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THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

SYDNEY

10.01 AM, MONDAY, 13 MAY 2019

Continued from 8.5.19

DAY 18

MR P. GRAY QC, Counsel Assisting, appears with MR P. BOLSTER and MS B. HUTCHINS

MS J. NEEDHAM SC appears with MS BUNCLE for Bupa Care Services Pty Ltd and Maureen Berry

MS HUTCHINS: Commissioners, the fourth case study concern Bupa Aged Care Australia facility leaked here in Sydney in the suburb of Willoughby. If I start with my opening, I understand there's some parties that wish to announce their appearance.

COMMISSIONER TRACEY: Yes.

MS NEEDHAM: May it please you, Commissioners, my name is Needham, I appear with MS BUNKLE for the Bupa Australia Health Care Holdings Proprietary Limited, Bupa Aged Care Australia Proprietary Limited and MAUREEN MARY BERRY, instructed by Herbert Smith Freehills.

COMMISSIONER TRACEY: Thank you, Ms Needham. Yes, Ms Hutchins.

MS HUTCHINS: Operator, please bring up the Bupa tender bundle index. Commissioners, I tender the Bupa Willoughby case study tender bundle.

COMMISSIONER TRACEY: Yes. The Bupa Willoughby case study tender bundle will be exhibit 3-34.

EXHIBIT #3-34 BUPA WILLOUGHBY CASE STUDY TENDER BUNDLE

MS HUTCHINS: Commissioners, the focus of this case study will be on the quality and safety of care provided to a lady who was resident of a Bupa facility before her death at 70 years of age. She will be referred to as DE during the course of this case study and her picture will now be displayed. Mrs DE was born in May 1947. She had two daughters, who will be referred to as DI and DJ, who will both also give evidence today. DI is her younger daughter and the principal narrative witness we will call. DJ is the older daughter and was her mother's authorised representative under power of attorney. She will read a statement on certain aspects of the case.

In 2016, Mrs DE was 69 years old living independently in her own home. By late 2016 her daughters noticed that Mrs DE was experiencing some memory loss, forgetfulness and a small amount of confusion. In February 2017, Mrs DE suffered a fall at home and was found by one of her daughters on the bathroom floor. It is likely she had been there for 24 hours. She was taken by ambulance to Royal North Shore Hospital, where she stayed for several weeks. Tests in hospital suggest that Mrs DE may have been a stroke or a seizure. Mrs DE was a cancer survivor, having been diagnosed with lung cancer in 2002 and two brain tumours the following year.

At the time, Mrs DE had been through a period of radiotherapy in her brain and lungs. While she had been in remission since 2014, tests conducted in hospital during her stay in 2016 suggested that Mrs DE's cognitive and physical condition was deteriorating as a consequence of her previous medical treatment.

While Mrs DE was in hospital, on 3 March 2017 she was assessed by the aged care safety team and approved for both residential respite home care and residential permanent home care packages. At this time, her daughters had been exploring whether it would be possible to have her mother stay in her home or, alternatively, whether they could find a facility for Mrs DE to stay on a respite basis. Mrs DE returned home for a short time, but then on 26 May 2017 she had another fall. This time she suffered a bad fracture to her upper right arm. She was again taken to the Royal North Shore Hospital, where she stayed for a period of 41 days from 26 May until 6 July 2017.

During the period in hospital, her physical and cognitive condition declined. By the time Mrs DE left hospital, she had minimal ability to comprehend what was happening and her speech was extremely limited. Her mobility had also decreased specifically. She was essentially bed or chairbound, requiring full assistance with activities of daily life, including drinking and eating. Mrs DE's daughters made arrangements for Mrs DE to become a resident of Bupa on a respite basis. Mrs DE was only in Bupa for one night. However, within 36 hours of her admission, she was transferred back to the Royal North Shore Hospital. On this occasion, Mrs DE stayed in the Royal North Shore Hospital for 11 days before she was again transferred back to Bupa, this time on a permanent basis.

Mrs DE's daughter DJ had further discussions with Bupa representatives around this time, as it was decided that her mother was needing full-time care. Operator, please bring up tab 62. Commissioners, this is an extra services resident and accommodation agreement which DJ entered into with Bupa as her mother's authorised representative. On page 2 of this document – operator, please turn to page 2. Thank you. You can see that DA is indicated to hold her mother's power of attorney and that she's also the primary contact in relation to her mother. Also shown on this document under E, other contact, is that DI is identified as the other contact for her mother.

Operator, please go to page 11 of this document. Commissioners, you will see under the heading Care and Services at sub-clause 2.1, the agreement provides that the care and services provided to DE will include the care and services specified in annexure D and the quality of care principles. As you are aware, Commissioners, the quality of care principles are delegated legislative requirements that apply to all approved providers.

Operator, please turn to annexure D on page 29. You will see that this page sets out a range of services which Bupa agreed to provide to Mrs DE. These include various matters, including those listed at .2.1. Please go to the next page, operator. Which is personal assistance with activities of daily living. Operator, please zoom on that box. These activities are said to include matters such as:

> *Bathing; continence management; eating, including actual feeding if necessary; communication, including addressing difficulties arising from*

impaired hearing; sight or speech and checking hearing aid batteries and cleaning spectacles.

Operator, if you can go to .3.8 on page 31. You will see another range of services offered by Bupa including nursing services, including those specified as initial assessment and care planning carried out by a nurse practitioner or registered nurse and ongoing management and evaluation. The services include a long list of matters which are specified at sub-paragraphs (a) to (m), including at (a):

Establishment and supervision of complex pain management or palliative care program, including monitoring and managing any side effects.

And, at sub-paragraph (h):

Special feeding and for care recipients with dysphagia.

Mrs DE was a resident of Bupa for a period of four weeks before her death on the evening of 15 August 2017. The operator will now display a brief chronology of the various transfers between Mrs DE's home, the hospital and Bupa which I have just mentioned.

During her stay, Mrs DE and her daughters relied on Bupa to provide care that met her mother's specific needs. Later this morning, Mr Gray will take you to hospital and medical records showing that, in addition to her impaired cognition and immobility, Mrs DE had a number of other relevant conditions that required consideration and proper care. The level of care provided by Bupa to Mrs DE fell well below her daughters' expectations.

In September 2017, following unsuccessful attempts to resolve their concerns with Bupa Mrs DE's daughters lodged – DE's daughter DI lodged a formal complaint regarding Bupa's conduct with the Australian Aged Care Complaints Commissioner. This complaint led to an investigation into the matter by the Complaints Commissioner and findings being made against Bupa in this regard. Mrs DE's daughters will each give evidence today detailing the issues that they experienced with the care provider to their mother, including mismanagement of the palliative care process, including a lack of appropriate communication with them and inadequate or absent support from staff at Bupa Willoughby on the evening of Mrs DE's death.

You will also hear evidence from Ms Maureen Berry, the executive clinical adviser at Bupa Aged Care Australia Proprietary Limited, and a statement from an additional Bupa witness, Dr Ross, will be tendered. The evidence as a whole suggests that the care of Mrs DE at Bupa Willoughby fell short of an acceptable standard with respect to her aspiration, risk and swallowing difficulties, her risk of developing pressure injuries, due to her immobility and timely detection of pressure injuries; her nutritional care; her access to personal aids, which affected her quality of life and dignity; her pain management over an extended period; her lack of an end of life plan

and inadequate palliation or comfort in some periods of the final days of her life. Commissioners, I now call the first witness, Ms DI.

<DI, AFFIRMED [10.12 am]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Operator, please display the witness statement of DI. Good morning. Is the statement now on the screen the statement you have prepared for the Royal Commission?

DI: Yes, it is.

MS HUTCHINS: And do you wish to make amendments?

DI: No, I don't.

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

DI: Yes, they are.

MS HUTCHINS: Commissioners, I tender the witness statement of DI, document WIT.0101.0001.0001.

COMMISSIONER TRACEY: The witness statement of DI, dated 17 April 2019, will be exhibit 3-35.

EXHIBIT #3-35 WITNESS STATEMENT OF DI DATED 17/04/2019 (WIT.0101.0001.0001)

MS HUTCHINS: In your witness statement, you detail your experience regarding your mother's time at Bupa residential aged care facility in 2017. I would like to ask you first about the events which led up to your mother's move into Bupa, starting first of all with what her condition was like around 2016.

DI: 2016 Mum had been living on her own, very happily, very mobile. Towards the end of that year we start – over the course of the 12 months I think we started to see a very slow cognitive decline in Mum. We put it down to old age and forgetfulness, nothing too concerning. We never had any concerns about her living on her own, going about her everyday business, catching public transport, things like that. She

was very self-sufficient. And she had the odd fall, but nothing – nothing of too much concern to my sister or I.

MS HUTCHINS: And how was her mobility at this stage?

DI: It was fine. She would walk from her apartment down – 20 minutes, 30 minutes down the road to the supermarket, come back with her shopping. She was very mobile. She would cook at home. She would catch buses on her own. She was very self-sufficient.

MS HUTCHINS: In February 2017 your mother became a patient at Royal North Shore Hospital for several weeks. What led to her hospitalisation on that occasion?

DI: We – my sister and I would both normally speak to Mum every day, if not every second day. Given she was living on her own we always checked in with her. We tried to call her on several occasions during that day and to no avail; we couldn't get in contact with her. It then got to about 7 o'clock, 8 o'clock at night and there was still no answer which became concerning because Mum didn't go out at night, she was very much a homebody. And so I rang my sister and said, "Look, I think maybe we need to go and check on Mum". My sister went over there in the evening and had a key to Mum's house and let herself in, and Mum was on the floor of the bathroom. She was not quite with it. She was covered in urine. She had obviously been there for quite a while. And straightaway my sister called an ambulance and an ambulance came and they – their first impression was maybe Mum had had a stroke or some sort of seizure. She took her to Royal North Shore, and then Mum's stay within the hospital commenced then.

MS HUTCHINS: And during that time in hospital what was your mother's cognitive condition like?

DI: Mum was okay. So I think after the initial fall a couple of days after – into her stay at the hospital, they were doing tests. She was sort of saying to us, "When can I go home, why am I here?" She had no recollection of what had happened but she was eating; she would come and meet us at the lift when we came to visit her in hospital. We would walk her downstairs and get some morning tea when we were there. So she was still very mobile and happy. She would laugh with the nurses. She was still very much her old self but obviously they were testing to see what had caused this fall or this seizure or whatever it might have been.

MS HUTCHINS: And at this time, what was the plan in relation to your mother's care when she left from the hospital?

DI: So we – we realised, my sister and I both had young babies at home. So we realised that obviously Mum couldn't come and stay with us if she was to leave hospital so we looked into respite care, and it very much was only for respite at that stage. We thought – my sister looked into what was available. We thought maybe

for a month or so she could have some respite care, get better and then return to her apartment to live on her own again.

MS HUTCHINS: Were you looking at residential aged care facilities at this time?

DI: We were. We spent a few days and we probably visited around six to eight facilities, very much looking at it from a respite perspective but, obviously, in the back of our minds we thought maybe further down the track this might be somewhere that Mum might need in the future but certainly not in the immediate future. Yes, it was very much for respite.

MS HUTCHINS: And was your mother able to accompany you to any of those facility visits?

DI: She didn't because she was very – she was very against aged care, even for respite. In fact, actually she did – I correct myself, she did attend one visit with my sister. She went to Bupa in [REDACTED] and that was purely just for respite care and walked – it took much cajoling to get her to go and have a look, walked in with my sister, and I think they were there for all of five minutes, and then "I'm not old, I don't belong here and I don't need to be here. I don't want to be here". So we sort of – we then took it upon ourselves to visit, just my sister and I, to have a look and make that decision for her.

MS HUTCHINS: And in February 2017 an ACAT assessment was done. Do you remember what the outcome of that assessment was?

DI: I wasn't across the full detail because I know that my sister managed that process with the application and the assessment in hospital but it was for high level care and also a home care – not high level care, it was a home care package 4 from memory, I think, and that's where we started looking at options for someone to come and help Mum in her home. Yes.

MS HUTCHINS: And so when she was discharged from hospital in May 2017, where did she go then?

DI: When she was discharged from hospital she went back to her – yes, she went back to her apartment in Mosman, yes.

MS HUTCHINS: And was she looking after herself at that time?

DI: She was. We had a few concerns around how able she was to look after herself. We would have conversations and she would be a bit – quite scattered, she would be confused, she told me a few times that she had fallen out of bed in the middle of the night. So alarm bells were starting to ring but she was still, the carer was coming, she was still able to shower, go to the shops with the carer, come back. We were keeping a very close eye on her but she was starting to look like she might have been cognitively declining a little bit more.

MS HUTCHINS: And she returns to the Royal North Shore Hospital again on 26 May 2017. What led to her hospitalisation on that occasion?

DI: It was very similar to the first occasion. We tried to get hold of Mum on several occasions throughout a particular 24-hour period and we hadn't been able to. Again, it got to night-time; still no answer. Mum's best friend had also been trying to contact her and rang us to say do you know where your Mum is, I'm worried. My sister and Mum's best friend went around to Mum's house again, opened the door, and Mum was just inside the front door. She had fallen over in the kitchen and she had broken her arm. So my sister called an ambulance and Mum was returned to hospital.

MS HUTCHINS: Your mother stayed in hospital from 26 May 2017 to 16 – sorry, from the 17th to 6 July. What was her condition like at that time?

DI: She was very much a different person. So it was like when she broke her arm and went to hospital, all of a sudden cognitively, she had declined significantly so she – there was no more walking around at the hospital. She was completely in bed and reliant on assistance and she was bedridden. She could speak to us and communicate. She had limited communication, though, smiling and saying hello and saying various words but she was a completely different person. She needed help, she needed to be moved by nurses if she was to toilet or to shower or things like that. So it was instantaneous, it was – it was -she had gone downhill all of a sudden after that experience of breaking her arm.

MS HUTCHINS: And what was her appetite like when she was in hospital?

DI: It was okay. She was eating solid food but she did need a fair bit of assistance as far as – she wasn't particularly mobile with her arm so she needed someone to help her. Mum's sister came to visit from interstate and spent a lot of time at the hospital feeding Mum and we could really, see when Mum's sister was there, cognitively and her awareness and engagement would really increase because she was there feeding her and making sure that she got the fluid and all the food that she needed. So it was definitely a challenge, and I know that we spent time at the hospital speaking to the nurses there, too, encouraging – really encourage Mum to eat. And you could see because Mum had someone sitting beside her all day in her sister, that having that nutrition and that fluid really helped how aware she was of what was going on.

MS HUTCHINS: And in relation to her ability to communicate, did this decline during the period of your mother's stay at hospital?

DI: It did, yes, it did. So we would slowly start to see, some days it would be a little bit better and then it would decline again but then it was fast getting worse and worse. And then the most we would get, I think, was a smile when we walked in, but there was certainly no conversation. There was certainly – she couldn't move any of

her body. Definitely needed help with absolutely everything; if her arm was itchy we would scratch it for her, so she was very incapacitated.

MS HUTCHINS: And were you aware whether your mother was in any pain at this point in time?

DI: She was, because when the nurses would move her – he needed to be turned because she had pressure sores while she was in Royal North Shore and when the nurses would move her it was very – it was really distressing. We would usually leave the room because she would be howling and moaning and she was very, very upset. She also had quite bad arthritis. And – and she would often groan and sort of ache, and we would try and move her limbs a little bit and she would wince in pain, but that was obviously giving her some pain; couldn't tell us necessarily where it was or to the extent but she – you could tell that something was really bothering her. I believe the pressure sores were on her buttocks so obviously that was very uncomfortable for her in the hospital bed.

MS HUTCHINS: Turning now to your decision to send your mother to Bupa Willoughby, when was it that that decision was made?

DI: We had initially looked into Bupa Willoughby for respite only, and that was obviously before Mum had the second fall – had the fall where she broke her arm. We went to visit the facility. We felt that for respite or longer-term care it seemed to meet the needs that we would want for our mother. We didn't really know what we were looking for when we – you know, this was the first time my sister and I had even walked into an aged care facility, I believe, apart from when we were obviously looking at places for our Mum. So we didn't really know the questions to ask; we felt we would get a good feel from the care manager, Kristine Min, who spent time with us to talk us through, you know, the level of care – and there must have been, in hindsight now, we must have felt really reassured that that would be the right place and she would be in the very best of care at Bupa Willoughby.

MS HUTCHINS: And do you recall during those discussions with Kristine Min you talked about what your mother's physical and cognitive condition was like at that time?

DI: Yes, we did. We spent a fair bit of time talking to her about that. Obviously, there was Mum's clinical condition and her broken arm and bed sores and things like that. But we also spent a lot of time talking to her about Mum's needs and wants and her personality and we were really assured by Kristine that that would all be taken into account, and we felt really comfortable that they knew the full extent of Mum's condition, her cognitive decline, the challenges with her hearing and her vision. We were really nervous, too, about sending her there. So my sister and I spent a lot of time, you know, sharing that information and making sure we felt 1000 per cent comfortable that they fully understood what Mum needed in the absence of us being able to provide that care for her at home.

MS HUTCHINS: And when your mother was first admitted to Bupa on 6 July 2017, were there further initiation processes at that time?

DI: I believe – and my sister managed the admission process with Bupa, I believe that there was a – there was some – there were lots of forms that my sister filled out as far as Mum's daily routine, what she liked to do, what her interests were, what her had personality was, what – obviously what foods she could and couldn't eat, what foods she did and didn't like, all those sorts of things, so again we were really nervous and we wanted to make sure that they had the full story and that they were fully prepared so that we could hand over care for Mum at such a time.

MS HUTCHINS: And your mother was in Bupa for one night before she was transferred back to the Royal North Shore Hospital. How did you find out she was being transferred back?

DI: I believe my sister received a phone call – so my sister was the key point of contact – and that Mum was unwell and they believed that it may have been pneumonia and that they were going to transfer her back to Royal North Shore Hospital so my sister obviously called me straightaway and told me that that was what was happening.

MS HUTCHINS: Were you able to visit your mother in hospital at that time?

DI: Yes, I believe – yes, we did go back to hospital. I think she was there for about another – just over a week and a half and we did go back and visit her.

MS HUTCHINS: And did you notice any further changes in her condition at that time?

DI: I guess it was – it was further decline. Obviously, we were having these conversations about aged care and I remember saying to my sister, "We should tell Mum where she's going because she needs to know", and we did but we can't be – we couldn't have been sure that there was any comprehension as to what was happening or what we were saying. So that, when I think about that time, that's sort of indicative of the state that she was in. That she couldn't – there was no communicating, there was no – I don't even know if she had realised she had gone to Bupa and then back to Royal North Shore again.

MS HUTCHINS: On 18 July 2017 your mother was transferred back again to Bupa, this time as a permanent resident. Did you have further discussions at this stage personally with any of the staff about your mother's condition at that time?

DI: Not me personally, I don't believe because I knew my sister had undergone that admission process with Kristine and the team at Bupa Willoughby and we felt confident that they had everything that they needed. You know, they sent Mum back to Royal North Shore because of the pneumonia so we were of the belief that they would have all the discharge notes and know where Mum was at, and they're the

specialists in their field so we kind of – I didn't personally have any further conversations around what next or - - -

MS HUTCHINS: Was your Mum able to communicate at this point, for example, if she was in pain would she be able to tell somebody that?

DI: I really doubt it. I think, from memory, any time we went to see her at Bupa Willoughby the most we would get was a bit of a smile, but there was – there was certainly no – or if we tried to feed her maybe she would – she would, you know, shake her head, but there was no other communication, as far as if we said to her, "Are you in pain?" Like, there was just – she was staring in the distance – staring into distance a lot. And we were never really sure if she knew that we were there.

MS HUTCHINS: I would like to turn now to your observations that you made personally regarding your mother's care during her time at Bupa. During this stage, was she able to feed herself?

DI: Absolutely not.

MS HUTCHINS: And why was that?

DI: She couldn't move her limbs. So she was completely – completely bedbound, completely – you know, we would pick her hands up to cut her nails or put some hand cream – she couldn't move any part of her body. She could move her head and neck slightly, I think, to look out a window or – but, as far as her limbs, she couldn't move them.

MS HUTCHINS: And so were staff at Bupa assisting your mother with feeding?

DI: As far as they were telling us, yes, they were.

MS HUTCHINS: And is that what you observed?

DI: I – most times when we would go and visit, I and I would be couple of times, every second day, likewise with my sister, there was usually a tray of food beside Mum's bed or in front of her and some drink. The tray was usually untouched. The food was usually untouched. So we would often try and help Mum eat and encourage her to eat. She was – it was challenging. She didn't really want to. But we could talk her through. And it was really – if we worked at it, we could really get her to eat some potato or whatever it happened to be. So it looked like to me, when we would go, that the tray was left in front of Mum and there was maybe one spoonful that had been taken out and then it sat there. And it was usually cold.

We would usually bring mousse and ice cream and all sorts of things, because we knew that, obviously, Mum wasn't eating, because there was no – much of the plate hadn't been touched. So we would really try and just get her – and we would say to the nurses, "Give her ice cream, if there's ice cream in the freezer. She loves it and

she will eat it. Give her that." You know, every time we would go Mum's face was more sunken and she was becoming a lot more unwell. So it was really evident. And, obviously, we had family members visiting from interstate, who would come for a couple of days and then return a week later. And they also observed that she was really declining and she clearly wasn't being – eating much or drinking much, because she looked really unwell.

MS HUTCHINS: Did you ever have any conversations with either personal care workers or nursing staff about your concerns about whether your mother was getting enough food?

DI: Yes, we did. So I spoke to them on a couple of occasions – or one occasion when Mum's sister was there about – there was a full plate of – a tray of food in front of her. And we said – and the assistant came and removed it and threw it in the bin. And we said, "Why are you taking that away?" And she said, "She's not hungry." And we said, "Well, how do you know, because she can't speak?" And she said, "She doesn't eat. She doesn't eat" and quickly threw it away. So that was kind of the first concern for us where we thought, "How much time are they actually taking to spend with Mum?" Because we knew that you needed to sit there for a little while and help her.

And we did raise it in a family conference later in early August, I believe, with the care manager and the GP to talk about if they were helping Mum. And, you know, they had showed us food charts that she had been eating and she had had a cup of tea and she had this. Well, Mum didn't even drink tea. So she had never had a cup of tea in her life. So we're kind of like "Hang on a minute." And there's a whole – she has had a whole bowl of soup here and a cup of tea. And we're like, "That doesn't sound like Mum." And then there's a full tray of food in front of her. So we started to get quite concerned that perhaps it was just too hard for them.

