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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

BROOME

9.30 AM, WEDNESDAY, 19 JUNE 2019

Continued from 18.6.19

DAY 25

MR P. BOLSTER, counsel assisting, appears with MS E. BERGIN and MS E. HILL

COMMISSIONER TRACEY: Please open the Commission. Yes, Ms Hill.

MS HILL: If the Commission pleases, I call Dr Kate Fox.

<KATE SUZANNE FOX, AFFIRMED [9.31 am]

<EXAMINATION-IN-CHIEF BY MS HILL

MS HILL: Please take a seat, Dr Fox.

COMMISSIONER TRACEY: Please sit down and make yourself comfortable.

DR FOX: Thank you.

MS HILL: Dr Fox, could I ask you to state your full name, please.

DR FOX: Kate Suzanne Fox.

MS HILL: And whereabouts do you live?

DR FOX: In Broome, Western Australia.

MS HILL: What do you do for work, Dr Fox?

DR FOX: I'm a general practitioner.

MS HILL: Dr Fox, you've prepared two statements for this Royal Commission.

DR FOX: I have.

MS HILL: Operator, could you please display document ID WIT.1145.0001.0001. Dr Fox, do you see your statement on that monitor before you dated 16 June?

DR FOX: I do.

MS HILL: And is that the first of the statements that you prepared for the Royal Commission.

DR FOX: It is.

MS HILL: And are the contents of that statement true and correct?

DR FOX: Yes.

MS HILL: And are there any changes or amendments that you seek to make to that.

DR FOX: No.

MS HILL: Commissioners, I tender that statement.

COMMISSIONER TRACEY: Yes, well, I will take them as two separate exhibits. The statement of Dr Kate Suzanne Fox dated 16 June 2019 will be exhibit 4-13.

EXHIBIT #4-13 STATEMENT OF DR KATE SUZANNE FOX DATED 16/06/2019 (WIT.1145.0001.0001)

COMMISSIONER TRACEY: And her second statement bearing the same date will be exhibit 4-14.

EXHIBIT #4-14 SECOND STATEMENT OF DR KATE SUZANNE FOX DATED 16/06/2019

MS HILL: If that statement could be taken off the monitor, operator. Dr Fox, you work at both BRAMS and at the Aboriginal community Bidyadanga.

DR FOX: I do.

MS HILL: Could I ask you to describe your role at BRAMS.

DR FOX: At BRAMS I work as a general practitioner. BRAMS is a large Aboriginal community-controlled health organisation based in Broome and it is comprised of – multiple people work there, most of which are Aboriginal people. There's – so Aboriginal health workers, Aboriginal health practitioners, most of the administration staff and the driving staff, the account staff are all Aboriginal and there's an Aboriginal board that governs Broome Regional Aboriginal Medical Service. And I also work with other GPs. It's a service that has multiple GP consultation rooms, it has a dental space and dental service, antenatal service, child health service as well, and I see patients there on a daily basis that come in on a sort of walk-in basis so people are seen as they arrive.

MS HILL: Is that based in Broome, Dr Fox?

DR FOX: That's in Broome.

MS HILL: Is there such a thing as a typical day at BRAMS?

DR FOX: Yes.

MS HILL: Are you able to describe that to the Commissioners, Dr Fox.

DR FOX: So I arrive at BRAMS. There's a morning meeting that all staff are expected to attend where – whereby, you know, important announcements are made or most importantly there's a list of people that are required to be seen for review that day that are read out and if we're having trouble locating people, then other people in the room might know where they will be or can help us, you know, help us out with trying to find them. And – and after the meeting there's, everybody goes to their individual jobs and the clinic will open and patients come through, and each – so patients will generally come through and be seen first by an Aboriginal health worker or an Aboriginal health practitioner who perform, depending on their capacity and their skillset, might just perform general observations on them, so vital observations and then send them off to see a doctor or may take a short history, may do an ECG or whatever they think is necessary.

And then the patient will go back to wait in the waiting room, or if the GP is available, a GP will come and grab them and I will take them to my consult room and – and perform a consultation and they leave. And the day goes like that.

MS HILL: Where do patient come from to attend at BRAMS?

DR FOX: So largely, Broome. They're, you know, Broome patients but Broome is the biggest regional centre in the Kimberley and there are a lot of services in Broome that aren't available outside of Broome. So lots of patients – or people travel to Broome for those various reasons, but, so Broome services a lot of the, you know, remote communities or even people that are visiting from Kununurra.

MS HILL: In your statement you describe working at Bidyadanga, which this Commission has heard a bit about this week, for two days each week. How do you travel to Bidyadanga?

DR FOX: I travel to Bidyadanga on a – a small plane.

MS HILL: And would you describe the setting of the Bidyadanga community to the Commissioners; what's it like?

DR FOX: So it's – it's a – so it's one of the largest Aboriginal communities in WA of a population of, maybe the stats will tell you, between seven and eight hundred but can – the population can swell to around 1000 during busy periods. It's located about 200 kilometres south of Broome on only recently sealed roads the whole way. There's been a lot of advocacy that's gone into getting a sealed road to the community. It's close to the coast and – and, yes, it's a community that has multiple different services available to it which I can - - -

MS HILL: Certainly.

DR FOX: - - - describe if you like. There's a health clinic which is where I work when I go down there. There's a police station. There's municipal support through a council and other support such as Centrelink. There's a school that goes all the way up into year 12 which is amazing, and there's a home and community care service which I know you guys have heard from some of the service providers at HACC. There's a women's art centre in the community that has recently got up and running again which is great. There are – there's a kiddie link which is also just started to happen which is about providing care for children for a small period of time.

MS HILL: Is there such a thing as an average day at the health clinic at Bidyadanga?

DR FOX: Yes, there's an average day. It's definitely – it can be really different every day but an average day for me would look – so I would – I would leave, so fly out of Broome on – at 8 o'clock and would arrive in the clinic by about 9 am and usually the clinic is open by then, and there are patients already in clinic that have already been seen. So rural area nurses. Bidyadanga is a little bit different in terms of its clinic set-up so it's a lot smaller. It doesn't have as many resources or access to staff but it's a smaller community. It's – there are – so Aboriginal health practitioners, Aboriginal liaison officers and Aboriginal administration staff members.

And then there's also rural area nurses, who none of which are Aboriginal at the moment, and there's two senior GPs, myself and a full-time GP that's new to the – new to Bidyadanga. She's newer than I am to Bidyadanga. And they also – there's also GP registrars that – so KAMS is – supports registrar GP, GP registrar training. So there are GP registrars that come to work at Bidyadanga and other communities that are under the auspices of KAMS for six to 12 month blocks. So the average day when I get there will involve – it's a similar set-up to BRAMS so I will – the rural area nurse or an Aboriginal health worker will see a patient first and then I will see them after, and I guess it's different in that the – they don't – Bidyadanga doesn't have the same amount of access to services that Broome does.

So we, you know, we don't have quick access to pathology results or X-rays or CTs so if somebody is requiring emergency care, then that's – we're required to provide it and it takes resources away from – from the – the clinic and, yes, can be much more complex care than I provide in Bidyadanga, yes.

MS HILL: How long have you been working at the clinic at Bidyadanga?

DR FOX: So I've been on and off at the clinic in Bidyadanga for two and a half years, yes.

MS HILL: Dr Fox, you completed your medical studies and then residency in Perth.

DR FOX: Yes.

MS HILL: You obtained your fellowship of general practice in 2018.

DR FOX: I did.

MS HILL: When did you move to Broome, Dr Fox?

DR FOX: The beginning of 2017, so January 2017.

MS HILL: What motivates you to work in Broome and then more remotely in Bidyadanga?

DR FOX: So I'd like to preface that response by just saying that I'm very aware that I'm a junior GP and I'm relatively new to working in remote Aboriginal health, and that I'm aware that there is a lot of burnout in my line of work and that what motivates me, well, I guess, my experiences – life experiences, five, 10 years down the track may not be, you know, may – will provide me with different motivations, and, you know, I'm not sure where I will be but at the moment I am incredibly motivated to do what I do.

And I think put simply it's about being able to contribute to something that I feel passionate about and have – and knowing that I can make a difference and even if it's just on an individual level I think that ideally it's a bigger – there's a bigger picture difference, but I think that day-to-day difference that I can make in people's lives that is – motivates – motivates me and I think my interest from – in Aboriginal health is a product of my life experiences as well, which started, you know– starts from being – growing up in the country and being a country kid and having a passion for rural areas and rural health, and then being lucky enough during my medical degree to have amazing exposures to Aboriginal community-controlled health organisations, both in remote and rural settings, and witness firsthand the inequities that associated with – with, you know, with Aboriginal health outcomes. And then, was lucky enough again to get a job at KAMS which is an amazing provider of Aboriginal medical services and had some amazing female GP mentors when I arrived at KAMS and started working at Bidyadanga that were of the same mindset as me and believed in the same way of practicing Aboriginal health care.

And I'm motivated to be able to – now motivated to be able to continue that. I think in terms of Broome, Broome is a pretty lovely place to live and to work. I don't think there's much that's required to motivate here if you're interested and you kind of – the natural wonders Australia has to offer. Broome is a beautiful place to live and work. And my husband has a – supportive partner has a good job in Broome as well so that helps in terms of motivation. And just going back quickly to Bidyadanga community, so working remotely, the community itself is a really lovely community that are incredibly caring and considered and welcoming and forgiving of people that make mistakes. So I think there's a lot to motivate me.

MS HILL: Could you describe the physical location of the clinic at Bidyadanga, Dr Fox?

DR FOX: So it's located in, I would say essentially in the middle of Bidyadanga community, yes.

MS HILL: How do people access the clinic?

DR FOX: So people – so most people in Bidyadanga don't have access to their own transport and they're required to – to walk to clinic if they are able. We do – clinic has access to vehicles to be able to pick people up if they require care. That – and there's, you know, there is a – every morning there will be a health worker and a – a rural area nurse that – whose job it is to look at the recalls of people that we want to see and go out and find people to bring them into community.

