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**TRANSCRIPT OF PROCEEDINGS**

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O/N H-1030606

**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**

**PERTH**

**9.46 AM, WEDNESDAY 26 JUNE 2019**

**Continued from 25.6.19**

**DAY 28**

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

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Good morning, Commissioners. I call Stuart Woodley. I understand,  
5 Commissioners, there have been some problems with the link but we've largely  
resolved them.

COMMISSIONER TRACEY: Good.

MR ROZEN: Mr Woodley, can you hear me okay?  
10

MR WOODLEY: I can, yes.

MR ROZEN: Thank you. Perhaps if Mr Woodley could be sworn, please.

15

**<STUART RANDALL WOODLEY, AFFIRMED** [9.47 am]

**<EXAMINATION-IN-CHIEF BY MR ROZEN**  
20

MR ROZEN: Mr Woodley, could you please state your full name for the transcript.

MR WOODLEY: Stuart Randall Woodley.  
25

MR ROZEN: And Mr Woodley, did you make a statement recently for the Royal  
Commission?

MR WOODLEY: I did.  
30

MR ROZEN: A statement dated 23 June 2019?

MR WOODLEY: Yes, that is correct.

35 MR ROZEN: And our code here for that is WIT.0272.0001.0001. Have you had an  
opportunity to read through your statement before giving evidence this morning, Mr  
Woodley?

MR WOODLEY: Yes, I have.  
40

MR ROZEN: Is there anything in the statement that you would like to change?

MR WOODLEY: No, there's not.

45 MR ROZEN: All right. And are the contents of your statement true and connect?

MR WOODLEY: They are.

MR ROZEN: I tender the statement of Mr Woodley dated 23 June 2019, Commissioners.

5

COMMISSIONER TRACEY: Yes. The statement of Stuart Woodley dated 23 June 2019 will be exhibit 5-21.

10 **EXHIBIT #5-21 STATEMENT OF STUART WOODLEY DATED 23/06/2019 (WIT.0272.0001.0001)**

MR ROZEN: If the Commission pleases. Mr Woodley, thank you for making yourself available at short notice to assist us. You have been asked to answer a number of questions about your involvement in responding to a complaint that was made by Ms Noleen Hausler in late 2016, early 2017. You understand that?

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MR WOODLEY: Yes, I do.

20

MR ROZEN: Yes. And Ms Hausler has given evidence to this Royal Commission in the form of a witness statement which is exhibit 5-9 I think.

COMMISSIONER TRACEY: Ms Hausler is 5-9.

25

MR ROZEN: Thank you, Commissioner Tracey. I just want to read you three sequences from her statement, Mr Woodley, because they provide us with some context for the questions that I'm going to ask you. Do you understand?

30 MR WOODLEY: Okay. Yes.

MR ROZEN: All right. At paragraph 233 of her statement, which is WIT.1124.0001.0031, Ms Hausler says:

35 *It was extremely concerning to me on 11 December 2016 when emergency paramedic services needed to be contacted to insert an intravenous cannula to administer fluids and antibiotics.*

40 Now, I just pause there in the reading. That's in the context of some health concerns about her late father who was a resident at the Mitcham facility.

MR WOODLEY: Yes.

MR ROZEN: You understand that.

45

MR WOODLEY: Yes.

MR ROZEN: Going back to the statement she said:

*The RN could not find the contact number for the EPS.*

5 The emergency paramedic service. Then she goes on:

*It took over one hour plus a phone call initiated by myself to Rachael Musico to find the number.*

10 MR WOODLEY: Yes.

MR ROZEN: And then she went on at paragraph 235 to say:

*I raised this concern at a meeting on 13 December 2016.*

15

And she says:

*Those at the meeting informed me there is a contact phone numbers book in the nurses' station.*

20

She said:

*This being the case, why didn't the RN know?*

25 So I just ask you to accept that's the context for the complaint that she raised with the Aged Care Complaints Commissioner. Do you understand that?

MR WOODLEY: I do.

30 MR ROZEN: All right. Now, I will just ask you a little bit about yourself, Mr Woodley and then I will ask you some questions about that. You've been employed at Japara since 2012.

MR WOODLEY: That is correct, yes.

35

MR ROZEN: You initially were employed as quality manager; is that right?

MR WOODLEY: Yes, that is correct.

40 MR ROZEN: Sorry, I didn't mean to talk over you. We've had evidence from other quality managers. Your responsibility was to assist with ensuring that various Japara facilities that you were responsible for met their legislative obligations; is that right?

MR WOODLEY: That's correct, yes.

45

MR ROZEN: And you were also – part of your task was to ensure that they met internal procedures and policies that were applicable to them.

MR WOODLEY: Yes.

MR ROZEN: All right. Now, in 2017, in February, you moved into a different position as group quality manager.

5

MR WOODLEY: Yes.

MR ROZEN: And in the hierarchy at Japara that's a position that's senior to the position of quality manager.

10

MR WOODLEY: Yes. It was a new position.

MR ROZEN: Right. And you had quality managers reporting to you from that time on; is that right?

15

MR WOODLEY: Yes.

MR ROZEN: You managed a team of about seven quality managers who performed the functions that you were previously performing when you had that role.

20

MR WOODLEY: Yes.

MR ROZEN: They were accountable to you.

25

MR WOODLEY: Yes.

MR ROZEN: And you were accountable to the CEO, Mr Sudholz; is that right?

MR WOODLEY: Yes.

30

MR ROZEN: Right. Now, we've had evidence from Ms Julie Reed, who you would know from previously employed by Japara.

MR WOODLEY: Yes.

35

MR ROZEN: Her evidence is that she resigned in January 2017. Was the role you came into a role that was similar to the one that she had previously held, albeit under a different title?

40

MR WOODLEY: No. Julie Reed's role was taken over by Wendy Waddell.

MR ROZEN: I see.

45

MR WOODLEY: At the time of Julie's retirement, we created a few extra roles in between Julie and where Julie was and the quality managers, so it was a new role that I took on some of the responsibilities that Julie used to have.

MR ROZEN: All right.

MR WOODLEY: She used to manage the quality managers directly; now I manage them directly and then I reported to Wendy Waddell.

5

MR ROZEN: Okay. I want to ask you some questions about the complaint that was made by Noleen Hausler and just so that it's clear, it was a complaint she made to the Aged Care Complaints Commissioner and their code for that complaint was S17/006439. Don't – you don't need to concern yourself too much with that, but it's important that we know what complaint we're talking about. As you will be aware there were 11 issues raised in that complaint. You understood that?

10

MR WOODLEY: Yes.

MR ROZEN: Yes. And it was part of your function to enable Japara to respond to those 11 issues; is that correct?

MR WOODLEY: That's correct, yes.

MR ROZEN: Your task was to interrogate – I use that term in a neutral fashion – you would interrogate relevant documents and employees of Japara to enable the response to be made; is that right?

20

MR WOODLEY: That's correct. I was in Victoria the whole time so the people at Mitcham collected the information and sent it over to me, and then I reviewed that and made sense of it and wrote a response.

25

MR ROZEN: And the events that were the subject of a complaint all occurred in 2016 when you were a quality manager employed by Japara; is that right?

30

MR WOODLEY: Yes. I had not much direct contact during Clarence Hausler's time at Mitcham.

MR ROZEN: Yes.

35

MR WOODLEY: You know, that was handled by Diane Jones who you've spoken to.

MR ROZEN: Yes.

40

MR WOODLEY: It was in 2017 when I took on the new role that I was involved in the actual responses or decision-making.

MR ROZEN: All right. And the way the complaint was processed was that a letter was sent to Japara by the complaints commissioner setting out the 11 issues and seeking a response from Japara in relation to each of them; is that right?

45

MR WOODLEY: The complaints department called myself and Wendy Waddell and went through the 11 points with us and we discussed, you know, we understood what the issues were.

5 MR ROZEN: Yes.

MR WOODLEY: And then they sent us the letter after that discussion and asking us to respond.

10 MR ROZEN: Okay. And issue number 5, as I think you're aware, is the issue that we're concerned about, and that's the one that related to Ms Hausler's concern about the inability of the nurse to find the number for the paramedic on that night on 11 December 2016. You understood that that was issue number 5 that was being explored and investigated by the complaints commissioner?

15

MR WOODLEY: Yes.

MR ROZEN: Now, paragraph 13 of your statement, do you have a copy of your statement in front of you, Mr Woodley?

20

MR WOODLEY: I will get it from someone. Yes, thank you.

MR ROZEN: Thank you. It might assist you if you read it with me.

25 MR WOODLEY: Paragraph 7?

MR ROZEN: Paragraph 13 at the top of page 3.

MR WOODLEY: 13. Yes.

30

MR ROZEN: Yes. Do you see that you write:

*I believe that when the complaint was first received by Japara we were contacted by the complaints department by telephone.*

35

MR WOODLEY: Yes.

MR ROZEN: That "we" is yourself and Ms Waddell who you mentioned a moment ago.

40

MR WOODLEY: Yes.

MR ROZEN: All right. You then go on:

45

*During the telephone call we advised the complaints department that the facility manager had provided the number for the ECP –*

that's the paramedic.

MR WOODLEY: Yes, service.

5 MR ROZEN:

*...when contacted on 11 December 2016.*

MR WOODLEY: Yes.

10

MR ROZEN: So that was the information that you provided. You said:

*The facility manager gave the relevant information on the night.*

15 MR WOODLEY: Yes.

MR ROZEN: Relevant phone number.

MR WOODLEY: Yes.

20

MR ROZEN: And you write:

*I recall being told that this would not be a sufficient response to issue 5.*

25 Do you see that in your statement?

MR WOODLEY: Yes.

30 MR ROZEN: Doing the best you can, and I understand this was some time ago, what was said by the representative of the complaints commissioner. Did they say that that wouldn't be a sufficient response or did they give any - - -

MR WOODLEY: No, what they said – sorry.

35 MR ROZEN: Go on.

40 MR WOODLEY: They read out the issue that was raised and, you know, that we could not locate the number, and I said, but the nurse, she may have been under pressure, she may have been a bit flustered. She couldn't find the number so her action was to ring the facility manager who could then tell her the number and that number was 000. And I said, "Is that a sufficient response?". They said, "No, that is not what the complainant is looking for. She wants to know that we've done something about it so next time if the nurse needs the number, that won't happen again". So I had to not just say what happened; I had to say, you know – I had to  
45 reassure Ms Hausler that we had put something in place so it would not occur again.

MR ROZEN: All right. In paragraph 14 of your statement, you say:



*Following this call I sent the emails in document –*

and then you identify the document which is attached to your statement.

5 MR WOODLEY: Yes.

MR ROZEN: And you say:

10 *...in the context of trying to determine what further response could be provided  
to the complaints department.*

Do you see that?

15 MR WOODLEY: Yes.

MR ROZEN: And the email that we're talking about, which is what I really want to ask you about, are attached to your statement as attachment SW-4, and in the evidence before the Commission, they're tab 144 which I think you have in front of you. An email chain involving yourself - - -

20 MR WOODLEY: Yes.

MR ROZEN: - - - Ms Jones and Ms Musico?

25 MR WOODLEY: Yes.

MR ROZEN: I understand it can't be shown on the screen for technical reasons, but as long as you can see the document, Mr Woodley.

30 MR WOODLEY: Yes.

MR ROZEN: All right. Now, we need to read this, as with any email chain, from the end going upwards, don't we, Mr Woodley?

35 MR WOODLEY: Yes.

MR ROZEN: To understand the sequence.

40 MR WOODLEY: Yes.

MR ROZEN: And this email chain only concerns issue number 5. I take it there were other emails to do with other issues that were the subject of the complaint?

45 MR WOODLEY: Yes.

MR ROZEN: And in each of them, you were writing to the relevant officers within Japara who had direct knowledge of the relevant matters; is that right?

MR WOODLEY: Correct, yes.

MR ROZEN: And so we see at the bottom of that page that you've written to Ms Jones who was the quality manager with responsibility for the Mitcham facility; is that correct?  
5

MR WOODLEY: To Diane Jones and to Rachael, yes.

MR ROZEN: Rachael Musico was the facility manager.  
10

MR WOODLEY: Correct.

MR ROZEN: And you've then set out – you've quoted the question that you've been asked by the commissioners, that is – the commissioner, issue number 5:  
15

*Concerned that the service could not locate the contact details for the extended care paramedic on 13 December 2016.*

Do you see that?  
20

MR WOODLEY: Yes.

MR ROZEN: And then if we turn to the second page of the email chain.

MR WOODLEY: Yes.  
25

MR ROZEN: There's a heading Our Response. Do you see that?

