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TRANSCRIPT OF PROCEEDINGS

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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

10.02 AM, THURSDAY, 16 MAY 2019

Continued from 15.5.19

DAY 21

MR P. GRAY QC, Counsel Assisting, appears with MR P. BOLSTER and MS B. HUTCHINS
MS K. RICHARDSON SC appears for the Commonwealth

COMMISSIONER TRACEY: Please open the Commission. Yes, Mr Bolster.

MR BOLSTER: Good morning, Commissioners. Yesterday you will recall that Dr Westbury showed us a document which was part of the educational material of her RedUSe project, and we've been provided with a copy of that. Could the operator please call up RCD.9999.0060.0001, and that's the document in question, Commissioners, which I now tender.

COMMISSIONER TRACEY: Yes, the University of Tasmania document entitled Reducing Use of Sedatives will be exhibit 3-69.

EXHIBIT #3-69 UNIVERSITY OF TASMANIA DOCUMENT ENTITLED REDUCING USE OF SEDATIVES (RCD.9999.0060.0001)

MR BOLSTER: Thank you, Commissioner. The next witness is Professor Joseph Elias Ibrahim, whom I now call.

<JOSEPH ELIAS IBRAHIM, AFFIRMED [10.03 am]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: If Professor Ibrahim's statement, which is WIT.0115.0001.0001 could be brought up. Thank you. Professor Ibrahim, you will see on the screen to your right a copy of your statement.

PROF IBRAHIM: Yes, I see you redacted my birth date. Thank you.

MR BOLSTER: That is your statement?

PROF IBRAHIM: It is.

MR BOLSTER: And are the contents of that statement true and correct to the best of your knowledge, information and belief?

PROF IBRAHIM: They are.

MR BOLSTER: Professor Ibrahim, I just wanted to start out with your expertise, and it is extensive. You have been a medical practitioner since 1985.

PROF IBRAHIM: That's correct.

MR BOLSTER: And you're a fellow of the Royal Australian College of Physicians.

PROF IBRAHIM: Yes.

MR BOLSTER: Since 1994.

PROF IBRAHIM: Yes.

MR BOLSTER: You obtained a PhD in epidemiology and health services from Monash University in 1999.

PROF IBRAHIM: That's correct.

MR BOLSTER: The topic of that research was investigating the relationship between quality of care and performance indicators.

PROF IBRAHIM: That's correct.

MR BOLSTER: We will come back to that later. You're a fellow of the Australian Faculty of Public Health Medicine.

PROF IBRAHIM: Yes.

MR BOLSTER: You're a consultant specialist in geriatric medicine.

PROF IBRAHIM: That's correct.

MR BOLSTER: In the public system in Victoria.

PROF IBRAHIM: That's correct.

MR BOLSTER: You are regularly called on to provide opinions to coronial courts around the country.

PROF IBRAHIM: Occasionally, in three States, yes.

MR BOLSTER: And you are associated with the Victorian Institute of Forensic Medicine.

PROF IBRAHIM: Yes.

MR BOLSTER: What's the role in relation to people in aged care with the forensic medicine in connection with the Institute of Forensic Medicine?

PROF IBRAHIM: So the Department of Forensic Medicine, which is part of Monash, has a relationship with the Victorian Institute of Forensic Medicine. It's the academic arm, really, of the Institute of Forensic Medicine, and there is where I

perform the education, training and research activities into patient safety and aged care.

MR BOLSTER: Now, you have written extensively, and we won't go through all of the publications but I want to focus on a couple. The first of those is a document – if that can be brought up RCD.9999.0063.0145. Before I turn to that, could I formally tender Professor Ibrahim's statement, Commissioner.

COMMISSIONER TRACEY: Yes. The statement of Professor Ibrahim – you will have to give me the date, it has gone off the screen.

PROF IBRAHIM: 23 April.

COMMISSIONER TRACEY: Of 23 April 2019 will be exhibit 3-70.

EXHIBIT #3-70 STATEMENT OF PROFESSOR IBRAHIM DATED 23/04/2019 (WIT.0115.0001.0001)

MR BOLSTER: Thank you, Commissioner.

That document is a large collection of recommendations about how to assist in relation to residential aged care, isn't it?

PROF IBRAHIM: That's correct. We thought it was relatively modest given we had only covered seven topics, not the entire range of injuries that cause death.

MR BOLSTER: Now, that report followed a study that you carried out, a previous study about nursing home residents which dealt with data on premature deaths of nursing home residents in the Commonwealth.

PROF IBRAHIM: That's correct.

MR BOLSTER: All right. If we could bring up that document, please. That's RCD.9999.0063.0131. And if we could go to the first table on that – in that document, please, table 1, and if that could be called out. Could you please assist the Commission with summarising the nature of this particular paper by reference to that chart.

PROF IBRAHIM: The basis of the data is looking at all deaths reported to the Coroner since 2000 to 2014. So our team had to go through all of the deaths reported because there is no marker for a person dying in residential care to be able to identify them. So our team went through 230,000 deaths to identify those that were potentially in residential care. And we confirmed 22,000 deaths, as you can see in the middle, were – occurred of a resident. And then when we looked at that we were focusing predominantly on what we call external cause deaths which are injury

deaths. The reason we did that was we knew we would be debated or contested on preventability or prematurity if we did anything else, and so we identified 3289 deaths due to injury which we looked at in detail.

The 18,000 natural cause deaths would have taken far too much resource for us to investigate to find out why so many had been reported to the Coroner. As most people would know deaths reported to the Coroner usually have some unusual aspect to them, and we remain curious to this day as to why 18,000 natural cause deaths have been reported.

MR BOLSTER: If we could go to the next table, please, which is a summary of your conclusions, could you please talk us through the effect of that table.

PROF IBRAHIM: So this goes through the causes of death by injury category and we've essentially broken them down into three categories. Intentional cause deaths which is down the bottom which is suicide, resident to resident assault, and there was one homicide as you can see. The other groups are called unintentional deaths so they're typically falls, choking, asphyxia, burns such as thermal injury, and complications of clinical care. So they're the main categories, and in terms of injury prevention that's sort of standard nomenclature used throughout the world to try and identify approaches for prevention. What I want to highlight in that table is the incredibly small number of deaths from complications of clinical care which we might come back to later. There were only 39 deaths reported to the Coroner as complications of clinical care over 14 years which beggars belief.

MR BOLSTER: What do you characterise as complications of clinical care?

PROF IBRAHIM: Well, this is according to the classification used by the Coroners, or the National Coroners Information System, and so they're usually errors of omission related to clinical care, either by a doctor or a nurse. We think that number is incredibly small and due to underreporting and failure to recognise misdiagnosis, mistreatment, inappropriate treatment, and we think that a lot of the complications of care, clinical care are either tied up in those listed as falls, or potentially in the natural cause deaths which we didn't have the resources to investigate.

MR BOLSTER: Yes. Right. If we could go to the final table in that paper. The table 3, you will see the rate per 100,000 resident admissions. Could you talk us through the effect of that table? It would seem that the rate of natural cause death is decreasing over time, that is on the left-hand column. The external cause falls rate is increasing over time, and the external cause other is relatively static compared to the other two. What's going on there, Professor Ibrahim?

PROF IBRAHIM: So our, when we looked at this, the natural cause deaths we believe were reduced because in South Australia up to about 2005 they were reporting all deaths occurring in residential aged care under the belief that these were in care deaths. The – and so that's part of the reason there has been a drop-off in natural cause. The other reason there's a drop-off in natural cause is the New South

Wales court changed their legislation to reduce reporting of deaths for people over the age of, I think, 72 or 73 so that would have reduced some of the natural cause deaths being reported. The external cause deaths falls, there was a significant increase because of the requirement in Victoria in around 2007 to improve reporting of falls deaths, which we believe should have been followed nationally because falls are – are a cause of injury and if we don't look at those we're never going to understand how to reduce them.

And so that rate has been increased and that really caught the eye, I think, predominantly of the media and is a headline item. The thing that we were most interested in and wanted to try and convey is the external cause other, and there has really been no change in that over 13 years, and so having removed the natural cause, having removed the falls and so any controversy around how you would interpret that, we're left with the conclusion that nothing has changed in 14 years in Australia in reducing harm from injury that is clear and obvious to all, as a cause of premature death.

MR BOLSTER: Pausing there, your PhD topic, which we mentioned previously was about quality, measuring quality in care generally.

PROF IBRAHIM: That's correct.

MR BOLSTER: Why do we choose – why have you chosen in your research to focus on the coronial side, the death side?

PROF IBRAHIM: So really there's – for aged care there's no choice. So for my PhD we had access to hospital level data across the country. That work was funded by the Federal Government to look at performance measures as to whether we could determine or rank the quality of care in hospitals. Using those same principles the only data available to our team or to any team in Australia is that through the courts and through the National Coroners Information System. So in terms of being able to collect data, it already exists; it wasn't being used. Death is a non-contested outcome. No one can argue that death did or did not occur. Whereas if you enter the debate about whether someone was harmed and is still alive from quality of care you get into debates around the degree and whether that injury was severe or not severe, and the metrics for that don't – exist but aren't being used for us to be able to research.

We use the death data because no one could stop us using it. So we, of course, had to go through ethics, but no one can really stop you getting access to court level data except the court. Getting access to data from the Health Department is incredibly difficult. Getting access to data from AIHW which we did for ACFI cost us in the order of $25,000 to get a cube of data, and another $50,000 in trying to clean that data to use it. So in terms of why the coronial data is – the deaths that are reported usually have a cause that is preventable. The data is available. The investigation information is available for us to learn something from, and most clinicians will listen to – though you might not – will listen to the outcome of a court finding or the

Coroner's. So in terms of potential influence in changing practice, that's why we were using that data. We weren't doing this purely as a research exercise. Our intent was always to come out with something that the country could use to help older people.

MR BOLSTER: You refer in your statement to the data from the Coroners Courts as being a proxy for data that you might otherwise achieve from the Department of Health.

PROF IBRAHIM: Yes.

MR BOLSTER: Is that what you're talking about?

PROF IBRAHIM: So if I had my hat on as a pure academic, we would want prospectively collected data that was the control of the researchers as to how that's gathered and reported so we know the information we're going to collect and we have a standard way of collecting it. The use of large administrative or secondary datasets is now common practice and has been for the last 20 or so years in Australia. We would need to get the ACFI data to link that to the hospital data in each state and jurisdiction to start to have a dataset that could be analysed in terms of the nature of – that would give us the numbers. That still wouldn't give us a sense of the quality of care that was being delivered and we're then left with proxy judgments at any rate. So, you know, the – the linkage of data would be incredibly helpful.

There are substantial costs associated with it and the times in accessing that data requires going through usually different departmental ethics committees before you can get your own institutional ethics committee. It took us 18 months to go through the ethics requirements for AIHW. If I was a career academic and not a clinician – and my livelihood is made from clinical practice – I would not be at the university if I was non-productive for 18 months waiting for data.

MR BOLSTER: If we can go back to table 2, please, and you have listed there seven categories of death: choking, there's suicide, resident to resident aggression, homicide, etcetera. To what extent were they considered in your second paper that dealt with recommendations?

PROF IBRAHIM: So for the recommendations we had to make a pragmatic decision about how much data we could analyse, and so we could not analyse the natural cause deaths because of sheer volume. We did not analyse the falls deaths because – for two reasons: the volume of data there required an enormous amount of resources, and in terms of research there's a lot of research on live people that look at interventions. We chose the topics that no one typically looks at, and that people find very difficult to confront. The team I had with me are also young, highly motivated, social justice-minded people who I have enormous respect for, and they led me to looking at suicide, resident to resident aggression, complications of clinical care, particularly medication use. We then looked at choking deaths, deaths from unexplained absences, and particularly respite care was another topic that we thought

was very important to look at, and that generated enormous debate and trolling with people believing that we were against respite care, rather than we were wishing to improve respite care.

MR BOLSTER: We will come back to each of those categories a little bit later but in tandem with this you also publish a regular information sheet called Communique; correct?

PROF IBRAHIM: That's correct.

MR BOLSTER: If we could bring up, please, the Communique document, RCD.9999.0063.0137. When did Communique start?

PROF IBRAHIM: So the first Communique looked at hospital-related deaths back in 2003 when we were working in partnership with the Victorian Coroner's Office and the Victorian Institute of Forensic Medicine. This communique specifically for residential aged care was part of an initiative funded by the Victorian State Health Department and they have been steadfast supporters for the last 12 years. It has been going now for 12, 13 years where our 50th issue will come out this month, and that was designed to – one of the issues we discovered in working with the legal system is information from the courts was not getting out to clinical staff in a manner that they're familiar with. So legal judgments usually go anywhere from 20 to 50 pages and they're not sequenced correctly for a clinician.

So what we do is take the cases, sequence them in the pattern that's familiar for clinicians, keep them as brief as possible and to the point, highlight the key learnings, highlight additional resources they might use, and try and make sure that we frame the case as such that it could happen to you, and it's not the individual involved that led to the set of circumstances, and to then encourage people to use that for learning and to argue their case with their executive or board of management to generate change.

MR BOLSTER: All right. We have in front of us the 10th anniversary edition. That's from, I believe, last year, and I just wanted to have a look at one of the case studies that you refer to there. It's on page 7 of the document, if that could be brought up, please. Is this the typical format, that you have articles by clinicians but you also critically have various clinical summaries taken from cases from the Coroner's Court?

PROF IBRAHIM: That's correct, yes.

MR BOLSTER: And in this edition you refer back to a case study from the very first edition in 2011. It's about a person called Mrs H.

PROF IBRAHIM: Yes.

MR BOLSTER: And you make some comments about how relevant it remains, even to this day. Could you walk us through that particular clinical summary, and tell us how – if you could just for now walk us through that summary, and then I will ask you another question after that.

PROF IBRAHIM: So the resident, Mrs H, was 78 years old and was a heavy smoker and lacked the dexterity and mobility to go out to have the cigarettes that she wanted or enjoyed for her life – quality of life. And I think that in this case, the resident had taken the cigarette, been left alone, the cigarette had fallen and she had immolated, gone up – so I think that – so having died from burns related from cigarette smoking, was really a highly contentious issue for myself and our team in that clinically we would never condone cigarette smoking. It's bad for everyone universally and should not exist. So if anyone smokes, they should stop. But I was then faced with the dilemma here of if I respect the person's rights and their right to choose and live how they want to, then sadly, I've got to come out in support of someone smoking a cigarette, not for its health benefits but only in terms of respecting that person's right to choose.

And that really creates, I think, the dilemma we currently still face about the balance of paternalism and a person's right to autonomy. The other frustration, really, is that having looked at cases from when I started at the court in 2002, reviewing cases, and every year we continue to review cases and the same themes come through. It might be a different aged person, they might have a different set of diseases. It might be in a different state or a different sized home, but the same themes repeat and it is incredibly frustrating and disillusioning in terms of our ability as a country to learn from them.

MR BOLSTER: So have you done any research or analysis of the take-up rate of the material that's in Communique?

PROF IBRAHIM: So we've evaluated this Communique on at least four, possibly five, occasions. Again, it's in terms of we live in a world where you've got to justify your existence, and so we've completed those surveys, had them peer reviewed, published in academic journals to prove that we're not making anything up and open to scrutiny. And universally we find about half the readers say that they change their practice based on it. You've got to be a little bit wary when people say they change when you're asking them, have you changed to be good; most people will agree that they've changed to be better people. Substantiating that takes a lot more effort and would cost us more than the production of the newsletter itself.

We also know that we've got a secondary distribution list that's probably – for every one subscriber, there's probably another 10 readers. Again issues to do with spam laws, privacy, confidentiality, mean I can't – I don't have anything definitive beyond our subscriber list. And the anecdotal evidence is that I know that senior clinicians will take the Communique in their hand to their executive or to their board and say, "I've been telling you this same thing for two years now. This has led to someone going to court. If we don't change this could be us." And in terms of ammunition to

support the clinicians to improve practice I think that's probably where its biggest impact has been.

MR BOLSTER: I want to change direction now and talk about, in general terms, your perspective about the purpose of residential aged care. You go into that at some detail at paragraph 22 of your statement.

PROF IBRAHIM: Yes. So I have my own opinion. What I would really ask the Commission is for internal consistency which we don't have in the country. So if we say it's one thing, then it should deliver on that. I believe that residential aged care is a place where older people should be able to go and enjoy their life. If you have to go to residential care, it usually means you've survived to 80. You've usually got three to five diseases. You've lost your home, you've left your family behind. You're coping with having dementia or severe arthritis. You're coping with having people support you with your day-to-day living and toileting. I would have thought at that point in life you deserve to have something decent happen to you, and so I think that residential aged care should have the goal that it's a place where people can at least enjoy their last few months or years before they die. They know they're going to die. We know they're going to die.

And what currently happens is most of us sit around waiting for them to die, and if they die quickly then it's a good job done. Everyone sort of thinks that's a good thing, and it's clearly not, and it wouldn't be acceptable in a paediatric palliative care-type service and it's not acceptable anywhere else. We're very clear on the purpose of a school. We're clear on the purpose of a hospital. We're clear on the purpose of a prison. We're clear on the role of the AOC for the Olympic Committee. We've got no illusions about what they're supposed to do. So we know what they're supposed to do. We can see their outcomes and if they're not producing we get angry and we change it.

In residential care, it seems to me no one has been angry for a long time. And no one – because the product of residential aged care – and my apologies to the residents there – the product of residential aged care is death, and deaths occur one third every year and so it seems that residential aged care is working well because every year 50,000 people die and that's what we expect so things are happening smoothly. And the way the legislation is written tells you what services are to be provided. The mission statements for residential aged care vary but they're typical of any human service or any hospital and depending on who has done the wordsmithing is we will respect people, we will work in partnership, we will provide world standard care and we are caring folk are the general themes for any human service. And I don't see this as a lived experience. I am not a resident. I feel awkward – so I'm not representing residents, they will have their own view about it.

But in terms of measurement, you can't measure something if you can't define it, and the beauty for the Parliament and for the Government and for the Health Department is if it's not defined, you can't ever do anything wrong because you can switch your definition or what you think the role is. And you will have seen from residential

aged care is on one hand it's a palliative care unit when you want it to be, and then the next minute it's a brokerage or concierge service for people to go skydiving. And in between the hospital – the acute hospitals don't want any of the residents to come to them. What is it? And no one knows and you choose the one that's most convenient for your argument. And so if we don't have a clear definition that we all understand, we can't measure it, and if we can't measure it we can't call people to task about the nature of their work, and that's where we're currently stuck.

And that's, again, one of the reasons we've used Coroners' data to look at injury because I would dare anyone to argue with me generally, but I dare anyone to argue with me about death from an injury is a premature death which means someone has died before their time. If they're 90 or 95, I don't care. What I care about is they've died before they were supposed to. So if you're supposed to get to 95 and one month, and we've taken a month off you, that's not right. And every time I speak publicly and I ask – and again I ask anyone in this room, would you give me a week of your life? Now, for nothing? Would you give up a week of your life for me? And universally, no one would give up a week of their life. They wouldn't even give up a day. Yet, we accept people dying prematurely because we believe they're old and have no benefit to society, and that's just wrong.

MR BOLSTER: I want to read to you a piece of transcript from last week from a resident, and she said this:

> *So people come in and they're told this is your home now. Well, it's not. It's an institution and it's where you live, but it's not a home and no matter how many times they tell you, it's still not your home. So my answer always, to anyone who tells me that is, this is where I live but it's not a home.*

What do you – what's your response to that?

PROF IBRAHIM: I'm going to go, "I told you so". It's pretty clear that it's not – it's not a home. We sell it as a home and we don't behave as if it is a home because we restrict what people are able to do. People generally do not go to residential care as a choice; they go there out of necessity. And as I said before, I think if you have to go somewhere that's not your home, you deserve something better than you're currently getting.

MR BOLSTER: Should it be an aim of the system to make it more like a home?

PROF IBRAHIM: I think this is where you get into the tension about trying to – I don't think we sufficiently understand the population of older people, and I think from one of the discussion papers, the Commission would have seen that there are at least three populations that access residential care at the moment: those that enter and die quickly within a month to six months; those that are there for more than three years and some more than six years; and then there's a middle group. The needs of the residents are different and so some residents need a home-like atmosphere with – activities is the wrong word, but they need somewhere to live

because they need help with their personal care and they need to be able to have a purpose to their lives.

Other people are frail, needing palliation and palliative care with high-end nursing care and pain management. And then there's a large group of people who have multiple chronic diseases that need fine-tuning, regular clinical assessment to make sure that they're in optimal health to enjoy their life. So there's a large difference in grouping. The other issue with what is a home is – is impossible to define. You know, if you go back to that old adage, home is where the heart is it's – I don't know. A home for me is very different to what it might be for you and to anyone else here. So to say it should be your home, I don't think is true. To say it should be a place where you're happy to, or accepting to live in, sure. And it's the same thing in terms of hotels. When I go to a hotel I'm not expecting it to be home but I'm expecting a certain level of function, cleanliness, and I guess, use.

So I don't – I don't know and I think the – we haven't actually asked older people what they want and if we have asked them, we haven't listened, and we're designing things based on, at the moment, my understanding is homes are being, or residential aged care facilities are being designed based on square footage because the square footage of your room determines your ingoing fee and what you can charge people. So if I'm being charged extra for a window and double for two windows, then the decision about the build is not from the residents' point of view; the drive for the build is really for profit.

MR BOLSTER: You also talk in your statement about the word "safety" and the various levels at which it is used in the context of residential aged care. Could you please elaborate on that.

PROF IBRAHIM: I think this is, and this is what irritates people about the precision of language that's needed. And so I don't have a definition for residential aged care, the only definition we've got is based on the approved provider status and those that are accredited which is how we looked at it. When we look at the word "safety" you can't talk about that unless you actually define it. The common use of the word "safety" as a doctor is the one we would use from the Institute of Medicine which is about safe clinical care, that you provide care that falls within the bounds of what's known that doesn't harm the patient. The issue around feeling safe and so often people talk about safety as "does the resident feel safe". And some residents feel safe in a group. Some people don't feel safe by themselves. Some people feel safe if their door is locked. Others don't mind. That personal sense of safety is the second.

The third one is what I call the defence we all use when we tell an older person they should go to care and we tell them, "You should go there because you will be safe." And what we mean is that the things that might befall you in the community won't befall you in residential care, which is not true. And that places a huge and unfair burden on the staff and the aged care providers to provide safety for the person. So if I am advising someone to have their loved one go to residential aged care and they

say "They will be safe there now", I say, "Well, they're not going to be any safer there. If they're likely to fall now, they're likely to fall there."

The only difference is they might be found a little bit sooner if they're in residential aged care. If they have trouble choking or eating foods, they will have the same issue there. You do not go to residential care to suddenly become safe. There's no magic wand when you enter those doors that change the laws of – change your biology or the laws of nature. You're in a different place and there's some extra people around. If you think that's safe, well, that's safe, but that does not mean no harm will befall you.

MR BOLSTER: How should safety be prescribed by the Commonwealth in a policy sense when you come to regulating residential aged care?

PROF IBRAHIM: Well, I think there needs to be a clear differentiation about the types or meanings of the word "safe" and what does it mean for residents, and for it to be clear that being safe, or, as some have said, that, you know, the idea is you don't go to residential care to be cocooned in cotton wool or bubble wrap so nothing ever happens to you. The legislation has got to be sophisticated enough to match the complexity of the society we live in. We keep looking for simplistic solutions for complicated problems, and all we do is make things worse by denying the complexity behind it.

