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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

HOBART

10.00 AM, TUESDAY, 12 NOVEMBER 2019

Continued from 11.11.19

DAY 65

MR R. KNOWLES SC, counsel assisting, appears with MR P. BOLSTER and MS Z. MAUD
MR H. AUSTIN QC appears with MR J. CLARIDGE for Southern Cross Care
MR R. PHILLIPS appears for Ms Helen Marshall

MS MAUD: Commissioners, the first witness this morning is Judith Anne King who is here in the witness box.

<JUDITH ANNE KING, AFFIRMED [10.00 am]

<EXAMINATION BY MS MAUD

COMMISSIONER PAGONE: Yes, Ms Maud.

MS MAUD: Can you state your full name for the transcript, please? Can you state your full name?

MS KING: Judith Anne King.

MS MAUD: Have you asked that I call you Judith this morning?

MS KING: Yes, that's fine.

MS MAUD: Judith, you're married to Professor Neville King.

MS KING: Yes.

MS MAUD: You've been married for 37 years, and you've lived in Tasmania since 2008.

MS KING: Yes.

MS MAUD: And you've made a statement for the Royal Commission in relation to Neville's experience living at the Glenara Lakes Aged Care Facility.

MS KING: Correct.

MS MAUD: Is that right?

MS KING: Yes.

MS MAUD: Can you see a copy of your statement there in front of you and the first page on the screen with the date 5 November.

MS KING: I can, yes.

MS MAUD: Dated 5 November 2019, and it has a code WIT.0611.0001.0001.

MS KING: I can't see the code.

MS MAUD: It's in the top right corner.

MS KING: Yes. Now I can, yes.

MS MAUD: Yes. Have you had an opportunity to read it recently?

MS KING: I have.

MS MAUD: And are there any corrections you would like to make?

MS KING: No.

MS MAUD: Are its contents true and correct to the best of your recollection and belief?

MS KING: Yes, absolutely.

MS MAUD: Yes. I tender the statement, Commissioners.

COMMISSIONER PAGONE: Yes. The statement of Judith Anne King dated 5 November 2019 is exhibit 13-10.

EXHIBIT #13-10 STATEMENT OF JUDITH ANNE KING DATED 05/11/2019 (WIT.0611.0001.0001)

MS MAUD: Thank you. Now, Judith you're retired now. You've been retired since 2013; is that right?

MS KING: 2003.

MS MAUD: 2003; I beg your pardon. Now, you previously worked as an RN and the assistant director at the Alfred Hospital, and you were also a director of nursing and CEO in the private health sector. What kind of organisations were those that you were in that role?

MS KING: At the Alfred I was an assistant director, in the private health sector; a small hospital, mainly surgical but we had medical patients as well. That covers it.

MS MAUD: And before you retired you were the national manager at Australian Red Cross with responsibility for the Pacific region.

MS KING: Yes, I also – it was the first aid, health and safety services role which was training 100,000 people a year in CPR and advanced and basic life support.

MS MAUD: Okay. Now, Neville was a professor of psychology at Monash University.

MS KING: Yes.

MS MAUD: And last year he was awarded the Officer of the Order of Australia; what was that in relation to?

MS KING: For services to humanity. Neville and international colleagues introduced cognitive behaviour therapy to the world and it was rolled out into 63 different countries. It's helped hundreds of thousands, perhaps millions of people have better lives and have coping skills on a day-to-day basis that otherwise they wouldn't have had. So he's done an extraordinary role, made a great contribution.

MS MAUD: And what's Neville – what kind of person is he?

MS KING: He's one of those people who's a once in a lifetime person. Well - - -

MS MAUD: Take your time, and take a deep breath.

MS KING: He's shy. He's gentle. He hardly ever boasts or shows ego. He's one of the highest achievers I've ever observed. He's written six books and hundreds of articles. He established the Cognitive Behaviour Change Journal which is a pre-eminent journal still in place worldwide. He helped professionalise psychology in Australia, setting up the Australian Cognitive Behavioural Therapy Association, the Australian Behavioural Modification Association. He has contributed constantly all his life and an incredibly hard worker and a very smart man.

MS MAUD: In 2011 Neville was diagnosed with Huntington's Disease. Had he, in fact, been displaying symptoms - - -

MS KING: Yes.

MS MAUD: - - - earlier than that?

MS KING: From the mid-1990s, I was aware that something was wrong. I knew it was neurological, but I didn't have the skills because it wasn't my area. But I could see this gradual decline occurring. And we went to a multitude of doctors and had a multitude of tests which all came back as normal. However, in 2011 in Victoria at the Alfred Hospital they looked at all those tests and it was very clearly Huntington's. It's an awful disease and the radiologists didn't recognise the disease on the MRIs, so it had been there all along.

MS MAUD: Before his diagnosis you had, in fact, been his carer at home full time from about 2008?

MS KING: Mmm.

MS MAUD: At the time that he was diagnosed in 2011, just briefly, what were the symptoms that Neville was displaying?

MS KING: In 2011, he had – can I go back a couple of years? He was increasingly unable to perform the activities of daily living. He was unable to contemplate outcomes of his behaviour. He paid Stonnington Council rates four years in advance and hadn't paid rates in other areas. When I took over the finances I was astonished to see the mess that they had got into. He tried really hard to hold on, to function as normally as possible, and it was apparent that it was getting harder and harder. In 2011 he had what we call a nervous breakdown. He became obsessive compulsive, paranoid. He thought the police were chasing him for a fine where he had gone down a one-way street from 10 years previously. He didn't have enough white socks. I had to get all the socks out and show him he had 24 pairs of white socks.

And there were a series of things that just kept escalating and he was in a state of high distress. If I was driving somewhere I had to put the child lock on the car because he would try and get out of the car at 100 kilometres an hour. And I was taking him to different doctors who were diagnosing him with just anxiety, and it was very clear that it wasn't just anxiety. So that's when I made the contact with Alfred Hospital and we went up north.

MS MAUD: So after he was diagnosed, what were the strategies that you used to manage the symptoms of his disease when you were caring for him at home?

MS KING: We were using the same strategies. We'd talked about it because we've both got a health background. Using his cognitive behaviour therapy to modify his behaviour and his responses socially, because the disinhibition was increasing as he wasn't medicated at that time. We used a neuroplastic approach, use it or lose it, and people with Huntington's and neurodegenerative diseases need to be able to keep as active as possible. It keeps their muscles strong, it keeps their blood flowing, it oxygenates their brain. It gives them something to do in a situation that's fairly uncontrollable and just it's psychologically positive to keep working at being the best you can be.

He does daily – still does daily brain training using the Lumosity, he does daily speech and swallowing therapy using his iPad Lingraphica app – and thank you Launceston General Hospital for their speech pathology, and wonderful support. So that helps him with his swallowing. It helps him with his speech. It helps him with his walking. It helps him be the best he can be under the circumstances.

MS MAUD: In 2016 Neville suffered a heart attack.

MS KING: Yes, massive.

MS MAUD: And in 2017 you had some health issues of your own which made it difficult for you to continue caring for Neville at home. So in November 2017 you decided it would be necessary for Neville to move into permanent care.

MS KING: I had had two serious – two major operations and I will say what they are. I had a hip replacement, and then I had cancer and – I had three cancers which required massive surgery and it became harder and harder to look after Neville. He was going in and out of nursing homes during my hospitalisation and I was bringing him home after surgery, and I just wasn't physically well enough. I didn't have enough time to recover. So we started to talk about my health decline which often happens to carers; they just get worn out and these diseases emerge. And we started talking. We'd started doing respite care at different facilities around Launceston to try and locate the better or a better facility that he could go into.

MS MAUD: And from 17 July 2018 Neville moved into Glenara Lakes - - -

MS KING: Yes.

MS MAUD: - - - as a permanent resident. What were his health and care needs at that time?

MS KING: He was reasonably good. In May he had been able to walk up to Governor Warner to receive his award at Parliament House, albeit with the help of our grandchildren. He was so proud. He was very orientated. He was able to feed himself, dress himself, walk with assistance. He was reasonably high-functioning.

MS MAUD: Was he continent?

MS KING: He was continent most of the time. One of the things that happens with Huntington's and a lot of the neurodegenerative conditions is that you lose the continence ability. And it happens to a lot of older people with illness, not just with the neurodegenerative diseases. It's far more common than people realise. With a toileting regime at home he was continent. I would toilet him after meals, an hour after meals, like you do when you've got children; it's exactly the same thing. We would use incontinence pull ups, just in case. They rarely were used. So he was good.

MS MAUD: And in the first few weeks after his admission to Glenara Lakes, how often were you visiting?

MS KING: Fairly often. I had had a fall and did a compound fracture to my knee and injured my spine in the May of 2018. So it was – I was in pain back then, but I was visiting as often as possible. Several times a week, four, maybe five times a week.

MS MAUD: And has that continued? Is that roughly how often you visit?

MS KING: No, I haven't been able to. The spinal injury worsened over time, and the vertebra was pressing into my spinal cord and I was gradually paralysing from the waist down and I had surgery in June this year to rectify that. So I haven't been

able to walk properly for 12 months, and now I can walk really well and I'm a centimetre taller.

MS MAUD: How often are you visiting Neville now?

MS KING: I've had this recurrent chest infection so once or twice a week when possible. I live 55 minutes from the nursing home. I would like it to be more often. If I could I'd like to be there every day to make sure he gets the fluids and that sort of thing but that's not physically possible at this point in time.

MS MAUD: Okay. When Neville was first admitted to Glenara Lakes, were you involved in the preparation of a care plan for him?

MS KING: I had a discussion on the night of admission with a registered nurse, and she took a lot of information, but that was the extent of it. I never saw the care plan. When I asked to see it a few months ago it didn't have any of the information regarding Neville's specific needs.

MS MAUD: Following his admission to Glenara Lakes have you been able to take Neville on regular outings?

MS KING: I've tried to. He has – because his medications weren't being administered in the right dose at the right time he had difficulty getting in and out of my car, and because of my back injury I couldn't manoeuvre him into the vehicle. And some of the staff thought that they weren't allowed to come out to the car to help put him into the vehicle.

MS MAUD: Okay. I just want to stop you there, Judith. The outings that you have taken Neville on, what are they?

MS KING: We go out for a drive. We've always loved going driving together and Tasmania is such a beautiful place so there's plenty to see. In earlier times, we would go to a bakery and have a coffee and a bun, but I can't get him out of the car.

MS MAUD: Are there regular outings that you go on?

MS KING: Not as regular as I would like.

MS MAUD: Okay. Do you have a regular or semi-regular Wednesday activity?

MS KING: Yes.

MS MAUD: What's that?

MS KING: Yes, we go to Film Society – Launceston Film Society on Wednesdays, not when it's subtitled because he can't read the subtitles anymore. And the support of the Launceston Film Society has been fantastic.

MS MAUD: So to enable you to take Neville on those regular outings, were there arrangements that you put in place with staff at Glenara Lakes?

MS KING: Every week I had to repeat the same thing, every week for a year. I would organise the maxi taxi for pick-up and drop-off. He needed to have his medications – diazepam and Seroquel – prior to going out. It calmed him down. People with Huntington's get overload, and that can cause all sorts of excitable behaviours. And in the exciting part of the movie the last thing you need is someone in the back row to yell out "Shoot the person." So we had to make sure he had the meds and when he received his medication it was fine, it was a really positive experience. We've just resumed going to the movies and he's had a great time out.

MS MAUD: Okay. In that period shortly after his first admission to Glenara Lakes, were there any changes in Neville's health that you observed?

MS KING: Yes. We anticipated – Neville and I discussed what we thought would happen because he was very with it. He anticipated that he would have a reaction to leaving home, being in a strange place with people he didn't know, because he's so shy, and he does have an underlying anxiety which he's always controlled. We anticipated that the Huntington's may flare because of the changed environment but it would only be a temporary situation. But within two weeks, he was not walking properly. He was agitated; he couldn't look at you in the eyes. He – the whole thing. He wasn't able to hold his attention. His memory was compromised. And it was alarming.

MS MAUD: And, being alarming, did you raise that with staff at Glenara Lakes?

MS KING: I did.

MS MAUD: Who did you raise it with?

MS KING: I raised it with everybody, everybody I could speak to, the carers, the registered nurses and the facility managers.

MS MAUD: And what specifically were the issues that you raised and how were they addressed?

MS KING: Well, I spoke about his declining gait. At home he had done daily treadmill and he would every day walk 150 metres down to the – unaccompanied to the letterbox and with no falls, nothing. And I asked that he have physio. And he did have that for a short period of time, but it wasn't consistent. And the treadmill fell by the bye. So it went down from two times a week to one time a week to nothing. I spoke about his declining cognitive function. I wasn't getting anywhere. And that's when I started contacting the GP and medical specialists.

MS MAUD: Was Neville still walking around the facility once he was living at Glenara Lakes?

MS KING: No. He was when I was there, but it was quicker to put him in a wheelchair for the staff to move him around. And that's still happening. He's a man who can walk, who enjoys walking, but he doesn't have the option to walk.

MS MAUD: Was that something that you discussed with staff?

MS KING: Over and over constantly.

MS MAUD: And what were you told in response when you raised that issue?

MS KING: That he was an increasing falls risk. If they'd listened and not overloaded him – he can walk holding onto your index finger. If somebody's on this side putting their hands around him or rubbing him on the back or doing things behind him, it's distracting and that increases his risk. I can walk him to the dining room now. I did it late last week.

MS MAUD: These occasions when you were raising these issue, was staff at Glenara – was that in conversations – is that how you raised the issues?

MS KING: When I saw them automatically coming in to put him into the wheelchair, the carers, I would speak to them and say, "Neville is able to walk. Could you please walk him to the dining room." Some would, some wouldn't. I think they had instructions that they had to have two people to walk him. And they were worried about falls. And this is me surmising, because no one actually told me that. So they were putting him into the wheelchair. He hasn't fallen when I'm walking him to the dining room.

MS MAUD: You said that you had also raised concern about these issue with the facility manager. How did you raise those concerns?

MS KING: In writing and meeting with the facility managers.

MS MAUD: Was there a particular way suggested to you how you should go about raising issues?

MS KING: Yes. The first facility manager, who's here today, was great. She suggested a communication book, that I buy a book, and that I write those things in. And she also suggested that I put signs around his room and in the bathroom, which I did. And I wondered if there were too many and I checked and they said, "No. That's fine." But they were ignored.

MS MAUD: Are you aware of the use of compliments and complaints forms at Glenara Lakes?

MS KING: Yes. There's a tiny little form with about eight lines on it. And I did fill that in on multiple occasions, but I didn't get a response using that. I found it more effective to do an email or a letter.

MS MAUD: All right. Now, I want to take you to the 15th of August last year, an occasion when you arranged to take Neville out. Can you recall how Neville was when you arrived at Glenara Lakes on that day?

MS KING: I don't have that up there, so I just need to look.

MS MAUD: It's paragraph – you deal with this day on – in paragraph 38.

MS KING: 38. We were going to the Film Society. Every time we were going to Film Society, I would make five to six phone calls every week to try to get them to have him ready. There is, and there continues to be, a breakdown in communication in the nursing-carer handovers. And I don't know what they've got on the care plans about his outings, but he was wet, he wasn't dressed. I was getting feedback from the maxi taxi company that was causing problems, because he wasn't ready to go. And they're – they don't have enough maxi taxis as is, so having delays of up to 15 minutes to half an hour was a problem for them.

MS MAUD: Okay. I just want to ask you, on this particular outing, how Neville was in terms of his behaviour.

MS KING: He was really agitated, he was disinhibited, he was uncooperative. I was trying to get him into the toilet at the cinema and it was impossible to get him to cooperate. And that's not him. That's a sign of him not having had his medication.

MS MAUD: And so did you discuss that with staff at Glenara when you .....

MS KING: Yes, as soon as we got back. I spoke to the registered nurse on duty and I was assured that that nurse had given him those medications at 4.30 and he had done it personally. And I said to him, "Well, that's interesting, because I took Neville out at 3. He wasn't there. And the drugs were signed for. The drugs have not been administered."

MS MAUD: So this issue of administering the medication, were there strategies that Glenara Lakes developed to ensure that happened when required?

MS KING: There were efforts on multiple occasions to see that that occurred. One clinical care coordinator highlighted things in yellow. It didn't change the behaviour of the delivery of the drugs. I believe that there were discussions in nursing handover about proper giving of medications, but I think it's something you need to ask the staff just what strategies they tried to put in place, because it didn't bring about the change that was needed.

MS MAUD: Okay. In – at the end of August last year, you and Neville went on a holiday to Queensland. How was Neville's health while you were away?

MS KING: It was fantastic. It was the last thing on his bucket list; he wanted to see whales. And there were thousands of white caps out there on the boat that day

and he thought every single one was a whale and we just let him. When he yelled loudly that there were whales coming to hit the boat, we thought – and then we turned sideways and there were two huge humpbacks coming straight at us. Luckily, they dived. He was great. I had two young women from Launceston come with us to give me a hand, because my back was really bad by this stage. And he was able to walk; he was able to talk. We were able to go to restaurants and have meals. He loves Japanese food. He coped with all of that. He had a wonderful time, and so did I.

MS MAUD: And when Neville returned to Glenara Lakes, how was his health?

MS KING: He got out of the taxi, he had a soft plush toy humpback whale. He walked into the facility saying, "Whale. Whale. Whale." And all the other residents who had been excited about him going on the trip, because everybody was there as we were leaving, they were all excited when he came back. He walked back in and he shared his experience verbally with everybody. And the excitement was palpable. It was wonderful.

MS MAUD: And did he continue in that way?

MS KING: No. Within a week he was back to not being able to walk or talk clearly.

MS MAUD: Okay.

MS KING: He had declined quite dramatically.

MS MAUD: On the 2nd of October last year, you emailed Richard Sadek, the CEO of Southern Cross Care. Why did you do that?

MS KING: There had been so many ongoing issues. And it's so tiring having to go you through the same thing multiple times every week with no change. It became very apparent that Neville wasn't receiving the medications in the right way. There is a drug called pradaxa, which is a blood thinner. And when Neville had his heart attack, he's got a four-centimetre clot in his left ventricle. Now, the left ventricle's just that little tiny part. If you do that with your fist and divide your hand into quarters, the left ventricle's just that small part. And that had a four-centimetre clot, which had the capacity to flick off and cause a stroke.

It's absolutely essential that he had the pradaxa given in the right way. Pradaxa has to be taken out of the foil and given immediately, because it deteriorates very rapidly. On the instruction of the clinical care coordinator, the pharmacist that makes up the Webster packs had been removing the pradaxa from the foil for at least one week in advance, so the drug was not working, could not work. And I was told one week or two weeks in advance. So he was being given an anticoagulant drug that couldn't function. And it increased the risk of him having a stroke greatly.

MS MAUD: So was that an issue that you raised in your email to Mr Sadek?

MS KING: Yes. Yes. Yes. But I had raised it with the nursing staff prior to that. I had raised it with the facility manager. I had raised my concerns and there had been no change. It was just by the bye when I rang the chemist to check on an account. I asked the question about the pradaxa and the full story came out.

MS MAUD: Was that the first time that you had sought to raise an issue beyond the level of the facility manager?

MS KING: Yes.

MS MAUD: Okay.

MS KING: Only because I'd failed. I wasn't progressing. I tried really hard to progress it in the facility, but nothing was changing. So – and Neville's health was being compromised, so I took it to the next level.

MS MAUD: Did you receive a response from Mr Sadek?

MS KING: Yes. He was going on holiday.

MS MAUD: Okay. Was there further follow-up after your email?

MS KING: There was a meeting in January.

MS MAUD: Okay.

MS KING: And I had raised concerns about the process of the medication giving and there were – there appeared to be changes in the organisation. I don't know what action had actually occurred in response to my letter. There was no feedback from that. And then I had the meeting with Mr Sadek in January.

MS MAUD: And who attended that meeting in addition to you and Mr Sadek?

MS KING: I can't remember who the facility manager was at that time, because there had been four in a 12-month period. So I honestly can't remember which manager was there. But Mr Sadek did most of the talking.

MS MAUD: And, just briefly, what were the issues that you were raising?

MS KING: The massive loss of my husband's property, the breaking of my husband's property, the disappearance of his nearly $6000 hearing aid, the breaking of his spectacles, the loss of about $1000 worth – damage to about $1000 worth of clothing. And I was told – I asked about the duty of care to resident's properties. And I was told by Mr Sadek and I was astonished when he said they didn't have a duty of care, because these were residents. Duty of care rested with patients only and

that Tasmania was not a signatory to the national duty of care document. I've never heard of the national duty of care document.

MS MAUD: What was the outcome from the meeting?

MS KING: Mr Sadek agreed that he would do me a favour and pay to repair a clay statue that Neville bought when he was courting me, if the cost was reasonable. Well, the cost was not reasonable. It's very expensive, so it's broken at home. And there's really no outcome. I was sent a page of a handbook that had supposedly been written in January 2019. It was a handbook I had never seen, saying that they had no responsibility for resident property.

MS MAUD: Did Mr Sadek also say that he would pass on the notes of the meeting to the executive manager of clinical services and also the executive manager of home care and residential services?

MS KING: He did. I didn't know who they were and I didn't hear from them.

MS MAUD: You didn't hear from them?

MS KING: No. And it was a comprehensive dated time document. It was chronological. I would get very thorough notes.

MS MAUD: Okay. Now, you said that when Neville first was admitted to Glenara Lakes he was continent. By January this year, was that still the case?

MS KING: No. When he first got there and he had the pull-up pants, he was told not to worry about the toilet, because he was wearing pull ups. And it was alarming. And it was said in such a casual way, that that was just normal practice. That's why I started keeping paper towels, because I knew that there were problems with care. And the quality of the care depended on the staff that were on duty at that time, as with every organisation. Some of the carers are fantastic, and they are still fantastic. Others should not be involved in the aged care industry, unless they can improve their practice.

MS MAUD: Have you raised issues in relation to the management of Neville's continence with management at Glenara Lakes?

MS KING: Absolutely. I asked about toileting regimes. I spoke about what we had done at home. It was really bothering Neville. You know, nobody would choose to be incontinent because they can't get to the bathroom. And to have that ability taken from you when you're aware, it's horrible. It's just one of the many things that crushed people when they go into care processes.

MS MAUD: As a result of raising these issues, were there strategies developed to manage the issues?

MS KING: There were. And I think the facility managers that tried to do it. They brought in toileting plans, going to the toilet regularly. They tried to have the right types of pull ups, because there are meant to be pull-up incontinence aids in each room; I think it's the night staff are meant to put out. More often than not those were empty. And whilst the toileting plans were introduced, they weren't followed.

MS MAUD: Okay.

MS KING: Or again, depending on which staff member was on, they weren't followed.

MS MAUD: I want to ask you now about February this year. Neville had an appointment with Dr Gleason who's his treating neuropsychiatrist.

MS KING: Yes.

MS MAUD: What was the reason for that appointment?

MS KING: Fortunately, Neville's specialist – previous Huntington's specialist had committed suicide in 2016. So from 2016 until then, there were no specialists in Huntington's in northern Tasmania, so we were floating free and frightened during that period. Dr Gleason came down from Melbourne, and he's a fabulous doctor. He – Neville was showing delirium, and it was out of character. It was sudden onset and his condition had deteriorated quite rapidly. I had asked the staff - - -

MS MAUD: I just want to stop you there. When you say he was showing delirium, can you explain what that means.

MS KING: Okay. He was getting on the bed on all-fours and yelling. He would be standing on his bed. They had to put the bed futon-like on the floor. He was unable to keep your eyes, he couldn't pay attention to a conversation. He was disorientated in time and place. He was agitated and anxious. He was somebody in a lot of discomfort.

MS MAUD: And you said that that had come on suddenly.

MS KING: Sudden.

MS MAUD: Did Dr Gleason identify a reason why that - - -

MS KING: He did a really thorough examination. When you see a good doctor doing a great examination of a human being it's something to behold.

MS MAUD: What was the cause that he identified?

MS KING: He identified acute delirium due to acute dehydration, and I was stunned that that could happen because that's negligence at the nursing home.

MS MAUD: Did Dr Gleason recommend changes to his care?

MS KING: Absolutely. He considered writing water on the drug chart so that the registered nurse on duty would have to be accountable to check that the water was given. I said, "Can I have a look at it?" I spoke to the catering manager to get three drinks at breakfast, lunch and dinner and that would give him 1800 mils, and then with the other cups of tea and fluid, he should have got up to two and a half litres, if the fluid had been administered. So there was a strategy in place. It's just the staff didn't implement it.

MS MAUD: Did Dr Gleason recommend that there be a fluid chart kept?

MS KING: Yes. He asked for a fluid input chart, not an output chart. It took 11 days with me haranguing management as to why the chart hadn't been started because Neville was still delirious. I was going in every day because he was desperately thirsty. And by the time that I would get in there, it would be 4, 5 o'clock; I would give him up to a litre or a litre and a half because the fluid chart wasn't completed. Carers would tell me that they would fill it in at the end of a shift; and that's not how you do fluid charts. You administer the fluid and you document the fluid once it's been administered. You don't do it at the end of the shift because you've got so many different people that you're looking after it's inaccurate. So they were doing the chart in order to have the chart filled, not to give the resident the fluid that they required.

MS MAUD: Did you raise a concern about that with staff at Glenara Lakes?

MS KING: I did, and I still am.

MS MAUD: Who did you raise that with?

MS KING: With the carer coming in. You know, one day I got there and there were four cups of tea sitting out on the hand rail outside Neville's room. He's not allowed to drink fluids unsupervised because he chokes. There was a litre of fluid. It was a day's worth of his cups of tea. They were all cold, he hadn't had them but they were all recorded on the fluid chart. I raised it with the registered nurses on duty, I raised it with the clinical care coordinator, I raised it with facility management, and I put it in writing to the facility manager.

MS MAUD: On those occasions when you raised that issue, what was the response?

MS KING: I was always reassured it would be addressed.

MS MAUD: And was it?

MS KING: No. I think they were – if I can qualify that, I think there was a genuine desire at the facility manager level to address it. It was just that there's a culture in

the system of – it's a custodial dementia care model from 50 years ago: feed them, change them when they're wet. That was really the care that was being given.

MS MAUD: All right. Now, I want to take you to 6 October this year. Is that Neville's birthday?

MS KING: It was.

MS MAUD: Yes. Did you take him out for his birthday?

MS KING: Yes. I was post op a couple of months and, again, I – I wasn't allowed to twist or turn or put him into the car. I arranged with the current facility manager, and she's a very kind person, to have help getting Neville into the car and we set off on our adventure. So Neville had a great time. But the stench of urine in the car was shocking. We got over to Evandale market and I was getting him a coffee and I had to have all the windows in the car open because the smell was so strong. I checked; all his clothes were dry, his pull-up was dry, so this was stale residual urine on his skin.

MS MAUD: When you took Neville back to Glenara Lakes did you speak to staff about that?

MS KING: I spoke to the registered nurse on duty and I spoke to the four carers who all acknowledged the smell, and they said, "We're sorry." And they took Neville into the bathroom and did hygiene, gave him a wash, used one of his lovely scents. He really likes to smell nice, and changed his clothes. By the time we got back to Glenara his pull up was wet. But it was fresh urine, it wasn't the stale stench that had been present earlier.