MR WOODLEY: Sorry, yes.  
30

MR ROZEN: Our Response, and you have, there, typed the answer that you – you were proposing to give to the commissioner in response to its investigation about that issue; is that right?

MR WOODLEY: Yes.  
35

MR ROZEN: Yep. And other than some very minor changes, that is, in fact, the response that appeared in the letter that went back to the commissioner; is it not?

MR WOODLEY: That is correct.  
40

MR ROZEN: Yeah.

MR WOODLEY: That is correct.  
45

MR ROZEN: Yeah. The attachment number changed, I think, because there was a bit of a change in the numbering; is that right?

MR WOODLEY: Possibly, yes.

MR ROZEN: Yes. All right. So that was the answer that you were proposing and then underneath it, you wrote to Ms Jones and Ms Musico:

5

*Do we have evidence that it was listed somewhere on the day?*

And by - - -

10 MR WOODLEY: Yes.

MR ROZEN: - - - that question you were inquiring of them whether there was a listing of the number on the 13<sup>th</sup> of December 2016 at Mitcham, weren't you?

15 MR WOODLEY: Correct.

MR ROZEN: Yeah, and that was because you knew that what the Complaints Commissioner wanted to know. What was the state of play on 13 December 2016?

20 MR WOODLEY: Where could the number be found or why couldn't the number be found, yes. That's what they were asking.

MR ROZEN: Yeah. They wanted to know whether it was available to the nurse?

25 MR WOODLEY: Yes.

MR ROZEN: Yep. And so you asked Ms Jones and Ms Musico whether it was available, and you then went on and said:

30 *If not, add it to the contact list now.*

MR WOODLEY: Yes.

35 MR ROZEN: Why were you directing them to add it to the contact list now in February?

40 MR WOODLEY: When I - I was just trying to find out what the situation was on the night, was it on the contact list or was it not. When they said it wasn't there, I was actually quite happy because then I thought, okay, now I know what I can do, what improvement I can make to reassure the complainant we've made an improvement so it won't happen again. So as I explained, they weren't privy to the conversation with the Complaints Department, so I was explaining that's what we need to do. We need to fix the contact list to show that we've made an improvement so it won't happen again.

45

MR ROZEN: Mr Woodley, you well understood that what the Complaints Commissioner was asking was whether the number was available to the nurse on the night in question, didn't you?

5 MR WOODLEY: I think we had established that the number wasn't available on the night in our phone call.

MR ROZEN: Well, you don't say that in your statement, do you, that that's what you told them in the phone call? Or have I missed something? The paragraph - - -  
10

MR WOODLEY: Well, I said at the – during the night, the nurse could not find the number anywhere, so she contacted the facility manager who gave her the number.

MR ROZEN: Yes, but, Mr Woodley, you understand there are at least two  
15 explanations for the nurse not being able to find the number. One is - - -

MR WOODLEY: Yes.

MR ROZEN: - - - the number was there, but she didn't know where to look - - -  
20

MR WOODLEY: Yes.

MR ROZEN: - - - which might raise a question of her training.

25 MR WOODLEY: Yes.

MR ROZEN: Yes, and another explanation is the number wasn't there which might raise a more fundamental problem about – of a systemic nature at the Mitcham facility. Do you understand the distinction I'm drawing?  
30

MR WOODLEY: Yes.

MR ROZEN: Yep, and you understood that that's precisely what the Aged Care Complaints Commissioner wanted to ascertain. You've got to ascertain what the problem is first before you come up with a solution, don't you, Mr Woodley?  
35

MR WOODLEY: I – yes, I suppose.

MR ROZEN: Yep. Going back to your email, this is the email of the 20<sup>th</sup> of  
40 February. At the very end of it, you wrote, "If not" – in other words, if the number was not there on the day - - -

MR WOODLEY: Yes.

45 MR ROZEN:

*- - - add it to the contact list now.*

Do you see you wrote that?

MR WOODLEY: Yes.

5 MR ROZEN: And you went on:

*We are only saying it is –*

capital I, capital S –

10

*on the list, not was –*

capital W, capital A, capital S.

15 MR WOODLEY: Yes.

MR ROZEN: What were you conveying to Ms Jones and Ms Musico there?

20 MR WOODLEY: I was saying we're not saying that it was there on the night. I'm saying that we've fixed it now and it's there now. I think it's quite clear what my intention of the statement was. I was making it clear.

25 MR ROZEN: I suggest to you, Mr Woodley, that the reason you have included the words "is" in capitals and "was" in capitals is that what you're conveying to Ms Jones and Ms Musico is that, "We're not lying in our response to the commissioner. We're just not giving them a complete answer to the question that they're asking." What do you say to that?

30 MR WOODLEY: No, I was explaining – they didn't understand what I had to do to make the complainant happy, that we had to tell them that it was there now, not that it was there on the night. That's what they wanted to know.

35 MR ROZEN: Well, the concern that they wanted to know couldn't be clearer, could it, Mr Woodley? If you go back to the first page of the email exchange.

MR WOODLEY: Yes.

40 MR ROZEN: The concern is only concerned with what was the state of play on 13 December 2016.

MR WOODLEY: I will grant you I could have written a much more thorough response, but I was not trying to - - -

45 MR ROZEN: Well, it's not just a - - -

MR WOODLEY: - - - mislead them.

MR ROZEN: It's not just a matter of a more thorough response. You didn't answer the question that they were asking. You answered a different question, didn't you?

5 MR WOODLEY: I answered the questions that they asked me to answer in the phone call.

MR ROZEN: I see. Is there any reason why you didn't detail that that's what they asked you to provide them in the phone call in your statement at paragraph 13? You said - - -

10 MR WOODLEY: No. And, in hindsight, I should have explained that we'd had that conversation, but I didn't. There's no reason for that.

MR ROZEN: You see, all you say in the statement made a few - - -

15 MR WOODLEY: Yes.

MR ROZEN: - - - days ago is:

20 *I recall being told that this would not be a sufficient response to issue 5.*

Do you see that?

MR WOODLEY: Yes.

25 MR ROZEN: In paragraph 18 of your statement, you accept, don't you, that, in hindsight, it would have been preferable to specify the circumstances that existed on 11 December 2016. I think there's a bit of confusion, and I'm not criticising you for this, about those two dates, 11 and 13.

30 MR WOODLEY: That was the department's error.

MR ROZEN: Indeed. You accept that it would have been preferable to tell them about the circumstance on 11 December 2016.

35 MR WOODLEY: Yes.

MR ROZEN: You say that, don't you?

40 MR WOODLEY: Yes.

MR ROZEN: What I'm trying to understand, Mr Woodley, is why you didn't. It was such a simple question and it could have been so simply answered.

45 MR WOODLEY: I wrote a bad answer. That's my answer.

MR ROZEN: So I think we're agreed that you didn't answer the question.

MR WOODLEY: Very well. Yes.

MR ROZEN: Yep. You want the Commission that accept that there's an innocent explanation for that.

5

MR WOODLEY: Yes.

MR ROZEN: That's what it comes down to?

10 MR WOODLEY: Yes.

MR ROZEN: Are you able to tell us the date of that phone call that you describe in paragraph 13 of your statement?

15 MR WOODLEY: No, I'm not. The letter that they sent us to outline the complaint is often sent the same day or the day after.

MR ROZEN: It's a pretty small window that we're looking at, isn't it, between the date of the letter and the date of your response which is 20 February; is that right?  
20 The phone call happened in that intervening period?

MR WOODLEY: Yes.

MR ROZEN: Are you in the habit of making notes of such phone calls when you're  
25 talking to regulators about formal complaints?

MR WOODLEY: No, because they go through the 11 points of the complaint and then they say, "We'll send you a summary of those complaints at the end of this phone call." So we don't know what they're going to talk about when they ring so  
30 - - -

MR ROZEN: I'm not sure you're answering my question. You understood you were having a formal phone call with the regulator about a formal complaint that had been made with your employer; that's right, isn't it?

35

MR WOODLEY: Yes. Yes.

MR ROZEN: And are you saying you made no notes of that telephone call?

40 MR WOODLEY: I made no notes of that meeting.

MR ROZEN: Do you know if Ms Waddell made any notes of that telephone call?

MR WOODLEY: No, she made no notes of that meeting.

45

MR ROZEN: You've inquired of her, have you?

MR WOODLEY: No, but she was there at the time and we were just listening.

MR ROZEN: I see. And is that standard practice that no notes are made of such telephone calls within Japara?

5

MR WOODLEY: Of those phone calls, no, it's not.

DR RUNGIE: It's not standard practice.

10 MR WOODLEY: No.

MR ROZEN: Ordinarily, notes would be made is that what you're saying?

15 MR WOODLEY: No, if they rang me tomorrow with the same thing, I wouldn't have taken notes. I would wait for what they have put in their letter.

20 MR ROZEN: I see. You accept, don't you, Mr Woodley, that, particularly in the position you hold which is a very senior one within Japara, that it's important that you are – not only provide honest answers to regulator's inquiries, but you also have to provide complete answers, don't you?

MR WOODLEY: I do.

25 MR ROZEN: You accept now that the answer you provided was not a complete answer - - -

MR WOODLEY: I do.

30 MR ROZEN: - - - in hindsight?

MR WOODLEY: I do.

35 MR ROZEN: The reason it's particularly important for someone in your position is you set the tone, don't you, as for a quality manager for your subordinates?

MR WOODLEY: Yes.

MR ROZEN: Yep. You know that part of your role is to lead by example.

40 MR WOODLEY: Yes.

MR ROZEN: That is, to lead the quality managers by example.

45 MR WOODLEY: Yes. Can I read para 19 of my statement.

MR ROZEN: You may.



MR WOODLEY: Well, as you know, I was new in that role at the time. Since that time in the two years I've been in the role, we've reviewed the way we respond to all complaints.

5 MR ROZEN: Yes.

MR WOODLEY: So, you know, we're more thorough now explaining what happened at the time, what actions we've identified – what gaps we've identified in the situation, what we've done about it and even what we've evaluated that what we did is effective. Now, that's also an increased expectation from the Complaints Department because it's changed from the Aged Care Complaints Commission to the Aged Care Quality Commissioner. So we have made improvements since that time.

15 MR ROZEN: Thank you.

MR WOODLEY: And I don't think this would happen again.

MR ROZEN: Thank you, Mr Woodley. Can I ask are those changes documented in some way?

20 MR WOODLEY: No, I said process, so when I'm talking to quality managers and they've begin me a draft response, I say, "We haven't been thorough enough here. Can you go through and make those particular points."

25 MR ROZEN: I want to ask you about one more matter, if I may - - -

MR WOODLEY: Yes.

MR ROZEN: - - - Mr Woodley. You should have a document in front of you which has got a code in the top right-hand corner, JOH.0001.0005.5917.

30 MR WOODLEY: Yes.

MR ROZEN: It's behind tab 123. Do you have that? It's headed Reconfirmation of Issues letter.

35 MR WOODLEY: Yes.

MR ROZEN: Do you see that?

40 MR WOODLEY: Yes.

MR ROZEN: Once again, if we go to the second page of that, please. First, you will see in the middle of the page, there's an email from Jerome Jordan. Do you see that?

45 MR WOODLEY: Yes.

MR ROZEN: Mr Jordan was the Executive Director of Operations at Japara Healthcare Limited at this time, October 2016.

MR WOODLEY: Correct.

5

MR ROZEN: Was that a position senior to yours within the hierarchy?

MR WOODLEY: Yes. It was of the same level as Julie Reed, but he was more operations. Julie was more clinical care.

10

MR ROZEN: I see. This is an email dated 19 October 2016.

MR WOODLEY: Yes.

15 MR ROZEN: Sent to you notifying you of an issues letter in another complaint that had been made by Noleen Hausler.

MR WOODLEY: Correct.

20 MR ROZEN: That's right. A different one to the one that I've been asking you about.

MR WOODLEY: Correct.

25 MR ROZEN: Mr Jordan wrote:

*Hi Stuart, please find attached complaint in relation to Mitcham and Mr Hausler for your attention. Please engage with [subject to a non-publication direction] who is happy to take your call.*

30

Do you see that?

MR WOODLEY: Yes.

35 MR ROZEN: And [subject to a non-publication direction] was Ms [subject to a non-publication direction] from the Aged Care Complaints Commissioner; is that right?

MR WOODLEY: Correct.

40 MR ROZEN: And then, to see your response or the action that you then took, we go to the first page at the bottom. There's an email from you to Ms Jones and Ms Musico of Mitcham; is that right?

MR WOODLEY: Yes.

