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THE HONOURABLE T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

IN THE MATTER OF THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

MELBOURNE

9.21 AM, FRIDAY, 11 OCTOBER 2019

Continued from 10.10.19

DAY 55

MR P.R.D. GRAY QC, counsel assisting, appears with MS B. HUTCHINS and MS E. BERGIN
MR G. KENNETT SC appears with MR B. DIGHTON for the Commonwealth of Australia

COMMISSIONER PAGONE: Ms Bergin.

MS BERGIN: Good morning, Commissioners. Good morning, Mrs Nieuwenhoven.

MS NIEUWENHOVEN: Thank you.

<CATHARINA GESINA NIEUWENHOVEN, SWORN [9.22 am]

<EXAMINATION BY MS BERGIN

COMMISSIONER PAGONE: Yes, Ms Bergin.

MS BERGIN: What is your full name?

MS NIEUWENHOVEN: Catharina Gesina Nieuwenhoven.

MS BERGIN: And how old are you, Mrs Nieuwenhoven?

MS NIEUWENHOVEN: Nearly 79 in a couple of weeks.

MS BERGIN: Where do you live?

MS NIEUWENHOVEN: I live in Parafield Gardens, South Australia.

MS BERGIN: Have you prepared a statement for the Royal Commission?

MS NIEUWENHOVEN: I did.

MS BERGIN: And is there a copy of your statement there in front of you?

MS NIEUWENHOVEN: There is.

MS BERGIN: Do you have any amendments to your statement?

MS NIEUWENHOVEN: No.

MS BERGIN: Is it true and correct to the best of your information and belief?

MS NIEUWENHOVEN: Yes, it is.

MS BERGIN: I tender the statement of Catharina Gesina Nieuwenhoven dated 2 October 2019.

COMMISSIONER PAGONE: Yes, thank you. That will be exhibit 10-25.

EXHIBIT #10-25 STATEMENT OF CATHARINA GESINA NIEUWENHOVEN DATED 02/10/2019 (WIT.0515.0001.0001)

MS BERGIN: Mrs Nieuwenhoven, you were born to parents in Amsterdam in the Netherlands.

MS NIEUWENHOVEN: That's right.

MS BERGIN: And you lived in Amsterdam your family.

MS NIEUWENHOVEN: I did.

MS BERGIN: And you had seven siblings.

MS NIEUWENHOVEN: I did.

MS BERGIN: And you lived there until you were nearly 16 years old.

MS NIEUWENHOVEN: That's correct.

MS BERGIN: You came to Australia by ship with your family and you initially stayed in a hostel in Woodside in South Australia.

MS NIEUWENHOVEN: We did.

MS BERGIN: And then you later moved to the northern suburbs of Adelaide.

MS NIEUWENHOVEN: We did.

MS BERGIN: You've now been in Australia for over 60 years. Where did your parents meet?

MS NIEUWENHOVEN: They met in Amsterdam. They lived not far away from one another at all, in the middle of Amsterdam.

MS BERGIN: What was your role in the family with seven siblings?

MS NIEUWENHOVEN: I was the eldest of eight children, of course, and I didn't always have to take care of my family but often I did.

MS BERGIN: Your parents moved to Australia in 1956.

MS NIEUWENHOVEN: That's right.

MS BERGIN: Why did they decide to move to Australia?

MS NIEUWENHOVEN: Because at the time, in '56 there was a war looming in Hungary and my parents said we have already had two world wars and we want to get out and Australia wanted people to work here and Holland wanted to get rid of people. So it was an exchange.

MS BERGIN: How did you remain connected with the Dutch community after moving to Australia?

MS NIEUWENHOVEN: Because we always mixed with a group of Dutch people for quite a while until we more or less felt comfortable with the Australian society. A lot of people did that. You stuck to your own community for a while but then you moved out and you mixed with Australian society.

MS BERGIN: Now, after moving to Australia, you met Willy, who was coincidentally on the same ship as you from the Netherlands to Australia but that's not how you met.

MS NIEUWENHOVEN: Yes.

MS BERGIN: How did you meet?

MS NIEUWENHOVEN: My husband wanted to be a Catholic at the time and my father was quite a strict Catholic and so he was sent – my husband was sent by the Dutch priest at the time to see my father and that's how we met.

MS BERGIN: You and Willy had seven children together.

MS NIEUWENHOVEN: That's right.

MS BERGIN: And your children, to this day, live in South Australia or in Queensland.

MS NIEUWENHOVEN: Four in Queensland and three in South Australia.

MS BERGIN: Unfortunately, Willy died in 2001 when he was 66.

MS NIEUWENHOVEN: That's right.

MS BERGIN: And you continue to live in the northern suburbs of Adelaide in a house by yourself.

MS NIEUWENHOVEN: That's right.

MS BERGIN: Mrs Nieuwenhoven, tell us about your mother.

MS NIEUWENHOVEN: I had a good mother. She developed cancer – I've forgotten the name – and then she got better after a while but when my father died she got the cancer back again and she became quite incapable of looking after herself, she was too frightened. So she lived with my sister for five years until she needed hospice care which was very difficult to get at the time.

MS BERGIN: When did she start to need assistance?

MS NIEUWENHOVEN: When she was dying, because she couldn't speak the language at all and she was quite fluent in English, but my brother said one day, "For goodness sake go and see Mother, I can't understand her at all. She is all yabbling away in Dutch," which I thought was very sad, because in her dying days, there was nobody that could assist her.

MS BERGIN: So your mother reverted to the Dutch language late in life as her health deteriorated.

MS NIEUWENHOVEN: Exactly.

MS BERGIN: And where was she living after the cancer diagnosis?

MS NIEUWENHOVEN: She was in three different hospices at the time and at the time you could only stay for six or eight weeks, then we had to shift her, and she finally died in Mary Potter.

MS BERGIN: Did you look for a facility for your mum in South Australia where the staff spoke Dutch?

MS NIEUWENHOVEN: It wasn't available. It just wasn't there at the time. It wasn't catering for migrants at all.

MS BERGIN: And what were your reflections on this gap at the time?

MS NIEUWENHOVEN: I felt very sad and that's why I looked into the Dutch community as a whole and I thought that's going to happen to some of those people as well.

MS BERGIN: What did this prompt you to do?

MS NIEUWENHOVEN: My mother's inability to speak the English language.

MS BERGIN: Operator, could you bring up tab 121. Mrs Nieuwenhoven, this is a letter that you wrote in about 1989. And there's an English translation on the right-hand side of your Dutch, of your letter in Dutch. What publication was this in?

MS NIEUWENHOVEN: In the – in the - - -

MS BERGIN: Was it a letter to the Dutch social club?

MS NIEUWENHOVEN: Dutch community, the Dutch social club in Salisbury.

MS BERGIN: And it's published in a historical - - -

MS NIEUWENHOVEN: No, it's just in their Dutch letter, their communication letter they sent to the Dutch people, nothing official.

MS BERGIN: I see. Could you tell us what prompted you to write this letter?

MS NIEUWENHOVEN: Well, as I said, when I looked at the amount of people that were there at the time and I think there were about – well, don't take it for granted but I think about 300 people, and I thought that's going to die down because these people are all my parents' age and surely the amount of people from there would need care where the Dutch language is at least understood, maybe not spoken but understood.

MS BERGIN: At the foot of the letter, you have a request to the people who are reading the publication and you say that:

> *It's so important, especially as one gets older to be able to maintain a cosy environment and Dutch customs. It may be possible to hire a home because the need may perhaps only be for 15 to 20 years. Don't wait until it is needed because it will be too late. Something needs to be done now. Interested people can ring me.*

Did many people ring you?

MS NIEUWENHOVEN: Four.

MS BERGIN: What did they ring you to say?

MS NIEUWENHOVEN: They said you can't do it, you're opening a can of worms.

MS BERGIN: That was in response to your proposal to - - -

MS NIEUWENHOVEN: My letter.

MS BERGIN: - - - set up an aged Dutch home or nursing home in Adelaide.

MS NIEUWENHOVEN: That's correct.

MS BERGIN: What did you do next?

MS NIEUWENHOVEN: Well, I wasn't going to give up. So I went – I wrote to the Dutch community that had a home in Victoria. I went there, and they said we

can't help you, but we can help you with suggestions but that's all. We haven't got any money at all. So then I called another meeting in Adelaide and I had – you know, in a Dutch club, and I had 20. From there, I called a meeting on the Dutch radio in Adelaide and I had 40, and from then I had a man who worked with the government and he knew where to pull the strings, so to speak. He knew his way around. He was a great help at the time to help us set up.

MS BERGIN: At this time were you looking for sources of funds?

MS NIEUWENHOVEN: I did.

MS BERGIN: Where did the funds come from?

MS NIEUWENHOVEN: From, we used to run bingo, rice dinners. My husband and I used to go to trash and treasure trying to sell some stuff so that we had some money. We had to show the government that we could raise some money in order to get a grant so – and my husband and I opened a tax file so that we could claim at least some of the money. We had no money at all. So, and then – yes, we raised quite a bit of money and then I remembered that there was a fund in the Netherlands for migrants the Queen set up. So I wrote to my cousin and within 4 weeks I had a big cheque back. So we showed the cheque to Neal Blewett at the time and then we got the grant for 1.6 million.

MS BERGIN: For 1.6 million. And the cheque that you received from the Netherlands – who provided that?

MS NIEUWENHOVEN: The Dutch government through Queen Juliana. Actually, it was her fund, but I don't know any more about it. I just wrote to my cousin and she sent a cheque back, so I don't know what she did at the time, but it was a miracle.

MS BERGIN: So then you had sufficient funds to build your dream. And how did you go about the next phase?

MS NIEUWENHOVEN: Well, we had a committee of – I can't even remember that, maybe about 12. Among them was an architect who has since passed away and he worked with the Housing Trust. So again, he knew who to ask, where we could start and I wanted a home in my area because my friends all lived there but the Salisbury Council said we don't need it, we've got enough homes. And so the Marion Council was the only one that said we will have you, providing you give room to anybody, any nationality. But since we were filled up, then if a Dutch or Belgian person comes for a room, they get preference to another person, if there is no more other room, yes.

MS BERGIN: So when the facility opened, how many beds did it have?

MS NIEUWENHOVEN: 36.

MS BERGIN: And what services did it offer?

MS NIEUWENHOVEN: The Dutch community, the Dutch language spoken and Dutch customs, which was very important. Yes, and usually aged care but very cosy, you know, flowers everywhere, table cloth and, yes, I felt quite at home, paintings on all the walls and, yes, it was typical Dutch.

MS BERGIN: What did you call it?

MS NIEUWENHOVEN: Rembrandt Living.

MS BERGIN: How is it going now?

MS NIEUWENHOVEN: Well, we've got 90 rooms now. It's quite – they had a big extension some years ago and, yes, it's doing okay.

MS BERGIN: Do you remain involved?

MS NIEUWENHOVEN: No, I just remember – I'm just, yes, well, the organiser, I suppose. But no, it's too far away. I would love to but it's too far away.

MS BERGIN: When you needed respite care yourself, did you go there?

MS NIEUWENHOVEN: Yes, I did, and for a fortnight and I was thoroughly spoilt. And I felt quite at home but my eldest son said, "You revert back to Dutch so quickly when you were in there". But I saw the care, especially of a very demented old lady, and they spoke to her in Dutch and fed her and cleaned her, and the care was really very gentle. So that impressed me, it really did. Yes.

MS BERGIN: In your statement you explain that you receive home care services through Rembrandt Living now.

MS NIEUWENHOVEN: Yes, I do.

MS BERGIN: And that you have sometimes conversations in Dutch with the care worker.

MS NIEUWENHOVEN: Yes, I do.

MS BERGIN: How did you go about organising a Dutch-speaking care worker?

MS NIEUWENHOVEN: I didn't because there are many different nationalities working for Rembrandt. She just happened to be Dutch, so we have a coffee and I make her lunch, and it's nice, yes.

MS BERGIN: How often does she come to visit you?

MS NIEUWENHOVEN: Once a week.

MS BERGIN: And what services does she provide?

MS NIEUWENHOVEN: Once a week she vacuums and washes floor and the other week she changes the bed and hangs out the washing because I can't do it on my own.

MS BERGIN: Mrs Nieuwenhoven, are there other aspects of sort of culturally sensitive care that you receive through your home care package?

MS NIEUWENHOVEN: No, I don't think so. Or did I mention that?

MS BERGIN: No, I don't think so.

MS NIEUWENHOVEN: I don't think so, either.

MS BERGIN: What would you ask for if there were – would there be changes that you would ask for if you could change anything about the way your home care package services work to make them more culturally appropriate? Or are you happy with them as they are?

MS NIEUWENHOVEN: I'm happy the way it is, thank you.

MS BERGIN: Okay. How did you find the process of applying for a home care package through My Aged Care?

MS NIEUWENHOVEN: I didn't know much about it and my doctor recommended I need some help and then through working with the council, which I do, I had a lady and she was in charge and she said, "Tina, don't say anything, I will be there when you are assessed." So she was a great help for me to be there and I was assessed at level 2, and then later on somebody came some years later and I was assessed at level 3.

MS BERGIN: And Tina is your care worker; is that right?

MS NIEUWENHOVEN: Sorry?

MS BERGIN: Who was Tina that you mentioned?

MS NIEUWENHOVEN: No, I'm Tina.

MS BERGIN: Sorry. Who was the person that attended with you when you had the ACAT assessment?

MS NIEUWENHOVEN: The first one was Sue Lecki, and the second one, I'm not sure now; I can't remember her name.

MS BERGIN: Sure. How did you find reading the home care package agreement?

MS NIEUWENHOVEN: I found it quite difficult. I didn't know in the beginning what I was entitled to at all. I read through it quite a few times but as my saying is it's all a little bit in high English. It's all right if you are university educated but for the normal people, some of the wording is difficult to understand, especially for, I mean, I'm a migrant and I can read it but a lot of people are just from a simple background and they don't understand.

MS BERGIN: Yes. In the future, if you had to go into a residential aged care facility, would you consider going to Rembrandt Living?

MS NIEUWENHOVEN: I would, because I'm so Dutch.

MS BERGIN: And what are the features of the facility that are particularly Dutch?

MS NIEUWENHOVEN: Well, we celebrate, for instance, the king's birthday and Christmas is – well, the same in Australia anyway but we have quite a few sing-songs in our language. And people interact with one another, you know, yes. It's just different, it's not that you get less care. You don't, because I helped for 10 years; I was administering aged care for 10 years so you get good care anywhere, it's just the atmosphere.

MS BERGIN: Is that partly about facilitating social connection?

MS NIEUWENHOVEN: Yes, that's what it is. That's what it is. Especially when people lose their language in dementia, as I mentioned before, it's very necessary that they're understood, not so much to be spoken to, you can always get some helper that will, you know, translate for them, but the need is there, when a person is, you know, sick and not being able to speak the English language, yes.

MS BERGIN: Do many of the staff speak Dutch at Rembrandt Living?

MS NIEUWENHOVEN: A fair amount, not all but a fair amount. There are quite a few staff working from different nationalities. I spoke to somebody from Bhutan, from China, Indonesia and they all said we're so happy working here, and the atmosphere is really good so that's a compliment to the home.

MS BERGIN: Why do they say that the atmosphere is good, do you know?

MS NIEUWENHOVEN: Well, I think because the interaction between people and, yes, and the CEO, she is very good in taking care of her establishment. She is very good. So that makes a difference too. So, yes.

MS BERGIN: Are there any many Dutch-speaking residents at Rembrandt Living?

MS NIEUWENHOVEN: I think the majority would be Dutch. Not all, because I've spoken to a few from different cultures, but the majority is, yes.

MS BERGIN: In your statement you say that you worked as a community liaison officer.

MS NIEUWENHOVEN: Yes, I do.

MS BERGIN: Could you tell us when was that?

MS NIEUWENHOVEN: I've been like that for about four or five years, I suppose. It's all to do with the council. I'm a Northern Community Ambassador as well and we used – well, I travel on public transport quite a bit, and you talk to people at bus stops and everywhere and, you know, people complain about something and they said, "Well I've got this package or I need care, where will I go?" And so I tell them, "Well, you've first got to be assessed. Here is the number for My Aged Care. That's the first step you do." And then you, yes, you just have to ask for a better explanation of what you are entitled to because they're quite surprised what you can do with your package.

And that's the whole problem, I think, if a migrant gets a package, it first of all needs to be explained in – an interpreter, when they get assessed and then when they get the package, they need to have an interpreter again to explain what they can do with their package, in simple language. And I think that's not quite there.

MS BERGIN: Are you aware whether there are State or Commonwealth services offered that if you're, say, not available and other community liaison officers aren't available to meet with a client, are there any funded staff or funded services to help people with access in South Australia?

MS NIEUWENHOVEN: I'm not sure. I don't know at all. But I think the basic thing is they need to know – much more advertised maybe in community groups how to do it and have it written down, not just said in the hall because people forget altogether. It has to be more simple, in my opinion. And it has to be interpreted by proper interpreters, not by people that have just lived here a year because they don't get a proper interpretation at all. It needs to be proper interpreters.

