reduction of Mrs Santoro's painkillers, particularly given her chronic pain syndrome and dementia.[570] He acknowledged that, in addition to the prospect that she might suffer increased pain as a result of the reduction of painkillers, she might also suffer withdrawal symptoms.[571] He agreed that she might become irritated and agitated as a result of increased pain and withdrawal symptoms.[572]

Dr Tay also accepted that pressure injuries, such as the one on Mrs Santoro's heel, could be very painful.[573] He acknowledged that, given Mrs Santoro's chronic pain syndrome, pain management for her heel wound was absolutely vital. That was particularly so, he agreed, because Mrs Santoro's dementia meant that behaviour such as agitation might result from an inability to communicate about her pain.

567 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3089.26-3090.5.

568 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3090.1-5.

569 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3090.24-3091.5.

570 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3092.45-3093.21.

571 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3090.37-3091.5.

572 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3090.24-3091.5.

573 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3092.40-3093.21.

In this context, it is not acceptable that there were no formal recorded pain assessments for Mrs Santoro between 18 July 2018 and 17 October 2018. We also note the evidence of Ms Ng that, as late as 15 October 2018, Mrs Santoro was not being given analgesia before the dressing on her very serious heel wound was changed.[574] Ms Ng said that a doctor from Austin Outreach told her at that time that provision of pain relief at the time of dressing changes was 'the humane thing to do'.[575] Mr Cohen conceded that, at Assisi Centre, 'Mrs Santoro did not receive pain relief prior to having her dressings changed until such time as this was requested by Austin Outreach' and that her pain 'was not managed in accordance with Assisi's policy'.[576]

In respect of management of Mrs Santoro's pain, Counsel Assisting submitted that:

a. Assisi did not keep adequate clinical records about Mrs Santoro's pain management[577]

b. there were no pain assessments for Mrs Santoro between 18 July 2018 and 17 October 2018[578]

c. Assisi staff did not manage Mrs Santoro's pain effectively or properly[579]

d. there was also inadequate assessment of how pain on the part of Mrs Santoro might have affected her behaviour.[580]

Assisi does not accept that such findings should be made. Among other things, Assisi refers to the clinical notes for Mrs Santoro which record observations and assessments made by Assisi staff about her pain, including the effectiveness of pain medication administered.[581] Dr Tay submitted that Mrs Santoro's pain was complex and he was guided in his management of the issues by the geriatrician and Austin Hospital medical staff.[582]

We consider that the evidence generally supports findings in the terms proposed by Counsel Assisting at subparagraphs (a) to (c) above. Even acknowledging that basic pain observations and assessments were recorded by Assisi staff in progress notes for Mrs Santoro during the period from 18 July 2018 to 17 October 2018, we still find that Assisi did not keep adequate clinical records about Mrs Santoro's pain management. Among other things, there was not, but should have been, a formal review or update of Mrs Santoro's 'Pain Care Plan' undertaken by Assisi staff during that period from

574 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0014-0015 [85].

575 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3072.22-33.

576 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at [208] (page 44).

577 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92h].

578 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92i].

579 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92x].

580 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92y].

581 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [58]. See also, for example, Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 420, ACL.501.0001.6683 at 6903, 6910, 6915, 6921, 6923, 6926, 6928, 6931, and 6932.

582 Submissions of Dr Tay in reply to submissions of Counsel Assisting, 1 August 2019, RCD.0012.0019.0003 at [19]-[24].

18 July 2018 to 17 October 2018. Up-to-date clinical documentation of that kind would have played an important role in the consistent and effective treatment of pain experienced by Mrs Santoro. The lack of up-to-date documentation of that kind meant that Mrs Santoro's pain was not managed as effectively as it should have been. This is particularly the case given Mrs Santoro's chronic pain syndrome, of which Assisi staff were or should have been aware, and her potential inability, as a person living with dementia, to communicate effectively about pain experienced by her. Finally, and while we have some reservations about the adequacy of understanding by Assisi staff of the potential connection between Mrs Santoro's pain and her behaviour, we do not consider that there is sufficient evidence available to us to make a finding of the kind proposed by Counsel Assisting at subparagraph (d) above.

Use of anti-psychotic medications

Ms Ng only received a full description of the medications taken by her mother and their doses in an email from one of Dr Tay's colleagues on 20 September 2018.[583] By that time, she had become concerned about the possible side effects of medications on her mother and, in particular, her mother's drowsiness.

Dr Tay's records indicate that he mentioned to Ms Ng in and after June 2018 that her mother would be administered Quetiapine.[584] He also gave evidence to the Royal Commission that he informed Ms Ng about the prescription and administration in August 2018 of Oxazepam and of higher doses of Quetiapine.[585] However, he did not keep proper records of what he had told Ms Ng in obtaining her consent, as the holder of a medical power of attorney, to the use of those medications.[586]

Dr Tay accepted that, from 14 June 2018 onwards, he was well aware of Ms Ng's concerns about the sedative effects of anti-psychotic medication on her mother.[587] He also accepted that, at all relevant times, he was aware that Ms Ng would want to be informed of any increased dosage of Quetiapine or the introduction of some other anti-psychotic medication such as Oxazepam.[588] In that context, his records should have documented how he obtained informed consent from Ms Ng to the use of these medications.

583 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0013 [74]-[76]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3068.23-3069.11; Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 216, AMN.0004.0001.0001.

584 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 246, DET.0001.0001.0001 at 0006 and tab 247, DET.0001.0002.0001 at 0009 and 0065-0067; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3080.41-3081.36.

585 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3111.11-3114.11.

586 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3101.42-3102.13.

587 Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0004 [26].

588 Transcript, Eric Tay, Darwin hearing, 10 July 2019 at T3103.9-14.

In respect of the use of anti-psychotic medications, Counsel Assisting submitted that Dr Tay did not take sufficient steps to obtain informed consent from Ms Ng before the prescription and administration in August 2018 for Mrs Santoro of Oxazepam and of considerably higher doses of Quetiapine.[589]

Again, Assisi does not accept that such a finding should be made.[590] The Royal Commission received lengthy written submissions from Dr Tay on prescription of anti-psychotic medications and dosing changes[591]—he also does not accept that the evidence supports the finding proposed by Counsel Assisting. We agree and do not make a finding of that kind. However, as we have already observed, Dr Tay's records were inadequate insofar as they went to consent obtained from Mrs Santoro's medical power of attorney, Ms Ng, about the use of anti-psychotic medications for Mrs Santoro.

Wound management for pressure injury on right heel

On 20 August 2018, Mrs Santoro was transferred to the 'high care' unit in Assisi Centre, known as St Francis.[592] By that time, she had had another fall on 8 August 2018, for which she had again been admitted to hospital. Ms Ng agreed to the move because she understood that there were more staff for each resident in that unit than in the 'low care' unit.[593]

Before Mrs Santoro's move to the 'high care' unit, Ms Ng had expressed concerns to Assisi staff about their management of the risk of pressure injuries for her increasingly immobile mother.[594] Mr Cohen agreed that there was a failure by Assisi staff to routinely provide Mrs Santoro with a ROHO cushion when she was sitting in a wheelchair and that this fell short of an appropriate standard of care for her.[595]

For the following reasons, we find that there were serious shortcomings in the treatment of Mrs Santoro's pressure injury on her right heel and that those shortcomings were systemic at Assisi Centre. Assisi staff were aware of that pressure injury at the time of Mrs Santoro's discharge from hospital on 17 July 2018. Assisi staff also knew at that time that Mrs Santoro was a diabetic and experienced poor circulation in her lower legs and was losing weight. In the circumstances, any pressure injuries of this nature required careful and prompt treatment by care staff at Assisi Centre.[596] We find that that did not occur.

589 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92z].

590 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [58]. See also, for example, Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 240, ACL.501.0001.6683 at 6903, 6910, 6915, 6921, 6923, 6926, 6928, 6931, and 6932.

591 Submissions of Dr Tay in reply to submissions of Counsel Assisting, 1 August 2019, RCD.0012.0019.0003 at [25]-[35].

592 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 239, ACL.501.0001.3848_E.

593 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0012 [67]-[68].

594 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0007-0010 [40]-[43] and [56].

595 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0040 [208].

596 See, for example, Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3092.18-38.

According to evidence Dr Tay gave at the hearing, Assisi staff did not inform him of the pressure injury until 13 September 2018.[597] In his earlier written statement, he had said that he was informed of that injury on 30 August 2018. Either way, it is inexcusable that Assisi staff did not tell him about it for well over a month after they became aware of the injury. It is also difficult to understand how Dr Tay did not independently become aware of this injury on one of his consultations with Mrs Santoro after 17 July 2018.[598]

According to his evidence at the hearing, Dr Tay first examined the pressure injury on 13 September 2018.[599] Despite his awareness of Mrs Santoro's diabetes and low blood pressure and the risks presented by those conditions for pressure injuries, he said he was not concerned about the wound. In forming that view, he did not, however, ask Assisi staff how long the wound had been on Mrs Santoro's heel.[600] He should have done so. He conceded as much and stated that knowledge about the duration of the wound's existence 'would have been critical information'.[601] Two days after examining the heel wound for the first time, Dr Tay went on leave for three weeks.

By mid-September 2018, the wound had deteriorated badly. There is no dispute that proper records of the progression of the wound were not kept by Assisi's care staff.[602] Only two photographs of the wound were taken over the entire period. The progression of the wound was not adequately recorded. There is nothing to suggest that the record-keeping was only poor for Mrs Santoro. We regard the poor record-keeping about residents' wounds as a systemic issue at Assisi.