45

MR ROZEN: And the subject is the same and you say:

*Good afternoon.*

And then if we go to the second page it continues :

5            *Another complaint re Mr Hausler's care. I will discuss how we are to approach ongoing complaints with Julie on her return on Monday.*

MR WOODLEY: Correct.

10          MR ROZEN: And the Julie there is a reference to Julie Reed.

MR WOODLEY: Yes, I think she was on sick leave.

15          MR ROZEN: All right. And you're writing this in your then capacity as a quality manager; is that right?

MR WOODLEY: Yes.

20          MR ROZEN: Then if we go back to the first page – and I'm sorry to jump you around - - -

MR WOODLEY: That's all right.

25          MR ROZEN: Ms Jones responded to you on the same day, 19 October 2016. She wrote:

*I don't want to say this is getting really old. Regards Di Jones.*

30          Do you see that?

MR WOODLEY: Yes.

MR ROZEN: That probably should read "I don't know what to say".

35          MR WOODLEY: Yes.

MR ROZEN: That's what you understood she was saying to you. And do you see your response at the top of the page? I might ask you to read that out if you could please, Mr Woodley.

40

MR WOODLEY:

45            *I was speechless. I want to talk to Julie about progress with VCAT. We need to stand up for our rights and say this is harassment.*

MR ROZEN: You thought it was harassment, didn't you, the complaints that were being made by Ms Hausler?

MR WOODLEY: No, that's not what I meant. I was saying it was harassment by the department.

5 MR ROZEN: The department conveying to you complaints it had received from Ms Hausler was harassment by the department.

MR WOODLEY: Okay. So the – we all agree that a horrible incident happened to Mr Hausler in – the end of 2015.

10 MR ROZEN: Yes.

MR WOODLEY: We reported to the police what had occurred. We reported to the department that we need to report to you that an assault had occurred. The Aged Care Accreditation Agency came in and reviewed the whole process. The aged care  
15 agency came in again and reviewed the whole process. I think after it was on television they came in for a third time and reviewed everything we did for all our residents. Not one of those people had said there was anything wrong with what we had done. A whole year later after that incident, so this is October 2016, the same  
20 department writes a letter to us saying we've just found out there was an incident in 2015. Can you tell us all about it and what you've done. And I'm like how many people from the same department are going to come out and want the same information when possibly couldn't they communicate with each other and say what do we know about this and what can we do.

25 MR ROZEN: Mr Woodley, you knew that there were three assaults within a period of 10 days concerning the late Clarry Hausler, didn't you?

MR WOODLEY: Yes, I did.

30 MR ROZEN: And one of those, the very first, was on 31 August 2015, wasn't it?

MR WOODLEY: Yes.

35 MR ROZEN: And it wasn't reported to the department until more than a year after it occurred, in 2016.

MR WOODLEY: Is it a year; is that correct?

40 MR ROZEN: Perhaps I stand corrected there; it might have been August, but it was nearly – it was either just before or just after a year. I don't have the date in front of me.

MR WOODLEY: Yes.

45 MR ROZEN: Now the explanation that has been given for that by Ms Reed was that Japara didn't know about that incident until it was in The Advertiser, the Adelaide Advertiser newspaper. Do you understand that?

MR WOODLEY: I understand that's her evidence, yes.

MR ROZEN: So it wasn't as if this was as at October 2016 old news, was it?

5 MR WOODLEY: Sorry, it's 12 months later.

MR ROZEN: Yes. But the report had only just come in in relation to one of those incidents, hadn't it?

10 MR WOODLEY: I don't think so. The incident was in 2015.

MR ROZEN: Yes.

MR WOODLEY: It was a reported a couple of months after it occurred.

15

MR ROZEN: That was the 1 September incident that was reported a couple of months later. The 31 August incident was not reported until 2016. Are you not aware of that, Mr Woodley?

20 MR WOODLEY: I do not have the dates straight in my head, I'm sorry.

MR ROZEN: The use of capital letters, which you've obviously fond of, indicates what, emphasis presumably, does it?

25 MR WOODLEY: I was trying to support Di and Rachael, that they're trying to care for 30 other residents including Mr Hausler and the department keeps going back and asking them the same questions.

MR ROZEN: So what, Japara was the victim in all this, was it, Mr Woodley?

30

MR WOODLEY: No. Diane was a co-worker; I was just supporting her, you know, saying you're going to have to spend another week answering the same question again.

35 MR ROZEN: What's the reference to VCAT, Mr Woodley; what's that all about?

MR WOODLEY: VCAT, I said the wrong thing. I don't know what the South Australian version is. As I said, I'm not – it's the Guardianship Board.

40 MR ROZEN: Do you mean SACAT, the - - -

MR WOODLEY: Yes, SACAT, sorry. I - - -

MR ROZEN: - - - guardianship application.

45

MR WOODLEY: At the time I was working in Victoria. I didn't know what it was called in South Australia.

MR ROZEN: I see.

MR WOODLEY: I can't recall what I meant. I can guess that maybe Julie Reed was answering the same questions that were in the document the department had sent  
5 us and so was saying rather than Rachael having to start from scratch and write all the response again, she might be able to just help use some of the information we had gathered for the guardianship hearing.

MR ROZEN: Was there some proposal to initiate some proceeding in, I think it's  
10 the South Australian tribunal, I think we've established, by Japara against Ms Hausler or does this relate to her guardianship application?

MR WOODLEY: I have no knowledge. I only knew that Julie was responding to  
15 some questions from the Guardianship Board.

MR ROZEN: Finally, Mr Woodley, we've got a statement from the man who's ultimately your boss, Mr Sudholz.

MR WOODLEY: Yes.  
20

MR ROZEN: He was asked:

*What is Japara's attitude towards complaints made by family members about  
25 care?*

And this is the evidence that he has given in paragraph 54 of his statement to the Royal Commission. He says:

*Japara views any complaints, including complaints made by family members,  
30 as a means to improve the services and care we provide.*

Do you understand that's the evidence he has given?

MR WOODLEY: Yes.  
35

MR ROZEN: Do you think your email of 19 October 2016, in which you're accusing the regulator of harassment in pursuing a response from your organisation about a complaint made by a family member, is consistent with that approach to  
40 complaints?

MR WOODLEY: It doesn't read that way. I wasn't saying we shouldn't respond. I was just saying to my colleague, you know, you're going to have to do a lot of work again.

45 MR ROZEN: Is it another - - -

MR WOODLEY: I'm the biggest complainer in the world in my personal life because I know it results in better service for other people.

5 MR ROZEN: Is it another example of unfortunate language in an email in hindsight, Mr Woodley?

MR WOODLEY: Yes. It was an email between me and Diane.

10 MR ROZEN: No further questions, Commissioners.

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

15 MR WOODLEY: All right. Thank you.

**<THE WITNESS WITHDREW [10.24 am]**

20 MR ROZEN: Commissioners, I think we need to have a brief break while we reorganise the seats.

25 COMMISSIONER TRACEY: We will break the link to Melbourne and the Commission will temporarily adjourn.

MR ROZEN: Thank you.

30 **ADJOURNED [10.24 am]**

**RESUMED [10.34 am]**

35 COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: Commissioner, I call Anna Urwin, Emma Murphy, Gaye Whitford, and Patti Houston. Commissioner, they will give their evidence in a panel form.

40 COMMISSIONER TRACEY: Yes.

**<ANNA CHRISTINE URWIN, SWORN [10.35 am]**

45 **<EMMA-KAITLIN MURPHY, SWORN [10.35 am]**

<GAYE MARGARET WHITFORD, SWORN

[10.35 am]

<PATTI ANNE HOUSTON, SWORN

[10.35 am]

5

<EXAMINATION-IN-CHIEF BY MS HILL

10 MS HILL: Mrs Whitford, if I could start with you, could you please tell the Commissioners your full name.

MS WHITFORD: Gaye Margaret Whitford.

15 MS HILL: And whereabouts do you live?

MS WHITFORD: Streaky Bay, South Australia.

MS HILL: And how old are you?

20

MS WHITFORD: Forty-one.

MS HILL: What is your occupation, Mrs Urwin – I apologise. Mrs Whitford.

25 MS WHITFORD: Yeah, registered nurse and residential care coordinator.

MS HILL: And what qualifications do you hold in respect to those?

30 MS WHITFORD: Bachelor of Nursing and I've just completed a graduate diploma in aged care.

MS HILL: And have you prepared a statement dated the 4<sup>th</sup> of June of this year?

MS WHITFORD: I have.

35

MS HILL: Operator, could you please display document ID WIT.1129.0001.0001. Mrs Whitford, do you see that statement displayed in front of you?

MS WHITFORD: Yes, I do.

40

MS HILL: Are there any changes that you'd seek to make to that statement?

MS WHITFORD: No, there isn't.

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

MS WHITFORD: They are.



MS HILL: Commissioner, I tender that statement.

COMMISSIONER TRACEY: Yes. The witness statement of Gaye Whitford dated 4 June 2019 will be exhibit 5-22.

5

**EXHIBIT #5-22 WITNESS STATEMENT OF GAYE MARGARET  
WHITFORD DATED 04/06/2019 (WIT.1129.0001.0001) AND ITS  
IDENTIFIED ANNEXURES**

10

MS HILL: As the Commission pleases. Ms Murphy, could I ask you to state your full name, please.

15 MS MURPHY: Emma-Kaitlyn Murphy.

MS HILL: And whereabouts do you live, Ms Murphy

MS MURPHY: I live in Brisbane, Queensland.

20

MS HILL: And how old are you, Ms Murphy?

MS MURPHY: I'm 21 years old.

25 MS HILL: What is your occupation?

MS MURPHY: I'm a registered nurse.

MS HILL: And what qualifications do you hold in respect to that?

30

MS MURPHY: A Bachelor of Nursing.

MS HILL: Operator, could I ask you to display document ID, WIT.1131.0001.0001. Ms Murphy, have you prepared a statement dated 7 June of this year?

35

MS MURPHY: Yes, I have.

MS HILL: And do you see a copy of that statement on the monitor before you?

40 MS MURPHY: Yes, I do.

MS HILL: Is there anything you'd seek to change or amend in that statement?

MS MURPHY: No, thank you.

45

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

MS MURPHY: Yes, they are.

MS HILL: I tender that, Commissioner.

5 COMMISSIONER TRACEY: Yes. The witness statement of Emma-Kaitlin  
Murphy dated the 7<sup>th</sup> of June 2019 will be exhibit 5-23.

10 **EXHIBIT #5-23 WITNESS STATEMENT OF EMMA-KAITLIN MURPHY  
DATED 07/06/2019 (WIT.1131.0001.0001) AND ITS IDENTIFIED  
ANNEXURES**

15 MS HILL: If the Commission pleases. Ms Urwin, could I ask you to state your full  
name, please.

MS URWIN: Anna Christine Urwin.

20 MS HILL: And you live in a coastal town in Western Australia?

MS URWIN: Yes, I do.

MS HILL: And what is your age, Ms Urwin?

25 MS URWIN: I'm 22.

MS HILL: And what is your occupation?

30 MS URWIN: I'm a physiotherapist.

MS HILL: And what qualifications do you hold in respect of that?

MS URWIN: A bachelor of physiotherapy.

35 MS HILL: Operator, could I ask you to display document ID WIT.1127.0001.0001.  
Ms Urwin, have you prepared a statement dated 12 June of this year?

MS URWIN: Yes, I have.

40 MS HILL: Do you see a copy of that statement on the monitor before you?

MS URWIN: Yes, I do.

45 MS HILL: Are there any changes that you'd seek to make to that statement?

MS URWIN: No, I don't.

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

MS URWIN: Yes, they are.

5 MS HILL: Commissioner, I tender that statement.

COMMISSIONER TRACEY: Yes, the witness statement of Anna Urwin dated the 12<sup>th</sup> of June 2019 will be exhibit 5-24.

10

**EXHIBIT #5-24 WITNESS STATEMENT OF ANNA CHRISTINE URWIN  
DATED 12/06/2019 (WIT.1127.0001.0001) AND ITS IDENTIFIED  
ANNEXURES**

15

MS HILL: As the Commission pleases. Mrs Houston, could I ask you to state your full name to the Commissioners.

MRS HOUSTON: Patti Anne Houston.

20

MS HILL: And where do you live, Ms Houston?

MRS HOUSTON: At Gawler in South Australia.

25 MS HILL: And what is your age?

MRS HOUSTON: I'm 64.

MS HILL: What is your occupation, Ms Houston?

30

MRS HOUSTON: I'm a personal care worker, certificate III.