MS BERGIN: And when you say that you meet with people and explain that the options they might want to consider through, for example, home care package services, do you meet with them face-to-face?

MS NIEUWENHOVEN: Yes, I talk to them on the bus or the train, not often but, you know, in shopping centres as well because they know me quite well and it's, "Hi, Tina. Hi, Tina." And then people talk to you if you're open to that. I mean, some people don't want to talk but – and they often complain to me. I say, "Well, don't complain to me. This is what you have to do in order to get things done."

MS BERGIN: You were saying about the importance of interpreter services to help people, migrant communities, for example, understand the services that are available. Are you aware of what's available in your area if people need an interpreter?

MS NIEUWENHOVEN: No, I haven't gone into that at all, no.

MS BERGIN: Commissioners, that concludes my examination of Mrs Nieuwenhoven.

COMMISSIONER BRIGGS: Mrs Nieuwenhoven thank you very much for your explanation of the challenges in the Dutch community. Listening to your comment about needing explanation around not only how you go about applying for a package but also once you get one, what you can do with it. It strikes me that that might also be a problem for the general Australian community. Have you found that?

MS NIEUWENHOVEN: Yes, I have, because it's mainly Australian or English-speaking people I talk to. Yes, they said it's too difficult, I can't understand it and – yes.

COMMISSIONER BRIGGS: Yes. So that would suggest that everyone needs a bit of help in establishing what your particular needs are and then designing a package of services around those needs.

MS NIEUWENHOVEN: That's exactly right, thank you.

COMMISSIONER BRIGGS: Thank you.

MS NIEUWENHOVEN: Thank you.

COMMISSIONER PAGONE: Thank you, Mrs Nieuwenhoven. Thank you for your evidence. It has been very helpful and very interesting.

MS NIEUWENHOVEN: Thank you.

COMMISSIONER PAGONE: You may go. Thank you.

MS NIEUWENHOVEN: Thank you.

<THE WITNESS WITHDREW [9.43 am]

MS BERGIN: Thank you, Commissioners. If we could please have a short adjournment to allow for some logistics.

COMMISSIONER PAGONE: Yes. How long do you think you will need?

MS BERGIN: Just a couple of minutes.

COMMISSIONER PAGONE: Five minutes. We'll adjourn for about five minutes.

MS BERGIN: Thank you, Commissioner.

ADJOURNED [9.43 am]

RESUMED [9.57 am]

MS HUTCHINS: Commissioners, there's going to be a slight reordering of the timetable in relation to the next witnesses. The next witness that I will call is Ms Moreen Lyons, who's currently in the box.

COMMISSIONER PAGONE: Yes.

MS HUTCHINS: And then that will follow with the evidence of Uncle Brian Campbell and Uncle Brian Birch .....

COMMISSIONER PAGONE: Yes. Thank you.

MS HUTCHINS: Thank you.

<MOREEN MARY LYONS, AFFIRMED [9.58 am]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Your full name is Moreen Mary Lyons?

MS LYONS: That's correct.

MS HUTCHINS: And you've prepared a statement for the Royal Commission?

MS LYONS: I did.

MS HUTCHINS: Operator, please call WIT.0424.0001.0001. Is this a copy of the statement in front of you?

MS LYONS: It is.

MS HUTCHINS: And do you have any amendments you wish to make to the statement?

MS LYONS: I don't.

MS HUTCHINS: Are the contents of the statement true and correct to the best of your knowledge and belief?

MS LYONS: Yes, they are.

MS HUTCHINS: Thank you. I tender the statement of Ms Moreen Mary Lyons dated 9 October 2019.

COMMISSIONER PAGONE: Yes. Thank you. That statement will be exhibit 10-26.

EXHIBIT #10–26 THE STATEMENT OF MS MOREEN MARY LYONS DATED 9 OCTOBER 2019(WIT.0424.0001.0001)

MS HUTCHINS: Ms Lyons, you're currently employed as the chief executive officer of the Aboriginal community-elder service?

MS LYONS: That's right.

MS HUTCHINS: And how long have you been in that role for?

MS LYONS: I commenced on the 15th of June this year.

MS HUTCHINS: And what was your professional experience prior to that role?

MS LYONS: I've worked predominantly in my career as an industrial relations specialist but in more recent years in diversity inclusion, writing employment strategies for Aboriginal employment, preparing the workplace and working on projects for the Buraja Gadjin Land Council, which is my people, my clan.

MS HUTCHINS: Yes. And the Aboriginal community-elders service: it's an Aboriginal-controlled not-for-profit care service?

MS LYONS: That's right.

MS HUTCHINS: And what do the various arms of its services include?

MS LYONS: There is 25 beds, which is split between high needs and what you would say – lower needs, more of a hostel environment, and there are day programs, where there – about 30 participants come in and do planned programs every day.

MS HUTCHINS: And what are the types of things that the day program involve?

MS LYONS: Well, it varies considerably, and it is guided often by what the participants are more focussed around. At the moment we've just commenced an arts project with Aboriginal artist Mick Harding, and they're going to do some significant pieces together in relation to that project, but they will work on – there's men's shed on the Wednesday. So – and the women's group later in the week, but they'll craft boomerangs; they'll get experts in to teach didgeridoo making. There's a lot of artwork, Aboriginal artwork. They enjoy very much sewing and making different – they've done some beautiful weaving with Aboriginal totems – and Torres Strait Islander. Beg your pardon, and it's very varied. They'll go out to exhibitions, activities such as aqua swimming; because they're older group of people, they like to have different sort of physical activities as well – that are suitable. It's – the programs are designed in conjunction with the participants.

MS HUTCHINS: And what type of people are the participants?

MS LYONS: They're Aboriginal men and women and Aboriginal men and women with sort of challenges intellectually. Then we have programs specifically designed, and that's been a more-recent intake, and the feedback from family and carers has been very positive for people participating and having that sense of community, coming together.

MS HUTCHINS: Yes. And what type of age range are the participants?

MS LYONS: Predominantly the day program is older, but there's – there are some younger people coming in more from the home, group homes, with different challenges. So that's a mixed age group. The residential-care, the high-needs is much older, up to 90s, and the hostel – we're finding we're getting applications from younger Aboriginal men and women, and that – the intake is 45, unless it's an emergency; we'll vary it.

MS HUTCHINS: 45. And do you have many younger residents in the residential-aged care facility?

MS LYONS: Yes; we are finding there is an increased demand and increased supports required in terms of allied health professionals and psychiatric services.

MS HUTCHINS: And are you able to explain a bit; in your experience what are the types of circumstances that have led these younger residents to require aged care at an earlier age?

MS LYONS: They, typically, have experienced considerable childhood and later-in-life trauma. It's very much connected to the intergenerational trauma of survivors of genocide. So there's a multitude of traumas that are involved in that process. Those traumas contribute to – are contributors to chronic health issues earlier or later in life, depending on the circumstances that that person's been living through. We

have people in the high-needs care that are now – surviving the stolen generation, that didn't know they had family until they turned up at the door when they were 14. That - - -

COMMISSIONER BRIGGS: Just take a little while. Have a drink of water. You'll be fine.

MS LYONS: They got turned out of these institutions at age 12 with nothing in their pocket and no family or anybody to look after them, which – I just can't understand why anyone would do that, and I think for many of our residents ACES offers, probably, the first taste of a routine of care and genuine care and support, a safe cultural and spiritual environment where they know they won't be turned out and they won't be hurt or harmed, and that has tremendous healing.

MS HUTCHINS: Yes. You mentioned that there's often chronic health issues. What are the types of issues that you often see amongst your residents?

MS LYONS: There's a body of respected Australian and international research on first-nation people that have been through the circumstances not dissimilar to Australia, and the findings are that Aboriginal and Torres Strait Islander people, as they age, are aging more rapidly than non-Indigenous people and will be three to five times more likely to suffer from dementia. And that is directly linked, the studies have shown, to childhood trauma. And many of the physical issues, chronic health issues and multiple chronic health issues are coming on earlier in life, and these studies are also showing that these are drivers of trauma that have come out of – arising from trauma.

MS HUTCHINS: And Aboriginal and Torres Strait Islander people are eligible to receive aged care services at your facility from age 45.

MS LYONS: Yes.

MS HUTCHINS: Do you think that that's an appropriate age for eligibility?

MS LYONS: I think that there – yes; it is. I would even suggest there's, probably, a need for there to be more flexibility to accept younger people.

MS HUTCHINS: And why do you think that would be?

MS LYONS: Just think the demand – there's people that are coming in that are elders, but they're homeless; a woman in recently, an Aboriginal woman: she was living in the park and to had fend off two assailants with a deodorant spray. There's some really horrific stories coming in, and I think – and a lot of the social-support organisations ring in, and we have accepted people under 45, because they've really needed that support. We get a lot of calls from the domestic-violence Aboriginal services, and again we take residents from those areas. So we find in the residential area it's a different type of accommodation, that's needed, and there's more of an

interest in – as people heal and feel safe, to want to do training and thinking about work and thinking about some of those more-challenging things as they progress. They become more social. They really blossom within the environment, I've noticed – and quite quickly. Yes.

MS HUTCHINS: Do you think for those Aboriginal people that are entering your services earlier – that you're, in effect, filling a gap for services that don't exist elsewhere?

MS LYONS: Absolutely. Absolutely. And the clinical-director comes over quite regularly, and we talk about the different needs. Someone cannot be separated from their pet, their dog or cat and how – we don't reject those people, because that's a family member. We think about how we can accommodate it. Some people will need some additional support to buy dogfood and so on. But that would be another trauma, to try and separate people from, probably, for some people their only kind of family member. So we again try and keep everyone safe, obviously, but we want to accommodate those supports where possible.

MS HUTCHINS: And how is it, that your service is funded?

MS LYONS: The majority of our funding, around 75 per cent, is Commonwealth funding. We receive various grants from the state – and specific funding, such as training an Aboriginal workforce, which is terrific and is really a huge bonus to our organisation. It provides us a lot of flexibility in training up Aboriginal people across a variety of areas. So that's terrific support there.

MS HUTCHINS: Yes. And I'll turn to the topic of your workforce shortly. But firstly I wanted to ask you about the service's guiding principles, which are Aboriginal values and respect for the elders. How important is an understanding of Aboriginal values to provide culturally-safe care to Aboriginal people?

MS LYONS: It's absolutely fundamental, because it's a part of how they'll measure whether they're safe or not and whether they can relax and whether they'll be accepted, and there's still very high instance of discrimination and racism prevalent. I've had residents come back, really distressed from quite blunt interactions with culturally-insensitive providers, and they've wanted to speak to a counsellor, but they want to speak to an Aboriginal counsellor. Understanding the ceremonies are vital, or – people will not feel settled and cared for appropriately, if those things are not in place and not understood. And a part of that is having Aboriginal employees working at the service.

MS HUTCHINS: And, in practice, how do you go about trying to understand the individual backgrounds of various residents in your care?

MS LYONS: There's, certainly, the history taken upon admission, but that's not the whole story, and the whole – the bigger picture and the story and the trauma: that is shared in a trusting environment over time. And the organisation is run collectively;

so residents can have, for example their lunch in their room, if they want to, but in the dining-room: that's where everyone will come together and talk, and staff will sit with residents and have a yarn, and it's very communal in that sense.

And you build up relationships and sit in the garden with residents and just – they'll – after a while, once they get to know you, will tell you about their life and different stories about what's happened. And so it's – I brought my pup in yesterday, because we'd had – one of the family had died, and everyone was a bit down, and it just brought so much joy to everybody, and everyone wanted to adopt him straightaway. So things like that are done together.

MS HUTCHINS: Yes.

MS LYONS: Yes.

MS HUTCHINS: Yes, and you note in your statement that 35 per cent of your workforce is Aboriginal. What are the benefits of having Aboriginal staff for your residents?

MS LYONS: Because there's the immediate recognition of – often where – probably, one of the first questions is "Who's your mob, and where's your clan?", and they'll know their ancestors or their aunts or uncles or their – everyone knows everyone, in some respect, through somebody, and that's very comforting to the elders, and they'll talk about those commonalities in friends and family. It's also very important, that there's a flow of ceremony occurring, so that you – when someone has passed, there's a smoking-ceremony in that room, that people that want to have – to return on land and will have those discussions, that people understand what those discussions mean and what they're about, men's shed, women's circle – and, culturally, that's something that Aboriginal employees, certainly, come in, knowing.

MS HUTCHINS: In relation to returning to land – is that something that many of your residents seek to do?

MS LYONS: Yes. Yes. It's a bit harder for some than others. There's – one of our older residents goes up to Dimboola, which is now known as "Wale", every year and stays at a sort of a hospital environment up there. But there's a real need to return to land. There's another one of our residents that – we're planning to help her; she wants to go back to Torres Straits Island. The call to land is very strong, to return to land is very strong and a part of why there needs to be sometimes financial support to allow people to fulfil their spiritual needs.

MS HUTCHINS: And in terms of finding Aboriginal or Torres Strait Islander staff to work in your facility – do you find that challenging?

MS LYONS: There's a very good network, word of mouth. With the funding that we get, we're able to train people, rotate them in through different positions to train

them. So the our head of catering came in and started an apprenticeship, and he's Aboriginal. Our – people that are in management roles came in as a program assistant, over years develop their skills at different training. So we have a keen eye to assist Aboriginal staff, develop their careers, and we're working with some of the universities to rotate out to the units there to give them a bit of a taste of different environments as well, that this is not the only safe place to work. But – not so far. I think we've had a lot of interest to work at ACES.

MS HUTCHINS: And in terms of the balance of your workforce that is not Aboriginal or Torres Strait Islander – what's their background like?

MS LYONS: We have a significant percentage of Sudanese working – doing their nursing-degrees in the residential area, Indian, Pakistan. So I think there would be about five or 10 per cent just Australian. It's very multicultural environment.

MS HUTCHINS: Yes. And how do you educate those staff members on understanding Aboriginal and Torres Strait Islander needs and how to provide culturally-safe care to those residents?

MS LYONS: We have ongoing training, and we encourage – so we have cultural-awareness training; that's a part of our training-schedule. We have guest speakers coming in to speak on these questions. We've had recently for example, people from the Treaty Commission come out and speak to everybody about what that is and what that means. So it's about ongoing professional development and education and having a training-calendar that is updating and including what needs to be accommodated as we – if we find there's a gap, we try and fill that gap as best we can.

So – there's a real interest too, which is good. People are keen to – quite often taking a group out to see an Aboriginal or Torres Strait Islander art exhibition for example is an education sometimes in itself, because the elders will be able to speak at length about many of the symbols and the – explain some of the artwork. And that's terrific as well; it's sort of training in motion.

MS HUTCHINS: And how is it, that people that may need your services get connected with your services?

MS LYONS: We get – we network out to all of the – we get referrals through – particularly, from the hospital services, from Aboriginal housing groups, from community groups. So – we've also put regular adverts in the Courier Mail, because we take – and we have – take admissions from around Australia. So we use a variety of social media to get the word about.

MS HUTCHINS: Do you think that there exists currently a challenge for Aboriginal and Torres Strait Islander people generally to be able to find aged care services?

MS LYONS: Yes, and I don't think we're well enough known either, and we're working on that. But, yes, I definitely do think so, and I think a lot of development and support and training could be provided to younger Aboriginal people, if they had a sound base with – which to work from. So there's some opportunities there as well, I think.

MS HUTCHINS: And do you think the My Aged Care platform is an appropriate entry point?

MS LYONS: Yes, I think it is; yes. I think there's some good supports in that funding-model. Yes. I think we've got some real benefit out of using those; yes.

MS HUTCHINS: And in terms of the, say, My Aged Care website – do you think that Aboriginal and Torres Strait Islanders would be well equipped to be able to use that?

MS LYONS: No. No. No.

MS HUTCHINS: And why would that be?

MS LYONS: That's not something that they'll, necessarily – they'll ask, or they'll have conversations within community or within clan or within their networks, and eventually someone may know about it, but – no; not at all, and that – certainly, needs to be more connection there. May be even a rollout within the land councils might help better understanding through those networks. There's elder communities throughout those that could roll out information. But – definitely no; they don't. Yes.

MS HUTCHINS: And by virtue of the traumatic experiences that you referred to earlier in a lot of Aboriginal and Torres Strait Islander backgrounds – what are some of the common care needs that arise when they do enter an aged care facility because of that background?

MS LYONS: Well, certainly, I'm seeing in the sort of younger bracket the significant issues are, usually, diabetes – there's a psychiatric demand for support there. Some of our residents will move in and out of more high-need psychiatric care and back in again. You know, the passing of one of the ACES residents really upset one of our residents and had to take a spell in – and we have to be aware of those changes in behaviour and talk to see, "How you are going? What's going on?" And then I think maybe, you know, then the clinical care will get involved. So having a good eye for how people are tracking day-to-day is really important.