It is also clear that some important Assisi records were created by staff well after the date of the events to which they related.[603] These backdated or 'retrospective' records did not comply with Assisi's record-keeping policy.[604] That the records were not contemporaneous does not reflect favourably on their accuracy and reliability, particularly when some records were created weeks after the events to which they related. Further, and as Mr Cohen conceded, the retrospective nature of these records meant that, prior to their creation, a reader of the progress notes, such as a general practitioner like Dr Tay, would not receive an accurate picture of a person's care needs.[605]

597 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3116.15-33. See also Exhibit 6-16, Darwin and Cairns Hearing, Statement of Dr Eric Tay, 2 July 2019, WIT.0248.0001.0001 at 0006-0007 [43].

598 See Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3116.35-45 and T3130.1-16.

599 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3117.10-22.

600 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3117.19-3118.1.

601 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3117.45-3118.1.

602 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 159, CTH.4003.9000.0327; Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3155.44-3156.37.

603 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3140.17-3145.12. See also, for example, Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 119, ACL.001.0001.0235.

604 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0038 [206] and 0044 [209].

605 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3157.25-3159.13.

Two of those backdated records were recorded as having been created by the nurse manager at St Francis on 3 October 2018 in the progress notes for Mrs Santoro, but related to events over two weeks earlier. The first of those records was said to relate to events on 17 September 2018 and, in respect of the pressure injury on Mrs Santoro's heel, relevantly stated:

> Noticed a small black area inside the open wound. so the wound is socked [sic. soaked] in Betadine. to review tomorrow.[606]

The second record was said to relate to events on 18 September 2018, in respect of the pressure injury, relevantly stated:

> wound reviewed again today. the wound site is opened to 50 cent size. the wound is stage 3 and black in colour. note left for GP to review. continued on Betadine dressing. needs daily dressing.[607]

Despite what this backdated progress note says, there is no record of the heel wound being brought to any doctor's attention for review until 3 October 2018. By then, the wound had deteriorated to such an extent that, in the words of the reviewing locum general practitioner, it was of '[s]ignificant depth with likely bony involvement'.[608] That doctor ordered an X-ray of Mrs Santoro's heel.

A subsequent entry in the progress notes by an independent nurse practitioner wound consultant on 9 October 2018 recorded that the wound on Mrs Santoro's heel was 'chronic' and extremely serious, being graded stage 4.[609] The consultant otherwise recorded that she was 'able to see and feel bone' and noted that an X-ray showed likely osteomyelitis or bone infection.[610] This was the first occasion on which Assisi had consulted a wounds specialist about Mrs Santoro's heel wound. By this time, it was around 2½ months since the pressure injury had first been observed and several weeks since it had begun to seriously deteriorate.

Assisi staff should have engaged the wound management consultant at a much earlier point in time, particularly given Mrs Santoro's diabetes, poor lower leg circulation and earlier weight loss. So much was conceded by Mr Cohen in his oral evidence before the Royal Commission.[611] Engagement of a wound management consultant in October 2018 was too late for effective treatment of the heel wound.[612]

606 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 119, ACL.001.0001.0235.

607 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 119, ACL.001.0001.0235.

608 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 169, ACL.501.0001.0609 at 0617-0618.

609 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 175, CTH.4003.9000.0445 at 0464.

610 See also Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 130, ACL.500.0002.0088 (heel wound photograph).

611 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3156.41-46.

612 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3121.25-37.

We find that the lateness of the engagement of the wound consultant was, at least in part, a by-product of Assisi staff's poor record-keeping practices. As Mr Cohen conceded, if the records relating to the heel wound on 17 and 18 September 2018 had been entered contemporaneously, rather than more than two weeks later on 3 October 2018, they would 'almost, undoubtedly' have been a trigger for earlier engagement of a wound consultant.[613] In giving this evidence, Mr Cohen accepted that poor record-keeping went directly to quality of care.

As the heel wound deteriorated, there were other deficiencies in Assisi's care for Mrs Santoro. A physiotherapist, engaged by Assisi, continued with weight-bearing exercises until 4 October 2018.[614] These exercises were paid for by Mrs Santoro's family over and above the fees they were otherwise paying for her accommodation at Assisi Centre.[615] Before 4 October 2018, there had been no communication by Assisi staff with the physiotherapist about the seriousness of Mrs Santoro's heel wound.[616] No consideration was given to how painful those exercises might have been and how that pain might have affected Mrs Santoro's mood and behaviour. Nor was the effect of the exercises on the progress of the heel wound apparently considered.

Ms Ng was not told of the very serious nature of that wound until 11 October 2018. Before talking with Assisi staff and Dr Tay that day, she was aware of the heel wound but 'was under the impression that it was not anything to be worried about'.[617] The diagnosis of osteomyelitis in her mother's heel wound was ultimately of very grave significance. The death certificate for Mrs Santoro dated 7 November 2018 relevantly states that:

MEDICAL	Cause of Death	Advanced alzheimer's dementia
	Duration of last illness	Right foot osteomyelitis; Atrial fibrillation, type 2 diabetes mellitus Lung cancer, hypertension Ischaemic heart disease[618]

Assisi staff failed in their responsibility to keep Mrs Santoro's family informed of changes to her health and, in particular, changes in the seriousness, size and depth of the pressure injury on her heel. They were not told of those things until it was far too late.

613 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3160.3-17.

614 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0015 [89].

615 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0011 [61].

616 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0015 [89]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3072.35-3075.4; Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 213, AMN.0002.0001.0001.

617 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3070.31-42.

618 Exhibit 6-13, Darwin and Cairns Hearing, Assisi supplementary tender bundle, tab 39, AMN.0005.0001.0001. See also Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3122.18-40; Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 248, DET.0001.0003.0001 at 0002.

In response to a subsequent complaint by Ms Ng, the Aged Care Quality and Safety Commission found, among other things, that:

> On examination of all the available information, we have found there were significant gaps in the care provided for your mother's pressure wound. Although the wound was present on her return from hospital, it was not managed effectively to promote healing. The pain associated with the wound was not assessed or managed effectively until later when it was acknowledged that the wound would not heal. Medical and specialist intervention was delayed until the stage of the wound was irreversible. Documentary assessment and monitoring was unsystematic, inaccurate and did not provide a clear picture of the care required or being given.[619]

In his oral evidence, Mr Cohen accepted that this was a 'very, very serious finding to be made by an independent investigator looking at the conduct of Assisi'.[620] Assisi's chairman, Mr Smarrelli, accepted that the finding was 'damning' and that it would be 'really hard to imagine a more serious finding being made about an organisation that exists solely to provide care for elderly people'.[621] Neither of them sought to refute any aspect of the finding.

Counsel Assisting submitted that, in relation to Assisi's management of Mrs Santoro's wounds, we should make the following findings:

a. Assisi did not keep adequate clinical records about Mrs Santoro's wounds and their management[622]

b. the records about Mrs Santoro's wounds failed to adequately describe their size and progression and did not contain enough photographs[623]

c. Assisi staff's creation of backdated records about Mrs Santoro's medical conditions compromised the quality and safety of care delivered to Mrs Santoro[624]

d. Assisi staff did not manage Mrs Santoro's wounds effectively or properly[625]

e. Assisi staff should have first sought assistance from a wounds management consultant or doctor or both about the pressure injury on Mrs Santoro's right heel around the time of her discharge from hospital and thereafter sought further assistance of that nature on a regular basis[626]

619 Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 207, ACL.501.0004.0003 at 0006.

620 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3146.37-40.

621 Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3174.22-34.

622 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92f].

623 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92g].

624 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92j].

625 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92aa].

626 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92bb].

f. when Dr Tay first examined the pressure injury on Mrs Santoro's right heel on 13 September 2018, he should have asked, but did not ask, Assisi staff how long the wound had been there[627]

g. by the time Assisi engaged a wounds management consultant on 9 October 2018 to treat the pressure injury on Mrs Santoro's right heel, the wound was chronic, extremely serious, irreversible and subject to osteomyelitis[628]

h. Assisi staff failed to keep Mrs Santoro's next of kin and medical power of attorney, Ms Ng, informed about important developments in her mother's medical status[629]

i. Assisi staff failed to inform Ms Ng about the seriousness of the pressure injury on Mrs Santoro's right heel until around three weeks after they first had real concerns about that wound, by which time it was chronic, extremely serious, irreversible and subject to osteomyelitis[630]

j. Assisi staff failed to inform the physiotherapist treating Mrs Santoro about the nature and seriousness of the pressure wound on her heel until 4 October 2018, which was far too late.[631]

Assisi concedes that findings as proposed by Counsel Assisting at subparagraphs (a) to (i) above are appropriate.[632] However, Assisi submitted that the proposed finding at subparagraph (j) should not be made.[633] Assisi says that the attending physiotherapist was not employed by Assisi and the decision to continue weight-bearing exercises was entirely a matter for the physiotherapist in consultation with the general practitioner.[634] It may be accepted that the physiotherapist was not an employee of Assisi. We nonetheless do not accept that Assisi staff did not have a responsibility to communicate with allied health practitioners, such as physiotherapists, about any known wound or wounds of a resident that might bear on delivery of care by that allied health practitioner to the resident.

We therefore consider that, on the evidence, it is appropriate to make the findings proposed by Counsel Assisting and set out above.

627 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92cc].

628 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92dd].

629 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92ff].

630 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92gg].

631 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92ee].

632 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [104] and [106].