MS HILL: And is that a certificate III in - - -

35 MRS HOUSTON: Yes. So a certificate III in aged care.

MS HILL: And have you prepared a statement dated the 4<sup>th</sup> of June of this year.

MRS HOUSTON: I have.

40

MS HILL: Operator, could I ask you to please display document ID WIT.1130.0001.0001. Mrs Houston, do you see a copy of your statement on the monitor before you?

45 MRS HOUSTON: Yes, I do.

MS HILL: Are there any changes or amendments you'd seek to make to that statement?

MRS HOUSTON: No, there's not.

5

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

MRS HOUSTON: They are.

10 MS HILL: Commissioner, I tender the statement of Mrs Houston.

COMMISSIONER TRACEY: The witness statement of Patti Houston dated the 4<sup>th</sup> of June 2019 will be exhibit 5-25.

15

**EXHIBIT #5-25 WITNESS STATEMENT OF PATTI ANNE HOUSTON  
DATED 04/06/2019 (WIT.1130.0001.0001) AND ITS IDENTIFIED  
ANNEXURES**

20

MS HILL: As the Commission pleases. Mrs Houston, you've been a personal care worker for about 10 years after a varied career. Could I ask you to describe to the Commissioners a typical day shift in your role as a personal care worker.

25 MRS HOUSTON: Sure. So my shift starts at 7 o'clock in the morning. I usually arrive at about 6.30 and make sure that I am up to date with all my messages and handovers that I need to be prepared before I go on the floor. Once we start working, there's not much time to be looking at computers and reading notes. So I will find out which residents are going to be showered for the day and also whether anyone  
30 needs to have a urine sample taken or maybe have to have their weight taken, so forth, and I write that down on a piece of paper in my pocket and take that onto the floor with me so that I'm well prepared to care for the people I'm looking after.

I also read a handover sheet which is presented on our Lead Care computer program  
35 and that will fill me in on everything that's happened in the home, all the residents for the day. Such things as if they had a fall overnight or they've become ill or anything out of the ordinary is recorded on that and that helps us to give our best care. Then at 7 o'clock, I will go into handover which is given by the night registered nurse. The staff that had been on overnight will hand over anything  
40 significant that's happened overnight in the home, and that's across the home. And then I will grab my keys and my phone and my – we carry a computer in our pocket so that we can do point of care contact, do our documentation on that. And then I will go onto the floor, find my partner and give her any information that she needs to know from that handover.

45

And then we commence work. So that involves helping people out of bed, showering them, dressing them and preparing them for the day, and that will happen

between 7 and 8 am, and I mostly work in the dementia area of our home which is my passion, and we will work together till 8 o'clock, sometimes separately with individuals or, otherwise, we may have to assist a two-person assist where lifters are required to help the person out of bed. And then at 8 o'clock is breakfast time, so we  
5 need to collect the trolley from the kitchen and bring the porridge and cereal to the – the area where we're working. And we make their toast and their coffee and, as much as possible, we bring residents to the table so that they can enjoy their meal sitting in the dining area.

10 Some people will refuse that and others are not able to – we just physically haven't got the time to have everyone in, in an hour, to the table, so we may have to take meals to rooms and some people will need assistance with their food as well. So that takes a little bit of extra time. After breakfast, return the trolley to the kitchen and then we continue with personal care work for the rest of the residents in the area, and  
15 that generally takes from 7 till 12 o'clock to attend to 12 people with two carers assisting. So the dementia area is actually divided into two sections. So we have eight people at one end and eight people at the other. So there's two carers for one lot of eight and two carers for the other lot of eight, but in the other part of the home, there are two carers to 12 people.

20 So at 10.30 in the morning, we provide morning tea which we prepare and serve to the residents, and, sometimes, we'll need to be taking that to them and actually physically assisting them to eat that and have their drinks. And then the care work will continue after that until lunchtime, and then once again we – a bain-marie  
25 service comes to the dining – to our dining room and we assist residents to the table to have their meal where possible. We encourage that so there's social interaction and, once again, some people will need to have assistance with eating their food. At 12.30, I take my lunch and that's for half an hour, and then at 1 o'clock, I'm back on the floor and the afternoon mostly consists of assisting people to the toilet and  
30 attending to their personal needs in that respect. And, where possible, we take as many residents as we can to the main living area where they are able to join in with activities provided by our lifestyle staff.

35 Yes. So my shift finishes at 3.30 in the afternoon. In between all of this, there will be documentation happening. It's supposed to happen at point of contact, but it's not always possible, but the other things that need to be done such as delivering laundry, skips to the laundry, returning trolleys to the kitchen, making beds, showering people. It's, you know, quite a busy time, and we do walk quite long distances from various areas of the home to get everything done. So – and – and then we will – we  
40 will be caring for people who may be in palliative care as well as those who are, you know, in more healthy circumstances, I suppose. Yeah. So, basically, that would be my day.

45 MS HILL: Mrs Houston, are you able to describe what person-centred care means to you in your role?

MRS HOUSTON: Person-centred care means to me is knowing a person very well. So when they come to the home, we do a complete care plan, so that really looks after their more physical sides of their needs. Most people that come in have multiple health issues that need to be cared for. One part of – of – one that I feel that we're failing in – particularly dealing with people with dementia is not addressing their emotional and personal needs as a person. So a person – I've actually written down here. This is a quote from Professor Tom Kitwood who has done a lot of work, written a lot of books in regard to person-centred care and his description is:

10 *A way of thinking and doing things that sees the person using the service for the consumer or resident as equal partners in the planning, development and monitoring of care to make sure it meets their needs. It involves working with people and their families to find the best ways to provide their care.*

15 So this is a whole – looking at a person as a whole, not just they need to be in a room, they need to be washed and cleaned. We need to be actually filling their needs as human beings, and so much time happens where people are sitting alone in a room or even sitting in a community room where they don't have any interaction with – one-on-one with people, and as a person working in dementia care, I find that really confronting and disturbing, and I would like to see that change.

MS HILL: Mrs Whitford, you've worked in aged care since 1997, and in the last nine years, you detail in your statement that you've been the coordinator of a 15-bed home.

25 MS WHITFORD: Mmm.

MS HILL: In your role, how many personal care workers are working in that home with you on a day shift?

30 MS WHITFORD: On the day shift, we have two in the morning, we have two in the afternoon and one on night shift.

MS HILL: And how do you feel about person-centred care in your role?

35 MS WHITFORD: I feel that person-centred care is a term that's overused. I think we are not fulfilling that term adequately enough. We need to be looking at a holistic view of the person, their emotional and spiritual needs, not just their chronic conditions. I feel that we don't provide enough time in order to achieve this with these people, and mental and emotional outcomes, when you do provide this time, is very rewarding.

MS HILL: Do you feel that you're able to support the personal care workers working with you to provide person-centred care?

45 MS WHITFORD: I certainly hope I do. My role – I come in – my hours vary a little, but I generally come in the morning and try to get what I can done in the office

and then I make it my duty to go out and at least assist one person every day to prepare for that day. I feel, in my role, you need to know what the care needs of the residents are before you can coordinate their care and to support the care workers because there may be certain aspects that I can pick up on that perhaps have been missed. In order to provide more comfort to the person, you know, maybe that's appropriate footwear or something small that can make a big change in their day.

10 MS HILL: Are there particular challenges that you face, Mrs Whitford, to delivering person-centred care because your facility is located rurally?

MS WHITFORD: Yes, very much so. Some of our resources are very limited. Our staffing is minimal. We have a very small volunteer base. Even access to allied health or geriatricians is, yes, very difficult, logistical concerns. And even often the inability to organise contracted alternative therapies to come in and assist because of the financial regulations. So, you know, providing – some people we've trialled before, enjoy yoga and I've had a local girl come in to provide this for them voluntarily, and they've actually really enjoyed it but we haven't been able to have the funds to support this as an ongoing activity.

20 MS HILL: Ms Urwin, you graduated as a physiotherapist in 2008 and you've had some exposure to working in aged care. Could I ask you to describe what the physiotherapist's role is in aged care?

MS URWIN: Yes, I graduated in 2018. So the physio role in aged care, what I've seen since I graduated and during my degree as well, is you attend the facility, and we go in. Our role is to apply specific therapies which we're funded through the funding model to provide. These consist of either technical equipment which is specific for pain management or therapeutic massage. So we can apply one of these two therapies for pain management, and that is our main role is for pain management. And what we do with the residents is we put them on a pain list and it's called the pain clinic. And we apply one of these two therapies.

MS HILL: And who directs what you do when you attend upon a residential care setting?

35 MS URWIN: From my role that I participated in with my current job, it was the facility managers provided the paperwork and then myself and my colleague would carry out the work, but I didn't really have much guidance per se because it wasn't – it's not really a job that's very difficult. It's not hard to complete once you have the paperwork and you have the list of residents and you know what to do. You just go to each person that's on your list and then you tick them off. It's basically a box-ticking system.

MS HILL: Would you ever have any interaction with the personal care workers of the places you're at?

MS URWIN: Yes, multiple – multiple times, and I think that personal care workers – I admire the work that they do in aged care. The work that the physio does, I think is a lot more passive and a lot more pointless than the care that the personal care workers give.

5

MS HILL: If I can turn to you, Ms Murphy, you've worked as an agency nurse in several aged care homes since 2017. How many different places have you worked at since that time?

10 MS MURPHY: It would be countless. Anywhere from 10 to 20 facilities throughout Queensland.

MS HILL: And how many residential care places would you attend in an average week for you, Ms Murphy?

15

MS MURPHY: It could vary. I could do five shifts at one facility in a week or I could do five shifts in five different facilities in the same week.

20 MS HILL: And do you see the same level of staff across the different facilities that you attend upon?

MS MURPHY: It does also vary so some facilities are quite a bit smaller so they might have a 60 resident capacity. Others are a lot larger, perhaps 150 residents in a facility.

25

MS HILL: What is the approach that you take when you walk through the door of somewhere new?

30 MS MURPHY: It's quite overwhelming looking after anywhere from 20 to 60 residents that you're not familiar with. So after handover I make it my duty to go around and see everyone, see what sort of needs that they have that aren't necessarily documented. Everyone in aged care is at a different level of care so I think it's really important to understand the needs that they have.

35 MS HILL: In your statement, you give an example of a husband and wife who live at the same facility, and if I could ask you to describe that example to the Commissioners.

40 MS MURPHY: Yes. So as an agency nurse I've seen multiple examples that I identify as poor person-centred care. The one that you're referring to was a married couple that live in residential aged care. They entered together. The wife has late stage dementia. So she has a tendency to abscond or wander, so she resides in a secure wing of the facility. And her husband, who also has dementia but is not as cognitively declined as she is, resides in a separate area of the facility, and so he  
45 often becomes confused and would like to go and see his wife, asks when can I go and see her. So because of restrictive restraint policies in aged care, he cannot reside in the same wing as her because he doesn't have the tendency to wander.



So he will come to the nurses and ask to be escorted to see her. He's allocated one hour twice a day to see his wife and he will come and ask us many times a day to come and see her, and often due to time constraints we have to let him know that he has already seen her twice today, he has to wait until tomorrow, or it's not his time yet. Or sometimes staff might be busy and he might only be able to see her once a day.

MS HILL: Why did you bring that example to the Commission's attention?

MS MURPHY: I think this is a really good example how person-centred care is not being executed correctly in aged care. It's demonstrated by the sheer volume and demand of our residents. As I said previously, I would look after 20 to 60 residents. Our care staff have the same volume issues so we can't give the time and attention that each person deserves. And this example is, you know, it really displays the challenges that we face in delivering person-centred care in aged care.

MS HILL: Mrs Houston, with that example in mind, have you been in that situation yourself from the perspective of your role as a personal care worker.

MRS HOUSTON: Yes, certainly. That would be a daily occurrence where I work, and particularly working with people with dementia; each of those people has quite different needs. And we have probably a large proportion who are two-person assist due to their mobility and so if you have two carers in an area and they are both with one particular person, then they're not able to be supporting anyone else during that time, so it does become difficult. And we need to be aware at all times that even when we're trying to be focusing on the person that we're with, that we have to be aware of everything else that might be happening outside the door, you know, making sure that people don't have falls. We have a no restraint policy so people are free to move as they are able and want to. And it's very demanding to try and cover all bases.

MS HILL: Are you able to cover all bases?

MRS HOUSTON: In a physical sense we are, but certainly not in an emotional sense. We're very lacking in that respect and our home has a few volunteers but not a lot and that would certainly fill the gap if we – we could have some volunteers who could come and sit. Because often people with dementia just need company. They just need to be being with. It's not that you have to have fantastic craft projects or anything like that happening. Sometimes it's just a comfort for them to have someone sitting with them and talking to them and just being in their reality at that time and, yes, so it is difficult at the moment.