MS HILL: How do older residents at Bidyadanga who may be frail attend upon the clinic?

DR FOX: So that's obviously the next level of difficulty with access because it relies on – it always is going to rely on somebody to be able to transport them to clinic, and it's – you know, we often have difficulties with older morbidly obese or, you know, even just frail patients who sometimes can't access the vehicles that are available to KAMS are not always easily accessible; they're usually four-wheel drives. The clinic bus has multiple steps to get up into it, so it can be really tricky to get older patients into clinic and sometimes, I know that HACC have access – sometimes have access to a car that they can use which is lower. We try to use that if we can, but also we – if we have the capacity, GPs and nurses can go out and do home visits as well.

MS HILL: In your statement and you've referred in evidence today to the complex care requirements of the older residents at Bidyadanga. What are those complex care needs, Dr Fox?

DR FOX: So, yes, Bidyadanga has a significant amount of complex, really poorly controlled but also difficult to control despite optimum – optimum management, chronic medical conditions. For example, people suffer from type 2 diabetes mellitus and all of the awful complications that come along with type 2 diabetes mellitus so – which, you know, nephropathy or damage to their kidneys, retinopathy or damage to their eyes which can lead to blindness, damage to the blood vessels of their heart and brain leading to stroke and heart attack, damage to the blood vessels and nerves of their feet which lead to chronic ulcers that can cause – you know, progress to needing amputations of legs, foot, limbs, and so there's – so diabetes is a whole world in itself which, you know, it – we are very much aware of that that's only one of the – one of the conditions that – the complex conditions that people in Bidyadanga suffer from.

Other ones would be chronic kidney disease which is highly prevalent in Bidyadanga and which progresses on to, in a lot of – not a lot but some cases to end stage renal disease requiring dialysis which brings into play things about being able to have, you know, have dialysis on country or have dialysis in, you know, to have to go off

country to Broome to be able to have dialysis, because it's three times a week that people – at least three times a week that they would need it. Other complex chronic disease requirements are respiratory conditions like chronic obstructive pulmonary disease, bronchiectasis, asthma. People suffer from heart disease, heart attacks, strokes, the usual – the usual complex – the usual chronic medical conditions like osteoarthritis and hypertension and, you know, high blood pressure and high lipids or dyslipidaemia, but with older people those conditions are much more prevalent and usually much more difficult to control.

And obviously, the usual complexities that come with being older are also suffered by people in Bidyadanga so just having frailty or mobility issues or incontinence issues all factor into the complexities, and other care needs like having – needing to – care needs for environmental health or, you know, social and emotional wellbeing, health, and mental health, all have a – a – you know, make the complexities, you know, outstanding in Bidyadanga.

MS HILL: In your statement you describe older Aboriginal people as presenting with recurrent complex acute needs. What does that mean for your ability to care for older residents at Bidyadanga, Dr Fox?

DR FOX: So by acute, I mean, so conditions that, where a patient experiences symptoms, or an illness or an injury that has happened in the last days to weeks to months, and they present to clinic with those conditions which could be having symptoms like, you know, coughs, colds, skin infections or other illnesses that are, you know, considered acute or chronic medical conditions like an acute exacerbation of their COPD or an acute kidney injury on top of a chronic underlying kidney injury. So people present to clinic with these acute needs that are complex as well. And being able to – and people present to do with their acute needs because they have symptoms from them and most of the chronic conditions that are complex and people don't have symptoms until it's way too far down the disease process, so that's the reason behind, and then it's the underlying health literacy that prevents people from being able to come in and address their chronic needs. But if you have lots of people that are coming in for acute care needs then it means it – it makes it incredibly difficult to be able to address underlying chronic care needs for older patients in Bidyadanga.

MS HILL: There are five languages at Bidyadanga and we've heard evidence this week about language barriers that can persist when working with older Aboriginal people. In your statement, Dr Fox, you describe language barriers as a crucial barrier to accessing care. How do you manage language barriers in your practice when you are working on country?

DR FOX: So, yes, language is – there's significant language – language barriers and particularly in older people who sometimes speak limited or no English. It's a really – it's a really tricky part of the job and I think there is – there are simple things that I've used to try and break down those language barriers such as even just learning some of the local language, languages, so the traditional owner's language of

Karajarri, learning some simple words that show that I am respectful and know those words and also can help the patient understand me and for me to help understand what's happening with them. Other ways of doing it include – so often, especially with older patients we will try and make sure that the home and community care team, so Faye or Ryan who I know you've heard from earlier this week, I will try and make sure that one of those – one of them can be present during the consult because even if they don't know the specific language that a person speaks, they have this amazing relationship with the older members of community and they are incredibly valuable in trying to break down some of those language barriers. So that's another – another way that I can work towards that.

I also frequently use family members as interpreters, which is, you know, often because older family members come in with their – family members come in with their older relatives and they know them the best and that has – is not ideal and has its own issues in terms of, you know, being able to culturally discuss issues in front of a family member, but I do do that. And I just make sure that I'm aware of those underlying issues. I also will use, you know, utilise the Aboriginal health worker or Aboriginal liaison officer that's in clinic as well at times, but again that's about being careful not to overstep any cultural boundaries that is might make it inappropriate to do so.

MS HILL: Do you use formal interpreters in your role?

DR FOX: I – I have to say I have not ever used a formal interpreter for Aboriginal patients in Bidyadanga. I know that the service is available. I don't know – I can't comment on it because I've never used it, and I – I don't know that they would have all of the five different, you know, Bidyadanga language groups. But the main – I think the main reason that I – for not using official interpreters is purely because I spend a lot of my time in consults trying to build trust and rapport with a patient and having a – over the phone interpreter- interpreting service, I think, would really break down that trust.

MS HILL: How do you build relationships of trust, Dr Fox?

DR FOX: So I think – so trust is – trust is really – it's really important to build relationships of trust, and I think, you know, trust is important in any therapeutic doctor/patient relationship but it's the next level when it's a white doctor and an Aboriginal patient, and I think that's due to the impact of – you know, historical impacts of colonisation and – and – and past discriminatory government policies and, you know, marginalisation of, you know, marginalisation, essentially there was exclusion of Aboriginal people from western – from white western health services. So – and those past discriminatory policies have engendered this transgenerational distrust in white people and white health services. So I'm fighting an uphill battle to build a relationship of trust and trust is important so that I can, you know, build some rapport and engage a patient in care and – and – and to, you know, make sure that they can be engaged and can be empowered to improving their own health outcomes.

Ways that I – that I do it I think are, you know, about having an awareness of those underlying issues that – that can lead to those distrustful relationships, and it honestly takes a lot of time and I think that's where continuity of care builds into it because you need to have time with patients to build up that trust, and I often spend a lot of my time in consultations just getting to know a person, talking about things that I – that we – that I know about them or, you know, talking about the footy or the Dockers and doing that before I can – and you know, often over multiple consults before I can even look at potentially addressing some of those complex chronic health needs.

MS HILL: How do you deliver culturally safe care in those set of circumstances, Dr Fox?

DR FOX: So cultural safety is a whole topic of its own and should always be defined by the people that are receiving the care, but yes, providing culturally safe care from an individual perspective as a doctor I think is about being – being, you know, having an awareness of the underlying issues, cultural and social and emotional issues, historical issues that affect that person's relationship with you. And having an understanding that your agenda of – of what you believe to be best practice or best care for that person which is based on your own background and your own beliefs and attitudes is not always what the patient will perceive to be, you know, the best management of care.

And it's about accepting that and – and, you know, for example, if a patient doesn't – doesn't want to go to an appointment in Broome or to be evacuated from community because they have a sorry camp or a funeral that they need to be attending, it's about hopefully knowing that you have that trust in that they feel comfortable to tell you that, and then accepting that, and working with them to – to – to troubleshoot and to, you know, reappoint appointments or to make sure they understand the risks of remaining in community and – and setting good safety nets for – in terms of, you know, if it was somebody that needed to be acutely evacuated.

MS HILL: We've heard evidence this week that older residents at Bidyadanga want to stay on country. Is that consistent with your experience, Dr Fox?

DR FOX: Yes.

MS HILL: In your experience, are older residents able to stay on country?

DR FOX: No, not as – no, not for as long as they would want to.

MS HILL: And why is that, Dr Fox?

DR FOX: I think it's an interplay of all the things we've been talking about today, so complex chronic disease and the other – the other barriers that come along with being an older Aboriginal patient living on country, means that it's not always, you know – it's not always possible to remain on country. And I think that in – is – is

because we don't – there aren't the resources to be able to remain on country. I think the – so, yes, ideally I think that's, you know, that's why there's a Royal Commission into aged care. I think we – it would be amazing to have some better resources for bigger communities like Bidyadanga so that – so that older people can stay on country because there is a deep – Aboriginal people in Bidyadanga have a deep connection with family and with country, and there's evidence to show that people do better, you know, staying on country for as long as they can.

MS HILL: What employment strategies would assist people living remotely, such as at Bidyadanga, to stay on country as they age?

DR FOX: So I think there's a – there's a few that we've alluded to. But I think the biggest – the biggest thing I would say would have to be having access to a home and community care service that has the capacity to be able to provide good quality effective care and I think that's about having, so in terms of employment strategies, it's about having enough suitably trained staff, ideally Aboriginal – Aboriginal staff and – ideally locally trained Aboriginal staff members, but I – you know, I want to impress the importance of suitably trained. I also think there needs to be employment strategies to try even improve not only, you know, people – staff members that have aged care, you know, culturally safe aged care training in home and community care services like Bidyadanga but also I think Bidyadanga in particular would benefit from having a home and community care services that has access to at least one clinical nurse specialist that's trained in aged care and ideally has renal training as well.

And I think the benefits that a nurse – a, you know, a trained nurse can bring to home and aged care services are help with things like medications, with recognising people – with recognising when people are unwell or might have signs of cognitive impairment or dementia and – and helping, you know, get them into clinic for review, and also being able to, you know, start that process of – of, you know, helping people understand more and improving health literacy levels about the importance of preventative health care and chronic disease management. Because it's ultimately those chronic diseases and the – everything that comes with it that prevents people from being able to remain on country. And in terms of a renal trained nurse, the – I mentioned before that Bidyadanga has a huge amount of chronic kidney disease that progresses on to end stage renal failure and at the moment most people have to leave country to go to get haemodialysis.