MS MAUD: Did you also raise the issue with the facility manager?

MS BENNETT: I did. I wrote to her that night.

MS MAUD: What was the response?

MS KING: I received what I felt was an upsetting email. She had spoken to all of the staff concerned who denied that I had raised it with them, and they denied that the issue had occurred. And I said to the facility manager, "You have a major issue here where your staff are not telling you the truth, and they're not delivering the care that's meant – that you want delivered". So the challenge is there for management to create that path where staff know what their duty of care is to the residents and if something goes wrong, they identify it so it can be looked at as an issue and looked at on how to improve it, rather than denying it.

MS MAUD: Did the facility manager respond?

MS KING: Yes. I went and saw her personally, and said I was distressed that my integrity was being questioned by the statements that she had put in that the incident had not occurred. And also I expressed my distress at the suggestion that I move Neville to another nursing home.

MS MAUD: When was that suggestion made?

MS KING: It's been made on multiple occasions by different managers, and it's an intimidating statement. And it's disappointing because it's a failure to address the issues that are occurring and, as a family member, as his advocate, I wanted them to address those issues. Each one is not a major issue; if it was fixed everything would be fine, and they're basic care needs for everybody. So it's astonishing that it just wasn't addressed and still is a problem.

MS MAUD: Did the facility manager also suggest that there be a meeting with the area manager?

MS KING: Yes.

MS MAUD: Was that something that you were interested in doing?

MS KING: No. This is local care needs and it should be managed within the facility. I felt each time they wanted to bring in the area manager – and couple of them are, with respect, were dragons. I shouldn't say that, but they were. They were brought in to intimidate, and I just sat there and thought this is wrong. And I wasn't going to engage in that, and I said to the current facility manager, "You would be better to use that time with your area manager to work out how to get your staff to tell you the truth and to put in systems to ensure that the residents do get good care and that when you get relative feedback it's seen as an opportunity to improve the care, rather than an adversarial situation".

MS MAUD: Judith, what motivated you to make a statement to the Royal Commission?

MS KING: I've been very sick; I don't know if I will outlive my husband. We're a little family of two. Neville won't have an advocate if I'm gone. And I'm so disappointed that people in aged care are being treated in this manner. I thought by making a statement for the greater good – because this is very hard to do – hopefully we'll be able to change the situation, not only for my husband but for all of us, everybody in this room, because we're all going to face the same situation. So I really hope that the Royal Commission in its report is regarded by the – whoever is in government and that these changes can occur.

It's a systemic failure and it's a toxic culture, and it's Australia-wide. You know, 92 per cent of people are saying in the ABC Australia Talks survey that they don't want to go to nursing homes. So – and all of my friends are saying, we don't want to go to

nursing homes, we would rather take our life into our own hands and on that last day finish it as appropriately as possible.

MS MAUD: Thanks, Judith. I have no further questions for this witness, Commissioners.

MS KING: Thank you very much.

COMMISSIONER PAGONE: Ms King, thank you very much for coming to give your evidence. It's a distressing story. Unfortunately, it's a distressing story that we hear more often than we should be hearing, but you've been very courageous in coming forward as you have. We thank you for doing that. It's important that the Commission hears it and that the community as a whole hears it. Thank you.

MS KING: Thank you. Can I just say one thing: 40 years ago when I was doing agency nursing, I would go out to nursing homes in Melbourne and I saw the same thing happening there. And it was worse – even worse then. So we're slow learners and hopefully now there will be a positive change.

COMMISSIONER PAGONE: We need to do better.

MS KING: We do.

COMMISSIONER PAGONE: Thank you.

MS KING: Thank you very much.

MS MAUD: If Ms King could be excused, Commissioner.

COMMISSIONER PAGONE: Yes. Thank you. You're excused from further attendance.

MS KING: Thank you very much.

<THE WITNESS WITHDREW [10.41 am]

COMMISSIONER PAGONE: Mr Knowles.

MR KNOWLES: Thank you, Commissioners. The next witness is – sorry.

MR PHILLIPS: If your Honour will – if the Commission pleases, my name is Phillips. I seek leave to appear on behalf of Helen Marshall who was a former facility manager of Glenara Lakes.

COMMISSIONER PAGONE: Yes. Thank you. There's no objection to that, I assume.

MR KNOWLES: No.

COMMISSIONER PAGONE: Thank you, Mr Phillips.

MR KNOWLES: Thank you Commissioners. The next witness is Mr Peter Williams, if he could be called to the stand.

<PETER GRAHAM WILLIAMS, SWORN [10.42 am]

<EXAMINATION BY MR KNOWLES

COMMISSIONER PAGONE: Yes. Thank you. Mr Knowles.

MR KNOWLES: Mr Williams, can you tell the Commissioners your full name for the transcript.

MR WILLIAMS: It's Peter Graham Williams.

MR KNOWLES: Thank you. And you've prepared a statement for the Royal Commission.

MR WILLIAMS: Correct.

MR KNOWLES: Yes. And that's dated 31 October 2019.

MR WILLIAMS: That is correct.

MR KNOWLES: And you see that there is a copy of the first page of that statement on the screen before you.

MR WILLIAMS: Yes.

MR KNOWLES: And that bears the document ID WIT.0609.0001.0001.

MR WILLIAMS: Yes.

MR KNOWLES: Have you read your statement lately?

MR WILLIAMS: Yes, I have.

MR KNOWLES: Thank you. And are there any changes that you wish to make to your statement?

MR WILLIAMS: There are two typographical errors that I would like corrected before it's submitted.

MR KNOWLES: Yes, indeed. And what are they?

MR WILLIAMS: So on paragraph 38 – sorry; paragraph 38. It's in the second line. I've used the word "procures" instead of "procedures".

MR KNOWLES: Yes. So that should be "procedures" instead of "procures".

MR WILLIAMS: Correct.

MR KNOWLES: Yes. And where is the second typographical error?

MR WILLIAMS: And the second is in paragraph 43.

MR KNOWLES: 43.

MR WILLIAMS: It's in the third line. It currently reads "I indicted", but that should read "I indicated".

MR KNOWLES: Are there any other changes you wish to make?

MR WILLIAMS: No.

MR KNOWLES: No. And subject to those changes, are the contents of your statement true and correct to the best of your knowledge and belief?

MR WILLIAMS: Yes.

MR KNOWLES: Thank you. I seek to tender the statement of Mr Williams.

COMMISSIONER PAGONE: Yes, the statement of Mr Williams dated 31 October will be exhibit 13-11.

EXHIBIT #13-11 STATEMENT OF PETER WILLIAMS DATED 31/10/2019 (WIT.0609.0001.0001)

MR KNOWLES: Mr Williams, can you tell the Royal Commission what your current employment position is.

MR WILLIAMS: My current employment position is executive manager, client services at OneCare Aged Care Service here in Tasmania.

MR KNOWLES: And when did you start in that position?

MR WILLIAMS: I started in that position in April this year, 2019.

MR KNOWLES: And what was your work prior to that?

MR WILLIAMS: Prior to that, I was employed as facility manager at Glenara Lakes from the 11th of February 2019 until the 19th of April 2019.

MR KNOWLES: And Glenara Lakes is an aged care facility owned and operated by Southern Cross Care Tasmania.

MR WILLIAMS: Correct.

MR KNOWLES: Yes. And prior to working in that role as a facility manager, can you outline some of the roles that you've had previously that involved work in the fields of clinical governance in aged care and health.

MR WILLIAMS: Sure. The previous role before moving to Tasmania I had was the national director for clinical governance quality and risk for St Vincent's Health Australia, the aged care division. So I was responsible for overseeing three states and 15 aged care homes in the clinical governance space. I've also been director of clinical services - - -

MR KNOWLES: Just pausing there, Mr Williams, how long were you in that role?

MR WILLIAMS: I was in that role from September '17 until January 2019.

MR KNOWLES: And – sorry. I interrupted you. Other roles that have involved clinical governance or quality assessment.

MR WILLIAMS: I have been director of hospital – a private hospital division in Brisbane, clinical director of services at St Vincent's Private Hospital. Also, director of clinical services within the aged care group of St Vincent's in Brisbane. That was from February 2015 to May 2015. I've been a manager governance and education coordinator at St Vincent's Health and Aged Care. And – yes.

MR KNOWLES: Did you also undertake a role as a quality assessor for a period of time in the aged care industry?

MR WILLIAMS: Yes. I was registered as a quality assessor for 12 months.

MR KNOWLES: Yes.

MR WILLIAMS: And also have been registered as an ACHS accreditor with the acute sector for a number of years, as well.

MR KNOWLES: Is it fair to say that you have considerable experience and expertise in clinical governance and quality assessment in health and aged care?

MR WILLIAMS: Yes. I would agree with that.

MR KNOWLES: Now, you worked for 10 weeks as facility manager at Glenara Lakes between February and April 2019.

MR WILLIAMS: Correct.

MR KNOWLES: And prior to taking up that position you were interviewed for the job on a couple of occasions.

MR WILLIAMS: Yes, I was.

MR KNOWLES: And when did those interviews take place?

MR WILLIAMS: I had an original phone interview in the December of 2018, followed up by a face-to-face interview in January 2019 at Glenara Lakes itself.

MR KNOWLES: And when were you notified that you had been successful in your application for the job?

MR WILLIAMS: In – after the January interview. So it was sort of early to mid-January when I was notified of the appointment.

MR KNOWLES: And were you told at that time, or around then, of the procedure that would take place for your orientation into the role?

MR WILLIAMS: Yes. Around then I was provided with an outline of what I would anticipate for an orientation program.

MR KNOWLES: And what was told to you at that time?

MR WILLIAMS: I was advised that I would have two days orientation with Richard Sadek, who was the CEO but acting facility manager at that time, and I would also spend three days in Hobart at the corporate office to understand the corporate system and structures.

MR KNOWLES: You subsequently had an orientation of sorts with Mr Sadek on – was it when you began, the 11th of February - - -

MR WILLIAMS: Correct.

MR KNOWLES: - - - 2019?

MR WILLIAMS: Yes.

MR KNOWLES: Can you describe what, in fact, transpired at that orientation.

MR WILLIAMS: I recall appearing on my first day, going into the facility. Mr Sadek wasn't there at that time, but eventually arrived. We had a meeting in the facility office over a cup of tea and we spoke generally about general information for about two hours, before he left to go back to Hobart. That was the orientation that I had with Mr Sadek on that first day.

MR KNOWLES: Now, you know now and you, subsequent to all of this orientation, found out that Glenara Lakes had been the subject of a serious risk decision in January of 2019.

MR WILLIAMS: Yes.

MR KNOWLES: And that had stemmed from review audit findings that had been made in December of 2018.

MR WILLIAMS: Yes.

MR KNOWLES: When did you first learn of the serious risk decision and the non-compliance that was uncovered in the review audit?

MR WILLIAMS: At no part during the interview process was I advised of their serious risk issues. Certainly on the orientation there was no discussion or disclosure of the extent of which those concerns had been raised. I discovered the issues, really, in my second week of employment, where I saw an email from Carolyn Wallace, who was the executive manager for client services, after she had prepared a continuous improvement plan, which was a requirement to submit to the Commission at the time following the non-compliance issue. So, once I read that, I recognised with my experience that there was, obviously, some serious issues and then sought to find those myself.

MR KNOWLES: And when you mentioned the Commission in that answer, you're referring to the - - -

MR WILLIAMS: Sorry.

MR KNOWLES: - - - Aged Care Quality and Safety Commission?

MR WILLIAMS: Sorry. Yes. The Aged Care Quality Commission, yes.

MR KNOWLES: And do you know why you weren't told of those matters at some earlier point in time?

MR WILLIAMS: I've thought about that a lot. But, to be honest, I can only make an assumption. And the assumption, is knowing it's difficult to recruit industry-experienced people in Tasmania, given the risks that were associated with Glenara Lakes, my assumption is is that the non-disclosure was a way of ensuring that I would take the employment.

MR KNOWLES: How did you actually get a copy of the review audit documentation, as well as the serious risk decision itself?

MR WILLIAMS: I found a report that was provided to the organisation that was sitting within the facility manager's office, but that was not pointed out to me at the orientation with Mr Sadek. I just found that through just searching for the information. But, also, then the email from Carolyn Wallace provided a bit more clarity around that.

MR KNOWLES: Now, during your time at Glenara Lakes, was that non-compliance that was the subject of the review audit and the serious risk decision resolved to the satisfaction of the Aged Care Quality and Safety Commission?

MR WILLIAMS: Yes, it was.

MR KNOWLES: And when was that?

MR WILLIAMS: The resolution came about in March 2019, really, just after a couple of weeks of my appointment working with the clinical care coordinator and myself to actively address those concerns raised and using my expertise to put in fast mechanisms to close the gap.

MR KNOWLES: And, despite having closed the gap, as you put it, did you have any residual concerns about the sustainability of changes that had been made at Glenara Lakes at that time?

MR WILLIAMS: Yes, I did.

MR KNOWLES: Okay. And, in summary, what was the nature of those concerns?

MR WILLIAMS: The concerns revolved around staff education and training for basic care needs, the inadequacies of current policies and procedures to govern clinical practice. The clinical governance structure in of itself was, in my view, lacking. Certainly, the limited HR support that was offered to me to deal with complex issues, HR issues. And the IT systems were also somewhat broken. And they, really, contributed to ongoing concerns.

MR KNOWLES: I will come back to each of those concerns that you've mentioned in a moment, but what did you think would happen if those concerns were not addressed?

MR WILLIAMS: My concerns were that, despite putting in mechanisms to address the existing gaps, those gaps would then reopen again at some point in time, as there were systemic problems. So my view would be that we would continue to see non-compliance with the accreditation standards and poor care delivery.

MR KNOWLES: And had you raised those concerns with people by March of 2019 that you've just set out in summary?

MR WILLIAMS: Yes, I had.

MR KNOWLES: Yes. And who did you raise those concerns with?

MR WILLIAMS: I had raised concerns with Mr Sadek directly on day one, particularly around the staffing structure. I had also raised through a facility manager report a number of issues that I've just disclosed. That was in March. I submitted it in April, but it was all March data.

MR KNOWLES: And did you come to have broader concerns about the clinical governance at Glenara Lakes over time?

MR WILLIAMS: Yes, I did.

MR KNOWLES: Yes. And what were those concerns?

MR WILLIAMS: I guess really simply, in my view, clinical governance is really about having clarity for a joint accountability responsibilities at the carers' level, the facility manager's level, but at a corporate level. There was really limited processes and systems in place that would help provide clarity around how do we govern our business. There was limited information that went from facility up to an executive level. So they were blind in a way. There was really limited information that they could work off that would give them an indicator that there were concerns at the facility level itself.

MR KNOWLES: Now, you said a moment ago that one of the concerns that you expressed related to staff.

MR WILLIAMS: Yes.

MR KNOWLES: And you expressed that on day one - - -

MR WILLIAMS: Correct.

MR KNOWLES: - - - with Mr Sadek. What was that concern? Did it go to numbers of staff?

MR WILLIAMS: Numbers of staff, but the qualifications of staff.

MR KNOWLES: Yes.

MR WILLIAMS: Obviously, coming into the role I wanted to understand the business and recognise that they had a dementia-specific unit, which is complex nursing care. And I was aware on day one that the dementia unit was staffed by a single carer on the night shift looking after 16 dementia-specific residents. That to me was of concern, given the qualifications that carers obtain to come into the aged care setting.

MR KNOWLES: And did you do anything about that during your time as facility manager?

MR WILLIAMS: Yes, I did.

MR KNOWLES: And what was that?

MR WILLIAMS: Essentially, I increased the number of carers who were providing direct care across the entire facility, across every shift, morning, afternoon and night shift. We put additional staff in. I also created the appointment of a clinical nurse, which was unusual, but it provided high level clinical expertise to support the clinical care manager and the registered nurses – better govern what was happening from a clinical perspective. So those additional staff was well and truly above the budgeted numbers that I was allowed to do, but it was raised within the Quality Commission's concerns around HR staffing that I wished to have addressed.

MR KNOWLES: And you say that, but that was one of the expected outcomes - - -

MR WILLIAMS: Yes.

MR KNOWLES: - - - that was found to be not met at the time of the review audit.

MR WILLIAMS: Correct.

MR KNOWLES: And was there any difficulties that you encountered in increasing staff numbers in the way that you describe?

MR WILLIAMS: The difficulties really came back to funding, essentially. The organisation has an annual amount of funds that are provided that you must work within as a facility manager. By putting on additional staff I was overspending on care delivery. And there was a requirement for me to then save money in other areas or to increase my ACFI funding in order to cover the cost.

MR KNOWLES: When you say "a requirement", how was that made clear to you?

MR WILLIAMS: Through the financial support that came from Hobart head office. There's, obviously, monitoring of your financial outcomes. And there was a discussion with me about, you know, managing my costs more appropriately.

MR KNOWLES: Now, you mentioned earlier one of your other areas of concern was the matter of human resources support for you - - -

MR WILLIAMS: Yes.

MR KNOWLES: - - - as facility manager.

MR WILLIAMS: Yes.

MR KNOWLES: Can you just elaborate on why you considered that you required additional or greater support in terms of HR.

MR WILLIAMS: Yes. Within the short time that I was in the facility manager position, I actively managed seven staff issues that were either reportable events with an allegation of elder abuse or inappropriate, you know, bad behaviour from staff. What I found as soon as I raised concerns with staff was staff members would then seek union support. And so a staff member would meet with me and have a union representative, who would often challenge my thinking and decisions to try and lessen, you know, the concern that I was raising. HR is a specialty area in and of itself and I felt unsupported as a facility manager to address the number of issues I was actively trying to manage without having HR support there. It's just a difficult space to sit in. And I felt like I didn't really address the issues appropriately.

MR KNOWLES: When you talk about those matters that were the – was it seven - - -

MR WILLIAMS: Seven.

MR KNOWLES: - - - incidents or issues that arose - - -

MR WILLIAMS: Yes.

MR KNOWLES: - - - in respect of staff?

MR WILLIAMS: Yes.

MR KNOWLES: What did they say to you about the culture that existed at Glenara Lakes?

MR WILLIAMS: I guess it was evident that there was a negative blame culture and that was quantified by, you know, the Better Practice Australia staff survey that was done, and I've mentioned that had in my statement. But I guess - - -

MR KNOWLES: What did that survey show, Mr Williams?

MR WILLIAMS: The survey showed that Glenara Lakes had the worst blame culture of all of the Southern Cross care facilities, and that the staff attitude towards

the organisation executive was extremely negative. They felt unsupported and un – yes, just unsupported.

MR KNOWLES: How might an organisation improve those cultural matters?

MR WILLIAMS: Bottom line, it's leadership. You've got to have appropriate leadership who is contemporary, who is able to have a humanist approach as well. We're dealing with people, and often when staff feel unsupported or undervalued or neglected they generally will, you know, not follow process. So my approach was about people. I walk the floors, I listen to staff, I sat with residents. I had meals with residents. I tried to understand what was going on and having that view, that what you walk past is what you enable. And so I actively had a process of calling out bad behaviour, putting it on the table through an open and transparent process and getting staff to recognise some of these behaviours in and of themselves so that they self-regulated rather than it just coming from top down.

MR KNOWLES: From your experience at Glenara Lakes, and you've just mentioned the issue of leadership, what were your impressions of the leadership of Southern Cross Care Tasmania's senior management and board?

MR WILLIAMS: To be honest, I felt it was extremely lacking in their support and direction. There was very limited contact from the senior executive team apart from the executive manager home care and residential south who was actively trying to cover the State and provide some direction and support because there were roles in the north that were just not filled and they were vacant, which created ongoing concerns from that point of view.

MR KNOWLES: Was that why you were reporting directly to Mr Sadek, the CEO?

MR WILLIAMS: Correct.

MR KNOWLES: So there were vacancies, you say, in that management tier - - -

MR WILLIAMS: Yes.

MR KNOWLES: - - - between him and you.

MR WILLIAMS: Correct.

MR KNOWLES: And was that through the majority of the time that you're a facility manager at Glenara Lakes?

MR WILLIAMS: Yes. The executive manager, home care residential north, north-west was vacant at the time of the interviews that I had, and it was vacant when I resigned from the position. And the executive manager client services had resigned from the position within a couple – two weeks of my appointment. So two key roles,

which is there to provide governance support, quality systems, education, direction was vacant.

MR KNOWLES: Now, moving to another concern that you mentioned earlier, you referred to the IT systems.

MR WILLIAMS: Yes.

MR KNOWLES: Can you just explain to the Commission precisely what you regarded as being problematic in connection with IT at Glenara Lakes?

MR WILLIAMS: Glenara Lakes had a clinical electronic medical records system called Autumn Care. Autumn Care houses every piece of the residents' information and clinical data. That system was well outdated and it was not supported by the vendor because it was so old. It frequently had synchronicity issues, and when I say that, multiple computers across the facility, when a nurse enters information on one computer, it should then appear in all computers and that frequently didn't happen. So information was missing in some computers. Staff and doctors, pharmacist, didn't have the most up to date information and that contributed to, you know, lack of care, lack of decision-making around clinical care needs.

MR KNOWLES: How would you have considered that that situation might be improved?

MR WILLIAMS: I raised my concerns about the synchronicity issues through an email to the IT system, just flagging that there was serious concerns. If you are, as an organisation, going to have an electronic incident management – or an electronic care management system there's a responsibility from an organisational level to ensure that it's up to date, that it's functional and that it's contemporary so that staff on the ground can deliver care and not to have work around a broken system.

MR KNOWLES: Another matter that you raised was clinical governance.

MR WILLIAMS: Yes.

MR KNOWLES: What do you regard as the hallmarks of good clinical governance in the aged care setting?

MR WILLIAMS: Clinical governance, in my view, simply should clearly articulate the joint responsibility and accountabilities of staff on the ground, managers and executives. It would have components of monitoring, so understanding what's going on within the facility, not just looking at clinical but looking at all components of business, financial, clinical, human resources. So understanding what's going on in the business, having a clear mechanism for reporting up to the executive information, and then having a process where the organisational executive are clearly analysing information that's coming to them and then providing direction back down to the facility to give guidance and direction of what should be – should be done.

MR KNOWLES: Just pausing there, what mechanisms were you aware of at Glenara Lakes to provide that information up the executive managerial chain?

MR WILLIAMS: There was an annual audit program so QPS Benchmarking was the system used to do audits at the facility level. Those audits were – data was inputted by myself and the care manager and provided back up to the organisation executive. There was a facility manager report of sorts, although I have to say the structure wasn't really clearly defined so I added what I thought was appropriate that executives should know about. There were policies and procedures, albeit limited and some of them clearly out of date. Yes.

MR KNOWLES: In terms of the QPS reports.

MR WILLIAMS: Yes.

MR KNOWLES: What did you actually see as to the results of the audits that were undertaken in that regard?

MR WILLIAMS: So in the short time that I was there, some of the audits was around, for example, documentation, medication management. So we would scan resident files and we would, you know, add a score based on the questions that were provided. I know that a number of the results that we submitted at the time were inadequate, we got low results. But at no point after I submitted that information did I receive anything back to give me guidance. In some of the evidence I have submitted the facility manager report for the March period, I did identify in that report that there were issues of concern and that it was – I took the liberty of ensuring that they were included in the quality improvement plan to address those concerns, but that was my expertise and knowledge knowing we've got to address them. There was nothing that came from the organisation itself.

MR KNOWLES: In terms of what you were aware of as being an apparent deficiency highlighted in the QPS reports - - -

MR WILLIAMS: Yes.

MR KNOWLES: - - - did you ever hear anything back from management above you as to what might be done or to ask for further information from you in that regard?

MR WILLIAMS: No, there was nothing.

MR KNOWLES: What would you have expected?

MR WILLIAMS: I would have expected at a corporate level a clinical governance committee would have reviewed the information the audit results coming from not only Glenara Lakes but all of the Southern Cross Care facilities, analysing what was presented so that the organisation in and of itself knew where the deficits were and

then, you know, clear direction about what needed to be improved. But given the fact that the executive manager client services position was vacant, given the fact that the executive manager home care north, north-west was vacant, I don't believe that that was actually happening during – during the time I was appointed, which again led me to believe that there was a failure of the governance processes to ensure that they were robust.

MR KNOWLES: One of the things you mentioned earlier as a hallmark of clinical governance was policies and procedures.

MR WILLIAMS: Yes.

MR KNOWLES: What did you see in that regard at Glenara Lakes?

MR WILLIAMS: Where the policies were housed on the local intranet it was difficult to navigate. Often things that I was searching for that might be something like catheter management, there was no policy that I could find. I know that Southern Cross Care did subscribe to Joanna Briggs Institute which is a nurse-led evidence-based program where you can log on and look at what the best evidence is, but that was also out of date. I think it was last updated in 2015. So my experience told me that this didn't contain the most contemporary and up to date information around clinical practice so it was difficult to then deliver appropriate care if I was trying to update a policy or change the way I wanted staff to operate.

MR KNOWLES: You ultimately left Glenara Lakes in April of 2019.

MR WILLIAMS: Yes.

MR KNOWLES: Why did you leave the position of facility manager there?

MR WILLIAMS: I guess within the short time that I was the facility manager, I – it was evident to me that the industry experience and knowledge that I was bringing to a home that needed expert support, I was just not able to influence the executive or the organisation to fix the gaps in governance and systems that were clearly evident to me. I'd come to the role as a national executive where I could influence a board, I could influence the executive and change practice, and as a facility manager I was not in a position to do that and I guess I could look up and see that things were not going to change. And I took on a role then in another aged care provider who I've been fortunate enough to be able to use my expertise in the way that I've built my career around. I want to be able to change the industry in a positive way, and I didn't feel like I would ever have that opportunity within Southern Cross.

MR KNOWLES: I have no further questions for Mr Williams.

COMMISSIONER PAGONE: Mr Williams, I just want to ask you one question if I may about the governance matters that you've raised. Obviously, organisations have different ways of dealing with governance and partly they involve evaluating and

identifying or identifying and then evaluating risks, so that sometimes some organisations have a risk management committee. Now, you've talked about a clinical governance committee which in a sense is a subset or a targeted aspect of that. And I understand that and I can see its great value. What would you recommend, not necessarily for an organisation like Southern Care, but for much smaller facilities, possibly in remote areas, where access to the people that have a clinical governance committee would be a difficult thing to achieve?

MR WILLIAMS: Yes. I do believe that there are core principles of monitoring processes, whether you're a large or a small organisation, that could be framed as part of, you know, the provision of aged care in and of itself. If we clearly define at a facility level what information you want to be monitoring or what should be monitored, even if you don't have a risk committee or a clinical governance committee, you would still have an executive manager of some descriptor or a CEO that could still monitor progress at that grass roots level. So I think it's just simply having a template of what information should be monitored on a weekly, daily, monthly perspective to provide an insight into what's going on operationally.

COMMISSIONER PAGONE: This may be a difficult question, and you should feel free to say that you don't feel comfortable to answer it, but when you began to address the problem, the clinical problems by increasing staff - - -

MR WILLIAMS: Yes.