And we're far more mature – we should be far more mature than that, but we really want – we want an easy answer. We want to forget about ageing, we want to forget about being old, we want to forget about the difficulties of disability and death. And so we rush to a really simple answer or we choose the answer that we like from what already exists. So, in terms of how the Commonwealth should address it, I think they've got to at least look at those three different domains and explore what – what can be impacted, what can you change. And then you write the legislation according to what's possible to change.

You can change a person's sense of safety by what is around them and the people around them and if you respect them and they're able to do things. So I feel very unsafe when people do not allow me to choose for myself. I – it's not a situation I tolerate well. Other people feel safer if others are choosing for them. That personal sense is more a sense of security or goes more to my anxiety or wellbeing. It has nothing to do with how a doctor or nurse is providing an injection of a blood thinning agent or an antibiotic. Combining the two as currently happens means if you talk – whoever you talk to will choose the definition of their preference to prove that they're correct.

And so we end up with this situation that no one knows what the other person is talking about and everyone is convinced that they're right and so nothing changes, as nothing has changed for the last 15 years. Despite all – all of the inquiries, and all of the promises and – I don't know if I've missed it, but I'm not aware of any of the political parties having made any statement about residential aged care or what

they're going to do with the findings of the Commission. And the election is on Saturday and there has not been a word spoken.

MR BOLSTER: Dignity of risk is a related concept. And you have quite a bit to say about that in your statement. Could you encapsulate, for the purpose of the Commission, what you mean by that, and how important it is in residential aged care.

PROF IBRAHIM: Well, I will start with – it's no more than important in residential aged care than anywhere else. It's really important in residential aged care, because hardly anyone respects it, which means hardly anyone respects the human rights of the residents in aged care. So dignity of risk is a concept from the 70s, came from the disability sector, which said that one of the fundamental ideas of being a person is you have autonomy: "I get to choose what I want to do with my life." And that's fine as long as I don't hurt anyone else. And so we accepted the idea of autonomy.

And when people look at autonomy, autonomy is being able to choose, and being able to choose not what the outcome of your choice is, but purely the act of choosing. And so dignity of risk is really about, "I get to do – or I get to at least try something that I want to do." Whether I succeed or fail is not the issue. Whether it's safe or unsafe is not the issue. Whether you think it's okay or not is not the issue. It has nothing to do with you. It's all to do with the person who is making their choice. So dignity of risk is, "I get to take risks with my life, because, by taking risks with my life I feel alive, I have my autonomy, and I learn. And sometimes things go brilliantly and I'm very pleased with my choice and sometimes they go horribly wrong and I'm not so happy with my choice, but I'm left always knowing I chose that and I screwed that up, and so I can live with it."

What we currently have is what we call is a clash of cultures. We've got paternalism, which has been longstanding, and remains. And even though I've been advocating for dignity of risk for some time, I'm still being accused of being paternalistic and even – and I start to see that because I have been promoting people being proactive in providing choice and I've been proactive in asking people to look to help people to do things.

MR BOLSTER: How does that play out for the resident? When are they entitled to make a choice that might be contrary to a safe, paternalistic approach to their care?

PROF IBRAHIM: So now every time. It's not complicated. We have autonomy. We can choose to stand up and leave here and I could leave now. I would understand the repercussions of leaving now, but I could leave now, I think, couldn't I? I might break the law, but that's a choice I w make. So it's not about – we're not giving – we're not giving residents dignity of risk. It's not something that we offer and give them. They have that because you have that and we all have that as citizens of Australia. We have that and we have that as a human right.

MR BOLSTER: How do we honour it, though?

PROF IBRAHIM: So we honour it very badly at the moment. We honour it in the absence of it. We honour it by saying, "Here are 25 activities, from bingo to completing a jigsaw puzzle to a book reading to watching the midday news", which is a suite of things that is on offer, but never addresses the question of, "What do you actually want?" and, "Can we help you achieve that?" And we get away with it because the generation that's in residential care at the moment are eighty – again, we go 85 year old women who had a hard life, made do, compromised, self-sacrificed and don't complain.

And so we think we're doing a good job because our mothers or grandmothers or great grandmothers have the personality type that sacrifices for everyone else. And we're doing them a huge disservice. We don't honour it and we get away without honouring it, because we say people have dementia and if they have dementia, they can't decide anything for themselves, which, again is just wrong. We get away with it because we say, "It's going to be dangerous for you or that it's difficult for us to do or the doctor has not recommended it." You don't go to your doctor for advice about how to enjoy your life. You go to your doctor if you've got a medical illness that has a treatment that they can provide treatment for. So we're not honouring it.

We need to do far more about saying this is actually entrenched in the Act. And it has been in the Act since 1997. What I find really puzzling is now that the new standards have come out, people are focusing on dignity of risk. But respecting your rights and choices was legislated – was legislated in '97 and facilities have been measured against that since there, but it has not been honoured. And so we can help people to take – so the onus is on us to be reasonable when people ask for something. We don't have to do everything we're asked, but we need to be reasonable in how we support the choices of others, the same as everyone else here would have been supported in decisions they've made.

MR BOLSTER: I wanted to turn then to the broad category of the recommendations that flow from your 2017 publication. And if that could be brought up, please. And we might start with the issue of suicide. And if you could, please, bring up page 197 of the document itself. Can you see that in front of you, Professor Ibrahim?

PROF IBRAHIM: I can, thank you.

MR BOLSTER: And since this is the first time we've looked at the recommendations themselves, if we could just perhaps get you to focus on the key issues that arise in your recommendations that deal with the suicide risk in residential aged care.

PROF IBRAHIM: So the work in suicide that Briony Murphy led was highlighting that aged suicides occur in residential care. So that really wasn't well established or known. And the question we had was why would suicides occur in a highly supervised environment where people are meant to be – I go back to people are meant to be safe. Suicides occurred mainly – well, you know, so the risk factors

were male, recent admission or entry to residential aged care, being younger aged and cognitively intact.

So people often need to be cognitively intact to suicide, because you need to be able to plan, sequence and organise to end your life. The other work that involved was suicide was not part of the general suicide prevention plans for the country or the state, that residential aged care was not considered an at risk population, so there were no interventions there. We were unaware of any programs to assist family, other residents or staff to cope or manage following the death of a resident by suicide. We – again, this comes – it would have been good to have been able to research that, but getting access to the families of loved one that is had suicide, as you would understand, is really quite difficult work to do.

So the expert panel, along with the research, really highlighted that when people enter residential aged care they often feel their life is over. They've left home and everyone has had them prepped for its – in a sense it's time to die. You've given up everything of yourself, you've lost your home, you've lost your belongings. Whatever you can stuff into a suitcase and into one room with a piece of furniture is now your home. So that if residential aged care is not a place where you would like to live, you're going to get, I guess, more distressed. It also raised the question of why isn't residential aged care a nice place to live anyway? It shouldn't just be done because it might reduce suicide.

MR BOLSTER: What about mental health screening and assessment on entry? Does that happen and should it happen and what effect would that have?

PROF IBRAHIM: So the screening is part of the ACFI. So – part of the ACFI. It you're able to screen and identify someone who has mental health issues, you will get a bump in the amount of money you get. So some of that screening is done for that reason. The screening, as I understand, is not done for clinical reasons. If all residents are screened, the – there's no requirement to act on the indications of the screening. If people do look – or diagnose depression or anxiety, the level of follow-up around that is not sufficient.

The Federal Government recently – or just a year ago improved access to mental health services. And it's a fallacy to say they improved access. What they did was to re-equate access to mental health services that were already available to those in the community. And so that had been a longstanding gap. So if we want to prevent suicide, then we want to reduce the burden of mental health, which means identifying, treating depression and anxiety. And we have those treatments available and they're readily available in the community, but they don't seem to have really penetrated into residential aged care, where there are preconditions for you to be sad, upset and have mental health issues, because you have physical health issues, you have had substantial losses.

And in terms of the life stress chart that people used to produce about predicting whether you're going to have ill health, which include – I don't know if anyone

recalls – divorce, changing home, death of a loved one, you have a high level of stress moving into residential aged care. And so we considered that more work needed to be done there. We needed to include suicide in the national strategies. We needed better access to mental health. We need better access to psychologists, psychiatrists. And some of the fundamentals really are starting with screening.

MR BOLSTER: Your earlier research for the 13 years from 2000 to 2013 identified 146 cases.

PROF IBRAHIM: Yes.

MR BOLSTER: Is that an underreporting, do you think, consistently with your earlier evidence?

PROF IBRAHIM: So we have argued that's underreporting. The reason we say it's underreporting is that we only identified or classified cases where it was non-contested that it could be suicide. Again, I was expecting, having been around in 1990s when the health care was identified to be performing poorly and causing significant harm to patients, was aware of the backlash in producing data that said there was underperformance or harm caused by care.

So the suicides – suicides were clearly identified. I don't want to go into the means, but the suicides were not people that stopped eating or withdrew from care. It really had to be a clear act that was identifiable, visible and defined by the coroner. So those have been underreported. Our worry with producing this data was not the – was that people would underplay it, saying 140 suicides over 14 years is 10 per year. There are 200,000 residents, so 10 deaths out of 200,000 is not so bad, if you're counting numbers. It's a ridiculous way to look at it. But I was aware that these were strategies that had been used before in health. The reason we looked at suicide was we couldn't look at depression. And so if you want to use suicide as the tip of the iceberg, then the volume of people that are depressed is at least one in four in residential care.

MR BOLSTER: Why couldn't you look at depression? Why can't - - -

PROF IBRAHIM: Well - - -

MR BOLSTER: - - - the health department give you stats about that?

PROF IBRAHIM: Well, I don't know that the Department has the stats on it and they certainly wouldn't give me the money to do that, because it was like – so - - -

MR BOLSTER: Would antidepressant prescribing give you a window on that?

PROF IBRAHIM: So getting the medication data would give you a window on how much antidepressants were prescribed. The question that you would end up asking is, "Are the antidepressants being used for depression?" Are they actually – so – and

are they being appropriately used or inappropriately used? And the classic then would be the use of antipsychotics. If you got the volume of use of antipsychotics, you're left with the question of, "Are they being prescribed or used appropriately or not?" It gives you high level data the same way that the coroners' data gives you high level death data. So there are gaps in it.

And the way to address those gaps is to review the clinical records of the residents to determine whether the diagnosis is correct, whether the treatment has been initiated and titrated to the correct dose. And so once we get into measurement of quality of care, the ability to argue or contest findings is really quite profound if it's not done to a very high standard. And that type of study would run into the millions. The amount of money we got for our work from the health department was on the record as around $800,000 for two and a-half years.

MR BOLSTER: I want to turn to choking now and dysphagia. If we could please go to paragraph – to page 53 of the document. Now, in the case of choking, it's a significantly larger number of deaths.

PROF IBRAHIM: Yes.

MR BOLSTER: Over the 13 year period we're talking about 261 people. How does a choking death in a nursing home occur typically?

PROF IBRAHIM: So the choking deaths we looked at here were the ones that had choked on food or medicines. And so these are usually bolus, not the aspiration. So, you know, if you're going to – the examples that comes to mind is a resident choked on a decorative glass grape, so mistook that. Another resident choked on chocolate cake. And others might have choked on a piece of sausage. So it's really – usually people with swallowing disorders which is common from stroke, Parkinson's disease. Swallowing problems occur as we get older, because the muscles in the gullet don't work so well. And you then have either the food is not cut up finely enough, the person wants to have something that they enjoy or they've taken food that's not theirs. And so that, you know, they then get an obstruction to the airway and die.

MR BOLSTER: If we look at, in broad, we don't have time to run through them one by one.

PROF IBRAHIM: No.

MR BOLSTER: The themes of your recommendations involve attention to care planning.

PROF IBRAHIM: Yes.

MR BOLSTER: So identifying risk in a particular person, preferably with reference to some sort of dysphagia screening tool.

PROF IBRAHIM: Yes.

MR BOLSTER: What is your understanding of the prevalence of adequate planning and screening in this field?

PROF IBRAHIM: So I'm aware, from speaking with speech pathologists, that the level is incredibly low and so access to speech pathology in residential aged care is far lower. I – I would be guessing, but I would think that less than 10 per cent of people with a swallowing disorder get the assessment that they need.

MR BOLSTER: Is the choking data increasing or decreasing over time?

PROF IBRAHIM: I - - -

MR BOLSTER: Let me have a look at that.

PROF IBRAHIM: One of the issues with the – so that the choking data we've excluded aspiration, which is another form related to swallowing.

MR BOLSTER: So that's a form of pneumonia that affects the lungs. Correct?

PROF IBRAHIM: That's right. And so we've not looked at that. And that's described far more commonly. And that's somewhat more difficult to prevent.

MR BOLSTER: And when you referred to bolus - - -

PROF IBRAHIM: Yes.

MR BOLSTER: - - - a few moments ago, that's matter in the throat, isn't it?

PROF IBRAHIM: That's right. So if you want to think of a Brussel spout or – that would be a bolus of food that would obstruct.

MR BOLSTER: Right. Okay. We might then turn to the next area. And, in that respect, can I ask you to look at the question of resident to resident aggression. If we go back to pages 172 to 195 of the report. You place some emphasis on the way resident to resident aggression is defined. Why is that?

PROF IBRAHIM: The – when we started the work, resident to resident aggression was considered homicide. So in terms of the court or legal system, the death of a person at the hands of the other would be homicide. It's a very difficult area to research, if we're going to call it homicide. Some people want to downplay it and so don't give it any regard at all, saying that one person with dementia who has no intent or is unable to form intent knocks another person with dementia, who didn't know to get out of the way, is not homicide and is not an incident requiring substantive investigation or consideration. And our research looking at what people in the workplace consider is it's either normalised and accepted, or it is at the other –

other end of the spectrum. In terms of needing to define resident to resident aggression, people have a different tolerance about what they consider to be aggression, and the – and I think you've only got to look at the changes to corporal punishment for children as to how society has reflected and changed its view about what is abuse or aggression. And so if one resident shouts at another, is that aggression or do you need to physically lay hands or do you need to physically lay hands and cause damage?

You start to open up a whole lot of interpretation and so you can't compare one site to another, you can't compare one year to another unless you've got a clear defined – and we come back to this measurement – metric, because the world doesn't – the world does make decisions based on opinion but every time I've ever been involved, it's always well, where is the evidence to do this, and so to get sufficient evidence about the nature of resident to resident aggression we need far better definitions. It was in a sense easy for us because the outcome is death and, again, we come back to I again challenge anyone to come and contest that this wasn't a serious outcome. If I had looked at resident to resident aggression more broadly and had come up with the statistics that have occurred in the States where it might be as much as one in five residents are subject to some form of resident to resident aggression, people would have howled me down saying that's not the case.

MR BOLSTER: Just pausing there, there's legislative reporting requirements in the Commonwealth system for both physical assaults and sexual assaults. What happens with that data?

PROF IBRAHIM: I don't know. I've asked for the last two years and I've not heard an answer that would satisfy me as a citizen, let alone as a researcher. I – I – all I know is what is in the annual reporting requirements the Department has to do according to legislation, and they provide a one paragraph summary saying the number of incidents that have occurred. There's no state breakdown. There's no breakdown of nature. There's no breakdown, whether it's resident or staff perpetrated. There's no explanation as to whether they've used that data or fed it back. There's – I don't know. I would happily analyse that data for free if it was provided to our team.

MR BOLSTER: There are also carve-outs for reporting in the case of people who have a cognitive impairment. How useful is that when it comes to identifying the extent of this problem?

PROF IBRAHIM: Well, I think carve-out is the wrong term. So it's not – it would be better to say carved in. The only thing that's carved in, is if you've got someone that's cognitively intact and given that two-thirds of the residents have some form of cognitive impairment, that eliminates two-thirds of the population already. Then the onus is on the provider because the responsibility sits with the provider to report so there's not an obligation there. You then have interpretation of the staff about your willingness to report and if you report an incident, are you going to be rewarded for reporting it, or are you going to be faced with two or three days of work, and then

complaints about what you're doing which means it's going to be underreported. So the system does not work. The exclusion for people with dementia makes no sense because the people with dementia are the ones at the greatest risk, and so we set up a system which is not accountable to anyone.

So there has been no accounting by the Department of what they've done with that data for 10 years now, and no one seems interested in that fact. And so we're not using that data. We've carved in only for people with cognitive – who are cognitively intact. For staff that have the guts to report is what comes through. And so I, you know, it doesn't work for me.

MR BOLSTER: Leaving aside the reporting, your recommendations seem to focus on staffing-related issues and adequacy of staff to manage people with a predisposition towards aggression.

PROF IBRAHIM: Yes.

MR BOLSTER: Could you elaborate on that, please.

PROF IBRAHIM: So again I come back to the – we look at resident to resident aggression leading to death because we actually wanted to understand what was the care being provided to people with dementia. So that's our window into it. What we know from the experts and what we know from other research is that staff that are unable to recognise, unable to manage residents with dementia, potentially will often escalate situations. Telling someone with dementia who is lost, confused, and unable to process information to settle down, go somewhere, or behave does not work. It's not how you approach someone who is cognitively impaired. Staff are usually time pressured. The ability to manage someone with dementia requires a certain level of education and training which I don't believe exists in the personal care workforce, and probably doesn't exist even with the nursing staff and doesn't exist within the medical staff.

It's not – you don't qualify in medicine and nursing and suddenly you know how to manage someone with dementia. Your degree doesn't provide you that level of skill. And so it's not unusual for a difficult situation to have emotion met with emotion which escalates the situation, and gets a hell of a lot worse.

MR BOLSTER: The related topic of sexual assault was not the subject of your coronial research.

PROF IBRAHIM: No.

MR BOLSTER: But in your statement you've dealt with that.

PROF IBRAHIM: Yes.

MR BOLSTER: Could you indicate to the Commission what the particular issues are in that area, and how they could potentially be addressed?

PROF IBRAHIM: So the issues – so sexual assault was particularly challenging work and we were fortunate that Daisy Smith really wanted to look into that and she led that work for us. Sexual assault is hidden, generally, in the community. It's hidden in institutions and it is invisible in residential aged care. No one wants to believe it occurs because no one actually wants to believe that anyone over 30 has sex, let alone anyone over the age of 80 would do that. So people don't even comprehend that sexual assault could occur because they don't even complicate that you could be – sexuality occurs in older age. We then have confusion about who do you report – what is it, who do you report to, what is done with it, and when the reports are made, the police rarely proceed with it because you end up possibly with two people with dementia, or the person with dementia who's concerned about a staff member asked is this behaviour normal or unusual for them, and they will say well, when they're particularly distressed they will behave that way but they usually settle, trying to identify the incident.

So it's rare that anything is reported, unless it's an eyewitness account which is again undeniable, and we think the level of sexual assault that was reported in Victoria to the clinical forensic medicine team over essentially 10 years was less than 30 cases, and it's really difficult to comprehend that there would only be 30 instances over that period of time.

MR BOLSTER: Is there international research on this?

PROF IBRAHIM: The international research mostly comes out of the States and again it's all very, very thin because it's not a subject area that (a) people want to fund because, as I said, I haven't met an organisation yet that will stand behind us and say we are proud to sponsor or support research into sexual assault in residential aged care. The nature of the work is highly difficult to proceed through ethics to get consent to do any of that research, and the trauma suffered by the people involved is horrific. So it is – it is largely – it remains hidden.

MR BOLSTER: I wanted to turn then to the topic of physical restraint which you deal with at paragraph 180 of your report, and at some detail, commencing at page 116 of the 2017 recommendations. You have a perspective on what constitutes physical restraint that suggests that it should be viewed as a broader concept than it is traditionally viewed by, for example, the quality principles. Could you expand on what you mean by physical restraint?

PROF IBRAHIM: So physical restraint has got a number of definitions internationally and I think that the Europeans would consider restraint as denying people free access or ability to move out of a room. In Australia, we've tended to look at physical restraint as where it's clear that you've been shackled or tied down. We would be tending more towards the view that restraint is restraint of movement which you don't have to be shackled. It's just that if I'm locked into a facility I

would consider that a form of restraint personally, and I think that if we're going to respect choice, respect people, then we need to be addressing that whole idea about locked doors and why are they locked. So the use of restraints generally is sadly still widely accepted, though people will all react abhorrently when they hear it but it's still used.

And this is where you say, well, we're not walking the talk about eliminating restraints and lap restraint belts is still restraint. There is no evidence I'm aware of – and I'm happy to be proven wrong – that physical restraints improve your life or protect you from anything. The problem with talking about physical restraint is that the information that the public, the courts, the clinicians are most exposed to are the ice-addicted people that turn up to emergency department and hurt staff and others. A 90-year-old grandma that's five foot three that's a bit upset is not likely to come at you and hurt you substantially, and justification for restraining that person, which usually makes their condition worse, makes no sense. It's disrespectful and really ought not be allowed.

When we say, and as I've said, the only possible justification is if there's an imminent threat to life that you might restrain someone. The protections around restraint are so dismal that it allows people to be restrained for prolonged periods of time and they get forgotten. The person gives up. It's not – it's not – they don't accept the restraint. You give up. And what can you fight? And it just – it beggars belief that it still goes on in aged care.

MR BOLSTER: Is there any data available about the prevalence of it?

PROF IBRAHIM: So the Victorian State Department has been collecting data around physical restraint use, I think, since 2006 from when we worked with them on developing quality indicators. I understand that the Federal Government has mandated the collection of restraint data as of the first – 1 July. The Department must have access to two – well, the Department has stated publicly that 210 facilities provide data on their pilot set of indicators, which includes physical restraint. I would, therefore, ask you to ask the Department what the rates are being reported.

MR BOLSTER: That's not published?

PROF IBRAHIM: Not published that I can access, no.

MR BOLSTER: Are there other jurisdictions where restraint data, both chemical and physical, is regularly published, and is there a policy imperative that that occur?

PROF IBRAHIM: For aged care I'm not aware of. I think that internationally I've not looked at the area. Chemical restraints is vexed because of the nature of those assessments. Physical restraint I think is far easier to count and observe. When we did our evaluation of physical restraint, what we found in Victoria was the – how people interpreted the definition was quite broad, and so people didn't consider it restraint if you put a seatbelt on someone to stop them falling because you were

doing something safe. What they considered restraint was when you were stopping them from hurting themselves. And so you have again this whole issue of interpretation.

The need for restraint is – is not – is a desperate measure. So good people end up using restraint in care and there are – and as a junior doctor, I would have prescribed restraints as part of my training. It would have been the norm in the eighties and nineties.

MR BOLSTER: What's the position now? What are medical students told about it now?

PROF IBRAHIM: In general, so any medical students, I would say it's just not allowed.

MR BOLSTER: Is there a clinical standard about it?

PROF IBRAHIM: I – there are position statements on it. I'm not aware of what the medical schools teach. They rarely teach much about aged care and I doubt they would go into physical restraint. The use of physical restraint means that you've not sufficiently examined, worked up the resident with sufficient help from other health professionals to work out why that person is agitated or distressed for you to initiate restraint.

MR BOLSTER: What's your response to the recent Quality of Care Amendment Principles?

PROF IBRAHIM: So I – like all things, I conditionally support the idea that there is a public statement that says physical restraint should not be used. The requirements don't go anywhere near far enough, and I've used the example here of making a law does not change people's behaviour. So I have spent my career saying people should stop smoking and exercise and eat well. And I've not followed that advice for myself. People know the road rules about drink driving, wearing a seatbelt. Laws only change behaviour if you enforce them, and you enforce them with sanctions or rewards that sufficiently motivate behaviour change. Having a statement saying physical restraint is banned and not providing training, resources, a way of enforcing and sanctions for it, means it's going to be next to useless and they might as well never have said it.