We do have the capacity at Bidyadanga to have a home haemodialysis centre, and we do have one older member of community on home haemodialysis in Bidyadanga at the moment and she has – her daughter is her carer which is an incredibly difficult care job to do. She's required to work the machines and put her mother on home haemodialysis three times a week as well as trying to work a full-time job, and they have no on-the-ground support from a renally trained specialist. It's all phone advice from a company that works in Perth. So I think that would be, you know, having a renally trained nurse would go a long way towards improving older people's ability to remain on country.

MS HILL: Do see many carers in your role at Bidyadanga?

DR FOX: Yes, I see carers.

MS HILL: What observations do you make of the carers that you see?

DR FOX: The carers that I see are incredible and I think they are often not only caring for one really unwell patient, they – or family member. They have multiple different people in their lives that they're caring for, and just take it as the norm and often I see a lot of carer fatigue where people, the carers themselves don't really even recognise how they're being burnt out and, you know, aren't able to look after themselves. And it's hard. It's really hard and I spend a lot of my time advocating for carers and, you know, giving – trying to help look after them and living them access to, you know, online carer support numbers and things like that.

MS HILL: What support is available to carers on country, Dr Fox?

DR FOX: So there's, on country, the only – there's no specific carer support but there is – except the clinic. And the home and community care service, but the home and community care service also provide – so they provide respite for the carers in that carers can – so the person being cared for can go to the home and community care centre in the morning and that provides a bit of respite for the carer, but other than that there's nothing else on country.

MS HILL: Do carers have access to respite beyond Bidyadanga, in your experience?

DR FOX: So there's respite for the – yes, for the – for the person requiring care that – the only place is Germanus Kent which is in Broome, but it's often really difficult – well, you know, I've heard stories about potentially sending people to Derby and especially for the home haemodialysis patient, sometimes that respite needs to come from Perth, which sounds ridiculous, but it's often really difficult to get access to that respite care at Germanus Kent because it's full and there's not a lot of other avenues.

MS HILL: Dr Fox, what would improve the quality of care for older residents at Bidyadanga?

DR FOX: I think – I think there's a lot of things that can – that can improve the quality of care for older people at Bidyadanga and I think my statement outlines a lot of things. I think there needs to be a broader government or broader government priorities on, you know, addressing and preventing Aboriginal people from becoming sick in the first place but I think in terms of specifically in Bidyadanga the most useful thing would be improving the home and community care service that we've just talked about. And I also think the other important thing is being able to ensure that services that are providing care can have – can, you know, access continuity of care and be able to have continuity of care, because that's a really important part of – of having quality aged care for Aboriginal people.

And – and there's – I know there's a lot of turnover from clinic staff in Bidyadanga, in fact, I've been there for – one of the longest standing and I've been there for two and a half years. So I think if you can improve continuity of care which is, I know, across the board in remote Australia to it's not an easy topic to tackle but I think that's another thing that would be important. But in terms of, you know, service support in Bidyadanga it would be the home – improving home and community care service we have.

MS HILL: Thank you, Dr Fox. Commissioners, that concludes my examination.

COMMISSIONER TRACEY: Thank you, Ms Hill. Can I just explore a little further the concept of continuity of care because in your statement you made reference to the fact that you provide services to a lot of people who come into Broome periodically and presumably drift off back to country. And the related question, of course, relates to trust because from what you've said, you've got to have ongoing association with someone to build up the requisite degree of trust. Do you find it difficult when you're only seeing people once a year or - - -

DR FOX: Yes. Yes. Yes, it's incredibly difficult and difficult for many – many reasons, so there's lots of things that interplay with that in terms of, you know, the communication between service providers which I also talk about in my statement a little bit that – that make it really difficult to be able to provide adequate care for somebody that's just come in from another community and it takes – you know, usually takes up a – I'm the type of person that likes to be able to – that likes to be prepared and to be able to know as much as I can, and it takes up a lot of my time trying to find out information about where that patient is from, what their medications might be, and how I can help them, yes, that is the same in Broome and Bidyadanga. And in terms of the – the – the trust, yes, that's – that's lost, isn't it, when there's – well, not lost, but you've got not a lot of hope of building up a significant amount of trust if you're seeing a patient on a once-off basis once a year, yes.

COMMISSIONER TRACEY: And that leads me to a related question and it's this: if you're trying to find out as much as you can about a patient's medical history, how are medical records managed in a remote area like this?

DR FOX: So we have an electronic system called MMEx that is – so there's a lot of, you know, different care providers use different systems. MMEx is one that's used by all of the KAMS clinics, so it's a lot easier to – not significantly easier because the – even though I might have access to an MMEx file I don't necessarily have access to that patient's MMEx file from Halls Creek, and I need to get the patient's consent to be able to access their – their file in Halls Creek which is a whole process of getting that done and isn't usually able to be done on the day. It would take days and sometimes longer to be able to get that. So – but having someone – a patient from the same KAMS, you know, MMEx clinic is easier but when it comes to somebody that's from – like, I saw a WACHS, Western Australian Country Health Service clinic or another clinic then it becomes incredibly difficult and that's where

we rely on picking up the phone and trying to get in contact with someone from the clinic or sending over a - - -

COMMISSIONER TRACEY: Well, just to take a practical example, you've seen somebody from an outstation you hardly had contact with, but you've diagnosed some problems, and you know the person is going back to that station. If the flying doctor has to come to provide some treatment to that person at a later date, would the flying doctor have access to the records that you've taken?

DR FOX: They wouldn't have access to the records but the way that it – so if that patient was from an outstation that was out of Bidyadanga, it would be the – the, you know, Bidyadanga clinic that would be the people – is a whole other level of complexity – that would be providing that emergency care for the patient. So, you know, if – if they could get into Bidyadanga clinic, but – and that would mean that I would be – I would be the doctor that would be calling and speaking to the RFDS and giving them the information over the phone, which is – there's quite a structured way to do that. But if it had to be – so say it was an outstation where it wasn't a Bidyadanga doctor or clinic that was providing the care, then – then, you know, that's – RFDS have an incredibly complex job because they sometimes pick up people – fly to remote outstations to pick up people without having – you know, with only having spoken to the individual themselves or a layperson and so they wouldn't have access to any medical records.

COMMISSIONER TRACEY: It must make it very difficult to provide care. We've heard a lot of evidence about the difficulties aged Aboriginal people have of accessing entitlements under My Aged Care, a lot of it being caused by their inability to provide various forms of records, including medical records. Do you get called on from time to time to provide reports for elderly patients with a view to getting such entitlements for them, and could you – if so, could you tell us how you see the system working? Do you have trouble dealing with it or - - -

DR FOX: I have done, yes. I have to say I don't – I don't know – I haven't had a lot to do with the new My Aged Care system, but I – yes, have had to do – provide medical reports for it, but I haven't had huge conversations with people about the complexities of it. I am aware that it doesn't work well and that there's long wait lists to be able to get access to care, and I think the idea that it's online makes it very difficult as well for patients, especially remote patients that, you know, may not have that kind of literacy or even a computer or phone available to do that. But I am not – I don't have a lot of experience with it so I don't know if I would be able to comment past that.

COMMISSIONER TRACEY: And one last and different matter: how do you manage with pharmaceutical matters? Do you have a pharmacist who travels with you to the clinics and how is medicine dispensed once you've prescribed something for a patient?

DR FOX: Yes, that's a really valid point. So I don't think I mentioned it much in my statement, but in Bidyadanga there is a small pharmacy that is ran – or run by the rural area nurses and the GPs that are down there with the help of Kimberley Pharmacy Service which is a Broome-based pharmacy service. Pharmacists – a pharmacist will travel down to Bidyadanga once – I think they're trying to do it once a month at the moment to provide that support. But largely the clinic is run by no on-the-ground pharmacy support. There's a certain amount of medications that rural area nurses have access to be able to – to dispense and supply without needing to have a doctor do them and that's – there's very rigid, you know, pro forma for those medications and the times in which they would be able to supply them. And then it's – it's GPs that are doing the rest of the medication dispensing and supplying. There's always – Kimberley Pharmacy Service are very supportive and there's always over the phone support if you need support from it as well.

COMMISSIONER TRACEY: It must be very hard to encourage your patients, the elderly patients to take their medication and are there – I assume that's part of the role of the community nurse to follow up and see that the medicine is being taken as prescribed.

DR FOX: So I think that's everybody's – everyone's responsibility and it's an ongoing issue that we have. And I don't think it's unique to Aboriginal people. I think I would struggle to take the amount of medicines that some people are expected to take. I struggle to take a course of antibiotics properly, so I think, yes, people not taking their medications as ideally we would like them to be taken is a big issue. In terms of the advocacy to try and promote that is everyone's responsibility and everybody is aware of it and it's something we are constantly talking to patients about which, you know, comes back down to that health literacy and understanding the reason behind why we want people to take those medications, making people feel comfortable to tell us if they are having side effects from them that are stopping them from taking them.

The pharmacy that the – the pharmacist that will come down once a month is really trying to do some advocacy efforts there as well, so having their own separate, you know, consultation with a patient to talk about their medicines and to find out some of those things that GPs and nurses and health workers don't always have the time to do. So it's really tricky, yes. Yes.

COMMISSIONER TRACEY: One of the additional complexities of rural medicine.

DR FOX: Yes.

COMMISSIONER TRACEY: Dr Fox, it's been fascinating just hearing about how things are dealt with, with the need to adapt medical practice to suit the environment in which it's being provided and we're very grateful to you for taking the time off what I'm sure is a very busy day for you, to come and tell us about it. Thank you very much.

DR FOX: No worries. Thank you. Thanks for giving me the opportunity.

<THE WITNESS WITHDREW [10.21 am]

COMMISSIONER TRACEY: We will take a short break while a video link is established to Darwin.