And helping people understand about being safe, you know, like you can come and go when you like, obviously, but maybe it's better to be in before it gets dark because some of our residents are quite vulnerable in the hostel and haven't necessarily had a lot of guidance around those issues. And so we try to guide them towards safe practices and safe – although we can't make them, we are not going to

make them but we try to guide them around keeping safe and so on. And some of those things are new concepts for some of our residents.

MS HUTCHINS: And for residents that may have had a history of being in institutions previously, whether it be, you know, homes or incarceration, do you have particular challenges with those residents in how their attitude might be to being in another type of facility?

MS LYONS: Yes, that's a really question that we are asked about, you know. Not being institutionalised, "How free am I to come and go? Why do I have to fill out these forms to tell you where I'm going?" There's a lot of suspicion around that and, you know, we talk through those – those points and are very clear with our residents around their rights and their flexibilities to come and go as they wish.

We're actually increasing opportunities with weekend services and bus services to take people out and about a bit more. But people are very wary at that point and it takes, you know, significant discussion. And often people will come into the hostel area and say, "I'm going to stay two weeks" because they want to have a foot in and a foot out if they don't like it, you know, if they feel that it's going to be institutional.

And, you know, the majority of times people stay on permanently and they're very happy. But we say "Yes, come and say overnight, a weekend, a week, a fortnight, whatever you are comfortable with". That works really well, so that people can try it out before they make that final decision. And even if they make that final decision they can leave but they need to feel that they are only staying for a weekend if that's what they want to do, because of those previous institutional environments.

MS HUTCHINS: Yes. And the processes you describe are obviously quite time extensive from a staffing perspective; are you aware of whether you have higher numbers of staff for residents than what you might see in a more traditional style aged care facility?

MS LYONS: We do. Yes, we do. Because we have, potentially, people that are going to, you know, if they're not properly cared for are going to potentially not be able to manage their pain and talk about self-harming and those sort of things. And get very distressed very – for different triggers that might occur. And those conversations – I have residents that like to pop into my office every afternoon for a yarn, and I stop and have the yarn because it doesn't matter what else is going on, that's an important conversation to have every day and I make other things wait to have those conversations, and apologise if it's late, you know. And, you know, everyone is great, they will give you an extension of time or whatever but you must take those conversations when they're sought, I believe.

MS HUTCHINS: And your facility is located here in Melbourne in Brunswick East.

MS LYONS: It is, yes.

MS HUTCHINS: Do you find many of your residents come from this Melbourne region?

MS LYONS: Yes, yes.

MS HUTCHINS: Are you able to comment on any observations that you've been able to make about, I guess, the experience of Aboriginal or Torres Strait Islander people that have, you know, grown up in, say, in Melbourne rather than maybe the experience of someone that might have grown up on their traditional land, say?

MS LYONS: I probably haven't been in ACES long enough to give you an in-depth answer to that. What I have noticed is that people blossom in a safe environment quite rapidly. And quite often residents will come in and they don't want to socialise and they're really scared and they just grab their lunch and run back to their room, and they don't want to go to any of the groups work. And then gradually over time because everyone is talking and including them and just being, you know, friendly, they come out of their shell more and more. And then they come to you and they say, "I want to go to men's club next week." "Okay. That sounds good. Do you want someone to walk up with you?"

It's just the end of the complex but that's a big step for some people. "I didn't go this week but I'm going to go next week". And then eventually they'll get there and they're really proud of themselves, and the next thing they are sitting in the dining room with other people having their meals. And, you know, one resident said, "I'm going to sell The Big Issue now." That was a huge step forward because when he came in he just didn't engage at all.

And he came in and showed me his whole uniform and his satchel and he was just so proud that he got – and went for the interview. That sort of progress – and wants to learn different skills now, it's happened in a really short time. Now, he's not – he's got his issues that we need to look after. I'm not saying it's a fairy tale and it's 100 per cent but that's significant improvements and improvement in his health and wellbeing and lifestyle in a pretty short time, really.

MS HUTCHINS: And do you have a sense of what proportion of your residents might come from Melbourne?

MS LYONS: I would think at least 70, yes.

MS HUTCHINS: We've touched already on some of the programs and initiatives that your service offers both for residents and the day program people coming in. You mentioned things like the Men's Shed. So what does that involve?

MS LYONS: That's – that's where there's yarning and making of artefacts and the elder male residents go down and share their knowledge and understanding with – and also some of the younger Aboriginal male staff go down if they want to. And they make things together and talk and they have the music on and it's just a very

nice opportunity to teach skills such as boomerang-making. I've seen them making boomerangs down there, not that I'm supposed to be peeking around the corner, but I did.

And painting them up and a part of our new program is all the artwork that is made by our residents and day program people will be on our website – our new website and all the money will go back to those artists as an opportunity for them to have some extra money. But it's just a great community environment. The women's group, more recently were working with the elders making a possum skin cloak and sharing stories, talking about what different symbols mean, and history, their own histories. And that's a very sacred ceremony and we are very privileged to have that shared at ACES and it's very much enjoyed.

MS HUTCHINS: Yes. And what are some of the other, I guess, measures or practices you put in place that are aimed towards meeting Aboriginal and Torres Strait Islander cultural needs?

MS LYONS: Well, all of the events throughout the year that are calendared for – that Australians in general would be aware of such as Reconciliation and NAIDOC week. We have a huge community breakfast for NAIDOC week and, you know, I think 200 people come through in a very short amount of time. And it's a great opportunity because everyone gets together and shares the celebration with our residents and our staff. We have regular events such as people come – elders coming in but also younger men are doing it now with the didgeridoo playing. We have started the pet therapy program which is not particularly cultural but very important to residents with dementia. The therapy is very beneficial. Smoking ceremonies.

MS HUTCHINS: Yes. And you're also commencing an Indigenous vegetable patch.

MS LYONS: Yes, yes. And that's, again, through our volunteers program. We have got some experts coming in about land development and so on to set that up. That's going to be developed with Indigenous herbs and spices and different natives, and the residents are very keen to be involved in that and do the oversight. And we've spoken with the elders specialist dietitian from the Aboriginal Health Service and she is fully on board, thinks it's a great idea because we are going to incorporate those traditional herbs and medicines and so on into the menu and everyone is very excited about that.

MS HUTCHINS: And I'm aware you're also looking to set up opportunities for residents to potentially speak about their culture as a way of bringing in money for those residents - - -

MS LYONS: Yes.

MS HUTCHINS: - - - directly. Could you tell us a bit more about that.

MS LYONS: Yes. I regularly get calls from, I suppose, mainly from parents of children that know me and talk to them and sort of there's a real demand for the knowledge and we have the knowledge to share. So we are looking at – and, again, we will establish this through the website and through social media a bit more but let's share the wealth of knowledge that we have directly with, I would think in the first round, educational services would be great. There's a real thirst for that knowledge. But I have said to people I will be certainly happy to ask the elders, but I would like the schools to make a donation to that elder and they were happy to do that. So that's, yes, a really nice synergy, I think, of education and elder knowledge that I think we'll be able to roll out more in 2020.

MS HUTCHINS: Yes. And in terms of residential aged care facilities that are not a specialist Aboriginal and Torres Strait Islander facility, so say more mainstream for want of a better word, do you think that those types of facilities would be able to provide appropriate care for Aboriginal and Torres Strait Islanders?

MS LYONS: No. And I think if that was the only option, Aboriginal people won't seek to be admitted into western services predominantly where they've had to be for high needs health issues. We're still getting calls from different families now to have them moved out and we have got people coming over next week to transfer over to ACES because they're not happy. And I think it will create some significant issues if there weren't – there's going to be a considerable spike in demand over the next 10 years for aged care services for Aboriginal people and there needs to be some really good planning around that or there will be a real crisis in terms of how people are looked after and where they're looked
after.

Because even in coming, as I said earlier, into an Aboriginal organisation such as ACES, people want to be sure that all of those components that we talked about earlier are going to be present. And I don't think you can just go and test a western nursing home for a couple of days or something. But I just don't believe they would, in the main, opt for that sort of care.

MS HUTCHINS: And what do you think the main challenges would be for a mainstream provider to meet Aboriginal and Torres Strait Islanders' cultural needs?

MS LYONS: They would need to have a component of trained Aboriginal staff. They would need to have a training for their general staff, awareness around how the facility is set up; things like discussions are more circular for Aboriginal people. So we are setting up a fire pit at the moment; we're going to have everything around there for yarning sessions. But how the service is planned and designed, there's a long list of items that need to be considered. Artworks and arts and artefacts is just fundamental. I think personally, and I've said to Mick Harding, I think it's in Aboriginal people's DNA, the love of arts. Those sort of programs delivered by Aboriginal and Torres Strait Islander people are really important.

The possum cloak ceremonies with the elders – this is a part of the end of life process and the tradition and ceremonies that go with that and the going back on land and the sorry business, that need to be understood, that currently are not in place in western nursing homes.

MS HUTCHINS: There's no further questions from me, Commissioners.

COMMISSIONER PAGONE: Yes. Thank you.

COMMISSIONER BRIGGS: Yes, thank you very much, Ms Lyons for what you have had to say. It has been very helpful. I'm particularly interested in the intergenerational aspect of what you do. We have had TV programs recently on kids coming in and so on. But you actually have an intergenerational service and it would be kind of nice if you could just talk to us about why that works or how that works for Aboriginal and Torres Strait Islander people.

MS LYONS: I think – I think it has been a necessity but it's a necessity that – it's worked very well because I feel that the younger residents are really benefitting from the interaction and community of the older residents, and the additional oversight and care of the Aboriginal nursing staff and general staff. And I think even the fact that the head of the catering is Aboriginal and wants to do the Indigenous sort of spices and things like that is really important, and that's something the younger residents are very interested in as well. It's kind of – it's developed over time, I've noticed. It is a part of working – every Wednesday is Men's Shed. I think that's been – and the women's groups where the different age groups come together and work on projects together and learn about each other.

We're doing a big project with Mick Harding which everyone will be involved in, men, women, staff if they want to. That will be another merging together of the different components of the organisation on a project. And I just see it as being very beneficial for all the parties. And I think our younger residents really, really enjoy those opportunities of sitting with the elders. And I notice even, you know, the really quite young staff members sitting down and having lunch with the elders and really enjoying those discussions. And it just warms my heart when I see it, to be honest; I just love seeing them all together.

COMMISSIONER BRIGGS: As an outsider, it seems to me like there is a genuine sense of purpose amongst Aboriginal and Torres Strait Islander elders to share and to bring on the younger people. Am I right about that?

MS LYONS: Absolutely. Absolutely.

COMMISSIONER BRIGGS: Could you explain that a bit more?

MS LYONS: I think it's – it's certainly seen as part of the role of an elder and a recognised elder to guide, support and mentor younger counterparts. And I have heard our elders giving some really good advice to some of the young fellas about

different things that they didn't think were too good for them and to learn from their advice and guide them. But also in the traditional ways – some of our elders work with the Aboriginal children that are in foster care and they take them on camps and, like, how to survive in the sort of bushland and get back in touch with those kind of grassroots things and build confidence out of those programs or, you know, we have elders residents that work in the Koori Courts and they will give some of those young people a real talking to about what they need to be doing.

But it's, you know, a good love and genuine care that it's delivered with and I think people hear that and that truth in that. And nothing is forced so you don't have to go up here or you don't have to go there and you don't have to – so it happens organically and it's very – it's very nice how these relationships grow amongst the different generations.

COMMISSIONER BRIGGS: Thank you. That's very helpful, Ms Lyons.

MS HUTCHINS: Nothing arising, Commissioners.

COMMISSIONER PAGONE: Ms Lyons, thank you very much for giving your evidence. It has been very informative and has been very helpful to the Commission.

MS LYONS: Thank you, your Honour. Thank you. I should go?

COMMISSIONER PAGONE: You may go.

<THE WITNESS WITHDREW [10.39 am]

MS HUTCHINS: If it remains a convenient time for the Commission, a morning tea break.

COMMISSIONER PAGONE: Yes. Well, it's a few minutes early but I suppose that might be of assistance to everybody else. So perhaps if we resume at – is 5 to 11 going to work for everybody else?

MS HUTCHINS: Thank you.

COMMISSIONER PAGONE: Right. Five to 11.

ADJOURNED [10.39 am]

RESUMED [11.00 am]

COMMISSIONER PAGONE: Ms Hutchins.

MS HUTCHINS: The next witnesses we will hear evidence from today are both Aboriginal elders. Out of respect for these witnesses, and in accordance with their wishes, I will address them both as Uncle during their evidence.

COMMISSIONER PAGONE: Yes, thank you.

MS HUTCHINS: The next witnesses we call are Uncle Brian Birch and Uncle Brian Campbell.

<BRIAN WILLIAM CAMPBELL, AFFIRMED [11.00 am]

<BRIAN KEITH BIRCH, AFFIRMED [11.00 am]

MS HUTCHINS: Uncle Campbell, what is your full name?

UNCLE BRIAN CAMPBELL: Brian William Campbell.

MS HUTCHINS: And you're 65 years old?

UNCLE BRIAN CAMPBELL: Yes, I am.

MS HUTCHINS: You currently live at the Aboriginal Community Elders Service.

UNCLE BRIAN CAMPBELL: Yes, I do.

MS HUTCHINS: And Uncle Birch, what's your full name?

UNCLE BRIAN BIRCH: Brian Keith Birch.

MS HUTCHINS: And you're currently 83 years of age.

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: And you also live at the Aboriginal Community Elders Service.

UNCLE BRIAN BIRCH: That's right. Yes.

MS HUTCHINS: Uncle Campbell, how long have you lived at the service for?

UNCLE BRIAN CAMPBELL: Where I am now?

MS HUTCHINS: Yes.

UNCLE BRIAN CAMPBELL: Nine weeks.

MS HUTCHINS: Nine weeks. And you first entered there on a respite basis.

UNCLE BRIAN CAMPBELL: I went there under the domestic violence elder abuse respite.

MS HUTCHINS: Yes. And what were your circumstances?

UNCLE BRIAN CAMPBELL: Where I used to live, I was getting bashed on a regular basis by a 20-year old, and people in the house did not take any – look after me. And I was just getting abused all the time.

MS HUTCHINS: Where was the house that you were living?

UNCLE BRIAN CAMPBELL: Out at Werribee.

MS HUTCHINS: Yes. And was that your own personal house?

UNCLE BRIAN CAMPBELL: Half and half, yes. And the person who come into my house was with my granddaughter and he was only a would-be, could-be, anyway, as far as I'm concerned, and he was the one doing all the abuse.

MS HUTCHINS: Yes. And so did you try to look for somewhere else to live before ending up in the aged care service?

UNCLE BRIAN CAMPBELL: As has been pointed out to me many a time when looking for accommodation for elder abuse victims, yes, especially males, there's nothing. In Victoria, they bring these laws in and it's not there to cater for males; it's more catering for females under the Domestic Violence Act. So that's the only reason I ended up at ACES.

MS HUTCHINS: Did you apply for any other kind of housing?

UNCLE BRIAN CAMPBELL: They turn around and told me porky pies on that; you can apply for this and apply for that, and they turn around and go – when you go to apply for them, they say no. So you end up in places where, really, I'm too active for being where I am but it's the safest place I can be at the moment so that's how it is.

MS HUTCHINS: Do you remember what the other type of housing you applied for was?

UNCLE BRIAN CAMPBELL: They asked me about private housing, public housing and – what was the other one they wanted me to go and take – it's a drug and rehab unit in the city here somewhere and I said, "Yes, thank you very much, no". So - - -

MS HUTCHINS: Yes. And when you say they told you to go, was there a particular service that was trying to help you?

UNCLE BRIAN CAMPBELL: Yes, I had VACCA, which is part of the elders group in Werribee and my worker, Poh, he had been busting his buns for that. Didn't use the bad words. So, you know, every time I asked him to find something, look out for something for me, he goes out of his way to do it so I'm greatly appreciated with that. I'm not a great fan of trying to get on public housing. Public housing is five years for emergency and maybe 10 or 15 years for any normal person. So, you know – I'm here.

MS HUTCHINS: And Uncle Birch, how long have been at the ..... aged care?

UNCLE BRIAN BIRCH: Three years, yes.

MS HUTCHINS: Three years. Before you were living in the service, whereabouts did you live?

UNCLE BRIAN BIRCH: In Brunswick.

MS HUTCHINS: In Brunswick. Was that in your own home?

UNCLE BRIAN BIRCH: No, I was renting a place there.

MS HUTCHINS: Sorry?

UNCLE BRIAN BIRCH: I was renting a place.

MS HUTCHINS: You were renting a place?

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Yes. And did you live by yourself?

UNCLE BRIAN BIRCH: Yes, I did there.

MS HUTCHINS: And then you had to go to hospital.

UNCLE BRIAN BIRCH: Well, I had a heart operation, you know, a pretty big one, they had to put another valve in. So I said to the doctor "I can't go home, I've got no one to look after me" so he got me at ACES, yes.

MS HUTCHINS: And so the doctor helped you to get in touch with the residential aged care facility. Was it through the doctor that you became aware of it?