COMMISSIONER PAGONE: - - - and you were told that's all good and well but actually you've got to reduce costs, how – I mean, presumably you can see the need for a balance between the care that's needed and the available funds to pay for it.

MR WILLIAMS: Yes.

COMMISSIONER PAGONE: What do you think ought to be done in those circumstances, if I can put it as vaguely as that?

MR WILLIAMS: Yes, look, I do agree there is a balance and we have limited funds and I understand that. But I guess when you balance that up against the risk of a sanction and the cost to an organisation to go through that process, having additional staff for a period of time, in my view, to ensure that safe care is provided and you re-establish clinical systems is appropriate. I don't know that there's an easy answer because simply increasing the funds to an aged care home or increasing staff doesn't necessarily equate to good care.

COMMISSIONER PAGONE: No.

MR WILLIAMS: It's a combination of increased funds and staffing associated with appropriate education and training, associated with appropriate monitoring, you know, for all staff because carers who make up the bulk of our employees, 80 per cent of our employees, are not registered, as we know, with any authority. So a carer

who delivers bad care and is terminated from one organisation can just simply walk to the facility down the road and be employed and there's no awareness of those issues. So I think it's a broader – a broader issue, broader than just funding.

COMMISSIONER PAGONE: All right. Well, you talked also about the importance of leadership.

MR WILLIAMS: Yes.

COMMISSIONER PAGONE: And the examples that you gave were – I don't wish to understate their importance, but they were homely in some respects. Examples of leadership that you gave included things like walking down the corridors, talking to people, having lunch with the people, listening to people. These are often things that are part of a person's personality. It's difficult to prescribe or regulate or mandate them. As a systems issue, how does one deal with that? Or more particularly, let me put it differently - - -

MR WILLIAMS: Yes.

COMMISSIONER PAGONE: - - - you in your role as a leader, how would you help us, as the role of those who need to make recommendations about systems, deal with that?

MR WILLIAMS: It's a really good point because I think for most of my career I've been told as an industry leader that I'm too soft. I'm emotionally intelligent, but I'm not strong enough to change culture and I disagree with that wholeheartedly. We work in a human industry, and so therefore you've got to have a human connection, you've got to have emotional intelligence. I do think there's got to be better scrutiny over the appointment processes of those who go into a facility manager role or above that. You cannot do a facility manager role from behind a desk.

That disconnects you from the operations and you lose touch with reality. Just from a systems perspective, you know, a lot of nurses will be moved up into a management role but they're not necessarily good managers, they're good clinicians. And I think there's got to be a lot of work done around the appointment process, orientation and even the training that really sits within these roles.

Facility managers role are critical to the success of a business and when you get a good facility manager you know that you're going to have good outcomes, but how do you make that decision. That's really the question. It's a hard one to qualify.

COMMISSIONER PAGONE: So what's the answer to give us?

MR WILLIAMS: The answer would be probably better scrutiny around the recruitment of the qualifications people hold and almost aptitude testing for whether someone is appropriate for a facility manager role or not.

COMMISSIONER PAGONE: Thank you. Thank you, Mr Williams. You've been very helpful.

MR WILLIAMS: Thank you.

MR KNOWLES: Nothing further from me.

COMMISSIONER PAGONE: Mr Williams, you are excused from further attendance.

MR WILLIAMS: Thank you.

<THE WITNESS WITHDREW [11.17 am]

COMMISSIONER PAGONE: Mr Knowles, we will have a 10-minute break at this stage.

MR KNOWLES: If the Commission pleases.

ADJOURNED [11.18 am]

RESUMED [11.30 am]

COMMISSIONER PAGONE: Yes. Mr Knowles.

MR KNOWLES: I call the next witness, Ms Helen Marshall.

<HELEN MARY MARSHALL, SWORN [11.31 am]

<EXAMINATION BY MR KNOWLES

COMMISSIONER PAGONE: Yes, Mr Knowles.

MR KNOWLES: Thank you, Commissioners. Ms Marshall, can you tell the Royal Commission your full name.

MS MARSHALL: Helen Mary Marshall.

MR KNOWLES: Thank you. And you prepared a statement for the Royal Commission.

MS MARSHALL: I have.

MR KNOWLES: That's dated the 27th of October 2019.

MS MARSHALL: Yes.

MR KNOWLES: And do you see the first page of that statement displayed on the screen in front of you there - - -

MS MARSHALL: I can.

MR KNOWLES: - - - bears the document identification number WIT.0603.0001.0001.

MS MARSHALL: Yes.

MR KNOWLES: And have you read your statement lately?

MS MARSHALL: Yes, I have.

MR KNOWLES: And are there any changes that you wish to make to it?

MS MARSHALL: No.

MR KNOWLES: And are the contents of your statement true and correct to the best of your knowledge and belief?

MS MARSHALL: Yes, to the best of my knowledge.

MR KNOWLES: I seek to tender the statement of Ms Helen Marshall dated the 27th of October 2019.

COMMISSIONER PAGONE: Yes, thank you, Mr Knowles. That will be exhibit 13-12.

EXHIBIT #13-12 STATEMENT OF HELEN MARY MARSHALL DATED 27/10/2019 (WIT.0603.0001.0001)

MR KNOWLES: Ms Marshall, you were the facility manager at Glenara Lakes from the 15th of January 2018 until the 26th of October 2018.

MS MARSHALL: Yes, I was.

MR KNOWLES: And you're also a registered nurse with over 45 years of experience?

MS MARSHALL: Yes, I am.

MR KNOWLES: Yes. Now, as facility manager at Glenara Lakes, who did you directly report to?

MS MARSHALL: I directly reported to the director of residential business services, as it was then.

MR KNOWLES: Yes.

MS MARSHALL: I believe it's been renamed.

MR KNOWLES: Who was that?

MR KNOWLES: Mrs Pauline Robson.

MR KNOWLES: Yes. And do you know who Ms Robson in turn reported to?

MS MARSHALL: To Richard Sadek, CEO.

MR KNOWLES: How were you yourself able to raise matters with senior management, including the CEO?

MS MARSHALL: I was informally told that I could not contact the CEO directly. I – there was an organisational chart that there was a spelling error on. And I emailed Richard, because he'd sent it to all the facility managers. I emailed him and said there was a spelling error. And then I was informed that, "No. No. You don't do that. You go through his secretary."

MR KNOWLES: Were you able to raise matters with senior management and the board through your monthly facility manager written report?

MS MARSHALL: Yes.

MR KNOWLES: And was there a format that you were provided with for the preparation of those reports?

MS MARSHALL: Yes. It was the format that had been used by the previous facility manager and other facility managers in the organisation.

MR KNOWLES: And that format, did it set out particular matters that you were required to address?

MS MARSHALL: Yes, it did.

MR KNOWLES: And, typically, those monthly facility manager reports, were they one to two pages long?

MS MARSHALL: That's correct, yes.

MR KNOWLES: So they didn't contain a great deal of detail - - -

MS MARSHALL: No, they didn't.

MR KNOWLES: - - - it's fair to say.

MS MARSHALL: That's fair to say.

MR KNOWLES: Yes. Now, did you, in your time as facility manager, ever raise concerns about matters at Glenara Lakes in one of your facility managers' reports?

MS MARSHALL: I raised issues, as far as I can remember, about the education required for trained nursing staff.

MR KNOWLES: Were there other matters that you raised in your reports?

MS MARSHALL: Complaints. There were complaints – information passed on to the board, as well.

MR KNOWLES: Yes.

MS MARSHALL: ACFI information, how many residents were admitted, how many were discharged, audit results, education that we've had, HR information.

MR KNOWLES: Did you ever get a response to those matters that you raised in your facility manager report from anybody up the chain of command?

MS MARSHALL: No.

MR KNOWLES: Did you expect that, in respect of some matters – you mentioned staff training – you might get some response?

MS MARSHALL: I was hoping for a response. I repeatedly asked for education almost from the time I started there. I recognised there were lacking the necessary skills and knowledge of, especially for trained nursing staff. So I flagged that very early on when I started at Glenara Lakes and continued to ask for it until I resigned.

MR KNOWLES: What were some of the matters that you regarded as lacking in terms of people, skills and training?

MS MARSHALL: Medication management, wound care, skin care, pain management, time management, the ability to assess residents or assess residents that were unwell. Sorely lacking.

MR KNOWLES: Now, you've said in your statement that you as facility manager were responsible for effecting or putting into place at Glenara Lakes Southern Cross Care's continuous improvement system?

MS MARSHALL: Yes.

MR KNOWLES: What was that continuous improvement system of Southern Cross Care comprised of, so far as you were aware?

MS MARSHALL: Just flagging areas for improvement and how you would go about those improvements and then the outcomes.

MR KNOWLES: Okay. So when you say that, what's an example of an area of improvement that you might have flagged?

MS MARSHALL: Gosh. And I know I raised so many. Elder abuse education. I'm pretty sure I put elder abuse, education because that was also lacking on – from cleaners right through. So I put that as a CI. And how I managed that was I asked the clinical services manager, "Could you provide education on elder abuse." And I was provided with a two-page questionnaire, which then – it went right through all Southern Cross care facilities. That was our education – was a two-page questionnaire.

MR KNOWLES: Sorry. A two-page questionnaire - - -

MS MARSHALL: On elder abuse. So I was provided with the answers. And every staff member had to just answer the questions. So that was the education.

MR KNOWLES: And that's an example, you say, of something being flagged and addressed through the – I used the term addressed advisedly - - -

MS MARSHALL: Yes.

MR KNOWLES: - - - but addressed through the continuous improvement system at Southern Cross Care.

MS MARSHALL: Yes. Another example was the dementia unit. And it was a secure dementia unit. And we had – we had two double doors and people were constantly banging on those doors if they could – if their loved ones passed through. So I suggested that, instead of making them look like doors of a prison, which they do, we get a murals painted on the wall. So I approached the auxiliary and they funded Flying Colours to do one with a waterfall scene and the other one was a garden scene. So it was quite beneficial to the people on the inside. They didn't feel

like they were in prison, because the doors no longer looked like doors; they looked like scenery.

MR KNOWLES: So these were matters that perhaps required some instant response. And that was something that you say would occur from time to time?

MS MARSHALL: Yes.

MR KNOWLES: Do you regard the continuous improvement system as being effective at a deeper organisational level across Southern Cross Care?

MS MARSHALL: No.

MR KNOWLES: And why is that?

MS MARSHALL: I don't think that there is enough support for managers at Southern Cross Care. I think that you have strict guidelines as a facility manager to act within. If you're requesting something such as education, I would expect that you would be responded to and given a timeframe. And that never happened throughout the nine months I was there.

MR KNOWLES: Now, you may have heard me ask questions of the previous witness in respect of the auditing arrangements through QPS - - -

MS MARSHALL: Yes.

MR KNOWLES: - - - or Quality Performance System - - -

MS MARSHALL: That's right.

MR KNOWLES: - - - at Glenara Lakes. Were you provided with those audit reports yourself when you were facility manager?

MS MARSHALL: I looked at our responses, but never saw the reports. The reports went through to the director of clinical services.

MR KNOWLES: So you never received a copy of quarterly reports about the results of the audit in respect of Glenara Lakes?

MS MARSHALL: Not that I can recall.

MR KNOWLES: Okay. In terms of the audit responses that you provided, did you ever analyse those responses to assess whether there were trends or problems that needed to be addressed?

MS MARSHALL: There weren't on the audits that I performed. There weren't trends. Medication management was identified as one of the audits. And that was where I was seeking assistance in educating the staff.

MR KNOWLES: When you say that, it was identified as - - -

MS MARSHALL: Missed signatures and omitted medications. So for me that's quite significant, you know, if a resident's missed medication and it's missed ongoing or for several days, it's not picked up, or people are given antibiotics and it's a seven day course and they're actually given it for 10. For me that highlights there's a lack of awareness by staff.

MR KNOWLES: And are these matters, though, that you picked up just by collecting the data for the purposes of preparing the report .....

MS MARSHALL: Looking at the audit chart – looking at the medication charts.

MR KNOWLES: Yes. That is, collecting information that would then be submitted for the purposes of the QPS report being prepared.

MS MARSHALL: Yes.

MR KNOWLES: Which you didn't see from what you can recall.

MS MARSHALL: No. Also, we did paper audits that included medication management, as well.

MR KNOWLES: Right. Thank you. Now, just in relation to those QPS audits, if I can return to them, in your statement – and this is at paragraph 10.1 at the bottom of page 4. You've said in relation to monthly audits that:

Glenara Lakes met the standard benchmarks during that time.

MS MARSHALL: Yes, as far as I'm aware.

MR KNOWLES: Are they the benchmarks that were set by QPS? Is that - - -

MS MARSHALL: Yes.

MR KNOWLES: Do you know how QPS set the relevant benchmarks?

MS MARSHALL: I think they do an average of facilities across Australia.

MR KNOWLES: Right. And that was the benchmark that you say Glenara Lakes was measured against and met either - - -

MS MARSHALL: Yes.

MR KNOWLES: - - - as equal to or surpassing the benchmark. Is that what you understood to be the case at the time?

MS MARSHALL: Well, as far as I'm aware, yes.

MR KNOWLES: Yes. Okay. Would you expect to be told if Glenara Lakes had not met the benchmark?

MS MARSHALL: Absolutely. Yes.

MR KNOWLES: And are you saying to the Royal Commission that you were never told that Glenara Lakes had not met the benchmarks?

MS MARSHALL: I was never told Glenara Lakes had not met the benchmarks.

MR KNOWLES: All right. Can I take you to the document at tab 107 in the tender bundle. It will just come on the screen in a moment, Ms Marshall. You see there that's a document QPS Benchmarking Report Aged Care for the quarter from April to June 2018 in relation to Glenara Lakes apartments.

MS MARSHALL: Yes.

MR KNOWLES: Have you ever seen that document before?

MS MARSHALL: No. I don't recognise it.

MR KNOWLES: Okay.

MS MARSHALL: Or I can't remember if I've seen it, but I don't think so.

MR KNOWLES: All right. Well, can I just take you in that document to the page – the first page after the cover page, which is _0001. Have you ever seen a chart like that that refers to risk trends at an aged care facility as measured by QPS?

MS MARSHALL: I've looked on QPS myself, yes.

MR KNOWLES: Right. But had you – did you see this one in relation to the quarter from April to July – sorry – April to June of 2018, to your recollection?

MS MARSHALL: Not to my recollection.

MR KNOWLES: Okay. Do you see in the bottom left-hand corner there is a benchmark not met - - -

MS MARSHALL: Yes, I did.

MR KNOWLES: - - - measure? And that's the darker squares. Unfortunately, it's not in colour; it's just in black and white. But do you see that, as at this particular quarter, there are a number of benchmarks which were not met at Glenara Lakes?

MS MARSHALL: Yes, I do.

MR KNOWLES: And they relate to matters such as, just working down the list, aggressive episodes, dementia, I think it is.

MS MARSHALL: Yes.

MR KNOWLES: Falls, total, general. Then there are a number of other falls measurements where the benchmarks were not met, pressure injuries externally, not met, then quality of care audit. Do you see that one?

MS MARSHALL: Yes.

MR KNOWLES: That's not met and that had not been met for four quarters. So had you ever been – you said earlier that, so far as you were told, you'd not been informed that any benchmarks were not met by Glenara Lakes?

MS MARSHALL: That's right.

MR KNOWLES: Am I to infer from that that you didn't see this document and you were never told about the results in this document?

MS MARSHALL: No, I don't believe I was.

MR KNOWLES: Okay. Now, if I go to the next page, do you see, just taking by way of example quality of care audit, about three lines from the bottom, that says that the benchmark – and I don't profess to understand how these scores are arrived at, Ms Marshall, but the benchmark is a score of 92.5 and the result was 80.82. So the quality of care audit was below the benchmark.

MS MARSHALL: Yes.

MR KNOWLES: Yes. Now, in that regard, if I can just go over to the next page. And do you see, if we move to the bottom of the page, there is a reference to the quality of care audit. There's some comment that's provided by QPS and then it continues across to the top of the next page. And it says:

> *Quality of care audit results have decreased by 7.16 per cent to attain 80.87 per cent compliance.*

Then - - -

MS MARSHALL: I can't see.

MR KNOWLES: Pardon me. Do you see that's - - -

MS MARSHALL: I can't see.

MR KNOWLES: Your screen's gone black. Sorry. We're having a slight technical issue here.

COMMISSIONER PAGONE: Mr Knowles, I think somebody's come up with a temporary solution. But if that other screen doesn't work and you might need to go to other pages, it might be desirable if the screen that's currently on the bar table – it looks as though the cable is long enough – might be able to fit at the other end of the witness table.

MR KNOWLES: Yes.

COMMISSIONER PAGONE: The only issue there seems to be PowerPoint, but presumably that's not the problem.

MR KNOWLES: That's certainly one solution, I'm happy to - - -

COMMISSIONER PAGONE: Well, if you don't disconnect the cable, so that you don't create the problem.

MR KNOWLES: The relevant page, which is the last page of this document, is on the screen of the laptop that is now before Ms Marshall.

COMMISSIONER PAGONE: Yes.

MR KNOWLES: The difficulty is it's not the last document that I'm going to.

COMMISSIONER PAGONE: Exactly. Exactly.

MR KNOWLES: So I think a more appropriate solution is as, Commissioner, you have suggested.

COMMISSIONER PAGONE: So it looks as though the problem might be one of the cables, rather than the machine. It seems we have yet another solution, Mr Knowles. It seems that the machine on the associate's table is visible and legible to the witness. Excellent. Well, thank you, all, for that assistance. Mr Knowles, back to you.

MR KNOWLES: Thank you, Commissioner. Apologies, Ms Marshall, for that. So you should have before you the fourth page of the QPS quarterly report for April to June of 2018, in which the comments from QPS are set out relating to the benchmark for quality of care audit, which, as you recall, was not met. It was some 12 points off the mark. And do you see there that, among other things, it's said that the score card

identifies a number of critical and high priority clinical practices requiring improvement.

MS MARSHALL: Yes.

MR KNOWLES: Just stopping there, were you ever told about that?

MS MARSHALL: No.

MR KNOWLES: In June, July of 2018?

MS MARSHALL: No.

MR KNOWLES: No. It says:

> *Communicate with staff the consequences of the non-compliant area on resident care, as well as the accreditation process.*

Were you ever – did you get that communication, Ms Marshall, yourself?

MS MARSHALL: No.

MR KNOWLES: Were any of these matters that are set out in respect of observation, resident waits and so on that require improvement ever raised with you?

MS MARSHALL: Not raised with me, but they're issues that I raised with the staff.

MR KNOWLES: Yes.

MS MARSHALL: Yes.

MR KNOWLES: But in terms of the results of this quality monitoring system that was used through QPS, you never saw this report, you never received any feedback as a result of this report from management up the chain from you or from the board?

MS MARSHALL: No.

MR KNOWLES: All right.

COMMISSIONER BRIGGS: Ms Marshall, can I ask you a question. Was it ever the practice in Southern Cross Care to bring together all the facilities managers and discuss performance and issues across the board or did that never occur?

MS MARSHALL: We did have meetings, several facility manager meetings. There were no issues raised such as this. It was purely financial.

COMMISSIONER BRIGGS: Okay. Thank you.

MR KNOWLES: Would you have liked to have seen this information yourself, Ms Marshall?

MS MARSHALL: Absolutely.

MR KNOWLES: Now, can I take you to tab 110 of the tender bundle.

COMMISSIONER PAGONE: Well, could I just ask you this question before you go on. If the meetings were purely financial, how could you have a meeting that was purely financial without knowing about these kinds of matters?

MS MARSHALL: This – the QPS was never raised.

COMMISSIONER PAGONE: No. I understand that. But what impact would a meeting on finances have if you didn't know about these kinds of concerns that might to be addressed require something to be done about the financials?

MS MARSHALL: I understand your question, but the two were never correlated.

COMMISSIONER PAGONE: So what does that mean about the meeting insofar as it was taking place about financial matters?

MS MARSHALL: Financial matters took into account our ACFI income and the break-even strategy.

COMMISSIONER PAGONE: Yes. So I suppose what I really meant to ask you, and I've been doing it very badly, was if you are going to have a meeting – so putting to one side Southern Cross Care - - -

MS MARSHALL: Yes.

COMMISSIONER PAGONE: But, as a matter of general consideration, given your position and knowledge, if you are going to have a meeting about financial matters, are details like this important for the financial matter?

MS MARSHALL: Absolutely they are.

COMMISSIONER PAGONE: Yes. All right. Thank you. That's what I meant to ask.

MS MARSHALL: Yes. Sorry.

COMMISSIONER BRIGGS: Can I ask a little bit more, though. And it runs to the cultural question. So Southern Cross Care has how many facilities in Tasmania again?

MS MARSHALL: Nine.

COMMISSIONER BRIGGS: Nine. That's what I thought. So it's got nine facilities, there are nine facilities managers in the room. Was not one of you brave enough to raise these quality issues or performance issues to balance out what may well have been quite a tight hierarchical structure, according to the evidence we've heard?

MS MARSHALL: I was the only one who opposed the break-even strategy.

COMMISSIONER BRIGGS: Thank you. Thank you.

MR KNOWLES: What did you have to say in that regard?

MS MARSHALL: I said that I couldn't compromise anymore staffing cuts, I couldn't compromise the quality of care to the residents at Glenara Lakes. And I actually said, "If I have to cut one more hour, I will go." And go I did.

MR KNOWLES: So when you say that, you made these comments at a meeting around October 2018.

MS MARSHALL: Facility manager meeting.

MR KNOWLES: Is that what you're saying?

MS MARSHALL: I made them at a meeting, at a facility managers meeting. I made them to the finance manager, who was the director of residential business services, and face-to-face with Richard Sadek.

COMMISSIONER PAGONE: And do you think that the approach that the others were taking, that is to say, that the decision-makers were taking were that they just didn't understand the operational needs of caring?

MS MARSHALL: I – I think they should have understood the care needs, because I tried to explain that we had 88 residents, one registered nurse, one EN and one part-time EN in the dementia unit and not enough carers to cover the layout. Glenara Lakes was a significantly different layout to most of the other Southern Cross facilities and yet I was expected to still make the same staffing ratio as everybody else.

COMMISSIONER PAGONE: But at a more general level, so going forward for other facilities that might or might not be comparable, do you think that if they understood what was needed in running a facility, they would have approached things differently?

MS MARSHALL: I don't think so.

COMMISSIONER PAGONE: You don't think so.

COMMISSIONER BRIGGS: Why is that?

MS MARSHALL: I think it was the break-even strategy. It was regardless. It was, this is what had to be met to survive - - -

COMMISSIONER BRIGGS: Yes.

MS MARSHALL: We had to meet it.

COMMISSIONER BRIGGS: Yes. So, fundamentally, finance is dominating the quality of care principles and objectives of the legislation.

MS MARSHALL: Yes.

COMMISSIONER BRIGGS: Yes.

MR KNOWLES: Thank you, Commissioners. Ms Marshall, you will see on the screen there a QPS Benchmarking report for the whole of Southern Cross Care Tasmania for the same quarter. Do you see that from April to June 2018.

MS MARSHALL: Yes, I do.

MR KNOWLES: Now, can I take you to the third page of that document – sorry, yes, the third page – it's a page with a matrix on it. The next page. There it is. It seems to be presented slightly – there we go. So do you see there, there is a matrix that sets out the nine facilities.

MS MARSHALL: Yes.

MR KNOWLES: And then some benchmarks that have been measured by QPS and there's a code of those benchmarks as to whether or not they are high risk, medium risk, no submission, not subscribed, better than benchmark.

MS MARSHALL: Yes.

MR KNOWLES: Now, it's not clear what some of those things are because it's not in colour but one thing that you agree, I take it, that is clear is that certain things that are marked dark are high risk.

MS MARSHALL: Yes, they are.

MR KNOWLES: Do you see there that Glenara has high risk at this time assessed in respect of aggressive episodes, dementia-specific, two falls categories and also urinary infections?

MS MARSHALL: Yes.

MR KNOWLES: And were you ever told about that QPS Benchmark assessment of high risk at Glenara Lakes in those areas?

MS MARSHALL: No.

MR KNOWLES: It's something you would have wanted to know about?

MS MARSHALL: Absolutely.

MR KNOWLES: Because if you don't - - -

MS MARSHALL: You can't manage properly.

MR KNOWLES: Now, can you go now, operator, please, to tab 160 of the tender bundle. And this is the last of these QPS documents that I will go to, but this is for the next quarter. Do you see that in relation to Glenara Lakes?

MS MARSHALL: Yes.

MR KNOWLES: So you're still facility manager at Glenara Lakes at the time of this report. Can I take you to the next page in the document, and do you see there, again we have a similar chart setting out where the benchmarks are not met.

MS MARSHALL: Yes.

MR KNOWLES: And I won't go through all of them but of interest, the quality of care audit, do you see that that continues in this quarter to be a benchmark not met?

MS MARSHALL: Yes, I do.

MR KNOWLES: And has been not met for five successive quarters?

MS MARSHALL: Yes.

MR KNOWLES: Now, if we go to the next page, the quality of care audit result is set out, I think, about five lines from the bottom of the page, and do you see that the result is now 78.98? That, I'm putting to you, is a reduction on the previous period - - -

MS MARSHALL: Yes, it is.

MR KNOWLES: - - - which was around 80 so that shows a trend that is downward, at least over that two-month period.

MS MARSHALL: Yes.

MR KNOWLES: And if we go to the next page, you will see there is a section related to quality of care there, and it says that:

The quality of care audit measurement has been trending down over three audit cycles.

And it's then suggested that these audit findings be communicated with staff. Again, I take it you were not told about these audit findings?

MS MARSHALL: No.

MR KNOWLES: Again, it says:

Discuss this information with the team responsible and reinforce the correct policies and procedures to ensure the resident care plan is being followed.

Were you, just on that – I take it that was not discussed with you at the time.

MS MARSHALL: No.

MR KNOWLES: No. Just on the question of policies and procedures, what were the policies and procedures like at Glenara Lakes and, more broadly, Southern Cross Care on your assessment?

MS MARSHALL: Lacking.

MR KNOWLES: And why do you say that?

MS MARSHALL: Lacking. They didn't have detail on clinical procedures, how to perform clinical procedures. It was very difficult. I was given a two or three page index, if you like, a quick find because when you went to the intranet, if you clicked on a policy, it actually wasn't called – I can't think of an example, BGL readings. It wasn't called BGL readings; it might have been called diabetes, something. So it was very difficult to get something up on the intranet.

MR KNOWLES: Were the policies – sorry.

MS MARSHALL: They were small. They were small. They didn't have a lot of information.

MR KNOWLES: Were they up to date? Had they been reviewed in recent times, to your knowledge?

MS MARSHALL: Not to my knowledge, no.

MR KNOWLES: Now, just on this point about trending down over three audit cycles, would you agree that in colloquial terms what all this suggests is that there was a clinical care time bomb about to go off?

MS MARSHALL: Absolutely.