MR BOLSTER: Can we turn then to - - -

PROF IBRAHIM: But it's a good thing that it's on the public record.

MR BOLSTER: Thank you. Could we turn to the issue of respite care, which you mentioned in passing earlier. It would appear from the statistics and from your report that respite care can be a dangerous option for people, but at the same time

there's a tension with providing the respite that the carers who live with the person require. How do you reconcile the two issues?

PROF IBRAHIM: This one caught us by surprise and it has been our hardest subject area to get published. Every time that we've sent our research people have – so these are academic reviewers will come back and criticise us for saying that respite is dangerous, how dare we, it's not possible that it could be dangerous. If you stop and think about it, even for a little bit, respite care is for the carer, not for the person who is in respite. So respite care is to help the carer, and it's really important we have strategies to help the carer because over 50 per cent of carers have either physical or mental health issues related to the burden of caring. So very important that they're looked after.

But if I take a person from their home, from their loved one who knows them intimately, knows their habits, their likes and dislikes, they know the layout of the house, they know where the step is, they know where the lights are, they know where the toilet is, they know when to take their medicines, and I take them to a strange new place where there is noise and people I don't know who say things in ways I don't know, with a layout I don't understand, with no indication where the toilet is, who aren't giving me my medicines on time or the way that I normally like it, it should be no surprise that I will slip or fall or become incontinent or become distressed or want to leave.

And while it's perfectly okay to talk about transitions of care in health and how dangerous they are, and the need for handover and better communication, for some reason talking about transitions of care in aged care have brought out almost the worst aspects or criticisms of our work, when what we were trying to say, because we knew anecdotally that the sector treated respite residents differently to the permanent ones, and so the workup for respite residents was nowhere near the level of detail or comprehensiveness of the regular residents, that harm is likely to occur. And so, no surprise, we found the people that go to respite care fall more than ones in permanent care. And it makes perfect sense.

MR BOLSTER: Isn't it just a subset of the transitions in care that you refer to that are always dangerous? Going to hospital is dangerous. Coming back from hospital can be dangerous.

PROF IBRAHIM: Yes. The difference is is that in health care people are aware of and are trying to do something to reduce the risk. That has not been occurring in aged care.

MR BOLSTER: If we could go to page 144 of the recommendations, in broad terms, your recommendations deal with, effectively, preparing for respite in some form of pre-respite admission process. That's assessment.

PROF IBRAHIM: Yes.

MR BOLSTER: Could you expand on that.

PROF IBRAHIM: So I think, knowing that there are risks, there are ways to pre-plan. So, "Do we know – how well do we know the residents or person coming in? Have we actually listened to the family?" And we had one case report where the loved one – the staff at the facility did not listen to the information that was conveyed by the carer about how to care for their loved one, which then led to catastrophic consequences. People that go into respite care have left, because no one has known that they weren't supposed to leave, and subsequently died. Pre – so planning means that you've identified the risks, you understand the person and you set up to receive them. It's not very complicated. But we're not doing that set of work.

MR BOLSTER: A lot of times we hear that the respite admission can be a form of test driving the facility with a view to going there on a permanent basis.

PROF IBRAHIM: Yes.

MR BOLSTER: Is that a useful way of approaching a care in transition – care transition into a nursing home?

PROF IBRAHIM: In part it is. I think that respite is a try before you buy. So I think it's important for some people to experience what residential care is like. And we ask – the patients I am involved with will ask them sometimes to try residential care, because sometimes it's not as – you know, for all the bad things I've said today, it's not as awful as some people think and it does meet the needs of a certain group. And if you're going to give up your home, then I would usually say, "Well, go to respite for two weeks and see, is – will it deliver what it is that you want and need?" And if it does and it's a better option, then take that.

But it – so in terms of try before you buy, it does – it does have some merit. In terms of how we manage it, we should be able to manage it better, because we've spent twenty – 20 years now talking about handovers or transitions of care in health. They're doing transitions in surgery. We know the basic principles, which is pre-planning, having the approach when the person is there, and having the approach when they leave. They're not complicated ideas. It's the execution where we're falling down in.

MR BOLSTER: Yes. You point to the – a desirability of having some form of central electronic system to manage patient records as a means of ensuring that the facility has the information they need, presumably from the GP. To what extent is that sort of system in operation in this country?

PROF IBRAHIM: I'm really not that well equipped to talk about it. The whole idea of electronic medical records I find incredibly frustrating, as they were advertised as the panacea in the 1960s and they still haven't arrived. There are substantial problems with accessing electronic records, because of proprietary ownership, the

ability to link the GPs with the hospitals, with the facility, with the pharmacy. And so you end up with this idea – and, again, the recommendations are from the expert panel, not my own. So I'm tied with it would be fabulous to have one system. The likelihood of achieving that I think is really very complicated.

MR BOLSTER: All right.

PROF IBRAHIM: But there is no reason why you can't have a passport or some document that picks out the three or five high risk areas to do with medication, behaviour or needs to be communicated consistently.

MR BOLSTER: In respite, what's the difference that you put forward as likely to make a difference?

PROF IBRAHIM: Well, I think it's the approach. It's the orientation of the residents and being able to take more time with them, in the same way that people take time with a permanent residents. I think this goes to human nature about – we invest in the person that's going to be living with us for a year and the person that's dropping in for the night, we roll out the couch and say, "Here's a blanket. Have a sleep. And you're gone in the morning." The effort that we put in is substantially different.

MR BOLSTER: And your perspective is it should be no different from the permanent transition?

PROF IBRAHIM: Well, if the permanent – well, the first question is why should it be different? And no one can give me a reason that it should be different, because you're looking after a – you've got to provide care to a person. I don't know why it should be different. The care going to hospital is no different in terms of the procedures or the information you've got to gather, whether you're there for a day, a week or a month.

MR BOLSTER: I want to turn then to the last aspect of your recommendations that I wanted to cover today. And that is the term "unexplained absences". What's wrong with the term "wandering"?

PROF IBRAHIM: Well, wandering is pejorative, as are elopement, as are escaping, or as are running away. Unexplained absence goes to the question is that, "We don't know why that person has left." Wandering suggests that it's purposeless activity. And that may not be the case. And there's a huge debate about whether people actually wander or "I am lost and looking for a way and, just because I'm not doing it systematically, I'm now wandering."

The people want to go outside for a whole lot of reasons and I think everyone here will want to leave the building at some stage. So it's no surprise that an older person wants to leave the building to get some fresh air. Some people want to go back home. Some people want to go outside. Some people have lost their way looking

for something else. Unexplained absence is the best use of term, and it took me a year to get used to that, because we used to always say that they had left without consent. Discharged at own risk. So unexplained absence is simply a statement that we do not know why this person is not here, and that we need to understand how that came about, and work backwards from there.

MR BOLSTER: And, the response, what should be the response to the unexplained absence?

PROF IBRAHIM: After it has occurred?

MR BOLSTER: Yes. Well, is it something that ought to be stopped or controlled?

PROF IBRAHIM: So the reason we looked at unexplained absences was I was arguing for an open door policy in residential aged care. And so the debate about having an open door policy is that there's two things: that everyone will suddenly leave and die from exposure or all the criminal elements in our society are now going to flock to residential aged care to make their nefarious living. Neither is true. 20 people over a decade died from an unexplained absence.

So I still can't – so you can either use that to say the existing system is wonderful and that's why so few people have died or we say it seems to me very few people die when they leave, because most of the community, and I don't know the crime rate in Australia, but in Japan it's under three per cent, I guess our crime rate is not much that higher. But 95 out of 100 people in our country are likely to help an old person if they are lost and are seeking help. And I would say that's the reason most people, when they leave a facility, make it back safely. The small number that don't is usually due to late notification, a failure in terms of a search strategy.

And one of our arguments here is a national database would have saved enormous time and energy for the – you go back for the resident who left, their family, the staff that were distressed, the police that were called out, the air search and rescue, if they were involved, the coroner to investigate the death. And it is not very difficult to develop a policy and strategy that is universally applicable to every residential facility about how to approach an unexplained absence, what the role of the police should be and how we reduce the callouts, save money, get better care and actually provide residents with the opportunity to go out in a way that they don't feel the need to escape or run away.

MR BOLSTER: Well, what would that strategy involve?

PROF IBRAHIM: Well, you go back to this whole issue of dignity of risk is, "Well, if I don't have to argue with you to go out," and you say "Fine, I trust you to go out" and "maybe I just want to go out to the front door, maybe I just want to go out to the bounds of the – the boundary of the place. If I tell you and you support me going out, then we've got a plan and we know what's going on.-" Otherwise, I'm back to the days of, you know, a 15, 16-year-old saying well, sure Dad, I will be home

tonight, I'm just studying really hard and be quiet and then nick out the window. It's – it just makes no sense not to have a policy that allows people freedom of movement.

MR BOLSTER: Does that apply to the entire cohort in the nursing home? What about the dementia resident?

PROF IBRAHIM: So I'm aware of some facilities that are able to manage that with dementia, because most of the time we react to our fears, not to reality. So we think that everyone with dementia suddenly is going to go outside. Most people spend their time indoors anyway. Not a whole lot of people rush out. If you're able to organise structured activities to take people out, maybe they don't want to go out. And maybe it's just really about having the choice and freedom that you could go out if you wanted to. Because, again, I come back, "I know I can leave, so I'm not fretting about 'can I or can I not'".

And so people with dementia are still people. And the question then is what do you prefer is, "I am locked, secure in a 20 bed facility with 19 other people with dementia who I'm struggling to communicate with because we're all in – each in our own world", versus, "If the door is open and I can work with others or share time with others, that might help me, or the fact I see daylight means I'm less agitated or I go for a walk means I'm less agitated." I don't know, but it's a quality of life issue.

And at the moment if you say to me, "What would I rather?" I would rather people died going out for a walk than remain safe forever till they die. Because that's what we're doing, saying, "Stay here till you die nicely so it doesn't bother me. I open the door and something goes wrong, then it's my fault and I've got to be accountable to someone and I find it really difficult to be accountable and I don't want to have to defend my actions to anyone, so please do me a favour. Everyone just stay in this room and I'm going to go off and enjoy my life, but it's of no concern how you spend the rest of your days, knowing that your life is finite."

MR BOLSTER: I've heard you use this phrase about residents as being stateless.

PROF IBRAHIM: Yes.

MR BOLSTER: What do you mean by that?

PROF IBRAHIM: Well, I sometimes like to be provocative. Sometimes it's the truth. And for me, at the end of the day, it's the truth that residents are stateless. The federal – I'm not going to go federal, because it's evidence government ..... Parliament does not care about people in residential aged care. If they truly care, they would do something, or they would at least say something. They don't say anything, they don't act. They've had God knows – you know how many reports they've had. There have been 20 plus reports on the state of the sector and we now have the Royal Commission, which I don't think we needed, but we've got it and so hopefully someone will listen, but the gallery is sparse so we've not got the same

attraction as money in the banks. Stateless because Federal Parliament doesn't care. They're citizens of the state but the state doesn't provide care because the Federal Government is supposed to. The Federal Government doesn't provide care because the states are supposed to. Clinical care is the hospital run by the state, not by federal. GPs, paid through the federal department, clinical care in the Act is the responsibility of the provider. Provider has no responsibility over the clinicians. The clinicians who provide the care have no obligation to the provider.

I – where do I go if I have a complaint, and it's now centralised so I go to one place. Where do I go if I want to appeal? I only have civil courts. If I go to civil courts in Australia will I get a hearing? I won't because I'm not working, I haven't suffered enough and we don't have any sort of penalties that mirror the US. So I am left with my daughter, and sadly I don't have a daughter – important to have a daughter if you're going to get old – really important because they at least look after you. What we end up with is a daughter making a complaint and being typecast as vexatious, a troublemaker who isn't coping with the disability or her mum nearing end of life. And so they are discounted, and there is no one left for the residents who, as I said earlier, 80 to 90-year-old woman who had a hard time, sacrificed her life for the betterment of everyone else, and is still doing it and no one seems to give a toss.

MR BOLSTER: You wanted to raise with the Commission a sketch. If we could bring up RCD.9999.0059.0001. This is a still from a film that you have produced on the concept of dignity of risk; correct?

PROF IBRAHIM: Yes, it's an extra sketch that Jeremy has mocked up for us in the, I guess, last week when we've been talking about the debate between paternalism and, really, autonomy. As I said, my conversations with people not in medical practice, and particularly legal, has framed it that for all of my efforts to be proactive and helping to educate around providing choice, all I've done is really consolidate the idea of paternalism because I didn't approach the issue that it doesn't matter what I think about what you want to do, if that's what you want to do and you're capable of doing it and it doesn't hurt me, I have no right to stand in your way.

Whereas what I've been trying to encourage staff generally to do is how do you make older people happy in their last years of life? How do you balance the risk with the potential benefits that we need to understand the values of older people? I still hold to those but that remains paternalistic because I'm still, and this is where, you know, for eight years I've been arguing it and it didn't click until probably a month ago, I'm still paternalistic in my approach, and so if we're going to get anywhere we've got to confront the reality of an older person in residential care with dementia and multiple disabilities who requires help to get through the day is still a person who has rights and they have the right to choose what they want to do, and they don't need to justify it to anyone. Our responsibility is to be reasonable in supporting them for their wish.

MR BOLSTER: Is there anything that you want to explain about the drawing, so that it has the – has that meaning?

PROF IBRAHIM: Well, I was hoping, actually now that we've seen it, I'm going to need the complementary one which is the other way which would actually probably be the resident with me in their lap telling me that, you know, I'm a grown-up and I can make my own decisions. I think really that the argument here is that – we don't talk about paternalism or autonomy, we end up talking about duty of care and choice. Or duty of care and risk. And then we mash it and then call it choice and it's a balanced choice that we will discuss together. But as we change each layer we lose the sight that the paternalistic approach through the medical, nursing and, really, the whole aged care sector overwhelms any ability of a single resident to be able to exercise their wish as a person. And that we will argue, and I can argue any which way around a duty of care to say I will protect the duty of care and my duty of care is protecting myself first, not the resident.

And then if I'm protecting the resident, then my duty of care is both to their physical wellbeing, but I also have a duty of care which isn't clearly listed to respect their autonomy. And every time we talk about duty of care we talk about it as if it's one-sided. It's the duty of care of the professional to behaviour professionally. Whereas the duty of care of a professional is to fulfil their professional responsibilities and their duty of care to the human rights of the person that they're involved with, which means we ought to be supporting residents to be – their autonomy.

MR BOLSTER: I have no further questions, Commissioners.

COMMISSIONER TRACEY: Professor, you, if I may say so, with respect, have enormous learning and empathy in relation to the care of the elderly. Given the demographics that we're confronting in this country, we're going to need dozens if not hundreds of people with your skills and knowledge to care for them. Can you give us some appreciation of what training programs within your specialty are currently in operation and your view as to whether they're going to be adequate to produce a skilled group of geriatricians who can look after the ageing generation in the decades to come?

PROF IBRAHIM: Firstly, my wife would be horrified to think there would be 100 people like me anywhere. The current – currently we're not prepared. Not just ill prepared, we're not prepared. So the training for specialist in geriatric medicine rarely involves any attachments or work in residential aged care. The volume of people coming through medically are essentially being absorbed into the acute health system in providing care, acute care of older people, or into the community. There are substantive, I think, barriers to practicing in residential aged care because it's a foreign environment to what doctors normally work in, in terms of medical practice I think now is so specialised that you're lost if you don't have people around you. And the supports that are provided in terms of practice in a hospital make it difficult in residential aged care. The structures of residential aged care are such that they're not well prepared to receive doctors.

I also think that doctors are not the best – I don't think doctors are necessarily the best clinical specialty for residential aged care. A lot of the issues that we currently

face require non-pharmacological techniques, so particularly for dementia which would be better applied through nurse practitioners, rather than medical specialists. If you look at some of the models in America, having a medical director in terms of supporting the standards, training and being a source of expert knowledge for difficult cases would be the model I prefer. What we need is more cross-training in aged care for the allied health side, speech pathologists, physiotherapist, occupational therapist. The people that make a difference to a person's life are in allied health.

The people that speak best with the larger part of the workforce would be nurse practitioners who understand the nature of a nurse's work and how to fit that in. Doctors have a clear role that is currently, I don't think, being met or we're not servicing very well at all. And that's really about taking a stand around what treatment is therapeutic and what's not, and about arguing the case for what's needed. And we have been poor advocates compared to oncologists, to mental health, to almost any other specialty in terms of resourcing for the population that they look after. You know, the – my biggest disappointment was when we had the workforce shortages, I think 15 years ago, across the country. We simply opened more medical and nursing schools instead of exploring the idea of new types of clinicians that have the overlap skills to meet the population needs.

I forgive – not that anyone is asking for my forgiveness – the current situation to a degree because it's the first time in our history that we've had such an older population with multiple diseases that are predominantly chronic, and the move to being patient-centred and having far more partnerships in decision-making is not how our health system was set up or configured, and our health system is back in still, I think, the 1970s, looking to treat young – to cure young people of diseases that we no longer have. And so we've not moved with the times.

And as I always say, that if we do nothing, then the people that will pay the penalty is everyone in this room. And so if no one wants to do anything, then the system that we accept now is what awaits us, and if I'm around long enough I will come around and say "I told you so".

COMMISSIONER TRACEY: You may be very conscious that we are concerned about those issues, and there is always an element of self-interest involved.

PROF IBRAHIM: Yes. As one of the Coroners told me, in a race it's always the horse called self-interest that wins. I think that – I think one of the biggest issues is there – and our work, so not sounding to boast, our work has got international standing very quickly, and I like to say that's because we did a good job, but the reality is that it has international standing really quickly because no one has been doing any work in the area, and that if we don't have that sense of inquiry in research and that sense of inquiry in residential aged care facilities, then nothing changes and hospitals work because there are multiple disciplines who challenge and question each other.

One RN in a facility looking after 30 residents with five PCAs is not likely to be challenged and that – that registered nurse has got nowhere to look for – to calibrate, test ideas or determine whether what they're doing is or is not contemporary. And so residential aged care, despite there being 200,000 people in care, are really highly isolated small areas of practice, and very hard there for that group to generate change internally, especially if they're not equipped or resourced or have been empowered to speak up. And I – and I think that having a predominantly female nursing workforce who look to solve problems and make do means that people – that they don't get the support they need or the support that they deserve.

If you go to a – if it was a group of doctors, the AMA would be banging on about the need for resources, more pay for doctors, more – more resources for residents, and the situation is not good enough. When the ANF say the same thing, they're predominantly met with silence. And if it wasn't for – if it wasn't for the nurses in the aged care system and the people there now, the whole thing would just be just a complete catastrophe. You know, as bad as I've painted it, the people working in there are good, well-meaning folk who aren't able to do the job that should be done, and aren't doing the job that we've got the contemporary knowledge for. And so if they walk away I'm not quite sure what we would be left with. But things are not good enough and it's not acceptable the way it is now.

COMMISSIONER TRACEY: Thank you very much for sharing your views with us. They have been registered and we will take them into account when we come to make our recommendations, but you can be assured that we are very conscious of the concerns that you have expressed, and the need to have something done about them.

PROF IBRAHIM: Thank you.

COMMISSIONER TRACEY: Thank you for your attendance.

<THE WITNESS WITHDREW [11.55 am]

COMMISSIONER TRACEY: The Commission will adjourn until 12.15.

ADJOURNED [11.55 am]

RESUMED [12.15 pm]

MR BOLSTER: Commissioners, if I could just attend to the tender of some of the documents that were shown to Professor Ibrahim.

COMMISSIONER TRACEY: Yes.

MR BOLSTER: The first of those is RCD.9999.0063.0145. That is the Victorian Institute of Forensic Medicine, Recommendations for Prevention of Injury-related Deaths in Residential Aged Care Services, dated 2017. I tender that.

COMMISSIONER TRACEY: The Victorian Institute of Forensic Medicine's document entitled Recommendations for Prevention of Injury-related Deaths in Residential Aged Care Services, dated 2017, will be exhibit 3-71.

EXHIBIT #3-71 THE VICTORIAN INSTITUTE OF FORENSIC MEDICINE'S DOCUMENT ENTITLED RECOMMENDATIONS FOR PREVENTION OF INJURY-RELATED DEATHS IN RESIDENTIAL AGED CARE SERVICES DATED 2017 (RCD.9999.0063.0145)

MR BOLSTER: Next, the article published in the Medical Journal of Australia in June 2017 by Professor Ibrahim and others, entitled Premature Deaths of Nursing Home Residents, an Epidemiological Analysis. I tender that.

COMMISSIONER TRACEY: Yes. The Medical Journal of Australia article entitled Premature Deaths of Nursing Home Residents, an Epidemiological Analysis – what was the date?

MR BOLSTER: June – 5 June 2017.

COMMISSIONER TRACEY: Dated 5 June 2017 will be exhibit 3-72.

EXHIBIT #3-72 THE MEDICAL JOURNAL OF AUSTRALIA ARTICLE ENTITLED PREMATURE DEATHS OF NURSING HOME RESIDENTS, AN EPIDEMIOLOGICAL ANALYSIS DATED 03/06/2017

MR BOLSTER: Volume 11, issue 4 of the Journal Communique, published in January 2017. That's RCD.9999.0063.0137. I tender that.

COMMISSIONER TRACEY: The Victorian Institute of Forensic Medicine article – or publication, rather, entitled Residential Aged Care Communique, volume 11, issue 4, dated January 2017, will be exhibit 3-73.

EXHIBIT #3-73 VICTORIAN INSTITUTE OF FORENSIC MEDICINE PUBLICATION ENTITLED RESIDENTIAL AGED CARE COMMUNIQUE, VOLUME 11, ISSUE 4 DATED 01/2017 (RCD.9999.0063.0137)

MR BOLSTER: And, finally, the undated sketch diagram, which is RCD.9999.0059.0001. I tender that.

COMMISSIONER TRACEY: Yes. The cartoon bearing that identifier will be exhibit 3-74.

EXHIBIT #3-74 SKETCH DIAGRAM (RCD.9999.0059.0001)

MR BOLSTER: Thank you, Commissioners.

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. We now move to the evidence of three Commonwealth witnesses. Firstly, I call Christina Mary Bolger, who I understand is already in the witness box.

<CHRISTINA MARY BOLGER, SWORN [12.19 pm]

<EXAMINATION BY MR GRAY

MR GRAY: What is your full name?

MS BOLGER: Christina Mary Bolger.

MR GRAY: I will the ask operator to bring up WIT.0106.0001.0001. Is that a statement you've made for the Royal Commission? Do you wish to track to the last page to see your signature? Operator – thank you.

MS BOLGER: It is.

MR GRAY: Thank you. And that's a statement you've made for the Royal Commission dated 18 April 2019?

MS BOLGER: That is correct.

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

MS BOLGER: I do not.

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

MS BOLGER: That is right.

MR GRAY: They are?

MS BOLGER: Yes.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The statement of Christina Bolger, dated 18 April 2019, will be exhibit 3-75.

EXHIBIT #3-75 STATEMENT OF CHRISTINA BOLGER DATED 18/04/2019 (WIT.0106.0001.0001)

MR GRAY: Thank you, Commissioner.