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: And you said you've been there for three years now?

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Uncle Campbell, you were born at Stradbroke Island?

UNCLE BRIAN CAMPBELL: Yes, I'm a Murri. They call us a Murri.

MS HUTCHINS: Yes.

UNCLE BRIAN CAMPBELL: We're Queenslanders.

MS HUTCHINS: Yes. And what was your parents' background?

UNCLE BRIAN CAMPBELL: My dad is Aboriginal and my mum is Jewish. I was taken away from them when I was one year old – or going on to one – and I didn't see them until I was 15. I was part of the Stolen Generation, and I have never had that nurturing as a family, and so that's what happens with us. And I think that's the biggest problem I have in life is that I never had that family connection, but I had family connection with my grandfather at 15. He taught me a few of the Aboriginal things I had to learn and from there on I just was here.

MS HUTCHINS: Is your grandfather still at Stradbroke Island?

UNCLE BRIAN CAMPBELL: No, he is in spirit only. But he is not here in what you would call full life, yes.

MS HUTCHINS: Yes. And when you were taken, when you were one year old, where were you taken to?

UNCLE BRIAN CAMPBELL: Tufnell Home.

MS HUTCHINS: How long were you there for?

UNCLE BRIAN CAMPBELL: Until I was nine and a half.

MS HUTCHINS: And then where did you go?

UNCLE BRIAN CAMPBELL: They sent me over to Enoggera Boys' Home and I was there until I was 15.

MS HUTCHINS: What did they tell you about your family there?

UNCLE BRIAN CAMPBELL: Nothing. They wouldn't tell us anything. They didn't want to tell us that my father was Aboriginal. We weren't to deal with our language, our culture or anything like that, and that's why a lot of Aboriginal people committed suicide because they weren't told about their family. And when they

come into aged care, like we will get back into that aged care side of it, they don't – look, most aged care places, I've only met one – two, in Victoria, that do actually look after Aboriginal people as Aboriginal people, not a number in the system, or a figure so they get their money bumped up. And, like, ACES and the one in Shepparton; they're the only two I know what actually look after Aboriginal people with the dignity of an Aboriginal person.

MS HUTCHINS: Yes. And when was it that you were reunited with your family?

UNCLE BRIAN CAMPBELL: I was 15 and Mum and Dad got me sisters out of Tufnell and my little brother, and I was only 15 and a half when I got to know them and I got to see my first time ever, my family as a family, not as an individual person.

MS HUTCHINS: And where did you live then?

UNCLE BRIAN CAMPBELL: We lived in New Farm, of all places, and Clay Street, New Farm. Spent, what, two years there, then we moved to Sydney because we moved once. The Joh Bjelke-Petersen era let us have that freedom of movement, when the Federal Government handed it down in the referendum, that we were allowed to move. That's when we moved and we pissed off down to Sydney. Sorry; I shouldn't use that word. My apologies, your Honour.

COMMISSIONER PAGONE: It's quite all right.

MS HUTCHINS: And then when was it that you moved to Melbourne?

UNCLE BRIAN CAMPBELL: We moved to Melbourne when I was nearly 19, moved to Shepparton, actually, not to Melbourne. You can always notice all the black fellas all lived up in Shep. So we had a big family up there. I've got a lot of rellies still living there and I've got a lot of people who have dealt with all this before so I've got a really good friend called Uncle Roy; he's from that area. And me and him talk about it all the time about our issues in life. And he is in home care so – or resi care or aged care, what you like to call it, and he's happy where he is. He's up with the Aboriginal community. So it's a connection he has and it's a connection I'm having where I am at the moment so I'm feeling a lot safer there.

MS HUTCHINS: Yes. And Uncle Birch, you grew up in Fitzroy.

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: What was that like?

UNCLE BRIAN BIRCH: I loved it. I did.

MS HUTCHINS: And did you have any siblings?

UNCLE BRIAN BIRCH: Yes, five.

MS HUTCHINS: Five.

UNCLE BRIAN BIRCH: I got married when I was 17. The girl was 15; we had five kids. Yes.

MS HUTCHINS: Yes, and then later in life you got married again.

UNCLE BRIAN BIRCH: Yes, I got married again. I went to Mildura to work up there, and I met a girl in church and I married Lorraine; 34 years, I was married. She died 10 years ago, yes. She had MS when I met her, yes.

MS HUTCHINS: Yes. And did you know what your parents' background was growing up?

UNCLE BRIAN BIRCH: Me mother was Koori. Me father was a bad man, you know he had guns, but he left when I was three years old. Yes.

MS HUTCHINS: He left when you were three years old.

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Did you know, growing up, that your mother was Koori?

UNCLE BRIAN BIRCH: Yes. Well, you know, I wasn't sure at the time because up at Fitzroy when I was 37 and oh he said we come from the Yarra Yarra tribe; I didn't know.

MS HUTCHINS: You found that out when you were 37 that you were from the Yarra Yarra tribe?

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Yes. And before that you weren't aware of that part of your history.

UNCLE BRIAN BIRCH: I wasn't sure, yes.

MS HUTCHINS: Yes. And why do you think it was that that wasn't something that was spoken about when you were growing up?

UNCLE BRIAN BIRCH: I don't know really, I don't know. My mum protected us, and at the time with the Aboriginal people, the welfare come out and just find them and they could them away as they are.

MS HUTCHINS: The welfare would come out and ..... - - -

UNCLE BRIAN BIRCH: Yes - - -

MS HUTCHINS: - - - take you away.

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Yes. And so you said she would hide you.

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Yes. And how did you – you found out about living at the Aboriginal Community Elders Service through the doctor at the hospital.

UNCLE BRIAN BIRCH: That's right, yes.

MS HUTCHINS: How do you find it at where you are now?

UNCLE BRIAN BIRCH: I love it.

MS HUTCHINS: You love it. What do you like about it?

UNCLE BRIAN BIRCH: It's just very relaxed there, you know, it's good.

MS HUTCHINS: Yes.

UNCLE BRIAN BIRCH: I know a lot of people there and I've got a room on me own and I really like it, yes.

MS HUTCHINS: You are an artist, aren't you?

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Yes. You like to paint?

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: And you can do that at the - - -

UNCLE BRIAN BIRCH: Yes. At ACES, yes. I went there to the college 10 years ago and I learnt to paint and won a few awards and, you know, I got a painting in the National Gallery, yes.

MS HUTCHINS: Yes.

UNCLE BRIAN BIRCH: I don't paint for money, I just enjoy it.

MS HUTCHINS: Yes. And do they help you get your paint supplies?

UNCLE BRIAN BIRCH: Yes, I get the money, I buy them but there's a lady, Sue, she comes in and helps me and – yes.

MS HUTCHINS: Yes. And Uncle Campbell, how do you find living at ACES?

UNCLE BRIAN CAMPBELL: Well, like I said earlier on, it feels really safe and I made a comment yesterday to a trainer what comes in every so often to train up the staff. I said to her, "What do you think of the place?" and they said, "It looks like a big family." And I said that's what it's meant to be like, as an Aboriginal community. You are a family within yourselves. You might have a difference of opinion, but we still are a family and that's the bigger thing that I like there plus you get fed well. Like all black fellas, if you don't feed us we don't go anywhere.

MS HUTCHINS: What kind of food do they give you there?

UNCLE BRIAN CAMPBELL: I beg yours?

MS HUTCHINS: What kind of food do you get?

UNCLE BRIAN CAMPBELL: Well, today is fish and hamburgers, it's Friday, yes. And you get fruit salad or salad or – on it. And, you know, you get food – every day is a different meal and Wednesday is bacon and egg day. Everybody comes in for bacon and eggs. So that's one thing we look forward to.

UNCLE BRIAN BIRCH: I don't eat bacon.

UNCLE BRIAN CAMPBELL: But that's what they call it, bacon and egg Wednesday.

MS HUTCHINS: Yes. Do you like the food, Uncle Birch?

UNCLE BRIAN BIRCH: Mostly we do and – most of it I do like, yes. I can't eat meat much because I can't digest it, but when they have fish there, I love it. They are good cooks up there, yes. I like soup and with the vegetables in it. I like to have it like that. Yes.

MS HUTCHINS: Do the staff know what types of things you can and can't eat - - -

UNCLE BRIAN BIRCH: Yes, because they come out and ask you what they want. Yes.

MS HUTCHINS: They ask you want; is there usually some options available?

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Yes. What do you think of the staff at the facility?

UNCLE BRIAN BIRCH: It's good – it's pretty good. Yes. They could be improved, you know, because there's a lot of girls the nurses' aids and they're good, most of them are good but they can be improved, for sure, yes.

MS HUTCHINS: What type of improvements are you thinking of?

UNCLE BRIAN BIRCH: Probably the nursing, particularly. There's one girl, she is an Indian and she is excellent.

MS HUTCHINS: What is it that you like about her?

UNCLE BRIAN BIRCH: She'll go the extra mile, she will do something for you, she is really good, yes.

MS HUTCHINS: How do you find the staff, Uncle Campbell?

UNCLE BRIAN CAMPBELL: I find them friendly and culturally safe and they understand our needs. There is a couple what, you know, they're young and they're still learning but they still respect us as elders and as Aboriginal people. They don't stop learning from us and we don't stop teaching them. So it's the best way they like doing it, they actually ask you questions, "Is this going to be all right for you?" and you go yes or no. That's how it is with them.

MS HUTCHINS: Do you have the feeling the staff has enough time to spend with you?

UNCLE BRIAN CAMPBELL: Well, yes, in some contexts it would be, but not in all. Okay? So like, if you want to go out for the day, you have to plan it, like everywhere; you have to plan ahead, and sometimes it can be – it has – circumstances change it. So that makes their job a little bit harder; then they got to change things around. So it's one of those things where you've got to be just aware of what you're doing with them.

MS HUTCHINS: Yes. Yes. And what are some other things, Uncle Birch, that they do at the facility that make you enjoy it so much?

UNCLE BRIAN BIRCH: Really it can be improved. I can't say much. It is a good place but need to be more staff and more activities and gather together as a group and – can be improved a lot. You know?

MS HUTCHINS: Are there any activities that you do besides the painting?

UNCLE BRIAN BIRCH: No; none.

MS HUTCHINS: Uncle Campbell, do you get involved in any of the activities that are on offer?

UNCLE BRIAN CAMPBELL: When I'm not doing anything, I go with the PAGroup, which is up in the kitchen area, and I hang around there or go to the men's shed on Wednesday to do crafts, but apart from that, now I try not to, because that takes time away from the others that need it, where I'm active enough to be able to go out on my own and do all that, where some of the clientele are not active enough to do that. And they're trying to get them to become active. So you give them more time with them.

MS HUTCHINS: Sure. And what is the PAG Group?

UNCLE BRIAN CAMPBELL: That's the – what do they call it. It's called – it's for – planned-activity group. So that's what it is. It's a concept that was brought in around about four years ago, I think, that – it was to be for activity for elders and our older people, and for Aboriginal people it was a kick in the guts – sorry; use that word again – a kick in the stomach, when that wasn't brought in for them. So they actually did it three years after, a year after the original one started. So it only takes a year after, a bit long for most places to organise people, especially Aboriginal people; yes.

MS HUTCHINS: And as one of the younger people that – who would be residing at the facility - - -

UNCLE BRIAN CAMPBELL: That's nice.

MS HUTCHINS: How do you find that experience?

UNCLE BRIAN CAMPBELL: I find it – because I'm learning from some people what they have experienced life as well as what I have, I find the camaraderie amongst us all is very good, because we're so connected with our culture, with ourselves as well, and a lot of people – some people get a bit moody, but that's understandable, but the quality of life there is better for them than they would've been if they were in mainstream. Their quality there is a lot better in that sense, where you have – your quality of life is improved when you're there, not sitting in a corner, just sit there all day and do nothing.

MS HUTCHINS: Would you feel comfortable being in a non-Aboriginal-and-Torres-Strait-Islander-specific facility?

UNCLE BRIAN CAMPBELL: Nope. No way.

MS HUTCHINS: And why is that?

UNCLE BRIAN CAMPBELL: Because I've got my parents, who live in one accommodation place wherever it is aged care – I wouldn't even send my dog to it. I wouldn't even feed my dog there; my dog would reject it. So – I would be bitten by my dog, if I sent him to that place.

MS HUTCHINS: Because of the quality of the food there?

UNCLE BRIAN CAMPBELL: Quality, staff – what else could I put down. There's the food quality. Well, if you get a little bowl, that much food on your plate, and they said that's your main course – "See you". And my parents need constant care with them, because my dad's in a princess chair, and one episode there when I went there – he wanted to go to the toilet, and they said, "We'll get to him when we can", and he had to soil himself before they could take him to his toilet to change him. So – my mum was the same. She's in a wheelchair, because they wouldn't give her enough exercise to keep going. So she's in a wheelchair. I very angry about it, but I have to put up with that, because – five years they've been there, and in that five years I've seen my parents deteriorate that quick it's not funny.

MS HUTCHINS: And in terms of that facility's ability to meet your father's particular cultural needs - - -

UNCLE BRIAN CAMPBELL: They do not – it took me and my little brother a good three years, to knock them over the head and to tell them what an Aboriginal person is, and that's just getting them to understand what we are, who they are and what they doing.

MS HUTCHINS: And what were the types of things you were trying to explain to them?

UNCLE BRIAN CAMPBELL: The cultural aspect, about how he needs to be treated respectfully, not treated as a number – "We'll get to you when we can" type of thing. And my dad is – was a very proud Aboriginal man. My mum's very proud woman, and it's just deteriorated their confidence, and Dad doesn't even want to go out the front door anymore. He hasn't been out of that front door of that place for five years. My mum hasn't either. So you can tell we have now got the idea they're institutionalised, which is really wrong, again. It's that particular place. Okay?

MS HUTCHINS: And what do you see as the main differences between where they are and the kind of service and care that you're receiving where you are?

UNCLE BRIAN CAMPBELL: Well, we – where they are: they only get there as a number, and they're a number to a corporate body, and they don't – the corporate bodies don't care. They're only there for the money. Whoopee. But they're not there for the quality of life. Where we are here, we've got a small amount at the moment, but the staff what do – they look after the quality of life we have. It's very important, that that happens with elderly people. And some of the institutions of – some of the aged care units, places I've seen: there's not too many out there what'd look after anybody with any empathy. How's that for you? Is that a good word today?

So there's one I know really close to where I used to live, and it never, never, ever took anybody out, did anything with them. And they were all there, sitting there,

waiting to die. That's all it was. And so the one where my parents are. All they do is sit there all day, either watch TV or sit in a couch and just wait to die, and that's not my parents, and I don't like that. But, again, what can I do about it? There's nothing.

MS HUTCHINS: And, Uncle Birch, do you think you would be comfortable in an aged care facility that's not specialised for Aboriginal and Torres Strait Islanders?

UNCLE BRIAN BIRCH: No. I wouldn't be.

MS HUTCHINS: No. Why is that?

UNCLE BRIAN BIRCH: I just feel – I love it there, where I am, and I'd get upset, if I had to go somewhere else now.

MS HUTCHINS: Sorry. I didn't - - -

UNCLE BRIAN BIRCH: I'd get upset, if I had to live somewhere else.

MS HUTCHINS: You'd get upset, if you had to live somewhere else.

UNCLE BRIAN BIRCH: Yes.

MS HUTCHINS: Do you think that you'll stay where you are now?

UNCLE BRIAN BIRCH: Yes. I will.

MS HUTCHINS: Yes. And what about you, Uncle Campbell: do you think you'd stay where you are, or would you like to leave?

UNCLE BRIAN CAMPBELL: Well, I'm – like I said once before, I'm very active in my own mind and in my physical activity. I would love to be back on independent living, but I wouldn't like to be independent living in Victoria, but – everybody wants to go home to country, but – that's one thing I would love to see, but that's not going to happen in a hurry. So I would stay there as long as I can, because I'm feeling safe there, and that's – the main thing for me is safety. I – and I have my independence as well there; so it's not as all-cut-and-dried like most places are.

MS HUTCHINS: And do you still feel a connection to Stradbroke Island?

UNCLE BRIAN CAMPBELL: I always will. I've been up there nearly three – two – nearly three years ago now, walked back on country, and I upset a few people on the ferry when I went across. I stripped down to my undies and walked on land, and everybody just looked at me with a stupid look. "What's this fellow doing?" And I felt really comfortable when I walked on country, and all my spirits come back and haunted me and told me I should've been there ages ago. So that's something what non-Aboriginal people cannot understand, what the spirit does to you, how you feel.

MS HUTCHINS: And so eventually would you like to return there?

UNCLE BRIAN CAMPBELL: That's my bucket list; yes. Yes, yes. That'll be the last place I go.

MS HUTCHINS: And, Uncle Birch, with your upbringing in the Melbourne kind of urban environment, do you have a similar kind of connection to land or country?