ADJOURNED [10.21 am]

RESUMED [10.27 am]

COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: If the Commission pleases, I call Ms Roslyn Malay who's appearing on video link from Darwin.

COMMISSIONER TRACEY: Yes.

MS HILL: The audio is currently on mute so we're not able to hear Ms Malay at the moment.

THE WITNESS: Hello.

MS HILL: Good morning, Ms Malay. Ms Malay, have you just taken the affirmation or are you about to do so?

THE WITNESS: I'm about to do so, myself.

<ROSLYN MALAY, AFFIRMED [10.29 am]

<EXAMINATION-IN-CHIEF BY MS HILL

MS HILL: Thank you, Ms Malay. Ms Malay, I want to start by asking you some questions about who you are. What is your full name, Ms Malay?

MS MALAY: My name is Roslyn Malay.

MS HILL: Whereabouts do you live?

MS MALAY: I live in Broome.

MS HILL: What do you do for work?

MS MALAY: I am a project officer researcher for the UWAs Centre for Health and Ageing.

MS HILL: And have you prepared a statement dated 2 June 2019?

MS MALAY: I certainly did.

MS HILL: Do you have a copy of that statement in front of you?

MS MALAY: Yes, I have.

MS HILL: Are the contents of that statement true and correct?

MS MALAY: That's correct.

MS HILL: Are there any changes that you would seek to make?

MS MALAY: No.

MS HILL: Commissioners, I tender that statement with document ID, WIT.0174.0001.0001.

COMMISSIONER TRACEY: Yes, the witness statement of Roslyn Malay dated 2 June 2019 will be exhibit 4-15.

EXHIBIT #4-15 WITNESS STATEMENT OF ROSLYN MALAY DATED 02/06/2019 (WIT.0174.0001.0001)

MS HILL: Ms Malay, before I ask you further questions, was there anything that you wanted to say to the Royal Commission this morning?

MS MALAY: Yes, I do. I would like to acknowledge and pay my respect to the traditional owners of the country we are meeting on, which is the Larrakia and the Yawuru nation, to their owners past and present and emerging. I also would like to extend my knowledge and respect to the Stolen Generation and to the families and also to all of older Aboriginal and Torres Strait Islander people in Australia.

MS HILL: Thank you, Ms Malay. Ms Malay, in addition to your role at the University of Western Australia, you're also the co-chair of the Aboriginal and Torres Strait Islander Australian Association of Gerontology Ageing Advisory Group; is that right? Commissioners, the link appears to have paused.

COMMISSIONER TRACEY: Well, we won't leave the bench just for a minute and see if communications can be restored and if not, if it's going to take a little time we will adjourn and you can tell us when we're ready to come back.

MS HILL: Thank you, Commissioners. We just lost the link there, Ms Malay. Can you see and hear us still? Are you able to see and hear us, Ms Malay?

MS MALAY: I can see you Ms .....

MS HILL: We're just having a few glitches with the link. I was just asking you about your role with the Aboriginal and Torres Strait Islander Australian Association of Gerontology Ageing Advisory Group. Are you the co-chair of that group, Ms Malay?

MS MALAY: Yes, I am.

MS HILL: Ms Malay, did you grow up in Broome?

MS MALAY: ..... because Broome was not a very good – it wasn't as .....

MS HILL: We're just going to try another solution, Commissioners. Commissioners, I believe that efforts are going to be made to make the connection by telephone. If we could just have a short adjournment.

COMMISSIONER TRACEY: Yes. We will adjourn temporarily. If you arrange for our associate to be told when we're ready to resume.

MS HILL: Certainly, Commissioner.

ADJOURNED **[10.34 am]**

RESUMED **[10.47 am]**

COMMISSIONER TRACEY: I'm sorry, Ms Malay, that you've been incommoded while we've sorted out this problem but we think we've fixed it and we can get on with hearing your evidence. Yes, Ms Hill.

MS HILL: Thank you, Commissioner. Ms Malay, can I ask you to tell the Commissioners about your family background.

MS MALAY: I'm a member of the Yurriyangem Taam Kija clan group from the East Kimberley. Hang on, excuse me. No, this may I just take a moment there, Ms Hill.

MS HILL: Certainly.

MS MALAY: When you're asking about my background, what is it specifically are you asking me?

MS HILL: Did you grow up in Broome, Ms Malay?

MS MALAY: No, I didn't. No, I didn't grow up in Broome. I was raised in – out on the station and then we moved into Halls Creek – Turkey Creek, then to Halls creek.

MS HILL: When did you move to Broome, Ms Malay?

MS MALAY: And – excuse me?

MS HILL: When did you move to Broome?

MS MALAY: I moved to Broome 30-odd years ago, back at 1984 and I've lived there most – all this time.

MS HILL: Are you able to describe the relationship you have with communities in the Kimberley?

MS MALAY: Well – hang on, can I just find my notes?

MS HILL: Certainly. Perhaps if I can take you to paragraph 6 of your statement, Ms Malay.

MS MALAY: Yes, I'm sorry, I'm just – I have been the – I've been key to the team by completing ..... in various community across the Kimberley region. I have a wealth of cultural knowledge and mentoring that – and advising non-Indigenous colleagues about cultural consideration and ways to engage with community around research.

MS HILL: Could I ask you then to turn to the last page of your statement, Ms Malay, at paragraph 57, and could I ask you to read that.

MS MALAY: Well, I am well known throughout the Kimberley region for the work I do in research – in researching in elder Aboriginal health. I'm recognised as the role model and the leader to my families, friends and in the community.

MS HILL: How did you establish those relationships, those connections to communities, Ms Malay?

MS MALAY: My experience working in the remote community region is – with my work role as a researcher and a project officer, I have – I – with my work as a research and a project officer – excuse me, I'm a bit - - -

MS HILL: Please take your time, Ms Malay.

MS MALAY: I am a field – I am one of the few Aboriginal research officers working in the Kimberley and have been instrumental in improving the lives and health of older Aboriginal Australians who live in the Kimberley. I'm ..... and passionate about health and wellbeing of our older Aboriginal people. I have been involved in advising capacity in all projects that I have worked on. I have – working groups ensure that people of the Kimberley are representative. I have been working – I have working groups to ensure that people of the Kimberley are represented. I have been involved in the communication and relationships building within the Kimberley region as well as recruitment and participating and interviewing people within the Kimberley area.

In summary, I have been the key research and contact person and adviser for the project within the Kimberley region. I am currently in – involved in running a – running the Kimberley arms of several research projects that are looking to improve the health of Aboriginal and Torres Strait Islander people as they age.

MS HILL: What are people telling you about ageing when you go out to these communities?

MS MALAY: Well, what are they saying is that there's a lot of challenges that they are facing due to a lack of services. There's – there's issues with communications, as you know language is – English is pretty much their third or fourth languages. Communication is a big barrier – a barrier for them. Access to services is very hard. And I guess they want to see better services.

MS HILL: What do older - - -

MS MALAY: And the services that people provide and that, you know, delivers the services to the communities.

MS HILL: Ms Malay, what do older Aboriginal Australians tell you about residential care?

MS MALAY: Well, older Aboriginal people, what they're saying about the residential care is pretty much a death sentence to them. It's not where they want to end up. They prefer to stay on country, to be able to continue their leadership in their role that they play in the community. And that they don't – that they don't want to end up in aged care because it's a death sentence, like I mentioned. And the thing is – their comment is you go there to die.

MS HILL: What about - - -

MS MALAY: They would rather stay on country and to die, if that makes any sense.

MS HILL: What do older Aboriginal Australians need to be able to stay on country?

MS MALAY: Better service provider, better care – care – care plan, where family and the community members are all involved in their care plan. Older Aboriginal people like to stay on country longer than they would otherwise. It's to be – ensure that they have family connections, they're still connected strongly to the land, law, culture, be able to continue that and pass all that knowledge down to the younger generation.

MS HILL: Could I ask you to turn to page 4 of your statement, Ms Malay.

MS MALAY: Yes.

MS HILL: At paragraph 22 you say that:

> *There's an urgent need for there to be an Aboriginal and Torres Strait Islander employment strategy in aged care.*

MS MALAY: Yes. I think local people often do not have the skill to require to apply for certain jobs or are not made aware of vacancy prior to them being filled internally. Racism is also a barrier for Aboriginal people entering the workforce. I believe that there's an urgent need for the Aboriginal and Torres Strait Islander aged care workforce employment strategy, keeping cultural ..... in the training for non-Indigenous employers, we need current leadership in the sector to promote cultural safety, first, by working collaboratively with local Aboriginal traditional owners – owner groups to improve – to increase the two-way sharing. We need cultural leadership in the sector to promote cultural safety, firstly, by working together. We need employers to understand and respect Aboriginal employers' obligations such as attending sorry business and law business.

MS HILL: Thank you, Ms Malay. Do older Aboriginal Australians have cultural needs that ought to be addressed in - - -

MS MALAY: Yes, I believe so, definitely.

MS HILL: And what are they?

MS MALAY: Language, trust, respect, spirituality, connection to families, kinship, genders plays a very big part when you're caring for someone. Recognition of identity, who they are, respect them for who they are, who we are, I guess, understanding their emotional expression, for example, sorry business, dietary requirements, smoking ceremonies. And I guess it's – end of the day it's respecting their belief.

MS HILL: What does culturally appropriate care mean to you, Ms Malay?

MS MALAY: Valuing and treating Aboriginal and Torres Strait Islander people as individuals, respecting their dignity where culture is valued. And strength, spirituality, law, strong connection to families, like I mentioned, kinship, gender.

MS HILL: From what you were told, Ms Malay, does the current aged care system deliver culturally appropriate care to people living remotely?

MS MALAY: From what I was told the current aged care system does not deliver culturally appropriate care from few people that have been working in the aged care sector.

MS HILL: What are people saying to you about their experience in aged care?