Ms Bolger, you are the executive director, regulatory policy and performance at the Aged Care Quality and Safety Commission; is that right?

MS BOLGER: Yes.

MR GRAY: And previously, before the commencement in operation of the Commission, you were at the Australian Aged Care Quality Agency; is that right?

MS BOLGER: Yes.

MR GRAY: And I want to ask you about a position of the Commission that you've noted at paragraph 34 of your affidavit. Paragraph 34 is on page 0009 at the foot of the page. You say there:

> *There has been a concern expressed by the Commission and by others nationally regarding the inappropriate use and overuse of restraint, particularly chemical restraints.*

And you refer there to other entities, including the Australian Commission on Safety And Quality in Health Care, in particular with reference to the third atlas of health care variation and also the AIHW. Is that reflective of a concern held within the Commission, that the Commission understands there to be an inappropriate use and overuse of restraint, particularly chemical restraints?

MS BOLGER: That is correct, yes.

MR GRAY: And do you personally share that institutional opinion of the Commission?

MS BOLGER: I do.

MR GRAY: And what do you base that on?

MS BOLGER: The evidence that's of – been available for the Commission in relation to, not only the atlas of health variation which has highlighted this as an issue for people over 65 generally in the population. But it was also brought to the attention of the Aged Care Quality Agency, the previous entity, through findings following the Oakden inquiry and the Carnell Patterson review of aged care regulatory processes.

MR GRAY: Thank you. And where you refer there to chemical restraints, are you referring to the whole family of anxiolytics, being benzodiazepines, on the one hand; antipsychotics, on the other; and a third family of antidepressants, or just the first two?

MS BOLGER: Psychotropic medication.

MR GRAY: Generally.

MS BOLGER: The general category, yes.

MR GRAY: I want to ask you about a topic you've mentioned in two places in your statement, at paragraph 9 and paragraph 85, which is risk profiling and the risk-based approach to the Commission's work. A little bit of context. The Commission – the Commission, that is, the Aged Care Quality and Safety Commission, has a role of assessing the compliance of residential aged care providers against the accreditation standards currently. That's so, isn't it?

MS BOLGER: That's correct.

MR GRAY: And those accreditation standards, as of 1 July this year, are going to be replaced with a single quality framework?

MS BOLGER: Yes.

MR GRAY: And, at the same time, is it the case that there will also be amendment of the quality of care principles to include two provisions related to the regulation of the use of restrictive practices?

MS BOLGER: Yes.

MR GRAY: Now, it's currently, and will be for the rest of the year, the Commission, that is the Aged Care Quality and Safety Commission's, task to continue to assess approved providers of residential aged care against the standards, meaning the single quality framework; is that right?

MS BOLGER: The accreditation standards.

MR GRAY: Yes. And, after July, those standards will be constituted by the single quality framework?

MS BOLGER: Yes.

MR GRAY: And in that context, risk profiling is the approach that the Commission is attempting to use when it undertakes its task of assessing compliance; is that right?

MS BOLGER: The term there, "risk profiling" is a broader one which we apply through understanding the performance of the sector as a whole, the performance and compliance of individual services at the sector, and also the profile of risk that might be relevant to particular consumers within the service.

MR GRAY: But it's an approach that the Commission is seeking to apply now and in the second half of the year - - -

MS BOLGER: Yes.

MR GRAY: - - - when the single quality framework will be in place?

MS BOLGER: Yes.

MR GRAY: And is that risk-profiling approach an approach that has been adopted by the Commission as a result of the Carnell and Paterson report?

MS BOLGER: The Commission's approach, yes, continues the work of the previous agency in response to those reports.

MR GRAY: Right. What's the detail of how risk profiling is done, with respect, and that is currently and projected into the second half of the year once we have the Single Quality Framework, what's the way in which risk profiling is done with respect to the risk of overuse of psychotropics?

MS BOLGER: So the risk profiling that's undertaken is primarily based on performance of the service, intelligence that we've received through either complaints, referrals from the Department or, indeed, members of the public and consumers of services, and that information is used to form a view of the relative risk at that service, and the profiling of that risk then informs both the frequency and the scope of our compliance monitoring of the service.

MR GRAY: When you say intelligence from the public, potentially staff and others, do you mean complaints?

MS BOLGER: Complaints are included, yes, but they are amongst other sources of information. We get direct calls from members of the public, calls from staff, and, of course, we're alert to other issues that arise through the media and public discourse.

MR GRAY: So the risk profiling, to the extent that it relies on the sources of information you've just mentioned, is reactive to those sources of information being received by the Aged Care Quality and Safety Commission; is that right?

MS BOLGER: Yes, reactive in terms of being responsive to those risks, yes.

MR GRAY: What about any proactive steps to gather data which is capable of being used for risk profiling in the absence of reports from third parties, such as the public, media and so on?

MS BOLGER: Yes. Not currently to the extent that it – we are aspiring to. There is a measure which is in development which is a more sophisticated risk-profiling instrument that pieces in development with Department of Health and the Commission.

MR GRAY: And what is the state of progress of that instrument? Do we have any idea how long it will take before it is ready to be tested, say?

MS BOLGER: There is a pilot test that has been undertaken by the Department, and we understand that there's a prototype that will be available for further testing before the end of the financial year – sorry, before the end of the calendar year.

MR GRAY: When will it be possible to evaluate that instrument to determine whether it can be rolled out?

MS BOLGER: I think the testing for that will occur early next year, 2020.

MR GRAY: Can you tell the Royal Commission the name of that instrument? If you can't – if it's - - -

MS BOLGER: I don't think we - - -

MR GRAY: - - - public interest immunity or something like that, say so, but if you're able - - -

MS BOLGER: I think we're just currently calling it currently the risk profiling.

MR GRAY: Risk-profiling instrument?

MS BOLGER: Yes.

MR GRAY: What's currently being done with specific reference to trying to calibrate the degree of risk that a particular approved provider presents on the particular topic of overuse or potential overuse of psychotropics?

MS BOLGER: I think the evidence that is collected on-site through our assessment contacts and our compliance monitoring is giving us a real line of sight to the nature of the problem, particularly in areas of compliance with behaviour management and medication management. Those are two areas that the Commission is aware that there is increased findings of noncompliance. They are two of the top five areas of noncompliance out of the accreditation standards as a whole.

MR GRAY: Are there increased levels of noncompliance, did you say?

MS BOLGER: That is correct.

MR GRAY: Is that because the Commission, that is, the Aged Care Quality and Safety Commission, is now taking a stricter approach to what amounts to compliance in those areas than was previously the case under, say, the agency's watch?

MS BOLGER: No, I think we've become better at detecting noncompliance. There are a few reasons for that. One being the shift in July 2018 to unannounced re-accreditation audits. All re-accreditation audits are now unannounced, which means that the providers have no notice of the day that the quality assessment team will arrive, and I think that that has led to a stronger observance of care in practice on any given day, and that has led to increased findings of noncompliance across a number of areas.

MR GRAY: In its February hearing, the Royal Commission heard evidence that, in fact, findings of noncompliance and serious risk had increased before the commencement of unannounced visits in the financial year 2017/18 when compared to the preceding two financial years. That suggests that something else is affecting the rates of those findings in 2017/18. Do you know what that something else might be?

MS BOLGER: In 2017, we also introduced as part of our compliance monitoring a focus on the areas of greatest risk of potential harm to consumers, and they included areas such as medication management, behaviour management, pain management and so on. And that has meant that the scope of our assessment contacts have focused on areas of risk and as a consequence rates of findings of noncompliance have increased.

MR GRAY: I asked you about what's currently being done that informs risk profiling with respect to psychotropics, and you referred to information collected on the site, particularly in the areas of behaviour management and medication management. Isn't risk profiling a step that one takes in order to determine who are the targets of heightened scrutiny? But you're saying the evidence that is currently being used to assist that process is actually dependent on already being at the

premises, or being at the site of the target of scrutiny. Can you assist the Commissioners on that?

MS BOLGER: Yes, I can.

MR GRAY: It seems a little circular.

MS BOLGER: So the frequency of our compliance monitoring, that is a form of compliance surveillance, if you like. The assessment contact isn't a full audit. It is a – an unannounced visit to the service, but it would determine the level of action that the Commission takes where we have reasonable grounds to believe that the service is not meeting the standards which would then escalate to a full audit. So it's a proportionate regulatory oversight to help determine a level of risk. And as the Commission becomes more equipped with a broader range of data sources that are available, both in the Department of Health and elsewhere, that will help inform a risk profiling that can, you know, supplement and enhance our understanding of risk.

MR GRAY: I understand the latter part of what you've said which is aspirational, but with respect to the former part, are you saying that if the quality assessors, on either the site audit, review audit, or assessment contact, find evidence of concern with respect to behaviour management or medication management, say, then that results in a decision within the Commission, that is, the Aged Care Quality and Safety Commission, to up or increase the frequency of visits in the future to that site? Is that what happens?

MS BOLGER: It's not the only decision. It may be one of the decisions, but a decision to escalate to a review audit can have consequences in terms of determining the period of accreditation, varying that period or revoking it. And we also refer information to the Department of Health, where we understand that there may be non-compliance under the Aged Care Act and there are further actions available to the Department in terms of sanctions.

MR GRAY: If it's just the case that if material of – if information of concern about compliance with those expected outcomes is found during a visit, then a review audit might result. Isn't that the way it has always been at the agency? What's different about – it doesn't sound like a different risk profiling approach in the period after Carnell and Paterson, does it?

MS BOLGER: I would suggest that it is, because we're actually making better use of that information. And part of that is the use of the complaints data. And having integrated the complaints function into the Commission from 1 January this year has meant that we have stronger line of sight to the complaints information, which, again, is a form of intel for the Commission. Previously, the quality agency relied on referrals to the quality agency. And, whilst those referrals had been increasing, having that information available in a single entity is enhancing our risk – our understanding of risk.

MR GRAY: You referred to unannounced visits. Do they occur at night?

MS BOLGER: They can. The Commissioner has introduced one of the measures since – the commencement of the new Commission has been expanded our unannounced program. And there are now targeted visits that are happening at night and over the weekends, as well.

MR GRAY: Are you able to say what the proportions are of visits during business hours compared with visits at night or over the weekend?

MS BOLGER: I'm not able to give you those figures, although they can be made available.

MR GRAY: Just focusing again on this idea of a risk base or a risk profiling approach to determine the overuse of psychotropics, you say in paragraph 85 that the risk-based approach will be supported by mandatory compliance with the National Aged Care Quality Indicator Program. And you refer to one of the indicators currently in that program being physical restraint. And you say you understand this program will expand to collect two further clinical indicators, one of which is medication management. Do you have any knowledge of the content of the proposed indicator for medication management?

MS BOLGER: I don't have the detail of that, no.

MR GRAY: Do you know whether it will be directed to the purpose of revealing the overuse of psychotropics or will it be something else? Probably pharmacy, for example, or the frequency of reviews?

MS BOLGER: I believe that chemical restraint is in the scope for the new quality indicators.

MR GRAY: Has the Commission been – that is, has the Aged Care Quality and Safety Commission been consulted with a proposed scope for that – that proposed new indicator?

MS BOLGER: We've not got the detail of that, no.

MR GRAY: Ms Bolger, the Aged Care Quality and Safety Commission has a variety of steps that it takes during site audits, which include the CER, consumer experience report, process, which involves asking questions, including of residents, as I understand it; is that right?

MS BOLGER: Yes.

MR GRAY: And the obvious point when one considers the particular subject matter of this hearing of the Royal Commission is that a person living with progressively worse dementia might come to the point where their cognitive decline makes it very

difficult for them to communicate with a quality assessor from the Commission. Now, in your statement, you've said that there's a tool that is used by quality assessors called the Short Observational Framework For Inspection, SOFI?

MS BOLGER: Yes.

MR GRAY: Is that tool capable of revealing whether somebody is under psychotropic restraint or psychotropic prescription?

MS BOLGER: No. It's not the design of that tool to detect that.

MR GRAY: So what is being done by quality assessors currently – quality assessors of the Aged Care Quality and Safety Commission to form a view as to whether a particular approved provider is condoning excessive use of restraint in – particularly in chemical form?

MS BOLGER: The quality assessors are assessing those matters under medication management and behaviour management. And there is guidelines available for them under the current accreditation standards of the matters that they are prompted to consider for those assessments. The Commission has communicated with the quality assessors about the importance of this issue for the Commission and for the quality and safety of care for older Australians, and there is information that we've made available through our quality assessor portal to support their understanding of the issue. And there are a number of steps in progress that will further support this for quality assessors.

MR GRAY: And, after 1 July, the accreditation standards will be replaced by the single quality framework, but will the process be similar, in that quality assessors of the Commission will be looking for evidence of overuse of psychotropics, potentially for restraint purposes, when they're considering the standard 3, clinical care aspects; standard 8, clinical governance aspects of the standards? Is that right?

MS BOLGER: That is correct. I think it fundamentally goes to standard 1, as well, around consumer dignity and choice.

MR GRAY: And this will involve, what, taking a sample of the files of the residents, trying to meet the 10 per cent benchmark for consideration of the circumstances of 10 per cent of the residents, either directly through questioning of the resident, through paperwork or through contact with relatives? Is that the modus operandi?

MS BOLGER: Yes. The current process is interviews, observations and document review.

MR GRAY: And is 10 per cent going to remain the litmus test or the benchmark for the extent of scrutiny of those matters?

MS BOLGER: 10 per cent is the – yes. That applies to the legislative requirement for interviews with consumers. We can and do increase that sample based on risk. And our current audit methodology, which is being developed to support assessment under the new standards, provides some guidance in that area for quality assessors. So they may choose, for example, to purposefully increase the sample where they – where risk is evident in a particular area. And that is part of our risk-based approach to compliance.

MR GRAY: It gets us back to the risk profiling, doesn't it, but I've already asked you my questions about that. But, in the absence of a sign of risk that raises the bar, there isn't any other trigger to scrutinise more than, what, a handful of residents' care plans and files; is that right?

MS BOLGER: Not entirely, no. So the assessors will be provided with the information relating to the profile of the service. The risk information has been strengthened by the application form where we have asked specific questions about the characteristics of the consumers at the service that go to particular characteristics like consumers being subject to guardianship or non-English speaking or diversity characteristics such as LBGTI or Aboriginality, and those characteristics are also helping the quality assessors to determine an appropriate sample and to ensure that they have sufficient line of sight to those consumers who may be at greatest risk.

MR GRAY: Are these the screening questions?

MS BOLGER: No, they're not.

MR GRAY: These are different?

MS BOLGER: This is information that we seek on application for re-accreditation.

MR GRAY: Thank you. I want to ask you about the screening questions because you haven't mentioned them in any of the answers to any of the questions I've asked so far. But you do say in your statement that there are screening questions that have been introduced since about the end of January which include what's the percentage of residents in the particular service who have been prescribed psychotropics. Is that used to inform how many files will be reviewed during a particular site audit, review audit or even assessment contact?

MS BOLGER: It's used to inform it, yes.

MR GRAY: When are those screening questions asked? Are they asked at all three kinds of visits?

MS BOLGER: No, they can be asked more broadly at the re-accreditation audit but they're specifically intended as part of that compliance monitoring during an assessment contact because they are part of a suite of questions that helps direct the

focus of the assessment and which accreditation standards, in fact, may be subject to scrutiny. Unlike an audit where all assessments – all standards are assessed.

MR GRAY: Now, I will come back to the information that is received by the Commission later in your evidence, but can I just ask, is there any compulsion on the approved provider to provide an answer to a question of that kind, if it hasn't got the information to hand, can it just say, well, we haven't worked that out?

MS BOLGER: There is a requirement for the service to provide information that is requested by the Commission. If we're not getting satisfactory responses to the answers to those risk-screening questions there's a number of steps that we can take. We can formally request that under the quality – the Commission's rules, and in any case, the absence of an understanding of their own risk and what the profile of consumers at the service was would certainly raise concerns with us about the level of risk at the service.

MR GRAY: To the extent that the whole process might rely on that information, I suppose it's simply a self-report from the approved provider; just say a particular approved provider gives you inaccurately low information about that, how likely is it that the sample of files that are reviewed are going to pick that up?

MS BOLGER: I think it's not solely relied on by the assessors. They are also making observations as they enter the service about the level of restraint that may be evident and I think that they are also able to go to the documented evidence in the care plans themselves to assure themselves that they're getting an accurate picture of the extent of chemical restraint at the service.

MR GRAY: Is there a guideline within the Commission for the quality assessors to have to review a certain percentage of the files of a particular service when they perform, say, an assessment contact?

MS BOLGER: No, there's not.

MR GRAY: What about a review audit?

MS BOLGER: No.

MR GRAY: What about a site audit?

MS BOLGER: No. There's general guidance about the sufficiency and the quality of evidence that's required to make a decision, but that varies depending on the nature of that evidence and the weight that the assessors can rely on that as being reliable evidence.

MR GRAY: All right. Now, Ms Bolger, you didn't convene either the stakeholder workshop or the Aged Care Clinical Advisory Committee which both were consulted

on the formulation of recent new amending principles on restrictive practices. That's right, isn't it, you didn't convene those, either of those bodies?

MS BOLGER: No.

MR GRAY: You were consulted, though, it appears on some of the work product of those bodies?

MS BOLGER: Yes, I was.

MR GRAY: And consulted also on proposals for the amending principles on restrictive practices and the explanatory statement that was going to accompany it?

MS BOLGER: Yes, I was.

MR GRAY: And could I just ask you about some of the emails around that series of events. And do you know – do you recall when you were first involved in consultations about those matters? Was it in March or was it earlier in February?

MS BOLGER: My recollection is that it was in March, with the convening of the first working group teleconference when some papers were distributed prior to that meeting.

MR GRAY: Thank you. Well, operator, please display tab 91. And with respect to that working group, I think I might have called it a stakeholder group or committee, but the working group was the reference to the industry representatives and other stakeholder bodies, as opposed to the clinical experts; is that right? The 18 March workshop involved - - -

MS BOLGER: It was a stakeholder group; that's correct.

MR GRAY: The stakeholder group.

MS BOLGER: Yes.

MR GRAY: Industry representatives and the like.

MS BOLGER: Yes, subject matter experts.

MR GRAY: Thank you. And you have sent this email, I suggest, to an officer of the Department, Ingrid Leonard, on 21 March and you've attached to that email a marked-up version of the summary of discussions on 18 March in respect of the working group's meeting, or the stakeholder group's meetings; is that right?

MS BOLGER: Yes.

MR GRAY: Thank you. And in the covering email, you say to Ms Leonard that – I beg your pardon, this is to Ms Laffan, Ms Amy Laffan. You say that:

> *The document is a fair record of the discussion. I think that that there were dissenting views on the adequacy of the assessment for physical restraint which are not captured here.*

Whose dissenting views were they; do you recall?

MS BOLGER: It was difficult to know whose comments were being made because it was a teleconference, and not all the speakers introduced themselves. So no, I wasn't able to identify who they were.

MR GRAY: Did you or anybody else from the Aged Care Quality and Safety Commission have dissenting views on the adequacy of the assessment before physical restraint could be used?

MS BOLGER: I think it was about, yes, there were some concerns expressed around the assessment processes, yes.

MR GRAY: And in the covering email, you seem to be alluding, in the next paragraph beginning "The drafting will be tricky" but you seem to be alluding to possible ways in which the process for assessment could be strengthened; is that right? Is that the purpose of that sentence or that paragraph?

MS BOLGER: Yes. I think I was intending there that there may be ways where the approach to physical and chemical restraint could be joined up.

MR GRAY: And are you familiar with the regime around elimination and reduction of restrictive practices in the disability sector under the NDIS?

MS BOLGER: I have some familiarity, yes.

MR GRAY: Is that the sort of approach you were considering, that there be an integrated behaviour assessment plan and so forth?

MS BOLGER: Yes, that's correct.

MR GRAY: And then in the last paragraph you say:

> *From the Commission perspective it will give much stronger authority for findings of noncompliance but we will also need to consider what forms of evidence are needed for each element.*

Do you mean, by that sentence, that if those provisions strengthening the prescriptions for assessment before either of these forms of restraint can be used are

adopted, then that will give the Commission a better chance to be able to make findings of non-compliance?

MS BOLGER: I think that last comment was in relation to the principles as a whole, as opposed to one specific piece, that the principles would give stronger authority for findings of non-compliance.

MR GRAY: Thank you. Just going to the attachment, that's tab 92, I ask that that be brought up. The particular point about assessment that you made in the email seems reflected in comment CB7 near the foot of the page, Ms Bolger. That seems to link to reference to the care recipient having been assessed as requiring restraint by a registered nurse or other health practitioner with day-to-day knowledge of the care recipient. And you're referring to the need for a holistic behavioural assessment, etcetera.

MS BOLGER: That's correct.

MR GRAY: And, can I just ask, that was your view expressed to the meeting, was it, that there really should be integration, if I can put it that way, with a holistic behavioural assessment?

MS BOLGER: I don't think I expressed that at the meeting. I think I observed that to be some of the comments that had been made. And I thought it was worth further consideration.

MR GRAY: Yes. And, sitting now where you are in the witness box, is it your opinion that that would be a better approach, to have assessment by way of a holistic behavioural assessment as a precondition of these forms of restraint being applied?

MS BOLGER: I think a holistic behavioural assessment, yes, is needed. And the extent of that and by whom was the issue that I was raising.

MR GRAY: Okay. And that's a very fair point, because you can give a name to a particular plan and that doesn't necessarily make it a holistic behavioural assessment; correct?

MS BOLGER: That's correct.

MR GRAY: What are the key features that you see as important in a holistic behavioural assessment?

MS BOLGER: I think that that type of assessment needs to be collaborative with the consumer and those that they choose to be involved in their care, that it needs to be comprehensive and cover aspects of the person's individual needs. It needs to be in the context of the care setting, so that it is relevant to the type of behaviours that might be evident in the care setting. I think that it also needs to, as is suggested here, that day-to-day knowledge, so over a fairly continuous period, in order to be able to

form a view. That it also needs to be updated and reviewed. And I think the care context is a very important part of that.

MR GRAY: Have you, since the making in April of the new amending principles on restrictive practices, been able to look at those principles and form any view about whether they meet, in your view, the requirement for an assessment of that kind before either physical or chemical restraints can be applied?

MS BOLGER: I think that the provision that relates to the assessment can give scope for that type of assessment, but there would be further guidance and further education around what was required to do that well.

MR GRAY: So it isn't spelt out in as much detail as you would have liked to see; is that right?

MS BOLGER: I think it is dealt with at the level of the legislation sufficiently to provide further advice and support for the sector.

MR GRAY: All right. Now, in that comment CB7, you also refer to:

> …*and the conflicting demands on caregivers.*

Are you referring there to the person who conducts the assessment, a matter you alluded to a minute ago? This document referred to the assessment being done by a registered nurse or other health practitioner with day-to-day knowledge of the care recipient. And you've made this reference to the need for holistic behavioural assessment – you've already addressed that – and the conflicting demands on caregivers. Are you able to explain what you meant by that aspect of the comment?

MS BOLGER: I think this comment was triggered by some of the conversation that had been evident at the working group, from my recollection, but I felt it was worth noting, because there – the RN, obviously, has the day-to-day knowledge and the continuous observation of the care recipient. But they – if there are not sufficient staff, for example, to support an adequate assessment and the provision of care that addresses the problems and provides alternatives to the use of restraints, then that can be a bit of a conflict.