633 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [104].

634 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [75].

Maggots in the right heel wound

On the morning of 11 October 2018, eight maggots were found by Assisi care staff in Mrs Santoro's heel wound. Mr Cohen conceded that this development was 'entirely inconsistent with acceptable clinical practice'.[635]

Ms Ng and one of her brothers had arranged to meet with Dr Tay that morning to discuss their concerns about the medications being administered to their mother. The meeting was to be attended by Ms Ng and her brother, as well as Dr Tay and the nurse manager at the high care unit, St Francis.[636]

When Dr Tay arrived at Assisi Centre for the meeting, the unit nurse manager was in a room speaking with Ms Ng and her brother. The nurse manager asked them to leave the room so that she could speak with Dr Tay alone. Dr Tay gave oral evidence that the nurse manager then told him about the discovery of maggots in Mrs Santoro's heel wound and that she had not yet told Ms Ng and her brother about it.[637] Among other things, he said in his evidence about the disclosure of the discovery of maggots that:

> that's something I've never understood to this day. They [Assisi] waited until I got there.[638]

Dr Tay told the nurse manager that the discovery of maggots should be disclosed to Mrs Santoro's family immediately. At the subsequent meeting with Ms Ng and her brother, Dr Tay discussed Mrs Santoro's medication and then informed Ms Ng and her brother that a matter of more significant concern was their mother's heel wound.[639] He told them that there was a bone infection, or osteomyelitis, at the site of the wound. He also them that maggots had been found in the wound earlier that morning.

Ms Ng gave evidence that the nurse manager told her and her brother at the meeting that 'maggots are often' used in modern medicine.[640] In her evidence, Ms Ng said that she was appalled by that comment.[641] In her view, the nurse manager seemed unwilling for Assisi to take responsibility for the serious problems with Mrs Santoro's heel wound.

635 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0043 [208].

636 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3071.5-3072.4.

637 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3120.43-3121.23.

638 Transcript, Eric Tay, Darwin Hearing, 10 July 2019 at T3121.18-23.

639 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3071.5-3072.4.

640 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [83]; Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3071.5-3072.4.

641 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3072.1-4.

Ms Ng also gave evidence that, in a telephone conversation with the nurse manager later that day, the nurse manager suggested that the maggots must have entered the wound when visitors took Mrs Santoro outside.[642] If a fly landed on the wound to lay maggots, the wound must have been exposed. Properly dressing the wound was the responsibility of Assisi and its staff, and not visitors who took Mrs Santoro outside.[643]

Counsel Assisting submitted that it was open to the Royal Commission to make findings that the nurse manager was reluctant to inform Ms Ng and her brother about the maggots for fear of repercussions from Assisi management[644] and that, following the disclosure by Dr Tay, the nurse manager sought to downplay the seriousness of that discovery.[645]

The nurse manager did not give evidence to the Royal Commission in relation to allegations about her conduct on 11 October 2018. On 26 July 2019, the Royal Commission received correspondence from her in which she denied any reluctance on her part to inform Mrs Santoro's family of the discovery of maggots in the heel wound.[646] In these circumstances and having regard to the principles we have discussed in the introduction to this volume of the Interim Report—that is, that we apply a civil standard of proof, guided by the principles discussed by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 366 at 361-2—it would not be appropriate to make findings about the conduct of the nurse manager on 11 October 2018. We do, however, note that, according to evidence given by Mr Cohen, she and another nurse manager at Assisi have been the subject of recent investigation by the Australian Health Practitioner Regulation Authority.[647]

Palliative care

Not long after being told on 11 October 2018 about the extreme seriousness of their mother's heel wound, Ms Ng and her brothers were forced to think about palliative care for their mother. Around 15 October 2018, a doctor from Austin Outreach told Ms Ng that, unless she was prepared for Mrs Santoro to have her foot amputated, palliative care was the only realistic option for her mother.[648] Mrs Santoro was then moved to Assisi's makeshift palliative care room on 17 October 2018.[649] The room was noisy and unfit for that purpose. People entered the room to use a sink in the room until a sign was placed on the door.

642 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [84].

643 See also Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3184.25-47.

644 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92hh].

645 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92ii].

646 Exhibit 6-13, Darwin and Cairns Hearing, Assisi supplementary tender bundle, tab 39, AWF.600.01113.0002 at pages 3-4.

647 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3144.44-3145.7.

648 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3075.16-47.

649 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0015-0016 [93].

By this time, Ms Ng and her brothers had arranged for one of them to be with their mother around the clock 'to make sure her pain was managed'.[650] Ms Ng observed that her mother was in pain when care staff tried to turn her in bed.[651] According to Ms Ng, she sometimes had to remind care staff not to turn her mother until she had received additional pain medication that had been prescribed by Dr Tay.[652]

On 23 October 2018, Mrs Santoro left Assisi Centre for a dedicated palliative care unit elsewhere.[653] There, Ms Ng observed that the environment was quiet and peaceful and that her mother's pain was managed. On 25 October 2018, only two weeks after Ms Ng had been belatedly told about the seriousness of her mother's heel wound, Mrs Santoro died.[654]

Counsel Assisting submitted that we should make findings about the unsuitability of the palliative care environment provided to Mrs Santoro at Assisi Centre[655] and the inadequacy of her pain management at the time of that palliative care at Assisi Centre.[656] Assisi submitted that no such findings should be made.[657] Assisi says that it 'does not have a dedicated, purpose designed palliative care room for its residents' and 'in any event, there is no requirement for aged care providers to have a separate palliative care room on site'. Assisi submitted that it made all efforts to provide an appropriate, comfortable environment for Mrs Santoro and her family.[658]

Irrespective of the existence or otherwise of any requirement for an aged care provider to have an onsite palliative care room, Assisi does not appear to dispute, and we find on the evidence before the Royal Commission, that in this instance the palliative care environment provided to Mrs Santoro and her family at Assisi Centre was makeshift, noisy and unduly busy. We further find that that environment was generally unsuitable for palliative care. In addition, based on the uncontradicted evidence of Ms Ng, we have concerns about the palliative care pain management provided to Mrs Santoro by Assisi staff.

650 Transcript, Anamaria Ng, 10 July 2019, T3077.10-20; Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0016 [96].

651 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0016 [96].

652 Transcript, Anamaria Ng, Darwin Hearing, 10 July 2019 at T3077.10-20; Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001at 0016 [96]-[97].

653 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0016 [98]-[100].

654 Exhibit 6-15, Darwin and Cairns Hearing, Statement of Anamaria Ng, 18 June 2019, WIT.0169.0001.0001 at 0016 [101].

655 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92jj].

656 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92kk].

657 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [108].

658 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [85]-[86].

Systemic problems and clinical governance

Mr Smarrelli gave evidence that the former Chief Executive Officer of Assisi, Mr Martin Sammut, resigned as Chief Executive Officer in May 2019 following a special board meeting held on 15 May 2019 at which the board had decided to terminate the employment of Mr Sammut for serious misconduct.[659] Mr Smarrelli stated that the board had lost faith in the Mr Sammut over his failure to inform the board of the true seriousness of the problems with Mrs Santoro's care.[660]

Mr Cohen gave evidence that identified 15 different areas in which the treatment of Mrs Santoro departed from Assisi's policies or in which the policies themselves were deficient in some way.[661] Those areas included, but were not limited to:

- undue waiting times for attention
- the failure to remove the hip wound staples until that wound became infected
- unmonitored weight loss
- unexplained medication changes
- poor wound management
- a failure to manage pain appropriately.[662]

He accepted that at least some of those 15 areas of deficiency were significant.[663] In her last months, Mrs Santoro's quality of life was significantly compromised. Assisi does not appear to dispute that aspects of Mrs Santoro's treatment at Assisi Centre contributed to that outcome.

Mr Cohen stated that those and other issues relating to Assisi's care for Mrs Santoro would be the subject of investigation in a 'root cause analysis'.[664] He gave evidence that the Assisi board directed Mr Sammut in February 2019 to undertake that analysis.[665] It is unclear what was done at that time. However, Mr Cohen gave evidence that the root cause analysis was only 'formally commissioned' by him in May 2019, some three months later.[666] He said that Safer Care Victoria, as well as a geriatrician and a wound specialist, had been engaged to assist with the work. The root cause analysis had not been completed at the time of the

659 Exhibit 6-19, Darwin and Cairns Hearing, Statement of Donato Smarrelli, 7 July 2019, WIT.0288.0001.0001 at 0010 [71]-[74].

660 Exhibit 6-19, Darwin and Cairns Hearing, Statement of Donato Smarrelli, 7 July 2019, WIT.0288.0001.0001 at 0009 [67] and 0010 [70].

661 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0038-0044 [208]-[209]; Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3148.26-44.

662 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0038-0044 [208]-[209]; Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3148.46-3149.5.

663 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3150.1-5.

664 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3153.1-15. See also Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3152.11-26.

665 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0006 [34].

666 Exhibit 6-17, Darwin and Cairns Hearing, Statement of Paul Cohen, 1 July 2019, WIT.0258.0001.0001 at 0006 [34].

hearing before the Royal Commission on 10 July 2019.[667] At that time, around five months had passed since the board had first sought the root cause analysis. Mr Cohen gave evidence that a 'very early draft' of the document had been prepared and he was 'hoping' that the final version would be available by around 24 July 2019.[668] He also stated that he understood that there was an ongoing obligation on Assisi to provide the root cause analysis to the Royal Commission.[669] Nonetheless, at the time of writing the Interim Report, Assisi has not yet provided the root cause analysis to the Royal Commission. The ongoing delay is lengthy and unexplained. In the absence of any explanation, the delay reflects poorly on Assisi's governance and its purported commitment to remedy past failings. It remains our expectation that Assisi will provide the root cause analysis to the Royal Commission as soon as possible.