MR KNOWLES: And that is really what happened later on in the year when the Aged Care Quality and Safety Commission in its review audit found that there were seven expected outcomes that were not met?

MS MARSHALL: Yes.

MR KNOWLES: Do you agree with that?

MS MARSHALL: Yes.

MR KNOWLES: Which was the cause of a serious risk decision in early 2019?

MS MARSHALL: Yes.

MR KNOWLES: But this information suggests that the germ of what was going to come was there earlier on in 2018?

MS MARSHALL: Yes.

MR KNOWLES: Now, can I take you to tab 137 of the tender bundle. In the midst of all these QPS reports that you've been taken to today, apparently for the first time, this is your facility manager report that you provided to the board in July of 2018; do you agree?

MS MARSHALL: Yes.

MR KNOWLES: And is this the typical form and content of such a report that you were referring to earlier?

MS MARSHALL: Yes.

MR KNOWLES: Yes. You've mentioned understaffing, a need for more training on certain things, and that corresponds with the evidence that you gave earlier to the Royal Commission. You've said in respect of – up the page – major changes in residents or core business issues – there are three dot points; one of them is that there has been a slight increase in ACFI remuneration. You don't say anything there in that part of the document about quality of care audit issues.

MS MARSHALL: No.

MR KNOWLES: Or anything that might have been uncovered by the QPS audits, do you?

MS MARSHALL: No, I do not.

MR KNOWLES: There's nothing in there in your report about standards of clinical care that are being delivered to residents at the time or issues that you've identified in that regard?

MS MARSHALL: No.

MR KNOWLES: There's – is it fair to say that there's nothing of that sort set out in your report at all?

MS MARSHALL: No. That's right.

MR KNOWLES: Can I take you to the third page of that document, where there is a reference to audit outcomes and QPS audit results. Am I right in thinking that's the material – this is under the heading Audit Outcomes – do you see that, Ms Marshall?

MS MARSHALL: Yes.

MR KNOWLES: Just a bit before halfway down.

MS MARSHALL: Yes, I do.

MR KNOWLES: Am I right in saying that that audit outcomes section just refers to the collated data that you've collected - - -

MS MARSHALL: Yes.

MR KNOWLES: - - - to pass up to your superiors for the purposes of preparation of the QPS reports that I've taken you to earlier today?

MS MARSHALL: Yes.

MR KNOWLES: So in terms of audit results you're just talking about the data - - -

MS MARSHALL: Yes, I am.

MR KNOWLES: - - - that you've collected. Okay. And you simply say in respect of audit outcomes that that data is being sent to the director of clinical services.

MS MARSHALL: Yes.

MR KNOWLES: That there's nothing otherwise said as to what the data shows.

MS MARSHALL: No.

MR KNOWLES: It doesn't go to any issues of concern about clinical care?

MS MARSHALL: No.

MR KNOWLES: No. Do you agree that this report doesn't suggest that there are any real problems that exist at Glenara Lakes at the time, in terms of clinical care?

MS MARSHALL: No, it doesn't.

MR KNOWLES: Sorry, you - - -

MS MARSHALL: It doesn't.

MR KNOWLES: And that stands in stark contrast to the QPS reports that we've seen?

MS MARSHALL: Yes. I didn't send the QPS reports to the director of clinical services; the care coordinator did.

MR KNOWLES: Yes. I see. Now, if I can leave off this document and return to a paragraph in your statement, which is paragraph 10.4. And in that paragraph you've said in the second sentence:

> *Quality and safety meetings were held at Glenara Lakes of which I was not required to attend.*

What were those meetings and who did attend them?

MS MARSHALL: They were State meetings so - - -

MR KNOWLES: State?

MS MARSHALL: State-wide meetings so they were held at Glenara Lakes or held in the south. And as far as I know, they were chaired by the director of clinical services. A representative from Glenara Lakes attended or – there used to be two, I believe. One decided not to be on the committee any more, so there was only one and we never got feedback from those meetings.

MR KNOWLES: So who was the person that attended from Glenara Lakes at the meeting?

MS MARSHALL: Cheryl Thomas.

MR KNOWLES: And what was her position?

MS MARSHALL: She was a lifestyle coordinator.

MR KNOWLES: So she didn't have clinical expertise?

MS MARSHALL: No.

MR KNOWLES: So why was she attending this meeting and not somebody with clinical expertise?

MS MARSHALL: That was organised before – that was part of the committee before I was employed. So it was her or – and the maintenance man as well, but he resigned from the committee.

MR KNOWLES: Did you not think that it might be important for you to go to those meetings yourself?

MS MARSHALL: Facility managers weren't to attend.

MR KNOWLES: Sorry, the facility - - -

MS MARSHALL: Facility managers were not to attend these meetings.

MR KNOWLES: When you say that, what do you mean, was that something that was a direction from someone else?

MS MARSHALL: It was a direction from the director of clinical services; facility managers were not required to attend these meetings.

MR KNOWLES: What was the rationale so far as you understood it for that?

MS MARSHALL: I have – I have no idea what the rationale was. That was the way it had always been.

MR KNOWLES: Did you question that yourself?

MS MARSHALL: I did question it, but I was told facility managers do not attend these meetings.

MR KNOWLES: Right. Do you think it would have been useful for someone with clinical expertise to attend that meeting, whether it be you with your nursing background or somebody who was the clinical care coordinator?

MS MARSHALL: Absolutely.

MR KNOWLES: Now, I just wanted to ask you a couple of questions in relation to complaints handling. How were complaints handled at Glenara Lakes?

MS MARSHALL: If it was a simple thing like a maintenance issue, I would deal with it straightaway and I would see that as a maintenance issue. Other forms were written or verbal. I would meet with the resident or the resident's family, or the staff member if it happened to be, and then those would be documented and put in the comments and complaints folder.

MR KNOWLES: What would happen if a complaint wasn't resolved after a couple of days? Would it be escalated in some way?

MS MARSHALL: It – I would – if it wasn't, depending on the complaint, so if we're talking about medication management for instance, then I would continue to follow that up. I would ask for advice from the director of residential business services or the director of clinical services. So they would – on something that I couldn't solve or resolve, they would be involved.

MR KNOWLES: Was there a standard complaints handling procedure at Glenara Lakes or more broadly at Southern Cross Care that you were made aware of?

MS MARSHALL: Not that I was made aware of, no.

MR KNOWLES: So it was an ad hoc process that really depended on your own judgment as to what you thought appropriate in the given circumstances.

MS MARSHALL: Yes, it was.

MR KNOWLES: Was data about complaints collected and analysed for trends and root causes of those trends?

MS MARSHALL: No.

MR KNOWLES: Were senior management and the board ever made aware of information about complaints so far as you were aware?

MS MARSHALL: Yes, significant complaints, yes.

MR KNOWLES: Yes. And did you ever receive any feedback from senior management and the board about how to resolve significant complaints?

MS MARSHALL: I had support from the director of residential business services. She sat in on a couple of complaints issues with me, so I did have support from her, yes.

MR KNOWLES: Yes. So what, she attended meetings that you had with the person who was making - - -

MS MARSHALL: With family members to try and resolve the issues, yes.

MR KNOWLES: Yes. Was there anything else that occurred in terms of feedback that you got about the complaints and how they were handled?

MS MARSHALL: No.

COMMISSIONER BRIGGS: Might I ask, Ms Marshall, did you hear the evidence last evening about alarm bells not being answered quite regularly?

MS MARSHALL: Yes, I did.

COMMISSIONER BRIGGS: And as somebody who responded quickly to maintenance questions, was this a maintenance issue or was it a staffing issue?

MS MARSHALL: A staffing issue.

COMMISSIONER BRIGGS: And how did you respond to those problems?

MS MARSHALL: So not answering call bells, I would actually speak to the staff. I did a call bell summary and that would be done every two weeks and the average was 10 minutes or under, which is reasonably average for aged care facilities. If you scanned each of the wings, and I would see consistently that something was over 10 or 15 minutes then I would actually look at the shift and talk to the staff involved to see what the issues were.

COMMISSIONER BRIGGS: Thank you.

MR KNOWLES: Just finally, you have said – and this follows on from the questions that were asked of you by the Commissioners earlier about the meetings that you attended, the break-even strategy and questions of care and quality of care. Can I take you to paragraph 11.3 of your statement. It's at page 7 of the statement, and towards the bottom of that paragraph, you say:

> *I think the reduction of care staff hours without the clinical leadership on sharing how this was able to work in other Southern Cross Care facilities, this lack of state-wide leadership left a large gap. Although the facility still had greater staff/resident care ratios than other residential aged care facilities, how this was achieved without any impact on care was not shared once the director of residential business services was restructured out of the clinical support which was given to the director of clinical services.*

MS MARSHALL: Yes.

MR KNOWLES: Can I just ask you to elaborate on that. Do I take it that you're saying that there was necessarily some impact on the quality of care as a result of cuts that were made in respect of staff hours?

MS MARSHALL: What – what happened was the – there was a facility – a Southern Cross facility who had achieved a reduction in staff/resident – yes, staff/resident ratios, and they had made the break-even strategy, and I was supposed to implement that, but that wasn't shared with me how that occurred. But taking staff ratio or resident ratio and the layout of Glenara Lakes was not taken into consideration either.

MR KNOWLES: That was Ainslie, was it, that had achieved that result?

MS MARSHALL: No, Rosary Gardens.

MR KNOWLES: You've mentioned layout. Were there any other differences that you were aware of between that aged care service and facility compared with Glenara Lakes?

MS MARSHALL: I believe our staff were poorly lacking in skills, which is what I've said. They needed education and training.

MR KNOWLES: What about the residents? Were there differences in the acuity of care needs of residents?

MS MARSHALL: Yes, we had a – yes, we had a dementia services – a dementia unit which was 16 bed and the staff – the staffing in there was – I would call fraught with danger when there was an ECA from 9 o'clock at night till 7 in the morning, and she was the only person there, or he, for nine hours straight.

MR KNOWLES: Now, there is just one final question: you've said that you received minimal support from the director of clinical services when you were at Glenara Lakes.

MS MARSHALL: Yes.

MR KNOWLES: Was that a matter that contributed to your decision to leave?

MS MARSHALL: Part of it, yes.

MR KNOWLES: What else contributed to your decision to leave Glenara Lakes?

MS MARSHALL: I felt I could no longer manage the facility under – under the constant pressure of having to cut staffing and which would impact on the resident care, and I pride myself on – I pride myself on not managing a facility that will compromise resident care and I couldn't stay.

MR KNOWLES: I don't have any further questions, Commissioners.

COMMISSIONER PAGONE: Yes. Thank you. Yes. Thank you, Ms Marshall, for your - - -

MS MARSHALL: Thank you.

COMMISSIONER PAGONE: You've been of great assistance. You're free to go.

<THE WITNESS WITHDREW [12.21 pm]

MR KNOWLES: I understand Mr Bolster will be taking the next witness.

COMMISSIONER PAGONE: Yes. Mr Bolster, we've lost a bit of time this morning. We adjourned for 10 minutes out of time, but we do need to keep sort of within the ambit.

MR BOLSTER: I have the next three witnesses.

COMMISSIONER PAGONE: Yes.

MR BOLSTER: And I will fit them all in within the time, Commissioners.

COMMISSIONER PAGONE: Perhaps if we adjourn it at sort of 5 or 10 past 1, that should make up a bit of time.

MR BOLSTER: That won't worry me, yes, I'm happy with that. Whatever suits the Commissioners.

COMMISSIONER PAGONE: All right. Thank you.

MR BOLSTER: 5 past 1, I will work to that. The next witness is Mr Andrew George-Gamlyn who I call.

<ANDREW MICHAEL GEORGE-GAMLYN, AFFIRMED [12.23 pm]

<EXAMINATION BY MR BOLSTER

COMMISSIONER PAGONE: Please feel free to sit down. Make yourself comfortable.

MR GEORGE-GAMLYN: Thank you.

COMMISSIONER PAGONE: Yes, Mr Bolster.

MR BOLSTER: Your full name is Andrew George-Gamlyn. Could you perhaps – perhaps if I spell your surname for the transcript, G-e-o-r-g-e G-a-m-l-y-n. That's your full name?

MR GEORGE-GAMLYN: Michael – Andrew Michael, to be precise, and there is a hyphen in George-Gamlyn.

MR BOLSTER: Thank you, yes. And you have made a statement that's dated 31 October this year; correct?

MR GEORGE-GAMLYN: Yes, I have.

MR BOLSTER: Have you got a copy of that in front of you?

MR GEORGE-GAMLYN: Yes, I have. Thank you.

MR BOLSTER: You may see it on the screen in front of you and we will show you some documents in due course.

MR GEORGE-GAMLYN: Thank you.

MR BOLSTER: Is there anything you want to change about your statement?

MR GEORGE-GAMLYN: No, there isn't.

MR BOLSTER: Are the contents true and correct to the best of your knowledge, information and belief?

MR GEORGE-GAMLYN: Yes, they are.

MR BOLSTER: I tender statement WIT.0592.0001.0001.

COMMISSIONER PAGONE: The statement of Mr Andrew George-Gamlyn dated 31 October 2019 is exhibit 13-13.

EXHIBIT #13-13 STATEMENT OF MR ANDREW GEORGE-GAMLYN DATED 31/10/2019 (WIT.0592.0001.0001)

MR BOLSTER: Mr George-Gamlyn, you are the ACFI coordinator for Southern Cross Care Tasmania; correct?

MR GEORGE-GAMLYN: Yes, that's correct.

MR BOLSTER: You report directly to the chief executive officer, Mr Sadek.

MR GEORGE-GAMLYN: Yes, I do.

MR BOLSTER: And he recruited you to that role.

MR GEORGE-GAMLYN: Yes, he did.

MR BOLSTER: And you have extensive experience in the delivery of clinical care as a registered nurse.

MR GEORGE-GAMLYN: Yes, I do.

MR BOLSTER: As a senior executive across a number of significant positions in health in Tasmania over the years; correct.

MR GEORGE-GAMLYN: Yes. That's correct.

MR BOLSTER: You have been the CEO of the Royal Hobart Hospital.

MR GEORGE-GAMLYN: Deputy CEO.

MR BOLSTER: Deputy CEO. I'm sorry. Yes, the deputy CEO. And you have tertiary qualifications in business administration and health administration.

MR GEORGE-GAMLYN: Yes, I do.

MR BOLSTER: So the role of ACFI coordinator, what does that, in the ordinary course, mean?

MR GEORGE-GAMLYN: Most organisations of a size of Southern Cross Care Tasmania would have somebody with – in that role or a title similar – similar titles. The objective is to facilitate the collection of the organisation's full ACFI entitlement. That would summarise the role.

MR BOLSTER: You not only do that for Southern Cross but you act as a consultant for other facilities around Tasmania and around Australia, I take it?

MR GEORGE-GAMLYN: Yes, in every State and Territory.

MR BOLSTER: Right. From small facilities to large facilities?

MR GEORGE-GAMLYN: From small organisations, so 16-bed would be about the smallest, up to about two and a half thousand beds would be the biggest.

MR BOLSTER: Right. Now, there's two levels of analysis that come through in the papers that we've seen.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: There's a quarterly report which you prepare which shows the way in which ACFI is moving across the country.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: Is that correct?

MR GEORGE-GAMLYN: Yes. That's correct.

MR BOLSTER: That's a fair summary of it?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: And it shows how ACFI rates for the key disciplines are going up or going down.

MR GEORGE-GAMLYN: That's correct.

MR BOLSTER: In terms of what's being processed and what's being allowed by the government; correct?

MR GEORGE-GAMLYN: What's being paid, yes.

MR BOLSTER: What's being paid.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: That's not all residential aged care in Australia but it's a selected group; correct?

MR GEORGE-GAMLYN: It's a statistically significant representative group; it's approximately 16-17 per cent of the national population.

MR BOLSTER: Right. In your statement at paragraph 5, you describe your primary role as being to support the maximisation of ACFI - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - across all of the facilities.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: And that gives rise to the second aspect of your work which is the monthly reports that you generate which show how each facility is going - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - in terms of its ACFI performance.

MR GEORGE-GAMLYN: Yes, that's correct.

MR BOLSTER: It's regarded as a performance indicator, isn't it; how they perform in maintaining their ACFI funding?

MR GEORGE-GAMLYN: You would want to know that every facility within an organisation was receiving its full ACFI entitlement at any given point in time.

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: So from that perspective yes, it is a performance indicator.

MR BOLSTER: Yes. In terms of your work for Southern Cross, is that a full-time job?

MR GEORGE-GAMLYN: No.

MR BOLSTER: How much time do you spend a month doing your work for Southern Cross?

MR GEORGE-GAMLYN: It varies from month to month. I couldn't say precisely. I give the time that is necessary to the task, depending on what is required from time to time.

MR BOLSTER: All right. Okay. And I want you to accept that there's no suggestion or any discussion to the effect that – I withdraw that. There's no suggestion that anything that happens in relation to ACFI is otherwise than in accordance with the guidelines. I just want to make that very clear.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: You make that clear in your statement.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: Yes. You mention in paragraph 7 – if that could be brought up – that:

> *There is no clinical reason to assume that the incidence of ACFI-qualified behaviours at Southern Cross facilities is different from national averages.*

Do you remember making that statement?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: Now, that – the importance of that statement needs to be understood in terms of the graph that you reproduce - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - shortly after that, or shortly before that in your statement. If we could bring out the graph which is headed Variance From National Daily Average ACFI, which is on the right-hand side of the page as I can see it. Yes, can you bring up that box. Thank you. Now, the critical numbers – well, let's go back a step. The first set of three columns, total daily ACFI payment.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: That's the, in effect, resident average per facility of ACFI?

MR GEORGE-GAMLYN: That's – that is correct. That's what it is.

MR BOLSTER: And so - - -

MR GEORGE-GAMLYN: Contrasted with the national average payment at that point in time.

MR BOLSTER: Yes. So you have the daily average for – let's pick Yaraandoo.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: You have the current daily average of 179.98, whenever this was. It doesn't really matter. You have a variance from a national average of 11.4 per cent. So that was 11 per cent above the national average.

MR GEORGE-GAMLYN: $11.

MR BOLSTER: $11. I'm sorry. Yes. That's six per cent - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - above the national average.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: So then that 179 figure is split into the three main ACFI categories.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: That's Activities, Behaviours and Complex Health Care.

MR GEORGE-GAMLYN: Yes. That's correct.

MR BOLSTER: And if we go down to the foot of the page – foot of that box. Sorry. The foot of that box – you see that the variance from the national average for each of ADL, VEH and CHC is set out by you in that last line. And your statement was, effectively, that you couldn't understand why the behaviours column, which shows a 13 per cent variance to the negative. - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - would be any different statistically from – for Yaraandoo or for any of the Southern Cross facilities when compared to the national average; correct?

MR GEORGE-GAMLYN: I didn't say I don't understand.

MR BOLSTER: Well, you assumed or you made the statement that you couldn't see why the residents would be any different from the national average; correct?

MR GEORGE-GAMLYN: That is correct. Yes.

MR BOLSTER: So the premise of that statement is that every facility, effectively, should try and conform to the average?

MR GEORGE-GAMLYN: No.

MR BOLSTER: No?

MR GEORGE-GAMLYN: No, that's not the case.

MR BOLSTER: What's behind that statement then?

MR GEORGE-GAMLYN: The premise is that, in the absence of explanation as to why it's not the case, that you would expect residents admitted to one facility, so the profile of residents anywhere in the country, to be, from a statistical perspective, the same as residents admitted to other facilities, that they would have the same profile of care needs, the same profile of behaviours and the same profile of complex health care requirements, with qualification. There's always qualification. It may be that somebody can demonstrate why they are different at a particular facility. But the starting point is why would they be different?

MR BOLSTER: Well, you don't point to any, as you say, good clinical reason why the nine Southern Cross facilities should be any different from the national average, do you?

MR GEORGE-GAMLYN: In – it's well known within the industry when we're talking about ACFI claims for behaviours why some facilities fail to collect the money that they're entitled to.

MR BOLSTER: Well, what is the explanation for that in the industry?

MR GEORGE-GAMLYN: The ACFI claiming process is very rules – rules-based, very rigorous in its compliance. There are two reasons, primary reasons, why people don't collect all of the behaviour income that the ACFI says they're entitled to. The first one is that they don't collect the data. When they don't collect the data, because the rules surrounding that are complex, onerous, hard to follow, and you have to resource the process fairly significantly if you want to collect the money you're entitled to. So that's the first reason.

Second reason they don't actually receive the money they're entitled to is because then the agency, consequent to extremely – requiring extremely strict adherence to the letter of the rules, will take money back from the facilities if they've used the wrong language in their claims. So they're, basically, the two reasons why people don't receive the money that the ACFI says that they would be entitled to.

MR BOLSTER: It's not as though Southern Cross lacked the resources or the motivation to collect the data to ascertain the appropriate level of ADL and behaviours; correct?

MR GEORGE-GAMLYN: I would disagree with that.

MR BOLSTER: You say that Southern Cross did not have enough support and infrastructure in place to correct what you regard as a proper amount for behaviours?

MR GEORGE-GAMLYN: At various times Southern Cross did not have the appropriate resources that – the problem is this is very much a mechanism. The ACFI is very much a mechanism for receiving the money that you need to provide the care. So it – and, unfortunately, it has to be resourced. But where clinical needs are sort of – sort of take precedence, and, of course, on a daily basis they always will, then the ACFI will come second. And - - -

MR BOLSTER: Let's take Yaraandoo again for an example.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: You knew that in around the middle of 2018 there was one full-time nurse whose sole responsibility was to deal with ACFI claims. She was a full-time permanent nurse - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - who didn't deliver any care. All she did was deal with ACFI claiming; correct?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: And you don't need to name her.

MR GEORGE-GAMLYN: As far as I'm aware. As far as I'm aware, that's her primary role, yes.

MR BOLSTER: Yes. And you, I take it, worked with her.

MR GEORGE-GAMLYN: I was in strong support of that.

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: How many times a month would you have been in contact with her to support her in the ACFI claiming role?

MR GEORGE-GAMLYN: Whenever necessary.

MR BOLSTER: And – well, how long was that? How often was that?

MR GEORGE-GAMLYN: I just need to clarify, if you don't mind, to make sure we're talking about the same person. Who are you talking about?

MR BOLSTER: Well, the person you dealt with at Yaraandoo when it came to ACFI claiming. She was not on the floor.

MR GEORGE-GAMLYN: Over the years I've dealt with a few people at Yaraandoo. I just want - - -

MR BOLSTER: Let's talk about the person who was there in the first six months of 2018 before the two enrolled nurses were transferred into the role in about September of 2018.

MR GEORGE-GAMLYN: Okay. So I'm assuming you're talking about the person who wasn't singularly dedicated to ACFI claiming. She also had a clinical role. I don't know.

MR BOLSTER: All right. Whoever the person was - - -

MR GEORGE-GAMLYN: ..... I'm not sure who you're talking about.

COMMISSIONER PAGONE: Mr Bolster, if there's some difficulty about naming the person publicly, write it down on a piece of paper and give it to him.

MR BOLSTER: I just don't have the name in front of me, Commissioner.

COMMISSIONER PAGONE: I see.

MR BOLSTER: Sorry.

MR GEORGE-GAMLYN: And I'm not trying to be argumentative; it's just there was a – when I first started working at Southern Cross, a there was – shortly after I started there was a person appointed to the ACFI role at Yaraandoo, a registered nurse, who it was highly appropriate, the appointment. There was then another person who had other things to do.

MR BOLSTER: All right.

MR GEORGE-GAMLYN: So wasn't able to give the amount of time required. And I don't know which person you're talking about.

MR BOLSTER: Let's forget about the person. Let's talk about the involvement you had at Yaraandoo assisting whoever it was at Yaraandoo - - -

MR GEORGE-GAMLYN: Yes. Yes.

MR BOLSTER: - - - with making sure that their ACFI claiming was up to standard.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: How often did you deal with whoever it was at Yaraandoo? What was your practice?

MR GEORGE-GAMLYN: Well, whenever required.

MR BOLSTER: Well, how often were you required to help?

MR GEORGE-GAMLYN: If a person is appointed to an ACFI role in Southern Cross, then it's my responsibility to ensure that they know what they're doing.

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: So I do that.

MR BOLSTER: And how did you do that?

MR GEORGE-GAMLYN: Face to face.

MR BOLSTER: And how often did you go to Yaraandoo?

MR GEORGE-GAMLYN: I can't recall. I can't .....

MR BOLSTER: Okay. Well, in the course of a month, from month to month, you would be preparing your report.

MR GEORGE-GAMLYN: That is correct.

MR BOLSTER: And attached to the report would be a list of around 30 or 40 people a month who had outstanding ACFI assessments or ACFI assessments in the wind; correct?

MR GEORGE-GAMLYN: There would be a number, yes, that's correct.

MR BOLSTER: Yes. And they were – and you kept an active interest in all of those people; correct?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: I'm not saying you saw them yourself.

MR GEORGE-GAMLYN: No. That is correct.

MR BOLSTER: But the file was something that you had a close connection with?

MR GEORGE-GAMLYN: Yes. That is correct. My – my role in Southern Cross, as it is for many organisations, involves working with staff and facilitating a review of the potential ACFI classification of the residents and recording that information in database, various record keeping systems - - -

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: - - - and then monitoring, tracking the submission of those claims. That's – that's my role.

MR BOLSTER: So that would, I take it, involve you being in close contact with whoever it was at Yaraandoo, Glenara Lakes, at Fairway, on a virtually a weekly basis, about how they were going with this process.

MR GEORGE-GAMLYN: No. That wouldn't be the case. It wouldn't be necessary.

MR BOLSTER: How often?

MR GEORGE-GAMLYN: As often as necessary. If an organisation is – or a facility is submitting their claims in a timely fashion, then they're doing their job. If they're not, or if there's reason to think that they may have issues, that they may need additional support with, then give them that support.

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: But my role with Southern Cross Tasmania is not direct operational preparing ACFI claims. That's not what I do.

MR BOLSTER: But every month you reported to the board on precisely how many claims were outstanding.

MR GEORGE-GAMLYN: That's – that is correct.

MR BOLSTER: You knew the names of each of the individuals for whom claims were outstanding or needed to be reviewed; correct?

MR GEORGE-GAMLYN: That is correct.

MR BOLSTER: And you kept in contact with the relevant ACFI managers at each of the facility, so that you remained on top of that situation every month; correct?

MR GEORGE-GAMLYN: That's correct.

MR BOLSTER: Nothing happened on the ACFI front that you didn't know about; correct?

MR GEORGE-GAMLYN: No, that is not correct.

MR BOLSTER: All right. Well, what slipped through the cracks in ACFI that troubled you? I will put it another way. Were there steps taken by the ACFI managers at the relevant facilities that troubled you or concerned you or were inconsistent with the direction that you wanted them to take?

MR GEORGE-GAMLYN: On occasion, yes, as there are at all organisations. The reason organisations ask me to support them - - -

MR BOLSTER: All right.

MR GEORGE-GAMLYN: - - - is because they perceive that there are issues with their ACFI. The number one issue with ACFI is for many organisations that they don't claim their full entitlement. So the data – the national data will demonstrate quite clearly that there are, you could estimate, about a third of facilities that are under-claiming their ACFI.