MR GRAY: And you hold a concern, do you, that the reality of the day-to-day demands in the services conducted by these approved providers is such that that risk will quite often be realised?

MS BOLGER: I think it's a risk in some settings, yes.

MR GRAY: Just finally before the Commission rises for the luncheon adjournment, can I ask you about a final aspect of the notes. At comment CB9 on the next page, please, operator, foot of the page, you refer here to the definition that has been employed for chemical restraint. And you say here:

I realise this is a recognised definition.

Just stopping there, did you understand it then and do you understand it now to be a definition that had come from the NDIS rules on restrictive practices?

MS BOLGER: That is correct.

MR GRAY:

I realise this is a recognised definition, but the exception seems very broad.

Is that the exception – just stopping there – commencing with – well, it's what you've shaded. "It does not include it", etcetera. I assume that's right:

Will we see a reduction in prescribing rates or just legitimatised use?

What did you mean by that?

MS BOLGER: I think the first reading of that definition is challenging, just in terms of understanding its intent. And it seems a broad exemption in terms of enabling treatment of the diagnosed mental disorder, physical illness or physical condition. And this was my first response to that definition.

MR GRAY: Is that a convenient time?

COMMISSIONER TRACEY: Yes. Are you proposing to continue with this witness after the luncheon adjournment?

MR GRAY: Yes. I think I've got at least 20 more minutes.

COMMISSIONER TRACEY: Yes. Very well.

MR GRAY: I will try to move a little more quickly, but - - -

COMMISSIONER TRACEY: The Commission will adjourn until 2 o'clock.

ADJOURNED **[1.03 pm]**

RESUMED **[2.05 pm]**

MR GRAY: Operator, please bring up tab 92. Ms Bolger, I was asking you questions about this document before lunch. I want to ask you about CB1. You say in that comment:

I think the group recognised that accountability needed to be strengthened, noting that best practice guidance had been available for some time.

Was that a reference to the 2012 decision-making tool?

MS BOLGER: That's correct, yes.

MR GRAY: And, indeed, that decision-making tool had been around in a different form from 2004; is that right?

MS BOLGER: Prior to that, yes.

MR GRAY: And was the point you're making there simply that without some sort of threat of real regulatory action, guidelines as to best practice are ineffective?

MS BOLGER: No, not in all cases, but I think I'm indicating that in this instance it is warranted.

MR GRAY: Yes. Now, I just want to ask you about the issue of informed consent. Informed consent was raised in the context of the stakeholder work group as something that would be required for not only physical but also chemical restraint; is that right?

MS BOLGER: I believe so, yes.

MR GRAY: Initially. And then some advice was received from the Commonwealth Medical Officer to the effect that that wouldn't be workable in respect of chemical restraint; is that the way you recall the discussions proceeding?

MS BOLGER: I don't have a clear recollection of how that advice was provided. My understanding was that it was through the committee that had been formed, and led by the chief medical adviser.

MR GRAY: Right. In respect of accountability, which is something you've mentioned in CB1, what did you mean? Did you mean that an individual must be held accountable and subjected to some sort of penalty if there had been misuse? There must be a real regulatory consequence of that kind?

MS BOLGER: I was referring to the accountability for the services that were subject to our regulation, yes.

MR GRAY: Did you mean an individual or the corporate approved provider?

MS BOLGER: The approved provider.

MR GRAY: And was this a reference to – well, I withdraw that. Operator, please put up the email at CTH.1007.1006.3871. Do you recognise this email to be an email from Amy Laffan, assistant secretary of the Department of Health to yourself?

MS BOLGER: I do.

MR GRAY: On 29 March 2019?

MS BOLGER: Yes.

MR GRAY: And operator, please go to the email on the next page, do you see there you've sent an email just prior to the one on the first page earlier on 29 March 2019, and you've sent that to officers of the Department and also cc'd to the Commissioner of the Aged Care Quality and Safety Commission.

MS BOLGER: Yes.

MR GRAY: Yes. And you've, in this email, said that there are points of concern with the current draft legislation and the – you've said EM; is that a reference to the explanatory statement to the amending principles?

MS BOLGER: Yes.

MR GRAY: And when you refer to the current draft legislation, are you referring to the then current draft of the amending principles of 2019?

MS BOLGER: I am, yes.

MR GRAY: And firstly, you ask for the title to be changed to "minimising or eliminating" with, I suggest, reference to the aspiration of eliminating the use of restrictive practices; is that right?

MS BOLGER: That's right.

MR GRAY: And that suggestion of changing the title to include the concept of eliminating was not adopted; is that right?

MS BOLGER: That is correct, yes.

MR GRAY: And you included that because, I suggest, the Commission's view is that it's not sufficient simply to try to minimise and regulate the use of physical and chemical restraint, but the aspiration should be to eliminate it; is that right?

MS BOLGER: That is correct.

MR GRAY: Next, if we go down to the fourth bullet point, you've said there:

Included concept of a period of restraint rather than use. It's an important word for changing behaviour.

And if we can go to the amending principles in a minute, if you need to, but it's the case, isn't it, that there hasn't been a fixed period of restraint incorporated in the amending principles; is that right?

MS BOLGER: Yes, that's correct.

MR GRAY: The Commission, I suggest, had the view that it would be important to include a requirement for a fixed period of restraint if restraint is to be used at all.

MS BOLGER: Yes.

MR GRAY: So in these two respects, the legislation – I beg your pardon, the delegated legislation, the amending principles as made, don't meet the views, or don't live up to what the Commission would regard as an appropriate form of regulation of restraint; is that right?

MS BOLGER: No, I think our role was to provide input with respect to our understanding of the regulation, and how it would be played out in practice, and that feedback reflected concerns that there were some ways in which it could be strengthened.

MR GRAY: Yes. All right. Just further to that point about including the concept of a period, it was also the Commission's view that not only should there be a prescribed period for the use of restraint, but that it had to be determined at the outset when the need for a restraint was determined upon. Is that the meaning of the next bullet point?

MS BOLGER: It is, yes.

MR GRAY: And that wasn't adopted either, was it?

MS BOLGER: No, it wasn't.

MR GRAY: And the next bullet point is that:

Each ongoing review should include the steps taken to test alternative measures, ie, offer alternative behaviour management.

That wasn't adopted either, was it?

MS BOLGER: No, it was not.

MR GRAY: With respect to the explanatory statement, again you've suggested on behalf of the Commission a stronger statement referring to the elimination of restrictive practices, but that wasn't adopted, was it?

MS BOLGER: I don't believe so. I would need to check that.

MR GRAY: Right. And the concept of a determined period wasn't accepted either; correct?

MS BOLGER: Yes.

MR GRAY: Did you get some change to the explanatory memorandum on the language of before a physical restraint is used. I will just ask you to go to the explanatory statement. There is one place in which that language is used. The explanatory statement is tab 105, and if we go to page 5315, please, do you see that heading about a quarter of the way down the page:

> *Before physical restraint is used. The four conditions which must be satisfied before using physical restraint are -*

On the basis of that it seems that you may – that this suggestion may not have been accepted either. Is that your recollection, that this suggestion you made in the last bullet point wasn't accepted either?

MS BOLGER: Yes.

MR GRAY: And, in terms of the language of elimination not being included, do you wish to go to the description of the purpose, Ms Bolger, on page 5311, about a third of the way down the page. Is that what you wanted to check in the document before answering my question?

MS BOLGER: Do you mind asking the question again.

MR GRAY: Yes. Certainly. Your suggestion about strengthening the language or changing the language to start with a strong statement of intent to reduce or eliminate restrictive practice does not seem to have been adopted, but I can't be certain so I'm asking you whether you recall.

MS BOLGER: Yes. It hasn't been adopted.

MR GRAY: Okay. Before finishing your email you said:

> *Further concern that may not be addressed in time is the intersection with state law on mental health, as well as prescribing practice, substitute decision-making laws.*

Did you have in mind here that the NDIS equivalent rules concerning restrictive practices defer to state laws regarding prohibitions and authorisations for restrictive practice?

MS BOLGER: No. It's really flagging some of the complexities of the intersection with state laws.

MR GRAY: Which are simply not addressed in the amending principles at all; is that right?

MS RICHARDSON: Well, I object to that question. It's specifically provided for in section 15E of the principles.

MR GRAY: Yes. It's a legal question. I will withdraw the question. Can I ask you, Ms Bolger, about the proposal – or, if there is a proposal, the proposal for enforcement of the amending principles for the next six months from – that means the six months after 1 July, I should say, and before 31 December 2019. You refer to the fact that the Commission will be continuing to review or assess approved providers for compliance with the standards. They will be in the form of the single quality framework by that time. But you don't actually in your statement appear to say that the Commission will be assessing compliance with new sections 15G and 15F of the amending principles per se. What is the Commission's proposal for how it is going to approach the enforcement of the amending principles? Is there an enforcement strategy?

MS BOLGER: The Department and the Commission have discussed the approach to oversight of these new provisions and the Commission will, within its existing regulatory functions, gather evidence against the aged care quality standards, but will do so with regard to the new principles on restraint. And where it is evident that we have information that indicates that those new principles aren't being met, we will refer that to the Department of Health, who will exercise their compliance functions and enforcement functions under the Aged Care Act.

MR GRAY: I will ask for tab 97 to now be displayed. This is another email from yourself. It's to Ms Leonard of the Department of Health and it's dated 28 March 2019. And this is an email, essentially, on the topic you just mentioned. You make the point in the email, probably about three-quarters of the way down the text of the email:

> *However, the Commission is not monitoring compliance with the restraint provisions, but with the aged care quality standards.*

Did you mean to make a point that the Commission isn't going to be guided by any particular compliance or enforcement strategy with respect to the new provisions, but it was just a matter of, if evidence was placed before the Commission going to the question of compliance with those provisions, that evidence would be brought to the attention of the Department, but that the Commission wasn't going to go out of its

way and try to monitor compliance with those provisions? Is that the point you were making?

MS BOLGER: No. I was seeking to provide clarity on the authority that the Commission had. And that was to monitor compliance with the Aged Care Quality Standards.

MR GRAY: It's a matter, isn't it, of the potential outcome indirectly being that a breach of new sections 15F and G might be brought to the attention of the Commission and then the Commission would bring it to the attention of the Department, but the Commission isn't setting out to monitor compliance with those sections?

MS BOLGER: Technically no, but this is an area of high priority for the Commission, and it is supporting many of the outcomes under the aged care quality standards, so it's not an area that will go unchecked.

MR GRAY: And the Commission will go about trying to check it in the manner you described before lunch; is that right?

MS BOLGER: That's correct, yes.

MR GRAY: Now, what about from 1 January 2020? Is that simply an unknown at present or are there – is there some certainty as to what precise functions that are relevant to monitoring compliance and enforcing 15F and G the Commission will get on 1 January 2020?

MS BOLGER: This is a very new provision, obviously, and we do anticipate getting within our regulatory remit the compliance monitoring functions that relate to quality and safety under the Aged Care Act. But we have a broader piece in consultation with the Department as to how those functions will transition to the Commission.

MR GRAY: And what's the progress of that piece?

MS BOLGER: I think that's a question for the Department.

MR GRAY: Right. Have they provided you with a document setting out precisely what they have in mind by way of empowering provisions in respect of enforcement of these new sections, 15F and G?

MS BOLGER: No.

MR GRAY: So it follows, does it, that, in the face of that uncertainty, it's too early for the Commission to start setting about formulating a – an enforcement plan or policy for these provisions?

MS BOLGER: In concrete terms, yes, but we are turning our minds to it as part of the broader compliance functions that we anticipate transitioning to the Commission.

MR GRAY: And when will that enforcement plan or enforcement policy be ready to be published? Do you know?

MS BOLGER: No, I don't.

MR GRAY: In terms of standard 8 of the new Single Quality Framework which will commence 1 July and over which the Aged Care Quality and Safety Commission will have direct responsibility for monitoring compliance, the closest standard relating to the regulation of restraint seems to be standard 8 that refers to the need to have a clinical governance framework which must minimise the use of restraints. Can I just ask you about that? Does that clinical governance framework consist of documentary processes? Is that what's meant by that expression?

MS BOLGER: Not solely documentary processes, no. I think the clinical governance framework goes to aspects of leadership and culture and commitment as well as the way that care is organised, how systems and processes support that care, the roles and responsibilities of people involved in care, how that's communicated. It is quite a comprehensive piece, a clinical governance framework. Includes also the oversight and the monitoring and reporting of outcomes of care.

MR GRAY: So are you saying to the Commissioners that it won't be sufficient for an approved provider to merely have fine-sounding documentary systems purporting to restrict the use of restraints. It will have to go further than that?

MS BOLGER: That is correct.

MR GRAY: And how are you going to monitor that?

MS BOLGER: The clinical governance framework is in draft and has just been developed for consultation, so aspects of that really go to some of the elements that the Commission is already picking up in different aspects of the accreditation standards, but it brings it together in a much more coherent piece that we are able to both hold providers to account, but also influence their development of such systems.

MR GRAY: I want to ask you about the screening questions that I raised before lunch. We – that is, the Office of the Royal Commission has received a letter from instructing solicitors on behalf of the Commonwealth. I will ask that be brought up. It's RCD.9999.0062.0001. And in respect of the two screening questions you refer to in paragraph 22 of your statement, the question was asked how many facilities are being visited with unannounced assessment contacts since the time the Commission added the two new screening questions on the restraints. And at the time of this letter, 13 May, the answer was 745 unannounced assessment contacts were conducted between 1 February and 30 April 2019. And is that information that's within your direct knowledge?

MS BOLGER: Yes, I'm aware of that.

MR GRAY: And the second question was in respect of the two screening questions, in respect of the question on psychotropic restraints, what levels of use of psychotropics are being reported, either in terms of, in effect, gross numbers or a percentage, and the answer that's provided in the letter is that the Commission is in effect unable to provide an answer to question 2. The reason seems to be – I'm paraphrasing but it seems to be that the information is not captured in a readily accessible form; is that right?

MS BOLGER: Partly. It wasn't intended to be captured in a way that was to be used as a data source.

MR GRAY: Why not?

MS BOLGER: Because there would be very low validity for that data which is currently asked as a question on entering a service by a quality assessor, and it is a very difficult thing to arrive at data that can be reported in a way that is reliable in relation to a measure such as particularly the psychotropic medication in terms of the complexity of the definitions around that as well.

MR GRAY: So that the reliability of the answer to the screening question is so low it's not even worth keeping the answers; is that it?

MS BOLGER: No, I don't accept that. I think that the reason why we're not confident that it – the information that is captured as part of the side order report can be relied on as data is that it's not asked in a way that allows it to be relied on as data. It is asked for a different purpose, which is to, amongst other screening questions, seven or so screening questions relating to other areas of risk, to assist the assessment team to focus on the areas of concern during the audit – during the assessment contact.

MR GRAY: At present, there's no coherent monitoring or enforcement strategy or plan in respect of these new provisions in the amending principles. Is that a fair comment?

MS BOLGER: Yes, but I think it reflects the timing of the new legislation and the matters that still need to be worked through.

MR GRAY: Thank you. I need to tender two documents. Firstly, the email chain of 29 March 2019, CTH.1007.1006.3871.

COMMISSIONER TRACEY: I will just wait for that to come up. Yes. The email exchange from Amy Laffan to Christina Bolger dated 29 March 2019 will be exhibit 3-76.

EXHIBIT #3-76 EMAIL EXCHANGE FROM AMY LAFFAN TO CHRISTINA BOLGER DATED 29/03/2019 (CTH.1007.1006.3871)

MR GRAY: Thank you. And secondly, the letter from Gilbert + Tobin to - - -

COMMISSIONER TRACEY: I think before that you also put up a different email.

MR GRAY: That was one of the documents that's already in the general tender bundle.

COMMISSIONER TRACEY: That's already in the evidence.

MR GRAY: Yes.

COMMISSIONER TRACEY: Before we leave this one, you did ask questions arising out of the attachment. Do you want the attachment to be part of the exhibit?

MR GRAY: I do indeed. Thank you, Commissioner.

COMMISSIONER TRACEY: Yes. So exhibit 3-76 will include attachment A to the email.

MR GRAY: Thank you.

COMMISSIONER TRACEY: Yes. And then the solicitor's letter.

MR GRAY: Thank you. Commissioner, I'm not certain that that email chain did have an attachment. I think it was simply a – the further pages of it are simply more emails in a chain. One of the other documents I took the witness to had an attachment but I believe that's already also an exhibit. Can I tender the letter of Gilbert + Tobin to one of the co-solicitors assisting in the Royal Commission dated 13 May 2019.

COMMISSIONER TRACEY: Yes. The letter from Gilbert + Tobin to the Commission's solicitors dated 13 May 2019 will be exhibit 3-77.

EXHIBIT #3-77 LETTER FROM GILBERT + TOBIN TO THE COMMISSION'S SOLICITORS DATED 13/05/2019 (RCD.9999.0062.0001)

MR GRAY: Thank you. Commissioner, I see that in respect of 3-76 there are references to attachments in that document but I haven't taken the witness to those documents and - - -

COMMISSIONER TRACEY: I'm sorry, it has gone from the screen so I can't follow you at the moment.

MR GRAY: CTH.1007.1006.3871.

COMMISSIONER TRACEY: I was looking at the attachments and B – you referred to B as well.

MR GRAY: Well, Commissioner, I didn't take the witness to those.

COMMISSIONER TRACEY: But do you want that to be an exhibit?

MR GRAY: No, I'm not seeking - - -

COMMISSIONER TRACEY: I was only referring to attachment A which was the one I thought you had taken the witness to.

MR GRAY: I didn't take the witness to either of the attachments.

COMMISSIONER TRACEY: Isn't attachment A the one with the highlighting?

MR GRAY: That was an attachment to another email which is already in the tender bundle. I'm sorry about the confusion, Commissioner.

COMMISSIONER TRACEY: All right. Well, do you want that other email in?

MR GRAY: It's already in. It has already been tendered in the general tender bundle.

COMMISSIONER TRACEY: All right. Well, we will go back to 3-76 and it's simply the email, not the attachment in the exhibit.

MR GRAY: Thank you, Commissioner.

COMMISSIONER TRACEY: Yes.

MR GRAY: I have no further questions for this witness.

COMMISSIONER TRACEY: Ms Bolger, earlier this week the ABC erred – aired, I beg your pardon, an investigative report that had resulted from a complaint to the Commission by a lady about the treatment of her father at an institution. Are you familiar with that program?

MS BOLGER: Yes, I am, Commissioner.

COMMISSIONER TRACEY: Yes. And you will be aware that it involved the placement of a hidden camera and the filming of certain acts within the confines of

the institution. And what I want to ask you is whether that has led to an investigation by the Commission.

MS BOLGER: There were a number of matters already under investigation by the Commission in the complaints functions, Commissioner. But it has led to further site – attention through our compliance visits.

COMMISSIONER TRACEY: All right. Well, I'm not then going to ask you questions about an ongoing inquiry, but what I do want to know is this. One of the allegations made in that program, as you will know, is that the institution itself, when provided with what looked like prima facie evidence of misconduct on the part of some of its employees, simply refused to look at the film that had been recorded. Does the Commission have access to that film for the purposes of its inquiry?

MS BOLGER: I'm not certain of that, Commissioner. I can check that for you.

COMMISSIONER TRACEY: Yes. Well, I would be grateful if you would arrange through your instructing solicitor for the Commission's solicitors to be advised about that.

MS BOLGER: I can say that the – it was available to the complaints functions, now that I recall. It has been available to the Commission.

COMMISSIONER TRACEY: Well, I assume that the Commission regards itself as free to examine the film and wouldn't take the attitude that the employer did of refusing to look at it?

MS BOLGER: That's correct.

COMMISSIONER TRACEY: Thank you. Yes. Thank you very much for your evidence, Ms Bolger. You're excused from further attendance.

<THE WITNESS WITHDREW [2.37 pm]

MR GRAY: Commissioners, our next witness is Amy Elizabeth Laffan.

<AMY ELIZABETH LAFFAN, AFFIRMED [2.38 pm]

<EXAMINATION BY MR GRAY

MR GRAY: What is your full name?

MS LAFFAN: Amy Elizabeth Laffan.

MR GRAY: And you're an assistant secretary in the Department of Health.

MS LAFFAN: Correct.

MR GRAY: And you've made a statement for the Royal Commission.

MS LAFFAN: I have.

MR GRAY: Please bring up WIT.0105.0001.0001. Operator, please track to the end of the document. Do you recognise that, Ms Laffan, to be a copy of the statement you've made for the Royal Commission dated 18 April 2019.

MS LAFFAN: Yes.

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

MS LAFFAN: No.

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

MS LAFFAN: Yes.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The statement of Amy Laffan, dated 18 April 2019, will be exhibit 3-78.

EXHIBIT #3-78 STATEMENT OF AMY LAFFAN DATED 18/04/2019 (WIT.0105.0001.0001)

MR GRAY: Thank you, Commissioner.

I want to ask you, Ms Laffan, about work done prior to January 2019 in respect of the task of regulating the use of restrictive practices of both a physical and chemical nature in residential aged care services. You've referred to the decision-making tool of 2012 which itself was an iteration of a document that preceded that time.

MS LAFFAN: That's correct.

MR GRAY: And that was a discretionary document; that's correct, isn't it?

MS LAFFAN: That's correct.

MR GRAY: In the sense that an approved provider might find guidance from it, but it wasn't mandated.

MS LAFFAN: No.

MR GRAY: Now, can I just ask the operator to bring up tab 22 of the general tender bundle. In this document, there's an email at the head of the chain from somebody called Kay Newman in the Department of Health and it's copied to you.

MS LAFFAN: Yes.

MR GRAY: And that document at the head of the chain is 26 June 2017.

MS LAFFAN: Yes.

MR GRAY: And it's a document that seems to be – or it's an email chain that seems to be concerning the preparation of responses to an email – to a media inquiry; is that right?

MS LAFFAN: That's correct.

MR GRAY: And the key points that are identified in the email immediately below the one at the head of the chain on the first page on Monday, 26 June 2017 at 10.18 am are these, in effect, as at that date, all of the matters which the Department was – all of the matters which the Department could be described as doing to take action to address the claim of widespread use of psychotropics in formal and informal aged care settings, under point 2.

MS LAFFAN: No.

MR GRAY: I will let you just cast your eye over it. What were the additional actions that the Department was taken in that respect?

MS LAFFAN: The additional actions are with respect to non-regulatory measures, so a number of programs that existed within the Department of Health, research studies that have been funded by the Department, the, at the time, voluntary quality indicator program.

MR GRAY: So the voluntary quality indicator program is referred to under point 2 in the last bullet point. And the third bullet point refers to resources that are available to guide aged care providers, recipients of care and their families to identify the alternatives to use of restrictive practices. But you're saying there was additional training in addition to those materials; is that right?

MS LAFFAN: Sorry. I was only looking at the first page of that exhibit when you asked the question.

MR GRAY: Well, sorry, – have you had a chance to look at this email in preparation for giving your evidence?

MS LAFFAN: I have.

MR GRAY: Yes. Is the entire list in the email a comprehensive statement of what the Department was doing at that time, June 2017, to address the problem of over-prescription or widespread use of psychotropics?

MS LAFFAN: No.

MR GRAY: And so what were the additional matters?

MS LAFFAN: For example, there are things funded through the six pharmacy agreement, so a quality use of medicines program and a residential medication management review program to specifically look at the use of drugs in aged care facilities.

MR GRAY: Okay. And this was at June 2017?

MS LAFFAN: Yes.