Mr Cohen otherwise acknowledged that poor record-keeping in respect of Mrs Santoro's pressure injury pointed to a systemic problem for Assisi with wound management and that this was a fundamental aspect of clinical care.[670] He stated that he still could not explain why Assisi's records had not included information about wound dimensions and size. He accepted that a report by the quality and risk manager at Assisi in October 2018 that any deficiency in the treatment of Mrs Santoro's heel wound 'was not a systemic failure' did not reflect the views of the current management team.[671] We agree with Counsel Assisting's submission that that report itself eloquently sums up the extent of systemic failure in Assisi in October 2018.[672]

Mr Cohen accepted that, having regard to the circumstances of Mrs Santoro at Assisi Centre, there was 'a pattern…of poor care and at some levels an unwillingness to accept responsibility for that'.[673] Referring to leadership culture, he observed that, for a period of time leading up to late 2018, Assisi's board of directors did not include any person with clinical expertise and that was a 'deficit'.[674] He also referred to a clinical governance committee established by the Assisi board of directors which had conducted its first meeting on 24 May 2019.[675] Mr Smarrelli gave evidence that, before 2018, previous compositions of the Assisi board did have medical practitioners on the board.[676]

667 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3167.6-9.

668 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3167.20-3168.2.

669 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3168.4-7.

670 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3155.44-3156.37.

671 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3164.7-43; Exhibit 6-13, Darwin and Cairns Hearing, Assisi tender bundle, tab 146, ACL.500.0001.9059.

672 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [88].

673 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3162.45-3163.10.

674 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3161.43-3162.12. In giving evidence to the Royal Commission, Mr Smarrelli was unable to name the new director on the board with clinical expertise. See Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3179.45-3180.2.

675 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3168.29-3169.43; Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3177.25-3179.38.

676 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [88]; Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3180.6-3180.9.

Nonetheless, Mr Cohen and Mr Smarrelli conceded that, at all relevant times in 2018, there had been no clinical governance committee and no person on the board with clinical expertise and arrangements at that time had not been adequate for proper reporting to the board of matters relating to clinical and personal care of residents.[677]

Of some concern in respect of future clinical governance at Assisi was the evidence of Mr Smarrelli. Senior Counsel Assisting asked what his explanation was, as chairman of the board of directors of Assisi, for the various deficiencies in care provided to Mrs Santoro. He replied:

> Well, my only explanation for that is that I—I have a CEO that we discuss the operations of Assisi. He manages the organisation and reports back to me. And I rely heavily on—on—on his reporting but, from my perspective personally, I—I can't give you a direct answer on that.[678]

Senior Counsel Assisting also asked Mr Smarrelli why it was not until the investigation into complaints about Mrs Santoro's care and the calling of this Royal Commission that Assisi realised that there needed to be more of a focus on clinical care governance. His only response was as follows:

> I—it's a difficult question to answer in many ways, but I can assure you that there is—no complacency on the part of the board. They are people who recognise very highly and regarded very highly in their respective professions, and this is so foreign to us, and to answer your question, I don't—other than to say it has occurred, it's fallen through the net, so to speak and, yes, we are ultimately responsible for what's occurred. But for—that it took this time or this incident and the Royal Commission, probably.[679]

In respect of deficiencies in Assisi's governance and resultant systemic problems, Counsel Assisting submitted that:

a. problems with record-keeping in respect of Mrs Santoro's weight management, wound management and pain management were systemic problems and compromised the quality and safety of care delivered to Mrs Santoro[680]

b. in 2018, there was little or no effective clinical governance by Assisi at Assisi Centre and that failing contributed to systemic deficiencies in the quality of care delivered to Mrs Santoro and others at Assisi Centre.[681]

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677 Transcript, Paul Cohen, Darwin Hearing, 10 July 2019 at T3168.29-3169.43; Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3179.27-3180.9.

678 Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3174.5-9.

679 Transcript, Donato Smarrelli, Darwin Hearing, 10 July 2019 at T3188.3-14.

680 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92k].

681 Submissions of Counsel Assisting the Royal Commission: Assisi Case Study, 24 July 2019, RCD.0012.0014.0001 at [92l].

Assisi submitted that the proposed findings are not supported by the evidence and should not be made.[682] In the main, we disagree. On the basis of the evidence to which we have already referred, we find that problems with record-keeping in respect of Mrs Santoro's weight management and wound management were systemic problems and compromised the quality and safety of care delivered to Mrs Santoro. We do not, however, make any finding in respect of Mrs Santoro's pain management while at Assisi.

Having regard to the evidence given by Mr Cohen and Mr Smarrelli, both of whom are in senior roles at Assisi, we find that there was a lack of effective clinical governance by Assisi at Assisi Centre in 2018 and that lack of clinical governance contributed to systemic deficiencies in the quality of care delivered to Mrs Santoro and others at Assisi Centre.

Conclusion

Mrs Santoro entered residential care at Assisi Centre in June 2017 and died on 25 October 2018. During her time at Assisi Centre, the care provided to Mrs Santoro was inadequate in a number of respects. Both her general practitioner, Dr Tay, and Assisi staff contributed to instances of inadequate care. Dr Tay's record-keeping in relation to Mrs Santoro was generally poor. There was also a lack of effective communication between Dr Tay and staff at Assisi. A lack of effective clinical governance at Assisi Centre during 2018 contributed to systemic deficiencies in Assisi's record-keeping for Mrs Santoro in respect of weight management and wound management. These systemic deficiencies were significant and compromised the quality and safety of care delivered to Mrs Santoro at Assisi Centre over the final months of her life.

Avondrust Lodge case study

Introduction

The Royal Commission examined the experiences of the late Mrs Bertha Aalberts at Avondrust Lodge residential aged care facility. Avondrust Lodge is in Carrum Downs on the Mornington Peninsula near Melbourne, Victoria, and is owned and operated by approved provider, MiCare Ltd (MiCare). It was formerly operated by DutchCare.[683]

682 Submissions of Assisi in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0017.0002 at [98] and [109].

683 Exhibit 6-37, Darwin and Cairns Hearing, Statement of Robert van Duuren, 2 July 2019, WIT.0260.0001.0001 at 0002-0003.

The evidence before the Royal Commission consisted of:

- the statement of Johanna Aalberts-Henderson, Mrs Aalberts' daughter, dated 26 June 2019[684]
- the statements of Robert van Duuren, MiCare's General Manager Residential Services, dated 2 July 2019 and 12 July 2019[685]
- the statements of Jan Rice, a wound consultant engaged by MiCare who treated Mrs Aalberts, dated 29 June 2019 and 10 July 2019[686]
- the statements of Petronella Neeleman, MiCare's Executive Director, dated 2 July 2019 and 11 July 2019[687]
- the oral testimony of those four witnesses[688]
- the tender bundle for this case study, which consists of 245 documents.[689]

In accordance with the directions we made on 17 July 2019, Counsel Assisting provided written submissions setting out the findings that Counsel Assisting considered should be made arising out of this case study.[690] In response to Counsel Assisting's submissions, solicitors for MiCare sent two letters to the Royal Commission:

- a letter to the Solicitor Assisting the Royal Commission dated 30 July 2019, addressing questions that arose during the testimony of Mr van Duuren and Ms Neeleman[691]
- a letter to the Solicitor Assisting the Royal Commission dated 31 July 2019, attaching written submissions.[692]

We note that in this correspondence, MiCare did not engage directly with the proposed findings suggested by Counsel Assisting.

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684 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001.

685 Exhibit 6-37, Darwin and Cairns Hearing, Statement of Robert van Duuren, 2 July 2019, WIT.0260.0001.0001; Exhibit 6-38, Darwin and Cairns Hearing, Supplementary Statement of Robert van Duuren, 12 July 2019, WIT.0260.0004.0001.

686 Exhibit 6-39, Darwin and Cairns Hearing, Statement of Jan Rice, 29 June 2019, WIT.0278.0001.0001; Exhibit 6-40, Darwin and Cairns Hearing, Supplementary Statement of Jan Rice, 10 July 2019, WIT.0293.0001.0001.

687 Exhibit 6-41, Darwin and Cairns Hearing, Statement of Petronella Dorothea Neeleman, 2 July 2019, WIT.0260.0002.0001; Exhibit 6-42, Darwin and Cairns Hearing, Statement of Petronella Dorothea Neeleman, 11 July 2019, WIT.0260.0003.0001.

688 Each witness was examined by Counsel Assisting at the Cairns hearing on 15 July 2019. MiCare was granted leave to appear, however Counsel for MiCare (who was present throughout the hearing) did not seek leave to examine any of the witnesses.

689 In the tender bundle, the document behind tab 126 is a copy of the MiCare progress notes relating to the care of the late Mrs Aalberts (MIC.0001.0001.0066). We were concerned that Mr van Duuren was unable to answer questions about the structure of the notes posed by Counsel Assisting (Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019, T3495.35-3498.29). We note that MiCare's solicitors provided a written explanation dated 30 July 2019 by way of follow up – Exhibit 6-35, MiCare tender bundle, Tab 245, RCD.0012.0021.0001.

690 Submissions of Counsel Assisting the Royal Commission: Avondrust Lodge Case Study, 24 July 2019, RCD.0012.0013.0001

691 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 245, RCD.0012.0021.0001.