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: Now, under-claiming. So a resident is admitted, a resident has a certain level of care needs. You – the facility needs money to meet the expense of that care need. There isn't actually a requirement to submit an ACFI. If you don't submit an ACFI, nothing will happen to you from a Commonwealth perspective; you just won't get any money. So, of course, you're going to submit an ACFI.

As a resident's care needs increase over time, which they tend to do, there is no requirement – as there's no requirement in the first instance, to submit an ACFI,

there is no requirement to submit a revised ACFI. But the care needs are increasing and the costs are increasing, so it is up to every organisation as sort of their primary responsibility of every organisation to identify those changes. Once you've identified them, you then have a responsibility to submit a revised claim in a timely fashion, because there is no retrospective payment.

So if you are giving a significant increased level of care for a resident, and you either don't identify it, or you do identify it but don't submit the claim, then you won't receive the money. And, as I say, there's nothing retrospective. So a primary element of ACFI management is to support the identification of changes in care needs so as the facilities are receiving the money that they need to provide the care and also to support the timely submission. From my perspective and my job, so long as the claims are being submitted in a timely fashion – or the primary responsibility – then that's it. Then everything that needs to be done is being done.

MR BOLSTER: Your job was to make sure that the claims were submitted on a timely basis every month; correct?

MR GEORGE-GAMLYN: Yes, that the potential was identified - - -

MR BOLSTER: And then - - -

MR GEORGE-GAMLYN: - - - and then that the claims were submitted.

MR BOLSTER: And you did that?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: Did Mr Sadek express any disappointment to you about your ability to do that over time? I'm talking about 2018, for example?

MR GEORGE-GAMLYN: Not – not that I recall. Well - - -

MR BOLSTER: Did you speak to him often about the ACFI process? Did you report to him about where - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - particular facilities were falling down?

MR GEORGE-GAMLYN: I might sort of add a little bit further background. It's the inherent nature of the ACFI, across facilities, that from time to time issues will prevent the otherwise optimal timeliness of the submission of the claims. So whenever that happens, well, you know, people obviously would ask, "Well, what can we do about that?" Yes, it's a standard conversation, it's why the reports I produce always identify the timeliness of the submissions, because you don't get paid until you submit them.

MR BOLSTER: And the reports you produced identified the individuals, identified the particular issue that they were requiring a reassessment in respect of; correct?

MR GEORGE-GAMLYN: The individual residents?

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: Yes. All right. And they were quite detailed reports, weren't they?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: Did Mr Sadek insist on seeing them every month?

MR GEORGE-GAMLYN: He was provided them every month as was the entire executive of Southern Cross Care.

MR BOLSTER: They went to the board every month, didn't they?

MR GEORGE-GAMLYN: Yes. A - - -

MR BOLSTER: A summary.

MR GEORGE-GAMLYN: A summary version.

MR BOLSTER: Yes, a potted version. Yes. Do I take it there's also no good clinical reason to assume that the incidence of ACFI complex health care at Southern Cross should differ from the national average as well? If we could bring that box back up.

MR GEORGE-GAMLYN: I am not – that would require me talking at some length about the – to answer that question, I would have to talk at some length about how the ACFI works in the complex health care domain and I'm not sure that you want me to do that.

MR BOLSTER: I want you to answer my question - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - and that is, was there a good clinical reason why complex health care at Southern Cross was 13.3 per cent above the national average at the time of this graph?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: What was the good clinical – the clinical reason?

MR GEORGE-GAMLYN: Well, no, it's an ACFI reason, and I would have to explain that, if I was to answer your question. Which I would like to do.

MR BOLSTER: Can you do that briefly, please.

MR GEORGE-GAMLYN: I will try, yes. The ACFI is an activity-based funding model which it does very well in the domains of the areas of activities of daily living and behaviours. That is, within reason it is able to differentiate residents on the basis of how much time they look after – sorry, how much time is required to look after them and assign the funds reasonably precisely, differentiating residents based on the amount of time they take. So – and that works very well in the activities of daily living and the behaviours domain. It does not work in the complex health care domain. Within the model there are some inherent fundamental flaws within the complex health care domain which means that there is not a direct relationship between the amount of time a resident takes to look after and from an ACFI perspective, the amount of money that you receive and the actual effort required and they're not – they're not linked.

So if I give you an example, a person with a colostomy who you have to look after, taken in isolation within the ACFI, there is no payment – that's an item that's recognised in the ACFI 12 complex health care, there is no payment, per se, for looking after a person with a colostomy, even though it's recognised. So it's when you can say and it's referenced, and I assume we might be talking about this in a while, there is an item of care provision, pain management, within the complex health care domain referred to as 4B; it's an allied health pain management therapy. If an organisation provides that therapy, which is generously funded, then they will, all things being equal, have a higher ACFI in the complex health care domain than if they don't provide it. And Yaraandoo, as far as I recall, at that point in time was providing that therapy.

MR BOLSTER: Let's talk about the pain therapy item - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - because you ran into problems with that in July last year when your provider, an organisation by the name of Libero - - -

MR GEORGE-GAMLYN: Yes, yes.

MR BOLSTER: They went out of business.

MR GEORGE-GAMLYN: Yes. Yes, that's correct.

MR BOLSTER: And what percentage of Southern Cross residents were receiving 4B pain relief at that time?

MR GEORGE-GAMLYN: I don't know the number off the top of my head, I'm sorry.

MR BOLSTER: It was a significant number, wasn't it, Mr George-Gamlyn?

MR GEORGE-GAMLYN: Yes, it would be. It would have been around the industry average for people who were providing 4B services.

MR BOLSTER: Didn't you prepare some reports about the likely effect in terms of revenue of that collapse?

MR GEORGE-GAMLYN: Yes, I did.

MR BOLSTER: Because you had some great difficulty getting an alternative provider for some time; correct?

MR GEORGE-GAMLYN: Yes. Yes. It took a – it took the organisation a – a period of time to find a replacement provider, yes.

MR BOLSTER: All right. Let's work through that issue. Perhaps we can bring up tab 11 and go, please, to page _84. This is the board papers from August 2016. If we could go to _84, please. And you will see there that for Yaraandoo, there's – if you go down, sorry, action taken on this issue – Action Taken to Address this Issue; that's at the foot of the page. Now, the issue was falling ACFI, wasn't it, at that time?

MR GEORGE-GAMLYN: Yes. Yes.

MR BOLSTER: And one of the actions that was suggested by the manager, or the manager of residential business at that time was the introduction of a pain management service. It says that:

> *The process began three months ago and involved assessment of residents to determine potential to benefit from the program –*

etcetera, etcetera. Was that a process that you were involved with?

MR GEORGE-GAMLYN: The introduction of the 4B payment, yes, yes. I recommended for a very long time that that service was provided. It was a service that was appropriately funded by the Commonwealth. Why wouldn't you provide it?

MR BOLSTER: And then there had been 17 ACFI reclassifications for residents participating in that group with a further seven ACFI submissions being prepared. A question for you about that is wouldn't the pain issue for residents be dealt with in the ordinary course in the daily care of them by the care staff? I mean, wouldn't it be the job of the care staff to assess residents for pain on a daily basis in any event?

MR GEORGE-GAMLYN: The Aged Care Funding Instrument, within the complex health domain, as I'm sure you would appreciate, the funding instrument is essentially a points driven tool.

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: How many points you've got dictates how much money you've got.

MR BOLSTER: Yes.

MR GEORGE-GAMLYN: Within that domain, so complex health care, there are three items that cover the delivery of pain management therapy. So there's an ACFI 12.3, 12.4A and a 12.4B. Each of those items involve the delivery of massage – pain management by way of massage therapy. The first item, 12.3, is an item that can be delivered by anybody, no qualification, no sort of limitations to the type of person who can deliver that service and it – it's therapy that needs to be provided for 20 minutes a week and it attracts one point. Which - - -

MR BOLSTER: Mr George-Gamlyn, that wasn't the question I asked you, with respect.

MR GEORGE-GAMLYN: Well, I thought it was.

MR BOLSTER: I asked you wouldn't the assessment of pain of residents be dealt with in the ordinary course by the people tasked with the clinical care of them? I didn't ask you for a summary of each of the categories of pain relief under the ACFI.

MR GEORGE-GAMLYN: My apology. So when you say the people delivering care, so would pain management assessment be undertaken by cert III care staff; is that your - - -

MR BOLSTER: By nurses, by care staff, the people who assess the residents every day.

MR GEORGE-GAMLYN: Pain assessments, other than a general, I guess, casual view is usually undertaken by a registered nurse with training in that field or an allied health professional. So somebody who is recognised as having the capacity not just to identify the pain, but to identify the degree of pain and from there, decide which of the three pain management service types that the ACFI offers would be most appropriate for that resident.

MR BOLSTER: So are you saying that it was the task of the care staff at Yaraandoo, for example, to decide which of the three - - -

MR GEORGE-GAMLYN: No.

MR BOLSTER: - - - ACFI categories of pain relief - - -

MR GEORGE-GAMLYN: No.

MR BOLSTER: - - - a particular resident should be on?

MR GEORGE-GAMLYN: No. No, I'm not saying that.

MR BOLSTER: Well, that's what it sounded like.

MR GEORGE-GAMLYN: My apologies. That's not what I meant to say.

MR BOLSTER: My question – let's go back to my question. The nurse comes around every day and makes an assessment of each resident, one would hope. You would expect that.

MR GEORGE-GAMLYN: Yes, yes.

MR BOLSTER: They'd determine every day whether there was a resident in pain, wouldn't they?

MR GEORGE-GAMLYN: There are levels of pain assessment. If there weren't, there wouldn't be specialist departments in hospitals dealing with pain assessment.

MR BOLSTER: You see, what I want to suggest to you is that this process was about identifying residents who would benefit from the service as a way of increasing revenue. What do you say about that?

MR GEORGE-GAMLYN: I'm saying that there is a service that can be provided within the ACFI for the treatment of pain.

MR BOLSTER: Right.

MR GEORGE-GAMLYN: Should residents have pain and should it be identified that they would benefit from receipt of that service, then yes, the role of the – the process involved identifying those residents that were suitable and delivering that service.

MR BOLSTER: How cheap are the costs of obtaining pain management for a nursing home compared to the grant they get or the ACFI contribution they get under 4B?

MR GEORGE-GAMLYN: The payments that are made within the ACFI for the delivery of 4B, with qualification – as there is with everything – exceed, generally, the actual cost of the service provision.

MR BOLSTER: They exceed them quite substantially, don't they?

MR GEORGE-GAMLYN: They can do, yes.

MR BOLSTER: Yes. If we can go, please, to the table. Keep going through the document to page 86, 0086, two more pages, please, and there should be a pain management table, pain management costs table.

MR GEORGE-GAMLYN: Can I – I suppose I'm not allowed to say.

MR BOLSTER: Actually, you might need to go back a page. No, if you go down - - -

COMMISSIONER BRIGGS: If you need to make a clarification, you can certainly do that.

MR GEORGE-GAMLYN: Well, I would, because I – the point – the way this is going is fairly obvious. Yes, it is the case that the income in many cases for delivering a 4B service exceeds the cost of providing that service in many cases. But as I did make the point right at the beginning when we were talking about this, we used colostomy as an example, there is essentially no money provided for that service, and as the ACFI says, if you – in the opening sentences of the ACFI, it's structured in a way that, on balance, the money you receive should be sufficient, it's basically on the swings and roundabouts, to cover the cost of the care provided. So to single out one item and say, well, maybe you're going to get more for that than it costs you, well, it would be factual but possibly inappropriate.

MR BOLSTER: If you could have a look, please, at the table that's in front of you. And you will see there that for – this was a pain management costs for the fortnight ending 21 August 2016. You will see that the cost there for all nine facilities, for 455 hours of pain service, was 40-odd thousand dollars. The ACFI income – this wouldn't surprise you, I take it – was around $211,000; correct?

MR GEORGE-GAMLYN: I don't recall having seen this table before. I'm not comfortable with the accuracy of some of the figures in it. But, without having the opportunity to break it down, I can't go further.

MR BOLSTER: Well, do you think that that is completely out of the ballpark as a figure - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - based on your experience?

MR GEORGE-GAMLYN: Yes, I do.

MR BOLSTER: All right. What do you think that – assuming the – well, what's your recollection of the cost?

MR GEORGE-GAMLYN: Well, I can tell you that depending – the problem is – and this is just, again, the way the ACFI works. The combination of items, not just the delivery of pain management, control the amount of money you receive. You could end up with a surplus of about $600 for delivery of a 4B, depending on how much you were paying for it. $600 per annum, I might say. Or you could end up with a surplus of maybe three, $4000 per annum. You could. But not those ratios there, no.

MR BOLSTER: If you could just – if the operator could go back up the page just briefly, there's a statement that begins with "the good news". Perhaps go to the previous page. Yes. See, under ACFI, the last paragraph, if that could be boxed:

> *The good news is the ACFI profile of Southern Cross Care has improved further even during the last two weeks. This is especially pleasing with the Yaraandoo result of $181 per resident per day achievement, significantly up from their $164 per resident per day two months ago. This is predominantly the result of the introduction of the pain management service for residents, which has taken approximately three months to establish from agreement to having residents assessed, participate and then having ACFIs submitted because of a major change.*

Now, in the short time we have left before lunch, if we could bring up, please, tab 132 at underscore page 88. And I'm going to ask you some questions now about what happened in 2018 when Libero left the scene. Just pausing there – I just note the time. If you could go to 88, sorry. Yes. And you see there paragraph numbered 4, "withdrawal without warning". Now, Libero provided services to all Southern Cross facilities?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: State-wide.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: And, effectively, it went overnight and it happened without any notice; correct?

MR GEORGE-GAMLYN: That is correct.

MR BOLSTER: Overnight you lost the ability to give 4B pain relief to any residents.

MR GEORGE-GAMLYN: That's correct.

MR BOLSTER: All right. Can I ask you about item 4B:

The impact of this is to cause a major business risk should any facility be subjected to a compliance review prior to full implementation of remedial management strategies.

Were they – was that your report or - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - was that your advice?

MR GEORGE-GAMLYN: Yes. They're my .....

MR BOLSTER: What did you mean by that?

MR GEORGE-GAMLYN: There is a requirement within the ACFI that if you're providing certain services that they are – (a) they need to be ongoing for as long as they're required, and (b) there needs to be a record of service delivery. And if there's not a record of service delivery, then you're not compliant. Well, clearly the service had been ceased, therefore, the residents needed to be re-assessed to determine what their requirements were if they needed 4B service, if they needed 4A service or if they needed 12.3 or if they needed something that was none of those things. And the documentation needed to be put in place, because that's a requirement of the Department of Health.

MR BOLSTER: All right. Well, we will continue with that discussion after lunch Mr George-Gamlyn.

COMMISSIONER PAGONE: We might resume at 2 o'clock, I think.

MR BOLSTER: 2. Thank you, Commissioners.

ADJOURNED **[1.06 pm]**

RESUMED **[2.02 pm]**

MR BOLSTER: Thank you, Commissioners.

COMMISSIONER PAGONE: Mr Bolster.

MR BOLSTER: Mr George-Gamlyn, just before lunch, we were talking about the inconvenience caused by the Libero withdrawal of service last year.

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: How long did it take to get the system back up and running?

MR GEORGE-GAMLYN: I don't recall the precise length of time.

MR BOLSTER: It was weeks or months?

MR GEORGE-GAMLYN: To the best of my recollection, weeks.

MR BOLSTER: Weeks?

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: Did Southern Cross continue to be paid the ACFI based on 4B?

MR GEORGE-GAMLYN: Yes, and in line with the ACFI rules.

MR BOLSTER: Right. But you sought to reassess residents for other alternative options, didn't you?

MR GEORGE-GAMLYN: Yes. Yes. To ensure that the organisation was complying with the rules.

MR BOLSTER: If we could bring up paragraph 16 of Mr George-Gamlyn's report – statement. You say there:

> *As the contracted –*

On page 10. Go over to page 10. There should be a sentence beginning:

> *As the contracted service provider –*

see that? It's at the foot of the page, the last six lines:

> *As the contracted service had been withdrawn, it was not possible in the short term to provide the services. It was, therefore, appropriate to identify those residents where therapies other than those defined within the definitions of ACFI 12B, or 12.4A - - -*

MR GEORGE-GAMLYN: 12B.

MR BOLSTER:

> *- - - would better meet the required needs and to switch to a new treatment modality.*

Was there a switch?

MR GEORGE-GAMLYN: Yes. There would have been for some residents, without doubt.

MR BOLSTER: And what proportion of residents switched?

MR GEORGE-GAMLYN: I don't have that figure available.

MR BOLSTER: If they switched from 4B to some other treatment modality, that as you say - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - best met their needs, why weren't they on the treatment that best met their needs in the first place?

MR GEORGE-GAMLYN: Because people's needs change. The – all the therapy as defined by the ACFI is a very, very intensive regime. So it requires pain management to be delivered by an allied health professional and only an allied health professional.

MR BOLSTER: It's a physio a number of hours a week, isn't it?

MR GEORGE-GAMLYN: It's a little bit more specific than that. So, yes, it is an allied health professional, which is either occupational therapist or allied health professional, but nobody else. It needs to be under the current rules. And the 4B has been redefined within the Act by the department three times. So in the current iteration of the rules four times a week for a minimum of 80 minutes. Now, there would be, and there are, based on the claims, a high proportion of residents who would benefit from that degree of therapy for a period of time, and, therefore, they receive it.

But, as far as ongoing forever, there wouldn't be many people who would need that type of therapy ongoing forever. So it's very, very reasonable and it's actually standard practice in many facilities to review people's pain management therapy periodically to – just to ensure that what they're receiving aligns with what they need.

MR BOLSTER: Why did it take the Libero withdrawal of services for that reassessment to occur here?

MR GEORGE-GAMLYN: Arguably, it should have been – and it was happening to a degree, but possibly it should have been happening at more intensively than it was prior to that, possibly. And that's up for debate. But certainly, I mean, this is a catalyst, you know? There's – okay. There is a reason to review everybody to make sure that, you know, are they on the required level of therapy intensity.

MR BOLSTER: Mr George-Gamlyn, how much money does Southern Cross spend a year, roughly, on making sure that it meets the ACFI rules, that it gets all that it's entitled to, that residents get all the care that they need? How much is allocated for those purposes?

MR GEORGE-GAMLYN: Again, I wish you would have asked me the question before, because then I could have come back and told you the precise figure.

MR BOLSTER: How many people are involved?

MR GEORGE-GAMLYN: There is an industry standard that says that you would want around about .6 of a full-time person per 50 to 60 residents. So you can work it out from there. So there would most probably be nine or 10 people across the organisation involved with ACFI at various levels of intensity and at various pay scales. But that is necessary because of the rules and, basically, the overhead cost of being compliant with ACFI.

MR BOLSTER: Wouldn't it be a better system if ACFI was replaced by some form of instrument that was assessed objectively outside of the organisation, so that all of those people – the time that those people could be devoted to care? Wouldn't that be a better result?

MR GEORGE-GAMLYN: I am aware, obviously, as you are, that that is a proposal from some people that that's what should happen. I think that the department, the government, the taxpayers should be very concerned about that, because historically bureaucracies are not efficient at doing just what that proposal suggests they will do. So we referenced the admission of certain, you know, lower care residents into aged care facilities. It happens arguably because of inappropriate assessments by the department's staff already.

MR BOLSTER: Don't you concede, though, that it creates the opportunity – I'm not saying this is the case in Southern Cross Care, but it creates the opportunity for a conflict of interest when you are having to go to such lengths to make sure that you maximise – your words – the ACFI income - - -

MR GEORGE-GAMLYN: Yes.

MR BOLSTER: - - - that the business receives.

MR GEORGE-GAMLYN: Yes. And I certainly don't step back from maximise or optimise or whatever else you want to say, because to do any less I would actually argue is negligent, because you need the money to provide the care for the residents. Yes, of course, there's an opportunity for people who want to be criminal to be so. And no doubt some are.

MR BOLSTER: We're not talking about criminal. We're just talking about a conflict of interest.

MR GEORGE-GAMLYN: Well, if you claim things you're not entitled to, then it must be criminal, I assume, if you knowingly do it.

MR BOLSTER: Isn't this system open to that occurring?

MR GEORGE-GAMLYN: Isn't any system?

MR BOLSTER: Well you – what is the ideal system? You're very experienced when it comes to ACFI and funding for providers of residential aged care services. What's the optimum system that would be the fairest and provide transparency that the Commissioners might wish to give consideration to?

MR GEORGE-GAMLYN: Thank you for asking the question. I actually think that the system – the ACFI system as is most probably about as good as it gets. You can move the deck chairs. And there are proposals to do exactly that. And they've been rearranged a few times in the past. The issue, from my perspective, is the policing of the current system by the Department of Health. I think it's inadequate. And if it was done in a different way than it currently is, then most probably the opportunities to, I guess, you know, claim things that you're otherwise not entitled to would be better controlled.

MR BOLSTER: The current system, though, it suggests or invites people to deliver care that's provided for in ACFI, as opposed to the care they actually need. Do you see that possibility?

MR GEORGE-GAMLYN: I do wholeheartedly, but if you look at the primary elements within the ACFI, so activities of daily living and management of people – of people's behaviours, they are the key elements that – the key areas of care that you would expect. So, therefore, it's focusing exactly where it should within the complex health care area. And it's very specific. You can claim for the care of a person with a catheter if they've got a catheter. You can't just give them a catheter.

MR BOLSTER: I have no further questions. Thank you, Commissioners.

COMMISSIONER PAGONE: Thank you. Thank you for your testimony. You're released from further attendance. Thank you very much.

MR GEORGE-GAMLYN: Thank you.

<THE WITNESS WITHDREW [2.12 pm]

MR BOLSTER: The next witness is Andrew Charles Crane.

<ANDREW CHARLES CRANE, SWORN [2.13 pm]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: Could you please state your full name for the Commission.

MR CRANE: Andrew Charles Crane.

MR BOLSTER: And you've prepared a statement dated the 1st of November this year.

MR CRANE: Yes, I did.

MR BOLSTER: Have you got a copy in front of you?

MR CRANE: I have got a copy.

MR BOLSTER: And you may see one on the screen immediately to your left.

MR CRANE: Okay. Thank you.

MR BOLSTER: Are you happy with the contents of that? Do you want to make any changes?

MR CRANE: To the best of my knowledge, it's a very accurate statement.

MR BOLSTER: All right. So it's true to the best of your knowledge, information and belief.

MR CRANE: Yes. I've been away for this a little while, so - - -

MR BOLSTER: Yes. Thank you. I tender witness statement 0559.0001.0001.

COMMISSIONER PAGONE: Thank you. The statement of Mr Andrew Charles Crane, dated the 1st of November 2019, will be exhibit 13-14.

EXHIBIT #13-14 STATEMENT OF ANDREW CHARLES CRANE DATED 01/11/2019 (WIT.0559.0001.0001)

MR BOLSTER: Mr Crane, I understand that you've had some health issues recently. And if you can let me know if there's anything that's troubling you or anything like that - - -

MR CRANE: No. I'm fine.

MR BOLSTER: - - - we, obviously, don't want to inconvenience you in any way, shape or form.

MR CRANE: Thank you for that.

MR BOLSTER: You were, until the end of last year, the executive manager finance at Southern Cross Care.

MR CRANE: That's correct.

MR BOLSTER: So, effectively, looking after the financial reporting and management of the entire Southern Cross group.

MR CRANE: Among other things, yes.

MR BOLSTER: Yes. And we have limited time, so I want to get to a couple of - - -

MR CRANE: Sure.

MR BOLSTER: - - - key issues directly and quickly. You talk about a robust debate at the executive budget committee level and at board level about a pathway to – what was the name of it again?

MR CRANE: Break Even. Pathway to Break Even.

MR BOLSTER: Pathway to Break Even. I do apologise.

MR CRANE: That's okay.

MR BOLSTER: Why was the discussion robust?

MR CRANE: I have to give some context, so I will try to speed it up. But the situation at Southern Cross and a lot of organisations with the change in government funding was that we were in an operating loss cash position.

MR BOLSTER: When was this?

MR CRANE: It was around 2016, I think. Our timelines are a little bit ..... but I'm pretty sure it was just as I started there. The discussion, when I say robust, is that Southern Cross Care, at the board level and at the executive level, made it quite clear that, you know, that we're here to serve people and – and that anything we did to correct our financial situation must take that into account. So the debate, essentially, was about how we do that. There was no debate about the fact that we needed to improve our situation, but the debate was clearly – well, the elder – some of the statesmen of the group who had been back there from the foundation right through were adamant that we must look after the people in this equation and that alignment was one of the things that attracted me to Southern Cross.

MR BOLSTER: The Pathway to Break Even you refer to as being a policy that was adopted by the board, having been initially formed at the budget committee level; correct?

MR CRANE: I would not call it a policy because I think there's a really – there's a real distinction there. A policy to me is something that you mandate. We were trying to define a framework that we could put guidelines or markers in the ground that we were going to work towards.

MR BOLSTER: One of the markers, may I suggest, was that it was not to impede the quality of care.

MR CRANE: Yes. And we - - -

MR BOLSTER: At any facility.

MR CRANE: Yes. And we took a lot of steps in that area.

MR BOLSTER: Where does one find a clear and transparent enunciation of what the pathway was?

MR CRANE: Well, the – there is no one size fits all for a start, so you can't simplify it to that point. There was a deliberate and – a deliberate design feature that we wanted to make sure the facility managers had a large say in how they moved to this position. We said that the overall target at its most benign point we could which was below the industry average.

We did that on purpose so we could make it a clear statement of mission that we were not looking for EBITDAs per bed of the commercial sense or even the top 25 or 50 per cent, we were looking to move the organisation almost to a harm minimisation position to break even, which would give us enough cash flow to reinvest in the equipment, the IT.

So we – we were – forward projections of operating losses so that was the plan that we were instigating. The design feature of it as well was that that pathway would be as – would be tested and iterative and take time and not be universal. Two facilities, for instance, we decided could not achieve Pathway to Break Even. I also point out that I think it's fair, too, that we've labelled it, sure, Pathway to Break Even but in essence it was normal business.

MR BOLSTER: Yes.

MR CRANE: But normal business often is defined in the budgets context but we wanted to define it in the context that covered many budgets and so we could get a resource planning in the hands of the facility managers that could improve – improve performance but also really reflected what they want. So it was not an attempt to be top down.

MR BOLSTER: Right. But in terms of a piece of paper that records what it was, did such a document – did such a resolution exist? For clarity's sake, so that everyone would know, well, we're all on the same page here, this is what we mean.

MR CRANE: The definition of break-even was defined in papers to the facility managers and to the board, a definition which was effectively that your ACFI plus your resident fees were required to cover your operating costs over time.

MR BOLSTER: So long as the quality of care was not compromised.

MR CRANE: Yes. The structure of that was absolutely there. I mean, I would like to go on to that if I get a chance at some point, but the – that is the framework. The pathway and the implementation and the governance of that was really specific on how we would do that in a careful considered way.