MR GRAY: And with respect to the RMMR, at that time it was available under the MBS once in a 12 month period?

MS LAFFAN: That's my understanding, yes.

MR GRAY: And now, what, it's available once in a 24 month period, is it?

MS LAFFAN: I'm not sure about any changes to that program.

MR GRAY: All right. Please bring up tab 36 and tab 37 if you're able to bring them up at the same time, please, operator. This is an email – I'm referring to tab 36 – from somebody called Callum Campbell in the Department of Health to yourself and copied to others dated 31 August 2018; is that right?

MS LAFFAN: That's correct.

MR GRAY: And there's reference to an email below, and that email appears below the dotted line and the request is:

> *Dear all, information is sought from areas that have a role directly or indirectly in the use of psychotropic medication and/or restraint. Request is intended to identify the various areas within the Department which have a related policy interest and/or any relevant data or information as it relates to psychotropic medication and/or restraint.*

And then there's reference to an attached table and a request to update it as appropriate. If we go to tab 37 is that a copy of the table that's referred to in that email as at 31 August 2018?

MS LAFFAN: It is.

MR GRAY: And have you had a chance to familiarise or re-familiarise yourself with that document in preparation for giving your evidence.

MS LAFFAN: Broadly, yes.

MR GRAY: As at 31 August 2018 was that a comprehensive statement of all of the matters within the responsibility of the Department of Health that bore on the question of trying to address the problem of potential overuse of psychotropics?

MS LAFFAN: No, it wasn't.

MR GRAY: What were the additional matters?

MS LAFFAN: So this was a draft put together by my team and it was for the purpose of seeking input in additional matters and additional details in there, so I can't talk to it being a comprehensive list.

MR GRAY: Right. Are there any missing matters that occur to you now or have occurred to you in preparation for giving your evidence today?

MS LAFFAN: Not that I'm aware.

MR GRAY: Not that you're aware of?

MS LAFFAN: No.

MR GRAY: You can't think of anything that's omitted?

MS LAFFAN: No.

MR GRAY: Can we please bring up tab 42. Tab 42 is an email from Maria Jolly in the Department of Health to a group email called ACRCD, executive and also to yourself dated 9 November 2018; correct?

MS LAFFAN: Correct.

MR GRAY: And it also takes the form of an email chain and the email I've just referred to is at – is last in the chain at the head of the document. And is the general topic of this email chain, in effect, the efforts and endeavours within the Department to consider recommendations by the Australian Commission on Quality and Safety in healthcare's third Atlas of Healthcare Variation.

MS LAFFAN: Not exactly. It was an email crafted to provide comment on the draft recommendations at that point in time.

MR GRAY: The draft recommendations of that Commission?

MS LAFFAN: Of the atlas. Yes.

MR GRAY: Yes. And there had been at least two different areas within the Department of Health that were engaged considering the draft recommendations at that time; is that right?

MS LAFFAN: That's my understanding, yes.

MR GRAY: Have you had a chance to re-familiarise yourself - - -

MS LAFFAN: I have.

MR GRAY: - - - with this in preparation for your evidence as well?

MS LAFFAN: Yes.

MR GRAY: So in the end Ms Jolly, who is your superior; is that right?

MS LAFFAN: She was at the time, yes.

MR GRAY: She said:

> *I would like a discussion with PSD.*

Who's that?

MS LAFFAN: Portfolio strategies division.

MR GRAY: Thank you:

> *Rather than just providing this advice we may be pitting one agency against another and be sounding a bit defensive.*

It seems that the draft response included in this email chain might not have actually been the advice that was provided in response to the recommendations in the third atlas; is that right?

MS LAFFAN: That's quite possible, yes.

MR GRAY: Now, do you know from any other conversations that you might have had with Ms Jolly late last year what she's referring to when she says "pitting one

agency against another"; is she talking about the Commission on the one hand and the Department on the other?

MS LAFFAN: No, my understanding is she's talking about the two Commissions, the Aged Care and the Health Commission.

MR GRAY: Right. The Aged Care Quality and Safety Commission - - -

MS LAFFAN: Yes.

MR GRAY: - - - on the one hand.

MS LAFFAN: Yes.

MR GRAY: Which is not yet in existence - - -

MS LAFFAN: That's correct.

MR GRAY: - - - at this time but is in the form of the agency at that time; is that right?

MS LAFFAN: The – the recommendations refer to the – to the Aged Care Commission even though it was yet to be established.

MR GRAY: Thank you. Right. And I just ask you to go to page 5925. One of the proposed recommendations in the third atlas under point 1 near the bottom of the page is:

> *Prescribers use antipsychotics for people 65 years and over as a form of restrictive practice only as a last resort and not until alternative strategies have been considered to prevent serious physical harm. The following conditions must be met.*

And then there's quite a prescriptive set of preconditions including:

> *Informed consent or substitute consent from a properly authorised person to be given in writing.*

That's – is that particular recommendation about that form of condition something that the health department, the Department of Health had a view on at the time of this email chain, 9 November 2018?

MS LAFFAN: I don't believe we had a particular view on it.

MR GRAY: Okay. Later on, fast-forwarding to the period after 22 January 2019, was it the case that the Minister did want to have a condition of that kind as part of the regulation for restrictive practices in residential aged care settings?

MS LAFFAN: Not specifically. My understanding was the Minister wanted regulation to be strengthened. So a broader statement.

MR GRAY: Right. Did the Department post 22 January 2019 initially have a position that informed consent had to be obtained before the use of either form of restrictive practice, either physical or chemical?

MS LAFFAN: That was one proposal considered, yes.

MR GRAY: In the end, that wasn't adopted with respect to chemical restraint; is that right?

MS LAFFAN: That's correct.

MR GRAY: And in emergency circumstances, not for physical restraint either; is that right?

MS LAFFAN: That's correct.

MR GRAY: There were other conditions but I won't – other conditions proposed under that item in the atlas. I won't go through them all but there's reference to a:

> *...structured consent form being mandated for use in residential aged care to help ensure prescribers comply with clinical and legal requirements.*

Was that ever seriously considered by the Department either at the time of this email in November 2018? I will ask you that question first.

MS LAFFAN: The – not by the Department, no.

MR GRAY: No. All right. And what about post 22 January 2019?

MS LAFFAN: So the recommendations of the third atlas were provided both to the chief medical officers, clinical advisory committee and also to the working group that helped develop the 2019 principles.

MR GRAY: And so you're saying they were provided to those bodies and the department in effect just accepted the responses of those bodies to those recommendations?

MS LAFFAN: We provided them as context and background in developing the proposals that were discussed in those groups.

MR GRAY: And this particular proposal was rejected, was it? The proposal for a structured consent form to be mandated for use in residential aged care to help ensure prescribers comply with clinical and legal requirements?

MS LAFFAN: I wouldn't say it was actively rejected, but it hasn't been taken up, I agree.

MR GRAY: We will come to the options paper that was prepared by the aged care clinical advisory committee in due course. There is a recommendation amongst the options of that document relating to documenting of consent, isn't there?

MS LAFFAN: I believe so, yes.

MR GRAY: Why wasn't that taken up in the principles? We can come to that in detail later, and we open up the principles, but off the top of your head are you able to answer that question?

MS LAFFAN: That's because - the need to get informed consent is a responsibility of the prescriber, and not the approved provider.

MR GRAY: But what about just documenting the fact that it has been done?

MS LAFFAN: For chemical restraint, again that would be the responsibility of the provider, sorry, the prescriber.

MR GRAY: Documenting that consent has been obtained?

MS LAFFAN: That's correct.

MR GRAY: Couldn't an approved provider ask a medical practitioner whether consent has been obtained and then document the answer?

MS LAFFAN: They could; that's a possibility, yes.

MR GRAY: But that wasn't taken up in the amending principles?

MS LAFFAN: No, it wasn't.

MR GRAY: I will skip (c) and I will ask about (d):

Approval of pro re nata PRN orders to be no more than three times a month.

Was that a matter that was the subject of discussion to your knowledge in any of the processes which led to the making of the principles in the work done after 22 January 2019?

MS LAFFAN: Not through the working group process although the issue of PRN medication was discussed but not that recommendation specifically.

MR GRAY: Ms Laffan, when you refer to the working group, are you referring to the Aged Care Clinical Advisory Committee or the stakeholders group?

MS LAFFAN: Sorry, the stakeholders group that I chaired rather than the Chief Medical Officer's Group.

MR GRAY: Point 2:

Aged care providers record the use –

This is another one of the third atlas proposed conditions:

Aged care providers record the use of antipsychotics as a form of restrictive practice on all applicable patients in their residential aged care facilities and report on this to the Aged Care Quality and Safety Commission.

Was that considered in the work done after 22 January 2019?

MS LAFFAN: It was considered prior to that.

MR GRAY: It was considered in the November period, was it?

MS LAFFAN: Yes.

MR GRAY: And was it rejected?

MS LAFFAN: Yes.

MR GRAY: Why was it rejected?

MS LAFFAN: Sorry, I thought you said protected, pardon me. It wasn't rejected, no.

MR GRAY: It wasn't rejected?

MS LAFFAN: No.

MR GRAY: It wasn't rejected in November. It doesn't appear to – perhaps the recording of the use of antipsychotics has found its way into some form of requirement in at least the records principles, I assume, but is that right?

MS LAFFAN: I would suggest that where that has been taken up is part of the Government's decision to expand the mandatory quality indicator program.

MR GRAY: I will ask you about that in just a minute. What about the reporting? The same answer, is it? It's now taken up in the Government's decision to expand the mandatory quality indicator program, is it?

MS LAFFAN: That's correct.

MR GRAY: So you say that under the expansion of the quality indicator program, combined with it being made mandatory, there will be an obligation, not only for the providers to record the use of antipsychotics as a form of restrictive practice, but to report on that to the Aged Care Quality and Safety Commission, do you?

MS LAFFAN: So there is still a question about whether that – the new quality indicator will be about antipsychotics or whether they could be about medication, mismanagement or overuse or something that – whatever that indicator is that's still to be determined through consultation but it could be about the use of antipsychotics.

MR GRAY: I see, so in effect you're speculating that it might be taken up by this program?

MS LAFFAN: The Government's commitment is to introduce an indicator about medication management, and what indicator that is is still to be determined.

MR GRAY: Right. There are various options for that. One would be that you have to report on any use of antipsychotics.

MS LAFFAN: That's correct.

MR GRAY: Or for that matter any use of benzodiazepines or even antidepressants.

MS LAFFAN: That's correct, it could be that.

MR GRAY: Another would be how frequently is medication regime – is the medication regime of the residents reviewed; is that right?

MS LAFFAN: Correct.

MR GRAY: Another option would be are there nine or more – are there any residents with nine or more medications prescribed to them, and that might raise polypharmacy concerns; is that right?

MS LAFFAN: Correct, that's another option.

MR GRAY: And are you saying there might be more options?

MS LAFFAN: Potentially.

MR GRAY: And the Government hasn't made any decision as to what the form of the medication management indicator will be?

MS LAFFAN: That's correct.

MR GRAY: Could be any of them.

MS LAFFAN: Could be, yes.

MR GRAY: The only decision that has been made is that there will be some form of indicator based around medication management.

MS LAFFAN: Correct.

MR GRAY: So doesn't that mean that there's no guarantee that the indicator on the medication management will usefully give an indication of whether psychotropics are being used for the purposes of restraint?

MS LAFFAN: Correct.

MR GRAY: It might or might not?

MS LAFFAN: That's right.

MR GRAY: And when are they going to become mandatory?

MS LAFFAN: Sorry. The two additional indicators, from 2021 – July 2021.

MR GRAY: Is there any decision, even in principle, on how they will be made mandatory? Is that going to be through amendment of principles?

MS LAFFAN: It will be, yes.

MR GRAY: And it's not until July 2021.

MS LAFFAN: For the two additional indicators.

MR GRAY: And when are the three existing indicators, which include physical restraint, being made mandatory?

MS LAFFAN: From 1 July this year.

MR GRAY: And is the legislation already drafted for that?

MS LAFFAN: It's being drafted. It has been drafted, yes, but government hasn't signed off on it yet.

MR GRAY: Is there an exposure draft?

MS LAFFAN: No, there isn't.

MR GRAY: Are you allowed to tell us – if you're not allowed to answer the question, I'm sure your counsel will object. Are you allowed to tell us what form that legislation takes? Is it an amendment to principles?

MS LAFFAN: It's an amendment to principles.

MR GRAY: Isn't there a concern that if you make physical restraint a mandatory indicator metric, you might create an incentive for approved providers to put more pressure on prescribers to prescribe chemical restraint?

MS LAFFAN: That's a possible perverse incentive, yes.

MR GRAY: Has that been considered in the course of government making its decision to make the three existing indicators of the national quality indication program mandatory?

MS LAFFAN: I can't speak to what government had in its mind, but certainly that was in my mind and my team's mind.

MR GRAY: Did you give advice to government that that was a concern and risk?

MS LAFFAN: We provide lots of advice to government, so yes.

MR GRAY: Please put up tab 52. This is the Minister's media release of 22 January 2019. It includes – beg your pardon. This is the commission's media release. I withdraw that. But on about the same – on about the same date, is it the case that the Minister issued a media release announcing the strengthening of regulation with respect to restrictive practices?

MS LAFFAN: On 17 January, yes.

MR GRAY: I beg your pardon. On 17 January. I think I've been referring to 22 January all along. I will ask you about 17 January. Put that media – we can take that media release off the screen. Thanks, Operator. On 17 January, the Minister announced the strengthening of regulation in respect of restrictive practices in residential aged care; is that right?

MS LAFFAN: That's correct.

MR GRAY: Now, prior to that time, did the Department provide formal recommendations as to how that strengthening of regulation might be achieved?

MS LAFFAN: No.

MR GRAY: Please put up tab 64 and tab 65 at the same time, Operator. On tab 64 is an – just a bare – it looks like an email. I'm not certain if it is actually an email or some sort of filing record. Do you know, Ms Laffan?

MS LAFFAN: Looks like it's the – the main kind of email is actually about the attachment and it's attaching that attachment. So that's – but that's the file record, yes.

MR GRAY: Thank you. Now, this email wasn't sent to you, by the looks of it. Nevertheless, have you been able to familiarise yourself with this email and the attachment in preparation for giving your evidence?

MS LAFFAN: Yes.

MR GRAY: And it's – the gist of it, as you say, is the attachment. The attachment is titled Draft For Discussion, but it's, essentially, a table setting out possible options; is that right?

MS LAFFAN: That's correct.

MR GRAY: For preventing unlawful use of physical or chemical restraints in aged care.

MS LAFFAN: Correct.

MR GRAY: And the left hand column says options provided to Minister January 2019. I assume that must be after 17 January 2019. Is that right?

MS LAFFAN: That's my understanding, yes.

MR GRAY: Given the answer to the question I asked you a minute ago.

MS LAFFAN: Yes.

MR GRAY: and option A is an additional regulation on consent arrangements. And the contacts for that include yourself. So is that one of the options that you worked on?

MS LAFFAN: Yes.

MR GRAY: And there are a number of other options, including targeted letters, expansion of residential medication management review. You've already said that's not your area. You don't know about that. There's pharmacy society, proposal to embed pharmacists. Again, I assume that's not your area.

MS LAFFAN: No.

MR GRAY: (e) additional funding for existing dementia programs. This is the area of Josephine Mond and others; is that right?

MS LAFFAN: That's correct.

MR GRAY: So if it's, essentially – and there's a final one on establishing an expert group, which was going to be, and was, your responsibility; is that right?

MS LAFFAN: Yes, to provide secretariat support. Yes.

MR GRAY: Right. And was this expert group, comprising medical profession, pharmacists, providers and consumer advocate groups – was that the stakeholder group that you convened?

MS LAFFAN: It's what then became the Chief Medical Officer's group.

MR GRAY: So, in effect, that proposal split into two, did it?

MS LAFFAN: Was kind of divided. That's correct.

MR GRAY: And the one that you convened that had industry representatives on it, that focussed did it, on physical restraint?

MS LAFFAN: Physical and chemical restraint.

MR GRAY: Both.

MS LAFFAN: Yes.

MR GRAY: Okay. The one convened by the CMO, called the Aged Care Clinical Advisory Committee, that focussed just on chemical restraint; is that right?

MS LAFFAN: That's correct.

MR GRAY: Thank you. Do you know when in January those options were put to the Minister?

MS LAFFAN: I'm aware of a – the ministerial submission, but I can't think of the date off the top of my head.

MR GRAY: All right. Do you have any knowledge as to why the Minister announced the strengthening of regulation on the use of restraints in residential aged care on 17 January?

MS LAFFAN: No, I don't.

MR GRAY: And is it the case that the Minister imposed tight timelines on the implementation of the various options that were chosen by government in that table? Is that - - -

MS LAFFAN: As part of the Minister's media release, he talked about the changes to regulation happening as soon as possible. So that was the timeframe put on by the Minister.

MR GRAY: Yes. And that consultation that you were tasked with coordinating, which split into the stakeholder group and the clinical committee, did you have directions that that had to be completed by a certain time in March?

MS LAFFAN: Not by a certain date, no.

MR GRAY: Okay. Just as soon as possible.

MS LAFFAN: Correct.

MR GRAY: In the event those consultations were completed in March; is that right?

MS LAFFAN: That's correct.

MR GRAY: They started in February in both respects, with respect to both groups, did they?

MS LAFFAN: I believe the first consultation was 4 March for the stakeholder group that I led and was earlier for the Chief Medical Officer's group. So in February, yes.

MR GRAY: Thank you. And they both concluded in March?

MS LAFFAN: Yes.

MR GRAY: Now, you've mentioned, I think it's paragraph 51 of your statement, a complaint from stakeholders in the group you convened that the process was rushed and there hadn't been an exposure draft of the amending principles; is that right?

MS LAFFAN: That's correct. That's a criticism that we've received.

MR GRAY: Yes. You then refer to a consensus being reached in a later meeting that no further meeting was needed, but were there dissenting views?

MS LAFFAN: Not on whether a further meeting was needed, no.

MR GRAY: Did the people who had made complaints about the process being rushed and there being no exposure draft ever withdraw those remarks?

MS LAFFAN: No.

MR GRAY: Was the process rushed?

MS LAFFAN: No. It was in short timeframe, though.

MR GRAY: In answering that it wasn't rushed, is it your evidence that all of the material options that deserved consideration did get consideration?

MS LAFFAN: Yes.

MR GRAY: The options that were considered by both the stakeholder group and the clinical group, to your knowledge, did they include any option for the imposition of potential pecuniary penalties in the event of breach of the new proposed provisions for regulation of the use of restrictive practices?

MS LAFFAN: No, they didn't in either group.

MR GRAY: Just didn't - - -

MS LAFFAN: Wasn't - - -

MR GRAY: - - - occur to anybody?

MS LAFFAN: Wasn't mentioned.

MR GRAY: Was there reflection given to the rules that apply in the NDIS scheme around regulation of restrictive practices?

MS LAFFAN: Yes, there was.

MR GRAY: I will bring those up. They are RCD.9999.0063.0097. These are the National Disability Insurance Scheme Restrictive Practices and Behaviour Support Rules 2018, Ms Laffan. Are you familiar with these rules?

MS LAFFAN: I wouldn't say familiar, no.

MR GRAY: Had you read them before embarking on the work that was done to formulate the amending principles in January and February this year?

MS LAFFAN: I didn't, but I understand that members of my team did.

MR GRAY: If we go to page 0103, we see there's a definition of a behaviour support plan, meaning a comprehensive behaviour support plan or an interim behaviour support plan. And there's a definition of an NDIS behaviour support practitioner, which means a person the commissioner considers is suitable to undertake behaviour support assessments, including functional behavioural assessments, and to develop behaviour support plans that may contain the use of restrictive practices. And the Commissioner is the NDIS Quality and Safeguards Commissioner, I should say.

Did either of the working groups in question, the stakeholder group that you convened or the clinical group, to your knowledge, consider adopting requirements for an NDIS – beg your pardon – requirements of the kind referred to in the definition of NDIS behaviour support practitioner relating to having a special person approved by a regulator being recognised as the person able to undertake behaviour support assessments with the requirement that restrictive practices only take place in accordance with those assessments?

MS LAFFAN: No. It had previously been considered and not supported by government.

MR GRAY: When was that?

MS LAFFAN: Following the Carnell Paterson review.

MR GRAY: Can you give an approximate date? I think that might have been in - - -

MS LAFFAN: I would say - - -

MR GRAY: July - - -

MS LAFFAN: - - - late - late to early – late 2017 to early 2018.

MR GRAY: And it wasn't raised in the papers provided to either of the groups that were convened to assist in consultations for the development of these principles for that reason. Is that what you're saying?

MS LAFFAN: That's correct, although I believe I referred to it in the Chief Medical Officer's meeting.

MR GRAY: Okay. And the conditions related to use of regulated restrictive practices, binding on NDIS providers, they in effect are enforceable via a civil penalty provision if conditions of registration are breached; is that right? That appears from page 0105, note 1. Is that within your knowledge or is that - - -

MS LAFFAN: It's not within my knowledge.

MR GRAY: Right. And just higher up that page in 7(a), the simplified outline at part 2, the thrust of that part of these rules is that requiring the use of restrictive practices – I beg your pardon:

> *...the conditions that are imposed by that part, include requiring the use restrictive practices to not occur where the relevant State or Territory prohibits such use. The undertaking in accordance with State or Territory authorisation*

processes and a behaviour support plan can be recorded by the provider and reported to the commissioner –

Again, that's the commissioner - that's the NDIS Quality and Safeguards Commissioner -

...so that the commissioner can effectively monitor the use of regulated restrictive practices in the NDIS.

This idea of requiring any use of restrictive practices to be reported to a regulator, that doesn't seem to have been included in the amending principles but you're saying it might be picked up in the mandated national quality indicator program once that becomes mandatory in 2021, depending on what the medication management indicator turns out to be in that program; is that right?

MS LAFFAN: That's correct, noting there's an indicator on physical restraint which comes into effect earlier, yes.

MR GRAY: Finally, the definition of "restrictive practice" to which these rules apply is regulated restrictive practice and it's on page 0104, and it's – it's quite broad. It's a lot broader than the definition of chemical restraint and physical restraint that's used in the amending principles that are being added to the Quality of Care Principles 2014. It includes, for example, seclusion, and environmental restraint. Was the consideration of the option of - - -

MS RICHARDSON: I will just raise an objection. The question hasn't been put to the witness as to whether she accepts it's broader in all respects. I think there's a premise to that question that hasn't been established.

MR GRAY: Do you accept that, that is it is a broader definition?

MS LAFFAN: No, I don't.

MR GRAY: And why is that?

MS LAFFAN: If you look at the definition that we've used in the 2019 principles we've specifically defined chemical restraint, and then we define physical restraint as all other types of restraint. So it's the broader – the broader definition which I suggest covers those other forms of restraint in the NDIS definition.

MR GRAY: Thank you. So your evidence is that physical restraint in the amending principles will be enforced on the basis that any seclusion of a resident in residential aged care is a physical restraint?

MS LAFFAN: Where it satisfies the definition in the principles, yes.

MR GRAY: And likewise, what, a keypad on a door might be an environmental restraint?

MS LAFFAN: Excuse me, I'm just referring to the principles. Yes, where that keypad is a device that interferes with the consumer's ability to make a decision or restricts their free movement, so I suggest that that would fit within that definition.