692 Submissions of MiCare in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0021.0003.

Background

Mrs Bertha Aalberts was born in Holland in 1930 and migrated to Australia in 1949. She married in 1951 and, like so many other post-war migrants, worked hard to raise a family. She and her husband had three children: two girls and a boy.[693]

Mrs Aalberts's husband passed away in 2005 and she lived by herself until 2018 with the help of her children. Mrs Aalberts suffered from atrial fibrillation, congestive cardiac failure, psoriasis, scoliosis, oedematous legs and other conditions.[694] Her preference was to remain in her own home for as long as possible.[695] Mrs Aalberts was assessed initially for a Level 2 Home Care Package and then in March 2018 for a Level 4 Home Care Package.[696] However, her family was distressed to be told that they would have to wait for at least a year for the higher level of care that was available under the Level 4 Package to be provided.[697]

Understanding that she was unable to remain at home, Mrs Aalberts was attracted to Avondrust Lodge, a Dutch-influenced residential aged care home on the Mornington Peninsula.[698] Avondrust is a Dutch word for 'evening rest'.[699]

Mrs Aalberts began living at Avondrust Lodge on 24 May 2018. She walked into the facility with the aid of a walking frame. Her daughter, Ms Aalberts-Henderson, told us that her mother was cognisant and continent. We also heard that Mrs Aalberts was 'able to ambulate and make decisions'.[700] Upon arrival at Avondrust, Mrs Aalberts was assessed as a high falls risk due to her limited mobility and poor eyesight caused by macular degeneration. She was also assessed as a high risk in respect of skin integrity.[701]

Mrs Aalberts had three falls while she was living at Avondrust that are recorded in the progress notes:

- On 26 May 2018, Mrs Aalberts was found sitting on the floor after misjudging the chair she was trying to sit on and falling.[702]

693 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0002 [3]; Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3453.32.

694 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0002 [6]; Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3456.39-40.

695 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3454.45-47.

696 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0002 [12]; Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3456.16-24.

697 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019 WIT.0220.0001.0001 at 0002 [12]; Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3456.16-19.

698 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3457.32-3458.8.

699 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3457.46

700 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3489.20.

701 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3494.10-17; Exhibit 6-35, Avondrust tender bundle, tab 65, MIC.0001.0001.0193 at 0197.

702 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0116.

- On 8 June 2018, Mrs Aalberts was found on the floor of her bedroom after she fell when she got up to answer a knock on the door. Mrs Aalberts suffered facial bruising and a lacerated left ear.[703]
- On 3 July 2018, Mrs Aalberts fell in her bedroom after returning from the toilet. She fell on her right wrist, which was subsequently diagnosed as broken at the Peninsula Private Hospital where she was taken on 4 July 2018.[704]

Ms Aalberts-Henderson visited her mother at Peninsula Private Hospital on 4 July 2018.[705] She was informed by nurses that her mother had bruises on her shins, including one which she described in her evidence to the Royal Commission as a 'very large haematoma'.[706] It is likely that this injury was caused by the fall on 3 July 2018.

Mrs Aalberts had a closed fracture reduction on her right wrist under a light anaesthetic on 5 July 2018.[707] Following this procedure, and probably as a result of the anaesthetic, Mrs Aalberts was 'very disoriented, frightened, a bit paranoid, with moments of lucidity'.[708]

While Mrs Aalberts was in hospital, Ms Aalberts-Henderson spoke to her mother's treating geriatrician, Dr Vikram Bhalla, about the haematoma on her mother's right leg. Doctor Bhalla recommended a skin graft. However, Ms Aalberts-Henderson, herself a trained nurse with extensive experience of anaesthetics and surgery, was 'very opposed' to this for two main reasons.[709] First, her mother's 'INR clotting rate' was very high and, as she explained, 'grafts don't sit well on oozy sites'.[710] Second, Ms Aalberts-Henderson was fearful that a second anaesthetic would exacerbate her mother's confusion.[711] She was also concerned that any graft would dislodge if, in a confused state, her mother tried to climb over her bed rails.[712] Finally, Ms Aalberts-Henderson was giving effect to her mother's wish to avoid surgery and her desire to return to Avondrust.[713]

703 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust, tender bundle, tab 126, MIC.0001.0001.0066 at 0109; a photograph of the ear injury is at Exhibit 6-35, Avondrust tender bundle, tab 13, JAA.0001.0001.0054; see also Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0004 [29]-[30].

704 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0102 and 0101; Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0005 [31].

705 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0005 [32].

706 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3463.31.

707 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3464.16-20.

708 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3464.36-37 and T3465.1-10.

709 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3453.36-46.

710 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3465.30-33 (the transcript mistakenly refers to 'graphs' at T3465.32 but this clearly should be 'grafts').

711 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3465.33.

712 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3466.5-8.

713 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0005 [35].

Ms Aalberts-Henderson understood the risks associated with the haematoma if the graft was not performed. Dr Bhalla explained to her that the haematoma was likely to burst, with the attendant risks of infection and becoming a chronic wound.[714] Mr van Duuren empathised with the 'tough dilemma' faced by Ms Aalberts-Henderson;[715] he respected her decision.[716] The wound consultant, Ms Jan Rice, told us that she 'fully understood' the stance of Ms Aalberts-Henderson in this regard.[717]

Management and care of Mrs Aalberts's right leg wound after she returned to Avondrust

On 11 July 2018, Mrs Aalberts returned to Avondrust from hospital with her wrist in plaster and with an unhealed right lower leg wound. Mr van Duuren confirmed[718] that Peninsula Private Hospital provided the following information to MiCare when it discharged Mrs Aalberts:

- a Discharge summary[719]
- a patient transfer form dated 11 July 2018 that referred to the 'instructions re wound on (R) lower leg'[720]
- a letter from the hospital geriatrician, Dr Bhalla, to Mrs Aalberts's treating general practitioner, Dr Nar[721]
- a 'wound worksheet' which advised that the wound should be photographed or traced weekly and the dimensions should be recorded, and which provided a simple form to record other important features of the wound on a daily basis[722]
- a 'pressure injury management plan'.[723]

Mr van Duuren expressed some doubt about whether the letter from Dr Bhalla came to MiCare.[724] However, in circumstances where it was produced to the Royal Commission by MiCare in response to notice to produce documents the Royal Commission we conclude that it did.

714 Dr Bhalla's notes of his conversation with Ms Aalberts-Henderson on 11 July 2018 about this risk are at Exhibit 6-35, Avondrust tender bundle, tab 69, MIC.0001.0001.0285.

715 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3507.42; Exhibit 6-37, Darwin and Cairns Hearing, Statement of Robert van Duuren, 2 July 2019, WIT.0260.0001.0001 at 0022.

716 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3508.4-7.

717 Transcript, Jan Rice, Cairns Hearing, 15 July 2019 at T3533.21-24.

718 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3511.20-3513.29.

719 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 68, MIC.0001.0001.0283.

720 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 70, MIC.0001.0001.0286.

721 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 67, MIC.0001.0001.0054.

722 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 71, MIC.0001.0001.0287.

723 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 72, MIC.0001.0001.0288.

724 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3509.3.

In addition, the MiCare progress notes record a detailed discussion on 11 July 2018 between the hospital geriatrician, Dr Bhalla, and the general practitioner who was treating Mrs Aalberts at Avondrust, Dr Nar. According to Dr Nar's notes, during that conversation, Dr Bhalla told Dr Nar that:

- he did not want Mrs Aalberts discharged but the family wanted her 'back in the [residential Aged Care facility] asap'
- she had two bullae on her leg which he wanted to surgically debride and graft 'but the family denied' and now it would end up a chronic wound[725]
- he would be 'happy to take [Mrs Aalberts] back if she gets any [worse] or her delerium [sic] increases'.[726]

In light of all of the above, Mr van Duuren agreed that, from 11 July 2018, it was 'pretty clear' from the correspondence from Dr Bhalla that MiCare had a 'difficult medical issue' to deal with in relation to Mrs Aalberts after 11 July 2018.[727] He also accepted that 'it was always open to Avondrust in the event that there was any concern about the ability of the [MiCare] staff to deal with this leg wound for [Mrs Aalberts] to be sent back to Dr Bhalla as he suggested could be done'.[728] Mr van Duuren gave evidence that he believed that Ms Aalberts-Henderson's stated preference that her mother be cared for at Avondrust was relevant to that decision.[729]

MiCare was on notice that the wound on Mrs Aalberts's right leg was serious and would require high level clinical care from competent nursing staff.[730] MiCare had a relationship with a highly experienced wound consultant nurse, Jan Rice. Ms Rice had extensive experience managing complex wounds on older residents.[731] Despite the seriousness of this leg wound, Avondrust did not involve Ms Rice with its management for two weeks. This delay is unexplained. It was unacceptable.

It is apparent that MiCare did not use the 'wound worksheet' provided to it by Peninsula Private Hospital.[732] Mr van Duuren gave evidence that it was not the practice at Avondrust to use the hospital documents. Rather, they would transfer that information over to Avondrust's internal record keeping software.[733] However, that was clearly not done in this case. Senior Counsel Assisting asked Mr van Duuren what other plan was in place at Avondrust to manage the wound. He drew the Royal Commission's attention to the

725 A bullae is a raised area of skin filled with fluid, such as a blister.

726 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0097.

727 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3509.30-34.

728 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3507.19-25.

729 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3507.33-36.

730 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3510.40-3511.15.