MS HUTCHINS: Did you form an impression about whether Bupa staff had enough time to spend with your mother to assist her with feeding?

DI: It certainly didn't seem like it. There was – again, I wasn't there all day every day with Mum, but when I was there – and if we did question them on it on a couple of occasions, they would pick up the fork and say, "See. See. She won't eat. She won't eat" and then take the tray away. So it seemed like – on several occasions Mum would be out in the common kitchen dining area. A lot of the more mobile residents were there and they were being attended to and eating their dinner and Mum was sort of sitting there in her chair unable to move. And it really seemed like it was a lot easier to help the residents who were self-sufficient and feeding themselves than sit there with my Mum. And there was another – another male resident in a similar condition to Mum who seemed to be of the – seemed to be undergoing the same experience, from my point of view, anyway.

MS HUTCHINS: And were there any instances where you witnessed other family members being able to successfully feed your mother?

DI: Yes, absolutely. So whenever my sister and I were there we would always – and she wasn't eating bowls of soup and things like that. But we would always sit there and help her. And she had thickened fluid and things like that, where we would all take the time to do it. And we were successful. And yes, we are her family, but we knew if we spent the time to do it, the appetite was clearly there, because she would eat it. One day she did devour three cups of ice cream, and so I then stocked up ice cream and brought her all those things that she enjoyed. So the appetite was certainly there. And whilst we didn't expect Bupa to force feed her, to make that effort to help her eat we felt definitely wasn't being made.

MS HUTCHINS: And during this period, your mother was assessed by a speech pathologist. Were you present during that session?

DI: I was. So I was there. My father's sister was also there visiting at the time. And the speech pathologist came in. I was there with my newborn child with me. She came and did an assessment with Mum, wrote up some handwritten notes. And she said to me, "You know, it's really important that your Mum is fed in the right way. There's a risk of dysphagia", I believe it was, so she needed a pillow to prop her up, she needed to be at a certain angle. She said if she starts coughing at all, you need to stop, because clearly something is bothering her in her airway.

So she talked me through, you know, all the parameters that she was putting around for the nurses on how Mum needed to be fed. And she said it's really important. And she put it up behind Mum's bed. And she said to me, "Now I'm going to show you a three and a-half minute video on how to feed your mother so that there is no risk." And, meanwhile, I'm holding my newborn child who is screaming. And I said to her, "I'm sorry. Why are you showing me this video?" And she said, "It's important that I show family members." I said, "Shouldn't you be showing this to the nurses here, because I'm not here every day. I come and visit – if this is really important, which it is, they need to be across it." She said to me, under her breath, "There's not a lot of point in that, and that's, really, why I show the family members who are here, because they're usually the ones that end up feeding them."

Again I sort of looked at my Dad's sister and was completely dumbfounded at what I had just heard. And that's when we thought, "Hang on a minute. What we had assumed is happening, that there isn't this care and attention being paid to the feeding of her, is probably the case." If she has more faith that me, with a newborn child, is going to be there to feed my mother, rather than the nurses and the care staff they have on hand who we had entrusted to do that job.

MS HUTCHINS: Your statement notes that your mother was dependent on hearing aids and glasses. How often would she need to wear her hearing aids and glasses?

DI: All the time. So Mum actually wore contact lenses before, obviously, she was in hospital, but, obviously, she wasn't going to wear them in hospital, so she had glasses for everything. She couldn't see who had walked into the room without glasses. She couldn't do anything without her glasses. She had worn them all – or

contacts all her life. She had hearing aids that she needed to wear all the time in both ears. So even with her hearing aids, she was hard of hearing. But certainly without them, even if we were shouting, she couldn't hear us. So she needed them in all the time. They were essential to her sense of knowing where she was and being able to communicate and understand people around her.

MS HUTCHINS: And did you make any observations about Bupa's management of your mother's hearing aids during her stay there?

DI: Yes, it was really frustrating and upsetting. Every – most time, Mum had two pairs of hearing aids in a case. And every time we would go to visit her – on a couple of occasions she had one in her ear. And we would – Mum – we didn't know if she could hear us, so she couldn't tell that she couldn't hear us. We would test if it was working. We would put a hand on it, and if it beeped. And it didn't. And we would pull it out and there was no battery in it. Most often when we went, there were no hearing aids in her room, there were no hearing aids in her drawer.

The first thing we would do is go to see Kristine Min, and ask her, as the care manager, "Does anyone know where Mum's hearings aids are?" She would look in – I remember going into her room and looking in a locked box and there was nothing in there. We were told that, "Perhaps they had come out when your Mum is being showered." I said, "Well, it's really important that Mum knows we're here. We're bringing her grandchildren to see her. We know that she is not well. For her quality of life and dignity, it's really important that she has these."

Likewise if the nurses are trying to talk to her. We need to find these. So we then – this went on for the whole period that Mum was at Bupa. And I went back to the hearing clinic on two occasions to reorder more hearing aids, because they went missing, which was a process in itself. They took around – over a week to place the order, we went and picked them up, we took them over to Bupa. And each time we went back there, they either weren't in the case, weren't in Mum's room, had gone missing or the batteries were dead and no one had, like – no one had told us about it, so we then went back to get more.

It was a really frustrating experience, because Kristine told us that she would make sure that the nurses on duty were aware, check the hearing aids were in each morning, before she showers, take them out, put them in a case, you know, basic kind of routine stuff to ensure that we didn't lose them. But the same thing kept happening. And even the woman at the hearing clinic was like, "What is going on with these?" because we were back there twice in the space of two weeks ordering more hearing aids.

MS HUTCHINS: And in relation to your mother's glasses, did you make any observations about whether they were being managed?

DI: Glasses were the same. So they went missing when Mum was transferred back after that first 48 or 24 hours at Bupa. So when she went back to Royal North Shore

the glasses were gone, she didn't have them at the hospital. My sister, I believe, had a conversation with Kristine to say, "The glasses aren't at the hospital. We don't know if Mum was transferred with them. Do you know anything about them?" "No. There's no sign of them here at Bupa." And then we thought, "Well, they've gone." So we ended up ordering another pair for Mum.

Kristine said to us they probably were lost in the transfer to hospital. Mum then returned to Bupa. And then, after about a week, the original glasses mysteriously turned up in Mum's room one day, so were clearly found again. And, again, we were just at a loss as to what is actually happening. We asked the question as to where things are and we're given a response and things go missing or they mysteriously turn up. So it was really – we just felt – like, we just had no – every time we walked in we would say, "Where are the glasses? Where are the hearing aids?" And on one occasion could I say both things were there, despite every time we couldn't find them I would walk to the nurses station and tell the nursing manager that I was concerned.

MS HUTCHINS: Next, I would like to turn to the issue of your mother's bed sores. Do you know when these first developed?

DI: I know that she had – I know that she had some when she was at Royal North Shore Hospital, but I know that there was one developed when she was at Bupa Willoughby when she went back after that, after 6 July. So at some stage over those couple of weeks I do remember the nurses communicating that she had a bed sore on her buttock.

MS HUTCHINS: And did you ever see it yourself?

DI: No, I don't believe so. From memory, when we were – once, I think, they might have been turning her and checking the dressing on the wound but I didn't see it, no.

MS HUTCHINS: And were you told what steps the care workers at Bupa were taking in relation to care of the bed sore?

DI: They had told us that they would be rotating her, and – the same at Royal North Shore Hospital, that they would be rotate her every four hours, I believe it was, to make sure that that wasn't exacerbating, and it could alleviate the pain. I was of the understanding that she was also meant to be on an air bed, air mattress. I'm not sure if she was. I don't know. I can't categorically say if she was or not, but there was – she was definitely moved. She was taken out of her bed. We know she was taken out of her bed and put into an armchair each day. But, obviously, I wasn't there to see the turning every four hours.

MS HUTCHINS: I would like to turn now to the end of life planning. When you first entered your mother – sorry – the second – on the permanent basis, did you understand that this was for palliative care at this stage?

DI: Yes, we did.

MS HUTCHINS: And were there any discussions at the time that your mother went back to Bupa on a permanent basis about palliative care arrangements?

DI: No. So we – the discussion – the only discussion we had about palliative care was at a family conference at the Royal North Shore Hospital with a doctor there and a social worker. Once Mum moved to Bupa there was no conversations with my sister or I around palliative care, who gets involved, who's responsible, what that involves, is it something they manage internally. Do they bring someone – like, we had no idea what to expect as far as what was going to happen, what the process was, is there a palliative nurse at – we had no idea. Nothing.

MS HUTCHINS: And on 9 August 2017, a palliative care nurse, Susanna Sara, came to visit your mother to make a palliative care plan. Were you present at this meeting?

DI: No. So neither my sister nor I were there. My aunt, Mum's sister, who had been visiting, was there during that meeting. And she said to us that evening, "A palliative care nurse came to see your Mum today. Here's her business card." She tried to talk to me about what she was doing. And she said – I said, "Look, I'm not the endure guardian, you need to talk to the girls. I'm just here visiting. Like, I'm not the right person to speak to." And I spoke to my aunt, "Okay. Well" – and she said, "Look, Bupa will arrange a meeting with this palliative care nurse to talk through what – she has done a plan, apparently, with medications and to talk through what that means." And so we sort of said, "Okay. Well, we will assume that Bupa will have that meeting with us when the time is right."

MS HUTCHINS: And did you find out about this meeting or hear anything further from Bupa about this meeting?

DI: No. No, not until we had the family conference and asked them about it.

MS HUTCHINS: And is this a family conference that occurred on 10 August 2017?

DI: Yes. Yes.

MS HUTCHINS: And what was discussed at this conference?

DI: So we happened to be visiting Mum at Bupa and the concerns around the feeding had occurred. I had also – she had been there for nearly 10 days and – a week. And we had had no word if a GP had seen her. We thought, "I wonder how Mum's pneumonia is going." We hadn't received any communication as far as her health. So we said, "Well, we can we sit down with the care engine manager and find out what's going on? And we will also raise the concern about feeding."

So we had the family conference with Kristine Min; Joy Senaga, who was the GP at Bupa Willoughby and who had apparently been seeing Mum. Another nurse was there, as well, in the room. And my sister and I were there and we raised the concerns around the feeding. We raised the – we mentioned that a palliative – we found out a palliative care nurse had been to see Mum. What happened. And then Joy Senaga pulled out the notes and said, "Yes, she has. She has been to see her." And so I said, "Can we please have a copy of those palliative care notes." And she said yes, so she gave us a copy of those.

But there was no communication as to what to expect, what all those notes meant, how this would be – like, we didn't – we had been told this woman came from Greenwich Hospital. Why was Greenwich Hospital even involved? What does palliative care involve? We just sort of assumed that Bupa would be managing that. So we were none the wiser as to – this woman had come in to see Mum, "Here's her notes. And we will sort of keep you updated if her condition declines." That was the extent of the communication to us.

MS HUTCHINS: And your mother died on 15 August 2017. Between the case conference on 10 August and the 15th, was there any further communication with Bupa in relation to plans for your mother's palliative care or - - -

DI: No. No.

MS HUTCHINS: And, now turning to the events on 15 August 2017, on that day you went to visit your mother. What time was it that you arrived at Bupa?

DI: I went there in the afternoon to visit her as I would normally. It was around 1 o'clock.

MS HUTCHINS: And what happened when you arrived?

DI: I walked through. We had to walk through the dining area to get to Mum's room. And she was sitting in the dining area in her chair asleep. And she had the full tray of food in front of her. The other residents were no longer in the room. There were two carers or staff working in the kitchen clearing things up. And Mum was sitting there on her own asleep with this tray in front of her. And I noticed – I went up to give her a hug and I noticed that her breathing sounded a bit rattly, which was unusual.

So I went and – I believe I went and found Kristine and said to her, "Look, can you guys check Mum out, because she's breathing – her breathing was quite rapid, too, and she sounds a little bit rattly." And so then they came and checked her oxygen levels and then, I believe, moved her back into her room. And they gave her some oxygen and they said, "We will keep an eye on her. We will let you know how she goes. It should be fine." And then I said, "Well, she's sleeping. I might – I will call later and check in and see how she is."

MS HUTCHINS: How did you understand her condition to be at that stage?

DI: I wasn't concerned. We had sort of – you know, they had – she was sleeping. Her breathing was – she wasn't labouring or anything like that. We were – I just thought, "Well, I will call a little bit later in the evening and see how she is, but more thinking maybe the pneumonia has come back, maybe it's – maybe she has got a bit of phlegm in her throat." There was no huge concern.

MS HUTCHINS: And so, after you left, what happened?

DI: So I went home, then I – at about 6 o'clock that night I got a phone call, not sure why. I think they couldn't get hold of my sister, so I got a phone call. And it was – I believe it was DO from the nursing team saying – I answered and she said, "Do you want us to send your mother to hospital?" And I sort of said, "Well, what are you talking about? What's happening? What's the update on her condition?" And she said, "We don't know." Her English was very, very, very poor.

I sort of said look, "I don't know what her condition is, so can you tell me what's going on?" And she sort – "Could be pneumonia. I don't know. Do you want us to call an ambulance?" And I said, "Look, I don't know what's going on. Can we – I will come in. Let me finish dinner. My sister and I will come in and we will just see, because we can't make a decision based on no information in a phone call." And she was very difficult – she was – her English wasn't great, so it was very difficult to have an informed conversation with her. She did say, "I will call the out of hours GP to come and see." And I said, "Yes. Please do. And hopefully by the time we come to visit her or she would have been to see Mum and then we might have a better idea of what's going on."

MS HUTCHINS: What time did you return back to Bupa?

DI: We went back about 7 o'clock, 7.15.

MS HUTCHINS: Yes. And what happened when you arrived back?

DI: So we walked into the building and we walked into the corridor, which was about 50 minutes from Mum's room. And it sounded like there was an engine of a truck or a lawnmower engine running. It was this loud rumbling that was so disconcerting and scary I think as soon as my sister heard this we ran. So we ran to Mum's room, because we knew, obviously, we could hear that's where it was coming from. So we went in, there was no one in there with her, she was in her bed. I can only describe it as someone who had run a marathon and could not catch their breath. She was fighting to breathe. It was like her – it sounded – I have no medical background, but it sounded like her lungs were full of fluid and, like I said, a truck's engine running. And she was fighting. She was fighting so hard to breathe and clearly so uncomfortable. So - - -

MS HUTCHINS: Was there any staff member there assisting her at that time?

DI: No, not that time. No.

MS HUTCHINS: And did you look for a staff member?

DI: We did. So our first reaction – we threw our bags down and one of us stayed with Mum. I think my sister ran out and she was running the corridors trying to find someone. So went to the nurse's station, no one there, putting her head into people's rooms frantically trying to find someone.

MS HUTCHINS: And what were you doing at this point?

DI: I was sitting beside Mum holding on to her, saying – talking to her, "It's okay. It's okay. Like, we're here. It's okay. We're going to help you feel more comfortable," just reassuring her if – she was unconscious. Not unconscious, but her eyes are closed, reassuring her that we were there and that we would try and make – somehow make this better for her.

MS HUTCHINS: And how long was it until a staff member came to see her?

DI: It was probably a good 20 minutes, half an hour. Yes.

MS HUTCHINS: And do you remember who the staff member was?

DI: I don't remember. There were – on the night there were – there was DO and a male staff member, who I believe seemed to be more in charge. I feel – I think his name was DN, but I don't know who entered the room on that first occasion.

MS HUTCHINS: Yes. And what did the staff do when they came in?

DI: I remember them clearly changing the oxygen tank. And we were sort of sitting there and they went and got the oxygen tank and we were watching and – not much. There was no – there was no – there was no medication being administered to her. We were sort of watching this unfold thinking this must be what happens, this must be – but watching our mother so uncomfortable and fighting to take every breath.

MS HUTCHINS: Did you ask them about medication at this stage?

DI: We did. So we asked them what medication she had been given or pain relief to keep her comfortable. Both of their – their grasp of English wasn't great, so we were told that she had had morphine and that they were monitoring it. And we sort of said, "Okay. Well, she really – she does not look comfortable. Is there something else we can give her?" And I had the palliative care nurse's notes in my handbag, so I got it out. I mean, they don't mean much to me with, you know, the medications and the amounts on it.

But I said, "Look, this is, obviously, what the palliative care nurse has prescribed. Is she getting any of this? She's really uncomfortable. Like, you can't say you're

monitoring her for comfort levels when she is clearly distressed and fighting for every breath." And there was no communication. There was no, "It's okay. We will come back in 20 minutes and reassess her." There was no – they seemed to rush in and out of the room. They seemed to be very busy and run off their feet. And they did say to us – DN said to me later, "We're so busy tonight. There's too many issues. We're so understaffed." But there was no management whatsoever. We were literally in this room with Mum and every now and then someone would come in or we would go and find them and get them to come in and check on her again.

MS HUTCHINS: Did you get any advice that night about what was happening with your Mum and how to manage the situation?

DI: We did. So I had Suzanne Sara, who was the palliative nurse – I had her business card in my bag. So we had no communication. My sister and I were starting to panic. So we – there was a landline phone number on the business card, so I rang it. This was 9 o'clock, 9.30 in the evening. And it went straight through to Greenwich Hospital. And we were in this state of panic. We had no idea what was going on. And I said, "Look, Suzanne Sara has been to see Mum. She's a resident at Bupa Willoughby. We need some help here, because we're just in this room with our mother. She is clearly very uncomfortable. What can we do?"

This woman was so helpful. She said, "Look" – and I don't remember her name. She said, "I don't know your mum's case, but I will open a file and I will have a look." And she said to me, "Have they given her this? Have they given her that" And we said, "We don't actually know. She has had some morphine." She mentioned midazolam, which I then looked at the palliative care nurse's notes. We were in a state of panic. She was the voice of reason on the other end of the phone, not knowing who we were or what was going on, saying, "Ask them these questions." And, "It sounds like your mother might be going to go downhill."

You know, and we said, "Should we transfer her to hospital?" And she said to us, "Well, it's completely your call, but from the" – and she could hear Mum in the background, she could hear this breathing. And she said, "If I was you, and I'm not there, so I can't make the decision", she said, "I would leave her where she is, because she doesn't sound like she's good." But she could hear this rattling and she commented and she said, "That is really concerning." So we were kind of holding on to this phone call with this woman, because it was the only person that would speak to us. And she was wonderful. And thank God we could get hold of her, but there was only so much she could do, being not in the room and, you know, not the person taking care of Mum on that night.

MS HUTCHINS: And earlier you mentioned that the facility was going to call the afterhours GP. Were you there for the GP visit?

DI: Yes. So he came – I think he came about 8.30, from memory. And we were sitting in the room. And this man came in and was in the room for I think less than one minute and then muttered something to DO, the nurse, and walked out. And my

sister jumped up and said, "What is going on? What's happening with Mum?" And he said to us, which we just will never forget – he said, "This isn't really my area of expertise" and then walked out. And we just – we could not believe what was unfolding. And then DO left the room and then we're in this room again with Mum completely none the wiser as to what was happening.

MS HUTCHINS: Finally, following the night of your mother's death, you've given evidence in your statement regarding the complaints process with Bupa and the Aged Care Complaints Commissioner, just in broad terms, how did you find the experience of dealing with Bupa after your mother's death and were you satisfied with the dispute resolution outcome?

DI: Yes. So I – I followed up with Bupa a few – a week or so after Mum passed away with the general manager there, Joanne Money. We – I had a meeting with her, just her and I, to talk about my concerns; I emailed them to her in advance. We had what I felt was a really not productive but I had a meeting with her that I felt went quite well and I felt she really understood where we were coming from. I told her – very emotional – I told her what had happened. Joanne was also crying. She said to me she had gone through a similar experience with her grandmother – I can't remember how much earlier. She had only just started as a general manager at Bupa Willoughby so she said, "I am horrified, I will get to the bottom of how and why this happened. I'm so sorry. I completely understand why you're angry about this. I probably shouldn't be crying because it's not so professional but like it's really touched me, your story, and I'm horrified that our facility has let your family down.

So I really felt like she understood where we were coming from. Following the meeting with – Joanne Money said to me, "I'm going to look into this, and give me a week or two and we will get back to you". We then had a subsequent meeting with Joanne Money, Helen Steinke, who was a clinical adviser to – as part of Bupa, Joy Senaga was in the room as well, and we walked in, and we had sort of – this was their chance to come back to us and sort of explain or talk us through what had happened from their end. And we sort of sat there and no one said anything, and we said we were hoping to have some sort of feedback on our experience, "Joanne, you were really emotional in the last meeting. What – what has happened, have you looked into how this has happened". And Helen Steinke did most of the talking; Joanne Money and Joy Senaga said nothing.

We – it was a very stilted meeting, you know, looking through our records, we can see that your mother had adequate care, there were no, you know, she had pain medication on the evening, like it was a very, very different meeting to the first meeting. My sister and I were really angry. We were asking Joanne Money and Joy Senaga questions directly and were met with blank faces. At a time – our mother had only passed away three weeks, four weeks earlier. There was – it was a really – it was quite a shocking environment to be in. It was then that I decided to lodge a complaint to the aged care commission because we had been in – we had received nothing insofar as an explanation or even a dignified response from Bupa as to what

had happened. So I lodged the complaint to the Aged Care Commission around 21 September or the 23rd I can't remember the exact date.

MS HUTCHINS: Commissioners, I have no further questions for this witness.

COMMISSIONER TRACEY: Yes. Before we let you go, could you tell us about the response from the regulator to your complaint?

DI: Sure. So I – I went through quite a process with them over the course of about nine months, working on the investigation and the report that – they were great, they were fantastic to deal with and very thorough. The report that they came back with found they obviously called in all of the documentation from Bupa as far as Mum's medical charts and files and they found a number of instances throughout the four week period that Mum was at Bupa Willoughby that they had failed, particularly around – which is in my statement, I believe, around pain assessments. There were no pain assessments undertaken after, I think, 22 July. So for almost a month there were no pain assessments undertaken by Bupa Willoughby of Mum's condition. In addition, there were a lot of findings in there that – that were particularly confronting. They – I had a chance to review their findings. They said that they were obviously working with Bupa Willoughby on processes and training of staff and things moving forward.