MS MALAY: People are telling me that some of the – some of the issue that are – that they are facing there is – there's no respect in gender treatment in the care. When the – when the accreditation is due, it's just tick the box. And there's not many Aboriginal or Torres Strait Islander employees to be able to care for their own people in these facilities and it's due to racism. I was told that there was a lady who did her cert IV in ageing, who was actually working at an aged care facility prior and once she was qualified there was no job – there was no longer a need for her service at the aged care. So these are the things that we are facing in our communities, like I mentioned, racism plays a very big part to our health and wellbeing for our older people. I remember sometime back one of my family member had mentioned to me, "We want to be able to care for our own people our own way." That is – that is – and I'm saying that is and it means white people aren't looking after our people the way they should be just – the way they deserve to be looked after in these facilities.

MS HILL: How should older Aboriginal Australians be looked after, Ms Malay?

MS MALAY: Excuse me, can you repeat that, Ms Hill?

MS HILL: How should older Aboriginal Australians be looked after in aged care? What's your way?

MS MALAY: I think it should be very – it should be – our people – Aboriginal – Aboriginal and Torres Strait Islander people should be allowed to have choices in regards to how they should be cared for.

MS HILL: Do they - - -

MS MALAY: Emotionally, respectful, trustworthy, you know, to be trusted.

MS HILL: Are there choices for older Aboriginal people at the moment?

MS MALAY: I don't think so.

MS HILL: And why is that, Ms Malay?

MS MALAY: Because we still have a lot of older people who – who's not confident enough to be in mainstream aged care residential because of the treatment, they feel that they're not going to be treated with respect or how they should be treated.

MS HILL: How did you feel about giving evidence today, Ms Malay?

MS MALAY: Very nervous. I was very reluctant. Due to the fact that sometime back I had given evidence – given evidence to an inquiry and there was nothing done because it's – I mean, it's fine, all and well for us to sit here, or for each and every one of us to give evidence in regards to our – how older Aboriginal and Torres Strait Islander people are being treated in – as they get older and not to mention the Stolen Generation people and we're not being heard. So I think what I'm saying is I'd like, not only for myself but I'm sure I speak on behalf of everyone, you know, of all of us Aboriginal and Torres Strait Islander people and also the Stolen Generation people that we would like to see changes for the better.

And I would – I always say, every time I've gone out into the communities in my field doing my work, I would always make this comment that every older Aboriginal person needs to be treated with respect, with dignity because they are the ones who are the keepers of our law, of our culture, of our land, who keeps us very connected to our land, our law, our culture. If they weren't here everything would go pear-shaped. So I think in – in return, we need to respect our older people, and giving them the best treatment and the best care, in whatever years that they may, or might have left.

MS HILL: Do you have any additional thoughts that you would like to share with the Commissioners?

MS MALAY: As an aged care workforce there was something that I would like to mention there. I think that the better our services towards our older Aboriginal and Torres Strait Islander people I believe that it should be Aboriginal and Torres Strait Islander governed, run by us for our own people. It would save – I believe it would save a lot of taxpayers' money if we do it on our own. We don't need training in our culture. Our language wouldn't be a – wouldn't be an issue.

MS HILL: Ms Malay, do you have any concluding remarks that you would like to share with the Commissioners here in Broome?

MS MALAY: I would just – just like to – I mean my – yes, just that I was reluctant to give evidence due to the fact that I feel that – whether it's going to make any difference from the last time that I have given an inquest – evidence to the inquest.

MS HILL: Thank you, Ms Malay. Commissioners, that concludes my examination of Ms Malay.

COMMISSIONER TRACEY: Ms Malay, we're very grateful to you for giving us your evidence this morning. It is very important for the Commission to understand the views of elder Australians, including Aboriginal Australians as to how they consider they should best be cared for. And because of your experience and knowledge, you've been able to tell us those things and they, I assure you, have been registered. We can't promise you action because our job is to consider the evidence and make recommendations, but we are very conscious of the need to accommodate the requirements of the Aboriginal community and we will certainly take that into account in framing our recommendations. Hopefully the government of the day will act on those recommendations, and ensure that there are better services.

In the meantime, may I make this suggestion, and I – it really appears in parts of your statement: it is so important as we move, hopefully, to a situation where elderly Aboriginal people are being looked after in a culturally sensitive way by younger Aboriginal people that those people will be encouraged to undertake the necessary study so that they're there and available to assist their older brethren. So that anything you and others in the community can do to turn the minds of younger Aboriginal people to the desirability of training for these roles would be very important. We have heard some evidence about an aged care facility in the Torres Strait, for example, where 80 per cent of the staff are Indigenous people, and they are providing just that sort of care. They've gone and got the training and they're looking after their Elders. And if we can spread that model, we think it would be a very good thing for all Indigenous communities in Australia. So may I leave that thought with you. I'm sure you've already considered the issue, but it needs to be spread around the community because the training is there. We just need Aboriginal people to take it up. But look, thank you so much for your evidence. We're very grateful.

COMMISSIONER TRACEY: Do we need to adjourn briefly.

MS HILL: A short break for the next witness who is also appearing by video link.

COMMISSIONER TRACEY: Yes. Very well. Thank you again, Ms Malay.

<THE WITNESS WITHDREW [11.13 am]

COMMISSIONER TRACEY: The Commission will adjourn temporarily.

ADJOURNED [11.13 am]

RESUMED [11.18 am]

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Thank you, Commissioners, the next and final witness is Venessa Michelle Curnow who is on the video link from Darwin; if she could be sworn, please.

<VENESSA MICHELLE CURNOW, SWORN [11.18 am]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Might the document WIT.0243.0001.0001 be brought up on the screen. Ms Curnow, you have a copy of your statement there.

MS CURNOW: Yes.

MR BOLSTER: And it has got, at the top of the page, that number, WIT.0243.0001.0001 at the top right-hand corner.

MS CURNOW: Yes, yes.

MR BOLSTER: Is there anything about that statement you want to change or that you want to amend?

MS CURNOW: Yes, there's just one minor amendment in paragraph number 3, where it says:

> *I make this statement on behalf of Cairns and Hinterland –*

That should read:

> *I make this statement on behalf of Torres and Cape Hospital and Health Service.*

MR BOLSTER: All right. Thank you. We will note that.

MS CURNOW: That's the only - - -

MR BOLSTER: Now – all right, I tender that statement. Thank you, Commissioner.

COMMISSIONER TRACEY: Yes. The witness statement of Venessa Michelle Curnow dated 17 June 2019 will be exhibit 4-16.

EXHIBIT #4-16 WITNESS STATEMENT OF VENESSA MICHELLE CURNOW DATED 17/06/2019 (WIT.0243.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR BOLSTER: Attachments 1, 2 and 3 of that are found behind tabs 82, 83 and 84 of the tender bundle.

COMMISSIONER TRACEY: And those attachments will, to the extent necessary, form part of the exhibit.

MR BOLSTER: Thank you, Commissioner. Now, Ms Curnow, you hold the position of executive director, Aboriginal and Torres Strait Islander health for the Torres and Cape Hospital and Health Service; correct?

MS CURNOW: Yes.

MR BOLSTER: And you also are a board member of the National Congress of Australia's First Peoples.

MS CURNOW: Yes.

MR BOLSTER: And you're a board member of the Congress of the Australian and Torres Strait Islander Nurses and Midwives.

MS CURNOW: Yes, that's the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives.

MR BOLSTER: That's sometimes known as CATSINaM.

MS CURNOW: Yes.

MR BOLSTER: You have a long history as a registered nurse in aged care in the Torres Strait; correct?

MS CURNOW: All across Queensland and right up to Bamaga, Thursday Island, remote areas across there, and I've worked nationally as well.

MR BOLSTER: And your heritage is from the Torres Strait?

MS CURNOW: Yes, I'm Ait Koedal and Sumu Torres Strait Islander.

MR BOLSTER: And for those of us who are unfamiliar with that term, what does that mean?

MS CURNOW: Those are my two clans from Saibai Island in the Torres Strait.

MR BOLSTER: All right, thank you.

MS CURNOW: Kala Kawau Ya language group.

MR BOLSTER: Just stopping there for a minute, the language groups in the Torres Strait; how many are there?

MS CURNOW: There's about five different language groups in the Torres Strait islands.

MR BOLSTER: And how much of a difficulty does that present when it comes to people coming to Thursday Island and elsewhere to get aged care and primary care?

MS CURNOW: Well, particularly for older people it's difficult for some of them who've never been off community, who predominantly talk the native Torres Strait Islander language, and so when they need to access western services, they need – it's hard for them to understand fluently what people are saying in English, and particularly when they start talking in medical terms, it gets even more difficult.

MR BOLSTER: All right. Well, that's probably the first barrier to accessing aged care that we're going to talk about. What are the other barriers that are significant that the Royal Commission should take note of?

MS CURNOW: Do you mind if I, before I go on, Paul, just acknowledge country and - - -

MR BOLSTER: Certainly, yes.

MS CURNOW: Thanks. I just wanted to acknowledge the country where we're meeting, both here and over in Broome as well but particularly for Aboriginal and Torres Strait Islander people all over Australia as the Royal Commission findings and proceedings pertain to our older and Elders across Australia, and I would also like to acknowledge particularly our Elders and older people and our ancestors who've led the way and built what we have today and particularly acknowledge the Stolen Generation who were removed from culture and who are ageing as this Royal Commission findings will affect their lives as well.

And, of course, I need to acknowledge my Aboriginal and Torres Strait Islander colleagues in aged care as well, some of whom have been burnt out by the system and are no longer working in aged care, but have made amazing contributions to where we are today in aged care in Aboriginal and Torres Strait Islander aged care, and of those that are still working in aged care, who continue to provide their skills to aged care in some of the most difficult operating environments to make sure they look after our old people.

MR BOLSTER: Thank you very much, Ms Curnow. If we could go back to the barriers that people face when they access aged care in remote locations, particularly

North Queensland and the Torres Strait islands where you're based, what are the most significant things that the Commission needs to consider?