731 Transcript, Jan Rice, Cairns Hearing, 15 July 2019 at T3530.44-3531.1.

732 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 71, MIC.0001.0001.0287.

733 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3513.44-47.

'Wound Assessment and Management Plan' dated 12 July 2018.[734] While this document contains some of the information that such a plan should contain (by comparison to the one provided by the hospital), it is clearly deficient. Mr van Duuren accepted that it would have 'been good practice…to follow what the hospital proposed pretty carefully' and that it was a 'great guide'.[735]

In addition, MiCare did not follow its own plan. It stipulates that the dressing is to be changed 'daily by CCC [Clinical Care Coordinator] only'.[736] However, there is no record of the dressing being changed on 13, 21, 23 or 28 July 2018.[737] Moreover, on four days when the dressing was changed, this was done by a personal care worker.[738] This means that, on eight days after 11 July 2018, the treatment of Mrs Aalberts's serious leg wound was not managed by an enrolled or registered nurse. Ms Rice was of the view that management of this haematoma was 'the job of a registered nurse, for sure'.[739] Mr van Duuren, himself a registered nurse,[740] accepted that the wound 'needed to be attended to by someone that has the scope of practice that can manage that well'.[741] A personal care worker is not such a person.

Furthermore, MiCare's records do not contain any detailed observations of the wound's progress until 24 July 2018, that is, 13 days after Mrs Aalberts returned from hospital. By that time, the notes record 'wound broken areas as well as pockets of fluid. 2 cm round spot at top of wound black'.[742]

It was these developments that precipitated the belated contact with the wound specialist, Ms Rice. Mr van Duuren conceded that this occurred later than it should have.[743]

However, even the intervention by Ms Rice on 25 July 2018 did not result in daily observations being recorded in the wound management plan. Observations were still only recorded on 25 July, 2 August and 6 August 2018. No observations were recorded on the remaining 10 days. The photos contained in the notes graphically illustrate the severe deterioration of the wound during this period.[744]

734 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3515.1-6. The Wound Assessment and Management Plan is Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 98, MIC.0001.0001.0149.

735 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3513.11-22; see also T3512.25.

736 'CCC' was a term used at Avondrust to designate a registered nurse or an enrolled nurse – see Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3518.9-15.

737 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 98, MIC.0001.0001.0149.at 0150.

738 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 98, MIC.0001.0001.0149.at 0150. The dates are 14 July 2018, 15 July 2018, 20 July 2018 and 22 July 2018. This is confirmed in the report of the Aged Care Quality and Safety Commission dated 4 April 2019 – see Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 217, MIC.0001.0001.0149.at 0150 and tab 217, CTH.4007.9000.1005 at 1010.

739 Transcript, Jan Rice, Cairns Hearing, 15 July 2019 at T3534.15-17.

740 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3483.44.

741 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3518.20-21.

742 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 98, MIC.0001.0001.0149 at 0149.

743 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3516.15-23; see also T3548.40-3541.1

744 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 98, MIC.0001.0001.0149 at 0151.

When Ms Rice first saw Mrs Aalberts on 25 July 2018, she debrided the wound.[745] At that time, it was, in the words of Ms Rice, 'a nasty haematoma'.[746] Despite that, Ms Rice only examined Mrs Aalberts once again, on 6 August 2018.[747] Her entry in the progress notes on 6 August 2018 states that she was happy with the progress of the wound.[748] She noted some redness and swelling of Mrs Aalberts's foot and that antibiotics had been prescribed.[749]

Ms Rice knew when she took on the management of Mrs Aalberts on 24 July 2018 that she (Ms Rice) would go on leave on 13 August 2018 for a month.[750] In her oral evidence, she rejected the suggestion of Senior Counsel Assisting that, when she became responsible for the care of Mrs Aalberts, there might have been a need for her to have ongoing involvement in the case for at least a few weeks.[751] This was despite the seriousness of the wound and the age of Mrs Aalberts.

On 7 August 2018, the day after Ms Rice last saw Mrs Aalberts, a scan revealed a 5cm deep vein thrombosis (DVT) in Mrs Aalberts's right leg near her groin.[752] It is unclear on the evidence before the Royal Commission whether the DVT was related to the leg wound. Mrs Aalberts was transported to Beleura Hospital. By now, she was very eager to leave Avondrust, telling her daughter to 'get me out of here'.[753] Ms Aalberts-Henderson told the Royal Commission that her mother's change in attitude to the aged care facility was 'striking'.[754] As noted earlier, Mrs Aalberts had previously been very positive about Avondrust.

At Beleura Hospital on 7 August 2018, the extent of Mrs Aalberts's haematoma was revealed, to the shock of Ms Aalberts-Henderson and the nurses who were present. Ms Aalberts-Henderson told the Royal Commission that when the gauze was removed, she heard 'a collective gasp from everyone present'.[755] Ms Aalberts-Henderson described the wound as 'unbelievable to see'.[756] This left her in 'an ice cold rage'.[757] A photograph

745 As she recorded in the progress notes – see Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0079.

746 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0079.

747 Exhibit 6-39, Darwin and Cairns Hearing, Statement of Jan Rice, WIT.0293.0001.0001 at 0002; Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0068.

748 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0068.

749 Transcript, Jan Rice, Cairns Hearing, 15 July 2019 at T3543.41-43.

750 Transcript, Jan Rice, Cairns Hearing, 15 July 2019 at T3537.38-47.

751 Transcript, Jan Rice, Cairns Hearing, 15 July 2019 at T3538.1-5.

752 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0067.

753 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [52].

754 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [55].

755 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [53].

756 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019, T3479.2.

757 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [54].

she took at the time reveals the extent of the wound.[758] Ms Aalberts-Henderson told the Royal Commission that she could have put her hand in the wound and touched her mother's tibia.[759] It is not easy to reconcile this unchallenged evidence with the note made by Ms Rice two days earlier that she was 'happy with the progress of the wound'.[760] Two pressure injuries on her mother were also revealed to Ms Aalberts-Henderson for the first time. These are considered below.

A physician at the hospital informed the family of Mrs Aalberts that their mother had only three to six months to live.[761] As it turned out, she only lived for another two weeks and was pronounced dead on 19 August 2018.[762] While Mrs Aalberts's last days at the hospital were peaceful and she was well cared for, she was in pain every time she moved her legs. Ms Aalberts-Henderson told the Royal Commission that she cannot 'unhear her cries' and she cannot 'unsee what I saw'.[763]

Counsel Assisting submitted that we should conclude that MiCare failed to care adequately for Mrs Aalberts's right leg wound after 11 July 2018 by:

- failing to implement a wound management plan that met the standard of the plan provided to MiCare by the Peninsula Private Hospital
- allowing personal care workers to change the wound dressings on four occasions when this should have been done by registered nurses, or otherwise suitably qualified and experienced people
- failing to engage an expert wound consultant or otherwise appropriately qualified person on 12 July 2018 and certainly earlier than 24 July 2018.[764]

We accept this submission. MiCare's failure to adequately care for Mrs Aalberts's right leg wound is apparent from the evidence before us.

758 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [53]; Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 12, JAA.0001.0001.0052.

759 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [54].

760 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066 at 0068.

761 Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008-0009 [57]; Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3480.36-41.

762 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 128, JAA.0001.0003.0001.

763 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3482.23-24.

764 Submissions of Counsel Assisting the Royal Commission: Avondrust Lodge Case Study, 24 July 2019, RCD.0012.0013.0001 at 0013 [54a].

Pressure injuries

As noted above, when staff at Beleura Hospital examined Mrs Aalberts on 7 August 2018 in the presence of Ms Aalberts-Henderson, two additional wounds were revealed to Ms Aalberts-Henderson for the first time. One was a pressure injury on Mrs Aalberts's sacrum; the other was a large black pressure injury on her heel that was the size of a palm.[765] Ms Aalberts-Henderson was previously unaware of these injuries and there is scant reference to them in the progress notes.[766]

As previously noted, Mrs Aalberts had been assessed in May 2018 when she entered Avondrust as being at high risk of skin injuries.[767] When she returned to Avondrust from Peninsula Private Hospital on 11 July 2018, a 'Pressure Injury Prevention and Management Plan' prepared by the hospital accompanied her.[768] This plan made reference to the use of air mattresses, the importance of good nutrition, skin protection strategies, re-positioning, family education and wound care. Counsel Assisting submitted that if this plan had been implemented, it would have enabled MiCare to put in place a skin protection regime that accorded with best practice as described by Professor Geoffrey Sussman and Ms Hayley Ryan of Wounds Australia at the Royal Commission's hearing in Darwin.[769]

Peninsula Private Hospital's plan was not implemented; nor did MiCare have an alternative plan in place. Mr van Duuren conceded that there was no systematic approach in place to prevent Mrs Aalberts sustaining pressure injuries after she returned to Avondrust on 11 July 2018.[770] Mr van Duuren conceded that this constituted 'a gap' in the care provided to Mrs Aalberts.[771] Counsel Assisting submitted that there were also deficiencies in assessing Mrs Aalberts's risk of pressure injuries and implementing strategies, such as adequate repositioning and provision of a pressure-relieving air mattress, to reduce that risk.[772]

It is clear from the material before us that MiCare failed to implement a pressure injury prevention and management plan such as the one provided by Peninsula Private Hospital for Mrs Aalberts after her return from that hospital on 11 July 2018.

765 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3478.42-44.

766 Transcript, Johanna Aalberts-Henderson, Cairns Hearing, 15 July 2019 at T3478.35-36; Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 126, MIC.0001.0001.0066.