MS HILL: Mrs Whitford, have you had to deal with a situation like that in your role as a manager?

MS WHITFORD: Yes, I have. It's probably almost the opposite. People assume that married couples want to be together which often isn't the case. We've had a

lady with quite advanced dementia recently be relocated to the high end of the local hospital where her husband resides and they have looking at putting them together. But I sort of said to them perhaps that may not be her wish. So it's getting to know the person and their history and who they are, and not just assuming.

5

MS HILL: And what do you do to support the personal care workers that you're working with to understand the need for flexibility in those circumstances?

10 MS WHITFORD: Yes, I encourage, if they do stay a bit longer, that, you know, I try to help them out or let them – it's sort of providing that flexible time because we do have a lot of time constraints. Yes, I'm not – I think it's just being there, being a voice for them, going out and assisting them when you know that they're busy or if someone's calling out and you know that they're assisting someone, going out and attending to that person and maybe re-directing them and letting them know where  
15 they are. Yes.

MS HILL: How would you describe the relationship that you have with the personal care workers at your facility?

20 MS WHITFORD: I think we work quite well as a team and that's really what it's about. It's not just the team with the workers, it's the team with your residents as well. It's being almost an extended family. Just being aware, particularly in a smaller facility; I've worked interstate in Victoria in large facilities and I find a smaller facility is much more accommodating to person-centred care. We know each  
25 other. You know the needs. And yes, you just – unlike sort of working in different places, you tend to find who people are and what their needs are and monitor their progression and their care needs.

30 MS HILL: Mrs Houston, what do you need from your manager to be able to provide care that's flexible and responsive to the needs of your residents?

MRS HOUSTON: Well, I'm fortunate to have a very forward-thinking director of nursing and we've just currently undertaken training provided by Dementia Care  
35 Matters which is – they call it the Butterfly model of caring for people with dementia. And it's just a wonderful program that really gets to the heart of people and their slogan is Feelings Matter Most so that's where the care comes from. And we're in the process at the moment, a transition of change starting with our memory support area, so we're changing the environment. We're changing – we're not wearing uniforms anymore, we come in colourful clothing. We're using music. We  
40 are – there's a whole process of about 70 different things that we need to do to actually achieve the Butterfly model status and we're working towards doing that.

We have a group of very dedicated care staff who are giving – volunteering their time to meet with one another and continue this process so that it does happen for the  
45 wellbeing of our residents. And I'd really like to offer that model to the Commissioners and ask them to look at that as a way of going forward. From the point of view of training as well for care staff, the – part of it is an emotional

intelligence screening and I think people who are coming in to work as care workers should go through that process prior to even starting the Cert III training because I think if you don't have the right make-up in your person to be able to care for older people, then you're probably not the right person to be doing that work.

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And I think it needs to be supported with education around dementia. The University of Tasmania has a free course which is very good. And the Dementia Care Matters people have already written a great training program. The work is already done. And I've handed some of that information to Erin and asked her to forward that on to you so that you can see all the work that's being done. It's already operating in the UK and Canada and has been for the last 20 years. So we've seen it work and I've been to Barunga, the Butterfly House there, as they call it, and so I've walked through that home personally and that's what has inspired me so much to want change, and to see that it actually can happen without it having to be a major building project. There's just lots of things that we can just do on a daily basis, and it just sits at the heart of what care work should be and it is – it revolves around person-centred care so I really hope that you will look at that as an alternative to training for the future and as a model of care for people in residential care.

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MS HILL: How did you find out about that model of care, Mrs Houston?

MRS HOUSTON: I'm just trying to remember now. I can't – someone had been speaking about it, I had heard about it and then for some reason one day I just decided I'm going to go and have a look so I asked a couple of girls at work if they would like to come. And a registered nurse came with me and a couple of care workers and we went and met with Louise Charlton who was the person who did all the work to get the Butterfly model happening at Barunga and she was so inspirational. And they had just completed the process, I think, when we went to have a look and they were then building some more units to attach to that.

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But that was just a life-changing day for me just going into that home and seeing what could be done and just how happy the people were, how home-like the environment was, the engagement with people and it was very homely. They had a front door; you had to knock on the front door if you went to visit. It just wasn't people walking through there willy-nilly. And she told me that there was a lady there who hadn't been speaking for quite some time and how she had sort of come out of her shell once she was living in this different environment with a smaller number of people and having lots of interaction with carers and – and they live like a home. They have their meals together. They cook scones and have them for morning tea, and they go out in the garden and they feed the chooks and tend the vegetables. You know, it's more real; it's a real life instead of we've just put people in a box in a home and said, well, sit there, and we will get back to you when we can. That's just awful. It's not acceptable.

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MS HILL: Bearing in mind that your home is in a state of transition, what does it mean for the care that you're able to provide to the residents of where you work?

MRS HOUSTON: Well, we're gradually – people are coming on board with it as they are seeing it happen. I think for a little while some people have felt a bit uncomfortable about it and, you know, worried about the safety of residents, you know, risks involved in letting them do things that they might not have done before.  
5 So it's a complete culture change because it's not what we've learnt. When I first started aged care, we were very much a be polite and friendly but there's no "dear" or "darling", or you know no terms of endearment to be used. And we're finding now that – not all residents, but many of the residents do respond to human touch. They like to have a hug, particularly if they're teary or whatever, and because they  
10 are seeing the same faces continually, they're starting to build a bond with people.

We've probably just cut down the number, the amount of change we have in that area so that the residents just get to be familiar with the faces that they see. So, you know, you can imagine if you're not able to shower yourself and every morning  
15 there's a different person coming in there and they're going to take all your clothes off and they're going to wash your body, and you know, if we think about those things, that's really confronting and this is what we're doing to our older people.

MS HILL: Ms Murphy, as someone who goes to or attends upon different aged care facilities throughout the course of a week, how do you manage providing a consistency of care in overcoming those tensions that Mrs Houston has just described.  
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MS MURPHY: So I think it is a really real challenge to have new staff coming in all the time, and some residents aren't very open to having new people come in and deliver their care. They much prefer having more of a family feeling to the care that they receive. They like to have familiar faces. So for me, I tend to spend a lot of time providing emotional and social support, you know, making them feel like they're actually a person, they're not just a task that I'm completing. So often I will  
25 spend more time with them rather than just doing the tasks that are required to be done.  
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Again, because of the sheer volume of residents that we look after this means that time management is really challenging. Often as an agency nurse I will be staying  
35 back well after I finish just because I have spent that additional time talking to them and making them feel like they are valued and worthwhile of the time that I have for them.

MS HILL: Ms Urwin, when you attend upon an aged care facility are the residents that you see given a choice about the physiotherapy treatment that they receive?  
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MS URWIN: Initially, when they first arrive at the facility they're assessed for their pain levels to determine if they're appropriate for physiotherapy treatment. Once they're on that list, they have a trial period and then they get put on it permanently.  
45 From my experience, I haven't specifically seen people being asked if they're okay with this service. It's basically a trial run and we tell them that we're coming in to give them this service. We do it for a week and then they get put on the list,

essentially the majority of the time they don't normally get a choice to say yes or no. And if we are going to treat them – I worked mostly in the dementia ward, so that a lot of them are not cognitively intact. I didn't see much of a choice being given because it was a box-ticking type of service.

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I had to go, I had a certain list of people, a number of names I had to get through in a certain amount of time, and the majority of these people couldn't communicate verbally so I would sit down next to them, apply either the electrical equipment that is required for the – for their pain management or therapeutic massage which also supposedly delivers the same relief. But I – on the list that we are given we're supposed to ask them for their pain rating before and after the service. There's no real way to do that. You can do it through physical behaviours with cognitively impaired people but you couldn't really ask them. So I didn't see much of a choice being given to them.

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With the residents that were more cognitively intact, you would go and some of them would refuse and if you could ask them you would. Some of them would say yes, some would say no. If they refuse, we're required to go back, ask them at least two times throughout the day if they wanted the service and basically if we couldn't get to them and they kept saying no, you kind of go over and you talk to them, and I would be told to essentially start the treatment even if they had said no and try and just apply it in a way that they almost wouldn't really notice. And I think that's quite demeaning, really, if you're cognitively intact, and you're saying that you don't want something then you're still given it. Why – I feel like that's – it's not really – they're not really given much element of choice because if they have to be ticked and it's what we've been told we have to do, I don't see how that's really much choice given in the matter.

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MS HILL: Is it important to you that residents are given that choice?

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MS URWIN: Yes, I think so. I think it's very important because if you're living in a place that's going to be your home indefinitely and you don't have that sense of choice in what you do throughout the day or what treatment that you're given, how can you expect to have any sense of independence or any improvement in quality of life.

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MS HILL: You've given evidence earlier that you felt your role as physiotherapist was a lot more pointless than that of a personal care worker. Can I ask you to expand on why that's your view.

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MS URWIN: Yes. So the service we provide is supposedly for a service of pain relief. Evidence shows throughout – because I've only recently graduated, we've been obviously taught the most up to date evidence-based practice. From evidence based practice that I have learnt, therapeutic massage and electrical equipment that is supposedly to deliver pain relief is not a good function or deliverance of pain relief. So massage and TENS therapy which is often what we use – the electrical stimulation – may provide very initial pain relief for some acute soft tissue injuries

but the majority of people who are in aged care are obviously older, they have more chronic pain, it might be due to something different.

5 We tend to go in and assess these people for their pain but we don't – we ask them where their pain is and what it's like but we don't find out where it's coming from, so we don't give them a full proper assessment of the cause of the pain and then we apply a standardised approach to every single resident and that to me doesn't really seem like – that isn't what I've been taught to do. In my degree I've been taught to assess impairment to see where the problem is coming from and how to appropriately treat it, and I feel I have the tools to be able to appropriately treat it. However, in the model that is currently in the system, I'm not able to use my clinical skills to treat the problems that are at hand in these people.

15 So, for example, there would be maybe someone who has pain in their hip and the reason for that is they have very weak hip muscles and me giving them a therapeutic massage for 20 minutes is not going to improve their function or their quality of life whatsoever, whereas if I was able to go in and give them an exercise program, do some functional rehab training with them, maybe they would be able to sit to stand out of their chair a bit more easier. So that would be less work for the carers when they have to come in and help them off the toilet, and this person would gain more dignity, more sense of independence, a high level of function, and then it would take the workload off the rest of the care staff that would otherwise have had to help them get off the toilet.

25 MS HILL: The Commission has previously heard evidence about the aged care funding instrument ACFI, and it has heard that each resident in a residential facility is assessed across three domains, daily living, behaviour and healthcare. Mrs Urwin, has the – do you have anything to do with ACFI in your role as a physio?

30 MS URWIN: Most of our physio role is based on the funding model. So if a person comes in and they're assessed for their pain, they will be put under a level 4A or a 4B. Four A means that they get 20 minutes of massage weekly, and 4B means that they have to be seen four days a week for 80 minutes all up, so 20 minutes four times a day. Essentially, we have to deliver this service in this amount of time for this particular – the particular services that are specified in the ACFI model, and it's either, like I said before, therapeutic massage or electrical equipment specific for pain management which is not evidence based.

40 MS HILL: In your view, Mrs Urwin, can choice and control be achieved in the current aged care system?

45 MS URWIN: In terms of physiotherapy, I don't think it's being achieved to its full potential. I think if the model changed its – how it was funded for us to give treatment, then maybe there will be more a sense of choice and control because we would be able to apply an individualised treatment to each person who needs help to improve their quality of life and their function, and, therefore, overall, kind of independence and, like, helpful in the way that they – that they live in – in their home

which is essentially the aged care facility. I think that I don't have the ability to deliver person-centred care in terms of – of choice and control at the moment in the current funding model. No, I don't think so.

5 MS HILL: Mrs Whitford, if I can turn to you, how do you deal with the ACFI as a manager?

MS WHITFORD: Really, we're a MPS site so we don't have a lot to – I don't have a lot direct to do with the ACFI. Our referral process is through that system.  
10 Unfortunately, we have one physio for quite a large area. So we're lucky to get him for an hour a week. There is a physio assistant, but that is very infrequent as well. So, yeah, we – there's not a lot of communication between different departments as to how things are funded or what we're entitled to receive and the processes involved.