MS CURNOW: In the Torres Strait islands, just to give a geographic understanding for people who haven't been there or have only seen it on a map, there's a whole range of small islands between the tip of Australia and we share an international border with Papua New Guinea. And these islands will have groups of people of, you know, 1000 or less people living in small villages on some of these islands. Some of the islands are facing climate change issues, so there's – and there's also issues around food security and just general development as well in terms of lower rates of employment, lower rates of education attainment, poor infrastructure, less access to markets to build economic development opportunities and foster new jobs and employment and businesses, and things like that.

So that's the context of Torres Strait island and then Cape York is four-wheel drive accessible most – all of the year, and in part of the year in the dry season you can drive up to all areas of Cape York. So for about, you know, half the year, it's inaccessible even with a four-wheel drive due to flooding. There's about 2000 – or 1600 kilometres to the tip of Cape York from the nearest regional centre, and then from Torres Strait there's another couple of hundred kilometres to the international border. So there are barriers around infrastructure, general access to everyday living, you know, food supplies, electricity, internet, you know, the things of daily living, but then add a layer of access to health care and personal care and support for older people who are vulnerable and need extra help.

That adds an extra layer for them, you know, to be able to access an ATM in a local community that might not have wheelchair access, footpaths or be able to maintain a quality of life because they haven't got a wheelchair that can go down to the beach so they can join their family to go down and enjoy what's good about living in a remote part of Australia. And those sorts of things. So it has a lot of unique challenges, definitely.

MR BOLSTER: You talk in paragraph 24 about looking towards economically viable models for infrastructure that support local aged care. Can you speak briefly to what you mean by that.

MS CURNOW: Well, in this paragraph, I described a model that would look how the – it would be the responsibility – more responsibility would be with – and this is my personal view and not the view of the hospital and health service or the State in which I work – would be around being – the responsibility of government to work across agencies and across departments to look for those efficiencies in infrastructure funding. So if housing has an allocation of money or roads have an allocation of money or, you know, the northern Australia collaborative has an allocation of money for infrastructure that the – within those collaboratives there's a thought put to local planning around what would be the aged care need in a local community and that when they do go to build a house, which they're going to build anyway because they've got an allocation of money for housing, that they think about how that house

could support someone to age well at home in the community for as long as they can, with the – they have the internet access in that home so that they could have an alarm system in that home, you know, that there be wheelchair access, that there be intergenerational living, so a carer could live in the same house as an older person.

And this example, you know, that that's considered with local council and housing cooperatives around how they could maintain the buildings and that the care and services that are provided through the Department of Health and Ageing be funded to go in to provide the services but the housing component is funded by housing and that local council have particular housing for older people or people with disabilities. But then as the ageing population demographics change at that local community, if they don't have that many older people who require housing that could then be rented to a young family so it's an adaptable housing model.

It's still housing stock, as we've got hardly any housing stock but that housing stock is adaptable enough that it can meet a vulnerable population's needs as well, which is not – you know, all other houses could meet any person's needs in community, but aged people need a particular kind of housing stock where, you know, it's got wheelchair access. It might need to house a carer, could have that telecommunication link for, you know, 24 hour emergency access and those sorts of things as well.

MR BOLSTER: Thank you for that. Could we turn then to workforce-related issues. What's missing from policy when it comes to the training and education of Aboriginal and Torres Strait Islander peoples in the aged care workforce?

MS CURNOW: Yes, you know, the Department of Health brought out an Aboriginal and Torres Strait Islander Health Workforce Strategy and I make reference to it in my statement – in fact, I'm looking for the correct name for it.

MR BOLSTER: Paragraph 32?

MS CURNOW: 32. Thank you. And it – it seems to have fallen off the radar and doesn't – it talks about the health workforce but doesn't talk about the aged care workforce. Because when you look at Aboriginal and Torres Strait Islander aged care workforce you need to look at it in the context of Aboriginal and Torres Strait Islander developing communities, developing economies, and the poor outcomes that we experience across a whole range of areas and the way that we're going to overcome some of those issues is that using a – a local development model, community development model and having that co-design with Aboriginal and Torres Strait Islander people so that they can incorporate culture, and so not to go off subject but this health – this is the reasoning why we have an Aboriginal and Torres Strait Islander Health Workforce Strategy, and they considered all of these things but what's missing from that is that aged care component which we could, you know, get some efficiencies if we could, you know, be included in a health workforce strategy because a lot of our, you know, health professions provide services in aged care services the same as in health care services as well.

If we could get more registered nurses, more allied health people trained, doctors, as well as management, admin people, you know, we could have efficiencies if that health worker workforce strategy was – if aged care was included in that. So the health worker – the Indigenous health workforce strategy talks similarly about the infrastructure issue. If, you know, we could get that cross-agency collaboration, so between Department of Training and Education, Prime Minister and Cabinet who previously – I don't know who holds the portfolio at the moment for Aboriginal and Torres Strait Islander affairs, you know, were talking amongst each other, then we could have joint initiatives around workforce, because we've got close the gap targets in unemployment, and we've got close the gap targets in health outcomes.

So it would make sense that they prioritise work which we've got vacancies in, to have Aboriginal and Torres Strait Islander people trained up in those areas, so you could then reduce unemployment but also then have our own people working in health care or aged care which then provides safer health services, improves access to health services. Because I didn't mention around the barriers to aged care, there's also soft barriers as well, not just the physical barriers. There's barriers around cultural safety, if a person isn't able to communicate with a clinician, who's got, you know, a Masters or a PhD, and an amazing, you know, education background, that person still may not be able to understand what they're saying or access the treatment because they might not have the skill in cross-cultural communication or not be able to understand the context of what that person's circumstances are and how they're living and how they're able to access care and services.

MR BOLSTER: Can I ask a question about in the Torres Strait, training for nurses and carers, particularly Indigenous nurses and carers, what's the state of participation of the local Torres Strait Islander people in aged care training?

MS CURNOW: We – previously we had a high rate of participation and it was because we had, I want to say it was in the mid-2000s, dedicated allocation of funds for remote and Aboriginal and Torres Strait Islander training. And those funding allocations were given out to the registered training organisations who then needed to engage with service providers to find out what their training needs of staff were so it was still particularly targeted at existing staff; it wasn't for recruiting new staff and it wasn't for pre-vocational people. But that worked really well because they were then – the RTOs were responsible for developing local training plans, changing the delivery of training to suit local communities.

And they were then sort of charged with, or accountable for being able to – for education attainment rates then, so the people who – that more people were able to support to get qualifications. They were sort of – then acquit their funding that they received from the Department of Ageing back then. So that worked really well because there was that partnership between the RTO and the service provider, and the industry and service provider and it – the training was then made more appropriate to local needs, not just for the skill set that was needed for the old people and their care needs but also for the older – the adult learners and how they learn best.

But just in the last month or so, we've, in Torres and Cape, engaged a partnership with James Cook University and the Pro Vice-Chancellor of the Indigenous faculty, Professor Martin Nakata. And part of that work was where we were looking at a collaborative between education and industry, ourselves in health as service provider to look at how we could improve the Aboriginal and Torres Strait Islander participation and qualifications in our workforce. We've got a population of about 60 per cent Aboriginal and Torres Strait Islander people in our catchment but we only have an employment rate of about 12 per cent. So we're looking for our employment rate to reflect what the population is, and not to mention that we have an unemployment rate of about, you know, 30 per cent, in some areas higher.

So and as part of that they've done a mapping exercise where they've looked at what is available and it's a continuum to look at, you know, really early on what the curriculum looks like at the high schools in remote areas around STEM and how kids are ready to be able to, you know, undertake – apply for undergraduate courses in universities and become health professionals, but also whether we can offer a vocational path for those who don't want to go down the academic professional path and really want to do a sort of a trade in aged care or, you know, nurses aides or allied health aides or something like that. And so there's only, I think, three high schools in our area that – and RTOs that offer that cert II at that year 11 level.

So that's something that will come out of this initiative is developing those pathways and strengthening our relationships with the high schools and the RTOs around the curriculum strengthening, offering of the – the vocational pathways from high school, and then the tertiary access support that's needed to stay in university – to enrol in university and stay in university for the whole course. And that's something that we've done without any extra subsidy and we're at this stage looking for how we could support that across agencies and hopefully not have to acquit to five different departments or something like that.

MR BOLSTER: Could we turn to a different topic; and in paragraph 33, you reproduce a diagram that emphasises the importance of country. I wonder if you could talk briefly to the takeout that we, who are less familiar with these concepts than you, what should we draw from the approach to country for your people?

MS CURNOW: Yes. This – this here, this diagram is a really simplistic way to try to explain across cultures how important country is to Aboriginal and Torres Strait Islander people. So country is the circle in the middle of the diagram and country is also the circle on the outside of the diagram, so country is central to who we are and what we do and it also encompasses us as well because then on country we've got Aboriginal and Torres Strait Islander individuals and then we've got our family which is our broader networks and community. And then what encompasses all of us is country so it's central to each of us as individuals, but as a whole it encompasses us all as well and keeps us safe, feeds us, gives us shelter, and even has a spiritual aspect as well around a place of belonging and feeling and having feelings.

All of the stories are passed down as songs, dances, which are really emotive and, you know, the song research that's coming out more regularly now, I think we all know it innately as well, you can remember a jingle to an advert, you know, when you were a child kind of thing, you know, and it still sticks in your memory because those sorts of things are easily retained in memory and easily recalled in memory. So we are taught stuff through dance and song and stories; it has a beginning, it has a middle, it has an end. It has, you know, legends, a kind of way of people's – eliciting people's emotions and tying you emotionally to something. So our connection to country is not as a physical resource; it is partly as a physical resource, yes, we know we need to get food.

We know we need shelter and sorts of things, but at the same time we have a story about an animal and we have – so we end up with a spiritual connection and a belonging to an animal or a place. We have a story about a place, we have a song about a place, we have a dance about a place, we have artwork about places, and it's all around country and our connections to country. It's also about the rules of country and how, you know, we've got 400 different peoples or more living across Australia, different Aboriginal and Torres Strait Islander people, so we all have borders everywhere between different places. We didn't kill each other before colonisation.