MR BOLSTER: Right. Was there a minute though or a directive from the board to give people guidance about how they would go about doing this?

MR CRANE: Look, I received one statement in preparation for this from the chairman and he noted that it wasn't minuted; I wasn't sure if it had been or not minuted. The discussions at committee level and at board level were fully aware of what we were trying to achieve.

MR BOLSTER: Let's move forward, given the time - - -

MR CRANE: Yes.

MR BOLSTER: - - - and talk about the way in which it was done at Yaraandoo which was the last facility to have this process take place; correct.

MR CRANE: Yes.

MR BOLSTER: Why was it the last?

MR CRANE: Well, I – I guess others can see it in certain ways but one – one, the conversations that started sometime in December 2017 and plans were brought forward. It was generally an iterative process and there was a timeline. There was some delays, I agree with that, but in that discussion, the – our priority was ACFI first, so if they could get ACFI up through proper and appropriate claiming, then we weren't interested in roster changes. The second – the second element, we were looking for non-productive – sorry, non-labour costs second. We did a lot of analysis during that time.

It was heat-tested against industry benchmarks, it was heat-tested against the history of staffing there, and there was a lot of groundwork to be laid, a lot of conversations, meetings with facility managers. There was a whole lot of preparation needed to get that debate and that understanding underway.

MR BOLSTER: All right. In terms of implementing at Yaraandoo, Ms Robson says that she was the person who had responsibility for implementing Pathway to Break Even. I do apologise.

MR CRANE: I labelled it. Yes, I wish we hadn't now, but anyway. The – Ms Pauline Robson had that but I was actively participant in that process.

MR BOLSTER: Yes. And you prepared a number of papers and they're already in evidence.

MR CRANE: Yes.

MR BOLSTER: And I don't want to take you to them right now. Did you have an idea of how receptive the staff would be to that proposal in its final form, because I understand it went through a number of iterations over time.

MR CRANE: There's lots of iterations. I – I had some caution, for sure, and I will come to that in a minute. We had a – we – under the – under the pathway model, the facility manager was the strongest advocate and the strongest control in that place. We stressed to them that if they had any doubts about quality of service delivery under this model – under this framework, then they must say it, and I can point to emails that I've been provided that says that. We also – I was also quite aware that the EBA negotiations had been really problematic. We had negotiated an argument of capacity to pay, always a hard argument to – to prosecute when you appear to be a very asset rich organisation. And I remember – I remember quite clearly that the staff at Yaraandoo, during that process, were very – the trust level appeared to be dropped away.

MR BOLSTER: Yes.

MR CRANE: So there was a lot of caution around that aspect of it. And I think when we get to the point of where we delayed and then we refined it and then we reduced the targets after feedback, it was an attempt to neutralise that situation.

MR BOLSTER: Let me show you a document.

MR CRANE: Sure.

MR BOLSTER: Tab 92, please. Do you remember sending that email?

MR CRANE: Yes, I do. It was a conversation between two executives so it's probably a little bit robust but that's the nature of the game.

MR BOLSTER: Well, you introduced the word "pressure" there. What was the pressure that Mr – that Patrick was under at the time?

MR CRANE: Look, I took soundings all the time from Patrick. He put forward – he put forward his plans. He – in the emails that you put up, he stated that he really wanted to do this and get on with it. I know that Patrick had been provided support through other facility managers to mentor him, and – but I was very conscious of a new manager in this environment. So – and so it was the director of residential business. So what I was getting through to Pauline is is he just mirroring back what we want or has he really done the work necessary to affirm that we are okay on the quality issue.

There's other emails around April where we had asked Patrick to actually spell out the impact of this on the quality of care – they're referenced in that bundle – around the 11th – 10, 11 and 12 April. And I specifically said to him every time – and I took soundings that if you've got any doubt don't do it. And I – I didn't hear Patrick's evidence, but he's saying now that he felt pressured.

MR BOLSTER: Well, you used the word "pressured".

MR CRANE: Yes, but I mean, this was a conversation between two executives and the word "pressured" there is have we got this setting right. It's not – it's not is he pressured; it's just saying, you know – it's just – it's speaking out aloud saying where are we with this, have we got this right. That's the conversation that was happening. That's – that's – the pressure exists in a budget change situation where the staff numbers have been reduced. It's an horrendous job to be involved in.

MR BOLSTER: Do you maintain that the changes that were introduced in the second week in August had no effect or would have no effect on the quality of care?

MR CRANE: I – I need to make a couple of contextual things on that. Firstly – firstly, that we – we – we had a governance system in place that sought to identify the risk associated with these changes. The first line of that was that the facility manager had obligations strongly to speak out. The director of clinical services were auditing the control systems. The director of residential business was close to the game. The HR manager – and the CEO was pulling all that together. I took – took soundings from all those and we were getting absolutely no feedback that there was an issue there. I – I also contend that – that we – we – when we looked at it again nearer to the time of the implementation, we – we withdrew our support for his plan to say it was too – too extreme.

MR BOLSTER: That was an earlier plan though, wasn't it?

MR CRANE: It was an earlier plan, but they flowed on because it was – the original plan was the 23 hours and we – we argued he was – Patrick was very firm that that could be achieved. He put out his list of how he would go about it. We then moved to a point of saying that is too difficult to pursue. We – we were not insensitive to the – how difficult this was, especially if the – if what as I assessed, and this is my own personal assessment, that the trust post EBA was a difficult environment.

MR BOLSTER: I mean, you knew he was a very new and green facility manager.

MR CRANE: We did, yes.

MR BOLSTER: And he was even a very new and green nurse.

MR CRANE: Yes. Yes.

MR BOLSTER: And do you say that you satisfied yourself that on the basis that he told you that this would not impact on care?

MR CRANE: Yes. That – that was part of the deal and you have to understand there's a relationship going on there as well. It's – that had been worked on, a very careful relationship. But also the controls, the governance controls has the director of clinical services looking at that question, very strongly looking at that question. The director of residential business looking at that question, the HR and that. So it was not just me sitting there saying we need to sort these financial targets out because we're cashflow negative. It's not a great – a great position to be in. And, as a business, you can't sustain that forever.

But we – we were trying to be extremely careful that we – we understood the risks of – and to the extent that Patrick's assurances at the time in real time were very positive and that he talked to staff, etcetera. Post the sanctions there has been what I argue is some revisionism in that. But maybe his perceptions all existed. But I thought the system of controls was pretty powerful to – to look at the risk and mitigate them. I thought they were pretty adequate.

MR BOLSTER: Was the director of clinical services telling you that there were any clinical issues at Yaraandoo that might cause you to pause?

MR CRANE: That – that statement had never come our way from the clinical services at the audit and risk committee. There was a statement that she was keeping a strong eye on it. And that gave me assurance. And I, again, remember at the clinical audit risk committee saying if there was a risk here, they would stop it.

MR BOLSTER: Was the issue of the risk of regulatory action such as that which occurred ever raised or discussed?

MR CRANE: No, never. Not through any of those channels did I hear that we were in a space that our systems to manage our accreditation standards were in any way vulnerable.

MR BOLSTER: How – did you price the benefit to the budget of the cuts that were actually implemented?

MR CRANE: At Yaraandoo?

MR BOLSTER: Yes. What was the difference? How much did it make to the Yaraandoo bottom line, if it went as anticipated?

MR CRANE: Look, I haven't – I would have to look at the financial reports. I'm sorry. It's nine or 12 – 10 months ago now.

MR BOLSTER: Sure.

MR CRANE: And I can't remember exactly the quantum. I can say that, again, that there was nine facilities, there was retirement villages, as well, that were over. We had excluded two – two facilities from the target. But we – we were, if you look out the interest on investments, we were cash flow negative.

MR BOLSTER: Yes.

MR CRANE: And we – we had – when the government made some really significant funding changes, the – and withdrew funding and stopped indexation and then Fair Work put in a 3.1 per cent minimum wage, which affected 58 per cent of our workforce, our forward projections were pretty horrific. So the – the need to do something was paramount, but the board in all my discussions were willing to take time to get this done and to get it done right. So I haven't had the luxury of looking at the accreditation report to see what went wrong. I am aware that we didn't take clinical hours out of Yaraandoo. So – and I understand a lot of the clinical standards were the ones that ran into some trouble.

MR BOLSTER: Are you sure about that? I mean the – what was explained to residents was that they would lose eight hours of carer every day, in the morning, and then six hours in the evening.

MR CRANE: Well, I call those carer hours and clinical hours of the RNs, registered nurses, and – so there was some – there was some hours to be adjusted. Remember that that is far less than put forward. So I do think the controls to some extent picked up some risk in putting them forward. So we mitigated that and reduced the hours. I mean, this probably means very little, but the hours that were allocated to Yaraandoo were significantly above the hours of our other facilities. They were significantly above the hours they had in 2013. They were significantly above – when I calculated – I looked at the data very carefully. This was the macro look, not the on the ground look. They were significantly above the AMF ratios that they were putting out in the industry.

So, in saying that, I formed the view, after looking at the – the feedback from the – from each of the main parties, that eight hours was still good. I did rely on an inexperienced manager, but that manager was also part of a collective of facility managers who met. And that manager also had mentoring of really senior managers. Support would be put in to guide him through the early stages.

MR BOLSTER: Well, he says he didn't have any of that support in the early stages - - -

MR CRANE: Well - - -

MR BOLSTER: - - - and certainly didn't have it in June, July, August 2018.

MR CRANE: You will have to ask the director of residential that, but my understanding that he did have access to it. But I don't know. The timeline gets a little bit – I don't know about other people, but timelines tend to just lose a bit for me over time.

MR BOLSTER: Can I ask you - - -

MR CRANE: I also know at one stage that each of the facilities had direct access to a director. So there was avenues there, and those avenues were taken quite often. I thought the control of it was right. I know – I know that if you project forward and then say the organisation was sanctioned and then that the staff numbers were seen as one of the reasons, I wracked my brain on it, but – and I haven't seen that report in detail. I thought we were being, over nine months and over time, really cautious on that, the notion that we needed to make change, we needed to live within our means, but, overriding, we must – must not lose the Southern Cross mission. That's my strong understanding of it.

MR BOLSTER: All right. Let me ask you another question - - -

MR CRANE: Sure.

MR BOLSTER: - - - on a different topic. What's the budget per annum for ACFI assessment and ACFI claiming at Southern Cross?

MR CRANE: I missed the first word, sorry.

MR BOLSTER: What's the budget annually, or at the time you left, for ACFI claiming and ACFI assessments, all the people that ensure that you get the best out of ACFI? How much do you spend on that?

MR CRANE: I'm not – I can't quantify it for you. I can make a general statement of a personal view, but I'm not sure that adds to much. It's too much. That's all I can say.

MR BOLSTER: It's too much. Yes.

MR CRANE: Well, I think an overhead directed to the administration of the funding that could be directed to the provision of care distorts what we're on about.

MR BOLSTER: Yes.

MR CRANE: That's now – I know this is just a personal view, that if you have a funding model that had a significant fixed component that that was available to all residents who come through the door, that that – you could – you could absolutely improve the service delivery by re-directing that overhead – I call it overhead – to frontline services. I think it's a shame that we have to go to this extent. But I understand you can't just hand out government money either.

MR BOLSTER: The Commission is interested in what you've got to say about things like that. How would you frame a system? I mean, you've been involved in the industry for a very long time. You've been a CEO and a facility manager. How would you like to see these sorts of funding decisions made?

MR CRANE: Well, I would do everything in my power to stop the organisation devoting so much expense and overhead to such a system that needs a lot of attention. The reason it needs so much attention is that after a very short time a resident who comes into a home that may be having a claim for ..... an element that we can claim, the nursing staff very quickly just get used to it, so they forget about claiming it, because, you know, if Mr X is doing this behaviour of a morning, after day one that's quite unusual. After day three it's just who Mr X is. So the claim can – would be missed.

So my argument would be that you don't want your care staff investing your time in that process. You want your care staff investing your time in relationships and understanding and getting that deep understanding of the client. Because it's a complex – complex time in anyone's life. So I would unquestionably – and there's probably some naivety in this answer, but I would unquestionably make a fixed component of ACFI that covered, essentially, most things about daily living, a reasonable figure on – so I would move away from a needs-based system to a fixed component. And then – then there would be things that you could specifically claim on top of that if it was really complex.

MR BOLSTER: All right. Those are my questions. Thank you, Commissioners.

COMMISSIONER PAGONE: Mr Crane, I would like to pursue some of those matters, if I may. If you sit back and look at the ACFI system as a kind of a general global thing, you can sort of see that it's a way that somebody thought up of arranging for the care that was needed to get to the person that needed it. But there was a problem with that kind of objective, namely that there needs to be some form of accountability, for the reason that you've said; you can't just give out Commonwealth money. And that, therefore, means that you have built into the system an accountability that brings with it all of that administrative burden that you've talked – or that you and others have talked about.

So there's got to be an – well, assuming there has to be some form of accountability and that the accountability and governance carries with it a cost, and you've been close to that process, because you've – the ACFI system, effectively, puts the burden on the service provider to do all of that accountability and cost, which is why you

called it an overhead. You've said something about an alternative model, namely a fixed component. But can I just ask you to talk generally about how you would balance the elements needed in achieving the objectives of getting the care that's needed to those that need it at the same time as accountability and governance.

MR CRANE: Well, look, the way I see it is– and, again, it's my views. I'm not representing Southern Cross. I just need to point that out. I'm not sure that I do, but they are my personal views. The – my view is that the government under their rules for us as a society have made the decision that that one of its citizens at this point of time in its life needs care and support. It's made that decision through an assessment, an ACAT assessment.

So at that – at that point, it needs to – it's taken responsibility and, as the provider, we are, essentially, an agent of government who in trying to get this – this right has created a truckload of regulation and a truckload of compliance rules. And, to that extent, I feel, and I know I'm repeating what I said, I feel it distorts what the main game is, and that is to provide a client with as good a life and a good as death as you can get. And you trade off when you come into an aged care facility, full stop. You just have to, because life's not the same completely. You're not getting the home meals, etcetera, etcetera.

So I think one of the ways you could solve that – and I don't think it hits the outlays of the government horrendously – is that you get a – I'm just repeating what I said before – you identify a significant fixed component of the fee and then there are specific things you could define that may add complications to the management. Dementia is clearly – needs a lot of resourcing and a lot of help, a lot of specialist.

And so it then creates – it creates totally different set-up. You can divert – you can divert care staff to spend more time on relations than just tasks. You know, you're in and out of a room and onto follow-up. The carers have a difficult job, a difficult job if someone is lonely and wants to talk to you, but you've got another six showers to do. I mean, it's really complex. And so I think you could create a model without hurting your outlays terribly. I know governments need to protect your outlays. I'm not against that. That assists what the – what it's all about.

I think it's a shame that it's become an industry, ACFI management. I think it's a shame that you've got within facilities a lot of clinical staff, a lot of people out there trying to understand how – how to get this system right. And then you've got the executive of an organisation always trying to understand are we under-claiming because people have just accepted the person and we've lost – we've lost track of what – what their needs are under this ACFI instrument.

The other thing is, is that ACFI people come and they go so you have to retrain them and you lose momentum there. So I would – I would personally get rid of that – find any method to get rid of that, that industry and that – I won't be popular saying this probably – that industry and that overhead within it, because it's just a simple way to

be redirected. There are things you could mandate in that as well to make sure that it just didn't go to the bottom line.

COMMISSIONER PAGONE: Well, I think I'm interested in knowing what you think about that. You were certainly asked questions earlier on about whether the system isn't a system that creates a conflict of interest. Do you remember that question?

MR CRANE: Mmm.

COMMISSIONER PAGONE: Of course, that's the system that we've got. We don't have a system of a lump sum as you were talking about; but the fear presumably would be that if you had a lump sum system, the same human frailties or weaknesses that we all have that would make us susceptible to a conflict of interest might make us all susceptible to a lack of interest if we've got the money in our back pocket and don't need to account for it.

MR CRANE: That is the absolute thing that we have to find a way to solve. I'm haven't got any great wisdom in that because, as you say, the alternate model and this is where the specialists would have far more knowledge than me, the alternate model does have that risk that it would just flow to the bottom line, and then you've achieved absolutely nothing except an easier system. I don't think it's beyond comprehension to be able to stage – be able to set up frameworks that could protect against that. I – I think you, you know, that the government in return for a fixed fee could do some quite detailed specification of it. I know you have to be careful you don't create another industry around how you manage that, but you could get some specification of, you know, these are the society values, we want a certain amount of lifestyle delivered. You could be asking people to acquit that way, rather than acquit this way. We want this profile of service delivery.

COMMISSIONER PAGONE: Well, you've put it all in terms of "could" and I understand that. Do you have a view about what it might look like?

MR CRANE: Look, I – I – I haven't solved that completely in my mind, but I – I've often thought as I said, I won't go over what I just said about how this is distorted. I've often thought if you did get a fixed sum and did prescribe certain compliance issues, compliant matters like – without getting into ratios or whatever, you must meet these – these lifestyle hours. I mean, and you – you – yes, it gets complicated. I can't deny it, because it can create the same compliance issue that you've just tried to get away from in another way.

COMMISSIONER PAGONE: Well, is the solution perhaps to add to the ACFI formulas things like lifestyle matters and individual items that don't go to care but go to wellbeing?

MR CRANE: That may well be the answer. It may be that – I mean, the ADL part, maybe some fixed part of that, and you have other areas that you, if you provide, you

can claim on an acquittal basis. I think we might have had that funding model once before. I think I've just created the past but it's, yes, it's a really complicated job to solve this that you guys have got. But to me – to me that – anyway, to me, a job that sort of – it is task-orientated when people are frail and need time and need – it just seems – it just seems a little bit sad and ludicrous to me.

COMMISSIONER PAGONE: Well, Mr George-Gamlyn seemed to think that it was – that the ACFI system was at least theoretically about right. He would play around with some of the details, I think. But he seemed to think as a mechanism directed to getting care to the people who needed care with a system of governance so that you're ensuring some accountability that the care was given - - -

MR CRANE: That's true.

COMMISSIONER PAGONE: - - - was about right. Do you have any view about that?

MR CRANE: Well, the ACFI – the ACFI approach is that you need to get a good understanding of the resident's needs to make a claim, so that is valuable; there's no question about that.

COMMISSIONER PAGONE: The theory sounds good, doesn't it?

MR CRANE: The theory sounds good but in the end it's very much an averaging system. I mean, you – everyone talks about your average ACFI, and you're rostering linked to that, I mean, there's aspects that are directed, you know, I mean, if you – I've heard the conversation about pain management. There are specific things you have to do to get those funds so that is quite clear, although – then you can look at other ways to do it that is cheaper and things like that. So I'm getting well out of my depth, I think, but the – the notion – the notion that I – I would have are more principles than actual solutions and that is try to get – try to get as much care and time into the equation as you can within the existing model.

That would be a design principle I would have. I would be really looking at as much lifestyle because loneliness is a massive factor, and I would be looking at really trying to design a system that may be an add-on to the current ACFI or whatever, that gets rid of an industry and overhead approach to claiming. I haven't answered your question - - -

COMMISSIONER PAGONE: No, you've been very helpful, though. And just in relation to the last thing that you've said. If the theory is about right – let's assume that for the moment, but if one of the problems is that it incurs too many what you called overheads - - -

MR CRANE: I call them overheads. There's probably a better name for it, but - - -

COMMISSIONER PAGONE: No, overhead will do. Is there some way that the overheads – is there some systemic or mechanical way that the overheads could be reduced?

MR CRANE: Well, not under an ACFI model because you have to collect so much information and – and I suppose the people who would push ACFI say you must get a deep understanding of your resident anyway to help look after them, so is ACFI just a by-product of that? But I think it's become – that's partially true, but it's become a system that needs to be really worked at continually, and to my way of thinking I keep going back to that, that I think that to me is a waste of resource if it's not achieving any more than – than people just pushing the boundaries to get a certain dollar limit to keep the place running. It just – I haven't got the solution, but that to me seems to be a real fundamental waste. And at this – at a point when you're trying to really assist people in probably the most difficult phase of their life - - -

COMMISSIONER PAGONE: All right.

MR CRANE: You don't really want some of your care staff sitting in a room or getting out there trying to calculate ACFI scores.

COMMISSIONER PAGONE: Let me ask you one final matter, otherwise counsel will complain that I'm wasting his resource for the next witness. But one of the things that Southern Care brings into focus is what happens when a facility is providing care to residents, but the facility finds itself in financial distress. Do you have any thoughts about what should happen to assist such situations, whether it be the residents or the facility?

MR CRANE: So if I'm right, the facility is providing the care and doing - - -

COMMISSIONER PAGONE: What would you have liked to have happened at Southern Care where you realised you needed to break even and you weren't doing so?

MR CRANE: What happened when the government decided to withdraw some funding from the sector, we talk about whether our break-even strategy was blunt, that was really a blunt response because those for-profits who were doing large EBITDAs per bed – profits, they lost some profit in that – that squeeze. Those that had had a philosophy of covering their costs which was a mission-based approach that Southern Cross had, they suddenly lost viability, and you're then in a horrendous situation where your forward projections with Fair Work and indexation was stopped, it shows your cash declining. You're looking for other parts of the business to subsidise. You – you are in that situation where – where 83 per cent, roughly, or over 80 per cent of your costs are labour-related because it's people looking after people.

And you know you've got a relationship with the people on the ground and they – and they are – no matter what you say, they are quite stretched in what they do because maybe you can get the tasks done in a given day. But if you really want to stop and have a conversation on the way, which is valuable to a lonely person, you can't do it. So you've got – you've absolutely got two things in conflict there. Now, I believe as I've said before, Southern Cross really through their governance structures tried to resolve that as best we could. We really did try to resolve that.

But it's a really imperfect thing to try to resolve. So I have no answer because if you put more money in, the for-profits – I'm not trying to just take them out, but those that have got – have structured themselves in the way that they want to take it to surplus, you know, for shareholders or whatever reason, everything is very blunt and universal. There's a whole lot of different operating approaches going on under one sector.

COMMISSIONER BRIGGS: Are you in effect saying that the search for profit is chasing everybody to the bottom or forcing everybody to the bottom?

MR CRANE: I'm saying that we've got a – we've got a sector with a whole lot of different – different people operating within it. And I'm not making any judgment of whether - - -

COMMISSIONER BRIGGS: Okay.

MR CRANE: - - - a private sector company does better quality of service than a not-for-profit; there's arguments all over on that.

COMMISSIONER BRIGGS: Should there – sorry. Go on.

MR CRANE: It's alright.

COMMISSIONER BRIGGS: Should there be limits on profit-taking?

MR CRANE: I'm not sure how you can do that but what I think is where the direction is interesting to me, what you're talking about is how do you – we've had this ACFI model and it sounds like it was really theoretically a great idea but I think that the model should include some statements about how we want to assist these people where the government have made a declaration under their ACAT rules, at this time of their life we want to look after them because of frailty and other things.

That's what society has done through – and how do you diminish that trade-off when they come in the door and how do you make it a good journey and all those things. And I think that somehow – and I'm not saying that this is not what happens, I didn't ever expect that – it's now going down this path but I think that that – there has to be a method that puts what we value as a community into – into the equation.

COMMISSIONER BRIGGS: I think that's where the legislation comes into it.

MR CRANE: I think it does. There has to be some pure statement about what's important to us. You know, these are – these are – these are our family, and they're also – they're eventually our children, possibly. So if you look at – look at them – and I don't think – I don't personally think the outlays necessarily need to bust their bank. I think the thinking needs to sort of find a way through.

COMMISSIONER PAGONE: Mr Crane, my very final question to you: you have used an expression twice which I think the transcript hasn't picked up, so just to make sure that I've picked it up correctly, I think you've on two occasions used the financial concept of EBITDA.

MR CRANE: Yes.

COMMISSIONER PAGONE: Would you explain what that is and how it's spelt.

MR CRANE: It's a commercial measure of earnings before interests, taxation, depreciation and amortisation. It's a commercial measure that – and you see a listed company uses as a measure of performance. In terms of valuing aged care providers, without going into it, it's often used as a measure of per bed income, EBITDA per bed per annum. And that is then multiplied out to get a valuation of possible cash flows and if you're valuing the business. I do want to make sure you understand that Southern Cross were not in that space. We were just trying to minimise our losses.

COMMISSIONER PAGONE: I understood your evidence. Just, for the benefit of the transcript, it's ordinarily spelt EBITA. Is that right?

MR CRANE: TDA.

COMMISSIONER PAGONE: TDA. Sorry. TDA.

MR CRANE: It's depreciation and amortisation at the end there.

MR BOLSTER: EBITDA.

MR CRANE: Yes. I probably said the language probably wrong.

COMMISSIONER PAGONE: Mr Crane - - -

MR BOLSTER: Might the witness be excused. Thank you.

COMMISSIONER PAGONE: Yes. Mr Crane, you're excused from further attendance. Thank you for giving your evidence.

<THE WITNESS WITHDREW [3.01 pm]

MR BOLSTER: I call Pauline Robson.

MR D. MARCENKO: May it please the Commission, my name is Marcenko. I appear for Ms Robson .....

COMMISSIONER PAGONE: Yes, of course. Thank you.

<PAULINE ROBSON, SWORN [3.01 pm]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: Your full name is Pauline Robson.

MS ROBSON: Yes, it is.

MR BOLSTER: And you made a statement on the 28th of October of this year.

MS ROBSON: I did.

MR BOLSTER: And you have a copy of it in front of you.

MS ROBSON: I do.

MR BOLSTER: All right. Is there anything you wish to change about that statement?

MS ROBSON: No. It's accurate as far as I can remember at the time.

MR BOLSTER: All right. I have to ask you this question. Is it true to the best of your knowledge, information and belief?

MS ROBSON: It is.

MR BOLSTER: I tender statement WIT.0560.0001.0001.

COMMISSIONER PAGONE: Yes. The statement of Pauline Robson, dated 28th of October 2019, Exhibit 13-15.

EXHIBIT #13-15 STATEMENT OF PAULINE ROBSON DATED 28/10/2019 (WIT.0560.0001.0001)

MR BOLSTER: Ms Robson, I want to take you back to the middle of 2017 and the Pathway to Break-Even strategy. How did that arise in your work at that time, which was, effectively, managing the residential businesses of Southern Cross?

MS ROBSON: The Pathway to Break-Even was not a term that was used frequently in mid '17. Prior to that, we looked at proposals to improve the financial viability of a number of sites. The Pathway to Break-Even was discussed around looking at how we can move the organisation to financial viability and to stop making operational losses. And for that to be at each site was very different.

MR BOLSTER: Right.

MS ROBSON: So – yes.

MR BOLSTER: So when did you first hear the phrase Pathway to Break-Even?

MS ROBSON: Andrew and I discussed it during that time.

MR BOLSTER: That's Mr Crane.

MS ROBSON: Sorry. Mr Crane and I discussed it during that time and it was – it became part of the budget process in late 2017 in preparing for 2018.

MR BOLSTER: Were you present when it was discussed at the budget executive meetings?

MS ROBSON: Yes, I was.