I felt – when we got the report back, it made me feel, I was glad that the investigation had been done but I was left with this report. What do I do with this? We got – Bupa had offered to meet with us to apologise and I declined because I didn't feel, based on the last meeting we had with them, I didn't want to put myself through that again. They sent us an apology letter which was a couple of very quite insensitive lines around:

> *We're really sorry this has happened to you, and you didn't get the level of care you would expect from Bupa, yours sincerely.*

So I – the report was very – is very difficult to read but I didn't really know – we felt really helpless. What do we do with this now? Like, you know, yes, they put processes in place and hopefully, touch wood, that doesn't happen to families in the future or patients, but what do I do with this now; we felt completely let down by them, not only in Mum's level of care but in the way that they managed us. It really seemed like, based on their responses to – and again, you know, they're responding to the Aged Care Commission report in a certain way and for a certain purpose but their responses were really like it was just a blip on the radar for them. It felt, reading that report again and again and again where they had been found to have not provided the right level of care was really upsetting. And reminding ourselves that this was over a four week period, that these things happened in quick succession, we just thank God that she wasn't there for a year.

COMMISSIONER TRACEY: Thank you very much for sharing this dreadful experience with us. It has been very difficult for you, I'm sure, and it will assist us in

understanding how your mother's experience may be, unfortunately, typical of what often goes on in this sector. And we're hearing more and more stories of like effect. But thank you for sharing your very personal story with us.

DI: Thank you.

<THE WITNESS WITHDREW [11.07 am]

MS HUTCHINS: Thank you, Commissioners. I now call witness DJ.

<DJ, AFFIRMED [11.08 am]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Operator, please display the witness statement of DJ. Is this your statement that you've prepared for the Royal Commission?

DJ: Yes, it is.

MS HUTCHINS: Do you wish to make an amendments to the statement?

DJ: No, thank you.

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

DJ: Yes.

MS HUTCHINS: In your own time, please read the statement for the Commission.

DJ: Sure.

This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief. The views I express in this statement are my own based on my own knowledge except where they are based on information I have received. Where I have relied on information I believe that information to be trued. Where direct speech is referred to in this statement is provided in words or words in the effect of those which were used to the best of my recollection.

I am 42 years old. I live in Sydney, New South Wales and I am a media buyer. On 11 March 2017 I was appointed the enduring power of attorney for my Mum. I have read the statement that my sister has made to the Royal Commission. The events described by my sister accurately reflect how I remember them also. I make this statement to provide further detail regarding certain matters and events. On 26 May 2017 my Mum was admitted to North Shore Hospital after she had a fall at home, leaving her with a badly fractured arm. Mum was in hospital for several weeks. During this stay her health was deteriorating. Towards the end of her stay she was essentially immobile and required assistance with most activities such as moving in bed, eating, toileting and bathing.

Mum would often complain in hospital about pain or discomfort from her bed sores, fractured arm or arthritic knee. At the start of Mum's stay in hospital she was able to tell me when she was feeling pain through simple words, and I would then pass the message on to hospital staff. As time went on she lost the ability to speak as normal and it was more difficult to tell what was wrong, although there were times when she would moan, grimace or point to communicate that she was in pain. Also, Mum would regularly yell out when people touched her, and it was difficult to know whether this was from pain or because she did not want to be touched. I expect it was both.

While Mum was in hospital it became clear that she would need someone that was able to meet all of her needs. My sister and I both had young babies at the time and felt that her care needs were greater than our abilities. I took several days off work so that I could look for an appropriate aged care facility for her. On 2 June 2017 I called Bupa Willoughby and spoke to Linda Wilson. We had a general discussion about Mum's care needs and the services that Bupa Willoughby could provide. From this discussion I understood Mum would receive the level of assistance that she needed. I trusted that Bupa Willoughby would take care of Mum and felt comforted knowing that there would always be staff keeping an eye on her and that there would be doctors and nurses if she needed medical attention. I trusted that Bupa Willoughby would take care of Mum.

I would never put Mum into care if I did not think that her needs were going to be met and, certainly, given the Bupa brand, its size and reputation, I believe we were placing Mum in safe and caring hands. On 6 July 2017 Mum was first admitted to Bupa Willoughby. The admission was initially on a respite basis although it was the expectation at this time that it would likely evolve into a permanent placement. By this stage Mum did not have the cognitive capacity to make her own decisions and physically she was completely dependent on others.

When Mum was admitted I went to Bupa and met with the manager to complete the financial document, then with Kristine Min to discuss details about Mum's care needs. We discussed a number of Mum's health issues including her

general physical incapacity, bed sores and arthritis. We discussed that Mum required assistance being fed. We also discussed Mum's mental state; she was cognitively incapacitated at this time. I told Kristine that I held the enduring power of attorney for Mum. I also explained that Mum needed her hearing aids and wore glasses. She relied on these to be able to see and hear with limited capacity without them. I told Bupa that mum would be lost and very distressed without them. I also provided details about the types of foods Mum liked or did not like.

On 7 July 2017 Mum was readmitted to North Shore Hospital with aspiration pneumonia. Mum was in hospital for about 11 days. At some stage during this hospital admission I had a conference with a doctor, a social worker and a hospital registrar. Palliative care was briefly discussed at this conference and while I don't recall the specifics of this conversation I do recall it was mostly about counselling and support services that may be available, rather than any plans or directions about Mum's final days. On 18 July Mum was discharged from hospital and transferred back to Bupa Willoughby. Around this time I signed new accommodation agreements with Bupa, moving Mum from a respite to a permanent resident. Again, Bupa were informed that I was Mum's power of attorney and primary contact.

On 9 August 2017 a palliative care nurse from Greenwich Hospital, Suzanne Sara, saw Mum and drafted a palliative care journey. I found out about this appointment because my aunt had happened to be visiting Mum and my aunt told me about it during a telephone discussion that evening. I was not told by Bupa in advance about this appointment. As Mum's enduring power of attorney I would have expected Bupa to contact me to let me know that this appointment was happening. If I had known, I would have wanted to be present so that I could have input into Mum's plan and make sure it was in line with what I thought Mum would have wanted. I would also have liked to have been able to ask questions so that I could understand the state of Mum's health at the time, and what to expect in Mum's last days.

On 10 August 2017 my sister and I attended a family conference at Bupa Willoughby to discuss what was happening with Mum's care. This included wanting to understand what had happened at the palliative care nurse's visit. We felt very confused and out of the loop. During this meeting we were given a copy of Suzanne Sara's notes. We asked about whether we should transfer Mum to hospital if she got sick in future and were told that it was not recommended to transfer to hospital because she was so frail and it would likely cause her unnecessary distress. We were told that if Mum stayed at Bupa Willoughby she would be kept medicated and comfortable.

On 15 August 2017 at approximately 4 pm my sister called me to say that Mum was not doing well. We decided that we would go and see her later in the evening, and at approximately 6 pm my sister called again to say that Bupa had just called to ask her whether or not to send Mum to hospital. I was shocked by

this question because, firstly, we had not been given any information about why Mum would need to go to the hospital; secondly, we had been told several days earlier that transferring her to hospital would only cause Mum distress. My sister and I drove to Bupa Willoughby together. When I arrived, I could hear Mum's breathing from about 20 metres down the corridor, it was so loud. When I got into the room I could see that her breathing was very laboured and she looked uncomfortable.

There was no one around to help my mum. I ran around the facility doing laps of the corridors trying to find a nurse or just someone to assist. I felt quite panicked at this stage, and my sister and I were pretty much were taking turns running around looking for help and then one of us would stay with Mum. This went on for at least 30 minutes before we could find someone to help us. Even when we were able to find people, we felt they did not know how to handle the situation. I recall there being a male nurse there – or a male called DN, and a female, DO, who were both on duty that night. They did not speak very good English and it was very difficult to communicate with them, in particular DO. When we asked them for help, the female nurse told me, "We're busy, we will get there when we can".

When the staff members came to Mum's room they didn't do much. They would just adjust the oxygen tank and then disappear for about 30 minutes. We had a printout of the palliative nurse's medication plan and we got that out and showed it to one of the nurses. It felt like we were begging them to give Mum the medication listed on that plan. Eventually, they did give Mum something although it seemed to me that they had not even considered giving her drugs before we had asked. Over the course of the night we attempted to call the palliative care nurse directly at Greenwich Hospital. She was not available but the lady who answered the phone was incredibly helpful. She found Mum's file and spent a lot of time talking to us. She was the only person that night who spoke to us about what was happening and what to expect.

The whole evening of Mum's passing was a farce and, honestly, an absolute disgrace. There was not enough staff. The staff who were there did not seem to know what was going on and we were in the dark the entire time. After Mum's death my sister and I raised our concerns with Bupa Willoughby and tried to get some answers about what happened and why things went so wrong. In all of my dealings with Bupa Willoughby during this time I felt like they were trying to dismiss our concerns. I felt like they were not listening to what I had to say and did not want to admit fault. For an organisation that exists to care for people, it seemed like they had no compassion for us at all.

MS HUTCHINS: Commissioners, I tender the witness statement of DJ. Document WIT.0190.0001.0001.

COMMISSIONER TRACEY: The witness statement of DJ dated 12 May 2019 will be exhibit 3-36.

EXHIBIT #3-36 WITNESS STATEMENT OF DJ DATED 12/05/2019 (WIT.0190.0001.0001)

MS HUTCHINS: Commissioners, the next witness is Ms Berry. If it's convenient, may we suggest taking the morning break now?

COMMISSIONER TRACEY: Yes. Certainly. Thank you very much for your evidence.

DJ: Thank you.

<THE WITNESS WITHDREW [11.17 am]

COMMISSIONER TRACEY: The Commission will adjourn for 15 minutes.

ADJOURNED [11.18 am]

RESUMED [11.37 am]

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. In addition to the documents that have already been tendered through the case study tender bundle, Bupa provided documentary evidence in the form of two witness statements. In respect of one of those, the witness is not being called to give oral evidence but I will tender that statement. Operator, that is WIT.0148.0001.0001. That's a statement of Dr Timothy James Ross dated 26 April 2019. I tender that statement.

COMMISSIONER TRACEY: Yes. The statement of Dr Timothy James Ross – did you put a date on it, Mr Gray?

MR GRAY: 26 April 2019.

COMMISSIONER TRACEY: Dated 26 April 2019 will be exhibit 3-37.

EXHIBIT #3-37 STATEMENT OF DR TIMOTHY JAMES ROSS DATED 26/04/2019 (WIT.0148.0001.0001)

MR GRAY: Thank you, Commissioner. I call Maureen Mary Berry, B-e-r-r-y.

<MAUREEN MARY BERRY, AFFIRMED [11.40 am]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Ms Berry, in response to a notice from the Royal Commission, have you made a statement for the Royal Commission?

MS BERRY: Yes, I have.

MR GRAY: And do you have that available to you now?

MS BERRY: Yes, I do.

MR GRAY: It's a document bearing the code WIT.0148.0002.0001. Do you recognise that to be a statement you've made for the Royal Commission?

MS BERRY: Yes, I do.

MR GRAY: Do you wish to make an amendments to the statement?

MS BERRY: No, thank you.

MR GRAY: To the best of your knowledge and belief, are the contents of the statement true and correct?

MS BERRY: Yes.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: What's its date, Mr Gray?

MR GRAY: 1 May 2019.

COMMISSIONER TRACEY: Thank you. The statement of Maureen Mary Berry dated 1 May 2019 will be exhibit 3-38.

EXHIBIT #3-38 MAUREEN MARY BERRY DATED 01/05/2019 (WIT.0148.0002.0001)

MR GRAY: Ms Berry, until 2017, May, you were the clinical service improvement director of Bupa Aged Care Australia Proprietary Limited.

MS BERRY: Yes.

MR GRAY: I will be referring to that company as Bupa.

MS BERRY: Yes.

MR GRAY: Bupa was in 2017 and remains an approved provider under the Aged Care Act.

MS BERRY: Yes.

MR GRAY: And it has aged care operations in a number of residential aged care facilities; correct?

MS BERRY: Yes.

MR GRAY: One of those facilities is Bupa Willoughby; correct?

MS BERRY: Yes.

MR GRAY: As clinical service improvement coordinator until May 2017 your responsibilities included preparing certain work instructions on clinical care practices - - -

MS BERRY: Yes, it did.

MR GRAY: - - - within Bupa's facilities; is that right?

MS BERRY: Yes, it did.

MR GRAY: And those work instructions are in the nature of policies; is that right?

MS BERRY: Yes, it is, policies and procedures.

MR GRAY: Policies and procedures, thank you. And following May 2017 and on into the relevant period for present purposes, which is July and the first day of August 2017 you were the chief operating officer of Bupa; is that right?

MS BERRY: I was the interim chief operating officer of Bupa at that time.

MR GRAY: In both of those capacities, that is, as clinical services improvement coordinator and then as chief operating officer on an interim basis, your position was one of an executive role in the corporate structure of Bupa but not one of preparing – of providing direct care in the facilities; is that right?

MS BERRY: That's correct.

MR GRAY: You have no direct knowledge of the care that was provided to Mrs DE, the subject of this case study, do you?

MS BERRY: No, I don't.

MR GRAY: As you've said in your statement, you weren't involved in her direct care; is that right?

MS BERRY: That's correct.

MR GRAY: Did you receive communications contemporaneously with the events in the relevant period of July and the first half of August 2017 about Mrs DE's care?

MS BERRY: No, I did not.

MR GRAY: All right. So you're making inferences from the documents that are available to you for the purposes of giving the evidence that's set out in your statement; is that right?

MS BERRY: That's correct.

MR GRAY: You also refer to work instructions in your statement. This is at paragraphs 13 to 16, and you mentioned a minute ago that in your role up to May 2017 you had a responsibility for preparing work instructions on clinical matters; correct?

MS BERRY: Correct.

MR GRAY: Now, while you've referred in your statement to the general manager of a particular facility determining how best to communicate work instructions to staff, you say they were in place at Bupa Willoughby at the relevant time in paragraph 16?

MS BERRY: Yes.

MR GRAY: When you say "they were in place" you can't verify, to the Royal Commission, as to the extent with which they were complied with in any given instance; is that correct?

MS BERRY: Who do you mean by "they"?

MR GRAY: You cannot – they, the work instructions, you can't verify the extent to which the work instructions were complied with in any given instance of care.

MS BERRY: No, I cannot.

MR GRAY: Now, I would like you to look at paragraph 9 of your statement, if we can bring that out, please, operator. Thank you. Now, you say there in the – towards the tail end of the second sentence – I will just read the entire second sentence, Ms Berry:

I am informed that the individuals who were at Bupa Willoughby during the relevant period who I would expect to have knowledge of the matters referred to in the Commission's request are no longer employed by Bupa.

I just want to ask you about that matter. Firstly, the Commission's request, if we go over the page, page 0010 at paragraph 30 – beg your pardon, if we go over the page – pardon me. If we go back to page 0004, and you look at what you've extracted there under the heading Questions 4 and 5, are these the matters you're referring to as the Commission's request?

MS BERRY: Yes.

MR GRAY: And these are matters concerning the clinical assessment of Mrs DE at admission and assessment on an ongoing basis, and provision of care to Mrs DE, amongst other things.

MS BERRY: Yes.

MR GRAY: The people who you would expect have direct knowledge of the matters in questions 4 and 5 would include the nursing staff involved in assessing Mrs DE when she was admitted to Bupa Willoughby on the two occasions she was admitted; is that correct?

MS BERRY: Yes.

MR GRAY: And the people you would expect to have direct knowledge of those matters would be those nursing staff, particularly registered nurses involved in providing care or supervising care for Mrs DE during her admission at Bupa Willoughby; is that right?

MS BERRY: Yes.

MR GRAY: You've reviewed the progress notes in relation to Mrs DE for the purposes of preparing your statement and you've noted, I imagine, the names of the registered nurses who signed those progress notes from time to time?

MS BERRY: Yes.

MR GRAY: If we go to tab 160 at page 0295, do you see the first entry is recorded as being 6 July 2017 at 1435 hours, and there's a signature or some words underneath that entry alongside that in the third column, adjacent to the very bottom of the entry, and I suggest that the person who signed is DQ, [REDACTED]; do you agree?

MS BERRY: Yes.

MR GRAY: And then there's another entry on that day and – that's later in that day, 2130; alongside that in the third column there's a name DP, RN; do you agree?

MS BERRY: Yes, I do.

MR GRAY: And these are references to names that occur elsewhere in the care documentation, I suggest; particularly DP's name appears in a number of places, doesn't it?

MS BERRY: Yes, it does.

MR GRAY: And DP is DP who's a registered nurse and you refer to her as the person who prepared the interim care plan for Mrs DE on her first admission to Bupa Willoughby on 6 July 2017; is that right?

MS BERRY: Yes.

MR GRAY: In addition to those two registered nurses, are you also aware that a registered nurse called DN, who was also known as DN, was involved in the care for Mrs DE?

MS BERRY: Yes.

MR GRAY: And another registered nurse who was involved in the care of Mrs DE and in discussions with Mrs DE's daughters was DO, also known as DO, another registered nurse.

MS BERRY: Yes.

MR GRAY: And you were aware that she was involved directly, and you would have expected her to have knowledge of the matters requested in questions 4 and 5?

MS BERRY: Yes, I would.

MR GRAY: So who was it – well, I withdraw that. When you were told that the people – when you were informed that the people who you would expect to have direct knowledge of the matters requested of the Commission were no longer employed by Bupa Willoughby, did you give specific attention to any of those four people? That's DO (DO), DN, also known as DN, DQ and DP?

MS BERRY: No, I did not. I gave reference to the care manager, Kristine Min, and the manager of the home.

MR GRAY: Okay. You didn't turn your mind to those four registered nurses?

MS BERRY: No, I did not.

MR GRAY: Are you aware that as at 9 April 2019 those four registered nurses I've named were, in fact, still employed by Bupa?

MS BERRY: No, I had no idea one way or the other.

MR GRAY: Right. For the record, the evidence of that is at tab 169 which is a response by Bupa to notice 164. I beg your pardon, I should have said tab 169. That's a redacted document. I will ask that a hard copy be handed to you. Do you have a hard copy of tab 169?

MS BERRY: Thank you.

MR GRAY: Thank you. And Commissioners, I understand you have an unredacted version of document 169.

COMMISSIONER TRACEY: We do.

MR GRAY: Ms Berry, please go to row – the first row which is numbered 3. The name appearing there, can you confirm that the name appearing there is DQ - - -

MS BERRY: Yes, I can.

MR GRAY: - - - one of the registered nurses I just mentioned.

MS BERRY: Yes.

MR GRAY: The date of the relevant notice was 9 April 2019. You can just take that as a matter of assumption, and can you confirm that the column to the extreme right titled Whether Employed at Bupa Willoughby as at date of NDG94, in that column in respect of DQ the information provided is yes.

MS BERRY: Yes, I can, but at the top of the page it does say staff profiles as at 1 July 2017.

MR GRAY: Yes, but in that final row there's a specific question asking whether the employee is employed at Bupa Willoughby as at the date of NDG00094; correct?

MS BERRY: Sorry, I'm not sure where you're directing me to.

MR GRAY: I'm directing you to the final row of the first page of document tab 169, the final – I beg your pardon, the final column. If you look at the document, you should have before you a hard copy of tab 169, if you look at the final column on the extreme right-hand side of the page.

MS BERRY: Yes. Yes, thank you.

MR GRAY: Do you have that as a landscape document, Ms Berry?

MS BERRY: Yes, I've got it there.

MR GRAY: Can you confirm that the final row – I beg your pardon, the final column on the first page is entitled Whether Employed at Bupa Willoughby as at date of NDG0094.

MS BERRY: Yes.

MR GRAY: In respect of DQ the answer to that question in that column is yes.

MS BERRY: Yes, I can confirm that.

MR GRAY: Next row 17, DP, can you confirm that in that same column in respect of DP the answer is, again, yes.

MS BERRY: Yes, I can confirm that.

MR GRAY: And next, if you go to the – if you go two pages into the document and go to row 92, can you confirm that in respect of DN in the column relating to whether DN is employed by Bupa – employed at Bupa Willoughby at the date of the notice, the answer is again yes.

MS BERRY: Yes, I can confirm that.

MR GRAY: Thank you, and at row 101, in respect of DO by reference to the same column can you confirm that the answer in respect of DO is again yes.

MS BERRY: Yes, I can.

MR GRAY: Why didn't you turn your mind to whether registered nurses who were involved in the direct care of Mrs DE were still employed by Bupa so as to obtain more accurate information from their direct knowledge?

MS BERRY: I was provided with the documentation to go through, and I – my understanding was – my reference was about the care manager and the general manager, and I did not turn my mind to it and I can't explain that.

MR GRAY: Do you accept that that sentence I read out from paragraph 9 of your statement is, in fact, incorrect? Or are you just saying that you just didn't think – you wouldn't have expected the registered nurses to have the relevant knowledge. I will read it to you again:

> *I am informed that the individuals who were at Bupa Willoughby during the relevant period who I would expect to have knowledge of the matters referred to in the Commission's request are no longer employed by Bupa.*

Do you say that sentence is incorrect on the basis of the information I've taken to you?

MS BERRY: What I say is that the relevant employees that I was referring to was the general manager and the care manager. I was not referring to any other staff in the home.

COMMISSIONER TRACEY: It's individuals, plural.

MS BERRY: I beg your pardon, sir?

COMMISSIONER TRACEY: The word in your statement is "individuals" plural, not one.

MS BERRY: Yes. No, I was referring, your Honour, to the general manager and Kristine Min, the care manager.

COMMISSIONER TRACEY: Well, why did you write "individuals"?

MS BERRY: They're just two people.

COMMISSIONER TRACEY: That's multiple people.

MS BERRY: I stand corrected.

MR GRAY: So who are the two people you had in mind; what are their names?

MS BERRY: Kristine Min was the general manager – Kristine Min was the care manager and I do not recall who the general manager was at the time.

MR GRAY: So you specifically asked, did you, are the general manager and the care manager still employed?

MS BERRY: No, I was informed they were not.

MR GRAY: Well, why didn't you just say in that sentence that you were informed that the general manager and the care manager were no longer employed?

MS BERRY: In retrospect that would have been appropriate.

MR GRAY: In fact, what's happened is, as a result of you not turning your mind to the registered nurses who were involved in assessment and care, the Royal Commission is deprived of their accounts of assessment and care of Mrs DE. Would you agree with that?

MS BERRY: Yes.

MR GRAY: All right. Well, we will do the best we can with your account based on documentation; I do wish to ask you about that. In paragraph 11 of your statement – operator, if you would kindly zoom the bottom half of this page of Ms Berry's statement. Thank you. In paragraph 11 you say:

> *From my review of DI's statement, medical records and other contemporaneous documents –*

You make the following observations. And in respect of (a) you say:

> *In relation to the clinical care provided to Mrs DE during the relevant period, and in particular the management of Mrs DE's pain and discomfort while she was palliating –*

You say in your view:

> *Mrs DE was provided with clinical care that was appropriate to her particular needs and condition.*

Now, I'm going to be asking you some questions that go to that issue but is that, as you sit in the witness box now, the opinion you hold about the appropriateness of the care provided to Mrs DE?