We didn't start mass wars to take over other men's countries, but we also uniquely understood that if we poisoned water up in a water source above another man's country that will kill their food source down, and that could start a war so there's a lot of stories around not necessarily saying, you know, don't poison food. There's a place where you don't go or you don't do that, there's a song to it or a dance to it to explain that that's got to be passed down through a generation and the next generation as the same story so that nobody gets it wrong and it's quite strict.

MR BOLSTER: Now, you say in paragraph 34 that you see culture as a means of group survival.

MS CURNOW: Yes.

MR BOLSTER: Could you expand on that just briefly, please.

MS CURNOW: Well, if we innately trust – Aboriginal and Torres Strait Islander innately trust in their culture. They trust in their languages and, you know, it may from the outside seem easier for, you know, to go down a western lifestyle and live that way, but it – there's not that trust in that way of living. If we do rely totally on a western way of living, we will lose our way of hunting and our way of gaining our own food security, our way of living together, of knowing who our – our collective cultural insurance is, you know, how our families look after each other. We can't be isolated from each other, you know, which is what a western culture sort of like, popular culture has as, you know, their values and beliefs around, you know, to – it's – buy your food from the shop, you know, have, you know, small families and things like that.

Ours are very – it's a different way. We trust that those cultural practices have kept us surviving for this long and even actually kept us surviving through mass colonisation as well. So - - -

MR BOLSTER: Could I turn - - -

MS CURNOW: - - - we have faith in them.

MR BOLSTER: Could I turn then to the culture surrounding the family and the need to, or the obligation towards the older members of the family. Could you speak to that, please?

MS CURNOW: Yes. Looking after old people is just – we've got cultural practices that help us to – and rituals that, you know, remind us that old people are an important part of our lives so it's sort of inbuilt in us from a very, very – like you just grow up in it from when you were young. So the old people are the ones that teach you how to go out on country. They teach you all the songs, they teach you languages. So you have an innate respect for them and their place in community. And we – there's an understanding that we generally, you know, that we wouldn't be here without the older people. I know that, you know, there's instances, as there is with any culture, where, you know, there's elder abuse or things like that, but generally as our cultural belief, like, looking after our older people is part of who we are, and then having a relationship with the young people.

It's like our connection to their mother, and their mother before, and that's how we pass down our knowledges through the generations. So they will tell you stories about when they were young and that's your connection to your grandmother, or when your grandmother was young, that's a connection to your great grandmother. Like you hear the stories of, like, you know, that have been passed down through time and that's part of our culture as well so - - -

MR BOLSTER: How do you engage that - - -

MS CURNOW: - - - it's innately - - -

MR BOLSTER: Sorry, the time gap is annoying. How do engage that custom, that sense of obligation in delivering aged care?

MS CURNOW: Well, because we practice our culture, it's innate in our – if you've got an Aboriginal and Torres Strait Islander aged care service it's just part of your interactions with the old people that you're looking after. And, you know, the old people who access our services, they're family members of staff, they're family members of management, they're family members of the board of directors so, you know, we're interrelated. We all then know where each other is from, from generations ago, how we've intermarried and then we've got obligations to each other to look after each other.

And because we come with that belief and we have that shared belief that, you know, that older people are important in our culture and important in our societies, that we should look after them because they've looked after us, that then it's part of our aged care services, whether it be community aged care packages or residential services, it – and no matter what the – the way we provide services, we make sure that culture is part of it. And it's not necessarily written in a policy or procedure. It's just practiced. And it's part of the flavour of all the organisational culture of services.

MR BOLSTER: All right. I want to develop that to the concept of culturally safe care. How do you – you obviously work for the government and you're involved in the delivery of important health care services to a lot of Indigenous people, including older people. How do you make sure that culturally safe care is actually delivered on the floor of a hospital, on the floor of a nursing home, in-home care; how do you do it?

MS CURNOW: Well, you know, for us it would be employing Aboriginal and Torres Strait Islander people and, you know, there's a lot of – so in my current position where I work in a non-government organisation, I spoke already how I try to improve our employment targets of Aboriginal and Torres Strait Islander to reflect, you know, the population. But in – and I've worked for many years in Aboriginal and Torres Strait Islander aged care services before working back with Queensland Health. We just encouraged employment of Aboriginal and Torres Strait Islander people and some of the things we did to encourage people to apply for work in aged care was that we've got like a lot of informal carers, unpaid carers who are family members.

So we recognise that they already have a skill set, they're already delivering care, they already have an interest so we might then just employ them for a certain amount of hours so they could get some pay. But also then we then support them to get qualifications if they were interested and then if they – their carer responsibilities for that person changed, they might work full time back in the aged care services. That was one way we would encourage people to come and work for us, but really it's about, we – and there's a lot of evidence around that as well. I think the Indigenous Business Australia put out some data that Aboriginal and Torres Strait Islander people are more likely to employ Aboriginal and Torres Strait Islander people.

So that's just part of our operating, you know, we understand that they've got that skill set, that you can't teach people as well. You can teach an Aboriginal and Torres Strait Islander person about mainstream caring, how to lift people, how to turn people, you know, what type of medications to give and when, but it's harder to teach a non-Indigenous person cross-cultural skill sets because that's the kind of things that you learn over a long period of time and cross-cultural – cultural safety is at the – the – one end of the continuum. You start off at cultural competence awareness and then move on to cultural competence and then hopefully over time people can get to cultural safety, but it's a skill set that's built up over a long period of time.

And it requires immersion and a lot of exposure to culture which, unless you're living in the culture every day, you know, it's much easier to have an Aboriginal and Torres Strait Islander person employed than it is to teach someone all of those nuances, particularly because we've got such a diverse range of cultures as well. There's so many different Aboriginal and Torres Strait Islander cultures and even for an Aboriginal and Torres Strait Islander person, we then have another skill set around that cross-cultural communication. So we might not necessarily be from that specific cultural group but we understand some of the commonalities but then we're also able to adapt our practice more easily to suit the person from a different culture as well. I think that answered all of you question.

MR BOLSTER: It does.

MS CURNOW: Yes.

MR BOLSTER: I wanted to conclude with giving you an opportunity to identify three or four or five key things – key points that the Commissioners should look at when they're making their report to the government. What would you counsel them to do?

MS CURNOW: Yes. I think the really big thing is that we also recognise that our Aboriginal and Torres Strait Islander people, older people and our Elders, like I say, are the links to our knowledge that has been built up from time immemorial in Australia. So we've built up in living so close to the land and having that connection to country, traditional ecological knowledges of where, you know, around when different seasons, different food sources, which type of plants have medicinal properties, which type of plants have nutritional properties and things like that. So there's a whole internet – it's not even an encyclopaedia of knowledge, amongst these older Aboriginal and Torres Strait Islander people that we just don't even have access to in our schools to teach our kids or to like, you know, help to be part of Australia's food security because we all know, you know, that that's going to be a big issue around water security and food security for Australia over time as well.

And what will happen is that these people will pass away and that information won't be captured because of, you know, it gets harder for us to maintain our culture outside of institutions and outside of infrastructure. So if there were methods to bring that into our institutions, our schools, our universities, into our aged care services and programs as well, and, you know, there was proper support and recognition that this stuff is valuable and that it actually exists, because I don't even think people know that it exists. That – that – that would be the big – big take home point I think for the Commissioners. But one method that we could, you know, use to actually progress that would be to have investment in an Aboriginal and Torres Strait Islander Elders, and older persons collaborative research centre to build our evidence base and communicate across industry, clinicians and government departments, how we as Aboriginal and Torres Strait Islander people would like to care for and support our older people and Elders.

And how we can restrengthen our cultural practices and languages to ensure traditionally ecological knowledges of Australia are an integral part of Australia's national development and especially a critical part of protective factors to close the gap for Aboriginal and Torres Strait Islander people in multiple outcomes, not just health but also education, employment and better functional relationships and interdependence. To helping to support our old every people to stay in communities and fulfil their role in relationships and their ..... relationship in maintaining our humane qualities in our societies as well, such as how to be patient and how to care for people is really important and they shouldn't be locked away somewhere. They should be enabled to, you know, be part of our communities and our families, and how we look after them and we can keep our cultural practices of looking after them.

So the name of the collaborative research centre should not be ageing; it should be Aboriginal and Torres Strait Islander Elders and older persons, because the research is more than service provision models, although there could be projects that highlight viability solutions in Aboriginal and Torres Strait Islander aged care service provision in thin markets and also about ageing processes as well. But it would be more about the older people themselves and recognising how critical a contribution to society they are and not a burden because without them we wouldn't be here today. And they are living connection to a wealth of wisdom and lessons and experience of stories, of traditional ecological knowledges, cultural practices and fluent language speakers.

MR BOLSTER: Thank you so much. Commissioners, I don't have any more questions.

COMMISSIONER TRACEY: Ms Curnow, we understand you're involved in a very important conference at the moment and we're more than grateful that you've taken the time out to provide us with some insights into the culturally important issues that arise in relation to the care of elderly Indigenous Australians. We're most grateful and thank you.

MS CURNOW: Thank you, Commissioner. Thank you, Commissioners, yes.

COMMISSIONER TRACEY: Are we going to take a break?

MR BOLSTER: I thought we would proceed, Commissioners, if that was suitable to you.

COMMISSIONER TRACEY: Yes. Very well. Well, we will break the connection to Darwin and thank you again, Ms Curnow.

<THE WITNESS WITHDREW [11.57 am]

MR BOLSTER: Commissioners, that concludes the evidence for the Broome hearings. Since the beginning of this week, the Royal Commission has heard direct evidence about how aged care is being delivered at multiple remote and very remote locations through various models of care within the three largest States: Western Australia, Queensland and South Australia, as well as the Northern Territory. You heard evidence from Madeleine Jadai who told you about caring for her sister, Betty, in the remote community of Bidyadanga. Within the same community you have heard how Faye Dean and her staff pick up the clients each day, collecting the washing before taking them to the community centre where meals are provided. There is access to showers and laundry facilities, people are supported to access health services, and social services, and there are visits to country as well as social activities.