15 MS HILL: Do you feel that you're able to give residents, Mrs Whitford, choice and control at your facility?

MS WHITFORD: Sometimes. There's a couple of, I feel, blanket policies which  
20 are very metro based that just don't work out in the country. For example, our falls policy, being a small facility, I'm the only nurse there. So when I'm not there, if residents have a fall, they have to be transferred to an acute – acute hospital. If it's an unwitnessed fall or if they fall and hit their head, they must be transferred for a minimum of 24 hour neurological obs to be done which I find extraordinary that it's  
25 very distressing, particularly those with dementia, to take them out of their familiar environment and put them into an acute ward which is loud and very unfamiliar.

And, consequently, in my experience, they've actually had more falls because they get up in the night to try and go to the toilet and the toilet is no longer there, or they  
30 get agitated because they're not sure where they are. I know in larger facilities, they – they would have the registered nurses there to provide those services for the 24 hour up to 48 hours observation, but, certainly, in regional small facilities, we don't have that luxury. So residents do have to be transferred usually by volunteer ambulance officers.

35 MS HILL: Mrs Houston, if I could ask you to respond to that example that has just been given by Mrs Whitford.

MRS HOUSTON: Well, we are a larger home where I work. We have 53 residents  
40 and we always have a registered nurse in the home 24/7. So a fall would be attended to immediately and the registered nurse would then – or the enrolled nurse in charge would decide and go through the process of assessing the person to see whether they're injured or whether they are able to stay in the facility. If it was something obvious that there was, perhaps, a broken hip or something, well, an ambulance  
45 would be called immediately, but if there's no obvious harm to the person, then they would have the constant monitoring of temperatures and blood pressure and so forth

over – I think it's at least 24 hours and just continually monitoring that person to make sure that there's no ill effects from that fall.

5 MS HILL: Mrs Murphy, do you find that with the different residential care facilities that you attend, there are different practices and policies in place when it comes to falls?

10 MS MURPHY: Yeah, there is. So most facilities have the same policy. So regarding a fall, the registered nurse on duty will do an initial assessment and ensure that there's no acute injuries. If there is an acute injury or if it was an unwitnessed fall, generally, we would send them to hospital which I find, sometimes, can be unnecessary. If it is an unwitnessed fall and they don't have any injuries, we're sending them as a precautionary measure, but they don't necessarily need to be in that acute environment. I think it is sustaining quality of life if we can manage them  
15 in the home.

20 Other times, if there isn't an acute injury, we can continue to monitor them in the home for 24 hours which, sometimes, depending on the resident, I think can be maybe not the best practice. If they are a dementia patient, we're doing neurological observations on them which means asking them where they are, what the date is, you know, what the time is – things like that. Things that somebody suffering neurological issues – or cognitive decline, sorry, wouldn't generally know anyway. It's intrusive, invasive. We're often waking them in the middle of the night to continue doing these observations, and I think this really impinges on quality of life,  
25 and it's definitely not person-centred care.

MS HILL: What do you say would support a resident's quality of life and your ability to deliver person-centred care in that - - -

30 MS MURPHY: So dignity of choice, I think, is at the centre of person-centred care. Letting them exercise their right to choose how they want to be treated. Obviously, we have advanced health directives and assessments that when they are admitted, then in conjunction with their family, they will choose what they wish to happen, like whether they want to be sent to hospital, but, often, facilities can override this as  
35 precautionary measures. As I said, if it's an unwitnessed fall, regardless of whether they want to be sent or not, we send them to hospital. I think having a doctor more easily accessible for – for facilities would help as well. That way, we could have more comprehensive management in the facility. And just really understanding the needs and the wants of each resident, making it individual care.

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MS HILL: Would you like to respond to that, Mrs Whitford?

45 MS WHITFORD: Yeah. I just find this, in this day and age, we take them out of the familiar home environment and put them in an acute facility where no one knows them. Other than their basic neurological observations, I think they could be better assessed in their home, if you want a better word, by people that do know them and can tell when maybe something is a little amiss. Obviously, I think it is very



difficult, rurally, to access, you know, the required physio review in the time that they request post fall. It's difficult to even access the doctor, to be quite honest. A lot of rural towns, we're supported by locums. Some weekends, we may not have a doctor. You know, we need to be looking at nurse practitioners for these regions to assist the elderly and aged care facilities with prescribing basic antibiotics for a urine infection, or redoing the medication chart so that an analgesic can be given because, oh, we've used the last signature. I think it's – yeah, we just need to be – what works in the city does – definitely not work in a lot of country areas. We don't have the resources.

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MS HILL: And what's your experience of that, Ms Urwin?

MS URWIN: Honestly, I was going to ask if I could add to that. When I worked as a therapy assistant whilst I was in Perth – I wasn't, obviously, the physio running it – as soon as there was a fall, they would be – it wouldn't be a referral based system. If there was a fall, the physio would go and assess this person to make sure that they had no acute musculoskeletal injuries. Since I worked in my current role, it's a referral based system. So if somebody falls and no one puts in a referral, so a carer or a nursing staff member doesn't put in a referral for physio, we don't see them, even if we know that they have had that – that injury. So if there's no referral there, we're not funded to see them for that fall, we don't see them.

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And there was actually a situation where I – I walked into one of the main living areas and someone was on the floor being attended to after a fall by the carers and the nursing staff, and I went over to try and assist, and the actual staff, they – they didn't want me to help because they – I don't know if it wasn't because they were – weren't aware of the – of the training that we have in assessing musculoskeletal injuries or because they were told that we're – we're not supposed to be helping with that because of funding issues or – I'm not really sure why. But I was kind of almost brushed aside in that situation, whereas, I feel like the training that we are provided with during our degree puts us at the forefront of helping with – with those situations, and it just really shocked me that – that we aren't included in the – in the first on-call, kind of, assessment for those types of situations.

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35 MS HILL: How could you be included?

MS URWIN: Well, you – you would initially – because of the knowledge that we have of – of soft tissue and bony landmarks and things, you just – you'd initially assess for – for any fractures, for any hip breaks, for anything to do with the major joint areas. We can assess neuro observations. We can assess for dermatome level. So, like, any skin or neural issues. Like, we have a lot of assessment training to see that – if there's any initial injuries and then, ongoing from that, if they did have any injuries that weren't immediately needed to be treated in hospital, that could be a part of our ongoing treatment if we were able to have a little bit more autonomy in how we treated a resident.

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MS HILL: Mrs Whitford, you've given evidence about the valuable relationships and the importance for you of getting to know the residents in your home. Do you bear consistency of care in mind when you are working out the rosters for your personal care workers?

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MS WHITFORD: Yes, certainly. I also try not to give the care workers late earlies because they have voiced to me that they struggle sometimes with those sort of shifts, so I will try and – where I can, put them on, like, a couple of earlies in a row to just try and – yeah, some consistency, but we also have numerous things that happen in the home. Like, on a Friday afternoon, we have happy hour. So between 10 4 and 5, they get together – and it can often extend and we have some young kids who play music come and do that, and I've given them an old music book so maybe they can learn some of the older songs.

15 Uniting that aspect of their – and they – you know, a lot of these people danced and met at farm balls and stuff like that, so it really does stimulate memories and good times, and we also just have regular – once a month, we have the community lunch where – we put on. We set up the main activity room and encourage family or businesses to attend and they make a small donation and that includes a two-course 20 meal that they can actually sit down and have with their relative because they can't necessarily go out. And that just – it minimises social isolation.

MS HILL: Do you have a kitchen at your facility, Mrs Whitford?

25 MS WHITFORD: A limited kitchen. We used to have a full working kitchen, but that got, sort of, decommissioned and a lot of our meals come from the hospital now. There is a recent push to start using it again. Our – one of our late shifts, the L-shift we call it, primarily, their role from 1 till 4.30 is activities, and some of the carers will get residents in the kitchen, and they will bake scones and do lots of different 30 things because a lot of these ladies were fantastic cooks, you know. On the farms, they cooked for shearers, they cooked for all the workers, for numerous children, and they've still got that skill. There might be elements they need assistance with, but they certainly have got that skill and they feel valued, you know. If you give them a purpose each day, they're happy to get up and chip in and help.

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MS HILL: Mrs Whitford, what do you say the role of the kitchen was?

MS WHITFORD: It was the hub of the home. It provided a fantastic atmosphere. Just the smell, the sensory stimulation. You know, you can wake up, smell that 40 cooking, I'll go and inspect. It was also an extra set of eyes in the facility, you know. And residents often had a great relationship with our cooks because it was someone that wasn't in their personal space that they felt that they could go to and just have a general chat, you know. A friend there.

45 MS HILL: Mrs Houston, you've given evidence about your role in delivering food and understanding where residents are with food. What is your view of the role of food and meals in a kitchen space in a residential care setting.

MRS HOUSTON: Okay. Well, in our home we have four wings so the meals are served to each wing. As I said earlier, the breakfast trolley is collected from the kitchen by the care staff, by a carer in each wing. That has on it cornflakes and porridge and juice, that sort of thing. And then the carers make toast in the wing so  
5 we have that experience of the smells and it gets the appetites going because the smell of toast goes right through the home which is nice. And our meal times are fairly set in time. So 8 o'clock for breakfast is when breakfast is supposed to be served, and lunch is at 12 – well, it starts at 11.45, the first trolley comes out.

10 But I think that is something that is a part of the Butterfly model which is a major change that's required in that we need to have almost 24 hour access to food service. It encourages care staff and – or any staff, maintenance staff to sit at the tables with the residents and enjoy the meal with them, and it should be like a slow process  
15 where the food is enjoyed and it's an interactive time. And currently we just serve the people as you would in a restaurant where we put the food in front of them and some people will need some help but they have their meal and then they leave the table and we clean up after them. So it's a very – what would you say, it's not home-  
20 like. Whereas, you know, in your home, people come and go, they sit at the table, they get up and leave, they talk to one another, they laugh, they interact and I think that we could just do our meal service so much – in a much more homely and friendly way and that actually would help people eat better which obviously would help their health.

25 It's a social activity. It's conversation. And really when you don't have a lot happening in your life, meals can become quite an important part of, you know, what happens to you in the daytime and that's your enjoyment. So that's the one thing we're moving towards with the Butterfly care in the dementia area is to just be much more flexible, not so time driven by meal times.

30 MS HILL: Mrs Whitford.

MS WHITFORD: Yes. I would just like to add to that. I know the kitchen staff that assist us in our facility often remark how in the acute high end they actually need to physically assist feeding because it won't happen. The nursing staff are so busy  
35 out on the acute end that they drop the meals off, they go back to get them and they're still there so - - -

MRS HOUSTON: We had a lot of people that we have to assist like physically put the food in their mouths for them so - - -

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MS WHITFORD: Yes.

MRS HOUSTON: - - - that's quite normal.

45 MS WHITFORD: It's time constants.

MRS HOUSTON: It is.

MS HILL: Ms Murphy, as someone that attends a variety of different residential care facilities do you have any examples to offer to the Commissioners as a positive example of food service and delivery done well in aged care?

5 MS MURPHY: Yes, so a lot of facilities have well-documented care plans for each resident. So in aged care depending on cognitive ability or motor skills they could be on a modified diet or thickened fluids, for example, to aid in swallowing, so if this isn't well- documented it can obviously mitigate a lot of risks, clinically and social. I mean, if you aren't aware that the person can feed themselves then the meal may be  
10 dropped off and then if you go to pick it up, you might think maybe they're not hungry today, we'll take it away, but in actual fact they can't cut up the meal themselves. They can't feed themselves. So I think a good example is when it's really well-documented and when you have a really good team environment.

15 As an agency nurse, sometimes you aren't very welcomed to the environment, and sometimes you're not very well supported. Again, I would say that this mainly stems from time constraints. A lot of the time you don't have the time at the start of the shift to be well orientated. You kind of just get your handover and off you go. So I think it's really important to understand the needs of each person and if this is well-  
20 documented or you have staff that support you I think it makes it a lot easier and then it's a safe environment as well.

MS HILL: We've heard evidence in this Commission about the lack of motivation for people to work in aged care. In particular, Ms Murphy, you refer in your  
25 statement to the lack of motivation for qualified nurses to enter aged care. Why is that Ms Murphy?

MS MURPHY: I – personally, I believe it stems from a misconception of aged care. Personally, going through my training in my degree, it's not focused towards aged  
30 care at all. We're trained in a hospital sort of setting so a lot of the clinical placements that we do are conducted in a hospital environment. Aged care isn't very well talked about. I don't think it is identified as a speciality area, and it 100 per cent is a specialty area. I think you need very specific staff. As we were saying, you need people that are the right fit to provide emotional and social care. You need people  
35 that identify emotional and social care as an important paramount part of the wellbeing of people.