UNCLE BRIAN BIRCH: No. I never lived in the country much, only when I went to Mildura. But I love it, where I am. I love the city, and the only thing at ACES that – I mean it's unfair; we don't get taken out very often. Like to go once a month, buy some clothes, but it doesn't happen. There's no one to take you out. I've been saying this for three years, and it doesn't happen now. I think it's unfair. I really do.

MS HUTCHINS: Yes. So you'd like the opportunity to be taken out of the facility more often.

UNCLE BRIAN BIRCH: Yes, for shopping or something like that. Yes.

MS HUTCHINS: Yes. And did you say that only happens about once a month at the moment?

UNCLE BRIAN BIRCH: If you're lucky, yes. If there's no one to do it, no one will take you out.

MS HUTCHINS: I have no further questions, commissioners.

COMMISSIONER BRIGGS: If I may, it's – we really appreciate you giving your evidence, and I must say, throughout the year the Royal Commission has been running, Aboriginal and Torres Strait Islander people have been very generous in sharing with us your views, and I think we've learnt a lot, and I hope we can do something constructive to support what you want to happen. One of the things that we have heard a lot about is connection to family, and you have both spoken very eloquently about that. But what you were talking about just then, Uncle Brian, was – "Birch", I should say – is the need to get out more and so on.

UNCLE BRIAN BIRCH: Of course. Yes.

COMMISSIONER BRIGGS: Can you talk to us a little more about what you would like to do; you mentioned shopping. What are the other kinds of things?

UNCLE BRIAN BIRCH: I like clothes. You know? And I like to get some nice clothes and have a coffee and that, and it doesn't happen. There's no one – who's going to take us out; no one. We're not allowed to go out on our own; fair enough. And there's no one else to take us out. I think that's really unfair. I do.

COMMISSIONER BRIGGS: And if you – what's stopping you going out on your own?

UNCLE BRIAN BIRCH: Not allowed to. It's the rules. I couldn't go out on my own anyway, because I'm in a wheelchair and – so I don't know; it's pretty poor. Yes. I really do believe that. Yes.

COMMISSIONER BRIGGS: I think that's it. Thank you. Thank you.

COMMISSIONER PAGONE: Uncle Birch and Uncle Campbell, thank you both very much for coming and sharing your stories. I know some of it is difficult, perhaps, to relay, and it's really important for the Commission, for government and for the entire community, to hear the stories that you've told us. Thank you both very much indeed.

UNCLE BRIAN BIRCH: Thank you.

UNCLE BRIAN CAMPBELL: Thank you. Excuse me. Could I ask one question to the - - -

COMMISSIONER PAGONE: Of course, you can.

UNCLE BRIAN CAMPBELL: I've sat with the Royal Commission into deaths in custody. I've sat with the Bringing Them Home hearing; right? And out of all of them, hardly anything gets done, and is this one going to be the same?

COMMISSIONER PAGONE: Well, I certainly hope this is one that does get something done. That's our intention, that something gets done, and that's why we are gathering your stories and the stories of others.

UNCLE BRIAN CAMPBELL: Deaths in custody – they had 50 recommendations, and only three of them actually been – and that's over 10 years ago.

COMMISSIONER PAGONE: Yes. I'm pleased you asked the question, Uncle Campbell, and we might put that in the report when it comes out, the need for something to be done and that people like you come to these commissions to share your stories so that something gets done.

UNCLE BRIAN CAMPBELL: Thank you.

COMMISSIONER PAGONE: Thank you.

MS HUTCHINS: Ms Bergin will call the next witness.

COMMISSIONER PAGONE: Yes. Thank you.

MS HUTCHINS: These witnesses be excused.

<THE WITNESSES WITHDREW [11.27 am]

MS BERGIN: I call Jaklina Michael.

<JAKLINA MICHAEL, AFFIRMED [11.29 am]

<EXAMINATION BY MS BERGIN

COMMISSIONER PAGONE: Yes. Thank you, Ms Michael.

MS BERGIN: Good morning, Ms Michael.

MS MICHAEL: Good morning.

MS BERGIN: What is your full name?

MS MICHAEL: Jaklina Michael.

MS BERGIN: Have you prepared a statement for the Royal Commission?

MS MICHAEL: I have.

MS BERGIN: Is there a copy of your statement there in – on the desk in front of you?

MS MICHAEL: There is.

MS BERGIN: Do you have any amendments to your statement?

MS MICHAEL: I don't.

MS BERGIN: Is it true and correct to the best of your information and belief?

MS MICHAEL: Yes, it is.

MS BERGIN: I tender the statement of Jaklina Michael dated the 26th of September 2019.

COMMISSIONER PAGONE: Yes. Thank you. The statement of Jaklina Michael of the 26th of September 2019 will be exhibit 10 27.

EXHIBIT #10 27 THE STATEMENT OF JAKLINA MICHAEL OF 26/09/2019 [WIT.0457.0001.0001]

MS BERGIN: Ms Michael, you're the diversity manager at Bolton Clarke?

MS MICHAEL: That's correct.

MS BERGIN: "Bolton Clarke" a trading-name for RSL Care, Royal District Nursing-home and RDNS Home Care; is that right?

MS MICHAEL: That's right.

MS BERGIN: You worked for RDNS as a cultural-liaison co-ordinator from 1999 until 2009?

MS MICHAEL: That's correct.

MS BERGIN: And then you transitioned to Bolton Clarke.

MS MICHAEL: I worked as the diversity-manager for Royal District Nursing Service from 2009 to 2016. At that time there was a merger between Royal District Nursing Service and RSL Care, and from 216 up until now, I am the diversity-manager for Bolton Clarke.

MS BERGIN: Thank you, Ms Michael. You led the development of a cultural-diversity framework?

MS MICHAEL: Yes, back in 1999; yes.

MS BERGIN: And that's been published in three versions?

MS MICHAEL: That's correct.

MS BERGIN: In 2000, 2012 and most recently in the framework for 2017 to 2025?

MS MICHAEL: That's correct.

MS BERGIN: Commissioners, that document is in the general tender bundle. Bolton Clarke provides a range of aged care services in various states and territories?

MS MICHAEL: That's correct.

MS BERGIN: Could you please describe them for the Commission?

MS MICHAEL: Bolton Clarke is one of Australia's most – one of the largest and most experienced aged care providers. We are a not-for-profit provider. In

Queensland, New South Wales, Victoria and Tasmania we provide Commonwealth home-support program. In Queensland, New South Wales and Victoria we have home care packages, and in Queensland and New South Wales we provide residential-aged care services. We also provide retirement living in Queensland and New South Wales.

MS BERGIN: Yes, and Bolton Clarke CHSP program includes a community nursing-program with a focus on homeless people; is that right?

MS MICHAEL: That's correct.

MS BERGIN: And that's integrated with its HIV-AIDS program?

MS MICHAEL: Yes.

MS BERGIN: Bolton Clarke has taken the step, as you said, of developing its own diversity framework, which was led by you, starting in 1999. Why was this important?

MS MICHAEL: When you have a geographically-dispersed organisation and workers working in people's homes and in different environments, in order to understand and to have shared values for diversity, we, at the time, decided that we needed an organisational strategy that would support all our workers with understanding and responding to the diverse care needs and choices of care recipients. And so a structured strategy like the diversity framework that looks at establishing policy and practices to enable greater diversity and equity was required. And it was also a result of implementing the Australian government Department of Health aged care diversity framework. So it's our way of operationalising that.

MS BERGIN: Yes. Operator, could you please bring up paragraph 22A of Ms Michael's statement. This is – this paragraph contains Bolton Clarke's own definition of "diversity", which is, obviously, different to the definition of "special needs" in the Aged Care Act. Could you please explain why Bolton Clarke has taken a broader approach?

MS MICHAEL: This – we commenced work on this, on developing the definition back in 2013, when, with an extensive literature review, we could not find a definition that was applicable to the aged care system and to our care recipients. We've – together with the literature review and a range of other research methodologies, including focus groups with our staff and in-depth interviews with our staff and also external organisations such as CALD, LGBTI and Aboriginal-community-controlled organisations and their representatives, we looked to pull together a definition, as you say, a broad definition, that encompasses difference but also encompasses connection. And so that definition that is now adopted across Bolton Clarke does that. It presents to our workforce the notions that diversity does differentiate but that diversity does also connect people.

MS BERGIN: Ms Michael, you – the diversity conceptual model is one component of Bolton Clarke's diversity framework, as I understand it.

MS MICHAEL: That's correct.

MS BERGIN: Operator, could you please bring up figure 1, which is just directly above paragraph 29? As I understand it, in this diagram there's a list of diversity characteristics, and again that list includes characteristics that fall outside the "special needs" definition in the Aged Care Act; is it your view, that diversity categories should remain open?

MS MICHAEL: The diversity conceptual model does come – mention and include those people under the Special Needs Act, and it needs that protection. We also have gone outside the Aged Care Act and addressed issues such as the work from the World Health Organisation on the social determinants of health and also the work of the Australian Human Rights Commission. So there's human rights dispersed. And we've done that intentionally. And we believe through discussions with our workforce and other representatives that we do need to go outside; yes.

MS BERGIN: Yes, and just taking one example – gender is included as a diversity characteristic in your diversity conceptual model. How does gender remain relevant in considering a client's care needs as they age?

MS MICHAEL: So we've included gender as a possible diversity characteristic that can create disadvantage. There are patterns in health for specific genders that are much more prevalent, and our staff and our workers need to understand that. We know that women live longer than men. We know that women access services more readily than men. But on the other hand, there are some patterns that are also disadvantaging women, and also we take into account gender diversity and identification outside those two genders to allow for people to self-identify according to their gender. So that alone is a very big concept that our workforce needs to understand.

MS BERGIN: Yes, and, Ms Michael, is gender also relevant to the delivery of care to Bolton Clarke's clients? For example: is it the case, that some clients may prefer to receive care from staff of the same gender?

MS MICHAEL: Yes; absolutely. And it is very important, for us to meet that need as much as possible, because if we don't, people may refuse our service, and that's the reality.

MS BERGIN: Does Bolton Clarke aim to treat diversity as part of its usual business?

MS MICHAEL: Yes, we do.

MS BERGIN: And why is that?

MS MICHAEL: The ultimate reason and the most important reason for looking at diversity as business as usual is that ultimately it benefits our care recipients. So our care recipients: we look to ensure that they receive the services and care that they need in the way that is most important to them. And that would be the biggest benefit of diversity.

MS BERGIN: Ms Michael, I read that one of the components of Bolton Clarke's diversity framework is partnering with consumers for diversity. Could you please explain how this operates in practice?

MS MICHAEL: This is a model that we've developed, used, implemented in – for a number of years now in a range of service-and-product design. It's a set of processes that support the notion of learning from our consumers to make sure that the way in which we develop our products for instance, are relevant to those people.

MS BERGIN: Okay. Have you – we've heard earlier evidence – evidence earlier in this week about the Victorian Access and Support Program. Have you heard of that program? You aware of it?

MS MICHAEL: I have.

MS BERGIN: And how do you utilise that program at Bolton Clarke?

MS MICHAEL: From my knowledge, we work and interface with the Access and Support Service in two ways. One is entry into MAC or navigation support into MAC and then into Bolton Clarke for care recipients who are quite vulnerable and not able to do that on their own. And on the other hand, we, as a diversity team – so I have a small team of diversity co-ordinators; we are part of the access-and-support network so are aware of all the access-and-support workers out there so that, when a Bolton Clarke staff member, whether it's a nurse or a case-manager, identifies that one of our existing care recipients needs support and is quite vulnerable and needs to get back into MAC to be re-assessed, then the diversity team will support that staff member to support – to bring in the access-and-support worker to assist the care recipient with that.

MS BERGIN: Yes. What are the indicators that a client might need that access to that particular program?

MS MICHAEL: So with people of special needs, sometimes they may not disclose or share information with us about their safety or about their risks. Our workforce is highly trained to identify some of those, and even though we know that the person requires more services and more care, they may actually, for many, many different reasons, not accept care. The – in this – in one instance it may be that the nurse wants to support that client to get back into MAC, to get them back on a home care package.

Let's say it's a nursing service through Commonwealth home support program, but we – the nurse has identified that the client really needs a case-manager to support them with a number of different services but is only accepting nursing. With time limitations on the CHSP nurse, the opportunity to bring in an access-and-support worker who speaks the person's language and understands their culture, who can elicit maybe hidden safety and risk issues is of enormous support. And so the Bolton Clarke staff member, even though not knowing some of the hidden risks, understands that there are risks, so then is able to bring that Access and Support Specialist in.

MS BERGIN: Yes, and you mentioned that time is a consideration, because particularly under the delivery of CHSP services there are time limitations on staff; are you aware, how much time an access-and-support-program worker might, typically, spend with a client?

MS MICHAEL: From my knowledge – they are dealing with the most vulnerable people in the aged care system, and I hear that they're spending considerable time – and it does take time, to explain the aged care system, the role of MAC and also the different funding programs to individuals in order for them to make informed decisions; so from my understanding – it takes quite a lot of time, but I don't know exactly how long.

MS BERGIN: Yes. Sure, and what characteristics make the client group that you're talking about vulnerable?

MS MICHAEL: It's those clients who have multiple diversity characteristics. So – multiple situations and conditions that make it difficult, for them to participate in their care. We go to the diversity conceptual model to identify all those diversity characteristics, and they are the most vulnerable people.

MS BERGIN: Thank you, Ms Michael. Now, at paragraph 35(b) of your statement, you say that at Bolton Clarke all policies and procedures are written and underpinned by reference to diversity, they are universally applicable to all populations. Does this mean that policies at Bolton Clarke are not broken down into individualised special-needs groups, and is that an effective model?

MS MICHAEL: Generally speaking, yes, it does mean that. But where we have a very dedicated legislation, we may have a policy for specific populations. So for instance: we do have a dedicated policy on valuing carers in recognition of the Carer Recognition Act. But generally speaking, our policies are applicable to all people, and we try, wherever possible, to ensure that the position within the policy is universally applicable.

MS BERGIN: Yes, and as I understand it, your staff receiving training on policies and procedures on commencement of their employment with Bolton Clarke.

MS MICHAEL: Yes.

MS BERGIN: Can diversity be trained?

MS MICHAEL: Yes. I believe it can. And we use a number of strategies, models and processes to do that. I don't think there's one way of doing it. I think you need a gamut of strategies. One is policies; having the policies in place to guide your workforce is very important. We use the definition of "diversity" so that we have a shared understanding and a shared value across our organisation. The diversity conceptual model supports training and is used as a visual.

So sometimes it's really difficult, to list groups with special needs and conditions and situations, because it can become very long. So we intentionally have the diversity conceptual model as a visual for people to look at and think, "Wow. Is that how big diversity is?" And, yes, it is. We look to have a culturally-competent workforce, a workforce that has the skills and knowledge to be able to work with all people.

On an education – from an education perspective – so there is formal training, but from an education perspective, we encourage our staff to acquire knowledge. So we call that cultural knowledge, and we learn from our care recipients about what is important to them. And then we encourage our staff to take that knowledge and apply it to the next situation. So it's about building their knowledge. It's about building their awareness.

Cultural experience is really important, and we say to staff, "Use every moment as a learning-opportunity, because diversity is a life-long learning". We will never know everything about everybody, and being culturally competent and being able to elicit that knowledge is really important. Of course, the diversity team is available as an educative tool as well, and we get calls from our staff on a daily basis to assist them with problem-solving.

MS BERGIN: Yes, and you set out at paragraph 42 the education that Bolton Clarke does to help employees understand and develop their skills in this area. In recruitment, what factors or indicators or qualities do you look for in potential staff in assessing their aptitude for training in this regard?

MS MICHAEL: From an organisational-capability-and-capacity perspective, we do want a culturally and – diverse, linguistically-diverse workforce that can provide culturally-appropriate and safe care to people. We have – in the recruitment process, in all job advertisements, regardless of function and role, we have a very discrete statement on valuing diversity and the benefits that that brings to care recipients. We also look for and try to maximise the use of the language skills of our workforce. And so for all direct-care job advertisements, we do have a second statement, encouraging candidates who speak a language other than English to join Bolton Clarke. So they're two of the most effective ways, we believe.

MS BERGIN: Yes. What costs are involved in, for example the – in a broad sense, not in, necessarily, a dollar sense – in the education and training that you do of staff to implement the diversity framework?

MS MICHAEL: We have a number of strategies in-house to meet that, and there is a cost associated with that. It is quite resource intensive. We work closely with a range of departments, such as our human-resources department – that has the learning and development team there – to look at developing products, such as the – our code of conduct that all employees complete on commencing with Bolton Clarke; that has elements of diversity embedded throughout that.

We've also invested in – for all care staff – a very dedicated package on working with diversity as an introduction. The training of our managers, which is really important to us, because the diversity team lead diversity, but it's our managers and leaders, who drive it throughout the organisation – so we've invested in the training of our managers to support them, to implement and evaluate their diversity-action plans. And we have 48 of those.