MR GRAY: Thank you. Do you have any knowledge, Ms Laffan, as to why a regulatory approach, that is, an amendment to regulations around use of restrictive practices was announced in January 2019 given that it didn't appear to have been part of the general approach of government to this issue prior to that date? Or is it – is the answer the same as the answer to my question, why did the Minister make the announcement in January?

MS LAFFAN: That's correct. I can't speak for the government.

MR GRAY: Within the department, was there, prior to 17 January 2019, a view that the previous regulatory framework was ineffective to address the problem of use of psychotropics for the purposes of restraint?

MS LAFFAN: My view was the current – the current requirements in the – for the new standards satisfactorily dealt with restraint.

MR GRAY: So let's get that straight. The new requirements in the new standards, the Single Quality Framework that's about to commence as from 1 July, would adequately deal with restraint. Is that what you're saying?

MS LAFFAN: That was my view, yes.

MR GRAY: Okay. But what about the accreditation standards in schedule 2 of the quality of care standards 2014 now; did you have a view that they were not effective to regulate the use of psychotropics for the purposes of restraint?

MS LAFFAN: I had a view that they could be strengthened and that strengthening was done through the development of the new set of standards.

MR GRAY: Okay. And in respect of the new standards, that are going to commence on 1 July, was it standard 8 in particular that you considered to be the step that will strengthen regulation of inappropriate use of psychotropics for the purposes of restraint.

MS LAFFAN: One component, standard 8, yes.

MR GRAY: Is that the main change, because there has to be a clinical governance program that has that amongst its purposes or - - -

MS LAFFAN: There are others.

MR GRAY: Could we bring up tab 63, please. Do you see there at the bottom of – this is an email chain, you appear to have been copied into perhaps the penultimate email in the chain, from Michael Murray to Cathy Haffner, Brendan Murphy, cc Amy Laffan; do you see that?

MS LAFFAN: Yes.

MR GRAY: Dated 21 February 2019, and it's forwarding a chain of emails which include in effect a discussion between the CMO Professor Murphy, and the clinical adviser interim to the commission, Professor Murray; is that right?

MS LAFFAN: Correct.

MR GRAY: And I think it's Professor Murphy who said at the bottom:

> *It is accepted that some care staff request chemical restraint because of perceived or real workload issues in managing behaviourally disturbed residents.*

Do you see that?

MS LAFFAN: Yes.

MR GRAY: Is that a sentiment that you agree with? You accept that as well?

MS LAFFAN: I've certainly heard it before, so yes, I accept that.

MR GRAY: And perceived or real workload issues, I just want to ask you about that. Is the sentiment that you've heard and that I guess you agree with, a sentiment to the effect that some approved providers are in effect saving on staffing by using, or I beg your pardon, by requesting chemical restraint to manage behaviourally disturbed residents, rather than providing them with more intensive amounts of personal care?

MS LAFFAN: That is a sentiment I've heard expressed, yes.

MR GRAY: Yes. And so it follows, does it, that at least for those approved providers who are succumbing to this, and assuming that some medical practitioners might be prescribing to some degree influenced by any such pressure, those approved providers are actually saving on staffing costs to a degree by getting - in effect, procuring chemical restraint for some of their residents; is that right?

MS LAFFAN: That would seem the effect of it but I couldn't speak to staffing dollars or anything like that.

MR GRAY: No. Has there been any analysis done within the department of what might be the cost implication for the cost base of the body of approved providers,

886 approved providers, by reason of the removal of the use of psychotropics as a chemical restraint?

MS LAFFAN: Not to my knowledge.

MR GRAY: Okay. Presumably if is there were to be an effective regulation, in effect stopping approved providers from putting pressure on medical practitioners to prescribe psychotropics for the purposes of chemical restraint, there would be additional workload implications of that outcome – I mean, it's very hard to say there would be additional workload implications for this, that or the other approved provider but across the board there would be some increased workload implication if that were to occur; is that right?

MS LAFFAN: I accept that that's probably correct, yes.

MR GRAY: But it hasn't been costed?

MS LAFFAN: No.

MR GRAY: In your statement you make a few remarks about what you expect as a result of the new principles coming into force. What do you expect the result of those new principles will be?

MS LAFFAN: I would expect that services follow best practice and as a result I would expect that – that the use of physical and chemical restraint is limited – is reduced, pardon me.

MR GRAY: So do you say your expectation is there will be a material reduction in the use of psychotropics?

MS LAFFAN: Perhaps less so for psychotropics, given the role of the medical profession and it's not limited to the approved provider but for physical restraint, yes.

MR GRAY: Yes. And if we're talking in the broad sense about the use of keypads, that could be quite a radical change to the modus operandi of many approved providers; is that right?

MS LAFFAN: Yes, depending on the intent of that, the use of those keypads. It's the intent that defines whether something is used as a restraint or not.

MR GRAY: Well, assuming that you've got wings in residential aged care facilities around the country where there's a keypad lock imposed on entry and exit from that wing because of an intention to keep the residents who live in that wing within that wing, you're saying that is physical restraint, aren't you?

MS LAFFAN: Under this definition, it would appear so, yes.

MR GRAY: And, if that's right, then the effect of the amending principles is going to be that, absent all of the conditions that are set out in the principles being met, including prior informed consent save in emergencies, medical practitioner sign-off, etcetera, then those people can't be held in a wing behind a keypad – behind a keypad locked door; is that right?

MS LAFFAN: Without the meeting of those conditions, yes.

MR GRAY: Well, that would have enormous workload – increased workload implications for many approved providers, wouldn't it?

MS LAFFAN: I would suspect that currently a number of approved providers would already be keeping record of those things and – and making sure that those conditions are met even without the – the regulations in place.

MR GRAY: So it's – okay. So are you saying it's not, in fact, going to change the level of physical restraint so much as just, in effect, legitimatise that level of physical restraint? Is that what you're saying?

MS LAFFAN: No. I don't believe that's what I'm saying at all.

MR GRAY: Right. But you expect there will be a reduction in the use of psychotropic restraint. Do you expect there will be a reduction in the use of physical restraint, as well?

MS LAFFAN: Sorry. I think I said I expect there would be a reduction in physical restraint, but I wasn't necessarily sure with respect to psychotropics.

MR GRAY: I'm sorry.

MS LAFFAN: Yes.

MR GRAY: Okay. Well, with respect to physical restraint, you've said in answer to my question about the locked – keypad-locked doors, you expect a lot of approved providers are already keeping those consents and they will be able to meet the preconditions for physical restraint in that broader sense?

MS LAFFAN: That's correct, some would be.

MR GRAY: Some would be?

MS LAFFAN: Yes.

MR GRAY: But you expect there's quite a lot who aren't?

MS LAFFAN: I don't know the numbers either way, but yes, I would expect that, as well.

MR GRAY: Well, I mean, we've got a number of unknowns here. But I suggest to you that if your expectation is well founded, then there will be huge workload implications for a number of approved providers, probably a significant number of approved providers. They will have to put on more staff to try to provide more personalised care for the residents for whom they haven't met those conditions for physical restraint; agreed?

MS LAFFAN: I would suggest that we are, essentially, codifying what was already out there as best practice requirements for the sector.

MR GRAY: Yes, but – well, I asked you about the tool before. And that was simply discretionary; correct?

MS LAFFAN: It's – sorry. It is discretionary, correct, but it's the way that it's identified in the results and processes guide for providers as a way that they can demonstrate that they meet the standards.

MR GRAY: Nevertheless, if that had been doing the job, there wouldn't have been a need for these new amending principles to impose further prescriptions about the use of – or impose regulatory prescriptions about the use of restraint in the first place?

MS LAFFAN: Yes, I accept that.

MR GRAY: So there seems to have been a consensus that the decision-making tool and other education and guidance wasn't doing the job and that there was a real level of concern amongst experienced practitioners that there was significant use of restraint in residential aged care. Don't you agree?

MS LAFFAN: Agree, yes.

MR GRAY: Well, my point is that if you're right and the new principles are going to have an effect, that's going to have huge workload implications on a material number of approved providers who haven't previously been adopting best practice?

MS LAFFAN: It could, yes.

MR GRAY: Has that been the subject of any consideration as to whether additional funding is going to be needed to keep those approved providers viable?

MS LAFFAN: Not additional funding, no.

MR GRAY: Can we please – I should have asked you this before, but can we please display tabs 68 and 62 at the same time. In effect, I'm going back in time to the work of the clinical committee. Ms Laffan, you had a role in providing information and background material and data to that committee; is that right?

MS LAFFAN: Yes. Collating that data.

MR GRAY: Collating.

MS LAFFAN: Yes, that's correct.

MR GRAY: Thank you. In agenda item 4, there's a reference to – if we go over the page. That's all right. We will just stick with agenda item 4 and then we will come to the next document in a minute. Pardon me. If we go to page 6377 under the heading Relevant Data, it says "attached to this paper are", and then there are a number of things, including the reference to the ALRC Report on Elder Abuse, the Atlas for Health Care Variation, Dr Westbury's report on the RedUSe program and then Pharmaceutical Benefits Scheme data. Do you see that? Now, is that – I will just ask – just remembering that reference and it's referred to as attachment 4D down the bottom, is that document the document at tab 62, if the operator would please bring up tab 62. Short question is, assuming we get that in a moment - - -

MS LAFFAN: It's an Excel sheet that I've seen before, so if that's what you're referring to.

MR GRAY: Yes. Thank you. Yes.

MS LAFFAN: Yes.

MR GRAY: And that's broken down into age groups and across certain years.

MS LAFFAN: And types of drugs is my understanding, yes.

MR GRAY: Thank you. And, with the exception of data that's in, for example, Dr Westbury's report of the outcome of the RedUSe program and the other items that you had under the heading, was this the only, in effect, hard numerical data that was provided to the clinical committee?

MS LAFFAN: Yes, noting that the – that the area responsible for creating this table attended the – that part of the committee meeting to answer questions.

MR GRAY: Because it's the case, isn't it – we heard from Professor Murphy on this – that there isn't direct data as to the rate of prescription of any of these pharmaceuticals of concern in a residential aged care context?

MS LAFFAN: I would have to defer to Professor Murphy on that.

MR GRAY: All right. The committee expressed an opinion – well, I will withdraw that. You defer generally to Professor Murphy on the topics covered by the clinical committee; is that right?

MS LAFFAN: With most respect to the PBS data and given that other members of the department provided that data and spoke to that, I can't – I don't feel I could answer questions about that.

MR GRAY: And in respect of rate of over-prescription of psychotropics, it's just not an area within your knowledge; is that right? And you don't have data on it?

MS LAFFAN: That's correct.

MR GRAY: There's reference in agenda item 4 to the Victorian Public Sector Residential Aged Care Services having to report on a mandatory five indicators for the quality indicator program that applies just to those services in Victoria. You're familiar with that topic?

MS LAFFAN: That's correct, yes.

MR GRAY: The Victorian medication management indicator is about polypharmacy, isn't it?

MS LAFFAN: That's correct.

MR GRAY: And you're saying that might be what's adopted?

MS LAFFAN: It's one of the options, yes.

MR GRAY: But you don't know.

MS LAFFAN: That's correct.

MR GRAY: Could we go to tab 107, please. There were two ministerial briefs relating to the process that led to the making of the amending principles on minimising use of restraints; is that right?

MS LAFFAN: Correct.

MR GRAY: And this is the first of them, tab 107?

MS LAFFAN: That relates to Professor Murphy's group, yes.

MR GRAY: Yes. And you're the contact officer?

MS LAFFAN: I am.

MR GRAY: And if we go over the page, we see five options that are actually listed out of the last page or so of the clinical committee's options paper.

MS LAFFAN: That's correct.

MR GRAY: And one of those, 2A, is a requirement for documentation of the specific indication for prescribing, the behaviours to be addressed, and documentation that informed consent has been provided. See that?

MS LAFFAN: Yes.

MR GRAY: That requirement – both limbs of that requirement that I just read out don't appear to be reflected in the amending principles. Would you agree with that?

MS LAFFAN: Agree. Yes.

MR GRAY: And do you know why that option – or I don't know if it's a recommendation, but do you know why that option – both limbs of it don't appear to be reflected in the principles?

MS LAFFAN: My understanding is that option refers to chemical restraint and it refers to the documentation being kept by and the informed consent being sought by the prescriber and not the approved provider.

MR GRAY: And what do you base that on?

MS LAFFAN: I base that on some very strong feedback from the group that – from the chief medical officers' group that is the provider who – sorry – it is the prescriber who is required to seek informed consent from the person or their decision-maker.

MR GRAY: Yes. But it – well, just to challenge you a little on that, that may be so, that it's the – it was the clear view of the committee that it's the prescriber who has to seek and obtain the informed consent. But isn't the matter of documenting that informed consent has been provided a separate point? Can't an approved provider be subjected to an obligation of documenting that informed consent has been provided? And isn't that, in fact, what happens in the disability sphere?

MS LAFFAN: I can't speak for the disability sphere, but, as an option, that could be an option, yes.

MR GRAY: All right. And what about the weekly documentation of the impact of any behaviours, and the documentation of a formal 12 week review or other agreed point – other agreed time point? That doesn't appear to be reflected in the principles; is that right?

MS LAFFAN: No. Again, I believe that refers to prescribing habits and responsibilities of prescribers.

MR GRAY: There are five matters all together that are proposed by the clinical committee. And we've just referred to one limb of one of those five matters; correct? When the Minister made an indication in response to this ministerial

submission back on page 0374, he seems to have said, "I would like both options to be progressed, because they're equally important." Is that right?

MS LAFFAN: That's what his annotation appears to say, yes.

MR GRAY: And how did – did you have discussions in order to understand that indication and what was the meaning of that indication?

MS LAFFAN: Not discussions with the office, but I can recall discussing it within my team. And our understanding of that is that the Minister is referring to both these options that the clinical advisory committee came up with and also the regulatory options which were presented in another ministerial submission.

MR GRAY: Right. Let's go to that submission. Is that the document which I will now ask to be put up, tab 116?

MS LAFFAN: Yes, that's the document.

MR GRAY: So in effect, your view is that when the clinical committee's options paper was drawn to the attention of the Minister, that actually was a distinct piece of work from the proposal for the particular form of the amending principles, which is the subject of the ministerial submission at tab 116; is that right?

MS LAFFAN: A separate piece of advice, yes, but I note we referred to the work of the clinical advisory group in that submission.

MR GRAY: And in effect, you've drawn on some aspects of that work in that options paper in the ministerial submission, tab 116, which is on the screen now, but only some aspects of it. Is that right?

MS LAFFAN: That's correct.

MR GRAY: All right. Now, towards the end of that document on page 4550, under the heading Regulatory Burden Implications and/or Deregulation Opportunities, in the second paragraph it says:

> *The Office of Best Practice Regulation has assessed the regulatory impact of this measure as having no more than minor impacts.*

And then there's a reference, and then it says:

> *The proposed amendments create in law specific requirements of what is already expected of residential aged care providers.*

I just want to ask you about that. We've got the – I think it's what's called a pre-RIS authorisation.

MS LAFFAN: Regulatory impact statement, yes.

MR GRAY: Yes. And it does indeed say something to the effect of what you paraphrased here.

MS LAFFAN: That's correct.

MR GRAY: What I want to ask you about is this: if it was considered - or firstly I should ask, is that a view that you agreed with, that it had no more than minor impacts?

MS LAFFAN: It is.

MR GRAY: It is a view you agreed with?

MS LAFFAN: Yes.

MR GRAY: And you're again the contact officer for this ministerial submission, aren't you?

MS LAFFAN: I am.

MR GRAY: If it has no more than minor impacts, how is that consistent with the expectation you've expressed in your statement that the amending principles are going to have an effect in reducing the prevalence of these restrictive practices that are the subject of the amending principles?

MS LAFFAN: So this refers to amendments creating in law requirements that are already expected of aged care providers. So those requirements, I would include the requirements of the new standards and the additional requirements, for example, standard 8 that you talked about earlier and those – those changes similarly had regulatory costings done for those. So there were regulatory costings involved in those changes.

MR GRAY: So do you say that even without new section 15F and G, and without that broad description of physical restraint, picking up the use of keypads and so forth, that the cost of, in effect, having to allow people who are currently residing in wings behind keypad locked doors to be free to move around an entire facility unless the conditions in the principle is met, that actually has already been taken into account in the costings for the new Single Quality Framework?

MS LAFFAN: That's my view, yes.

MR GRAY: And what is that cost?

MS LAFFAN: That was $30 million over 10 years.

MR GRAY: And that's a cost that has been assessed in terms of what, the cost of care for additional attention to be provided for people who will no longer be able to be restrained behind keypad locked doors?

MS LAFFAN: There are a number of factors that are taken into account as part of regulatory impact statements and they include staffing and training, documentation, all of those sorts of requirements.

MR GRAY: Does it also include cost of care?

MS LAFFAN: I believe it includes cost of staff to implement the changes but cost of care, particularly, I'm sorry, I don't know.

MR GRAY: Will the Department be able to provide the documents evidencing that costing to the Royal Commission – to the staff of the Royal Commission after you've completed giving your evidence?

MS LAFFAN: I believe we could, yes.

MR GRAY: I will ask my instructors to make that request in formal correspondence. There's no reason why that request can't be met that occurs to you while you're in the witness box?

MS LAFFAN: The only thing that I would say is that it is a draft regulatory impact statement. We discovered upon drafting it that we, in fact, had an exemption and didn't need to finalise that regulatory impact statement, so it's not finalised.

MR GRAY: Right. Operator, please display tab 105. This is the explanatory statement for the amending principles. You're familiar with this document, Ms Laffan?

MS LAFFAN: I am.

MR GRAY: If we go to page 5320; at 5320 there's a reference to the new amending principles engaging – this is about three-quarters of the way down the page:

> *The amending principles engage the right to protection from exploitation, violence and abuse as contained in article 22 of the International Covenant on Civil and Political Rights, and article 16 of the Convention on the Rights of Persons with Disabilities.*

That's the UN disabilities Convention that applies to people with disabilities irrespective of age. Do you have any familiarity with the content of that international law provision, article 16 of the Convention on the Rights of Persons with Disabilities?

MS LAFFAN: No, not beyond the details - - -

MR GRAY: All right.

MS LAFFAN: - - - that you have up there.

MR GRAY: It seems that this was a matter that was taken into account in the preparation of the amending principles. Do you agree with that?

MS LAFFAN: That's correct.

MR GRAY: The short point is that the disabilities Convention applies to people who are over 65 when they incur their disability as well as people under 65 when they incur their disability. However, the aged – the aged care regime around restrictive practices which is the subject of the amending principles is, in effect – sorry, I withdraw that. The disability Convention applies equally to people whether they incur their disability before they turn 65 or after they turn 65; if you just accept that for the moment.

MS LAFFAN: I accept that, yes.

MR GRAY: It has been suggested, for example, in evidence of Mr Rees, Mr Glenn Rees, exhibit 3-40, that there should be stronger emphasis on the human rights of older Australians with dementia, and one of the points Mr Rees has made is that if an Australian incurs a diagnosis of dementia before they turn 65 they're entitled to benefits under the NDIS, whereas if they incur their diagnosis after they've turned 65 they're not entitled to those benefits and they fall within, in effect, the aged care system, but can't access benefits under the NDIS. Is this a topic I should be directing to Ms Mond or is this an area within your - - -

MS LAFFAN: I'm not sure it's an area within either of our expertise. It's a matter of government policy.

MR GRAY: Right. Finally, I will just ask that we display exhibit 1-27 which is the Australian Law Reform Commission report 131. That is RCD – thank you. If we go to page RCD.9999.0011.0316, these – the recommendation at 4-10 and 4-11 were referred to in your statement and there was that extract from the – from this report provided to the committee as we saw a short time ago in the agenda papers. Was there serious consideration given to adopting recommendation 4-10 and 4-11 in the drafting of the principles?

MS LAFFAN: Yes, there was.

MR GRAY: Why were those recommendations not adopted? Take your time to break down your answer in respect of each recommendation, if you choose.

MS LAFFAN: I don't accept that we didn't adopt those.

MR GRAY: So you say the amending principles do adopt these recommendations?

MS LAFFAN: Largely, yes.

MR GRAY: What about the requirement for the restrictive practice to be – this is 4-10(d):

As prescribed by a person's behaviour support plan.

That doesn't appear to be adopted, does it?

MS LAFFAN: To my mind that's covered in the amending principles when we make reference to the plan for care and services.

MR GRAY: All right. And in respect of 4-11, there doesn't seem to be a provision for a senior practitioner to provide expert leadership on an oversight of the use of restrictive practices.

MS LAFFAN: Again, to my mind that's one of the roles of the chief clinical adviser in the Aged Care Quality and Safety Commission.

MR GRAY: There's no process for the submission of behaviour plans to a regulator for approval or oversight by the regulator, is there?

MS LAFFAN: No, there's not.

MR GRAY: No further questions.

COMMISSIONER BRIGGS: Ms Laffan, thank you for your testimony today. I want to follow a little bit the issues about the NDIS and the decision of the government not to proceed with the NDIS rules on restraints at the end of 2007 or beginning of 2008. Did the Department make a recommendation that the Government should pick up any or some of the NDIS rules on restraints?

MS LAFFAN: I don't believe so, no.

COMMISSIONER BRIGGS: So in effect, the Government was accepting your recommendation not to do so?

MS LAFFAN: I would have to check back but I don't think we explicitly said – we explicitly said don't adopt those things. We provided information, advice as to what the model was, where it had come from and our views on that model.

COMMISSIONER BRIGGS: Is there a practice within the department of learning the lessons from other areas of human services delivery?

MS LAFFAN: Absolutely there is, yes.

COMMISSIONER BRIGGS: What practice is there looking at the lessons from the NDIS experience and transferring it into the aged care experience?

MS LAFFAN: So, for example, in the case of this – these principles, my team had at least a couple of discussions with the Department of Social Services to understand not only the regulations and the structure and how things worked but what the potential benefits or drawbacks were for those – for what was in place in terms of NDIS, and we also had our colleagues from the Department of Social Services attend our stakeholder group meetings.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Nothing arising from that, Mr Gray?

MR GRAY: No, thank you, Commissioners.

COMMISSIONER TRACEY: Thank you very much for your attendance, Ms Laffan, you're excused from further attendance.

MS LAFFAN: Thank you.

<THE WITNESS WITHDREW [3.59 pm]

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: If I can proceed to our next witness. Our next witness is Josephine Mond.

<JOSEPHINE MOND, AFFIRMED [4.00 pm]

<EXAMINATION BY MR GRAY

MR GRAY: What is your full name?

MS MOND: Josephine Mond.

MR GRAY: Have you made a statement for the Royal Commission?

MS MOND: I did.

Please bring up WIT.0144.0001.0001. Operator, please track through to the end of the document. Pardon me. Go to page 0031. 0031. Ms Mond, is this a copy of the statement you've made for the Royal Commission dated 18 April 2019?

MS MOND: Yes, it is.

MR GRAY: Do you wish to make any amendments.

MS MOND: No.

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

MS MOND: Yes, they are.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The statement of Josephine Monday, dated 18 April 2019, will be exhibit 3-79.

EXHIBIT #3-79 STATEMENT OF JOSEPHINE MOND DATED 18/04/2019 (WIT.0144.0001.0001)

MR GRAY: Thank you, Commissioner. Ms Mond, you're an Assistant Secretary in the Department of Health.

MS MOND: I am.

MR GRAY: You have responsibilities in respect of dementia policy in the Department; is that correct?

MS MOND: That's correct.