And I think sometimes working in aged care can hinder your career opportunities. So, for example, I think – well, I don't think, I am experiencing applying for hospital  
40 jobs you're less qualified to progress, so I think because aged care isn't very clinical and there isn't a lot of clinical opportunity because if something happens we will send them to a hospital, we're not managing them in care in the home and we can provide that care. So I think it's a misconception and I think that, generally speaking, the community isn't aware of the care that we provide in aged care, and  
45 certainly as a nurse that's training, preparing to graduate, I had no idea of the opportunity of the care that you could provide.

MS HILL: Ms Urwin, you're no longer working in aged care, are you?

MS URWIN: No, I'm not.

5 MS HILL: Is it something you're interested in returning to?

MS URWIN: At this point in time, probably not, no.

MS HILL: Why is that, Ms Urwin?

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MS URWIN: We have very limited potential as physiotherapists to actually apply the evidence-based knowledge that we've learnt throughout our degree, and I think that affects people's willingness to go into aged care following their graduation because people know as soon as you graduate and you get an aged care job, you're – unless you are making a huge effort to get out of it to apply for somewhere else you're pretty much stuck in – in that position. Like Emma was saying, you don't get good clinical experience, you don't get to use your evidence-based knowledge. You don't learn or progress in your physiotherapy skills working in aged care.

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20 So I think there's a huge lack of motivation, a lack of – of, yes, basically motivation to go into aged care because people know that they will not be using any of the skills that they have learnt as a physiotherapist to improve people's quality of life. It's all very passive. We don't improve function, we don't help people to gain a better sense of independence. It's almost when people know – I've spoken to students who are past, present and future, about pracs in aged care – most people do tend to have a practical placement throughout their degree – everyone just – it's the worst attitude towards it. So people will just say "I cannot believe that I have to go to this prac for five weeks. It's going to be such a drag, it's not – I'm not looking forward to it". Because you don't learn anything, it's static, it's passive.

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MS HILL: If I can turn to you, Mrs Houston, you've described the work you've been doing with Dementia Care Matters, and the Butterfly model, what opportunities are there for your career progression from your current position?

35 MRS HOUSTON: Well, probably nothing, really. What I'm doing is committing myself to my work and having the opportunity to speak today. But as far as improving myself or having a leadership position or whatever, there's no – you know, there's nothing offering at – you know, nothing that I can aspire to at this stage, as far as I'm aware. If I was to go through the nursing path, perhaps if I was an enrolled nurse or a registered nurse there might be – I might be considered for something, but because I am a personal care worker, it's not considered that I would have a leadership role, despite my passion and desire to do better. But it won't stop me from giving my best and that's where we're at, I guess.

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45 MS HILL: Mrs Whitford, you've described to the Commissioners the difficulty in attracting or engaging workers in a rural setting. Would you like to make some observations on what has been said?

MS WHITFORD: Yes, I think the job descriptions are very generic and often our roles, we've got different caps on, basically. They need to be more direct and more clear, the roles that we're expected to have and facilitate. I find that there's a very – feedback up is very muted. Often we may have issues that if it's not – we've got no way of feeding that upward and I find, yes, it's very much a dictatorship-type industry. I would love, yes, for some of the policy-makers to be able to explain why they've made that policy and perhaps receive the feedback as in this will work, this won't work, or just constructive, you know, criticisms, really. Yes, rurally, I just – I don't think there's a huge incentive for staff to go – other than a small locality allowance, there's not a huge incentive or drawcard for professionals to advance their career in the rural areas.

MS HILL: Ms Murphy, as someone who's at the beginning of their career in nursing what would motivate you to continue to work in aged care?

MS MURPHY: My passion would probably be the only motive. As I said, career-wise there isn't a huge progression ahead of me or anyone for that matter in aged care. I think you're quite restricted to where you can go with your career. I mean, I could move rurally which I think would expand my scope of practice a little bit but other than that I don't think there's much of a motive to stay in aged care. I guess, unless you are passionate about it and you do love providing the care, then it's probably not something that people would tend to stay in. And I do find that there is quite a large staff turnover in aged care because it is such a demanding and stressful industry. I think that people often – they burn out and then they go and look for something where it might be more manageable, particularly hospitals where you do have legislated staff minimums.

We don't have that in aged care which I think is the root of a lot of issues that we all face. We just have too many people to care for and I think the quality of care is sometimes affected and it's hard. It's hard to face that.

MS HILL: Mrs Houston, you've described in some detail the work of the Butterfly model, would you like to, using that model, describe a positive example to your mind of person-centred care?

MRS HOUSTON: Okay. It would be – it would be being able to go into a person's room and give them my full attention for however long it takes for their needs to be met in relation to getting them out of bed and showering them and dressing them, whatever. So it would be allowing them to choose what they want to wear, allowing them to do whatever they can in dressing themselves. So it might take five minutes for them to do up all their buttons but that would be so lovely just to let them do that instead of reaching over and doing it for them. Just to choose whatever clothes they want to put on, decide whether they even want to get out of bed. Sometimes people don't want to get up until 11 o'clock and that should be okay, if that's their choice.

And also with their food, just to – not just to have to come and sit at the table now because it's mealtime. To be able to say are you hungry or if they're not able to

respond obviously you have to present the food to them, but sometimes people just don't feel like eating, and the food gets whisked away then, so then they've just got to wait until the next lot of food arrives – and there's plenty of it, people are not left hungry at all – but I think we can just do so much more with food and allowing  
5 people to participate in the preparation of food, whether that might be pouring a cup of tea or spreading a piece of bread or something they would have done themselves and just giving them little jobs to occupy them. It can be as simple as folding some washing, some tea towels or, you know, just household things like sweeping the floor or going along with a duster, or just something that makes them feel they're doing  
10 what they did before. Taking someone outside and letting them hold the hose on the garden. That can be so enjoyable to them, and it's an opportunity to chat. You can talk about the weather, you can talk about the trees and the flowers and whatever it is in their past that we know through their personal life story. It's an opportunity to share that.

15 And the Butterfly Model is excellent in the way that it approaches behaviour management, and people with dementia often act out. They have what we call behaviours, but that comes from trying to express a need, and there will always be a need whether it's they're hungry, thirsty, they're tired, they have pain, whatever that  
20 might be, and it's up to care workers to be able to work through a process and find out what – what is causing that behaviour and then meeting that need and, you know, that takes a lot of time. It takes a lot of knowing of a person to do that. It takes a lot of patience and it takes a lot of teamwork and communication with one another so that we can compare observations about what's going on, and is this happening at the  
25 same time every day, and there's just so many factors to it.

And I think for a long time, aged care has not been acknowledged as a specialist field and it certainly is, and care work – care working is actually a specialised field in itself as well. And I've had other employment through my life, done lots of other  
30 things, but I just love doing what I'm doing. I was going to be a nurse. That's what I wanted to do, but once I was hands on with people in aged care, I didn't want to move on with that any further. I felt a real desire to be with people and to meet their emotional needs and not just be handing out pills, and then as you work down the scale, it just takes you further and further away from the resident. And, you know,  
35 nurses spend all day sitting in front of a computer typing care plans, but they don't actually come and sit with people and – and know them, and we do. We're the eyes and ears of nurses, and we are the voice and the advocate of residents.

40 MS HILL: Mrs Whitford, what needs to change?

MS WHITFORD: Really, staffing. You know, we work very hard to make these care plans, but no one has time to read them. In real fact, like, it ticks the accreditation boxes, but the time given could be so better spent. You spoke about the Butterfly Model. In our region, there's a big push lately for the Spark of Life which  
45 is a similar philosophy, and that is really person-centred care and how to adjust your environment to provide that. But a lot of training and a lot of time is required and everyone needs to be on board. Yeah, it's months of preparation. I think just access

– I often go in on a weekend to provide wound care, like, I might – I – I just know if I don't do it, it won't be done. And that's providing person-centred care because if it's not done and they have to be taken to the hospital for it to be done, well, that's not always appropriate in my eyes.

5

And we – about 12 months ago, had a resident who was stage – end stage palliative care. She was very fearful of hospitals. She made us – you know, wanted us to promise her she would never go to the hospital. Staff went above and beyond to ensure that she was comfortable in her home, she called it, and up until the last 48 hours, we managed to keep her there. That was a lot of volunteer time, people just being with her, sitting with her, and then she had a fall. Thankfully, by that stage, she probably wasn't quite aware that she had been transferred. But that was a major effort and everyone felt so proud that they were pretty well able to keep her wish. So it's just, yeah, you can't just knock off and go home.

15

MS HILL: What's your message to the Royal Commission, Mrs Whitford?

MS WHITFORD: I just think that aged care needs to be funded like the acute sector. Particularly in our rural hospitals, they're combined and it's often very – not very transparent where the lines are. A lot of our high end aged care are left when an emergency comes in. Now, I personally think there should be someone with them 24/7. They are your higher end care recipients that need someone to be there, particularly if they have a behavioural outburst and that could definitely impede on the other residents. For their own security and just your holistic view, you know. Being – someone being the eyes and ears and just sitting with them, being with them. It's very much understaffed, but not just understaffed. It needs to be an improved skill mix. You need to have people on the floor that can educate and assist the carers to provide the best care we can.

30 MS HILL: Mrs Houston, if I can turn to you, what's your message for this Royal Commission?

MRS HOUSTON: Well, I guess I wrote my submission from the point of view that, you know, so much has been said in previous hearings and is still to come, I guess, about the negatives of aged care and what's happening in homes, and my experience is that there are some fantastic homes, some fantastic care staff and dedicated leaders in the community, and that needs to be acknowledged as well. But my purpose was to try and find a way forward so that's why I brought the Butterfly Model to the table. I have no connection to them whatsoever. I don't belong – I'm not affiliated with them in any way, but I do absolutely believe in what they're doing and I think it's just such a positive and appropriate and tested and tried method of moving forward with aged care.

45 So I really just wanted to bring that forward so that it would be somewhere to go because at the end of this, there's – there's so much sadness and so much hurt for some people, and I think, for them, we need to show them some change and that we – you know, there – there is a way through this, and aged care in Australia just has to



have a complete culture change and we need to be valuing our older people. They are all people who have lived lives, paid their taxes and they're just ordinary people like us. We've had, you know, nurses and school principals and hairdressers and people of all walks of life that have come into our care that have worked really hard and had productive lives that, now, through no fault of their own, their age is affecting the way they can live, and we should be just there to serve them and to fill the gaps in their life and just to make a difference to just their ordinary everyday part of their living while they are still alive.

10 So that it's not just, "Well, we'll just stick them over there where we can't see them and we won't worry about that because it's all a bit yucky when people get old and, you know, they're just not themselves any more." And we are fearful of that. I think we're all are fearful of where our lives are going to go which is why we have to do something. Start making chance because we're all going to get older and any one of us here in this room could end up with dementia. There's no cure and there's no known cause, so any one of us sitting here today could easily end up in a residential facility. So think about how – what do you want if that happens to you, how you want to be treated, what choice do you want to have? You know, at the moment, you get put in a – a small room and you have a variety of people coming in and providing care for you, but there's so much missing, and it doesn't have to be like that.

MS HILL: If I can turn to you, Ms Urwin, what's your message to the Royal Commission?

25 MS URWIN: I think that we have an ageing population, people are getting older, they're living for longer and, with it, it is coming more issues, like physical issues, emotional issues, social issues. I think that what's most important in aged care which has seemed to be overlooked for a long time is the resident, is the person that lives there. That's their home; that's their life.

30 MRS HOUSTON: Yes.

MS URWIN: They should be the most important thing in any aspect of care, whether it be emotional, social or physical. My frustration is that the function is on – sorry, the focus is on pain, not physical function. The more that we focus on somebody having pain, the harder it's going to be to improve their physical function. And the happiness and satisfaction that you can give someone from such a small input for – to improve something that they can do more independently, like a hand movement or strengthen their legs or some sort of transfer so they can do things easier is so immense and none of us – because we're functioning physically so well, none of us would know how that feels, but you can see the results of people who have been rehabbed that they just – that it affects – physical function can affect emotional health.

45 So I think it's really, really important, and the issue is that we have – from a physiotherapy perspective, we have the skills, we have the knowledge, we're willing, and we're able to improve these people's quality of life, and we have so much access

to evidence based practice at the moment with the knowledge that we have on the internet and – and studies and things that are so up to date is so immense and we're not using these skills to improve the most important people in aged care's quality of life, and I think that – that needs to change sooner, rather than later.

5

MS HILL: Ms Murphy, if I can ask you that same question. What's your message to this Royal Commission?