Of course, there is investment when staff can self-identify their training needs. So – depending on where staff are working, in what area, what catchment they may need specific training for a particular population group, because they're seeing more of that group. So to build up their cultural competence, we will invest for them to attend training outside the organisation by other organisations such as ethnic organisations or Aboriginal-community-controlled organisations. There's an example; if I may give you one - - -

MS BERGIN: Yes, please do.

MS MICHAEL: In Queensland. Recently our Toowoomba-site manager felt that her staff needed training on cross-cultural communication and was able to bring in training from an organisation called Diversicare. So we have those relationships, and the diversity team facilitates those relationships.

MS BERGIN: Yes. You mentioned that managers get special training and you have 48 diversity-action plans. Do you have an action plan for each facility?

MS MICHAEL: Yes, we do.

MS BERGIN: And how do they differ from one to the next?

MS MICHAEL: So we – and another investment is with parts of our business to support us to build the diversity-action plans; they're electronic platforms on our shared systems at Bolton Clarke. So the format is similar. We use the six outcomes for consumers from the Department of Health aged care diversity framework and the four action plans that sit under that. We did some very-in-depth analysis of what's contained in the aged care diversity framework and the action plans to ensure that we encapsulate the messages and look to operationalise it to meet the care recipients that we care for. So we use the six outcomes. Then managers are trained to look to actions for their sites that meet the diverse needs of the care recipients of their workforce and even potential customers. And these are measurable actions that they

can collect outcomes and evidence against. So managers are responsible for their action plans, and they document everything electronically.

MS BERGIN: Yes, and in a practical sense what would be an example of an action plan that might be appropriate, for example in North Queensland, that might not be so appropriate in the CBD in Melbourne? Are there regional differences?

MS MICHAEL: Yes, there are. So I was recently working with the manager in Cairns, and her needs and the needs of her care recipients and workforce are very different to ours. In that instance, there are no – as an example: there is no access-and-support program out there. So the challenge for that manager and the workforce is to look at other ways of getting information to her staff and to support care recipients. So the diversity team is active in trying to facilitate that need.

MS BERGIN: Yes. And if there's, say, for example, a very vulnerable client along the lines of your description before with more than, with multiple diverse needs and perhaps health vulnerabilities as well in Queensland, how do you fill that gap where there's no access and support program?

MS MICHAEL: It's very challenging, and having an access and support program across Australia would be very beneficial for our care recipients. At the moment, we struggle. We struggle with that. So it's about identifying the service systems that are available in the community. And I must say that that's where the biggest gap is because sometimes we can't find those supports.

MS BERGIN: So then there are unmet needs.

MS MICHAEL: So the diversity team will support them as much as possible to source that type of support. But where that is not possible and that service is not available, our staff, our workforce, will look to support that care recipient as much as is possible under the circumstances, but there may be unmet needs, yes.

MS BERGIN: Sure. Ms Michael, just turning to the topic of interpreters and interpreting services that you offer at Bolton Clarke.

MS MICHAEL: Yes.

MS BERGIN: Could I ask you, operator, to please bring up paragraph 71(e) of the statement. I note that Bolton Clarke has a National Language Line or a telephone interpreter system for care recipients, and that's something that's funded by Bolton Clarke.

MS MICHAEL: Yes, it is. It's a telephone interpreter service that consumers can access when they need it.

MS BERGIN: And that includes both your home care clients as well as your residential care clients.

MS MICHAEL: It includes all care recipients and even potential customers.

MS BERGIN: Yes. And who pays for the cost of the interpreting service?

MS MICHAEL: Bolton Clarke does.

MS BERGIN: So, for example, if I am a home care package recipient, Level 3, and I speak English. But as I've got older I've got dementia and I've reverted to my first language, can I use the interpreting service without dipping into my home care package funds?

MS MICHAEL: Yes, you can.

MS BERGIN: And how long has this line been operational for?

MS MICHAEL: It has been in operation – so it started off in the Victorian part of our business, and then we, as a result of some evaluation and some improvement, we found that people in other States across Bolton Clarke catchments also wanted to access it and they were being disadvantaged because they were charged STD rates, calling from Sydney, for instance. So in about 2013 we expanded it and it became the National Language Line.

MS BERGIN: Yes. When you say at paragraph 57 – operator, if you could please bring up paragraph 57, you say that there were approximately 4000 instances of interpreters used across Bolton Clarke's aged care services. Is this a reference to the in-house interpreting service?

MS MICHAEL: We don't have an in-house interpreting service. We have supply agreements with two interpreter services, or suppliers. But we also access interpreters through TIS National which is the preferred provider for the aged care system.

MS BERGIN: I see, so the Bolton Clarke National Language Line is provided by Bolton Clarke through service agreements with interpreting services.

MS MICHAEL: That's right, with a company called VITS LanguageLoop.

MS BERGIN: Yes. Thank you. And it's a free service for Bolton Clarke clients regardless of the type of care they receive?

MS MICHAEL: That's correct.

MS BERGIN: In your statement you note at paragraph 105(b) that following the announcement of TIS as providing interpreters for the aged care program an analysis was done of the availability of interpreters. Was that analysis done by Bolton Clarke?

MS MICHAEL: It was done by Bolton Clarke, but we meet with TIS National regularly, probably on a monthly basis now, to understand the data.

MS BERGIN: And you say that a conclusion was drawn that reveals a high number of cancellations by TIS because of a lack of interpreters in high demand languages or dialects.

MS MICHAEL: That's correct.

MS BERGIN: On that example, for example, booking an Italian interpreter, who was making the booking for the interpreter?

MS MICHAEL: So we use an online portal; our staff all have access to that online portal with their codes and passwords. So our staff book those interpreters.

MS BERGIN: Yes, and they've presumably booked them, the interpreters, because there's a client with care needs and speaks a language other than English as a first language.

MS MICHAEL: That's correct.

MS BERGIN: So what is the consequence of the client of the interpreting service being cancelled.

MS MICHAEL: The challenge for Bolton Clarke in many situations where an interpreter is seen as critical to the admission, for instance, or the assessment, is that if we don't get an interpreter to allow and enable that effective two-way communication, we will not understand their needs. So I do have an instance where, you know, CHSP clients are waiting for long periods of time in order for their admission and their assessment visit to be taken. So clients can be put at risk.

MS BERGIN: Yes. And do you know, off hand, what sort of – or do you know from your experience what services they were waiting for?

MS MICHAEL: Nursing services, mostly.

MS BERGIN: Nursing services in the home?

MS MICHAEL: In the home, yes.

MS BERGIN: Do you consider that to be potentially a health risk?

MS MICHAEL: Yes, I do.

MS BERGIN: Does this show one way in which deficient communication can be a health risk to a potentially vulnerable client?

MS MICHAEL: Yes, it does.

MS BERGIN: Can it precipitate early entry into residential care?

MS MICHAEL: Yes, it can.

MS BERGIN: How common is that, in your experience?

MS MICHAEL: Anecdotally – I mean, this is – this is a new service that has been listed as the preferred provider aged care, very recently, three months. Before that, we also had more localised interpreter services. So we didn't see this cancellation rate at the rate that we're seeing it now. But I think that that waiting for effective communication, waiting and not – and Bolton Clarke not being able to step in, in a timely way, to understand needs and respond quickly can lead, and has led, to premature – only from anecdotes that I hear from our staff. I haven't seen actual data.

MS BERGIN: Yes.

COMMISSIONER BRIGGS: Could I perhaps just ask a question around that, please?

MS MICHAEL: Yes.

COMMISSIONER BRIGGS: Given the timeframe, if you are assigned a package and you're normally supposed to get the package organised so that it can deliver within a certain period of time, so what you're saying is that the absence of interpreter services that might help a person work through the nature of that package and so on, and form a relationship with a care provider, is such that they might miss out entirely on their place in the prioritisation queue and end up in residential care as a result?

MS MICHAEL: That could happen, yes.

COMMISSIONER BRIGGS: Well that's very disturbing. Very disturbing. Thank you.

MS BERGIN: Thank you, Ms Michael. Also on the topic of communication, you refer at paragraph 106(e) to use of Auslan interpreters and you note that funding is not provided for Auslan interpreters by the Department of Health for people trying to access aged care services who have a hearing impairment. Is it important, or why is it important that interpreters are provided by DoH to assist people who may have a hearing impairment and that sign languages are treated in the same way as other languages?

MS MICHAEL: It's crucial to understand a person's needs and to deliver the care that they need. So for care planning and for service delivery, we need that sign

language interpreter at that admission and assessment period, because that is critical to service delivery. At the moment, the national Auslan interpreter booking and payment service is available to our nurses. So those clients that are receiving nursing services, because it's deemed as medical. But recent attempts by our staff to access sign language interpreters through NABS – funded interpreters for home care package clients via a case manager is not funded. And, of course, we would not further disadvantage that client by paying for that sign language interpreter through their budget. So it's another investment for our organisation.

MS BERGIN: Do you know why a line has been drawn between the funding of foreign languages and the funding of sign languages in this way?

MS MICHAEL: With the reforms, I just don't believe it has been seen as a gap, nor addressed. I think it's something that needs to be looked at immediately.

MS BERGIN: Yes. And with reference to the example we talked about earlier, communication can be – can potentially delay access to aged care services.

MS MICHAEL: Yes.

MS BERGIN: And, accordingly, would you draw the same conclusion about a lack of access to Auslan interpreters being potentially a safety risk?

MS MICHAEL: Yes.

MS BERGIN: Also, on the topic of care, needs you explain that cultural influences can affect a person's understanding of illness. Could you please provide some examples and explain why that is the case, referring to paragraph 78 of your statement.

MS MICHAEL: Very briefly.

MS BERGIN: Yes.

MS MICHAEL: Culture impacts on health beliefs, and that's the notion that's presented in our diversity conceptual model as a central diversity characteristic. Whether it's an individual culture or as part of a group or community culture, and sometimes it's implicit and other times it's explicit, we don't understand our behaviour. But there is a lot of evidence to suggest that this connection is vital to understanding health behaviour of care recipients. There is literature on the fact that culture impacts on a person's perception of disease and the causation and how that disease is caused or that illness. On – culture impacts and the way people behave and seek treatment and also what treatment they accept. So it's important for an aged care system to understand that.

MS BERGIN: Yes. And perhaps it's most helpful if I direct the Commissioners to the Diversity Framework and the nine diversity stories that you've got at the back of the framework for further examples.

MS MICHAEL: Yes.

MS BERGIN: Finally, on the question of obstacles – or perhaps not quite finally - - -

MS MICHAEL: Okay.

MS BERGIN: - - - you say that providing aged care services to a diverse population is resource intensive and you said that earlier in your evidence today. Can you please explain how Bolton Clarke reconciles providing this resource intensive service with operating the business in a commercial way?

MS MICHAEL: So the investment from Bolton Clarke far exceeds the funding that we get for the diversity program. We are then left to invest further. We do look at other strategies. So we do seek funding outside the aged care system for the development of products, for instance. We do go to philanthropic trusts for funding. We also look to a training solution and provide our managers with training, again, an investment for Bolton Clarke outside funding, so that we, you know, do take them out of their regular roles. But we look to managers to equip them with skills and knowledge so that they can drive diversity across our organisation and lead it. And there are train the trainer packages to enable them to do that.

We also address that through greater use of technology. So we have seven digital diversity stories on dementia, diabetes and medicines available on our website that our staff use with their care recipients.

MS BERGIN: Yes. Turning to paragraph 88 of your statement, you note that there are general difficulties in taking the action plans published under the Aged Care Diversity Framework from government policy into something that can be operationalised, implemented and maintained across the organisation. Why is this?

MS MICHAEL: The way in which the Australian Government Department of Health Diversity Action Plan and the four action plans that sit under that, the way in which they're designed is at a very high level. And that is helpful. And we've used those very high-level statements such as the principles and the outcomes for consumers. But in order to do that, you need dedicated resources. You need diversity specialists to analyse the information, to work with other parts of the business to operationalise that.

It's not in a format that you can just take and operationalise. It's meant quite a bit of work at Bolton Clarke by the diversity team but also project managers, information management services, and other teams to get that theoretical information that's in the Aged Care Diversity Framework and the action plans to – into a format that can be

operationalised and embedded into existing systems of an organisation. So it's quite systemic and we need to go through quite rigorous processes to support the organisation to operationalise and implement that.

MS BERGIN: Yes. Thank you, Ms Michael. Finally, you offer a number of solutions or areas for change or reform at paragraph 106 of your statement. It seems to me that the first at least four of those topics relate to workforce.

MS MICHAEL: Yes.

MS BERGIN: Do you agree with that?

MS MICHAEL: That's correct.

MS BERGIN: How central is the workforce issue in your view in successfully servicing clients' diverse needs?

MS MICHAEL: I think it's probably one of the most important factors for providing to care recipients and to meeting their needs. We need a workforce that is culturally competent, a workforce that receives the training that they need and receives that training in an ongoing way to ensure that they are capable, that the system is capable to meet the needs of a very diverse care recipient population that we have.

MS BERGIN: Yes. Thank you, Ms Michael. I have no further questions, Commissioners.

COMMISSIONER PAGONE: I just want to ask you a couple of things about the diversity characteristic chart and how the process that you embarked upon to work out what you were going to put in it. How did you come up with the - - -

MS MICHAEL: Commissioner, I didn't hear the first sentence; which document?

COMMISSIONER PAGONE: I'm thinking of the chart.

MS MICHAEL: The diversity conceptual model.

COMMISSIONER PAGONE: Yes, that's I meant, the diversity conceptual model. And as I was looking at it whilst you were giving your evidence and looking at the words that had been chosen to put within it, I wondered what the process was that had been undertaken to decide what went in and what didn't go in.

MS MICHAEL: Thank you for that question. The diversity conceptual model was designed as part of a research study dating back to 2013. Work on that was informed by a literature review and so there were three sources of information that contributed and informed the initial design of the model. We had the nine special needs groups from the Aged Care Act, the World Health Organisation's work on the social

determinants of health elements in there and also a human rights approach was also used and components of that.

We then took that first iteration of the model and put it through some rigorous research methodology, including focus groups with our own staff and external organisations, to find out, from the people who were working with these populations as to what are the common and shared diversity characteristics of older people.

And we came up with cultural identity as the core and we didn't want to lose that because of its relationship with health beliefs and illness. And then our staff and external organisations were able to come up with another 27 diversity characteristics and these are situations and conditions that can make it difficult for people to participate in their care. We heard lots of stories about how a situation or a condition made it difficult for somebody to participate in their care.

But, of course, this is not an exhaustive list. We had an enormous debate about including pets, because when people have pets they don't want to leave their home and they will neglect their health because of their pet. So there was great discussion about that and many others, and many others. We couldn't include them all, the circle wasn't big enough. So part of the training is, you know, these are ones that we've identified as common and shared but, of course, there are others and it's about the individual and eliciting that from the individual.

COMMISSIONER PAGONE: Thank you for that. And I might just continue to ask a couple of questions about it because I was really very interested to see what went in and what didn't go in and so there are some things that look as though there is enormous overlap in some categories and then there are others which just seem unexpected, others that are not unexpected but they're only unexpected until you think about it, like hoarding, for example. I was a bit surprised to see hoarding there, and then I thought about it and I thought, well, in terms of residential care, hoarding would be kind of an obvious one because you end up often in a much tinier space, and if you are a hoarder, you've got real problems.

And then comorbidities. So I'm giving these as kind of examples that others who are listening may not have focused upon, but it did cause me to think how on earth would you go about deciding – by what rigorous process do you decide what goes in the circle and what doesn't go in the circle, especially when you, having mentioned the ones that I just have, then you've got this other one, end of life by which you don't mean ageing.

MS MICHAEL: No.

COMMISSIONER PAGONE: So can you tell us something about the rigorous process?

MS MICHAEL: So the rigour was through a range of methodologies, as I mentioned, informed by literature. But I think the most informative aspect of the

whole process was what our staff told us, what they see out in the community and in the accommodation that we provide and that's how they got on there. It was really advice from our staff because, ultimately, it's the staff that are going to be trained with this product.

COMMISSIONER PAGONE: Thank you.

MS BERGIN: Nothing arising. Thank you, Commissioner.

COMMISSIONER PAGONE: Well, Ms Michael, thank you very much. It was a very interesting process and very thought-provoking. Thank you very much indeed. You are free to go.

MS MICHAEL: Thank you.

<THE WITNESS WITHDREW [12.19 pm]

MS BERGIN: Commissioner, we are running ahead of schedule. We propose to have a longer lunch, if that's convenient to you, and call our final witness, Ms Elizabeth Karn at 2 o'clock as previously planned.

COMMISSIONER PAGONE: Yes, I think that's satisfactory from the Commission's point of view. We will adjourn now until 2 o'clock.

ADJOURNED [12.19 pm]

RESUMED [2.03 pm]

MS BERGIN: I call Elizabeth Ann Karn.

NICOLE PETA CLARK, SWORN TO INTERPRET

KYLIE CLEAR, SWORN TO INTERPRET

<ELIZABETH ANN KARN, AFFIRMED [2.05 pm]

<EXAMINATION BY MS BERGIN

MS BERGIN: What is your full name?