MR BOLSTER: And Mr Crane talks about a robust discussion there. What was – why was the debate robust?

MS ROBSON: The debate was robust because in some facilities we were making an operational loss and we needed to ensure that the quality of care to the resident was not compromised by any financial changes. So we talked about how we can manage the two together to enable Southern Cross Care to move towards a more sound financial basis.

MR BOLSTER: Where do I go if I want a definitive statement of what the Pathway to Break-Even was, or is there no such thing?

MS ROBSON: In February 2018, there was a meeting that the CEO and the board members, myself and Mr Crane, were present, and it was reaffirmed that the Pathway to Break-Even would reflect a movement towards 60 per cent of operational income being spent on operational costs. And there were minutes from that meeting. It was also referenced in Mr Crane's documents to the board. And it was also referenced in proposals that I presented to the finance and executive meeting.

MR BOLSTER: Let me ask you this. Is – was it the case that, whatever the pathway led to in a particular facility, it was not to compromise the quality of care?

MS ROBSON: Yes. In December 2017 I outlined the 12-step process that went through the Pathway to Break-Even. Point 12 of that was ensuring measurement and monitoring of quality indicators.

MR BOLSTER: Well, let me ask you this. You were in the facility till late 2018; correct?

MS ROBSON: September. Mid-September 2018.

MR BOLSTER: And you left because of a dispute with Mr Sadek, which we don't need to go into.

MS ROBSON: Yes.

MR BOLSTER: At that time, was there measurement going on of the quality indicators for Yaraandoo and Glenara Lakes in relation to their Pathway to Break-Even?

MS ROBSON: Yes, there were. There were a number of quality indicators that we were looking at. I wasn't responsible for managing and monitoring those quality indicators. They were provided to me by the director of clinical services. We also had – I regularly went up to Yaraandoo. We also had the HR manager going up to Yaraandoo, meeting with staff, having one-to-one meetings with the facility manager and individuals. I also attended a range of meetings up there.

MR BOLSTER: Were you – do you say that you were given the QPS benchmarking materials?

MS ROBSON: Yes.

MR BOLSTER: On a regular basis.

MS ROBSON: Yes, I was.

MR BOLSTER: How often were you given them.

MS ROBSON: I received those on a quarterly basis.

MR BOLSTER: For every facility for which you had responsibility.

MS ROBSON: I did.

MR BOLSTER: And that included Yaraandoo?

MS ROBSON: It included Yaraandoo.

MR BOLSTER: And Glenara Lakes.

MS ROBSON: And Glenara Lakes.

MR BOLSTER: Did those documents give you any cause for concern about clinical standards at those two facilities?

MS ROBSON: In February 2018, the CEO made it very clear that my role was not to be involved in clinical matters, clinical complaints or any clinical indicators. So I looked to the director of clinical services for feedback if there were issues of concern.

MR BOLSTER: All right.

MS ROBSON: At the audit and risk in August, the director of clinical services indicated there were no systems or trends or concerns and there were no issues that required further follow-up. And that's in the minutes.

MR BOLSTER: Well, my question was slightly different.

MS ROBSON: Sorry.

MR BOLSTER: It's whether you had – whether those documents gave you any cause for concern. You say you saw them. Were you worried about clinical trends at those two facilities?

MS ROBSON: I had some concerns about what was happening at Yaraandoo. And I heard what Patrick said on the stand. However, I organised for two very experienced facility managers who were achieving sound outcomes to spends time with Patrick at Yaraandoo coaching and supporting him.

MR BOLSTER: And how long were they there for with him?

MS ROBSON: They went up regularly from June to when I left. One of those people also had regular phone contact with him. And there were no issues raised from those phone calls with him. I also have a number of emails from Patrick in June, following discussions with unions and individuals and with the HR manager, that said there were no issues.

MR BOLSTER: Did you recruit Mr Anderson?

MS ROBSON: There was an interview panel comprising the director of clinical services, myself and the director of finance.

MR BOLSTER: All right. And were you concerned that – about his level of experience when you employed him?

MS ROBSON: I did. And I organised an induction week for him. I organised a three month induction program, which he appears to have forgotten about. And I also organised for him to have a buddy to explore and develop his clinical skills and facility manager skills.

MR BOLSTER: Well - - -

MS ROBSON: The director of clinical services also had a responsibility to support him on the clinical management of issues.

MR BOLSTER: He's critical of the induction and the support that he received early on.

MS ROBSON: Yes.

MR BOLSTER: But you say that there was plenty of support for him, do you?

MS ROBSON: I'm saying that if I had access to my documentation, I would be able to provide you with a copy of his induction program, which had a range of supports. I would be able to provide you with a copy of the buddy arrangements that were put in place to support him. And I would be able to provide you with emails outlining the supports from the facility manager at Ainslie Low Head, the facility manager at Mount Esk. And, during the change process, part of the proposal was to support Patrick by linking him in with a facility manager that had gone through this change a few months earlier.

MR BOLSTER: All right. So let me clarify the position. By June, when these changes were contemplated, you had clinical concerns based on the documents you had seen from Yaraandoo; correct?

MS ROBSON: I had some concern about him needing more support.

MR BOLSTER: Yes. And you had already put in place a regime to give him support?

MS ROBSON: When he started, that was put in place.

MR BOLSTER: Right. So the support regime had ceased by June/July 2018?

MS ROBSON: No. When we put the plan in place to look at the changes at Yaraandoo, he was aligned with the facility manager that had gone through that. Part of the proposal was for him to take his – two key people to go down to Hobart to meet with that facility manager. That turned into a video conference, because he wasn't able to make the time.

MR BOLSTER: All right. Well, how were you able to satisfy yourself that the – there would be no effect on the clinical care of the residents of Yaraandoo by the changes that were implemented in August last year?

MS ROBSON: By looking at the range of supports that were given to him from the facility managers, monitoring the ongoing QPS reports, the HR manager's involvement. Mr Crane and I regularly spoke to Andrew – to Patrick about any concerns, "Please speak out." I've seen his statement. He said he spoke out. That is not consistent with the emails I received from him or the discussions I had with him.

MR BOLSTER: All right. Can I please bring up tab 92, please. Do you recall seeing this email?

MS ROBSON: I do.

MR BOLSTER: "Is he complying under pressure?" was the question that Mr Crane raised – asked with you. Do you remember whether – what your reply was?

MS ROBSON: No, no idea. That's well over 12 months ago.

MR BOLSTER: All right. Well, he was under pressure, wasn't he, to deliver a budget cut?

MS ROBSON: He was under pressure to reduce the staffing costs that had grown to the extent that the facility was making an operational loss every month.

MR BOLSTER: Yes. But he – I withdraw that. At the heart of the Pathway to Break-Even was the principle that no care – the quality of care would not be diminished. Do you agree with that?

MS ROBSON: Yes, I do.

MR BOLSTER: And is it your evidence to the Commission that taking eight hours of carer staff out of the morning shift every day and then another six hours out of the evening shift every day would not impact on the quality of care?

MS ROBSON: My response to that would be that they had the highest care income ratio, and that part of aligning Patrick to review with the facility manager at a facility that had gone through this process was to assist him look at processes and practices to put in place so that care wasn't compromised. I previously reported in a board report that there wasn't a correlation between high staffing levels and high-quality outcomes.

MR BOLSTER: Well, you now know, don't you – I'm assuming you've read the audit report prepared by the Quality Agency; have you read that?

MS ROBSON: I have.

MR BOLSTER: It's a fair summary of that, isn't it, that it identified matters of concern on a clinical basis, well beyond the issue of staffing?

MS ROBSON: Mmm.

MR BOLSTER: Correct?

MS ROBSON: Yes.

MR BOLSTER: And is your evidence that you were unaware of the extent of that deficit?

MS ROBSON: I was. We had a director of clinical who was responsible for raising any ongoing clinical concerns. I was aware that the – Patrick had requested training as had other facility managers from State office and that was not forthcoming. I left in September. The review where Yaraandoo received sanctions was November. A number of those items were items that led up to that that were overseen by the director of clinical care. The continuous improvement system, the comments and complaints system which was reported at the audit and risk committee, the training; they were all managed by the director of clinical care.

MR BOLSTER: The director of clinical care really had nothing to do with the decision about the rosters, did she?

MS ROBSON: No.

MR BOLSTER: That was your decision?

MS ROBSON: It wasn't my decision. It was a recommendation by Mr Crane and myself, put to the finance budget committee on how to manage the operational losses of Yaraandoo based on an expectation from the board and the CEO which was reasonable, which was that services continued to be financially viable and not make a loss month after month.

MR BOLSTER: Who was the person that was tasked with responsibility for implementation. Was that you?

MS ROBSON: Myself. Yes.

MR BOLSTER: So Mr Crane and Mr Anderson were there to assist you to implement the Pathway to Break Even, were they?

MS ROBSON: We were to work together for this to occur. They weren't to assist me. It was a working collaborative approach.

MR BOLSTER: But as far as managing staff and managing the resources on the floor at Yaraandoo, outside of Burnie, a long way from Hobart, all of that fell to Mr Anderson, didn't it?

MS ROBSON: It did.

MR BOLSTER: And were you aware of the problems with the workforce at that time; the lack of engagement and the concerns that they had about their position?

MS ROBSON: I was aware that Yaraandoo was a difficult place. It's also why I organised for a competent facility manager who was achieving the break-even who had very similar outward circumstances, as in being a remote, away from Hobart facility and how she was able to provide support to him in managing some of the issues. I also had the HR manager go up and have individual meetings with staff and with Mr – with Patrick. There wasn't feedback that there were issues that should slow it down. We slowed down the process on two occasions to enable full consultation to occur.

MR BOLSTER: Originally the proposal in February was for a two or three-month engagement period with unions and staff and residents. That was telescoped down to a very short period, wasn't it?

MS ROBSON: No. The discussions started in February. It wasn't implemented until August. There was two weeks of consultation. There was discussion. There was then six weeks, I think, of promulgation of changes. The union came back with a number of queries based on their feedback from staff. I responded to those queries based on what Mr Patrick – what Patrick had told me, and they never raised further queries with me.

MR BOLSTER: I thought that the residents were told on 7 August at a meeting, the typical residents' meeting, that the changes were in place. Do you say the residents were told that earlier?

MS ROBSON: No, I'm saying the staff were involved in the process two months earlier.

MR BOLSTER: That's the negotiation with the union; correct?

MS ROBSON: Yes, yes. And with the staff and there were meetings in June, July with groups of staff relating to these changes. The HR manager, myself and Patrick met with the nurses. We met with the carers and we met with the catering staff.

MR BOLSTER: All right.

MS ROBSON: That then followed individual discussions.

MR BOLSTER: Was Mr Sadek given the final form of the changes for his approval?

MS ROBSON: Yes.

MR BOLSTER: What form did that take: an email or a letter from you to him?

MS ROBSON: The changes were approved at the finance and budget committee. There weren't changes to what had been approved. I note there's reference to the changes to the enrolled nurse positions. Again, that was all approved and if I had access to emails I would be able to find that.

MR BOLSTER: So the enrolled nurse positions, you're talking about the later change whereby two enrolled nurses became ACFI - - -

MS ROBSON: No, what happened is those – to put the context, those two nurses had shared responsibility while they were on the floor. There were – they had an ACFI responsibility, and they had an enrolled nurse responsibility. It was confusing. The registered nurse and the CCC raised questions about the team leader aspect of that. It was also advice given that because often they would be called away from ACFI or couldn't do care because of ACFI, we looked at separating out those functions and instead of having two people each week do components, we looked at the creation of an ACFI role. Those two people wished to share that so they did week in, week out. So there was actually no change to the enrolled nurse aspect of care.

MR BOLSTER: Well, other than the fact that those two gentleman who were highly thought of, and who were highly skilled were taken off the floor completely; correct?

MS ROBSON: No, they weren't. They worked on the floor with a shared responsibility. So one week they would do two days ACFI, three days EN, and the next week the other would do it. So what actually happened was we ended up with a full-time enrolled nurse and a full-time ACFI so that actually it was a separation of function. It was not a reduction in enrolled nurse hours.

MR BOLSTER: Have you seen the criticism of that decision by Ms Marshall in her statement?

MS ROBSON: I have.

MR BOLSTER: What do you say in answer to that?

MS ROBSON: I say that at the time Ms Marshall and other people raised the issue with me that in having those two people as team leaders, often the registered nurse on the floor and herself were bypassed in terms of some of the clinical management. So it was to strengthen some of that clinical management.

MR BOLSTER: All right. I have no further questions. Thank you, Commissioners.

COMMISSIONER BRIGGS: You had a very responsible job and you had a couple of facilities that were clearly struggling. As the executive manager of the arrangements in the north and the north-west, how much did you visit these facilities to try and work with the former facilities' managers, of which we've seen a number, together with the leading-edge staff to help them through this period of major change?

MS ROBSON: Until June I had sole responsibility for nine aged care facilities. I requested support in terms of administrative support to enable me to do that job. It was not accepted. In June, part of the restructure was to enable me to provide a greater focus in the north. To answer your question, I went to Yaraandoo regularly. I also had, as I say, two of the facility managers go up because I noticed that Patrick needed that assistance of people who had gone through and could look at the clinical practices. The director of clinical care did not go up to that facility. We also had a quality coordinator who was meant to go up and support and do audits. That wasn't particularly forthcoming in that time. So, sorry, to answer your question, if I look at my diary, I went regularly.

COMMISSIONER BRIGGS: But what you're saying is that it's not your fault that this was a problem, that the absence of people in other key positions was the issue. Is that what you're saying?

MS ROBSON: I'm not saying it wasn't my fault. I'm saying it was a shared responsibility, that the messages that I was getting indicated to me there weren't concerns.

COMMISSIONER BRIGGS: Okay.

MS ROBSON: The Audit and Risk Committee, the monthly reports from the facility manager, the indications that I got from going up and from what the other facility managers shared with me. I noticed that all the facility managers I did share the QPS reports, I actually emailed them. My rule was not to follow up with those. It was made really clear that that was a clinical issue and I had to take a step back from that. There was also facility manager meetings, one held in Hobart, one held in Launceston. When they went to Hobart there was four facility managers in the car and not once did Patrick raise, during that time, in that conversation, that he had any concerns, felt under pressure or has, as he said earlier, that his job was on the line. That was never communicated in those private conversations.

COMMISSIONER BRIGGS: On reflection, what level of experience do you think a facility manager might need in order to be able to deliver quality and safe care?

MS ROBSON: On reflection, I think Patrick needed more than he was willing to accept from support to enable him to do the job. One of the people who went up regularly said to him "I'll come up next week" and it was "No, don't, I'm okay.

Everything's fine, just give me a phone call." I think that we made the decision on appointing a facility manager based on a unanimous decision by three people looking at different aspects of what he could deliver and the support that he needed. I believe, yes, you need experience, but I also think you need enthusiasm and guidance and support to do your job.

COMMISSIONER BRIGGS: In hindsight, what should have happened? What would you have done differently to look after a couple of homes that were in trouble?

MS ROBSON: In hindsight, I would have been more insistent on the clinical governance support for those sites. I requested training in meetings. It didn't happen. I requested clinical support to those sites. It didn't happen. You know, I think in hindsight, if I had been more insistent, you know, but I went on audit and risk information. I went on that person. I mean, Yaraandoo had an unannounced visit in August where they were found to be compliant, indicators didn't raise for me major concerns. When the agency goes in in August and says they don't find any issues of concern and that they've met the outcome, that is again one of the many indicators I, as a manager, took on board.

COMMISSIONER BRIGGS: Was that an unannounced visit?

MS ROBSON: It was an unannounced visit and it was in August and it was met, the outcome was met.

COMMISSIONER BRIGGS: Who did you provide the advice to that you felt there should have been more focus on the clinical side?

MS ROBSON: I raised it at the executive in terms of training. I raised the issue around policies. I would have emails to substantiate that, if I had access to my emails. At least three facility managers, including Patrick, raised issues about the need to further improve the policy and clinical documentation to support managers.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Ms Robson, I would like to ask you something also, a bit related to questions that Commissioner Briggs has just asked you. You've got a very impressive CV, including a staggering 28 years as regional manager of the Commonwealth Rehabilitation Service. If we were still under the shadow of the Melbourne Cup, one would say that you're a stayer, but obviously a lot of experience. The events that occurred in Southern Cross is something about which we want to learn something and the significance for us really is what can we learn from that. And that's why I mentioned your experience because I suspect that given your length of experience and the nature of it, you might be able to help in giving us a glimpse at why the financial distress came about in Southern Cross, and then what should have been done at the time that it was discovered.

MS ROBSON: The financial distress occurred in a number of ways. One was the loss of the dementia supplement. Glenara Lakes had a small dementia unit. They were receiving a significant funding to support those people with dementia. In June – I think it was June 2015. Just before the start of the financial year, the government went, "Finished." Unfortunately, that facility had employed people with that funding to support people with dementia. That went, which meant their budget was completely behind from day one. There was no indexation last year. That created additional dramas.

There was also what I refer to as, in Yaraandoo particularly, bracket creep incrementalisation. When the issues of starting to make a loss became apparent over time, I did an analysis of the sign on sheets with the budget. So that was ensuring that we weren't putting on extra staff ongoing. Those sign on sheets indicated there were times when staff were put on to meet a particular resident's need, but it was for a specific period.

What I found when a facility manager moved on, I organised a review of the roster against the approved budget. And that indicated a number of ongoing positions, because I was being asked to explain why had Yaraandoo gone from a sound financial position to regularly losing money. And part of that was about the change in the ACFI profile at that site, and part of that related to increasing staffing costs outside of what would be seen as normal.

I think the – a lot of resources are put into managing the ACFI tool in – there was a reference earlier to someone working full-time in ACFI. When we looked at the changes at Yaraandoo, as part of that strategy, we looked at a three phase. One is to manage the contractual costs around services, food, supplies and things like that. The other was to ensure that we were receiving what the residents needed to manage their care. So we put on an admin support person four, five days a week to support the two ACFI people to manage that process. So they weren't taken away from clinical, but could give all the admin aspects to an admin officer. The other part was to look at the staffing.

Hindsight's wonderful. If I had to go back, it would be looking at ensuring a full analysis of some of the quality governance factors that seem to be missing, the training, the education, the policy development. And that was all what the facility manager spoke to me. I sat in on Helen's presentation. Until I was removed from accreditation processes by the restructure, I used to support the facility managers with some of that clinical preparing for the accreditation. In February, it was made clear I stepped away. And that was required. And I think you need a strong clinical governance framework to support facility managers.

MR BOLSTER: There wasn't one, was there, at the time .....

MS ROBSON: No. There was facility manager meetings which did discuss more than finances. We looked at issues of, "Are there any systemic quality issues across the organisation?" I've got emails from Carolyn Wallace that say no. She presented

to the finance a budget – sorry – to the audit and risk, there were no systems issues across the organisation from a quality perspective.

We did have Clinical Care Coordinator Meetings. All the clinical care coordinators, including the one from Glenara, which had two people go, and Yaraandoo, went to meetings chaired by the director of clinical to oversee clinical management in the sites. We also had an audit and risk-type committee, which was safety and health, which had other people involved that Helen – sorry – Ms Marshall referred to. So there was some, but it wasn't a strong, robust, clinical governance system, no.

COMMISSIONER PAGONE: I just want to ask you one last question about the word "robust", which we've heard many times. Robust discussions can take various forms. Sometimes it just means that people were asking hard questions that needed to be answered. Sometimes it may mean that there was conflict and contrast. Are you able to help with what was the nature of the relevant meeting. Was it just people looking – having a long hard look at themselves or was it that there was contest and conflict?

MS ROBSON: Probably a bit of both. There was context in terms of, "The ACFI performance is falling off. Why? What are you doing about it? How are you managing it?" There were strong discussions around that point at finance and budget, sometimes personally directed at me, sometimes general discussion. Afterwards, board members and individuals would say to me "Are you okay?" It was described as "robust". It was another way of sounding. "This occurred in 2017. This is occurring now. What are you doing about it?" And it was always about operational losses.

MR BOLSTER: Just one thing I wanted to clarify with you, Ms Robson. What you referred to as an audit report in August last year was, in fact, a contact report by one officer who spent seven and a-half hours there on one day; correct?

MS ROBSON: Yes, it is.

MR BOLSTER: Because it wasn't a full audit.

MS ROBSON: It was classed as an unannounced visit. It was one simple indicator in amongst a number of indicators that things were okay. It looked at HR and it looked at those systems.

MR BOLSTER: Yes. All right. I have nothing further. Thank you.

COMMISSIONER PAGONE: Thank you for your evidence, Ms Robson. You're free to go.

MS ROBSON: Thank you.

<THE WITNESS WITHDREW [3.36 pm]

MR BOLSTER: Commissioners, the next witness is Richard Anthony Sadek. I don't think I would be able to finish him today. And I think I would probably need another half an hour in the morning. Probably be the most efficient way to deal with it, but I'm in the Commission's hands.

COMMISSIONER PAGONE: We think it would be much preferable for you to finish today. If you need to go on until 4.30 - - -

MR BOLSTER: I will finish today.

COMMISSIONER PAGONE: - - - regrettable though that might be, but that would certainly be preferable.

MR BOLSTER: No. I will definitely be able to do that. I call Mr Sadek.

<RICHARD ANTHONY SADEK, SWORN [3.38 pm]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: Could you please state your full name for the Commission, please.

MR SADEK: Richard Anthony Sadek.

MR BOLSTER: And you've prepared a statement dated the 25th of October this year.

MR SADEK: I did.

MR BOLSTER: You have a copy of it in front of you.

MR SADEK: I do.

MR BOLSTER: Is there anything you wish to change about that statement?

MR SADEK: There is a change. It was my omission. I apologise for that. Under clause 28B, there is a second board director that was a representative on that audit and risk committee.

MR BOLSTER: And who was that?

MR SADEK: Mr John Shelberton.

MR BOLSTER: John?

MR SADEK: Shelberton.

MR BOLSTER: All right. Other than that, is the affidavit true and correct to the best of your knowledge, information and belief?

MR SADEK: It is. It is.

MR BOLSTER: Now, Mr Sadek, we don't have all that much time and I want – thank you. I tender witness statement 0492.0001.0001.

COMMISSIONER PAGONE: Yes. The witness statement of Mr Richard Sadek, dated the 25th of October 2019, is exhibit 13-16.

EXHIBIT #13-16 STATEMENT OF MR RICHARD SADEK DATED 25/10/2019 (WIT.0492.0001.0001)

MR BOLSTER: You've been the CEO of Southern Cross Care Tasmania since 1995.

MR SADEK: That's correct.

MR BOLSTER: And you have had a familiarity with Yaraandoo and Glenara Lakes, I take it?

MR SADEK: I have.

MR BOLSTER: And ongoing familiarity with those facilities for a long period of time.

MR SADEK: Yes. Since virtually their establishment as residential aged care facilities within Southern Cross.

MR BOLSTER: Yes. Now, in 2017, there were budgetary issues across the broader Southern Cross organisation; correct?

MR SADEK: Correct.

MR BOLSTER: And we've heard a lot over the last day and a bit about the Pathway to Break-Even strategy. As the CEO of the organisation, what was it and what did it mean?

MR SADEK: Can I just remark on the significance, financial losses that were occurring. The fact that there was a trending of losses that started in about 2013 that

continued to escalate up until the point, the date, the year that you've mentioned. The strategy was designed and developed, architect Andrew Crane and Pauline Robson and with my involvement, of course, to stop the financial losses continuing.

The landscape of aged care was also changing considerably and there were great changes that were occurring which impacted on our organisation to achieve an acceptable financial position for residential services. We had also adopted a position that each business unit, that is, business stream, home care, retirement living and residential should stand alone as a business unit on their own feet – on their own feet.

MR BOLSTER: If they couldn't do that, what was the alternative?

MR SADEK: Well, it – it required investigation as to the reasons why they couldn't. And that – and that's why the situation concerning residential services was examined. And, of course, an objective was set that in accordance with that position that we'd – we expected of other divisions.

MR BOLSTER: All right. And this was all discussed at board level?

MR SADEK: It was certainly discussed initially by the executive management team, and also referred through to the Budget and Finance Committee. And, yes, the board were knowledgeable of our position in this matter.

MR BOLSTER: In your statement, you make it clear that it was not to compromise the quality of care.

MR SADEK: Absolutely. Can I just mention the fact that Southern Cross Care has been in existence for 47 years. Our mission is to provide the highest possible care within the funding that's made available and within legislative requirements. A very important part of that is our mission is to provide the highest possible care. And that's why we exist.

MR BOLSTER: Well, let's take that to the nth degree. Assuming you can't afford to provide the highest possible care, what do you do?

MR SADEK: Look, I am the servant of the board. I'm the CEO. I'm responsible to the board. I am responsible to examine situations, report to the board, but also, in examining situations, suggest solutions.

MR BOLSTER: Well, I'm speaking theoretically this year. If you get to a point where you can't provide or produce or earn the income to provide the level of care that we're talking about, what's the option for the facility? Is it to remain open and provide a poorer level of care or is it to rationalise the business?

MR SADEK: It's important to investigate the circumstances that are causing that situation and develop a strategy or an objective to correct it – correct the situation

- - -

MR BOLSTER: And what if - - -

MR SADEK: - - - as far as I'm concerned.

MR BOLSTER: My question is, though: what if you can't?

MR SADEK: There are a number of options that would have to be considered to the board.

MR BOLSTER: Did the board get to that level?

MR SADEK: No.

MR BOLSTER: When it came to the implementation of the Pathway to Break-Even, were you across that when it came to each of the nine facilities in the group?

MR SADEK: The architect was Andrew, in consultation with myself and Pauline Robson, with an involvement by Andrew George-Gamlyn. We developed an objective based on an assessment and, importantly, on the basis of that we wouldn't compromise care. We wouldn't compromise the quality of care, where we would develop, take into account industry benchmarks, performances, the – at each individual facility, the demographics of the facility, the calibre of staff, the dependency levels that had already been presented, etcetera.

MR BOLSTER: Well, let's look forward.

MR SADEK: Sure.

MR BOLSTER: Look ahead to where you're at now.

MR SADEK: Yes.

MR BOLSTER: Since sanctions were imposed in November last year in relation to Yaraandoo, there was a period of time where you couldn't take new residents; correct?

MR SADEK: Correct.

MR BOLSTER: And that meant that there was a substantial decrease in resident – the residents you had to look after; correct?

MR SADEK: Correct.

MR BOLSTER: Because people unfortunately passed away in the interim; correct?

MR SADEK: Well, we – we had a declining – a resident population and we didn't readmit new residents, but we kept the staff - - -

MR BOLSTER: You couldn't do that because you didn't have the funding to do that; correct?

MR SADEK: We could have filled the beds but we wouldn't have got Commonwealth funding.

MR BOLSTER: Yes. And that process has only recently resolved in terms of sanctions; correct?

MR SADEK: The sanctions were lifted through a lot of hard work by the executives and supported by the team and sanctions were lifted on 9 August.

MR BOLSTER: Yes. So – and I believe that there are about 52 people out of 80-odd beds at Yaraandoo.

MR SADEK: 52. 54 at the moment.