MS BERRY: In particular to the management of the pain and discomfort, yes.

MR GRAY: Well, when you say "in particular" those are words of inclusion. Are you saying that only in respect of Mrs DE's pain and discomfort was she provided with adequate care or are you saying "in particular"?

MS BERRY: Well, the word is "inclusion", and there were other aspects of her care that my view and review of the documents supports that there was good care provided.

MR GRAY: Okay. So you're saying that all her clinical care was appropriate to her particular needs and condition?

MS BERRY: I would say that there are sometimes when the clinical care could have been provided more promptly and could have been responded to more swiftly.

MR GRAY: So are you stepping away a bit from the statement you've made at 11A? You're actually qualifying your opinion as originally expressed in 11A there; is that right?

MS BERRY: No. Inclusively on the matters of her pain management, I think that the clinical care was appropriate. There are times when care provision wasn't as prompt as it could have been or perhaps explained as well as it could have been or documented as well as it could have been.

MR GRAY: All right. Now, I want to ask you about a letter that Bupa wrote in the course of the complaints process before the Complaints Commissioner, which you would have heard evidence about a short time ago from Ms DI. Please bring up tab 118. Have you seen this letter before?

MS BERRY: Yes, I have.

MR GRAY: And this is a letter dated 4 May 2018. It has an attachment that's at a different tab, tab 116. I will just ask that the operator bring that up on the other screen so we have both documents available at the same time. Now, in this second document from tab 118, there's a series of points raised and responses made on issues of concern to the Complaints Commissioner; is that right?

MS BERRY: Yes.

MR GRAY: I would like to ask you a little bit about the letter of 4 May. If we go back to that, and go to the second page, page 2867, at the top of the page there, the introductory sentence is:

> *Whilst set out in greater detail in the enclosed table, the key issues identified in our review can be summarised as follows. Quality of care delivered to DE was inadequate. The quality of care delivered to DE at the care home was inadequate, primarily due to deficiencies in clinical leadership and supervision. During the period in which DE was a resident at the care home, both the general manager and regional director did not have clinical backgrounds, which weakened the connection between local level clinical oversight and our clinical governance processes.*
>
> *Both these roles have since been replaced with registered nurses, who both have clinical and business experience. The clinical care manager at the care home during DE's residency no longer works for Bupa and has been replaced. Bupa has identified the potential risk to care delivery from a lack of clinical leadership and supervision when both the general manager and regional director have no clinical background and we are addressing this issue at an organisational level.*

And then there's this sentence:

> *As noted above, the individuals who provided no direct care to DE are no longer employed at Bupa.*

And then there's a reference to further education for new personnel. Now, just asking you about the lack of clinical background of the then general manager and regional director over the relevant period, was that a matter within your knowledge at the time you prepared your statement?

MS BERRY: Yes.

MR GRAY: Yes. Isn't that relevant to the question of your opinion that the care provided – the clinical care provided to Mrs DE was adequate?

MS BERRY: No. I did not consider the relevance of the – of the operations – the regional director in – in that response. I was, in this, in reading this, I'm still referring to the registered staff and particularly the clinical supervision provided by the care manager of the home. I'm not referring to the regional director, who would not be providing direct care.

MR GRAY: Okay. I want to ask you about the gist of the point I read out to you. It begins with, and explains, that details are in the table. It begins with:

> *The quality of care delivered to DE at the care home was inadequate, primarily due to deficiencies in clinical leadership and supervision.*

Do you agree with that statement?

MS BERRY: I agree that clinical supervision and leadership were lacking in the home at the time.

MR GRAY: Okay. So you agree with the second part of the sentence, but you're not agreeing with the first part, that the quality of care delivered to DE at the care home was inadequate?

MS BERRY: Not in totality. So there are times when the quality of care was – was good, from what I gleaned from the notes and from the documents that I had to review. But I – I do agree that it wasn't consistent.

MR GRAY: Well, if we go back to the statement you've made and the opinion you expressed at 11A, you seem to now be saying that at times you accept, as was stated in Bupa's letter of 4 May, that the quality of care delivered to DE at the care home was inadequate; is that right?

MS BERRY: No, I'm not saying that.

MR GRAY: Okay. So you're saying that at times you thought it was good, but at other times, what, you're not sure?

MS BERRY: What I am saying is that, from my review of the documents and gleaning pieces of information from all parts of the clinical file and all documentation that I had to hand, that there is enough evidence there and enough signatures and enough documentation in progress notes and diet analysis and in medication signing to say that the right care was happening most of the time at the right time, from what I could read. But what I also would say is that there was a lack of clinical documentation of – appropriate clinical documentation of the care provided.

MR GRAY: Well, in summary, you seem to be saying that the documentation allows you to draw the conclusion that the care provided at many times was adequate, but there are deficiencies which means you can't draw that conclusion at all times; is that right?

MS BERRY: You could say that.

MR GRAY: Okay. So when you've made your statement – if we go back to it, please, at 11A. Thank you, operator. When you've made your statement in 11A, that in your view DE was provided with clinical care that was appropriate to her particular needs and condition, that's not true for all times, is it?

MS BERRY: It's true for the documented times that are there, and I can't comment for what is not there.

MR GRAY: That's different from what you've said in 11A. You haven't made any qualification in 11A and you're now qualifying your opinion to only those times where the documentation exists; is that right?

MS NEEDHAM: I object to that question, your Honour. To be fair, the chapeau of that paragraph should be included in the question to Ms Berry.

COMMISSIONER TRACEY: Well, I think the question was fairly put and I will allow it.

MR GRAY: So, with reference to paragraph 11A, where you've expressed the view that DE was provided with clinical care that was appropriate to her particular needs and condition, you've now, in your oral evidence, qualified your opinion about the adequacy of the care provided to DE and limited it to only those times where you have a documentary basis for that view and at other times you're unclear. I'm putting to you that the qualified view you've expressed in your oral evidence is different from the view that appeared in writing in paragraph 11A. What do you say to that?

MS BERRY: My – my review of the documents is what I'm relying on to form my opinion, and I can only – only give evidence on the documentation, given that I was not there.

MR GRAY: Operator, please bring up tab 168. Ms Berry, you heard Ms Hutchins' opening and the evidence of DE's daughters, and so I take it you have an appreciation of the general timeline of transfers of Ms DE from home to hospital, from hospital to home, and then back into hospital with a broken arm, and then an admission for under 36 hours to Bupa Willoughby and then readmission to hospital?

MS BERRY: Yes.

MR GRAY: Thank you. Now, I'm going to ask you about a document which comes in during that first hospitalisation. It's a document dated 6 March 2017. Is this an ACAT assessment?

MS BERRY: Yes, it is.

MR GRAY: And this dates to the period before Mrs DE broke her arm. Before that she had been found with a fall, we heard, and possibly a suspected seizure, and she had been hospitalised in February and March. You recall that evidence?

MS BERRY: Yes.

MR GRAY: Now, if you please, operator, go to page 9383. There are a number of matters referred to here documenting the needs of Mrs DE at that time, in March 2017, and they include, under skin integrity, the skin integrity for Mrs DE is intact at that time. But there's an additional statement there, isn't there:

Air mattress for pressure area care.

And that's a matter that you've adverted to in your statement, as well.

MS BERRY: Yes.

MR GRAY: And what that clearly means is that the ACAT assessment view is that there must be an air mattress for pressure area care for Mrs DE; correct?

MS BERRY: Yes.

MR GRAY: This document was available to Bupa at all times from 23 June 2017. You agree with that?

MS BERRY: Yes, I do.

MR GRAY: Yes. There's nothing in the records that Bupa has provided to the Royal Commission indicating that Mrs DE was ever given an air mattress during either of her admissions to Bupa Willoughby; is that right?

MS BERRY: There's nothing in there to indicate that.

MR GRAY: Yes. If she had been given an air mattress, you would expect that that would be recorded somewhere in Bupa Willoughby's records, wouldn't you?

MS BERRY: I would have, yes.

MR GRAY: Yes. Later in your evidence – and this is at statement paragraph 69. I will come to it chronologically – you do refer to a pressure injury detected on 13 August 2017, two days before DE died; correct?

MS BERRY: Yes.

MR GRAY: I want to ask you about some matters that took place a little later in that timeline of transfers between home and hospital and aged care. As you will have heard in the evidence, on 26 May 2017 Mrs DE fell at home and broke her arm. I withdraw that. She fell and broke her arm, and she was readmitted to hospital for a long stay, which lasted until 6 July; correct?

MS BERRY: Yes.

MR GRAY: Now, we have a discharge referral in the material that has been made available to the Royal Commission. I will ask the operator to bring up tab 50, please. Is this a discharge referral on the occasion of Mrs DE's discharge from hospital to Bupa Willoughby on 6 July 2017?

MS BERRY: Yes, it is.

MR GRAY: Now, in your statement at paragraph 19, you say:

> *It is not clear whether this discharge document was provided to staff at Bupa Willoughby –*

and the then GP, Dr Joy Senaga prior to or upon DE's arrival. You recall saying that in your statement?

MS BERRY: Yes, I do.

MR GRAY: But you also noted in your statement that the document was in the records of Bupa Willoughby on file; correct? Do you want to go to that?

MS BERRY: Where is that? Yes. It was contained in the file that I was reviewing.

MR GRAY: Thank you. Now, in respect of that discharge summary, the discharge summary, particularly in circumstances of respite care, is a very important document for an aged care home to obtain and analyse; correct?

MS BERRY: Yes, it is.

MR GRAY: And your own policies at Bupa made it very clear that, particularly in the case of respite care, which this was, there must be a discharge summary of this kind obtained from the hospital; is that right?

MS BERRY: Correct.

MR GRAY: And the reasons for that are perhaps obvious, but I suggest to you that the reasons are that the hospital will have identified care needs of the person in

question and it's imperative that those care needs be understood by the receiving aged care home and then implemented; is that right?

MS BERRY: That's correct.

MR GRAY: Now, at one point in your statement, as I mentioned a minute ago, you said it wasn't clear whether this discharge referral document was provided to Bupa Willoughby at the time of Ms DE's arrival on 6 July. You said that in your statement.

MS BERRY: Yes, I did.

MR GRAY: Are you trying to say that there's a likelihood that the summary – the discharge referral, that is, wasn't received by Bupa Willoughby on 6 July?

MS BERRY: I'm not sure, because it wasn't stamped as having been received.

MR GRAY: All right. There are some medicines or medications mentioned in the document at page 215. I will just ask the operator to go to page 215. Do you see in the bottom half of page 215 there are some particular medications that are indicated, coloxyl and Senna, Paracetamol, sodium valproate. Now, if those medicines appeared recorded on 6 July 2017 in the visiting GPs notes kept by Bupa Willoughby, that would suggest that this transfer document was, in fact, available and present at Bupa Willoughby. Would you agree with that?

MS BERRY: I would agree that the doctor at least had seen this.

MR GRAY: Yes. And if the doctor it seen it, that suggests that it was available to the staff of Bupa Willoughby; correct?

MS BERRY: Not necessarily.

MR GRAY: And why is that? Is that because the staff of Bupa Willoughby don't necessarily obtain information from visiting GPs? Is that a concern?

MS BERRY: No. It was a concern of mine that the document wasn't stamped and it may not have been in the clinical file at the time. But there is – it's clear that the general practitioner who visited the home did see this, but it's not clear to me that the staff saw it on that day.

MR GRAY: Now, you've said that the policies of Bupa were that, particularly with respite care, it was – that the aged care – the receiving aged care home had to obtain a referral document of this kind, a transfer – beg your pardon – a discharge document of this kind; correct?

MS BERRY: Yes.

MR GRAY: So it follows, doesn't it, that if because of this point about the absent stamp, if it was, in fact, the case that staff of Bupa Willoughby didn't receive the discharge referral at the time of Ms DE's admission on 6 July, it was imperative for them to take steps to obtain it as soon as they could thereafter from the hospital?

MS BERRY: Yes, I would agree.

MR GRAY: Yes. And if that didn't happen, that would be a gross breach of policy; correct?

MS BERRY: It would be definitely a gap in policy. There are steps they could have taken.

MR GRAY: Well, it would be very risky to the proper care of the incoming - - -

MS BERRY: Yes.

MR GRAY: - - - care recipient not to take that step, wouldn't it?

MS BERRY: Yes, it would be.

MR GRAY: So that – if that discharge referral or discharge summary document hadn't been received and wasn't sought promptly, that in itself would be substandard care, wouldn't it?

MS BERRY: It would be a gap in information that would direct care.

MR GRAY: Well - - -

MS BERRY: But I do recall from the notes that the general practitioner had written some entry that there was enough information there for the home to progress with.

MR GRAY: Well, we will see about that, because I've already – well, we will see about that in just a minute. But relying on a general practitioner's reference to some of the contents of a discharge referral would be no substitute from a careful analysis of the actual discharge referral, I suggest.

MS BERRY: I would agree with that, yes.

MR GRAY: And you've said it would be a gap in documentation, but it would be more than that, I suggest. You've said in your statement that a discharge summary – this is at paragraph 20 – is of assistance in understanding the clinical condition of DE at the time of admission. If you don't understand the clinical condition of the aged care recipient being received into care, that creates a risk that they won't be properly cared for; correct?

MS BERRY: It creates the risk that they may not have – the staff may not have all the information they need to provide a care plan and to direct the care.

MR GRAY: Now, I would like to go back to the detail of the 6 July 2017 discharge referral. On the foot of the first page, which is 0212, there's a reference to "active problems". There's a reference to right humeral fracture. Then there's a reference to "cognitive decline, cause unknown". There's also references to malnutrition, urinary retention. With respect to cognitive decline, you've observed in your statement that this is a matter that should have been noted in the interim care plan that was then provided; is that right?

MS BERRY: Yes.

MR GRAY: Yes. But it wasn't?

MS BERRY: It was not.

MR GRAY: And is that important because the knowledge that there's an active problem of cognitive decline means that you've got to tailor care specifically to the person with that cognitive decline in mind?

MS BERRY: Yes.

MR GRAY: There's also, over the page on page 0213, some histories, some medication changes, some social information. Then, over the page again, on page 0214, there's more detail about issues and progress of this admission – that means during the admission after the broken arm for those days in May and July in Royal North Shore Hospital; is that right?

MS BERRY: Yes.

MR GRAY: Yes. Issues and progress of this admission. There's detail about the right humerus fracture. There's detail about the cognitive decline. And there's reference to some of the detail of that, including decreased communication, regular crying out, etcetera. Appearance of hypoactive delirium; correct?

MS BERRY: Yes.

MR GRAY: None of this was in the interim care plan; is that right?

MS BERRY: Yes.

MR GRAY: Next there's, under the heading Malnutrition, reference to:

Patient had poor oral intake.

Now, just stopping there, I suggest that information about oral intake is very important, because an aged care facility has to do its best to maintain and enhance the nutritional intake of its residents.

MS BERRY: Yes.

MR GRAY: And so information about impediments to that have to be taken into account in formulating a proper care plan for the resident; is that right?

MS BERRY: Yes, that's correct.

MR GRAY: We will come to that in more detail in just a minute. And then, just finishing with this document, further to this issue about eating, under Discharge Plan at the foot of that page, if you have that, Ms Berry.

MS BERRY: Yes, I do.

MR GRAY: There's points 1, 2 and 3. I will skip over those. But, point 4:

> *Patient needs lots of encouragement for oral intake and supervision during meals.*

Now, can I just ask you about – before going to the documentation prepared at Bupa Willoughby on receiving Mrs DE into care, can I just ask you about aspiration risk. Is aspiration risk something that is associated with cognitive decline?

MS BERRY: Not necessarily, not by itself. It is – I correct myself. It is one of those diagnoses that can – can contribute to dysphagia.

MR GRAY: Cognitive decline can contribute to dysphagia?

MS BERRY: Can, yes.

MR GRAY: And I will just suggest to you that, in combination with the requirement for lots of encouragement for oral intake and supervision during meals, the assessment of cognitive decline suggested that a great deal of care needed to be taken with Ms DE in residential aged care to: (a) cater for or address aspiration risk and (b) address her nutritional needs. Do you agree with that?

MS BERRY: I agree that her nutritional and hydration needs at this time were needing to be addressed, but at this time she was also capable of enjoying her normal diet. So she had not been assessed as an aspiration risk and had not been diagnosed with dysphagia at this time.

MR GRAY: All right. Now, just over the page at 0215, do you see there there's a recurrence of this reference that I took you to in the ACAT assessment from March, in the middle of the page:

Problems, past history and alerts, all problems: risk of pressure area confirmed.

Do you see that?

MS BERRY: Yes.

MR GRAY: And does that mean there's still a risk of pressure area?

MS BERRY: Yes.

MR GRAY: Yes. Please bring up tab 53. Is this the interim care plan that was prepared for Mrs DE on her admission to Bupa Willoughby on 6 July 2017?

MS BERRY: Yes, it is.

MR GRAY: And, with the exception of a note made on the back of this sheet of paper, which I will take you through in just a minute, does it appear to you that this was never, in fact, updated at any time during either the first admission on 6 and 7 July or during the second admission from 18 July to 15 August 2017?

MS BERRY: Yes, that's correct.

MR GRAY: And does it also appear to you from your review of the records of Bupa that this interim care plan was not replaced with a more comprehensive care plan in any form?

MS BERRY: That's correct.

MR GRAY: And I will just show you the note on the back. It's a note on page 0256. Somebody has written in in handwriting an entry on 13 August 2017 about noticing a pressure sore on Mrs DE's left buttocks and they've said "commenced wound management"; correct?

MS BERRY: Yes.

MR GRAY: So, with that exception, there's no update of this interim care plan and no replacement with another care plan; is that right?

MS BERRY: That's correct.

MR GRAY: Okay. Now, this is the document that you commented upon in your statement and a short time ago in your oral evidence, to the effect that the cognitive decline of Mrs DE wasn't mentioned in this document; is that right?

MS BERRY: Yes.

MR GRAY: And it should have been?

MS BERRY: It should have been, yes.

MR GRAY: With respect to skin integrity on the first page in about the middle of the page, there's a reference to – is it four – 4/24, repositioning? Is that – does that mean that Mrs DE should be moved four times in 24 hours?

MS BERRY: Every four hours.

MR GRAY: Every four hours in each 24 hours – or every four hours at all times; is that what it means?

MS BERRY: Yes.

MR GRAY: Thank you. And that never seems to have been updated as an instruction; is that right?

MS BERRY: That's correct.

MR GRAY: There's a reference at the time of admission on 6 July to an excoriation in the groin; is that right?

MS BERRY: Yes.

MR GRAY: Is that not an area that's in direct contact with the bed and unlikely to be a pressure injury or is that a pressure injury?

MS BERRY: That's not a pressure injury, no.

MR GRAY: All right. Now, with respect to meals, there's reference to "full assist" and "cut up food", and you – beg your pardon. Not "cut up food" – "full assist and pour fluids"; is that correct?

MS BERRY: Yes.

MR GRAY: But that detailed information about the extra encouragement and the supervision, that doesn't appear to be recorded here. What do you say to that?

MS BERRY: It's lacking. It's completely missed.

MR GRAY: And with respect to hearing aids, you've noted in your statement that that has been omitted, as well.

MS BERRY: Yes.

MR GRAY: Although glasses had been mentioned.

MS BERRY: Yes, they had, but there's nothing documented here.

MR GRAY: Now, with respect to both glasses and hearing aids, I suggest to you these are critical aids to a person, especially a person with cognitive decline, to stay in touch with the world and have some communication and connection with people; is that right?

MS BERRY: I totally agree.

MR GRAY: It's really a fundamental dignity and personal issue, isn't it?

MS BERRY: It is. And Mrs DE was quite deaf and needed her glasses to see. And that would have been most helpful for her and her family and the staff.

MR GRAY: And, in respect of hearing aids, it just appears to have been omitted that Mrs DE had them in this interim care plan, obviously, but I just want to ask you about the importance of those. If you have somebody with cognitive decline, you might be running into communication difficulties; do you agree with that?

MS BERRY: You definitely would be running into communication issues.

MR GRAY: You would be. Compounding that with, in effect, the omission or deprival of that person's hearing aid means that they're far more likely to be bewildered, confused and distracted and far less likely to be able to communicate and follow tasks – task instructions communicated to them; agreed?

MS BERRY: Yes, I do.

MR GRAY: And they're likely to become agitated; is that right?

MS BERRY: Individual reactions are different, but it would definitely have an effect on her.

MR GRAY: So the omission of any consciousness of the hearing aids in the interim care plan is a material gap in care, I suggest.

MS BERRY: It's a material piece of information that would have directed the care.

MR GRAY: Now, just returning to other document – or we will go to other documentation around this time. Tab 171 is a diet analysis indicating that full assist is required. And you've explained that as meaning that the staff member needs to be with the resident for their meals and to bring food to their mouths, but the intention is without forcing the resident to eat food; is that right?

MS BERRY: Yes.

MR GRAY: Now, returning to the chronology, Mrs – I withdraw that, Commissioner. Can we make a direction to - - -

COMMISSIONER TRACEY: Yes. The name just spoken by counsel assisting should not be reported.

MR GRAY: DE was in Bupa Willoughby for one night and a total of less than 36 hours; is that right, Ms Berry?

MS BERRY: Yes.

MR GRAY: And the following day she was taken back to hospital by ambulance.

MS BERRY: Yes.

MR GRAY: And you say that, in your view, this was because of a pre-existing infection?

MS BERRY: Yes.

MR GRAY: And you make no acknowledgement in your statement of any substandard care in that 36 hours or so period of 6 and 7 July; is that right?

MS BERRY: Yes.

MR GRAY: DE's condition was diagnosed at hospital as aspiration pneumonia; correct?

MS BERRY: Yes.

MR GRAY: That's a form of pneumonia from inhaling particles, typically of food, into the lungs; is that right?

MS BERRY: Anything that's foreign to the lungs. It could have been saliva, could have been food, could have been fluid.

MR GRAY: All right. I will go to tab 67. This is actually a document not dated 7 July, but dated at the end of that hospitalisation period on 18 July. And it's called a discharge referral in respect of that second – beg your pardon – that period of hospitalisation just preceding the second admission to Bupa Willoughby; is that right, Ms Berry?

MS BERRY: Yes.

MR GRAY: And on this document, if we go, please, to the foot of the first page, Presenting Complaint, we have there a reference to the assessment by hospital staff

of the condition of Ms DE when she was readmitted to hospital on 7 July; is that right?

MS BERRY: Yes.