767 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 65, MIC.0001.0001.0193 at 0197.

768 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 72, MIC.0001.0001.0288.

769 Transcript, Professor Sussman and Ms Ryan, 11 July 2019 at T3325-3345.

770 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3514.30-38.

771 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3514.8-10.

772 Submissions of Counsel Assisting the Royal Commission: Avondrust Lodge Case Study, 24 July 2019, RCD.0012.0013.0001 at 0008 [30].

Food and nutrition

On 7 June 2018, Mrs Aalberts weighed 73kg. When she was next weighed at Avondrust on 26 July 2018, she weighed 65.5kg. She had lost over 7kgs (10% of her body weight) in seven weeks. Despite this significant weight loss, and the difficulty Mrs Aalberts had feeding herself after she broke her wrist, there is limited information in the progress notes to suggest that staff were regularly assisting Mrs Aalberts to eat.

Mr van Duuren conceded that the care staff should have used a 'food and fluid balance chart' as a systematic source of information about Mrs Aalberts's food intake.[773] This was not done. No changes were made to Mrs Aalberts's dietary plan despite a review by a dietician on 30 July 2018.

In light of these admitted deficiencies, it is of concern that the training in nutrition and hydration provided to care staff at Avondrust was so poorly attended. During the period from 1 May 2018 to 30 August 2018, MiCare offered one hour-long nutrition and hydration training session, which four staff members attended.[774] That training was conducted internally, by the Clinical Care Coordinator employed at the time.[775]

MiCare failed to monitor Mrs Aalberts's nutritional requirements and weight in a systematic manner.

This failure must be understood in the context of the broader evidence before this Royal Commission that adequate nutrition has a direct effect on the body's ability to heal. Dr Sandra Iuliano, qualified nutritionist and Senior Research Fellow at the Department of Medicine, University of Melbourne, gave evidence at the Cairns Hearing that poor diet can affect the body in three ways:

- it can lead to a decline in weight, which reduces the amount of padding available to support skin
- it can compromise a person's immune system
- in relation to diets low in protein, it can prevent the skin from healing.[776]

773 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019, T3501.17-44.

774 Exhibit 6-38, Darwin and Cairns Hearing, Supplementary Statement of Robert van Duuren, 12 July 2019 at WIT.0260.0004.0001 at 0024.

775 Exhibit 6-38, Darwin and Cairns Hearing, Supplementary Statement of Robert van Duuren, 12 July 2019, WIT.0260.0004.0001 at 0013.

776 Transcript, Sandra Iuliano, Cairns Hearing, 16 July 2019 at T3656.26-36.

Communication between MiCare and Ms Aalberts-Henderson

Ms Neeleman, MiCare's Executive Director, explained that the Eden philosophy of care which guides MiCare's operations emphasises the importance of relationships.[777] The significance of relationships between care workers, residents and their families to the provision of quality aged care has been explained by a number of witnesses who have given evidence in this Royal Commission.[778]

The communication by staff with Ms Aalberts-Henderson about her mother's rapidly deteriorating health was sorely lacking. The lack of information provided to Ms Aalberts-Henderson about the deterioration of her mother's leg wound and the appearance of the pressure injuries has been noted above.

That lack of communication arose in other areas of Avondrust's management of Mrs Aalberts's care. It was only in August 2018 that Ms Aalberts-Henderson learned of her mother's substantial weight loss at Avondrust. Although Mrs Aalberts had returned from hospital on 11 July 2018 with a broken right wrist that inhibited her ability to feed herself, it was not until 26 July 2018 that staff identified that she had lost a substantial amount of weight and organised a review with a dietician.

On 8 August 2018, Ms Aalberts-Henderson made a detailed written complaint to MiCare about what she considered was the poor care her mother had received.[779] She raised concerns about the poor wound care, the lack of staff, poor communication, the meals and the general attitude. While MiCare's response dated 9 August 2018 acknowledged that there were some 'opportunities to improve', it was largely defensive in tone. For example, on the question of staffing levels, Mr van Duuren responded:

> Our staffing levels meet legal requirements and Department expectations. It is at all times a reflection of Commonwealth government funding income hence is continuously reviewed and adjusted in line with changes. We value knowledge, skills and experience and therefore promote staff training and competencies.[780]

As Mr van Duuren accepted in his evidence, MiCare did not, at that point in time, concede any inadequacy of staffing levels or quality.[781] It was only the finding on 27 August 2018 by the Aged Care Quality and Safety Commission that staffing levels at Avondrust were inadequate that led to MiCare belatedly reaching the same conclusion.[782] These findings are discussed below.

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777 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3577.21-39. Evidence regarding the Eden philosophy of care is was also given by Sally Hopkins, Executive Director of Eden in Oz (see Transcript, Sally Hopkins, Darwin Hearing, 11 July 2019 at T3305.3-3325.14).

778 See, for example, Transcript, Lisa Trigg, Perth Hearing, 26 June 2019 at T2803.26-2804.14.

779 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 117, MIC.0001.0001.0035 at 0040-0041.

780 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 117, MIC.0001.0001.0035 at 0038.

781 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3555.16-18.

782 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3555.20-27.

MiCare's poor communication extended beyond the death of Mrs Aalberts on 19 August 2018. Until the statement of Ms Neeleman dated 2 July 2019 was provided to the Royal Commission, and despite the obvious failings in the care MiCare provided to Mrs Aalberts, senior officers at MiCare had not apologised personally to her family. We accept that the apology made by Ms Neeleman in her statement to the Royal Commission is both comprehensive and genuine.[783]

Ms Neeleman's explanation for the lack of an apology between August 2018 and July 2019 was that she asked the Aged Care Complaints Commission for a meeting with the family where she intended to apologise, but she was told that it was not yet the time.[784] When Counsel Assisting pointed out to her that the complaint was finalised in April 2019, Ms Neeleman conceded that she had not subsequently made any attempts to apologise.[785]

In its written submissions, MiCare asserted that the finalisation of the complaint was 'irrelevant, given that the family had previously declined an apology'.[786] We understand from that submission that MiCare considered the family's rejection of the request for a meeting to be the end of the matter. We consider that it is unlikely that Ms Aalberts-Henderson would have received a written apology but for this Royal Commission.

Between 11 July 2018 and 6 August 2018, MiCare failed to keep Mrs Alberts-Henderson adequately informed about the progress of her mother's wounds and was generally poor in its communication about her mother's care.

Staffing levels

MiCare's responsibilities under section 54-1(1) of the *Aged Care Act 1997* (Cth) include:

a. to provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question;

b. to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.

Part 3 of Schedule 1 to the *Quality of Care Principles 2014* (Cth), in force at the time, required MiCare to provide 'nursing services' including 'complex wound management'.[787]

783 Exhibit 6-41, Darwin and Cairns Hearing, Statement of Petronella Dorothea Neeleman, 2 July 2019, WIT.0260.0002.0001 at 0005-0007.

784 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3573.10-13.

785 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3573.27.

786 Submissions of MiCare Ltd in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0021.0003 at 0003-0004 [6].

787 See sch 1, pt 3, cl 3.8(e) of the *Quality of Care Principles 2014* (Cth).

Both the numbers and skills of staff at Avondrust between May and August 2018 were insufficient to provide for Mrs Aalberts's proper care. There were no registered nurses working at Avondrust during either the afternoon shift or the night shift for 60 residents with significant care needs, many of whom, like Mrs Aalberts, required extensive clinical care on a daily basis.[788] The Australian Aged Care Quality Agency assessed this rostering arrangement as meeting expected outcome 1.6 (Human Resource Management) in April 2018 but the same rostering arrangement was assessed by the same regulator as not meeting the same expected outcome in August 2018.[789] Expected outcome 1.6 stated:

> There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.[790]

As noted above, Mr van Durren justified these staffing numbers in MiCare's response to Ms Aalberts-Henderson's complaint.

MiCare made significant changes to the staffing roster at Avondrust after the August 2018 review audit by the Australian Aged Care Quality Agency and the imposition of sanctions by a delegate of the Secretary of the Australian Department of Health on 29 August 2018.[791] The Secretary's delegate required MiCare to appoint a nurse adviser and an administrator.[792] MiCare appointed Ansell Strategic (Ansell) to perform both those roles and Ansell provided reports to the Department, including a report dated 14 September 2018.[793] In that report, Ansell addressed staffing numbers at Avondrust:

> A review of rostered hours found that Personal Care Worker hours are consistent with those found in other facilities of the same size and resident acuity.
>
> However, it is considered that there are insufficient Registered Nurse hours to provide the clinical oversight required at the home. To this end, Management have commenced the recruitment process to employ RNs to undertake an afternoon shift.[794]

788 There are two staff rosters in evidence – one from April 2018 (Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 28, CTH.4007.1000.1386 at 1393-1395) and one from August 2018 (Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 123, CTH.1013.1002.0003 at 0011-0012).

789 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 28, CTH.4007.1000.1386 at 1393 and tab 123, CTH.1013.1002.0003 at 0010; see also Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019, T3560.17-3561.2.

790 See sch 2, pt 1, cl 1, item 1.6 of the *Quality of Care Principles 2014* (Cth).

791 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019, T3561.20-3562.9; Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 153, CTH.1013.1004.2998.

792 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 135, MIC.5001.0001.2800. The requirements were imposed pursuant to s 66-2(1) of the *Aged Care Act 1997* (Cth).

793 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 152, CTH.1013.1004.2881.