MR GRAY: I will ask that an organisational diagram in June 2018 be displayed at tab 4. And although you appear here under Aged Care Support and Population Health, it's just – your description – your position description at that point in time seems to be Specialised Programs and Regulation. Soon after, dementia policy seems to have been added to your description. Is that a correct understanding?

MS MOND: I had responsibility for dementia policy under this title from December '17. However, yes, shortly after this time, so about July/August 2018, there was a change in – and I – so I retained dementia policy, but lost other components of my responsibility.

MR GRAY: So are you saying that it's just a matter of title description, but you always had responsibility?

MS MOND: In relation to dementia, yes, that's correct.

MR GRAY: All right. You make a point in your statement – and this is in paragraphs 14 and 15 – about dementia policy needing to be holistic. And I just want to ask you some questions about that, particularly in light of some remarks that have been made by Mr Glenn Rees about the structure of the Department - - -

MS MOND: Yes.

MR GRAY: - - - and whether it's set up in a way that really facilitates holistic development of dementia policy. One of the points Mr Rees makes is that the Department previously had access to an expert advisory group specifically about dementia, but that that group was disbanded in 2014. Now, I know 2014 might have been before you took the responsibilities you currently have, but do you have knowledge – in effect, knowledge through your institutional connection with the Department of Social Services and - - -

MS MOND: Yes, I do.

MR GRAY: - - - Department of Health about this? Has there been in effect less knowledge available to the Department about the development of dementia policy in the years since the disbanding of that expert group on dementia, the group that was disbanded in 2014?

MS MOND: Whilst it's difficult for me to comment on the extent to which that engagement occurred at that time, what I can say is that I understand that when that group was disbanded it – along with other ministerial committees that were disbanded – it became the Aged Care Sector Committee, which is an enduring ministerial committee that I regularly attend and discuss dementia policies with.

Since then, I've also in parallel started a very human-centred design approach that I'm facilitating, both across the Department and the sector, around the issue of dementia, given it's both a health – well, not just health and aging, but, as you point out in that part of my statement, it's an issue that crosses a lot of sectors and lot of levels of government and we need to have a very different approach and actually stand in the shoes of those living with dementia if we're going to solve some of the more complex issues that pervade.

MR GRAY: And is that body, in effect, the only group that crosses between the aged care division and the health division of the department on issues of dementia?

MS MOND: No. It's one way we do. We also, over the past, say, six months or so have strengthened the aged care governance groups that we have within where we have people from both across the Department and the Aged Care Safety and Quality

Commission and other stakeholders come and discuss issues of policy and dementia. So we have some that we drive from within the aged care group. And – but it is probably one of the bigger changes we've done in engagement is through the dementia in the community project and how we drive that across the Department, so that everybody is thinking from their perspective about the role they play in, you know, the issues that we face with dementia.

MR GRAY: Mr Rees pointed to the effect that there's a surprising level of outsourcing of policy development by the Department in the area of dementia. And he gave the example of the KPMG pathways document in 2011 and the – and the actual National Framework on Dementia itself in 2013. Would you prefer there was a greater level of in-house policy development or are you comfortable with the extent of outsourcing of policy development on dementia?

MS MOND: I think we do a good job of harnessing the expertise we have in policy development and experts in the clinical field within health. But dementia is a very complex issue and I think that the outsourcing or the involvement of clinical experts or other experts when we face policy and program issues is very important. So I'm fairly comfortable with the balance that we have.

MR GRAY: Mr Rees in his statement considers or expresses the opinion that aged care policy, in his view, has been dominated by residential care and funding to the detriment of some of the measures that are in the national action plan and in the HWO – beg your pardon – the WHO action plan on dementia around timely diagnosis and support. What's your view on that?

MS MOND: And I think everybody who has heard the type of evidence that we've seen in the Royal Commission would agree that it's really important that we maintain a strong focus on dementia in terms of residential care and aged care more broadly. In terms of timely diagnosis, we do have a number of programs that – particularly the National Dementia Support Program and the Dementia Friendly Communities that really go to that – you know, the point of diagnosis, as well as important training programs that are assisting GPs and others to really be better at timely diagnosis. So I think the Department is doing a lot in regard to that. I think there can always be more that we can do. And we're continually looking at particularly training programs and other things to improve what's on – what's offered.

MR GRAY: The real gravamen of the point he makes with specific reference to outcomes that are referred to in the National Framework for Action on Dementia is there's an absence of any measurable milestone and an absence of evaluation and an absence of data. I will just take you to an example. If we bring National Framework for Action on Dementia, tab 9. If we please go to – pardon me – please go to page 5669, just as an example on diagnosis – beg your pardon – that's accessing care post-diagnosis. If we go to page 5666, that's Outcomes and Actions, the Need for Timely Diagnosis, heading 2.4. There are some laudable descriptions of what should be happening which are aspirational, but they're not measurable. What do you say to that?

MS MOND: The comment I would make about that is that this is a very complex thing to measure. We've heard quite a bit of evidence around the many pathways that a person living with dementia can take to diagnosis, and also that there can be a reluctance by some to even seek a diagnosis. So I know across the world and with some of my interaction I've had with the World Dementia Council, many countries grapple with how to improve measurement and evaluation in this area. But do I – do I think we need to see – you know, work on how we can strengthen evaluation and measures? Absolutely. It's critical to supporting people with dementia to get the early access to supports that they need at the point of diagnosis.

MR GRAY: Well, the Commission has been told – that's the Royal Commission. The Royal Commission has been told that there's actually no direct national data on what is the extent of diagnosis of dementia in Australia, which is a matter of concern, isn't it, if that's correct?

MS MOND: As a policy officer, I would definitely like to see strengthened data in that area. Absolutely.

MR GRAY: So at present, what – your area and the Department works on inference – sort of inferential measure of what the level of dementia in the community is, does it?

MS MOND: To a large extent, yes. So I did a reference in my statement data that we have from the Australian Institute of Health and Welfare. And, you know, there are – there is data that we – that we obtain which does extrapolate based on ABS-type data and then, you know, in relation to, for example, prevalence, looking at hospital data and around a reason for death and then making inferences around that. And, yes, it's the best that we have in some areas of dementia.

MR GRAY: The National Framework for Action on Dementia is expiring this year.

MS MOND: It is, yes.

MR GRAY: And you refer in your statement to the fact that there are consultations underway for the development of a replacement.

MS MOND: About to commence, yes.

MR GRAY: They're about to commence. So, going into those consultations, which will be at the COAG level, I assume - - -

MS MOND: They will.

MR GRAY: - - - will it be the Commonwealth's position that there should be measurable signposts, both in terms of timeline and in terms of the amount of money that's going to be spent, in acquiring direct data about the level of diagnosis of dementia in the community?

MS MOND: Certainly that will be my aim going into the consultation I would say, particularly in the areas where there is need for cost cutting-type issues to be resolved. So particularly where there's a requirement for us to work across levels of government or sectors, I think particularly those areas of focus need really strong actions in a future action plan on dementia.

MR GRAY: So will you be going into the consultations for a new national framework trying to achieve all of the directives that are in the WHO global action plan 2017 to 2025, including the need to have data on diagnosis? Is that what you're saying?

MS MOND: Yes.

MR GRAY: That document is already an exhibit, too, Commissioners, 3-41.

Mr Rees referred to the Korean national action plan as an exemplar: do you agree?

MS MOND: I'm only broadly knowledgeable around the Korean action plan. From Mr Rees' statement, you know, I agree to some of his views around measurable outcomes being very important. I am also aware that some of the issue that Korea continues to grapple with are not dissimilar to some of the things that we grapple with in Australia, particularly around health and aged care interface, early access to post-diagnosis supports, and how we support people with severe behavioural and psychological symptoms of dementia. And Korea has stated that they continue to be challenges, you know, even with their comprehensive plan but I think we have a lot to learn, not just from Korea but from countries around the world who are tackling dementia as we are.

MR GRAY: He says in paragraph 10 of his statement that:

> *The third Dementia Plan for Korea contains an evaluation of the previous plan and four clear objectives, actions, a budget and KPIs.*

I take him to mean a budget for a specific action, so this is the amount of money that will be spent on a particular action.

MS MOND: Yes.

MR GRAY: Is that the shape of the NFAD that you would be hoping to achieve next time around?

MS MOND: Yes, it is. I mean, without knowing the plan in a lot of detail but as you describe it, yes.

MR GRAY: Now, you refer in paragraph 89 to this forthcoming review of the NFAD providing an opportunity to clarify the role and improve collaboration between Dementia Support Australia and the State and Territory funded health

services. What precisely do you have in mind in making that remark? What are the particular areas of collaboration, if you want to take New South Wales as an example, what's – how would that collaboration actually appear on the ground?

MS MOND: If I could refer you to the – the soon to be rolled out specialist dementia care program which obviously is a very new and very important program which will be the third tier of servicing for those with the most severe forms of BPSD. Part of that program being a success will be the important role that Dementia Support Australia will play via the Severe Behaviour Response Team of conducting the assessment for eligibility into that unit. Many of the people who will be moving into that unit currently reside in the state hospital system, so often in older people's mental health facilities and so access for those Dementia Support Australia staff into the hospitals or that environment to conduct the assessment but also to have a really close and enduring relationship with the clinical care providers who have been providing the care for these people is going to be – so that's an example of where there will be a really strong need to have a collaborative relationship for DSA with the state clinical providers and the hospital system.

MR GRAY: I want to ask about another potential interface and it's one the Royal Commission has heard a lot about, and that is the question of whether access to primary and allied health is impeded to some degree for people who are in the residential aged care system. Is that a view that you share, that there are obstacles to access to primary and allied health and are they particularly acute for people living with dementia?

MS MOND: What we hear in our dementia community project is that particularly at the point of transition into new environments, so if I'm moving from the home into a hospital or home into a residential environment, there's often a change in the types of access to a GP, or the allied health services that I have. And that can, or the person with dementia is facing and so that can be – what we hear when we talk to people living with dementia or their carers is that can be very unsettling to be moving around between care providers, but also that, yes, there can sometimes be limitations to access, to the specialists or primary care providers that they have had prior to moving into a residential facility.

MR GRAY: Are there initiatives underway in your area of the Department with responsibility for dementia policy to try to address that problem?

MS MOND: Yes, so at the moment there's various programs that we – we have underway in partnership with the Primary Health Network to address some of those. But it's – it's definitely an area we need to do more. It's come out in our more recent kind of discovery work around dementia in the community and I see it as an area of priority and particularly not just access but coordinated care so that people have spoken about that multi-disciplinary team approach and that's something that's come up as a key policy concept area that we would see as a priority moving forward.

MR GRAY: I want to ask you about the different tiers in the - - -

MS MOND: Yes.

MR GRAY: In the program, the programs that are conducted by your area of the Department and I will move past the training programs and I will ask you about the interventions. So DBMAS, SBRT and now the specialist dementia care centres. With DBMAS and SBRT, off the top of your head if you're able to answer, what's the proportion of the target population within residential aged care who are actually getting access to these services? By that I mean one needs some instigation from the approved provider itself for these services to be accessed at need. Do you have data on what is the level of utilisation across the approved provider population?

MS MOND: No, we – well, what we do know is that Dementia Support Australia have visited around 60 per cent of residential aged care facilities. We also know that annually they support upwards of - I think it's around 16,000 people who need assistance in relation to their behavioural management supports.

MR GRAY: Is that including in community care as well?

MS MOND: That's a – yes, sorry, that's not only residential. It's – we know that the referrals for those services, about 80 per cent come from residential care providers, so it is the majority in the residential space. What we don't know, of course, is how many of the facilities that aren't contacting Dementia Support Australia have their own either specialist dementia consultant or, you know, ways to bring in those consultants to gain assistance with managing severe behaviours and we don't have figures on that.

MR GRAY: All right. Do you have plans to improve data collection in that regard? So you have a better picture of the level of population who actually do have access to the benefit of DBMAS or SBRT at need?

MS MOND: We don't have plans on that specifically in that we are really strongly focused on – I mean, what interests me most is the outcome that you get from that – that interaction, so if people are drawing on the services of Dementia Support Australia, you know, what is the outcome that they achieve from the time that they've spent with them? And we're getting a much richer dataset from Dementia Support Australia around that which has I think got broader usage as well.

MR GRAY: I understand you've said that - - -

MS MOND: But we don't have - - -

MR GRAY: You said that in your statement it has been evaluated.

MS MOND: Yes, that's right. But we don't – we certainly – I mean, we could consider it but it's not something we have discussed in relation to strengthening - - -

MR GRAY: You understand the point of my question, that people actually aren't granted that, your evaluation shows that DBMAS and SBRT have positive outcomes. What about the people who aren't getting access to them, getting the benefit of actress to them, because the approved providers aren't choosing that and you've said you not trying to measure that.

MS MOND: No, we haven't currently, no.

MR GRAY: And at the top of the triangle, I think in the paper that you've annexed on the Specialist Dementia Care Program, you've referred to that being available, one nine bed facility in each of the 30-odd Primary Health Networks - - -

MS MOND: Yes.

MR GRAY: - - - in the country at tier 6 of the Brodaty Triangle.

MS MOND: That's correct.

MR GRAY: Is that right? So that's for something less than – an estimate of something less than one per cent of the population.

MS MOND: That's correct.

MR GRAY: It still doesn't seem like very many beds. Is there data that support the choice of nine beds per Primary Health Network?

MS MOND: The nine beds came out of our extensive consultation and work with the expert advisory group, but also looking at – across the country and internationally at people who were providing specialist dementia care-type units. We went in with that consultation, testing whether around 12 beds would be appropriate. And the strong feedback would be – was that eight to nine beds would be a more appropriate number.

MR GRAY: In terms of the management of a particular facility?

MS MOND: Yes, that's correct.

MR GRAY: Yes. But whether that is the right or an adequate number for the large population of a Primary Health Network, you haven't done data on that?

MS MOND: No, we haven't. It is broadly understood that that will not meet the entire need that is there, the 35 units. This will be very strongly evaluated with a recommendation to government about the future need. A lot of the advice was to hasten slowly and learn very strongly throughout the implementation of this unit, so that, you know, that we can drive the learnings forward, but also have a strong evaluation and recommendation to government. So part of that will be testing both

the – is the eight to nine beds the right model and how you might then scale that type of program more broadly.

MR GRAY: And there has been one that's – the tender process has run. That's with Brightwater in WA. And that's it so far?

MS MOND: That's correct. And on 28 May we have the first tranche of 12 units. The tender process will close on 28 May, so we will be entering the assessment stage for those.

MR GRAY: So, doing the best you can to give the Royal Commissioners an estimate of what sort of timeframe there would be - - -

MS MOND: Yes.

MR GRAY: - - - before you have a robust evaluation of the first 35 units, what would that timeframe be?

MS MOND: So the idea is to commence the evaluation relatively immediately. We will have the first 12 that we're going to market for currently in operation from April next year, 2020. So I would think by the end of – it – really, it will be about how that implementation rolls out, so, really, it will be into next calendar year that we will start to have the early evaluation.

MR GRAY: What about for people who might be at tier 7 of the Brodaty Triangle? I notice that the paper annexed to your statement which, for the record is tab 46, but I won't go to it. That just referred to tier 6. What about tier 7?

MS MOND: So what I would say – and Professor Macfarlane spoke a little to this yesterday, tier 7, is that this is, really, the very, very severe behaviours and psychological symptoms of dementia that may even have a – they're often in a psychiatric-type unit currently. What I would say is we don't know to the extent to which these people may be catered for in a specialist dementia care unit. Certainly the advice from people who have experience – you know, a clinical level of experience that I don't have is that – and are offering state-type services in this capacity at the moment – is that they would require a level of one-on-one, you know, care that couldn't be provided within a residential aged care facility.

MR GRAY: Now, I said I would skip training. I want to come back to it, because there has been a lot of evidence heard by the Royal Commissioners on the importance of upskilling the workforce.

MS MOND: Yes.

MR GRAY: You've made a remark in your statement at 76, which is that:

Dementia training needs to be strongly embedded in the organisational culture of aged care and health care services.

In practical terms on the ground, what's the Department doing to achieve that or to facilitate approved providers achieving it?

MS MOND: So there's a number of things that are being done. The first one, whilst health – firstly, I would say health and aged care workforce broadly aren't my area of responsibility, but, obviously, as the Assistant Secretary of dementia I have a lot of involvement with that. Firstly, in terms of the aged care workforce task force, there's some very important work now happening around the – you know, what's the entry level-type training, the cert III and the cert IV and how we can ensure that dementia is a more strong and mandatory component within the entry level program.

But, encouragingly, the aged services, IRC, are also not stopping just at that level, but also looking at the higher education training, which will be really important, so that we embed it both in the health and in, you know, what can be provided for people as they enter the – the aged care spaces, personal care workers.

On top of that, the program within my responsibility, the Dementia Training Program, looks very strongly at the specific skills in dementia and the training that is required. So they offer, currently to around 7000 people each year, the Dementia Essentials Training Course, which is a three day course predominantly for personal care workers and nurses in the aged care environment, which is really not only just learning about the importance of, you know, understanding dementia and the trajectory and the types of care involved, but actually has – when I say embedding in my statement, it has a need to actually do some experiential-type component of that training in the workplace. So it really is about how you then go and interact with somebody with dementia as part of that, that three day training.

Finally, I would say in relation to the Dementia Support Australia, really, what they're doing is providing a level of training which is a role modelling and a problem solving of – of the – somebody's individual needs as they're facing dementia. So it's embedding it in a different way, which is lesser – which is actually more about how you might face people individually and solve their problems. So it's doing another level of a type of skilling altogether. So I think we're tackling it in many different ways and I think we need to. I mean, finally, I would say it strongly goes to culture. And I think that's critical.

MR GRAY: The Royal Commission has heard evidence there's generally a lot of turnover, especially with the direct care staff. The tenor of your evidence is that the department is supporting mandatory dementia training to be included in the Certificate III and Certificate IV in Aged Care; is that right?

MS MOND: That's correct.

MR GRAY: But if that turnover issue isn't addressed, presumably these other measures, the experiential training and so forth, will in effect fall on dry ground and won't bear the fruit that they should. Is the Department considering measures to try to address this turnover in staff? Or is that outside your dementia policy area?

MS MOND: Well, it is in terms of – I don't have that broad responsibility for workforce. However, what I – what I've observed and heard very strongly through our co-design piece of work is that, you know, it's somewhere where we need to have a multi-pronged approach to ensure that people have a career pathway and are supported so that when they get up in the morning and go to work, they're feeling like they have the skills to do their job and are going to bring the passion to their job. So what I would say about that is that I will certainly be looking, as we drive out a future policy approach to dementia over the next – well, short, medium and long term – that we do look at new ways to – to tackle the issue of how you support staff to – staff retention.

MR GRAY: Three final things. The WHO just this week has issued guidelines in respect of dementia awareness and prevention.

MS MOND: Okay.

MR GRAY: Is that within your policy area, I assume?

MS MOND: Yes, that's correct.

MR GRAY: And it's – the WHO guidelines on risk reduction and prevention. Mr Rees in his statement referred to the cessation of funding for Dementia Australia's Your Brain Matters and he seemed to be suggesting this was symptomatic of a de-emphasising of the importance of taking awareness and prevention measures seriously, and that Government wasn't funding those measures to the extent it should.

MS MOND: Okay.

MR GRAY: Is that right?

MS MOND: No, I don't think that is correct, I'm happy to talk about that particular item, the Your Brain Matters, firstly, and then more broadly. So in relation to that, it's a web-based product around how to reduce risk for dementia, and it came out of funding out of the former - what I now would refer to as the Dementia and Aged Care Services Fund - which is a research and innovation fund that funds short-term one-off-type initiatives or projects with a view to them becoming self-sustaining and scalable. So that was some funding of, I think, three to four million over a number of years to develop and promote the Your Brain Matters some years ago, and the great thing is that Dementia Australia have been able to keep that – that interactive tool updated and relevant without additional funding. So it's still an enduring resource which is exactly what we hoped to achieve with that type of funding.

More broadly in terms of stigma and risk reduction, we hear it is an ongoing issue and something that we need to tackle. The way we're tackling it now is that we have – we fund Dementia Australia to conduct the Dementia Friendly Communities Project, and they've got, I think 16,000 now, people who have signed up to be dementia friends, and are doing initiatives across the community which will be critical around stigma reduction and raising awareness. And equally the National Dementia Support Program provides, you know, a raft of supports in that area. So I think we're doing quite a lot and the – the World Dementia Council are very keen to see how Australia goes about evaluating Dementia Friendly Communities because people around the world are really grappling with how do you measure outcomes of community based awareness and stigma and risk reduction. So we're hoping to collaborate, actually, internationally on how we can strengthen measures in that area.

MR GRAY: Similarly, is the policy area in the Department relating to dementia considering whether the mainstreaming model for caring for people living with advanced dementia is still appropriate, or is this specialist dementia care unit program the beginning of a move towards a de-emphasis on mainstreaming?

MS MOND: I would say is that it's not about a de-emphasis on mainstreaming. It's really about making sure that people are in an environment where they can thrive. So I would – my view to that is that some individuals, even with a more advanced dementia - and I have seen examples where they can live comfortably and supported and safely in a more mainstream environment, but there's certainly - I've also seen strong, you know, some – well, evidence that I've seen myself but also heard clinicians confirm is that there's also evidence that actually having tailored, you know, units for the very severe behaviours is something that – that should be – create a really strong environment to help manage those behaviours so that people can transition back to mainstream. So that's really the position that we hoped to measure as part of that program, but to confirm.

MR GRAY: Finally, a big question, but it's your area that - - -

MS MOND: Yes.

MR GRAY: - - - you can answer if anybody can. Is there serious reflection being given to the discriminatory impact on people who get their dementia diagnosis after they've turned 65 constituted by the fact that they don't get access to the NDIS and get only access to the more limited support of the aged care system? It does appear to be inconsistent, I suggest, with the protections in article 14 and article 16 of the disabilities Convention, for example, which doesn't distinguish between people who have disabilities irrespective of what age they are. Why is it the case that people who incur their disability before they turn 65, in effect, get access to more support and subsidy than people who incur that disability after they turn 65?

MS MOND: The comment that I would make to that is that the work that I'm doing in the dementia in the community project has shown that that is an issue for people. But it's an issue in how people actually get the services they need when they need it.

And I've heard it as strongly from people with younger onset dementia who are facing – who are accessing services through the disability scheme or people who are accessing services from an aged care residential or from home, you know, through medical and other services. It's an area I'm interested in exploring further. In – and not necessarily in relation to - I support Ms Laffan's comment earlier that there has been a decision of government around how the National Disability Insurance Scheme has been established and the criteria of access to that, and it's outside of our realm.

But certainly what interests me and in the way I approach the work and the future of policy for dementia is really about how will people access the supports that they need, whether it be allied health, whether it be psychosocial at any age and at any stage of their dementia and we will be looking at ways to improve that and they may be looking at different models of how you treat dementia and that might be a longer term gain in terms of the policy framework.

MR GRAY: I have no further questions for this witness.

COMMISSIONER TRACEY: Ms Mond, thank you very much for your evidence. We're most grateful to you for coming and giving us the benefit of your views on some very significant issues. Thank you.

MS MOND: Thank you for having me.

<THE WITNESS WITHDREW [4.42 pm]

COMMISSIONER TRACEY: There's nothing else, Mr Gray? The Commission will adjourn until 10 am tomorrow morning.

MATTER ADJOURNED at 4.42 pm UNTIL FRIDAY, 17 MAY 2019

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