MR GRAY: And in the second point, it's said:

Found by paramedics with decreased GCS.

That's Glasgow Coma Scale, is it?

MS BERRY: Yes.

MR GRAY:

…and un-chewed food and medications in mouth.

Is that right?

MS BERRY: Yes.

MR GRAY: Now, doesn't the fact that Ms DE was found in that state means that she hadn't been properly supervised during meal times, as had been the direction in the original discharge referral of 7 July?

MS BERRY: I take that to mean that Mrs DE hadn't swallowed the food and medication that was in her mouth.

MR GRAY: And wouldn't staff have, as part of the supervision of Mrs DE's eating, been required to see whether she was swallowing the food that they were giving her?

MS BERRY: Yes. But that also does depend on the cooperation of Mrs DE, who sometimes would not open her mouth.

MR GRAY: Well, with a matter as serious as a person who has been sent to hospital with – with the concerns that must have led to that, wouldn't it have been incumbent on staff to coax her to open her mouth to check whether she was swallowing her food?

MS BERRY: It would have. It would be my expectation that if someone was feeding Mrs DE, that they ensure that she had cleared her mouth, and that if she wasn't – if they were unsure, that they would report that and keep her in an upright position.

MR GRAY: And it's not only un-chewed food reported as having been in Mrs DE's mouth, but there's also medications in her mouth. Now, I just want to ask you about

that. In your statement you say that you can't tell what they were, but you don't refer to this as inadequate care; is that right?

MS BERRY: What I'm suggesting is that at the time that she deteriorated and needed to go to hospital, she had been having some food and was given some medication. And I believe the medication was Paracetamol. And it could not have been there for very long, because the medication was still intact.

MR GRAY: How do you know or how do you believe it was - - -

MS BERRY: Because that is mentioned at the hospital from the medication chart.

MR GRAY: What medication chart is that?

MS BERRY: The signing sheet for that day.

MR GRAY: I just asked you to look at tab 116 on page 2. In that document – this is Bupa's response to concerns raised by the complaints commissioner. In that document, in the first full row, second column, it says:

> *The reference to un-chewed food in DE's mouth on the Royal North Shore discharge summary taken in the ambulance report would indicate that the care provided to DE was not of an acceptable standard and represented gaps in care delivery.*

Don't you agree with that?

MS BERRY: Yes, I do.

MR GRAY: All right. So you agree that the mere fact alone that there's un-chewed food and medicines in DE's mouth shows that the care being provided to DE in the period prior to that 36 hours or so, prior to that, was substandard. Do you agree?

MS BERRY: Sorry, I don't know what you mean by prior to the 36 hours.

MR GRAY: Sorry. Or during the 36 hours. So, prior to that food being discovered and that medicine being discovered un-chewed in her mouth, the care that she was given was substandard.

MS BERRY: In relation to clearing her mouth.

MR GRAY: Yes.

MS BERRY: Yes.

MR GRAY: And, in relation to clearing her mouth, that's a very important matter, because of aspiration risk, isn't it?

MS BERRY: It is, yes.

MR GRAY: Next, in the very next row:

> *We acknowledge there is limited documentation and, therefore, we are not able to confirm what food and medicines were provided to DE prior to being transferred. We acknowledge that a medication plan should have been completed.*

Etcetera. Do you agree with those remarks?

MS BERRY: That was prepared from an investigation, but I had further documents at my – my review to look at which included the signing sheets. And I noted that it was Paracetamol that she had been given, and that was likely the drug that was still in her mouth.

MR GRAY: All right. That's the best guess you can make as to what it was, but you can't be sure; is that right?

MS BERRY: No. It was the signing sheet that tells me that that drug was given.

MR GRAY: Okay. Well, whatever it was, I suggest to you that the opinion you expressed in paragraph 11A of your statement, to which I took you earlier in your evidence - - -

MS BERRY: Yes.

MR GRAY: - - - is undermined by this episode of Ms DE having the un-chewed mouth and medicine in her mouth on 7 July when she was taken by ambulance to Royal North Shore Hospital. What do you say to that?

MS BERRY: Well, I say at the time of me writing that statement I was particularly referring to the management of her pain and discomfort and I was not referring to the time that she was transferred to hospital with food and un-chewed – un-chewed food and medication in her mouth.

MR GRAY: Okay. Well, what about at paragraph 73 of your statement. If we go to page 0019, please, operator. You comment on this particular matter at 73C. You don't acknowledge any substandard care in that paragraph. I suggest you should have.

MS BERRY: In my statement there on paragraph C I do actually mention that that should have happened.

MR GRAY: Yes. It should have happened. You're saying it should have happened on the policies and work instructions of Bupa; is that right?

MS BERRY: It should have happened.

MR GRAY: Because it - - -

MS BERRY: It should have happened in the direct care of Mrs DE.

MR GRAY: Yes. And it didn't – the fact that it didn't happen is an instance of substandard care, isn't it?

MS BERRY: It's an instance of failure to follow good safe practices.

MR GRAY: I want to ask you about what happened during the second admission to Bupa Willoughby from 18 July. If we go, please, to tab 67. That's the discharge summary for that occasion.

MS BERRY: Yes.

MR GRAY: And if we go, please, to page 0199. In the discharge plan on this occasion, there are very precise instructions that have come from a speech pathologist about the way in which Mrs DE is to be assisted to eat and drink; correct?

MS BERRY: Yes.

MR GRAY: And, importantly, I suggest it also says:

> *Please continue to monitor for signs of aspiration/penetration, coughing, wet gurgly voice with oral intake reduced chest health and refer to medical/speech pathologist.*

Correct?

MS BERRY: Yes.

MR GRAY: With a requirement for speech pathology review and refer for physiotherapy. These are all important instructions for the proper care of Ms DE on her return to Bupa Willoughby on 18 July; correct?

MS BERRY: Yes.

MR GRAY: And the return to Bupa Willoughby was now going to be on a permanent basis; is that right? Not just respite, but permanent?

MS BERRY: Yes.

MR GRAY: And yet the only care plan document that continued in effect was the interim care plan of 6 July 2017; is that right?

MS BERRY: Yes. There is a reason for that, in which the comprehensive care plans for permanent residents take over a month to develop. And so there is a suite of assessments that are done over that time. And the interim care plan applies to respite and permanent residents in their initial admission.

MR GRAY: But no replacement interim care plan was prepared, was it?

MS BERRY: No, it wasn't.

MR GRAY: And it should have been, because Ms DE's health condition had materially deteriorated, particularly around these matters of chest health. Don't you agree?

MS BERRY: I totally agree.

MR GRAY: And the failure to replace the interim care plan, or at least update it, having regard to those matters I read out before concerning chest health, was a serious failure in care, wasn't it?

MS BERRY: It was a failure in updating that particular care plan, but there are work instructions to guide all the staff on how to provide care for her specific needs available to the staff.

MR GRAY: Now, I suggest that the failure to update the care plan or replace it had material consequences, and this can be seen from the physio therapist failing to assess respiratory status. Do you agree with that?

MS BERRY: Yes. He failed to address the respiratory status.

MR GRAY: And even when Ms DE was assessed by a speech pathologist on 26 July, there's no evidence that the advice of the speech pathologist on that occasion was incorporated into some new care plan. Do you agree with that?

MS BERRY: Yes, I do.

MR GRAY: Another potential risk was that, in conducting diet analysis, the RN conducting diet analysis didn't know about and didn't follow the speech pathologist's instructions. Have you reviewed the diet analysis documentation and can you comment on that remark?

MS BERRY: Yes. I have seen the diet analysis, but I need to have it in front of me. What tab is it?

MR GRAY: Yes. Please go to tab 171, operator. Now, in your statement - - -

MS BERRY: Excuse me, sir.

MR GRAY: Yes.

MS BERRY: This is not for the right period. This is for 6 July.

MR GRAY: Yes. Thank you. I withdraw that. Please go to tab 64. Looking at that, are you able to comment on whether the speech pathologist's instructions as set out in the 18 July discharge referral have been reflected?

MS BERRY: They are reflected in part, because this is a diet analysis. It isn't a care plan. So it does say smooth pureed food, can have banana and scrambled eggs. It does say to give medium amounts. It has ticked tea and orange juice, milk and sugar. And it has ticked that it's a new assessment. And it does tick full assistance.

MR GRAY: Thank you. Now, Commissioners, it's nearly 1 o'clock. However, if you were willing to sit a little later, I can conclude this examination.

COMMISSIONER TRACEY: Yes. You proceed as need be to complete this witness's evidence.

MR GRAY: Thank you very much. In respect of the matter of nutritional intake, there's also a document known as a nutrition and hydration assessment; is that right?

MS BERRY: Yes.

MR GRAY: What's the purpose of that document?

MS BERRY: The purpose is to assess the resident's nutritional requirements and their fluid intake requirements, and make that part of your plan on how you would care for a particular resident.

MR GRAY: All right. And it would have been a very important matter to undertake an assessment of that kind in light of the new information provided by the speech pathologist in the 18 July discharge referral in order to optimise Ms DE's nutritional intake. Would you agree with that?

MS BERRY: I would agree the information provided by the speech pathologist, the one in North Shore Hospital and the one that occurred at Bupa Willoughby, would have been very relevant and pertinent information to take into consideration in nutrition and hydration assessment.

MR GRAY: Now, in your statement at paragraph 48B, you do refer to this matter of the nutrition and hydration assessment, and you say that it was done. Do you recall that part of your statement?

MS BERRY: I beg your pardon. I say that what?

MR GRAY: You say it was done. You say at 48:

In the case of Mrs DE, it appears that, due to her rapid decline, some of what would ordinarily occur for a new permanent resident over a longer period of time was not able to take place. However, I note that following her transfer back to the home on 18 July 2017, the following usual steps did occur: (b) a nutrition and hydration assessment was completed.

Do you see that? Now, that should have been carried out promptly within a few days of Mrs DE returning to – Mrs DE returning to Bupa Willoughby, I suggest, because adequate nutrition would have been very important to her quality of life, wouldn't it?

MS BERRY: So there is a process of prioritising which assessments would be done on which days for a permanent resident. And, given that Mrs DE has a new diagnosis of dysphagia, I would have anticipated that that should have been done a bit earlier. Earlier in her admission.

MR GRAY: Thank you. Now, there was – in the document you refer to, there was a nutrition and hydration assessment carried out. And that's at tab 80, please, operator. This is a document – this is the document that you refer to in your statement at 48B, Ms Berry. And it's a nutrition and hydration assessment that's only prepared, in fact, on the day that Ms DE dies; correct?

MS BERRY: Correct.

MR GRAY: Now, I've found another document, which is not one you refer to, which is dated the day she's admitted on – at tab 170. I suggest to you that this document doesn't reflect the level of care and supervision that was directed by the speech pathologist, especially around the issues of ensuring that Mrs DE was very, very upright and monitoring her aspiration risk. What do you say to that?

MS NEEDHAM: I object to that, your Honour. Commissioners, that question is based upon a premise that Mrs DE had seen the speech pathologist on 18 July, and that's not the case.

COMMISSIONER TRACEY: Is there some foundation for - - -

MR GRAY: Yes, I will clarify that. I'm referring now to the speech pathologist's directions in the discharge referral of 1 July, Ms Berry. So I will go back to that document.

MS BERRY: What tab was that again, please?

MR GRAY: We will just give it to you. Tab 68. No, that's not it. Tab 67. Thank you. And if we go to – this is the discharge referral of 18 July, Ms Berry.

MS BERRY: Yes.

MR GRAY: That you've seen before.

MS BERRY: Yes.

MR GRAY: If we go to page 0199, we see there are directions under discharge plan point 2 as per speech pathology, and there are quite detailed instructions about being upright and alert for oral intake. And:

Please continue to monitor for signs of aspiration/penetration –

etcetera. Those are the instructions I'm referring to. And the gist of the question I'm putting to you about the 18 July 2017 nutrition and hydration assessment is that one doesn't see any of those instructions reflected in the nutrition and hydration assessment of 18 July. What do you say to that?

MS BERRY: They are missing from that, however, the staff do have at their fingertips, the dysphagia management work instruction which is very, very close, very similarly reflects this, and a later speech pathologist assessment.

MR GRAY: So if the staff had gone to the set of policies that were available to them at Bupa Willoughby and referenced that work instruction, they would have seen what they had to do, but that assumed that they were following – that would assume that they would follow policy; is that right?

MS BERRY: Yes.

MR GRAY: Okay. I suggest that the expectation that staff will follow policy is no excuse for not including detailed instructions in assessments and care plans.

MS BERRY: Yes, I would agree.

MR GRAY: I suggest that the absence of those instructions from the speech pathologist could have contributed to Ms DE not getting the optimal nutritional intake that she otherwise would have received. What do you say to that?

MS BERRY: No, they may have but they may not have either. The – at that time the staff still had the work instruction available to them, and later they did have the handwritten note from the second speech pathologist to guide them in the room.

MR GRAY: In relation to the important issue of getting as much food as possible, the absence of Ms DE's hearing aids, and the omission of these instructions from the speech pathologist, at least for some of the period in question, could have had a real impact on the extent to which Mrs DE was able to take in food. Do you agree with that?

MS BERRY: I do agree with that.

MR GRAY: Were the staff at Bupa Willoughby at the time adequately trained to properly assist people with cognitive issues with their feeding?

MS BERRY: I would expect so because this would not have been the only resident with a cognitive issue. However, Bupa Willoughby is not a home that has a specialist dementia unit such as, but there is training and instruction available, but I can't recall the last time staff were – had education on this – on this point of care.

MR GRAY: I want to ask about the risk of pressure injury and before doing that, I want to take you to what I believe is an internal audit report of about December 2016. It's at tab 29. Now, that document, Ms Berry, is entitled Self-Assessment Tool SAT Validation Report. Is that in the nature of an internal audit report?

MS BERRY: Yes, it is.

MR GRAY: Thank you. Could we please go to page 2079. Do you see there there's a heading near the bottom of the page 2.11, Skin Care. So under that heading there are findings and comments, are there, of the internal audit team?

MS BERRY: Yes.

MR GRAY: And is this a document that relates to Bupa Willoughby in particular? It does say Care Home Bupa Willoughby on the front; I should have mentioned that.

MS BERRY: Yes, it does relates to Bupa Willoughby at that time.

MR GRAY: Yes. And that time is December 2016; correct?

MS BERRY: Yes.

MR GRAY: So this is in, I don't know, the period of seven or eight months prior to the relevant period in this case study?

MS BERRY: Yes.

MR GRAY: Now, under that heading if we go to the next page, under that heading of Skin Care on the next page which is 2080, do you see there are a series of what appear to be findings or observations or comments about practices relating to skin care at Bupa Willoughby at the time; is that right?

MS BERRY: Yes.

MR GRAY: And one of those is in about the middle of the page, dot point:

Wound size not documented during review.

Next dot point:

Pressure area care directive incongruent between care plan and assessment.

So these are inconsistencies, are they, between care plans and assessments?

MS BERRY: Yes.

MR GRAY: And number 7 is:

Use of air mattress not reflected in relevant care plan.

So does that mean that there hadn't been an air mattress employed?

MS BERRY: No, it doesn't say that. It says that it's not documented.

MR GRAY: All right. Then there's, over the page, page 2081:

All pressure injuries regardless of stage, must be documented in incident forms.

Next bullet point:

Wound chart must have only one wound record.

Next bullet point, I will just skip the first two sentences:

All wound photos must have a label indicating resident's name, location, date and size of wound preferably using a ruler placed against the wound.

And finally, or penultimately:

Pressure area care directives and strategies to manage pressure injury, eg, air mattress, must be congruent between assessment and care plan.

In short, there were a number of shortcomings that had been observed at Bupa Willoughby around skin care of the kind I've read out to you, is that right, in December 2016; is that right?

MS BERRY: Yes.

MR GRAY: I took you to the ACAT assessment right at the commencement of this examination and asked you to note, in effect, the reference to air mattress for pressure area care in that document, I won't take you to it but that was back in March, but that was still indicated for Ms DE as a requirement for her - - -

MS BERRY: Yes.

MR GRAY: - - - pressure area risk mitigation; is that right?

MS BERRY: Yes.

MR GRAY: Yes. And it was also very important that she – that is, Ms DE – be moved in her bed and inspected for pressure area wounds or injuries; is that right?

MS BERRY: Yes.

MR GRAY: And the interim care plan noted that repositioning would occur every four hours; is that right?

MS BERRY: Yes.

MR GRAY: And that had not been reviewed, it doesn't appear that that was ever altered during Ms DE's admissions to Bupa Willoughby?

MS BERRY: Yes.

MR GRAY: Now, at tab 155 there's a document called a Braden Risk Assessment.

MS BERRY: Yes.

MR GRAY: Are you familiar with a Braden Risk Assessment?

MS BERRY: Yes, I am.

MR GRAY: Is the purpose of that to determine the level of risk that a particular person has to developing a pressure injury?

MS BERRY: Yes, it is.

MR GRAY: And a pressure injury can be a very serious threat to a person's health and wellbeing and it can be very painful; is that right?

MS BERRY: Yes, that's right.

MR GRAY: It involves, in effect, mortification of the flesh because of blood circulation issues; is that right?

MS BERRY: Yes. That's correct.

MR GRAY: And the Braden Risk Assessment scale has been filled out DN; is that right?

MS BERRY: Yes.

MR GRAY: It's undated; is that a serious gap in care?

MS BERRY: It's not a serious gap in care but it is a serious gap in documentation that might help direct care or might help us understand when the assessment was done and what the risk was.

MR GRAY: Well, I suggest that it goes beyond just a gap in documentation and is a serious gap in care because the particular risk assessment here resulted in a very low score which meant a very high risk; is that right?

MS BERRY: Yes.

MR GRAY: And, in fact, the reason you do these assessments as a nurse is to determine how often interventions and what kind of interventions are going to be indicated; is that right?

MS BERRY: That's correct.

MR GRAY: And the regimen that had been established at the admission of Ms DE on 6 July and the interim care plan for four hourly repositioning would have been inadequate for a high risk outcome from the Braden Risk Assessment scale; isn't that right?

MS BERRY: I would have expected her to be – Mrs DE to be nursed on an air mattress and to have a minimum of four hourly turns and pressure area care.

MR GRAY: Wasn't it Bupa's policy that for high risk there would be more frequent repositioning than four hours?

MS BERRY: Yes, yes, she could have been turned up to every two hours.

MR GRAY: Yes. So that's why I suggest that the absence of a date, in fact, is a gap in care because it seems that no date on this assessment of high risk is connected with the fact that the interim care plan requiring four hour repositioning was never altered. What do you say to that?

MS BERRY: Without the date it's difficult to know whether that contributed to it or not.

MR GRAY: All right. I want to ask about Ms DE's pain, the likely pain. She had arthritis of the knee, she had a fractured humerus; correct?

MS BERRY: Yes.

MR GRAY: Both of those conditions are intrinsically very painful?

MS BERRY: Yes.

MR GRAY: She also had pressure injury risk and we know that a pressure injury was identified on 13 August. I will just ask for you to comment on that. The document that records that it was first identified on that date was the back page, the handwritten notes - - -

MS BERRY: Yes.

MR GRAY: - - - on the back page of the interim care plan I took you to; do you want to see that again?

MS BERRY: No, no. It's okay.

MR GRAY: There's also a reference in progress notes to identification of that wound on that date, 13 August 2017.

MS BERRY: Yes, I recall that.

MR GRAY: We will look at a photo that appears to be a photo of this pressure injury. It's at tab 172. Now, do you agree that that is a photo of a pressure injury?

MS BERRY: Yes, the skin has broken and it has reddened.

MR GRAY: And it's predominantly on the left buttock.

MS BERRY: Yes, and you can also see evidence of healed pressure injuries.

MR GRAY: And with respect to the one where the skin is broken, what size is that? Is it about four centimetres long by three wide?

MS BERRY: It would have been helpful for the ruler to have been used as per the work instruction.

MR GRAY: Yes. And, in fact, we don't even have a label dating this photograph, do we, Ms Berry?

MS BERRY: No, we don't.

MR GRAY: But it's a fair inference, isn't it, that this is a photograph taken on 13 August when the injury on the left buttock was identified?

MS BERRY: Yes.

MR GRAY: And just looking at it, using your clinical expertise, would you say that that pressure injury has taken at least some days to develop to this stage where the skin is broken?

MS BERRY: Yes. I would say that it would have been reddened for some time.

MR GRAY: And - - -

MS BERRY: And eventually the skin would have broken.

MR GRAY: Now, if the staff were doing their job properly when they were repositioning Ms DE, they should have picked up the risk to that part of her body and the reddening and should have taken some steps to prevent it developing to this point. Do you agree with that?

MS BERRY: What I would say is that when staff were providing her personal cares, such as washing her – not necessarily turning, but washing her – they would have had an opportunity to view all of her skin and see what the condition was. So it's not necessarily when you're turning, but when you are providing personal cares. And they would have noted that it was becoming red and should have raised the alarm to the registered nurse.

MR GRAY: And, before reaching this point, I suggest that this – this location would have been very painful to Mrs DE.

MS BERRY: Yes.

MR GRAY: Before 13 August.

MS BERRY: Yes. She had already had a number of pressure areas sores that were – had occurred to her while she was in hospital. And they appeared to have healed, but that's very new skin and it's very easy for the new skin, with a minimum amount of pressure, to start to deteriorate again.

MR GRAY: Yes. So we will now go to tab 160 at page 302. This is the reference in the progress notes to the identification of this wound. 13 August '17 at 13.30, do you see there:

> *Carer reported about the pressure sore on left buttocks, dressing applied commenced on wound management and PAC.*

What's PAC?

MS BERRY: Pressure area care.

MR GRAY: Right. So does this suggest that there wasn't any wound management or pressure area care before that date?

MS BERRY: No, it doesn't. It does – it does suggest – it doesn't suggest that the pressure area care – that the pressure injury was noted before that date, but that does not mean that she wasn't receiving pressure area care before that date.

MR GRAY: And, in terms of the pressure area care that she was receiving, there's no documented record of what that was; is that right?

MS BERRY: Correct.

MR GRAY: Now, I want to ask you about the steps leading to palliative care and end of life care. There was an acknowledged failure by Bupa to make an end of life plan, contrary to Bupa policy; is that right?

MS BERRY: That's correct.

MR GRAY: And that was acknowledged in those letters to the complaints commissioner.

MS BERRY: Yes.

MR GRAY: In the context of end of life care and consultation with the family, it's a very important matter to include authorised representatives from the family in planning; is that right?

MS BERRY: It's critical.