THE INTERPRETER: My name is Elizabeth Karn.

MS BERGIN: How old are you?

THE INTERPRETER: I'm 68 years old.

MS BERGIN: Where do you live, Ms Karn?

THE INTERPRETER: I live in Wollongong, New South Wales.

MS BERGIN: Have you prepared a statement for the Royal Commission?

THE INTERPRETER: Yes, I have.

MS BERGIN: Is there a copy of your statement in front of you?

THE INTERPRETER: Yes, it's here.

MS BERGIN: Do you have any amendments to your statement?

THE INTERPRETER: No, I would like to leave it as it is.

MS BERGIN: Is it true and correct to the best of your knowledge and belief?

THE INTERPRETER: Yes, it's completely true.

MS BERGIN: I tender the statement of Elizabeth Ann Karn dated 3 October 2019.

COMMISSIONER PAGONE: Yes, thank you. The statement of Elizabeth Karn dated 3 October 2019 will be exhibit 10-28.

EXHIBIT #10-28 STATEMENT OF ELIZABETH ANN KARN DATED 03/10/2019 (WIT.0516.0001.0001)

MS BERGIN: Ms Karn, you are here with your daughter today?

THE INTERPRETER: Yes, that's correct.

MS BERGIN: Tina is supporting you as you give evidence?

THE INTERPRETER: Yes.

MS BERGIN: How many children do you have?

THE INTERPRETER: I have four children.

MS BERGIN: How many grandchildren do you have?

THE INTERPRETER: Lots. I've got 11 grandchildren.

MS BERGIN: What is your husband's name?

THE INTERPRETER: My husband's name is Walter Karn.

MS BERGIN: In your statement, you say that you and your husband are profoundly deaf.

THE INTERPRETER: Yes, that's correct.

MS BERGIN: What does this mean?

THE INTERPRETER: I was actually born able to hear and at about the age of four, I got meningitis which caused profound deafness. Differently, my husband was born deaf, never able to hear.

MS BERGIN: In communicating with me at the moment, what language are you using?

THE INTERPRETER: I'm using Auslan, Australian Sign Language.

MS BERGIN: How is Auslan different to other languages?

THE INTERPRETER: Auslan is a manual language. So we spell words with our fingers. We use our hands, our facial expression and our body language to communicate completely.

MS BERGIN: What other interpreting services do you use?

THE INTERPRETER: Usually I use my daughter as an interpreter.

MS BERGIN: Does your daughter live close by?

THE INTERPRETER: No, quite a distance away. An hour and a half away, actually, from my home.

MS BERGIN: If your daughter travels to your house to interpret for you, does she spend three hours in the car?

THE INTERPRETER: Yes, she is an hour and a half away so it's a three-hour round trip.

MS BERGIN: What is a relay service?

THE INTERPRETER: The relay service is a service that deaf people can use to speak to people, to communicate with people who can't sign. So it's an internet-based service.

MS BERGIN: How does it work?

THE INTERPRETER: So, through the computer, I would type to someone, even often an iPhone or iPad and that person would then speak to the person on the telephone that I want to talk to.

MS BERGIN: How do you communicate if your daughter is not free and there's no interpreter available?

THE INTERPRETER: So, if I was in the situation where I needed to communicate with someone, I would have to get pen and paper out and write to them.

MS BERGIN: Do you prefer Auslan of those options?

THE INTERPRETER: Absolutely. Auslan is my language so communication is so easy in Auslan.

MS BERGIN: How often do you use Auslan in everyday life?

THE INTERPRETER: So really it depends what I need. If I had to communicate something really serious, then I would absolutely insist on having an interpreter. If it was something really minor to communicate, I would probably make do with pen and paper.

MS BERGIN: Could you give an example of when you would use an Auslan interpreter for something serious?

THE INTERPRETER: So, if I went to the bank and I had to speak to the bank manager about selling some property, or my superannuation, so when my husband was getting close to want to leave work and we needed to make some decisions about our super, if I had to speak to a solicitor, even as minor as needing to understand what's wrong with my car, speaking to the mechanic, you know when he writes down those strange words that I don't understand to do with the car, an Auslan interpreter would help me understand everything.

MS BERGIN: Ms Karn, how old were you when you applied to the NDIS?

THE INTERPRETER: It was just before I turned 65. I was almost 64 when I jumped in and applied to the NDIS.

MS BERGIN: How did you hear about the NDIS?

THE INTERPRETER: So I had heard talk about the NDIS through the Deaf Society and we were so excited, I caught a train all the way to Sydney to get the information and go to a workshop, filled out some application forms and they said, "How old are you?" and I said "I'm not 65 yet." As soon as they found out where I lived they said, "Roll out doesn't happen in your area for a couple of years" so I was almost 64 and they told me I was going to miss out.

MS BERGIN: What services did you want?

THE INTERPRETER: What I wanted was access to interpreters. I would like a flashing fire alarm and perhaps a flashing front doorbell. Access to using an iPad so I could get some VRI interpreting, that's video relay interpreting.

MS BERGIN: What was the outcome of your application to NDIA?

THE INTERPRETER: The NDIA told me, "Sorry, you can't get in." They hadn't rolled out in my area before I turned 65.

MS BERGIN: How old were you when you applied to My Aged Care, Ms Karn?

THE INTERPRETER: It was just after I turned 65, when the NDIA made it very clear I couldn't apply. I thought, okay, well I will apply for My Aged Care because they told me I'm the age.

MS BERGIN: What services did you want?

THE INTERPRETER: Could you repeat that, please?

MS BERGIN: What services did you want from My Aged Care?

THE INTERPRETER: Well, I asked for interpreter access: that's all.

MS BERGIN: What was the outcome of your application?

THE INTERPRETER: They said, "No, sorry, we don't have that service in My Aged Care. We provide interpreters for spoken languages but not for Auslan."

MS BERGIN: How did you feel, Ms Karn?

THE INTERPRETER: I felt really excluded.

MS BERGIN: And why was that?

THE INTERPRETER: So, it was like they forgot deaf people. They didn't provide any kind of support.

MS BERGIN: What services would you have used the Auslan interpreter for, if you had been successful?

THE INTERPRETER: Well, all those personal appointments I spoke about.

MS BERGIN: How do you manage health – how do you manage appointments now, without an Auslan interpreter?

THE INTERPRETER: My daughter has to become my interpreter or do things for me.

MS BERGIN: If you were to pay for an Auslan-interpreter to come with you to an appointment – what would that cost?

THE INTERPRETER: Lots of money. $240 for up to two hours of interpreting is the standard cost.

MS BERGIN: Ms Karn, you're a member of the hearing-impaired community, including Australian Deaf Elders Facebook group?

THE INTERPRETER: Yes.

MS BERGIN: Do any members of your community have access to Auslan-interpreter – that you know about?

THE INTERPRETER: Those who are over 65 have no access, just like me. Those in the Facebook group that I'm a part of, the one you mentioned, the Deaf Elders: some of them get access, but those over 65 have no access to interpreting services.

MS BERGIN: Now, how do you feel about that, Ms Karn?

THE INTERPRETER: Really isolated and left out. It's like this barrier that we just can't push through.

MS BERGIN: Ms Karn, could you please read from paragraphs 16 and 17 of your statement?

THE INTERPRETER: I'll sign that. Shall I start now?

MS BERGIN: Thank you very much, Ms Karn.

THE INTERPRETER: As a Deaf Elder, I'm exhausted. I feel broken-hearted. So many of my friends are in the same situation as me. We feel excluded, ignored and isolated. Because of our age and our disability, we are forgotten. Where do we belong? When are we going to be included and accepted as a valued part of the Australian citizen? We just want the right to gain access to services and funding that allows deaf seniors, deaf elders, to have the right to communicate freely in our

country. If I can continue – Auslan Deaf elders wish to access My Aged Care, Auslan-interpreting packages, like our deaf peers who are under 65, who now have the NDIS. This would provide us with the access to the wider community without the language and communication barriers that are experienced in our everyday life.

MS BERGIN: Thank you, Mrs Karn. Why was it important, for you to give evidence to the Royal Commission today?

THE INTERPRETER: I want access for me but support the many, many seniors, deaf people in Australia who are over 65, who want equality, who want to be included in the community.

MS BERGIN: Is there anything else you wanted to say, Ms Karn, or something you wanted to read out?

THE INTERPRETER: Yes; there is something more. Deaf people over 65 access the same life and specialised services that people under 65 do. The Government is not considering us. They're not considering our needs. My Aged Care is not providing for us the way they do for other people our age.

MS BERGIN: Thank you, Mrs Karn. Thank you, Commissioners; that concludes my examination.

COMMISSIONER PAGONE: Thank you.

COMMISSIONER BRIGGS: Thank you, Mrs Karn. I'd like to ask you whether you or your friends have applied, through My Aged Care, for access to home care or residential-care services.

THE INTERPRETER: Some deaf people in Sydney that I'm aware of have applied for home care, and so they are in a situation where they need someone to help clean the house or do some cooking for them. But My Aged Care does not provide any access for personal interpreting.

COMMISSIONER BRIGGS: That must – it must be very difficult for you or for other people with hearing impairment, when carers come to your house. How does it work, that you're able to communicate in those circumstances?

THE INTERPRETER: So, in the past, I have actually heard people, when I'm in Sydney, I'm chatting with my friends – and they tell stories of people coming to their house to provide those in-home services, and they have to communicate by writing notes to each other, if the person can understand. There are some very generous people who have gone and learnt a little bit of Auslan, and so I've heard some really lovely stories where carers realise they need some sign-language skill.

COMMISSIONER BRIGGS: If people who are hearing-impaired develop dementia, do they lose the ability to sign or – what happens with communication?

THE INTERPRETER: Their sign language changes. So they become – it's like a simplised version of sign language.

COMMISSIONER BRIGGS: In residential care, there are many people who haven't been deaf for a long time but develop deafness over time. Are you aware of any arrangements that help those people communicate?

THE INTERPRETER: I couldn't actually tell you. I don't know a lot about that.

COMMISSIONER BRIGGS: Thank you very much.

MS BERGIN: Thank you, Commissioner.

COMMISSIONER PAGONE: Ms Karn, thank you very much for coming to give evidence. It is very important, for the Commission to have heard of your situation and for the community and the Government to have heard about it too. Thank you.

THE INTERPRETER: Thank you very much, Commissioners.

MS BERGIN: Mr Gray QC will now make a closing submission.

COMMISSIONER PAGONE: Ms Karn, you're free to go, if you wish. And I should've also thanked those who have come and are in the body of the court to have heard Ms Karn's evidence. I think she has spoken for more than just herself, and I hope that those in the audience who have come to hear her are happy with that fact and to give her support. Thank you.

<THE WITNESS WITHDREW [2.23 pm]

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, commissioner.

COMMISSIONER PAGONE: I think you had been angling for an extra five minutes. You have it.

MR GRAY: Thank you. In this hearing, we've led evidence about the response of aged care providers and the aged care system to the needs of people of diverse backgrounds, experiences and characteristics. As in previous hearings of the Royal Commission, in this hearing we have been privileged to witness powerful accounts of or about the experiences of people in the aged care system. This evidence has been at the very core of the hearing.

We heard from Angelos Angeli about his mother's experiences, from Anne Tudor about caring for her friend and spouse, Edie, and their experiences with the system,

from Brian Lynch, Janette Maguire, Malloy, from Uncle Brian Campbell and Uncle Brian Birch and just now from Elizabeth Karn. All of these witnesses spoke about their experiences, and we heard from Catharina Nieuwenhoven, based on her knowledge acquired as a community liaison officer.

We've also heard evidence from dedicated service-providers, including Samantha Jewell, Nathan Klinge, Helen Radoslovich, Dr Duncan McKellar, David Panter, Elizabeth Drozd, Moreen Lyons and Jaklina Michael. Several of the witnesses have suffered significant trauma in the past and are living with its effects. Their evidence was given courageously and at evident personal cost. We're very grateful for their efforts in giving evidence to the Royal Commission.

There are some basic points that are clear from their accounts and from other evidence received in this and in other hearings. Aged care must be accessible to the individuals who need it and tailored to their needs. It must be planned and delivered in consultation with them and with their family or other loved ones and in a way that respects their choices. It must involve respectful communication and trust between the provider organisation, its staff and the person who needs care. In short: it must be person-centred care that is planned and delivered through caring and respectful relationships. This cannot occur without a deep understanding on the part of the provider and its staff of the diversity of experience, background and characteristics of older people in Australia.

There are myriad ways in which a failure to appreciate and respond appropriately to that diversity can result in barriers to communication, trust and respect. The ways in which this can occur range from obvious matters, such as a language barrier, through to such more-subtle failures to inculcate culturally-safe care in the care environment. This can inhibit people from being able to communicate their needs.

It follows, that caring for people with diverse needs must be core business for aged care providers. Close attention and positive efforts are needed, and the work must be reviewed and improved continuously all the way through the aged care system, from linking people who need care to the point of access to the system, through the day-to-day interactions relating to in-home care or on the floor of the residential-care service, up through the corporate-governance structure of the provider organisations, to the making of policy at a systematic level. Responding to diversity is a quality-and-safety issue. Responding to diversity must also permeate the quality-and-safety monitoring-and-regulatory frame-work.

Commissioners, I'll now address some of the key themes which emerged from the evidence during the week. The first point is that caring for diversity is central and not merely incidental. If due care and attention is not giving to catering for diversity, it's easy, for services to be delivered in a standardised way. Avoiding this requires a systemic response. Individual characteristics need to be acknowledged and addressed by individual aged care providers and by the incentives and requirements which apply at the systemic level.

For example: Ms Samantha Edmonds of the national LGBTI health alliance and chair of the diversity subgroup of the aged care sector committee explained the importance of – and I quote – having a whole aged care system that's actually inclusive of people regardless of their diversity needs and that recognises their diversity needs and puts them at the centre rather than add-on and additions.

That said, commissioners, care is needed to avoid merely categorising people into cohorts of the population. There was evidence, for example, that a person might have different adverse experiences and exacerbated trauma from having multiple kinds of diverse needs. Dr Philip O'Meara spoke of the Victorian government department of health and human services Designing for Diversity approach and its tools, which encourage human services providers in Victoria to cater for the intersectional nature of diversity.

These tools acknowledge the need for policymakers and for service providers to understand a broad range of potentially overlapping characteristics, including amongst other things, religion, gender, sexual orientation, cultural language and communication requirements and other matters in order to effectively respond to a person's needs. Mr David Panter, CEO of ECH in Adelaide, explained that the current aged care system does not respond well to intersectionality as this requires a degree of sophistication which, in his view is currently beyond the majority of providers in the sector.

The next theme is communication. As a starting point, the witnesses emphasised how critical it is for people accessing and receiving aged care to be able to communicate, to be able to understand and be understood. Ms Patetsos explained that people have a right to know what is happening and the right to professional interpreters in situations where the correct level of interpretation is required and aged care is a perfect example of this. Without an ability to communicate, the basic rights of people are undermined, and they can become socially isolated. The right to be understood was also emphasised just in this afternoon's evidence from Ms Elizabeth Karn. The absence of Auslan interpreting services in the My Aged Care framework is disturbing and unacceptable. And the issue is not only access to Auslan.

There are significant limitations in interpreting services available in the aged care system and doubt whether it is sufficient to assist people to meet the very significant challenge of navigating an overly complex system and making their care needs known when they come from a CALD background. Commissioners, you heard evidence that, even putting language to one side, communication of needs will not occur unless people feel safe to disclose their background and life experiences.

A number of witnesses noted that trust can be difficult for many diverse groups, as organisations providing aged care have sometimes themselves been involved with their negative life experiences and there can be a lack of trust in what is seen as an authority figure. Ms Edmonds explained that after experiences of abuse and often of institutionalisation, we are now saying to the very people who have suffered that discrimination, and I quote:

Hey. Come and trust these services that actually discriminate against you for your whole life time. You know, you can trust them now. They're going to do person-centred care. You'll be fine and you'll get good services.

This leads to the concepts of cultural safety and also trauma-informed care. We heard evidence of the importance of providers and their workforce being educated and understanding diversity, cultural safety and trauma-informed care in order to be able to deliver high quality care that meets the unique needs of every person respecting their background and past experiences.

Ms Maguire, a Forgotten Australian, explained, for example, that educating people that Forgotten Australians were abused as children helps people to understand their history and that they may act in particular ways. Every provider in Australia has a responsibility to meet the individual needs of their care recipients without discrimination.

Malloy highlighted that providers need to be aware of the cycle of invisibility, and Ms Edmonds explains this cycle. If care is not being offered in an environment of cultural safety and if needs are not communicated, they're simply never going to be identified, with individual ramifications, not only for the safety, health and wellbeing of the person concerned but also with systemic consequences because accurate data on the needs of diverse groups will never become available.

Witnesses emphasised the importance of asking questions about diversity to break the cycle of invisibility, while at the same time understanding that you can't only ask people at the initial point of contact when people may not feel comfortable disclosing personal information.