794 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 152, CTH.1013.1004.2881 at 2882.

Ansell expanded on this opinion in a draft memorandum to Ms Neeleman dated 12 February 2019.[795] It noted that seven of the 13 non-compliances identified by the Aged Care Quality and Safety Commission were in relation to Standard 2 – Health and Personal Care. Ansell concluded that an 'underpinning reason' for this appeared to be 'the ongoing belief that care staff were effective in identifying and addressing clinical issues'. Ansell considered that 'this belief did not reflect an understanding or consideration for the increasing acuity of the residents'.[796] Mr van Duuren agreed with Senior Counsel Assisting that Ansell was informing MiCare that it had 'dropped the ball'.[797] Ansell concluded that registered nurses:

> were rostered for approximately 55 hours per week equating to **less than seven minutes per resident per day.**[798] [emphasis added]

Not surprisingly, in light of this, Ansell considered that:

> This was insufficient time to effectively assess and manage the clinical needs of elders, complete effective and defensible reporting, develop and review care plans and provide adequate guidance and oversight of the practices of staff in addressing such issues.[799]

Mr van Duuren agreed that Ansell was 'absolutely right' in this assessment.[800] He also accepted that the Board could itself have reached these conclusions about what MiCare's staffing arrangements meant for its residents without the need to engage a consultant.[801] However, he was unable to inform the Royal Commission if the staffing levels had been discussed at Board level.[802]

In response to these developments (and after the Royal Commission was announced), MiCare dramatically increased nursing numbers and hours at Avondrust, with effect from November 2018.[803] Mr van Duuren gave evidence that 'there has been an increase of 148.25 nurse hours per week, an increase from 54 hours per week'.[804] Mr van Duuren explained that this is to be understood as an actual increase of 148 nursing hours, so that the number of nursing hours after January 2019 exceeds 200 hours.[805]

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795 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3556; Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 211, MIC.5000.0001.0752.

796 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 211, MIC.5000.0001.0752 at 0752_0002.

797 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019, T3556.43-47.

798 See sch 2, pt 1, cl 1, item 1.6 of the *Quality of Care Principles 2014*.

799 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 211, MIC.5000.0001.0752 at 0752_0002.

800 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3557.35-37.

801 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3557.39-43.

802 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3558.1-2.

803 Exhibit 6-38, Darwin and Cairns Hearing, Supplementary Statement of Robert van Duuren, 12 July 2019, WIT.0260.0004.0001 at 0014.

804 Exhibit 6-37, Darwin and Cairns Hearing, Statement of Robert van Duuren, 2 July 2019, WIT.0260.0001.0001 at 0008.

805 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3561.38-3562.3; Exhibit 6-38, Darwin and Cairns Hearing, Supplementary Statement of Robert van Duuren, 12 July 2019, WIT.0260.0004.0001 at 0015.

We find that MiCare failed between May and August 2018 to meet its obligations under s 54-1(1)(b) of the *Aged Care Act 1997* (Cth) and expected outcome 1.6 of the *Quality of Care Principles 2014* (Cth) to maintain an adequate number of registered nurses rostered to work at Avondrust Lodge.

MiCare's response to the Royal Commission's approved provider survey

MiCare provided a response dated 8 February 2019 to the Royal Commission's approved provider survey. In its response about Avondrust Lodge, MiCare stated that there were 4.23 full-time equivalent (FTE) registered nurses working as at 30 June 2018.[806]

Both Mr van Duuren[807] and Ms Neeleman[808] conceded that this was factually incorrect. Mr van Duuren accepted that the correct figure was 1.4 FTE registered nurses working at that time.[809] In his evidence on 15 July 2019, he was unable to explain how this significant error was made.[810] However, he accepted an invitation from Senior Counsel Assisting to investigate the question and provide the Royal Commission with an answer.[811]

By letter dated 30 July 2019, MiCare advised the Royal Commission that its submission had been completed by a person who was no longer employed by MiCare.[812] MiCare apparently did not contact that person to seek an explanation.[813] MiCare submitted that 'the most likely explanation' for the incorrect information is human error, and that the current data was inadvertently entered rather than that applicable as at 30 June 2018 (as the Royal Commission had requested).[814] MiCare submitted that, given the short time frame allowed by the Royal Commission to provide the submission, the document may contain inadvertent inaccuracies.

Ms Neeleman explained that there was no intention to mislead the Royal Commission.[815] As noted, MiCare did not identify the person who completed the submission and accordingly that person has not been approached to give evidence to the Royal Commission about their intention.

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806 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 239, SUB.0001.0038.2255 at 2255.

807 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3550.41-44; T3553.19-21

808 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3591.20-28.

809 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3553.1-3.

810 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3553.23-26.

811 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3553.28-31.

812 Letter to the Solicitor Assisting the Royal Commission, 30 July 2019, RCD.0012.0021.0001 at 0002; Submissions of MiCare Ltd in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0021.0003 at 0004 [10].

813 Letter to the Solicitor Assisting the Royal Commission, 30 July 2019, RCD.0012.0021.0001 at 0002.

814 Letter to the Solicitor Assisting the Royal Commission, 30 July 2019, RCD.0012.0021.0001 at 0002; Submissions of MiCare Ltd in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0021.0003 at 0004 [10].

815 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3591.35.

However, we consider that the following features of the evidence are significant:

- the wide disparity between the figures
- the favourable impression created for MiCare by the inaccurate figures
- that the Royal Commission has no record of a request from MiCare for an extension of time within which to provide its submission
- that MiCare has not advised the Royal Commission of a single other inaccuracy in any of the submissions relating to their four facilities (including Avondrust).

On balance, and having regard to the standard of proof applied by this Royal Commission discussed in the introduction to this volume, we do not make a finding that MiCare deliberately deceived the Royal Commission. As MiCare conceded, in its submission to the Royal Commission dated 8 February 2019, MiCare provided incorrect and misleading information about its staffing numbers and particularly the number of registered nurses it had rostered. Put simply, MiCare did not tell the Royal Commission the truth in its submission.

Governance deficiencies

Ms Neeleman accepted that accountability 'begins and ends with the leaders: the board and senior management'.[816] However, we find that there was and remains a distinct lack of clinical expertise on the MiCare Board. Ms Neeleman gave evidence that since October 2018, none of the MiCare Board members have had any clinical expertise.[817]

Mr van Duuren was not able to comment on whether staffing levels had been discussed at Board level.[818] Counsel Assisting characterised this lack of knowledge as 'concerning', as it 'raise[d] a fundamental gap in the governance arrangements at MiCare'.[819] MiCare asserted that as Mr van Duuren was not a member of the Board, it should be 'unsurprising that he did not know whether a specific matter had been discussed at Board level'.[820]

816 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3579.3-11.

817 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3582.1-4.

818 Transcript, Robert van Duuren, Cairns Hearing, 15 July 2019 at T3557.45-3558.2.

819 Submissions of Counsel Assisting the Royal Commission: Avondrust Lodge Case Study, 24 July 2019, RCD.0012.0013.0001 at 0011 [45].

820 Submissions of MiCare Ltd in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0021.0003 at 0004 [8].

We accept that Mr van Duuren could not know the specifics of all topics that the Board discussed. However, as its own consultant explained, the 'underpinning reason' for over half of the non-compliances identified by MiCare was inadequate levels of clinical care staff,[821] and Mr van Duuren was the head of clinical governance at Avondrust.[822] In these circumstances, we consider it concerning that, if such a Board level discussion did take place, he was not advised of it or asked to provide information in relation to it. We conclude that it did not occur.

We consider that a strong governance arrangement should have included both reporting from Mr van Duuren to the Board about staffing levels, consideration by the Board of the adequacy of those staffing levels and feedback from the Board back to Mr van Duuren with their assessment. Had the Board appreciated that the staffing arrangements meant that each of the high care residents at Avondrust were receiving, on average, seven minutes of care from a registered nurse each day, we would expect that the Board would have been most concerned.

A review of MiCare's Board governance conducted by two Board members in early 2019 concluded that compliance with not-for-profit governance principles published by the Australian Institute of Company Directors was low in relation to risk management, compliance and culture.[823] We are advised by MiCare's lawyers that Ms Neeleman did not agree with those findings.[824] However, in her evidence Ms Neeleman accepted that 'irrespective of the report' there had been failings in respect of clinical governance at MiCare.[825]

Between May and August 2018, the MiCare Board did not have a sub-committee concerned with clinical governance. It now has a 'quality and compliance committee'.[826] Ms Neeleman accepted that there should have been such a committee in place in 2018.[827] It remains of concern that the clinical governance framework is yet to be signed off as at July 2019.[828]

We find that MiCare failed, between May and August 2018, to have in place an appropriate clinical governance regime such as a clinical governance sub-committee of the Board of Directors.

821 Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 211, MIC.5000.0001.0752 at 0752_0002.

822 Exhibit 6-37, Darwin and Cairns Hearing, Statement of Robert van Duuren, 2 July 2019, WIT.0260.0001.0001 at 0007.

823 See Exhibit 6-35, Darwin and Cairns Hearing, Avondrust tender bundle, tab 225, RCD.9999.0120.0007; Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3583.29-47.

824 Submissions of MiCare Ltd in reply to submissions of Counsel Assisting, 31 July 2019, RCD.0012.0021.0003 at 0004 [9].

825 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3584.12-20.

826 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3592.10-42.

827 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3592.42-44.

828 Transcript, Petronella Neeleman, Cairns Hearing, 15 July 2019 at T3593.26-29.