MR GRAY: It's critical. And it's critical, because the accepted clinical approach to palliative care encompasses care not only of the person who's dying, but of their family; is that right?

MS BERRY: Correct.

MR GRAY: And, indeed, there's a 2006 document Guidelines For a Palliative Approach in Aged Care. Are you familiar with that document?

MS BERRY: Yes. I am.

MR GRAY: We will just put that up, please, operator. It's RCD.9999.00049.00016. Now, just while that's coming up, I will ask you about the nub of what's said in it. It's said under the heading Family Conference that it's very important to have a family conference – well, it's recommended for the preparation for a resident's death. This is at page 167 to 8. Now, I just – in relation to that conference, one of the features of the conference that's indicated in those guidelines is that there should be, in effect, an education opportunity provided to family to understand what are signs that death may be imminent in their loved one; correct?

MS BERRY: Yes.

MR GRAY: And what are the usual changes that occur when a person is dying.

MS BERRY: Yes.

MR GRAY: And, in the absence of an opportunity being given to convey those matters, if we just – let's just look at those. So page 167, under the heading 14.4.6 Family Conference, there's reference there to:

…helping educating family members on what to expect –

in the penultimate line. And then, over the page, there are references to the questions that might come up, including those two matters that I mentioned at the top of the page. I tender that document.

COMMISSIONER TRACEY: Yes. If you could, operator, please go back to the first page. The Guidelines for a Palliative Approach in Residential Aged Care, dated May 2006, approved by the National Health and Medical Research Council, will be exhibit 3-39.

EXHIBIT #3-39 GUIDELINES FOR A PALLIATIVE APPROACH IN RESIDENTIAL AGED CARE, APPROVED BY THE NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL DATED 05/2006 (RCD.9999.00049.00016)

MR GRAY: Thank you, Commissioner.

And I take it, Ms Berry, you agree that those matters that I took you to in the document are important parts of adequate palliative and end of life care?

MS BERRY: Yes, they are.

MR GRAY: Now, against that context, the experience related by the daughters of Mrs DE were that they – there was a family conference on 10 August at Bupa, but it didn't involve education about those matters I've just mentioned. Do you agree with that?

MS BERRY: I don't know what other details were discussed.

MR GRAY: All right. That was on 10 August. On 9 August, the day before, there had been a visit by a palliative care nurse.

MS BERRY: Yes.

MR GRAY: But it appears that Bupa Willoughby hadn't coordinated any sort of meeting between the palliative care nurse and the daughters on that occasion?

MS BERRY: That's correct.

MR GRAY: And that was a short coming in care. Do you agree with that?

MS BERRY: It was a shortcoming in communication and preparing of the family about what was about to happen.

MR GRAY: All right. Now, in effect, the daughters were given a note of the palliative medication prescriptions of that palliative care nurse – or the recommendations, I should say, of that palliative care nurse.

MS BERRY: Yes.

MR GRAY: Correct? But that was no substitute to a proper family conference in a proper setting involving education and consultation?

MS BERRY: Not at all, no substitute whatsoever.

MR GRAY: All right. And, against that background, what the daughters received was a call on 15 August from a nurse at Bupa Willoughby not explaining their mother's condition in any proper detail. Do you agree with that?

MS BERRY: Yes.

MR GRAY: And that was unsatisfactory care, as well?

MS BERRY: That was completely inappropriate.

MR GRAY: All right. And then they had that terrible experience they related in their evidence on the 15th.

MS BERRY: Yes.

MR GRAY: Where it appear that is Bupa were short staffed. Have you been able to inquire into that?

MS BERRY: Yes. I'm not convinced they were short staffed. It was at a time after meals, putting residents back to bed, and – but all the rooms are private rooms and most of the residents of the doors shut. And it has taken them some time to locate somebody. But it does not necessarily mean that the home is short staffed.

MR GRAY: I will ask the operator to display tab 82. Have you seen this email before? This is an email from DO, also known as DO, a resident nurse who was on duty on the 16th.

MS BERRY: Yes. Yes.

MR GRAY: I beg your pardon, on duty on the 15th, I should say, 15 August 2017.

MS BERRY: Yes.

MR GRAY: You've seen this before? Doesn't this suggest that there were staffing shortages on 15 August at Bupa Willoughby?

MS BERRY: No, it suggests that that's a normal shift to me.

MR GRAY: All right. There's also a reference to this particular nurse, DO:

...doing most medications on ground floor due to two AINs meds incompetent.

MS BERRY: That means that they weren't deemed competent to provide medications, so that means for the residents that those two carers were looking after, that RN would have needed to include those residents' medications in her duties. But that is a normal thing. You have a mix of staff that do have medication competencies or don't.

MR GRAY: I will just ask you to go to another hard copy document that you have in unredacted form in front of you in the witness box. It's tab 174. And I will just ask you to identify that row 177 of that document relates to DO, or DO, DO; that's registered nurse, DO, showing that she was on duty on 15 August; is that correct?

MS BERRY: Yes.

MR GRAY: And 1785 which shows that DN was on duty on 15 August 2017; correct?

MS BERRY: Yes.

MR GRAY: Now, finally, I need to ask you about an important aspect of Ms DE's pain management. I asked you about the various conditions she was suffering from. They included arthritis of the knee. This is in the period of her second admission, the broken humerus. She also had a bowel or a stomach condition; is that right? Urinary retention.

MS BERRY: Yes.

MR GRAY: And that can be painful; is that right?

MS BERRY: She had an indwelling catheter in so there would be no pain associated with that.

MR GRAY: All right. And she had the pressure injury, nascent pressure injury issues that we've discussed which manifested in a wound from 13 August; correct?

MS BERRY: Yes.

MR GRAY: Now, what's the Abbey Pain Scale?

MS BERRY: That's a scale to determine if somebody is in pain when they aren't able – if they're verbally communicating it or the displayed symptoms, and diagnoses that may be present that would indicate the resident does have pain.

MR GRAY: Now - - -

MS BERRY: And what level.

MR GRAY: - - - during this second admission to Bupa Willoughby from 18 July 2017, Mrs DE was essentially unable to communicate verbally and was, therefore, indicated for the Abbey Pain Scale. Do you agree with that?

MS BERRY: I do agree.

MR GRAY: And yet the Abbey Pain Scale was only administered up to 22 July 2017 and then discontinued; is that right?

MS BERRY: Somebody stopped doing it, yes.

MR GRAY: And they clearly should, that is, the nursing staff at Bupa Willoughby, clearly should have continued to administer the Abbey Pain Scale on at least a daily basis for Mrs DE; do you agree with that?

MS BERRY: I do agree.

MR GRAY: And in the absence of that having been done, although there are references in progress notes from time to time of no symptoms of pain, it's impossible to form a reliable conclusion that she was not in pain. What do you say to that?

MS BERRY: I say that after a point in time – I can't recall the date, she was a long-term Norspan patch which is a powerful opioid drug that was covering her from the time it was applied to the time of her death, and that would have assisted with all pain that she was having.

MR GRAY: But at least until the time of the application of that patch, on or about 11 August 2017, in between the period 23 July to that point in time, there's no way of knowing the extent of the pain that Mrs DE was in because of the absence of a proper assessment of her pain?

MS BERRY: That's correct.

MR GRAY: And I suggest that that was a serious failure in her care by Bupa Willoughby.

MS BERRY: It was. It was a serious failure. I do agree.

MR GRAY: Right. I have no further questions.

COMMISSIONER TRACEY: Yes. Thank you for your evidence. You're excused from further attendance.

MS NEEDHAM: Commissioner, I just have a couple of questions I would like to ask in re-examination.

COMMISSIONER TRACEY: Have you spoken to senior counsel assisting?

MS NEEDHAM: I haven't. The practice guideline notes that we get re-examination. My learned friend does suggest we break for lunch.

COMMISSIONER TRACEY: Yes.

MS NEEDHAM: I won't be very long.

COMMISSIONER TRACEY: If you will speak to him over the luncheon adjournment.

MS NEEDHAM: I will.

COMMISSIONER TRACEY: And we will deal with any application upon our return.

MS NEEDHAM: Thank you, Commissioner.

COMMISSIONER TRACEY: The Commission will adjourn until 2.15.

ADJOURNED **[1.32 pm]**

RESUMED **[2.19 pm]**

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner, Ms Needham has an application to make to re-examine, and it meets with my concurrence, for what that's worth, on two topics, involving four documents.

COMMISSIONER TRACEY: Yes, Ms Needham, what's the application?

MS NEEDHAM: Commissioners, I have an application to ask some questions in re-examination of Ms Berry, relating to documents which have been dealt with in discussion with myself and Mr Gray, and relating to two particular topics. One is the

speech pathology recommendations and the other one, the issue of staffing on the day of the unfortunate death of Ms DE on 15 August 2017.

COMMISSIONER TRACEY: Very well. You proceed.

MS NEEDHAM: May it please, thank you, Commissioner.

<EXAMINATION BY MS NEEDHAM [2.20 pm]

MS NEEDHAM: Ms Berry, I'm going to ask you some questions arising out of some evidence given by Ms DI. Were you in the hearing room for the evidence by Ms DI?

MS BERRY: Yes.

MS NEEDHAM: Do you recall Ms DI saying that there was some information relating to her mother's feeding near her bed?

MS BERRY: Yes, I do.

MS NEEDHAM: Could you have a look at tab 68 of the tender bundle in the first volume, please.

MS BERRY: Yes.

MS NEEDHAM: And in paragraph 52 of your statement, you say – you refer to a handwritten document and you said that:

> *I expect that these additional handwritten notes prepared by the speech pathologist were for the purpose of displaying where DE was fed.*

MS BERRY: Yes.

MS NEEDHAM: Having heard DI's evidence this morning, are you able to make any further comments on the safe swallowing tips which is behind tab 68?

MS BERRY: Yes, so these reflect her documented instructions and she has clearly written them for the placement in the room where Mrs DE was being fed for the purposes of staff and family, and that they are also consistent with the work instruction on dysphagia management.

MS NEEDHAM: Thank you, and just for the record the work instruction on dysphagia management is tab 20 of the tender. I don't need to take you to that, I'm just noting that for the record. Ms Berry, the second document I would like to take you to is at tab 60, on this topic. And do you recall DI giving some evidence about a

conversation she had with the speech pathologist about training – information about swallowing being given to the family and to the staff?

MS BERRY: Yes.

MS NEEDHAM: Now, can you look at this chain of emails behind tab 60. Do you understand Rosemary to be a reference to the speech pathologist?

MS BERRY: Yes, I do.

MS NEEDHAM: And Kristine Min was the care manager - - -

MS BERRY: The care manager, yes.

MS NEEDHAM: - - - at the time. The email of 18 July 2017 refers to an in-service; that's an in-house training session. Is that correct?

MS BERRY: Correct.

MS NEEDHAM: Relating to swallowing, and can you just read the first email in that chain – well, top email in the chain of 18 July 2017.

MS BERRY: The in-service I would suggest is - - -

MS NEEDHAM: You don't need to read it out. Just read it to yourself, sorry.

MS BERRY: Okay. Yes.

MS NEEDHAM: Now, in the context where Ms DE was readmitted to Bupa on 18 July and with a requirement for a dysphagia diet and a follow-up by a speech pathologist, do you regard that level of training suggested by the speech pathologist as being appropriate in the circumstances?

MS BERRY: Yes, I do.

MS NEEDHAM: Now, the second topic I would like to ask you about involves two documents which are in the second volume of the tender bundle, if you wouldn't mind going to that. And the first of those documents is behind tab 152 and when you have that I would ask you to turn to page .0006 and .0007. Now, this is the response by Bupa to a notice to give information and the questions in relation to that notice to give information are about the levels of staffing as at 1 July 2017. Have you seen this document before?

MS BERRY: Yes, I have.

MS NEEDHAM: If you would look at paragraph 11; paragraph 11 sets out the following roster which was in place while Ms DE was at Bupa Willoughby.

MS BERRY: Yes.

MS NEEDHAM: Do you agree with that? And the information at page 11(a) – sorry, 11(b)(ii) relates to the afternoon shift.

MS BERRY: Yes.

MS NEEDHAM: Do you see that? Now, firstly, the afternoon shift describes what period of time?

MS BERRY: So roughly from 2.30 to 10.30 or 11.

MS NEEDHAM: To your knowledge was DE in Blueberry or in Jacaranda?

MS BERRY: She was in Blueberry.

MS NEEDHAM: And so if staffing protocols were maintained there would have been four PCAs, one community nurse and an RNIC in blueberry.

MS BERRY: Yes.

MS NEEDHAM: A RNIC is what?

MS BERRY: RN-in-charge.

MS NEEDHAM: And a community nurse?

MS BERRY: Is a registered nurse looking after that community or the home.

MS NEEDHAM: And what are PCAs?

MS BERRY: Personal care assistants.

MS NEEDHAM: Is there another term that's used for PCAs?

MS BERRY: Carers or aides.

MS NEEDHAM: Assistants-in-nursing; is that another term?

MS BERRY: Assistants-in-nursing, yes.

MS NEEDHAM: Thank you, I would like you to go to tab 174 in that same volume; do you have that?

MS BERRY: Yes.

MS NEEDHAM: And if you could look at the numbers on the left-hand column, the far left-hand column with the page starting at 1742 and you will see that - - -

MS BERRY: Sorry, I don't have any numbers on these pages.

MS NEEDHAM: This is the left-hand column. You may have an – sorry, an unredacted copy of that document separate to the bundle which shows the names. It's a spreadsheet or an Excel data sheet of names and positions. Do you have that?

MS BERRY: Yes.

MS NEEDHAM: And does the first column on the left start with 1742?

MS BERRY: Yes, it does.

MS NEEDHAM: And can you see, looking at the start time and the end time, there are a number of shifts which deal with 15 August 2017?

MS BERRY: Yes.

MS NEEDHAM: And they are starting at 3 pm; is that consonant with the afternoon shift?

MS BERRY: Yes, it is.

MS NEEDHAM: Now, if I can take you to the following entries. 1742 is under role description and AIN working in Blueberry; is that correct?

MS BERRY: Yes, it is.

MS NEEDHAM: Looking across to the start time, the end time and the afternoon shift.

MS BERRY: Yes, 3 till 10.

MS NEEDHAM: Thank you. And going further down, if you look at 1753; have you found that?

MS BERRY: Yes.

MS NEEDHAM: Again Blueberry.

MS BERRY: Yes.

MS NEEDHAM: 15 August.

MS BERRY: Yes. Three till - - -

MS NEEDHAM: 3 till 10 pm.

MS BERRY: Correct.

MS NEEDHAM: And that's also an AIN; is that right?

MS BERRY: Yes.

MS NEEDHAM: Now, the next one is 1759, an AIN in Blueberry.

MS BERRY: Yes.

MS NEEDHAM: Working between 3 pm and 9 pm.

MS BERRY: Yes.

MS NEEDHAM: Is that also the afternoon shift - - -

MS BERRY: Yes.

MS NEEDHAM: - - - although a slightly shorter one.

MS BERRY: Yes.

MS NEEDHAM: And the next entry, 1760, is another AIN working in Blueberry from 3 pm to 9 pm.

MS BERRY: Yes.

MS NEEDHAM: Over the page, there is an entry which I think you were taken to before which is 1777.

MS BERRY: Yes.

MS NEEDHAM: Do you see that that is the registered nurse who has been referred to as DO.

MS BERRY: Yes.

MS NEEDHAM: She is the community nurse who was working on Blueberry for the afternoon shift.

MS BERRY: Yes.

MS NEEDHAM: 3 pm to 11.45 pm.

MS BERRY: Yes.

MS NEEDHAM: Over the page, once more, the last entry,1785 -or at least the last on my printout; do you see that?

MS BERRY: Yes.

MS NEEDHAM: And that is the registered nurse who has been referred to as DN working from 2.45 pm to 1.50 pm as the registered nurse in charge.

MS BERRY: 1.15 am.

MS NEEDHAM: 1.15 am, yes, I'm sorry.

MS BERRY: Yes.

MS NEEDHAM: Now, in accordance with the rostering principles demonstrated by the document I took you to at tab 152, is that staffing level consonant with the Bupa rostering policies?

MS BERRY: Yes, very consistent.

MS NEEDHAM: Thank you. There's no further questions, thank you, Commissioner.

COMMISSIONER TRACEY: Yes. Thank you, Ms Needham. Yes, Mr Gray.

<EXAMINATION BY MR GRAY [2.30 pm]

MR GRAY: One questioning arising, Commissioner. Ms Berry, with respect to the level of staffing in the blueberry unit on 15 July 2017, and on the assumption that that level of staffing was in accordance with Bupa's rostering policies, doesn't the evidence of DI and DJ show that the staff levels rostered on that day were insufficient to adequately address the care needs of DE?

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

MR GRAY: No further questions.

COMMISSIONER TRACEY: Thank you. Yes. Thank you again for your evidence, Ms Berry. You're excused from further attendance.

MS BERRY: Thank you, your Honour. Thank you.

<THE WITNESS WITHDREW [2.31 pm]

MR GRAY: Commissioners, consistently with the practice that the counsel assisting team has proposed in relation to the three preceding case studies, in relation to this case study, as well, we propose to draft post-hearing written submissions which will include the findings that we propose you, the Commissioners, should make on that case study. And we will do so over the course of next week. And I will be seeking directions at the close of this hearing this week formalising those arrangements. And they will provide for an opportunity for Bupa to make responding submissions to the proposed findings in this case study within seven days of our written submissions.

Can I say that it's evident to the counsel assisting team already that the proposed findings in relation to the Bupa matter will, of course, cover the merits of the care for Mrs DE, but will also, in respect of this case study, address the question of the availability of witnesses with direct knowledge. Now, in that respect, I wish to make it clear to Bupa that there is a reference in the letter of 4 May 2018 that Bupa wrote to the complaints commissioner, to which I've already taken the witness and the Commission at tab 118. Operator, if you could please bring up tab 118.

In the second paragraph and the last – yes. Thank you – in the second paragraph, the last sentence reads:

> *As a matter of transparency, we note that, unfortunately, this review did not include interviews with the employees who provided direct care to DE, as they are no longer employed by Bupa.*

Now, that was a letter written on 4 May 2018. That's not exactly the date of the notice to which I took Ms Berry. Nevertheless, that raises an issue which we will be traversing in our post-hearing submissions in this case study. With that, I will conclude case study four and we will proceed to the further business of the Royal Commission in this hearing.

COMMISSIONER TRACEY: Yes. Thank you, Mr Gray. Ms Needham, do you wish to be excused?

MS NEEDHAM: If we may.

COMMISSIONER TRACEY: Yes. Certainly.

MS NEEDHAM: Thank you, Commissioner.

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Commissioners, at this juncture we take a different direction and we will approach issues of policy. We will come back to the Brian King Gardens case study close to four, but for now I call Mr Glenn Eric Rees. Could the witness statement WIT.0126.0001.0001 be brought up on the screen, please.

<GLENN ERIC REES, SWORN [2.35 pm]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Your full name is Glenn Eric Rees.

MR REES: That's correct.

MR BOLSTER: And if you have a look at the screen in front of you and to your right, you will see your witness statement.

MR REES: Yes, that's correct.

MR BOLSTER: It has certain personal items redacted. Are there any changes you wish to make to that statement?

MR REES: No, thank you.

MR BOLSTER: And is that statement true to the best of your knowledge, information and belief.

MR REES: It is.

MR BOLSTER: Mr Rees, in the time that we have available today, I would like to ask you, firstly, if I may, about your current position as the chairperson of Alzheimer's International. How long have you been in that position?

MR REES: Three years.

MR BOLSTER: And Alzheimer's International, is it the umbrella organisation of the various entities in each country, such as, for example, Dementia Australia?

MR REES: Yes, it is. 100 members across the world.

MR BOLSTER: And you for 15 years before your election in 2015 were in charge of Dementia Australia.

MR REES: That's correct.

MR BOLSTER: What was your precise role there? I want to get the title correct.

MR REES: I was CEO of Alzheimer's Australia.

MR BOLSTER: And, before that, you had a long history inside the Commonwealth public service dealing with aged care-related matters involving various reforms during the 1980s and 1990s; correct?

MR REES: That's correct.

MR BOLSTER: All right. We will come back to those in due course. But I wondered if we might start with what the international position is on dementia action. And if we can bring up the document RCD.9999.0050.0001. And you're familiar with that particular document, aren't you?

MR REES: Very familiar, yes.

MR BOLSTER: You may have had a role in preparing that document during the course of 2017.

MR REES: That's correct.

MR BOLSTER: That is the World Health Organisation Global Action Plan on the Public Health Response to Dementia; correct?

MR REES: Correct.

MR BOLSTER: Did Australia, other than yourself, have a role in developing that response?

MR REES: Not a close involvement. The document very much reflects the work of the WHO secretariat and contributions from organisations like Alzheimer's Disease International.

MR BOLSTER: And, in paragraph 6 of your statement, you refer to seven priority areas of action in the case of dementia. Could we bring up, please, the other document, RCD.9999.0050.0076. And if we could go to the second page of that document, that provides a useful summary, does it not, of the seven priority areas for action for dementia that were highlighted by the WHO?

MR REES: Yes, it does. And I should make the point that the WHO make the point very strongly about the interconnections between aged care policy, mental health, health policy and a whole range of other things. So it's predicated on a view that you need very active policies across areas.

MR BOLSTER: If we just pause there. The seven action areas – and we will go to a number of them in some detail later. The first is a policy or strategy, a plan or framework in place by the national government of each member. And Australia, of course, has had, since 2015, a dementia action plan; correct?

MR REES: It had one before that, too.

MR BOLSTER: Before that.

MR REES: So that was the second one.

MR BOLSTER: 2015.

MR REES: Yes.

MR BOLSTER: Yes. We will come back to that, as well. Public awareness campaigns were a feature of this particular document, weren't they?

MR REES: They were.

MR BOLSTER: Risk reduction strategies and targets were identified as action plan number 3.

MR REES: That's correct.

MR BOLSTER: And then number 4, which we will deal with in some detail later, dementia diagnosis, treatment and care. And that embraces, doesn't it, the follow-up following a diagnosis of dementia, that is, the services that are available to a person following a diagnosis and how they manage the system. Then we have support for dementia carers, information systems for dementia and dementia research and innovation. Now, at paragraph 8 and 9 of your statement you're critical of the approach of Australia in responding to that particular action plan. Am I correct in drawing that conclusion?