Appropriate occasions have to be sought and the question has to be asked, potentially, at multiple times. Ms Radoslovich said that sometimes they will have worked with someone for a long time before they declare particular information. She said we need to be open and to listen all the time and to be quick to respond. Ms Noeleen Tunny of Victorian Aboriginal Community Controlled Health Organisation (VACCHO) made the point on Monday that it is impossible to deliver person-centred care without embedding culturally safe care. She also said we have to:

...look at the holistic quality of care and take care outside an individualised western medical model when considering care for Aboriginal and Torres Strait Islander peoples.

Dr Duncan McKellar identified trauma-informed care as part of a person-centred approach to care. He noted::

To achieve a truly person-centred approach to care that will include intrinsically within it an understanding that everyone has some kind of trauma theme that they will encountered within their life story.

Dr McKellar outlined available approaches that organisations can adopt to enable them to provide trauma-informed care. Commissioners, the next theme I wish to address is leadership and culture and the concept of co-design. The Royal Commission is regularly hearing evidence about the importance of leadership. It's a topic that straddles virtually every area of its inquiry and this hearing was no exception. Many of the witnesses spoke of leadership from the top by boards and executives, and also of passionate staff who act as leaders within their organisations and go above and beyond. Mr Klinge held up the board of RSL Care SA as a good model of leadership.

Mr Panter described ensuring that the organisation is authentic is a key challenge for ECH in embracing diversity and he said this required the leadership of the organisation, both the board and the executive, to fully understand and support the approach taken. Ms Tudor encountered an example of good leadership at the facility where she was welcomed with her partner, Edie. Recruitment is critical. Dr McKellar described the importance of a values-based workforce as a core element of recruitment in his opinion. Such a workforce he said:

> *...is going to bring passion and care and commitment and humanity.*

Dr McKellar said values need to go across whole organisations from the CEO through to the people that are managing hotel services or cleaning or delivering food. A number of witnesses referred to the need to involve the relevant community of people in or seeking care through co-production or co-design so their diverse backgrounds and life experiences can be integrated in service design. Witnesses talked about co-design as an opportunity to involve the targeted community of people with diverse backgrounds and life experiences, and organisations representing them to design how services work are developed and also to advise government.

The next theme is navigation and assistance. At this hearing, as with almost every other hearing of the Royal Commission we heard about difficulties people face in understanding and using the current system including the need for improved advocacy and assistance with navigation of the system. These problems are compounded for people of certain diverse backgrounds. Ms Tunny stated:

> *My Aged Care has proved disastrous for Aboriginal people.*

Ms York highlighted the challenges faced by people who are homeless or at risk of homelessness. Aged care and the idea of ageing in place are predicated, she said, on the assumption that someone owns their own home and can sell their home in order to prove into residential care. She stressed that insecure or inadequate housing can have a huge impact on the delivery of home care. She noted that she had heard of clients with a home care package or Commonwealth Home Support program services where workers have had to be withdrawn due to an unsafe working environment in the home.

Ms Drozd spoke to issues experienced by the CALD population noting:

So the first barrier that comes to mind is truly being able to communicate, being able to communicate in English and we know that migrants who came in the sixties and seventies, they often haven't had the same opportunities to acquire good English. What we also know from the census data is that certain ethic communities do not use the internet in a significant way. So when information is available online, well, that is not information that they can access.

We heard from several witnesses about the access and support program which operates in Victoria as part of the Commonwealth Home Support program after transitioning from the former Home and Community Care program. It appears this program is only available in Victoria. Ms Michael noted:

My Aged Care may act as a barrier for some people with diverse characteristics accessing care. There are few culturally appropriate navigation and advocacy services nationally. I'm aware that the access and support program in Victoria is making a valuable contribution to the aged care sector. It is successfully providing culturally appropriate support and access/navigation to special needs populations.

Department of Health witnesses of the Commonwealth were not familiar with this program but acknowledged it was relevant to the work being done to pilot system navigators. That's a reference to the current navigated trial that is being conducted by the Department of Health or on its behalf. After Dr Hartland gave his evidence, the Royal Commission received a submission from the access and support program coordinator at the Ethnic Communities Council of Victoria referring to Dr Hartland's evidence and drawing attention to an evaluation report in 2015 by HDG Consulting Group titled Home and Community Care: Diversity Planning and Practice Implementation Review Project.

I will ask the operator to display this on the screen now: RCD.9999.0232.0001. Commissioners, this document includes descriptions and evaluations of the programs relating to diversity advisers and access and support amongst other things. Commissioners, I seek to tender this document by way of adding it to the general tender bundle in the hearing as new tab 138.

COMMISSIONER PAGONE: Yes, I'm content for that to happen.

MR GRAY: Thank you, Commissioner. Commissioners, Dr O'Meara told you that funding agreements under the program are currently in place until mid-next year, 2020, and that the program is currently in a transitional period which will come to an end at about that time. He explained that Victorian officials are in discussions with the Department of Health of the Commonwealth to ensure there is continuity of service. We will monitor developments on this topic. Ms Catharina Nieuwenhoven noted, in her experience as a community liaison officer:

> *Older people from the community have told me that they don't know how to use their aged care packages. Some of the people in the Dutch group that I've spoken to don't know what they're entitled to. They don't know how to approach My Aged Care.*

This leads me, Commissioners, to the next theme, which is the theme of government policy and administration. As to that matter, while some progress is being made, much remains to be done and in various respects no progress has been made at all. To take an example. The foundation of good policy is information. The Tune Review identified deficiencies in data about care for diverse groups in 2017 and Mr Tune made recommendations for improvement which had still not been adequately implemented by the Department of Health. There appears to have been little or no real urgency shown in the task.

First Assistant Secretary Jaye Smith's evidence indicates that work on an overarching data governance project is yet to commence. First Assistant Secretary Nicholas Hartland has been involved in an aspect of the task but even this did not commence until about a year after the Tune report and it appears it's bogged down in technical difficulties at present. The upshot is that it is not possible for a person to have their membership of a special needs group identified as part of their client record in the My Aged Care system. This is an important issue.

We've heard that the lack of reliable data collection and consequentially its analysis is a fundamental issue holding back the system and the sector when it comes to supporting care for people with diverse needs and experiences. Many witnesses lamented the absence of reliable data collection and analysis. They noted how critical it is, to collect and make available information at every point, not just for those who succeed in accessing aged care but also for those, we know, experience barriers in accessing care. Ms Mary Patetsos said:

> *It's absolutely critical, that we collect data at critical points on entry and on every point where it's possible.*

Without this data – that's the end of the quote, I should say. Without this data and proper contextual data – pardon me; this is the continuation of the quote.

> *Without this data and proper contextual data, it's not possible, to confirm if the current system or changes to the system are meeting the needs of vulnerable older Australians. Further, a much better understanding is needed, about the extent to which there might be unmet demand.*

A number of direct-evidence witnesses stated their desire to be identify within aged care data. Ms Tudor explained that she would have valued being asked – and I quote –

"Are you a couple? Have you been together long?" so that we were known more as people, given the stigma in the past that was being part of the LGBTI community.

Ms Maguire would like Forgotten Australians to be identified on paperwork. And I quote:

Being identified allows people to understand someone is a Forgotten Australian and has unique needs. It would help the government departments understand why we react to things in a certain way.

Ms Elizabeth Cosson, the Secretary of the Department Of Veterans' Affairs, acknowledged the deficiencies in data for veterans and the lack of sophistication of data collection and data matching across relevant departments. On a number of occasions she indicated a desire to move towards improvements in this area, not just within her own department but across government. However, she expected that improvements were – and I quote – a few years down the track.

We heard that the lack of data held by the department on all the special-needs groups had limited the available analysis, the impact of changes to the system for allocating home care packages. Dr Hartland said in this respect – and I quote –

So we have some data that we can give you on how six of the special-needs groups have fared post the increase in choice measures, but as we've discussed, we don't have data on care-leavers, parents separated from their children and LGBTI groups.

This leads me to the theme of policy-reform processes. The evidence about policy reform on aged care's response to diversity suggests that, while impressive documentation has been prepared, there's uncertainty about the extent to which providers and Government will actually implement what is in that documentation and what is needed.

We heard about the key role of the aged care sector committee, diversity subgroup. It plays an important role in attempting to ensure the needs and issues of people with diverse life experiences and characteristics are heard and listened to across the aged care sector. A panel of members of the subgroup on Monday, consisting of Ms Edmonds, Ms Patetsos and Ms Tunny, was very informative in this regard.

Facing resistance from sector bodies, the subgroup has prepared the diversity framework and associated action plans, three of them, with one more in progress, and these are in some sense adopted or to be adopted as government documents, but they are not binding. It is unclear, whether and how assessors of the Quality Commission will be guided by them in assessing compliance with the quality standards. The position of Ms Ann Wunsch from the Commission – that is from the Quality Commission – was that they should not become mandatory requirements, but they are available to be used in some way during assessment.

Disturbingly providers are allowed to make representations on the My Aged Care portal that they, the providers, are specialists in providing care for specified groups without there being any requirement for them to verify this in advance and, until recently, without there being any monitoring by government of the truth of these claims. Mr Smith, from the department of health, acknowledged that the lack of a quality assurance process to verify the claims of providers on My Aged Care needs to be looked at seriously and with urgency. Ms Wunsch of the Quality Commission gave evidence, that after this issue was raised by the Royal Commission and with effect from late September 2019, teams of assessors are now and will be giving attention to this issue. It remains to be seen, whether this will be a sufficient response to this important issue.

Turning now to another important gap in the regulatory process – as pointed out by Ms Michael, while providers have for many years obtained aged care places, which confer the right to subsidy, on the basis of conditions or, essentially, promises that the providers will accord priority to special-needs groups identified in applications for those places, there's been no follow-up from government agencies about the use of these residential-aged care places. There's, therefore, no accountability holding providers to conditions about according priority to people from particular special-needs groups.

I explored this issue with Mr Smith. I suggested that an elaborate centrally-planned allocation exercise, the ACAR, has been going on at great expense and in a very resource-intensive manner without there being any notion on the part of the department as to whether it is meeting the needs of diverse groups. And Mr Smith agreed. Mr Smith also agreed with your suggestion, Commissioner Pagone, that it is indefensible, for the Government to put an obligation on providers relating to responding to diverse needs but not to monitor whether that obligation has been met. Dr Hartland described the current process for allocating places to special-needs groups that previously operated in the home care sector and continues to operate in residential care – that is the ACAR – as inadequate.

A number of witnesses spoke of difficulties arising from the interactions and siloes between levels of government and between different Agencies of government. For example: Ms York indicated the housing-and-homelessness sector focusses on younger people and family violence, not aging, and the aged care sector doesn't understand homelessness. She also noted that every state has different legislation governing tenancies, which can be tricky for those working in the sector.

Ms Cosson noted deficiencies and her dissatisfaction with these deficiencies in the interface between DVA – Department of Veteran Affairs – services and Department of Health aged care programs, and she said that the systems do not talk to each other. This point was accepted by Dr Hartland of the Department of Health, who agreed, that progress to improve interaction between the relevant systems has been frustratingly slow. It's clear, that these siloes need to be broken down.

Consumer-directed care, which has applied as the delivery model for home care packages since February 2017, was another feature of the evidence this week. It's unclear, whether there was an analysis of the impact on special-needs groups done by the department before the implementation of consumer-directed care in relation to home care packages in February 2017. Dr Hartland was unable to identify any such impact analysis during the hearing. Dr Hartland pointed to data since February 2017, and he compared that to data about the allocation of home care places, as they were called, before that date

He claimed that the data suggested that, to the extent that some special-needs groups could be identified in the data – it appeared, they were marginally better-off or at least not significantly worse off. He also pointed to some survey material, although that is based on limited sample sets. The data's very limited, and in our submission, it's not sufficiently reliable to draw any firm conclusions.

Many witnesses were negative about the experience of consumer-directed care for people from diverse backgrounds and life experiences. However, it was acknowledged that the lack of data made it difficult to determine if it's meeting their needs or not. Ms Patetsos suggested that the high underutilisation, if I can put it that way, of home care funding could imply people don't understand consumer-directed care. She suggested that the same pattern being seen in the NDIS for CALD people means that we haven't got it right.

As we have heard for other people defined as so-called special needs groups under the Aged Care Act, Ms York suggested block funding allows flexibility in the approach for services targeting people who are homeless or at risk of becoming homeless. A number of witnesses have indicated that diverse groups can't rely on the market to meet the needs of everybody and there will be people who fall through the gaps.

However, we have also heard that the market may create possibilities and opportunities for providers to tailor their services to particular diverse groups. We heard that this was the view of the Department of Health when it implemented reforms to that mechanism for delivery of home care packages in February 2017. Dr Hartland said in this regard:

> *So we thought at the time that this was actually one of the big rationales for changing to this system was actually to help special needs. So at the time the thinking was that this new system of a fairer way of putting people on the queue would actually help special needs groups.*

However, as I've said, he didn't point to any impact analysis done prior to February 2017. I will now conclude. The current aged care system does not allow us to track or monitor access for many special needs groups. The system is transitioning from a centrally planned system to one with about a more marketised and consumer-directed approach. This appears to have been embarked upon with insufficient consideration of how the impact on diverse groups will be monitored. This must be remedied as a

priority. We have been struck by the apparent lack of accountability in the system in relation to the measures intended to respond to diversity.

We are left wondering whether practice on the ground matches the rhetoric of the commitments to diversity in the Aged Care Diversity Framework and in its associated action plans. Unfortunately, the lack of data and proactive monitoring leaves us in the counsel assisting team without a satisfactory answer to the question. We are unable to assist you, Commissioners, with anything more concrete as a result of those deficiencies. One thing we can submit is that the current situation is inadequate and must be fixed. There are two possible reasons that it has not been fixed: a lack of will or a lack of resources.

We have heard evidence from Dr Hartland that the issue is not a lack of resources, at least in respect of the data matters that he was addressing. That leaves us with concerns, in our submission, about the will of the department to drive reform that responds to the needs of people with diverse background and experiences. Embracing and respecting diversity, as I've said, must not be an add-on or a token gesture. In our submission, the Commonwealth Department of Health has much to learn from the Victorian Department of Health and Human Services Designing for Diversity Framework and guidance material. As a final note about the evidence in the hearing, I wish to repeat this message from Ms Tudor:

> *We all have to be very mindful that when somebody who has a very different background comes into residential care that extra effort is made to assist that person to settle in and to have a life there that is, you know, worthy of them as human beings and provides them with what they need. So someone who looks different or someone who is different, we need to be celebrating this. We need to be celebrating diversity and not be frightened of it.*

The Royal Commission has received many submissions from individuals and organisations about diversity in aged care. There's not been time in this hearing to hear from all of those individuals and organisations. A selection of the submissions that have been received are now published on the Aged Care Royal Commission website. They include submissions from the Ethnic Communities Council of New South Wales in conjunction with Seniors Rights Services, Flemington Chinese Golden Age, Tamil Senior Citizens Fellowship (Victoria) Inc, Multicultural Aged Care, National Aboriginal Community Controlled Health Organisation, Alliance for Forgotten Australians, and others. These are just some of the submissions that are now published and we anticipate publishing more submissions in the future.

Commissioners, earlier today you made directions for any written submissions by parties with leave to appear in this hearing to be provided to you by 5 pm on 25 October 2019, and for reply submissions to be provided to you within seven days afterwards. Finally, I wish to place on the record some information about the scope of the interim report which will be submitted to the Governor-General at the end of the month. The text of the interim report prepared by Commissioner Tracey and by you, Commissioner Briggs, was settled at the end of September. This was necessary

to meet publication deadlines to enable delivery to the Governor-General by the end of this month.

The interim report will include information about Commissioner Tracey and Commissioner Briggs' overall impressions about the aged care system and more detailed analysis of a limited number of topics. The interim report will not take into account the detail of the evidence at the Brisbane hearing relating to regulatory responses and will not include evidence from this hearing on diversity in aged care or the evidence at next week's hearing about workforce issues. The Royal Commission's next hearing commences here in Melbourne at 9.15 am, Monday, 14 October and it will focus, as I have said, on workforce issues. If the Commissioners please.

COMMISSIONER PAGONE: Mr Gray, thank you for those closing submissions. If you would please pass on our gratitude to all members of counsel and the number of people behind the scenes, some of whom are here in various positions and some who are not here, for the work that you've done in preparing the submissions. I think it's important to say that publicly because often the processes that take place in a hearing like this must, to the public, seem an easy exercise without really understanding or appreciating the enormous amount of time and effort that goes into its preparation. We, of course, are closer to that and so we see it but we should put on record both our gratitude and also our appreciation of the amount of time and effort that is involved by not just you, but all of those behind you. Please pass that on.

MR GRAY: I will. Thank you, Commissioner.

COMMISSIONER PAGONE: We will now adjourn, and the hearings will recommence next Monday at 9.15.

MATTER ADJOURNED at 3.03pm UNTIL MONDAY, 14 OCTOBER 2019

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