This model of care is mirrored in the direct community-based care that is provided by Mr Aitken's organisation within the APY Lands of northern South Australia. The care delivered in these locations is respectful and delivered by people who are embedded in and who are part of the community and who truly understand the cultural needs of the recipient. Trust and mutual respect are evident. This model of care is different to the form of aspects of home care described in previous hearings. Rather than care being provided to the older person in their home, it is provided in a community centre or a care centre.

It is a model of care that is provided in a context where residents do not have any realistic or close access to residential care in their local community. The evidence concerning facilities at Derby, Fitzroy Crossing, at Docker River, in Broome and on Thursday Island; you have seen a cross-section of how residential aged care is delivered in remote and very remote regions, and with a focus on Aboriginal and Torres Strait Islander peoples. A sizeable proportion of these facilities have largely been taken over by the current providers following the failures of their predecessors. You have heard that these providers are there because if they were not, there would be a very real question about whether any service could continue. With varying degrees of success, these facilities all seek to endeavour to deliver culturally safe care to those for whom they are responsible.

As we said in our opening, a principal focus of this hearing has been on cultural safety and we wish to close with some observations about that central issue. Broader policy matters surrounding funding structures in their various complex forms, broader workplace-related issues, labour market supply and demand and police checks are beyond the scope of these brief closing remarks. However, we do wish to outline some of the themes that surround and frame the issue of cultural safety. Can I begin with what Mr Aitken said about cultural safety. To quote him:

> *There's been lots of research and papers written about cultural safety. In our eyes, the judge of what cultural safety is is the individual. We will speak to the elder about what they need for us to be culturally safe, appropriate or whatever. It's an individual conversation and it's a respect that we treat*

everyone as an individual and with dignity and to us it's what cultural safety is all about.

For Dr Fox, cultural safety is a whole topic of its own, and should always be defined by the people that are receiving the care. Providing culturally safe care is about having an awareness of the underlying issues, cultural and social and emotional issues, historical issues that affect that person's relationship with you. Against that backdrop, it needs to be remembered that there is little, if any money to be made in attempting to deliver aged care services in remote and very remote Australia. This is clearly borne out by the absence of for profit providers in the areas under consideration. In remote locations, the costs of food, transport and staff combine to force providers to operate at a loss. Where the facility is part of a larger group, an operator may be able to absorb these losses with revenue from more profitable facilities, however for smaller independent providers the pressures must be enormous.

The warning of the Aged Care Financing Authority regarding the viability of regional and remote providers referred to in my opening bears this out, as does the evidence of Mr Preece regarding the losses at the Juniper facilities in the Kimberley. It must, therefore, be recognised that the organisations that operate in remote and very remote regions continue to do so because of a commitment to provide care. In many cases this commitment is the result of historical service delivery in the area and an organisational commitment. In broad terms, that commitment would seem to extend to the delivery of culturally safe care. There is, however, a degree of uncertainty, a lack of direction, and a lack of uniformity as to approach when it comes to doing that.

Put another way, whilst the new Aged Care Quality Standard makes express reference to cultural safety, it would seem relatively clear that the concept is understood as many different things to different providers. For Mr Aitken, it means delivering services that acknowledge, value and respect the elder's cultural identity and working with community to do so. It follows that where care is provided to any significant proportion of Aboriginal and Torres Strait Islander people the evidence at this hearing indicates, that is, it is essential that there is a real focus on the following matters.

Firstly, understanding the location and the people who live there. This involves understanding the role of the Elders within the community and in particular their responsibilities towards the community. As Ms Bridges pointed out, the care needs of Aboriginal and Torres Strait Islander people are intimately connected to family, community and culture, country and language. Secondly, it involves responding to the particular needs of the community, recognising that the community is likely to have an embedded collectivist culture, where there are obligations owed by and to the Elders. Mr Aitken explained the process of consultation that's required in these terms:

We were respectful in our conversations with community about what we were wanting to achieve in terms of aged care service delivery. Talking to as many different people as possible and certainly the Elders has really helped us, not only establish our service provision, but also enabled the Elders to really understand what it is that we were trying to achieve. And by dealing with the Elders in a respectful way, asking them how they wanted us to do business we've been able to get to a place now and we're still developing and improving all the time.

This is typified in the requirement of the communities in the APY Lands for community employment in service delivery. As Mr Aitken put it:

The employment outcome employing people related to the Elders to be cared for is what the community was after.

Thirdly, there is a need to obtain the trust of the community by respecting cultural matters. This is most likely to arise in the context of what are loosely referred to as cultural responsibilities and the need for Aboriginal and Torres Strait Islander staff to return to the community for sorry business and other cultural matters. It is also likely to arise when it comes to traditional ceremonies surrounding the passing of a resident. Fourthly, where the provider is a non-Indigenous organisation, one way to demonstrate and ensure cultural safety is through having a high level of Aboriginal and Torres Strait Islander staff delivering care.

Where there is local engagement with the community by the care provider, either through a partnership arrangement like that which operates in the Kimberley or even through community control like in Bidyadanga and the Looma projects described by Professor Flicker, the outcome is likely to be far better. Ms Bridges, who is associated with both Thursday Island and the Docker River, described the partnership in these terms:

Partnership is critical to understanding the needs of the people we care for and providing them with dignity and deep respect as they age.

Professor Flicker noted that where the care provided is not culturally safe, Aboriginal and Torres Strait Islander people will be reluctant to take it up and may in some cases refuse care. Ms Crawford expressed a similar view. She said:

If you don't have the trust of the communities the communities won't let you visit. They won't listen to you when you go and they don't want to work together with you. So having the trust of people in the communities is really important. We're very fortunate in KACS. We have, out of our 31 staff, we've got nine that have been there for 10 years or longer.

Faye Dean, when asked about the most important thing in delivering care, had this to say:

Respect again, and dignity. You go, you know, very slowly. You go at their pace.

In the context of the project at Looma, Professor Flicker attributed the success of that project to trust and ownership and respect. He said that the community had been listened to and that the service that was delivered was a service that they wanted. He talked about the need to earn trust against a backdrop where there is little to commend the Aboriginal community to trust the rest of us. He pointed out how this might explain why Aboriginal and Torres Strait Islander people do not immediately accept that the person in authority is there to do them good. In his words:

The legacy of the Stolen Generations presents a stark reminder of why Aboriginal and Torres Strait Islander people won't necessarily trust non-Aboriginal and Torres Strait Islander people.

Ms Bridges observed that it takes time to achieve and requires staff to spend time outside direct service delivery engaging with families and Elders. She pointed out how relationships are built over time and, again, how turnover of staff can affect the situation. At paragraph 66 of her statement she said this:

For many Aboriginal and Torres Strait Islander people there is a distrust of institutions and a reluctance to enter care. This distrust results from the history of marginalisation, racism and mistreatment of Aboriginal and Torres Strait Islander people, including forced removal of people from country.

The theme here is the need for connection for an Aboriginal and Torres Strait Islander person, connection not only to people, but also to every facet of country and how they are integral to and inseparable from that existence. Connection is central to a person's identity, sense of self and purposeful life. Much distrust has come from the intentional and incidental breaking of that connection by non-Indigenous people, services, and government. We wish to emphasise the role of the elder in Aboriginal and Torres Strait Islander society. Whilst the recent evidence of Ms Curnow really does speak for itself, we commend the observations in paragraph 31 of her statement where she said that:

Elders and old people have developed over their lives deep connections throughout their immediate extended families and communities. They may have amassed a large amount of social and cultural capital. The methods and values and beliefs for accumulating this social and cultural capital are embedded within all aspects of Aboriginal and Torres Strait Islander collectivist cultural practices, handed down from former generations. And it is not necessarily a purposeful act that is motivated by the need for insurance in times of need. From birth to death, Aboriginal and Torres Strait Islander social norms reinforce values and beliefs to look after each other and connect with each other from sharing food, stories, experiences, assets and solving collective public problems.

Finally, turning to a different topic, and consistently with the evidence the Commission has received in earlier hearings, the My Aged Care interface would seem to be woefully inadequate from the perspective of those who assist Aboriginal and Torres Strait Islander people in remote and very remote areas. On this, you need go no further than the evidence yesterday of Ms Crawford when she described it as "dreadful" and described it further in these terms:

> *It relies on people having the telephone, internet, being in a fixed address and speaking English, and being cognitively intact and not being too frail to not have the energy to deal with the system. So if a referral is made to My Aged Care then the My Aged Care people will try to contact the client if it's not made by a clinician. Then they will try and contact the client by telephone. On the My Aged Care system when you're doing referrals they have a tick-a- box that you can say the person speaks an Aboriginal language but there's no place to specify which Aboriginal language it is and they don't use interpreters, not even Creole interpreters when they telephone back to clients.*

Commissioners, before we close, I repeat the invitation made in my opening for people to come to the community forum that will be held here this afternoon at 2 o'clock. We remain keen to hear from all of those who wish to share their experience of these matters. The forum commences at 2 pm. I wish to close with the remarks of Faye Dean when she said on Monday morning:

> *Elders are our future, our culture, and that's who we learn off. Our Elders.*

Thank you, Commissioners.

COMMISSIONER TRACEY: Yes. Thank you, Mr Bolster. The Commission is indebted to counsel, instructing solicitors, and support staff for all the work that has been done to establish these three days of hearings in Broome. We're particularly conscious of the work that has been done to establish communications and record the proceedings. It has involved an enormous logistic task of moving equipment from one part of the country to another, and we're very mindful of the hard work that has been done by many people to ensure that these proceedings could proceed smoothly as they have done.

We endorse what has just been said by Mr Bolster about the importance of the opportunity provided this afternoon for the community to express views informally to the Commission. And we encourage all those who may be interested in making their views known to the Commission to take this opportunity which will shortly arise. The Commission will resume formal hearings in Perth next Monday and we will adjourn until 9.30 am on 24 June.

MATTER ADJOURNED at 12.17 pm UNTIL MONDAY, 24 JUNE 2019

Index of Witness Events

Index of Exhibits and MFIs