MR REES: I'm critical of the Australian effort at planning in the sense that the words are full of good intentions, but they're not linked to specifics in terms of dollars or outcomes that are expected. So, having said that, I also ought to acknowledge, as I do in my statement, that Australia is regarded as a world leader in dementia care. You can always do better, but I would have to say that the – the 2015 framework was prepared by consultants. There wasn't a great deal of ownership of that document. And it was almost slipped out after dark, so that the broader community wouldn't have really known it was there at all.

MR BOLSTER: We will come back to those criticisms shortly. But in paragraph 8 I just want to raise a point you make about the lack of interaction between aged care and the health system within the Department of Health. Why is such an interaction necessary when it comes to dementia policy?

MR REES: It's necessary, because health and care impacts on the quality of life of people with dementia from the point of diagnosis to palliative care. And unless you have a health system which is dementia-friendly, which understands dementia, people with dementia really aren't going to get the treatment they need. So you really do need good interaction between those who have a policy responsibility for

dementia in the health department and those who are responsible for palliative care, prevention, primary care, acute care or whatever the area might be.

MR BOLSTER: What about the NDIS?

MR REES: Well, the NDIS – I'm not sure that there would be an awful lot of contact between the aged care area and NDIS. Indeed, when I looked at the Productivity Commission's work on a national disability agreement, which is supposed to go across all boundaries to make sure that the NDIS liaises with other areas, there was no mention of aged care in the document.

MR BOLSTER: Yes. Interaction with other levels of government. For example, in the NDIS there is linkages to transport and other areas. Is that something that is missing from the policy response when it comes to dementia?

MR REES: I wouldn't say that there are linkages, but in terms of a concerted policy approach to addressing those boundaries in the way that the Productivity Commission ..... that the national disability agreement does, there's nothing formal that pushes that debate forwards.

MR BOLSTER: All right. What's missing, then, from the department's response to the dementia problem at this particular point in time? What's missing from the action plan in terms of a policy response?

MR REES: That might take an awful long while in terms of specifics.

MR BOLSTER: All right. Let's start it in steps. In terms of interaction, just the interaction, what's missing?

MR REES: What's missing currently, I think, is what we had in the period 2012 to 2014 which was a ministerial dementia advisory group that the Minister actually came along to from time to time, that had carers, clinicians, Alzheimer's Australia and others. And the deputy secretary in charge of the health department at that time, Rosemary Huxtable, promised me that she would ensure that across the department if that group wanted to talk to primary care, if it wanted to talk to prevention, if it wanted to talk to mental health, that would happen. And it was a good process, and I was very sad when that particular group died.

MR BOLSTER: And that was in 2014?

MR REES: About 2014.

MR BOLSTER: Has there been any suitable replacement for it?

MR REES: No.

MR BOLSTER: Can you give the Commission examples of what it did that was valuable?

MR REES: Well, for example, we had a an interesting discussion with the Minister about dementia in hospitals which was quite original at that stage. I mean, in terms of dialogue with the Minister and that led eventually to the Australian Health and Quality and Safety Commission taking an initiative, which involved them incorporating dementia into their standards, it involved them producing resources for consumers, for doctors, for health care managers. So you had what, in my experience, is quite rare in Australia which is a systemic approach to actually producing standards, producing resources, and then monitoring those standards, and I'm not in touch now with where the Commission has got to in that process but it will be very interesting to see the extent to which those standards are monitored and lead to improvements in care in hospitals.

MR BOLSTER: Right. One of the phrases that you use is that since the disbanding of that committee, progress in relation to dementia and health policy has lost its focus. What do you attribute that to?

MR REES: I think that committee was grit in the oyster, and it kept dementia front of mind. And I think when you get a new government they have their own priorities, and follow-up to Living Longer Living Better I don't think was really possibly top of mind. So things like doctor training and some of the other important but maybe less obvious things in Living Longer Living Better seemed to slip, and certainly the quality agenda slipped and it seems to me from the outside that it's only now beginning to catch up.

MR BOLSTER: All right. I would like to have a look at some of the aspects of the implementation of the WHO action plan. If we could go to page 11 of the action plan, that was the first document that we brought up. And if we could focus, please, on paragraphs 21 and 22. Thank you. See paragraph 21, this is in terms of dementia as being a public health priority, it was indicated that:

> *Governments should set up a focal point, unit or functional division responsible for dementia or a coordination mechanism within the entire entity responsible for non-communicable diseases, mental health or ageing within the health ministry in order to ensure sustainable funding, clear lines of responsibility for strategic planning, implementation, mechanisms for multi-sectorial collaboration, service evaluation, monitoring and reporting on dementia.*

How close is Australia to achieving that outcome?

MR REES: I would have to say that in terms of dementia, Alzheimer's Australia and the dementia community have been very fortunate to have people in the department who've represented our interests very well in terms of ageing and dementia.

MR BOLSTER: Yes.

MR REES: So nothing I've said about the difficulties of making linkages across health areas should be taken as a criticism of those in the department that have handled dementia. I would say that the people in the department in the dementia area correspond very well to those paragraphs.

MR BOLSTER: All right. In your statement at paragraph 68 you attribute the success of earlier reforms to policy competence of the Department of Health at that time, as well as a long lead time, and you refer to a lead time of around eight years for implementation. Can you come back – can you expand on that? What is – what do you mean by "policy competence"?

MR REES: There has been observations by a number of commentators that the end result of productivity dividends in the public service and the outsourcing to consultancies has devalued the capacity of the departments to handle policy, so at a general level that's what I meant. If I look specifically at dementia I think you would have to be surprised at the number of pieces of work that have been outsourced to consultants over the last three or four years.

MR BOLSTER: I mean, if there was policy competency inside the department, why would there be a need for the outsourcing of such a central document as a dementia action plan?

MR REES: I can't think of a good reason why a department should outsource a document of that kind because, in my view, the bureaucrats in the department actually enjoy and need to talk to the carers, the people with dementia, the other stakeholders. I feel the same about the pathways document which was another very valuable document but, again, it should have been produced inside the department, in my view.

MR BOLSTER: The background to the national dementia framework, it preceded the WHO action plan by two years. What was the impetus for it to begin with?

MR REES: As I said before, there was a previous plan to 2015.

MR BOLSTER: Yes.

MR REES: And there was a long gap between the first plan and the second plan in terms of its revision which might suggest that the plan didn't have a lot of priority. And maybe planning of that kind is not in the DNA of politicians, or sometimes departments. So the initial framework, which I think was about 2008 – about 2008, went for five years to 2013 or thereabouts.

MR BOLSTER: All right.

MR REES: And the idea was to capture the issues that needed to be addressed and insofar as possible to identify the actions and outcomes that go with them. The second part of that, really, has not been addressed in either plan.

MR BOLSTER: You say at paragraph 40 that it says all the right things but you query the commitment to achieve – the commitment of the government to achieve outcomes in respect of the bulk of the document; correct?

MR REES: That's correct.

MR BOLSTER: Could you expand on that, please?

MR REES: Well, if I compare the Australian plan with the Korean third national plan, there you have an example of a plan which has clear objectives, clear strategies, clear specific actions and outcome indicators. And the third plan is predicated on an evaluation of the second plan. And it has remarkable indicators in it, like actually measuring whether the prevalence of dementia is declining because of the actions that are taken in the area of prevention. I can't imagine that being possible in Australia at the present time.

MR BOLSTER: Why isn't that possible?

MR REES: Because we don't collect statistics and approach dementia in that kind of way.

MR BOLSTER: Could you give us an example of another outcome that's perhaps not linked to statistics where the Koreans can identify the outcome and are actually measuring it?

MR REES: Well, there're outputs as well as outcomes, so their outputs, for example, in respect of the establishment of respite centres, special services for people with dementia in nursing homes. Those actions are all specified. They have measurement of dementia awareness in terms of regular surveys of community attitudes and understanding of dementia that can be measured over time. They have very active policies for encouraging school children to take an interest in dementia and they measure the numbers of children involved and the numbers of schools that have committed to promoting an understanding of dementia among younger people.

MR BOLSTER: If we could go, please, to the WHO dementia plan, please, to paragraphs 84 through 87. That's pages 30 and 31 of the document. Dealing here with the issue of information systems which picks up the point you were just making about performance criteria, and the review of them, the WHO is recommending, in paragraph 84:

> *...a systematic routine population level monitoring of a core set of dementia indicators to provide the data needed to guide evidence-based actions, to*

improve services and to measure progress towards implementing national policies.

It goes on to develop that in some sort of detail. Is that a problem in this country?

MR REES: It's not a problem to the extent that I think Australia along with other countries has committed to be involved in the global dementia observatory. So in that sense, Australia is taking part in the international effort. In Australia, we have institutions like the Australian Institute for Health and Welfare which I think is a wonderful body that could do even more if it was given the resources, in my view, to build on the work it has done in the area of dementia and aged care more generally. So I think Australia has the capacity to do more in terms of evidence-based care. And the two things that are referred to, I think, would advance that.

MR BOLSTER: Go specifically to paragraph 87, and you see there:

Develop, implement and improve as needed national surveillance and monitoring systems including registers that are integrated into existing health information systems to provide availability of high quality multi-sectorial data on dementia.

Is there such a system in operation?

MR REES: I'm not involved in it, but I understand that Professor Brodaty and a number of colleagues have attracted quite a significant sum of money from the Dementia Research Institute to build such a registry and they will be building on the experience of Sweden and others who have such registries. So while it would be nice if we had that capacity in place, it is being put into place, would be my understanding.

MR BOLSTER: What about government though, government establishing those sorts of systems to track performance, and I'm thinking there in terms of the Quality and Safety Commission.

MR REES: Well, the Quality and Safety Commission has an important role, so does the AIHW to which I referred to before. So I think a focusing of effort on the collection of information and better resourcing some of that stuff would be a positive advantage.

MR BOLSTER: Well, that raises the issue of the market and the information that's available to people who wish to take part in the market; that is, to buy a place in either – in a residential aged care facility. How would you describe the state of information available to them before they come to make that decision?

MR REES: I think one would have to say that the information is very sadly lacking. I get questions from people in the community saying, "Glenn, do you know where my relative should go? How can I get help?" I don't go to websites; I ring up people

I know in the region to get some information. So it seems to me sad that consumers don't know in a timely way which services are under investigation in a serious way. It seems to me bad that you can't go to a website and see what the psychotropic levels of medication administration are. You can't go to a website and look at the skills and staffing mix of a residential care provider and get reassurance about the extent to which staff are trained. They may have palliative care skills or other things. I think for the consumer it is very, very difficult to know where to go. And keep in mind that many people with cognitive impairment will be at a great disadvantage in sorting out information. And many people with cognitive impairment do live alone, so they won't all have families and people to help them.

MR BOLSTER: Isn't that the sort of information, though, that the WHO is talking about in that particular portion of their action plan?

MR REES: The information that the WHO is collecting – and it's all set out in the protocols to the Global Dementia Observatory – is really at a much higher level. It's much more about the number of services, the type of services and so on. A lot of that information isn't outcome-driven in terms of services in Australia. It will be driven in terms of the outputs of services and the types of services that are in place.

MR BOLSTER: So the action area – the action area in question that we were just talking about, action area 6, is a high level policy collection of information and data; is that right?

MR REES: It's a high level data collection for the most part.

MR BOLSTER: Right.

MR REES: And keep in mind that classifying the collection of data across 180 countries, or however many finally take part in the observatory, is a very complex task.

MR BOLSTER: If you could just expand on precisely what the observatory is, for those who are listening and perhaps are unfamiliar with it.

MR REES: It's, basically, collecting, as I said before, a broad – a range of data about the types of services, how many people they help in individual countries. It's a massive collection. But, as I said before, it wouldn't help the family carer or the person with dementia, though, in Australia at a detailed level what services to use or where to go.

MR BOLSTER: All right. Perhaps if we could bring up the Australian Dementia Action Plan, which is at tab 9 of the general tender bundle index, please. And if we could go through to – if you show me the index, please. Actually I think I have the page reference for you exactly. Go, for example, to – just bear with me for a moment. Let's have a look at diagnosis, treatment, care and support on 5666. And if you could go down a couple of pages till you get to a shaded box that has the

summary of the recommendations. You see one of your – that's it. Thank you. One of your criticisms is that the current national framework has no stated outcome beyond general statements. I'm just wondering if you could have a look at these particular outcomes. And these are the outcomes on the need for a timely diagnosis. And if you could inform those outcomes with measurable results, how would you express those outcomes to make them more – to respond to the criticism you make, that they're too general?

MR REES: Well, at the global level I would like to know the extent to which people with dementia in Australia are diagnosed. We don't know. It could be 50 per cent, it could be less, it could be more. We don't know what the outcomes for people are post-diagnosis. Where do they go? What happens to them? We don't know. I would be reasonably confident that if you had outcomes in respect of diagnostic tools and so on, that GPs and so on are relatively well positioned in that sense.

I would love to know the extent to which nurse practitioners and nurses are used in education, training and diagnosis, so that we're losing – using less expensive resources than doctors and specialists. And my conviction, for example, is that nurses, and, particularly dementia nurse practitioners, could play a very useful role in terms of diagnosis, in terms of home visits and doing things which doctors simply don't have time for in terms of the personal situations of individuals. There are people like Len Gray in Queensland, who are doing very interesting things about telehealth and distance assessment and support of people with dementia. It would be very interesting to have some outcome indicators against that kind of activity.

MR BOLSTER: So for all the other aspects of the current dementia plan, which deals with accessing care and support, ongoing care and supports, care and support during and after hospital care, we don't have the time to go through them line by line, but it wouldn't be beyond the realm of someone with a commitment to policy in this area to identify measurable outcomes and measure them; correct?

MR REES: That's correct. For example, in hospitals it's useful to know the extent to which hospitals actually – actually know that somebody - - -

MR BOLSTER: Yes.

MR REES: - - - in their beds has a diagnosis of dementia. And there has been some good work done by the AHW and others to show that hospitals often aren't aware.

MR BOLSTER: All right. Thank you. Funding for delivering the outcomes that are in the report, such as it is, is that clearly identified in the budget position?

MR REES: There is no link between the plan and the budget. None. Australia has been generous, but very pragmatic in the way it funds dementia. So in 2003 I think something like 330 million over five years was allocated to dementia to training, to the dementia collaborative resource centres, to Alzheimer's Australia to do training and so on. Very pragmatic, and I'm not saying the money wasn't useful. I'm simply

making the point that concerns me from a consumer point of view, that the thing lacking in Australia is a systematic approach to thinking through policy to programs.

MR BOLSTER: Would it make a difference if aged care was at the cabinet table.

MR REES: Became?

MR BOLSTER: At the cabinet table.

MR REES: I've made the point in my statement that we've only had an Aged Care Minister in cabinet twice in 35 years. Junior ministers have been good, but junior ministers tend to get the crumbs after the Minister has taken the glamour. So we had reforms in 1984 – 97 period when we had a Minister for community services, and then we had a similar process of aged care reform when we had a Minister for Ageing and Mental Health in 2012/2013. I don't think that was an accident. So I think the political profile of ageing is important and, for the most part, it has been lacking.

MR BOLSTER: All right. I want to change tack slightly. I would like your thoughts on comparing the NDIS with the sort of policy response that you're advocating. There are points in your statement where you suggest that the response to dementia should be incorporated into the NDIS. Could you please tell the Commission what the position is there.

MR REES: Well, this is very much my personal view. And I should have made the point at the outset that I don't actually have an allegiance to any organisation and I'm certainly not speaking on behalf of Alzheimer's Disease International. It seems to me there's a great opportunity for this Commission in looking at the congruity of disabilities in aged care. You see in the legislated review of David Tune the suggestion that aged care should be working towards being demand driven.

The aged care sector go on to make observations which we might come back to, but which – with which I disagree, which is that will lead to a more competitive market. I don't see consumer demand driven approaches as anything more than giving effect to the consumers' wishes and needs and eliciting as best you can a response from the supply side. So I don't look at it in terms of a classical competitive market.

Why do I think the NDIS approach has merit? It's because if I go to their website, as an outsider, as an ageing person myself, I see a very simple explanation of what I can expect as a consumer. I see a simple process of being assessed for eligibility. I see a process of negotiation for assistance and the plan. I see a determination of funding. And then I see a range of options for management from self-management through to using a planning agency to manage. I see that as a good model. I see it as a model that is considerably more generous than the aged care model in its funding and its generosity.

And, as a policy person, I resent the thought that because you're under 65 you get access to the NDIS and if you're over 65, you get access to aged care programs, which in many ways are very limited in the assistance they're going to provide. So I wouldn't actually suggest at this point that you absorb one into the other. That would be indigestion. But I think what you can do, in looking at the integration of the community care part of aged care programs, is to say why not adopt the philosophy and the principles and the process of NDIS to aged care? Why reinvent the wheel in aged care if you've got a model that consumers with disabilities prefer?

MR BOLSTER: You mentioned the NDIS website. What's your view of the My Aged Care website, in comparison?

MR REES: I think I go along with the observations in the legislative review report, which, although it was written by bureaucrats, is reasonably critical, so I take it that there's grounds for substantial criticism. I always felt that IT platforms for people with mild cognitive impairment, carers who are traumatised, people who are vulnerable didn't make much sense. So while it may make sense to have a platform that gives information and can help people that had those kinds of skills, I don't think you should design an aged care or disability system without local area coordination and post-diagnostic support of the kind I argue for in my statement to the Commission.

MR BOLSTER: At paragraph 14 and 15, you prioritise timely diagnosis and support. And that would seem to be right squarely in the ballpark of My Aged Care; correct? I mean, it is the interface with the Department of Health when someone is freshly diagnosed with dementia.

MR REES: The central point of what I'm saying is that consumers need to know they have access to support. A person gets a diagnosis of dementia after maybe three years, maybe quicker, who knows? If they have a good doctor, they might get referred to another agency. If they get an indifferent doctor, they will be told to get on with their lives; there's nothing that could be done for them; "And, by the way, start looking at residential care." I think that's cruel. I think people with a diagnosis of any chronic disease should have the right to expect that post-diagnostic – post-diagnosis, they have some face-to-face contact that helps them work through their issues and plan for the future, whether it's diabetes, whether it's cancer or whatever it may be.

MR BOLSTER: Am I right in thinking, therefore, that your response would be, well, you can't rely on an interface like My Aged Care for someone with a cognitive decline; it has to be a percentage approach; there has to be a case manager or a relationship manager?

MR REES: There has to be a coordinator of some kind. I mean, think people tie themselves in knots over coordinators and case managers. I would – I'm arguing as a point of principle that, post-diagnosis, a person with dementia and their carer should be able to go either to a dementia coordinator. If they have very complex

issues, maybe a late diagnosis, and they've already got severe behavioural issues, then you might need a case manager to help them work through access to services. So there's going to be a variety of needs post-diagnosis, which is where you come back, I think, to the NDIS, which, for all the bureaucracy which people say it involves, still gives the individual flexibility, because their individual needs are being looked at.

MR BOLSTER: Scotland is a case study or an example that you refer to. What can we draw from the Scottish example for the newly diagnosed dementia person?

MR REES: Well, Scotland is interesting, because they were the first country in the world to be inclusive of people with dementia. So they actually involve people with dementia in policy the way we now do in Australia, although probably not quite so effectively. So in Scotland they have a policy promise of a one year post-diagnostic guarantee of support. So that involves helping the person with a plan, helping access to services, helping plan the future, maybe, if it's judged right, looking at advanced directives and so on.

MR BOLSTER: I want to change topic now to people in aged care – residential aged care, and the issue of mainstreaming, which you raise in your report. And you talk about how, effectively – correct me if I'm wrong – 90 per cent of the cohort with dementia in residential aged care can live comfortably with the other residents in aged care, those without dementia, usually referred to in terms of their frailty and their acuity. What's your thinking behind that position?

MR REES: There has been a long and difficult debate in dementia about the extent to which, if at all, you should segregate people. The evidence base for what you do, or might do, isn't all that strong. There are people like Dr Rosewarne and Mary Manain in the department in 2008 who have addressed this issue. My feeling, from having been in the area for a long while, is that, in the interests of residents, staff and the person themselves, some element of segregation is necessary. The numbers that that relates to I can't really take further than the Brodaty triangle that I refer to in my submission, maybe 10 per cent of people.

The most difficult issue for me as a policy person in that debate is whether that special care in a unit is transitional or permanent, and if transitional, for how long? If you look at the Murnane report in 2008 she was very much thinking in terms of transitional care and the person being returned back to mainstream. That has some attractions but people with dementia get very confused when their environments are changed. Across Australia, we have had over the last 20 years providers who've provided segregated care, with some success it seems to me. So I come back to that view that in funding aged care, in funding residential aged care places, the department really should be thinking about providing greater incentives to providers who seem to be doing a good job to actually provide that kind of segregated care.

MR BOLSTER: Where does that fit with some of the best case practice from around the world, which suggests that for people with a mild condition of dementia,

even to a moderate degree of dementia, the group home, the ability for them to wander in a safe setting, very different from typical residential aged care that we're used to in Australia, where does that fit in? Because that would seem to meet the needs of those people in a way that would be counter – running counter to what you're saying.

MR REES: I'm not sure about that. I mean, if I look at Japan or the Netherlands or countries that they – they have approaches that involve segregated care. They involve approaches that involve relatively small-scale domestic-style units. Australia has a fairly institutional provision, it seems to me, of aged care, even though as a country we've probably known since nineteen – the early 1990s what good design looks like. So I'm not sure that countries overseas don't wrestle with the same issue. Some of them might have been more inventive in their models of care but across their systems, I think you would find the same issues that we have in terms of design and when you allocate people to those areas and when they stay in mainstream.

MR BOLSTER: Assume, though, that best practice is the small-scale residential facility just for people with dementia – they're nowhere near the top of the Brodaty triangle, shouldn't there be incentives from government for the establishment of those sorts of facilities?

MR REES: If you're talking about mild to moderate people with dementia, I would be inclined to lift the bar for mainstream residential care facilities in terms of their capacity to care for people with dementia. If you start from the point that 70 per cent, 50 to 70 per cent of people in residential care either have dementia or mild cognitive impairment, it seems to me that people have a right to argue that aged care has a core responsibility for people with dementia. And if you believe that, then I think mainstream residential aged care has to care for a substantial number of people with dementia in a humane and open way, and not segregate them.

MR BOLSTER: I want to – we're running short of time but I wanted to deal with the future, give you an opportunity to inform the Commission what your vision is for the key elements of a system of care for those with dementia, and how it might be achieved in this country.

MR REES: Sorry, I won't be a second. I think the lessons of the past are that you need a clear vision, you need a clear strategy, and you need to stop false expectations. We had the privilege in the 1980s of eight years to implement the review at that time and the recommendations. We had endorsement from government about the stages that that reform process should go through. It seems to me that we need, in terms of the future of aged care, possibly longer than eight years to implement the changes that are necessary and to bring the NDIS and aged care into some sort of alignment in terms of philosophy and principle. So sort of thinking out loud about the number of elements of that change, I think there are probably eight that would occur to me.