MR BOLSTER: So have you costed the situation that's arisen because of sanctions? How much has it cost the bottom line of Southern Cross Care?

MR SADEK: We faced a substantial deficit last year, at the end of 30 June. And I would – I don't have the precise figures. It was in excess of a million dollars.

MR BOLSTER: Yes. Because when it came to the choice of maintaining your accreditation, or effectively going out of business, you chose to maintain your accreditation; correct?

MR SADEK: We – we, supported by the board, took the decision that we would rectify – work towards rectifying the situation to making Yaraandoo fully compliant, that's correct.

MR BOLSTER: And the cost of rectifying was significant?

MR SADEK: As I said, it cost a million dollars.

MR BOLSTER: And you kept the staff?

MR SADEK: We were required by the Commonwealth to maintain the current staffing level as an obligation in terms of progressing the facility back to full accreditation.

MR BOLSTER: All right. And even in that – against that backdrop, there was never a suggestion though that Southern Cross would close Yaraandoo?

MR SADEK: It wasn't contemplated.

MR BOLSTER: And was – but was that discussed at board level?

MR SADEK: No.

MR BOLSTER: Okay.

MR SADEK: Look, can I just make the important point here. Southern Cross Care had nine residential aged care facilities. It was the second facility within the portfolio of Southern Cross Care. It's where a lot of the Knights of the Southern Cross live and it was a very important facility in terms of its identity.

MR BOLSTER: You're talking about Yaraandoo.

MR SADEK: Yes, Yaraandoo. Its identity and its involvement in the history of Southern Cross Care. It was important for us to rectify the circumstances that occurred.

MR BOLSTER: All right. And – but that obviously was the – I withdraw that. That threw the Pathway to Break Even into another category, didn't it? I mean, you had no possibility of breaking even by adopting that policy in relation to Yaraandoo; correct?

MR SADEK: Correct. Can I say the objective of breaking even at other sites wasn't dismissed.

MR BOLSTER: Right. The budget went out the window when it came to maintaining the accreditation in the face of the sanctions; correct?

MR SADEK: It made Yaraandoo – how would I describe it – a special case where we needed to invest and make funding available to rectify the circumstances that occurred and bring Yaraandoo back to full compliance.

MR BOLSTER: And that was a decision the board made?

MR SADEK: Correct. Well, can I say supported by the recommendation of me to the board and the board being knowledgeable of our position in that matter.

MR BOLSTER: You've heard Ms Robson say today, I take it, that she came to you with the final changes to the – to the roster at Yaraandoo before they were implemented and sought and obtained your approval. Do you agree with that?

MR SADEK: The proposed changes or the process of examining options in terms of altering the roster and other service delivery changes were undertaken as part of a review with the facility manager, consultation with the director of finance, Mr Crane at the time. Involvement with Andrew George-Gamlyn, and a recommendation came to me and, in fact, on one occasion the recommendation came to me which I believe was too severe. It suggested that three ECA positions be also reduced. I declined to accept the recommendation.

MR BOLSTER: Why was that?

MR SADEK: It was just too severe. It would have caused industrial chaos. It would have, in my view, importantly, compromised the quality of care which was an important criteria that we pursued and I had asked to go away and re-examine that. Following that a recommendation came back to me which involved partial redundancies, etcetera, and I approved it.

MR BOLSTER: Well, in terms of quality and being a resident at Yaraandoo in the morning or in the evening, it meant there was one less carer to look after that resident; correct?

MR SADEK: Look, can I say this again: the review of the consequences of the delivery of services and particularly care on the basis that care would not be compromised was a role undertaken by the facility manager in conjunction with Pauline Robson and other players, including the involvement of the HR manager. And a recommendation would be made to me. So I had – I mean, you know, these – the executive team are highly experienced people who've got a long background in aged care, in finance. Andrew George-Gamlyn is a leading ACFI consultant, Jenny Thomas was a longstanding health – HR practitioner. And there's a degree of trust and acceptance and the work had been obviously done, consultation had occurred with the unions, and I was satisfied.

MR BOLSTER: But it sounds as though you decided to reject the earlier proposal but you decided to approve the proposal that was implemented; is that correct?

MR SADEK: Well the – as I hope I've said clearly, was the fact that the original proposal, in my view, was greater than the revised proposal that came to be and I was comforted by that.

MR BOLSTER: How did you satisfy yourself, given that eight hours in the morning and six hours in the evening were going, that that would not impact on the quality of care?

MR SADEK: My assessment of that was that we had, up until that time, no adverse findings in terms of accreditation reports. I had not received any complaints from residents about the care or relatives about the care. Can I just say – can I just digress slightly for a minute. I would like to apologise to those residents and their relatives who have experienced the circumstances that have been portrayed here at the trial – at the Commission. We're not about providing poor care. Our whole mission, our 47 years of existence is about providing the highest quality of care. So I apologise and I say I'm sorry for them to endure the tension and the anxiety that they have. So I take that into account when – when we look at the consequences of reductions of staff. It wasn't a compromise of quality of care, and I accepted the advice of my team in that regard.

MR BOLSTER: You've been a – you're a very experienced CEO. You've been in the role for a very long period of time. Did you honestly think that removing those hours would not affect the quality of care for the people at Yaraandoo?

MR SADEK: When the – the cost compared to the income was substantially over benchmarks I was – and given that the – the advice given to me and the recommendation given to me, I was satisfied that that wouldn't compromise and I was assured by that, and can I furthermore say it was mentioned in reports by the director of residential business services in her reports to the board from time to time that the quality of care wasn't going to be compromised.

MR BOLSTER: Ms Robson was not a clinician, was she?

MR SADEK: No, she wasn't.

MR BOLSTER: Mr Anderson was a brand new, inexperienced, untested facility manager; correct?

MR SADEK: Mr Anderson was appointed on the basis that he was a nurse. Our – traditionally we have a model that we prefer a manager, a facility manager to be – to have nursing qualifications and experience. He was appointed by a panel and recommended to the job. Yes, he was appointed and he was a nurse.

MR BOLSTER: Yes, but he was a very inexperienced nurse. That's my - - -

MR SADEK: He was. I beg your pardon, I didn't answer your question. I apologise. Yes, he came from a nursing position. He wanted to relocate to the north-west coast to be closer to his wife's family and, dare I say it, in retrospect we should have supported him much more fully than we did.

MR BOLSTER: Well, he wrote to you after he left, and he made a number of complaints about the lack of support he received in the time he was there, didn't he?

MR SADEK: Can I just correct that, please. I made a – I made an appointment to see him, I think, at Christmas time, '18. He – I asked him, could he put down a list for me, some suggestions as to what he saw the key issues at Yaraandoo as a basis of discussion. And he provided that to me, and went on leave. And then we came back and discussed the matters, as I recall.

MR BOLSTER: Well, do you recall the document headed Barriers to Satisfactorily Performing the Role of Yaraandoo Facility Manager; it's behind tab 222. Perhaps if that could be brought up.

MR SADEK: That is the list that Patrick provided me at my request for discussion with him.

MR BOLSTER: Yes, he didn't do that just before the Royal Commission. He did that back in February of this year, didn't he?

MR SADEK: Yes, prior to his resignation.

MR BOLSTER: And did any of that come as a surprise to you?

MR SADEK: Look, let's quickly have a look at it.

MR BOLSTER: Well, you read it, didn't you?

MR SADEK: Yes, I have. No, I have to accept the responsibility as CEO that we didn't provide him with the support that he obviously required as a newly appointed, young facility manager.

MR BOLSTER: Right. So you had the – you had this proposal from Ms Robson who had no clinical role. The facility manager was someone who was very young and very inexperienced in the role. What gave you comfort from their assertions that this would have no clinical effect on the people at Yaraandoo?

MR SADEK: The advice that was not only given to me but also expressed to the executive management team meetings by the director of residential business services that appropriate support mechanisms are being put in place for him to act appropriately.

MR BOLSTER: No, that's not my question, Mr Sadek. Please listen to my question. My question is what gave you confidence that the assurances of two people, one of whom had no clinical role, the other of whom was a very inexperienced facility manager, first time in the role, what gave you confidence when they said to you there will be no effect on quality of care to accept their advice?

MR SADEK: Because I have the utmost trust in my managers and obviously on this occasion that wasn't the issue.

MR BOLSTER: Mr Crane had no clinical experience, did he?

MR SADEK: Mr Crane was a very highly experienced financial member of our team.

MR BOLSTER: And were you aware, at that time, about problems with clinical oversight and clinical reporting and clinical auditing? Did you see the reports, for example, about Glenara and Yaraandoo as part of the benchmarking process?

MR SADEK: I was satisfied in respect of a report that Mrs Robson just referred to, that in August 2017 – '18, the accreditation audit had made a – undertaken a contact visit and had assessed – undertook a review of eight outcomes and assessed them as being compliant. I was also comforted by the fact that at regular executive

management team meetings there weren't any indications or expression of issues at Yaraandoo in a clinical sense. I was also satisfied that at audit and risk there were no major issues suggested. And in addition, I hadn't received, either from Patrick Anderson or, indeed, from any relative about resident care being compromised.

MR BOLSTER: Well, you now know that the complaints process at Yaraandoo was effectively non-existent, don't you?

MR SADEK: It could have been improved on.

MR BOLSTER: Well, how about you address my question: it was virtually non-existent; correct?

MR SADEK: I will accept that.

MR BOLSTER: So how were you to get word from residents about the problems that they were experiencing?

MR SADEK: The process for raising of complaints which was in place across the whole organisation was that the complaint would be referred to the – by the clinical care consultant in the first place, then escalated to the facility manager, then to the director of residential business services or, indeed, the director of clinical services depending on the nature of the complaint. And if it wasn't resolved through that process it would have been referred to me.

MR BOLSTER: And nothing was ever referred to you.

MR SADEK: No.

MR BOLSTER: No. And Ms Robson, did you hear her evidence when she said that she saw the audit report results and she had concerns about what she was seeing but was told that she did not have a clinical role and therefore she should not discuss that issue? Did she relay that concern to you?

MR SADEK: I don't recall but can I just make the point which is, I think, pertinent from my perspective. We were reliant on advice within the team in relation to those issues that you're questioning me about. The structure – I undertook a restructure of the organisation because it was apparent to me that the role undertaken by – and the expectation on Mrs Pauline Robson of oversighting and supporting nine residential aged care facilities was onerous and we had – and I, in my view, given the change in the landscape of aged care, with – with the greater emphasis on customer service and consumer expectation, that our – our approach of having a three siloed stream of service delivery and care – care delivery needed to be changed.

MR BOLSTER: When did Ms Robson complain to you that she was overloaded?

MR SADEK: I don't recall she did.

MR BOLSTER: Well, you say that one of the reasons for the restructure was because she had to look after nine facilities. When did you have a concern that she had too much work?

MR SADEK: I'm not sure about too much work but there was a – the case was about the finances continuing to dwindle away to an extent that it was of serious concern to me, and also the finance and budget committee and obviously the board.

MR BOLSTER: Well, she was, may I suggest to you, most concerned about the financial situation and the Pathway to Break Even, from that perspective; correct?

MR SADEK: She was concerned and party to adopting an objective to rectify the situation.

MR BOLSTER: My question for you is though: how it could possibly have been the case that you would have formed the view that the reduction of those hours would not compromise care at Yaraandoo when you approved that in July/August 2018? How could you have approved that?

MR SADEK: On the recommendation – I repeat, with great respect, the recommendation of experienced management team – executive management team members who had taken into account a whole range of issues associated with service delivery, had discussed options for the reduction that would not compromise care, and a recommendation coming to me.

MR BOLSTER: Helen Marshall gave some evidence this morning; were you present?

MR SADEK: No, I have not heard Helen Marshall's evidence.

MR BOLSTER: She talked about how the audit data that was collected in the various QPS reports that were – that people that were working for her spent many hours every week collecting, went up the chain to someone in your executive office, but never came back down to her. There was no report to her about what the reports showed. Is that – was that – is that a surprise to you?

MR SADEK: Somewhat. The process that was followed was the data would have been – would be collated and in – submitted to QPS. The QPS reports would come back quarterly. They would have – they were then distributed to the director of clinical services, the director of residential business services, the facility manager. The director of clinical services gave a report, a summary report on key outcomes or key issues or matters of concern, however you want to describe, to the audit and risk committee. I was a member of the audit and risk committee. I didn't receive the QPS reports. The – the – the aspects that were summarised and provided by the director of clinical services were then recorded in the minutes and referred to the board for information.

MR BOLSTER: Was it your practice not to receive or ask for the QPS reports for your facilities on a regular basis?

MR SADEK: I – I didn't – didn't see the need when the advice – when the review was undertaken by competent experienced executives.

MR BOLSTER: Well, the QPS reports showed that Glenara Lakes was below benchmark on key care issues for a considerable period of time. I want you to assume that the evidence shows that, and the Commission has been taken to the reports during the course of today. Is that a – does that come as a surprise to you?

MR SADEK: What period are you talking about, please?

MR BOLSTER: We're talking about from around July – well, let's talk about in the months preceding July 2018, the six months preceding.

MR SADEK: Preceding July 2018. Again, there was no referral to me of issues of concern for that period that you've just mentioned.

MR BOLSTER: Tell me, during the same period, did you receive the monthly and quarterly ACFI reports from Mr George-Gamlyn that showed the ACFI performance of facility at the same time?

MR SADEK: I received monthly reports from Mr George-Gamlyn.

MR BOLSTER: Did you read those?

MR SADEK: Yes, I did.

MR BOLSTER: Is there a reason why you would read the ACFI performance reports but not the QPS reports for the facilities that were delivering care to the people that you were responsible for?

MR SADEK: Because I had an experienced director of clinical care and a competent director of residential business services at the time to analyse those reports and provide information and wherein it was discussed at the audit and risk committee.

MR BOLSTER: You had a very experienced ACFI consultant to provide you with advice about the very same issue from an ACFI perspective, didn't you?

MR SADEK: Indeed.

MR BOLSTER: Well, your focus, may I suggest, based on what we've heard in the evidence and from what Ms Robson says was on ACFI performance.

MR SADEK: My responsibility as CEO, as a servant of the board, was to make sure and gain the trust and provide support to the executive management team to run the business or operate the business in the managerial sense as best as possible. When concerns weren't reported to me, I didn't – I didn't feel the need to take action.

MR BOLSTER: I just want to ask you a question arising from Ms Robson's statement. Can you just bear with me for a moment, sorry. If that could be brought up, paragraph 8, page 0007. Ms Robson says this in the last sentence:

> *The executive manager clinical services also provided monthly board reports, however, the CEO did not share the reports of the executives with each other.*

Can you explain what Ms Robson is talking about there? Does that – does that ring a bell to you?

MR SADEK: The executive manager clinical services – I'm not quite sure I understand 'the executive manager clinical services also provided board reports'. The board report, the – each of the executive management reports were provided as part of the board papers, and presented to the board. But I didn't provide the – they're individual reports, however, I did provide the – soon after the board meeting to the executive management team, all the key issues, and matters of importance, and recommendations or follow-up actions arising from the board meeting. In fact, indeed, as an extension, if there were key matters that were discussed at the board meeting I invited each executive manager to speak to their report or the particular issue at the time.

MR BOLSTER: Ms Marshall gave some evidence about regular quality and safety meetings that were held involving representatives from each of the facilities. Are you familiar with that process?

MR SADEK: I understood there were separate meetings coordinated and arranged by the director of clinical services but I wasn't involved.

MR BOLSTER: Did you ever go to any of those meetings?

MR SADEK: No, I didn't.

MR BOLSTER: What were they for?

MR SADEK: Obviously, to – to ascertain and have an involvement with staff other than nursing on matters that were of risk, or potential risk to the organisation.

MR BOLSTER: She says that the meetings were held across the State. They were focussed on ACFI and income and not care.

MR SADEK: I can't comment.

MR BOLSTER: She says that facility managers were told that they weren't to attend and other representatives, presumably the ACFI officers in each facility, were the ones that were required to attend. You know nothing of that process?

MR SADEK: Look, I – I'm not – I can't contest. I don't – I'm not aware of that – that – that point that Ms Marshall made, or in the context that she made it.

MR BOLSTER: Do you regard it as entirely satisfactory, Mr Sadek, that you chose, it would seem, not to inform yourself about the quality indicators that were reported to your organisation on a monthly and quarterly basis by QPS?

MR SADEK: Can I say to you that I was satisfied on the basis that the – that quality indicators that were of concern were discussed at each audit and risk committee meeting when – soon after the reports were provided to the director of clinical services, the director of residential business services and the facility manager and then, as I said, discussed at the audit and risk committee. The results were then provided – or the minutes of that meeting were provided to the board.

MR BOLSTER: You would have to concede, given what you now know, everything that's played out over the last 12 months, that there were clear clinical and quality issues at Yaraandoo that went undetected for a considerable period of time.

MR SADEK: I do, and can I say, in terms of remedying a repeat of that situation, part of the restructure was based on reviewing them – the organisational structure that existed before, but strengthening it and Mrs Robson – I've heard her evidence just a while ago, talked about her being relieved of her state-wide responsibility and the structure allowed support in an area sense, a north, north-west and a south sense to be created where that support could be given. In addition, because of the changing landscape of aged care service delivery and the consequences of that, and the expectations of that, the structure created an executive manager integrated and clinical services and also a manager of quality and risk. So the position descriptions that were designed also had clear KPIs associated in that context.

MR BOLSTER: My question to you though is this: has the board, with your assistance, stopped to consider what it was that went wrong? Has the board engaged in a process of introspection to try and figure out what went wrong? Because obviously there were aspects of clinical governance that were just not getting through to the right people. You would have to agree with that?

MR SADEK: Can I say that the new organisational structure which was ultimately approved by the board recognises the fact that we had to strengthen the reporting and review processes that you're referring to, sir.

MR BOLSTER: I accept that. What went wrong? How can we learn from this?

MR SADEK: What went wrong? Lack of support to a young facility manager.

MR BOLSTER: From whom?

MR SADEK: All members of the executive management team. I can see that and I, again, apologise to Mr Anderson for the circumstances he was placed in.

MR BOLSTER: You said – sorry.

MR SADEK: Secondly – secondly, we allowed – allowed Yaraandoo to be isolated without support from a clinical involvement perspective. We didn't put enough resources into training and education. So they were learnings from that sad situation.

MR BOLSTER: Do you keep a track now of how the clinical performance is going at each of the nine facilities?

MR SADEK: I am provided with regular reports by the two area managers about the clinical performance and issues associated with facilities in each of those two regions.

MR BOLSTER: Well, the clinical governance committee is not established yet, is it?

MR SADEK: It will be formally established on 27 November.

MR BOLSTER: All right. So what form do those reports take? Do they tell you how, for example, Yaraandoo is going with restraint?

MR SADEK: We haven't got the reports, the clinical governance committee yet. It's formed on 27 November.

MR BOLSTER: Okay. But you're still getting the QPS reports.

MR SADEK: Yes.

MR BOLSTER: Are they feeding through to you now after all this?

MR SADEK: No, but they will be.

MR BOLSTER: They will be. How much do you spend on QPS Benchmarking? How much does that cost?

MR SADEK: Sorry. I can't tell you.

MR BOLSTER: Just roughly, is it a million dollars a year?

MR SADEK: I couldn't tell you, sir.

MR BOLSTER: How much do you spend on ACFI management? How much of an overhead is ACFI management?

MR SADEK: The ACFI management in totality?

MR BOLSTER: Yes.

MR SADEK: I would say with the resourcing at each site being dedicated to ACFI management, half a million.

MR BOLSTER: Half a million dollars, all right. Why has it taken so long for the clinical governance committee to be established? I mean, you must have known since November when you first read the audit report that there were serious problems?

MR SADEK: At Yaraandoo?

MR BOLSTER: Yes. It's a year later.

MR SADEK: Well, it's not an excuse but it's the reality that we were – we were putting a lot of resources into rectifying the circumstances at Yaraandoo. We had a lot of work associated with the Royal Commission, the development of submissions. We were bedding down the organisational structure and making appointments to those roles and that just takes time. And if it – can I just say in respect of Glenara Lakes, I am comforted by the fact that a recent accreditation audit – a full audit, I think, on 23 to 25 August – October – October, rated Yaraandoo fully compliant in respect of all the eight new standards. So from that perspective, that gives me some comfort.

|MR BOLSTER: Can you assist the Commission as to why it took so long from the time of the initial sanction being imposed to the time when those sanctions were lifted? Why did it take so long? Is that a – should the Commission view that as an indicator of how serious the problem was at Yaraandoo or was it just a problem in implementing the changes that the administrators and advisers asked of you?

MR SADEK: The circumstance at Yaraandoo was a difficult one. The process of rectification started in November and was completed in August. We – it was a rocky road. We started out with 18 unmets. The first review undertaken, I think in February, resulted in five of those being met, which reduced it to 13. We put enormous amount of work into training, etcetera. That 13 went down to seven.

One of the problems that I was disappointed with was that the – there was no consistency with assessors when they came to review the circumstances. We had a different assessor nearly every time, which was disheartening to the staff, it was disheartening to the management and disappointing to me. We had a very hard road to rectify the circumstances, but I applaud the efforts of everyone concerned.

MR BOLSTER: Let me ask you - - -

MR SADEK: To answer your question specifically, I can't explain what – why all the – all the – the degree of difficulty that was encountered or the views that were identified by the assessors, albeit that I can say that there was regular consultation with the Commonwealth Department of Health, which support was given and evidence provided that we were rectifying the sad result as best we could. It was frustrating, also, obviously, from the residents' perspective, the families' perspective and our perspective, operation.

MR BOLSTER: One last topic from me. One of the complaints that Mr Anderson made to you in February was the lack of centralised training within the organisation. His point was that individual facilities were required to organise training for themselves. Was that the case, as far as you can recall, or was that not a matter that you dealt with?

MR SADEK: As I can – as I can remember, in each budget, in each facility budget, there is an amount of funds allocated for training. We do have a part-time or had a part-time person provide education. Can I also say, as part of the restructure, we support recommendations – well, sorry – before that, we support recommendations by facility managers through the executive management team for special case training. We have established, through the restructure of the organisation, supported by the board, with a large investment, what's called a talent management program.

The board approved a sum of money as a follow-up to the Yaraandoo circumstance, a large sum of money, for people who show some aspirations not only to stay and work in aged care, but, indeed, with Southern Cross Care. And we would support them in terms of further education to fulfil their – to fulfil their desires. So to answer your question, no formalised centralised training centre as such.

MR BOLSTER: All right. And so – I withdraw that. Just what should the Commission take as the message from the experience of Southern Cross in Yaraandoo and Glenara Lakes? What's the message that we need to understand in terms of the work of the Royal Commission?

MR SADEK: For me, first of all, that we – I could not continue to rely on information flowed to me and be satisfied with that. We had to change our position descriptions, so that there was an examination, an internal examination, to make sure that we were satisfied of situations occurring.

MR BOLSTER: So there needed to be - - -

MR SADEK: Due to the – sorry.

MR BOLSTER: There needed to be transparency and a clearer delineation of how information would flow up and down - - -

MR SADEK: Correct.

MR BOLSTER: - - - the organisational structure.

MR SADEK: Correct. And an important part of that was the creation of a manager of quality and risk position.

MR BOLSTER: All right. And has that been filled?

MR SADEK: It has.

MR BOLSTER: And what level are we talking about?

MR SADEK: We're talking about at a senior level, a management level within the structure.

MR BOLSTER: And what's the role of that person? Do they have a roving commission, effectively, to test compliance across the standards?

MR SADEK: Correct. Correct.

MR BOLSTER: Presumably, they don't have anything to say or do about ACFI.

MR SADEK: No. It's clinical.

MR BOLSTER: And what level is that person? How long have they been involved in the industry?

MR SADEK: A very long time. I don't have the – it's an experienced nurse, facility – previous facility manager and a person that's undertaken education and training for a long period of time. So extensively qualified and very appropriate for the role.

MR BOLSTER: So the residents in your various facilities can take comfort from the fact that that person will be travelling to the facilities and keeping an eye on clinical issues?

MR SADEK: They will be part of the integrated – the executive manager integrated and clinical services. That – that position of manager quality and risk will report to that job, that particular position, and, yes, do as you say.

MR BOLSTER: And do they have oversight of the complaints process?

MR SADEK: They will be involved in the complaints processes.

MR BOLSTER: How transparent is that? If I want to make a complaint today at Yaraandoo about the air-conditioning in my room or the size of the meal, how does a resident know how to do that?

MR SADEK: There will be a complaints procedure that would be followed or initiated. There will be a process that will be followed to make sure that occurs.

MR BOLSTER: There will be or is? What's there now?

MR SADEK: I understand there's one now.

MR BOLSTER: And what does it involve?

MR SADEK: Well, recording of the circumstances you've just described.

MR BOLSTER: All right. Are complaints coming up the chain to you?

MR SADEK: Not to me. I haven't had a complaint from Yaraandoo as such, but, again, can I reiterate, there is a process to be followed in relation to raising complaints or suggestions or even giving recognition through a process that is applicable in a standardised way across all our facilities.

MR BOLSTER: I have no further questions. Thank you, Commissioners.

COMMISSIONER PAGONE: Mr Sadek, thank you for your evidence. It has informed us. And I think you otherwise can be excused. Thank you.

MR SADEK: Can I just – Commissioner, can I just – I would like to take the opportunity to – as I said, I've apologised for the circumstances. I'm longstanding in aged care. And I would like to make a suggestion for your consideration that relates to aged care being better for people to be attracted to be employed in aged care and for our regions to have benefit from the system we've got now. And that – I'm trying to express it – relates to my view that aged care should be part of health services, should be part of the approach of health services generally. It shouldn't be a segment of care. It shouldn't be treated as a disease, so to speak, or be – and a funding based on that approach. I think that's a very important matter that I'm placing to you for your views and consideration in the futuristic sense. But I think that really needs to be taken into account.

Can I also say that many years ago Southern Cross Care initiated a review and suggested – it was an improvement. In fact, I think it was to the Productivity Commission in 2011. I might be wrong. It might have been before that. Suggested that the approach that I've just outlined be considered in relation to a new funding model and that the funding model that can be considered and be researched equate to a component of the Medicare levy that – that will provide some certainty of funding by the population at large to cater for the needs of the elderly and that – and their requirements when they enter into their twilight years.

I'm very passionate about that. A lot of work was undertaken at that time, I think by Professor John McCullum from the West – University of Western Sydney. It wasn't given much credence at all. But if you're looking at different funding models and looking at an alternative to replacing the tired financial dependency – assessment of dependency model that we've got, I would suggest to you that perhaps that might be an option.

COMMISSIONER PAGONE: Mr Sadek, thank you for those thoughts. And, by all means, do send anything else that you have along those lines. I'm sure we would be delighted to read them and have a look at them. Thank you again for your evidence. And you're excused from further attendance.

<THE WITNESS WITHDREW [4.31 pm]

COMMISSIONER PAGONE: And we will adjourn till tomorrow morning. I think it's 10 to 10. 9.50.

MATTER ADJOURNED at 4.31 pm UNTIL WEDNESDAY, 13 NOVEMBER 2019

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