The first would be consultation on the Commission's report, and to get the views of older people and other stakeholders on the directions that are proposed. I think the second step would be to stop talking about workforce and do something. And having watched workforce strategies be written now for something like 15 or so years, I think the time to do something about training and pay and registration in a serious way is probably on, so I would make that very high up in terms of phasing of action. The third element, it seems to me, is the development of assessment processes which government, consumers and providers trust. The fourth element for me would be to restructure at-home programs in the aged care sector in line with the principles of the NDIS, but I would probably be more sympathetic than I think the disability sector may be to block funding for those with low needs so that you avoid excessive assessments and other processes for people that may only need two to three thousand dollars worth of assistance.

My fifth priority would be to design coherent respite care which would include planned care. It would include transitional respite, and it would include respite in the community, and I think from my perspective the priority there is to have planned respite care for people with higher level care needs in the community so that the carer knows that is they can get regular blocks of care for the person with dementia. At present it's quite clear that it's hard to get long blocks of care and hard to get access to them at all. I would review at intervals – this would be my sixth element – the work of the Aged Care Quality and Safety Commission. I think it's a desperate comment on the priority for aged care and quality that some of the initiatives that have been waiting since 2012 are now coming into effect. So the Commission may do a good job but I think it needs to be looked at.

Seven would be a new funding system for residential care, and meanwhile I would simply index the amounts of subsidy until the new classification funding mechanism is put into place. So those would be my seven priorities, and I would quite like to see a Department of Community Services reinvented that would bring together policy for disabilities, ageing, homeless, housing and maybe child care.

MR BOLSTER: All right. There's one other matter I did want to raise with you. I should have raised it earlier. Antipsychotics. What's your view about the recent rule changes to the quality principles dealing with chemical and physical restraint?

MR REES: Despair. Despair.

MR BOLSTER: Why?

MR REES: I don't know why government doesn't articulate its expectation of care providers. We have standards that run to 160 pages. We have an Aged Care Act which is pretty hard to follow in terms of its disclosure provisions, and now we have the new amendments in respect of medical and chemical restraint. I've read them but it seems to me to leave huge areas open to discretion of the kind that have plagued the system for the last – many years. I think government in some form and the commission, the – the Quality Commission has to come off the fence and have a

system for monitoring psychotropic medications, and it has to have a view about antipsychotics, and it has to have a benchmark of a kind that focuses the attention of quality assessors, of consumers and others on the quantum of medications that are being consumed, in particular facilities.

There may be a reason for that in terms of their profile of people with dementia or people with very severe difficulties. But I think until the government says our expectation is clearly this, and it's not a word game, the industry has every right in some ways, very sadly, to say we're doing our best.

MR BOLSTER: What effect would publishing the prescription rate of antipsychotics and psychotropics have?

MR REES: I think it would sharpen the mind of providers in terms of how people think about their facility. I think it will help consumers, to the extent they're educated, to look at those markers and worry about the person that they're concerned about should go into those institutions. I think it would concern those, including pharmacists and those concerned with better use of quality medicines, to take more interest in pharmacy audits and things of that kind that actually start to make a difference.

MR BOLSTER: Does the aged care sector have a powerful voice in effecting these sorts of decisions?

MR REES: The aged – the residential aged care sector has an attitude which is totally defensive, as far as I can see, in response to criticism or change of any kind. It's membership-based. It serves the interests of all its members. I genuinely believe that they have served the residential care sector very badly because instead of focusing our attention on the residential care providers who are doing a good job, they've allowed the focus to be on those who are not doing a very good job. So I think the department, the media and advocacy organisations really ought to be engaging more with providers who are trying to do a good job, and working on that rather than allowing the whole sector to be damned by media stories.

MR BOLSTER: On those providers that are trying to do a good job, what stands out you about those types of providers?

MR REES: I think it's the – I don't know whether holistic is the right word, but it's the strategic nature of the thinking of their leadership. So they immerse their staff in their philosophy, they train their staff. They have team meetings. They worry about the social environment of their residential aged care facility, and not just the nuts and bolts of basic care. They involve residents if they can in the day-to-day life of the facility. Some providers will even look at mentoring residents, one with another, so that they get support. There's a totally different atmosphere when you walk into them. When I did the aged care review in 1985 I had a Minister to said to me "I like the residential care facilities the department hates", and he said "I will take to you some."

And the answer was the ones that he liked showed clear communication and relationships between the staff and the residents; they were warm and friendly. On the other hand, you would go to residential care facilities which had splendid infrastructure but not the communication, not the intimacy that you found in others. So that seems to me to be the difference, and there are facilities you can go to in Australia that demonstrate that quite clearly.

MR BOLSTER: I have nothing further. Thank you, Commissioner.

COMMISSIONER BRIGGS: Mr Rees, thank you for your evidence. We have been struck by the extent to which there have been many policy reports in the area of aged care, the slowness of the delivery, and I suppose we're looking around for the question of who is the steward of this system. Should it be the department? Should it be the government? Should it be somewhere else or do we need a steward at all? And the reason we ask this is the absence of a seeming coherent policy framework, or the responsibility for that needs to be somewhere.

MR REES: I think, Commissioner, the stewardship is more than one. I don't underestimate the power of a politician who is committed. I think a politician who believes what he's saying, who is passionate, who understands the language, who understands the philosophy is hugely important. And a Minister who is prepared to take risks, to make speeches which challenge funding mechanisms, philosophy in ways that show the stakeholders that business is intended. At the same time I think the department is important. I mean, I was relatively young in 1985, but I can still sense the evangelical purpose of that department of having a departmental head who was respected and had a high profile. For the first time I suspect – I might be quite wrong – for the first time I think services in Australia had a profile. They weren't buried in Health, they weren't buried in Social Security; they came together to foster change, and that was fabulous.

And I think, again, if the government of the day, whoever it is, means business in the area of disability and aged care, they need to head those areas up with high flyers and reward them like the Treasury or Foreign Affairs, because you're going to services that impact on the lives of the most vulnerable people in our community. I can think of nothing better than having homeless and housing programs alongside aged care. If you're worried about boundaries in policy, why wouldn't you have those things together? I think there's one other dimension I would mention if I have time, and that is to break the manacle that is the National Aged Care Alliance and national advocates and national organisations. I'm not saying that they're unimportant, but I do think that the voice of the consumer doesn't get through to the department.

I think some of the documents that come out from the national organisations are opaque and consensus-based, and don't necessarily represent the values of consumers on the ground. So I think the government of the day has to look for mechanisms, however difficult, which bring the department and the political process face to face with people with dementia, with older people more generally.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising out of that, Mr Bolster?

MR BOLSTER: No. Thank you, Commissioners.

COMMISSIONER TRACEY: Are you proposing to tender Mr Rees' statement?

MR BOLSTER: Yes, I was. I tender the statement of Mr Rees. That's WIT.0126.0001.0001.

COMMISSIONER TRACEY: Yes. The statement of Mr Glenn Rees dated 8 April 2019 will be exhibit 3-40.

EXHIBIT #3-40 STATEMENT OF MR GLENN REES DATED 08/04/2019 (WIT.0126.0001.0001)

COMMISSIONER TRACEY: Mr Rees, thank you very much for assisting us with your considerable experience and, if I may say so, deep insights into the way this system that we're examining has evolved, where it is now, and where ideally it should go. It has been of great assistance to us and we thank you.

MR REES: Thank you very much.

<THE WITNESS WITHDREW [3.40 pm]

MR BOLSTER: Commissioners, I also tender the World Health Organisation Global Action Plan. That's RCD.9999.0050.0001.

COMMISSIONER TRACEY: The World Health Organisation Global Action Plan will be exhibit 3-41.

EXHIBIT #3-41 WORLD HEALTH ORGANISATION GLOBAL ACTION PLAN (RCD.9999.0050.0001)

MR BOLSTER: And I tender the World Health Organisation infographic on dementia, RCD.9999.0050.0076.

COMMISSIONER TRACEY: Did you say intro graphic?

MR BOLSTER: Infographic.

COMMISSIONER TRACEY: The WHO infographic report will be exhibit 3-42.

EXHIBIT #3-42 WHO INFOGRAPHIC REPORT (RCD.9999.0050.0076)

MR BOLSTER: Commissioners, that turns us now to the Brian King Gardens case study, which we will come back to to deal with some matters that were left unresolved from last week. And I understand Ms England appears again for Brian King Gardens.

COMMISSIONER TRACEY: Yes. Well, we will deal with that evidence now, but I have to forewarn you that the Commission has to rise at 4 o'clock.

MR BOLSTER: I will do my very best, Commissioner.

COMMISSIONER TRACEY: If need be, we can resume in the morning.

MR BOLSTER: Firstly, Commissioner, could I call up the document WIT.0154.0001.0001 which is a supplementary statement by Mr Farmilo, of matters that would have been raised by my learned friend in re-examination. That can be tendered by consent and Mr Farmilo is not required for any further questions.

COMMISSIONER TRACEY: Yes. Very well. The statement of Richard Farmilo, dated 2 May 2019, will be exhibit 3-43.

EXHIBIT #3-43 STATEMENT OF RICHARD FARMILO DATED 02/05/2019 (WIT.0154.0001.0001)

MR BOLSTER: The next document I need to tender is SUV.0001.0012.3865, which is the Brian King Gardens response to the initial request for information by the Commission about which I asked Mr Farmilo questions last week. And I tender that, Commissioners.

COMMISSIONER TRACEY: I just need to wait until it comes up.

MR BOLSTER: If there's a problem with that, Commissioners, perhaps, given time is pressing, we might deal with that at another time. It's a formal tender.

COMMISSIONER TRACEY: Yes. Very well.

MR BOLSTER: Could I call Ms Amy Tinley, please.

COMMISSIONER TRACEY: Yes.

<AMY TINLEY, SWORN [3.44 pm]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Could Ms Tinley's statement, WIT.0164.0001.0001, be brought up on the screen. Ms Tinley, do you recognise that document in front of you?

MS TINLEY: Yes.

MR BOLSTER: And that's your statement that you prepared on 9 May.

MS TINLEY: Yes.

MR BOLSTER: And is that statement true and correct – I withdraw that. Is there anything about it that you wish to change?

MS TINLEY: No.

MR BOLSTER: Or correct? No. And the statement is true and correct to the best of your knowledge and belief?

MS TINLEY: Yes.

MR BOLSTER: You are a registered nurse?

MS TINLEY: Correct.

MR BOLSTER: And you have been a registered nurse for 12 years now?

MS TINLEY: Correct.

MR BOLSTER: You originally worked in oncology and palliative care. And in 2011 you began work in aged care. And you were the clinical leader at Brian King Gardens from December 2016 to September 2018; correct?

MS TINLEY: Correct.

MR BOLSTER: That's about 20 months.

MS TINLEY: Yes.

MR BOLSTER: And you reported to Mr Farmilo during that period.

MS TINLEY: Yes.

MR BOLSTER: And, as the clinical leader, were you the person responsible for decisions as to clinical matters for the residents of Brian King Gardens?

MS TINLEY: I was more involved in overseeing the care that the registered nurses delivered and following up that care.

MR BOLSTER: You led the nursing team.

MS TINLEY: Yes.

MR BOLSTER: And if the nursing team or a personal carer had an issue about a particular resident, they would come to you?

MS TINLEY: Correct.

MR BOLSTER: All right. Now, I want to talk about Mrs CO, who you recall. And, remember, we're not going to name her. If you could try and remember that, that would be helpful. From the time you started at Brian King Gardens, you often saw her sitting in the foyer and crying.

MS TINLEY: Correct.

MR BOLSTER: Correct? And you saw her wandering.

MS TINLEY: Correct.

MR BOLSTER: And that sort of behaviour continued over the next – well, it has continued to the present, hasn't it?

MS TINLEY: Correct.

MR BOLSTER: She still wanders around everglades; correct?

MS TINLEY: I no longer work at Brian King Gardens so I couldn't answer the question.

MR BOLSTER: Right. You left at some time the end of last year. Correct?

MS TINLEY: Yes.

MR BOLSTER: Well, let's talk about the time you left. That was December last year, December twenty - - -

MS TINLEY: September.

MR BOLSTER: September 2018. She was wandering around - - -

MS TINLEY: Yes.

MR BOLSTER: - - - Brian King Gardens? And she was still upset?

MS TINLEY: Yes.

MR BOLSTER: And she was still talking about her baby?

MS TINLEY: I believe so.

MR BOLSTER: Yes. In July of last year, about two months before you left, a pastoral care worker came and spoke to you about it; correct?

MS TINLEY: Yes.

MR BOLSTER: And the pastoral care worker, is that the chaplain at Brian King Gardens?

MS TINLEY: No. It was someone working under the direction of the chaplain.

MR BOLSTER: Right. Now, the pastoral care workers at Brian King Gardens, they're not clinically trained?

MS TINLEY: Correct.

MR BOLSTER: All right. Now, at that point in time, you had tried doll therapy on Mrs CO? And that's a way of diverting her attention and directing her away from the behaviours that are causing her concern; correct?

MS TINLEY: Yes.

MR BOLSTER: All right. But, on 4 July, the pastoral care worker told you that she could not settle Mrs CO and that she was getting worse; correct?

MS TINLEY: Yes.

MR BOLSTER: Did you make an assessment of her yourself?

MS TINLEY: Overseeing the clinical care of the whole home, I had been making day-to-day assessments of Mrs CO, because I saw her frequently.

MR BOLSTER: But did you see her on the forth - - -

COMMISSIONER TRACEY: I direct that the name of CO not be published.

MR BOLSTER: Sorry. If you could please just – you understand? Okay. You did not make an assessment of her yourself, did you?

MS TINLEY: I actually did see Mrs CO that day.

MR BOLSTER: And what - - -

MS TINLEY: Sorry.

COMMISSIONER TRACEY: I repeat the direction.

MR BOLSTER: Does the pastoral care worker have any clinical training to assist people deal with trauma of the kind that you mention in your statement that Mrs CO complained of?

MS TINLEY: I'm not aware of the pastoral care worker's specific training, but I do believe that, due to her extended friendship with Mrs CO in the form of a counsellor, she was properly trained to provide that care.

MR BOLSTER: Right. For how long had it been apparent to you that Mrs CO was suffering from trauma of that kind?

MS TINLEY: I believe that Mrs CO had been suffering from trauma from the day I started, and it had been escalating over the past month or two.

MR BOLSTER: All right. You say, though, that by 4 July, you formed the view that the behavioural interventions that were in place hadn't been working?

MS TINLEY: Correct.

MR BOLSTER: And what were they?

MS TINLEY: So what had previously been effective for Mrs CO was anything that was delivered one on one. So this could range from taking her to the café, taking her for a walk outside, listening to spiritual music in her room. Prior to this, what had also comforted her was spiritual group meetings and other group activities. And all of these were no longer effective.

MR BOLSTER: Right. And you were concerned, you say, that she could no longer be comforted; correct?

MS TINLEY: Yes.

MR BOLSTER: You say you went and spoke to Dr Ginger and that you told her what the position was.

MS TINLEY: Yes. I regularly checked on Dr Ginger on her clinic days.

MR BOLSTER: And she says something like:

This poor woman, reliving it all again.

Before saying:

We had better start something for her.

You recall that?

MS TINLEY: Yes.

MR BOLSTER: Can I just observe that you don't mention that there was any consultation between Dr Ginger and Mrs CO before she said that.

MS TINLEY: Leading up to this, Dr Ginger had been seeing Mrs CO at least monthly and was aware of all of her care needs.

MR BOLSTER: But your evidence in your statement is to the effect that you went and saw Dr Ginger, you told her what had happened, and she said straightaway, "We had better start something for her." Correct?

MS TINLEY: Yes.

MR BOLSTER: You don't recall Dr Ginger seeing Mrs CO, do you, or don't you?

MS TINLEY: Dr Ginger frequently saw - - -

MR BOLSTER: On that day, on 4 July.

MS TINLEY: I believe she did a physical review, which I was not part of.

MR BOLSTER: Right. Now, after that decision was made, Dr Ginger attempted to call the daughters, but she couldn't get through; correct?

MS TINLEY: Yes.

MR BOLSTER: And you and Dr Ginger then spoke about other residents.

MS TINLEY: Yes.

MR BOLSTER: Dr Ginger you say, tried to call the daughters again.

MS TINLEY: Yes.

MR BOLSTER: But she was not able to get through.

MS TINLEY: Correct.

MR BOLSTER: The matter was left at that point and you didn't speak to Dr Ginger about this matter again for how long?

MS TINLEY: I can't remember.

MR BOLSTER: And you tried to call them that day, as well, yourself.

MS TINLEY: No, I tried – I was sitting in the presence of Dr Ginger when she tried to call them.

MR BOLSTER: So the note in the care records which says that you tried to contact them at about 2.30 is the record of you making a call – of Dr Ginger making a call in your presence.

MS TINLEY: Yes.

MR BOLSTER: Is that right? So it was Dr Ginger that left the message on the mobile phone and not you?

MS TINLEY: Yes.

MR BOLSTER: Right. Okay. Would you agree with me that there's nothing in your statement that suggests the issue of consent for the prescription was ever discussed between you and Dr Ginger?

MS TINLEY: Could you please ask that again.

MR BOLSTER: Well, let me put it another way. Did you and Dr Ginger discuss the issue of getting consent for the mirtazapine to be prescribed and administered?

MS TINLEY: No. It wasn't part of my role or responsibility to gain consent for the medication.

MR BOLSTER: All right. Was there a procedural guideline in place at Brian King Gardens to deal with that?

MS TINLEY: No.

MR BOLSTER: And my question from a moment ago is that the word "consent" does not appear in any conversation that you had with Dr Ginger; correct?

MS TINLEY: Yes.

MR BOLSTER: And it's not at all clear that Dr Ginger conveyed to you that she had obtained that consent at any subsequent time; correct?

MS TINLEY: Correct.

MR BOLSTER: Yet Brian King Gardens arranged for the drug to be administered in any event?

MS TINLEY: Yes.

MR BOLSTER: Why was that?

MS TINLEY: We were following the order of the GP at the time.

MR BOLSTER: Ms Tinley, can I suggest to you, you knew when you followed that order, that the daughters had not spoken to Dr Ginger about that issue; correct?

MS TINLEY: I did not know at the time that the medication was started that the daughters had not called Dr Ginger back and discussed the medication.

MR BOLSTER: You didn't speak to Dr Ginger and ask her whether she had spoken to the daughters subsequently before the decision was made to administer the drug; correct?

MS TINLEY: Yes.

MR BOLSTER: Do you recognise – I withdraw that. Are you concerned that you gave a direction for the drug to be administered without knowing what the consent position was?

MS TINLEY: No.

MR BOLSTER: Why?

MS TINLEY: It's not within my role or responsibility to gain consent or be part of that conversation that the doctor has, either directly with the resident or with the family member.

MR BOLSTER: Is there no procedure in place to document the obtaining of consent for medical treatment inside Brian King Gardens for any of its residents?

MS TINLEY: Not that I'm aware of.

MR BOLSTER: The current facility that you're at – and I don't want to name it – is there a similar policy in place for medication?

MS TINLEY: Not that I'm aware of.

MS ENGLAND: I object to that.

COMMISSIONER TRACEY: What's the objection?

MS ENGLAND: The question is asked completely without notice, with respect. This witness has come to talk about her role at Brian King Gardens. She hasn't been given the opportunity to investigate what's in place. There has been - - -

COMMISSIONER TRACEY: Well, she either knows or she doesn't know. If she doesn't know she can say so.

MS ENGLAND: All right. Thank you.

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Is there a procedure in place for making sure that consent is obtained before medication is administered?

MS TINLEY: Not that I'm aware of.

MR BOLSTER: Right. When you worked in oncology and palliative care, can I take it that that would involve regular administration of very serious medication to people?

MS TINLEY: Yes.

MR BOLSTER: Correct? And was the issue of consent at all something that you turned your mind to before drugs were administered to residents, or your patients at the time?

MS TINLEY: I think palliative care and oncology is vastly different to aged care, so we would always ask and monitor the residents to see if they had pain and, yes, they would either consent on the spot, or we would make a clinical judgment call at the time.

MR BOLSTER: But do I take it from that answer that the issue of consent really was not something that you've been – that's come across your desk in your practice of the administration of medication whilst you've been a nurse?

MS TINLEY: At any given point a resident or someone in hospital can refuse a medication at the time of giving it, and we can take that as them saying yes or no to consenting to have those medications.

MR BOLSTER: Mrs CO was a person with dementia; she couldn't make that decision herself, could she?

MS TINLEY: No.

MR BOLSTER: You understood that.

MS TINLEY: Yes.

MR BOLSTER: You didn't ask Mrs CO do you want this mirtazapine, did you?

MS TINLEY: No.

MR BOLSTER: And I want to suggest to you that the reason why the daughters were called was to obtain that consent.

MS TINLEY: Yes, and that would have been the decision by the doctor to call the daughters and have that discussion. That wasn't part of my role.

MR BOLSTER: Yes, but your role was to administer the drug; correct?

MS TINLEY: No.

MR BOLSTER: Or to arrange for it to be administered by staff who reported to you?

MS TINLEY: Yes.

MR BOLSTER: And you arranged for that to occur without checking with Dr Ginger as to whether the consent had been obtained; correct?

MS TINLEY: Yes.

MR BOLSTER: All right. Nothing further. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you. Are you going to tender the witness statement?

MR BOLSTER: Yes. I tender the witness's statement. Thank you, Commissioner.

COMMISSIONER TRACEY: Yes. The witness statement of Ms Amy Tinley dated 9 May 2019 will be exhibit 3-44.

EXHIBIT #3-44 WITNESS STATEMENT OF MS AMY TINLEY DATED 09/05/2019 (WIT.0164.0001.0001)

MR BOLSTER: Commissioner, if there was any formal matters to tender we will deal with them at another time. Can I say, and you will have heard this from Mr Gray earlier today, that brings to an end, subject to some formal tenders if they're needed, the Brian King Gardens case study, and the comments that Mr Gray made about a timetable for submissions will – are exactly the same for this particular case study.

COMMISSIONER TRACEY: Thank you for that indication. Ms Tinley you're excused from further attendance.

<THE WITNESS WITHDREW [4.00 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 10 am tomorrow morning.

MATTER ADJOURNED at 4.01 pm UNTIL TUESDAY, 14 MAY 2019

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