10 MS MURPHY: Yeah, so I just want to elaborate on something Patti said earlier that personal care workers do provide the forefront of emotional care. I became a nurse because I want to care for people. At the moment, we do – nurses, we spend a lot of time in front of the computer. We're doing documentation, we're doing medications, and while they're all equally important parts of a person's care, it's fundamental to be able to look after and nurture their emotional and social wellbeing. And I think  
15 that what that would look like in aged care in terms of change is legislative minimums for staffing ..... care staff, allied health, registered nurses, we need more people in the industry.

20 I would like to see a bigger influx of qualified nurses, like, new graduates coming into aged care, a greater appreciation for the industry, and a bigger focus on the emotional side of care. Like, it is so important and so fundamental if you don't have a good social or emotional wellbeing, then you're not likely to engage in clinical care. You won't engage with the physio, you won't look to improve or maintain your quality of life, and I think to do the best that we can in delivering this care is  
25 dignity of choice, it's individual care. There's no one size fits all. You've got to adapt to each person, and I think, again, that's obviously such a time consuming process. So we just need more staff to facilitate these sort of changes that need to happen because these people, they deserve better care. They're paying for better care and we want to provide that.

30

MS HILL: Would any of you like to respond to what each of you have said?

MS WHITFORD: Yeah, I'd like to. I agree – in South Australia, the enterprise bargaining agreement recommends 3.2 hours per care per day for each resident.  
35 Currently, we're still not achieving that, and it's not very clear either, like, what do you class direct care? Is that allied health? Is that diversional therapy? Is it direct carers? So I think there needs to be some clarification around the actual staffing ratios. I also think that the fee structure needs to be a lot clearer. A lot of the elderly that come and want to enter are very concerned about the cost, and there's still  
40 definite confusion out there as to how much it's going to cost them. Do they need to sell their home? What can they do? They're very, very fearful.

45 These people have worked extremely hard and saved very well through years of depression, and that is a major concern for them, and I think we would be able to assist them earlier if they felt more confident with what they were – the requirement from them was. And regarding care plans, we do have the internet. However, rurally, we're still paper based. We don't have the network to facilitate Lead Care,

so we're still using a lot of our carer hours, old school. So even though the recommendations state that we use Lead Care or alternative, we don't have access to that. So we still have to do the full assessment and then write up the care plans.

5 MS HILL: Commissioners, that concludes my examination.

COMMISSIONER BRIGGS: Ms Urwin, thank you for your evidence. Why is it that you're not allowed or not able to apply your skills in the workplace? Is it there – you have got a strict requirement, but those two forms of therapies and that's it?

10

MS URWIN: Yep. So if you actually go and look at – back to the funding model under the Complex Healthcare heading, there is a few boxes, and it's got a whole bunch of different things on ..... caring things, but the things that relate to pain management is that you're either a 4A or you're a 4B. So you get – 4A is the 20 minutes per week of either electrical therapy to affect, basically, pain – to treat pain or therapeutic massage. If you actually go into the – the model says the funding – sorry, the funding model says that we use evidence based assessment to assess people's pain. If you actually go into the website, the Australian Pain Association website that has that assessment on it, part of that website says these two therapies should not be used as a base intervention for pain management as they're only passive temporary interventions.

15

20

So I don't know – even know where that has come from. So it seemed to have been kind of a gradual input of this system. It wasn't, all of a sudden, everyone has to be on a list. It's gradually management, kind of, encouraging people to get put on it and then more people and more people and, all of a sudden, it's just turned into this. We have to tick these people off. This is the only thing we have time to do. If we get time, then maybe if we have a referral for mobility assessment, then we'll – then we'll do that as well. But this has become, somehow, the main treatment, and I just don't understand how – who's decided that these therapies need to be implemented when strengthening and exercise based interventions are so much more evidence based for improving any sort of pain and quality of life.

25

30

COMMISSIONER BRIGGS: I couldn't agree more, and we will certainly have a look at that because enablement and rehabilitation done effectively is pretty fundamental to people's quality of life.

35

MS URWIN: Yep.

COMMISSIONER BRIGGS: So thanks for your evidence, and I might say thank you to your colleagues too. I really appreciate your frankness and your very interesting commentary on what it's like to work in the system.

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45

COMMISSIONER TRACEY: I would only add that the thing that impressed me most, despite all of the practical difficulties which you confront on a daily basis, the humanity that came across in your obvious great care for the patients who you've looked after over the years came through. And it's just so important that good aged

care be available in this country, and you've been very helpful in guiding us to know how that can be done. Thank you all.

5 MS MURPHY: Thank you.

MS WHITFORD: Thank you.

MRS HOUSTON: Thank you.

10 MS URWIN: Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until a quarter past 12.

15 <THE WITNESSES WITHDREW

**ADJOURNED** [12.02 pm]

20 **RESUMED** [12.20 pm]

25 COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Commissioners, before we turn to the evidence of Dr Patterson, there's an issue from Broome with the evidence that needs to be resolved. There's a statement of Mr Jaye Alexander Smith that needs to be tendered formally. It is WIT.0128.0001.0001. And it's dated 10 May 2019 and it should become exhibit 4-17.

30 COMMISSIONER TRACEY: 4-17.

MR BOLSTER: Thank you.

35 COMMISSIONER TRACEY: Yes. The witness statement of Jaye Alexander Smith dated 10 May 2019 will be exhibit 4-17.

40 **EXHIBIT #4-17 WITNESS STATEMENT OF JAYE ALEXANDER SMITH  
DATED 10/05/2019 (WIT.0128.0001.0001)**

MR BOLSTER: Commissioners, I call Dr Kay Christine Lesley Patterson.

45 <**KAY CHRISTINE LESLEY PATTERSON, SWORN** [12.21 pm]

**<EXAMINATION-IN-CHIEF BY MR BOLSTER**

MR BOLSTER: If document WIT.0247.0001.0001 could be brought up. Dr  
5 Patterson, that's a copy of your statement you can see there on the screen.

DR PATTERSON: No, I can see you.

MR BOLSTER: Well, you should in front of you have - - -  
10

DR PATTERSON: I have a copy here.

MR BOLSTER: You've got a copy there. All right. Well, take it from me that on  
15 the screen that I'm looking at there's a copy of your statement.

DR PATTERSON: There's one here now.

MR BOLSTER: Good. That is your statement, isn't it?

20 DR PATTERSON: Well, it's the cover of my statement.

MR BOLSTER: Yes. Okay. Well, is there anything about that statement that you  
wish to change?

25 DR PATTERSON: No.

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

30 DR PATTERSON: Yes.

MR BOLSTER: Now, Dr Patterson, you have been the Commonwealth Age  
Discrimination Commissioner since July 2016; correct?

35 DR PATTERSON: Correct.

MR BOLSTER: And that followed a long career, both as a lecturer and senior  
lecturer in gerontology.

40 DR PATTERSON: Yes.

MR BOLSTER: A senator for the State of Victoria for 21 years.

DR PATTERSON: Yes.

45 MR BOLSTER: Two years as the Minister for Health and Aged Care.

DR PATTERSON: Yes.

MR BOLSTER: Two and a half years as the Minister for Family and Community Services.

5

DR PATTERSON: That's correct.

MR BOLSTER: Could you talk very briefly about your work in gerontology, and your experience in gerontology particularly with reference to aged care and observations that you would like to make about your experience there.

10

DR PATTERSON: In the mid-1970s after I finished my PhD I was teaching allied health professionals – physios, speech therapists, occupational therapists, etcetera – and they were all doing child development and paediatrics. And I believed that they should be doing more work looking at the well older person, gerontology. And I said to the clinicians, “Why aren't they doing gerontology?” and they said “They're doing geriatrics”. And I said, “That's about the sick older person; they need to be looking at the well older person”. So I believed that introducing gerontology and lifespan development or psychology was important.

15

I did that at the undergraduate level and I also set up, with two other staff members, the first diploma – postgraduate diploma in gerontology. So it's been a passion of mine since the mid-seventies, this area of ageing.

MR BOLSTER: And what's your view about the need to focus on gerontology today?

20

DR PATTERSON: I think it's absolutely vital. I think it's – I think one aspect – I think one of the things we need to do is to see deep changes in education, not only of health professionals, including general practitioners and nurses, but also of any staff that are working in aged care facilities to actually get them to focus on what well ageing looks like, because many of them spend their lives working with sick elderly people and expect that that's how everybody is and that influences the way they treat older people. So I believe that education is absolutely vital – absolutely vital part of trying to get rid of some of the scourge of elder abuse and ageism that we see in our community.

25

MR BOLSTER: Well, that leads into your current role as the age discrimination commissioner. There's an educative role in that respect, isn't there?

30

DR PATTERSON: There is.

MR BOLSTER: And could you describe for us how that role is developed by you in the period that you have been the commissioner.

35

DR PATTERSON: Well, it has taken many forms. It's looking at how can we educate older people about what their rights are in terms of what they should expect

from the community, and it's about also educating people about the negative effects of ageism, for example, how it impacts on elder abuse, how it impacts on people's attitudes to older people and their treatment of older people. So I think it's absolutely vital that through my – all the work that I do, and I do a lot of speeches and attempt to actually raise the issue of ageism and the effect it has, or negative effect it can have on older people.

MR BOLSTER: All right. Recently we've had Elder Abuse Awareness Day and awareness week. What's the focus of your role in that field?

DR PATTERSON: Well, it's varied. It's about ensuring that older people understand what their rights are. For example, we recently had a function in Dubbo and after it a woman came to me and said, "My son has been stealing money from me. He has my power of attorney, I didn't know I could revoke it." I've been working with the Law Council, for example, to say lawyers have a responsibility in making sure people understand their rights when they make a power of attorney, and attorneys need to know their responsibility. And I think we've all fallen down in educating people about those issues.

And in aged care, because we're focusing on aged care here today, it's imperative that the staff understand their rights – what older people's rights are in terms of their enduring documents and what their responsibilities are. It's not okay, when a power of attorney says, "My mother can't have visitors" and it's a financial power of attorney – we've had an example of that recently – not to be able to say, "I'm sorry, that's not the right of a power attorney to dictate who visits", and to know what their residents' rights are.

MR BOLSTER: That complaint you were talking about, was that a formal complaint to the commission?

DR PATTERSON: No, it wasn't a formal complaint to the commission.

MR BOLSTER: Could you talk briefly about what the issue was there.

DR PATTERSON: The elderly woman believed that she wanted to move to another nursing home because her daughter had put her where she thought it was convenient for her. She realised there was a mediation program that was being trialled with a family mediation centre. I don't – we don't know how she got on to them and rang them and said, "I'd like you to come and visit. I'm having money taken out of my bank account and I want to move". And they then contacted the nursing home and said, "We want to come" and they said, "Well, you can't because the power of attorney said she can't have visitors". They then said, "We'll test that, we're on our way" and she realised that she had got it wrong. And they had a mediation session with the family and she was moved and the power of attorney was – I don't know what happened with the power of attorney but I know the whole thing was mediated.

And I think that we're seeing a lot of good work being done now with Family Relationships Australia and with family mediation centres in mediating some of these issues that older people don't want to end up in court.

5 MR BOLSTER: In paragraph 5 of your statement you identify three priorities. The one I want to focus on is elder abuse. We've started to talk about that in some detail. And you identify five actions that you are involved with in paragraph 5. The first one is community awareness. Could you speak briefly to what's going on in that space?

10

DR PATTERSON: Well, I have two staff and one borrowed from health and an EA, so I have to cut my coat to fit my cloth and I chose three areas. And as you've said, elder abuse is one of them. And it's about being out there, getting information into the press. I think people would agree that we've seen that issue, not just because of me, but because there's an increased interest in the area of elder abuse in the last five 15 to 10 years than there had been before. I think it was a bit like child abuse and family abuse earlier. It's about raising awareness, it's about educating older people, about working with the law and lawyers about what they can do.

20 It's about working with all these groups. I can't do it on my own but I can actually be an impetus for getting change. There's also, as I said, about education which I think is vital. We only have six elder law courses in Australia. Some of them are electives and I believe that the universities could do more to introduce elder law and the lawyers could do more to educate people. So there's – really, elder abuse is 25 everybody's business and it ranges right across the whole community.

MR BOLSTER: You refer also to the implementation of the ALRC report on elder abuse. We will talk about that in a bit more detail later but just broadly speaking what is the general state of the response to that report and the recommendations 30 contained in it, particularly when it comes to the aged care related facts.

DR PATTERSON: Well, there were 43 recommendations, and when I took on the position, we had – are willing to work report that Susan Ryan had written and the elder abuse report, and I have a – a version – two reports that sit on a – on a shelf, but 35 nothing happens, and I vowed that I would actually drive those recommendations. One of the things I've done is I've met with all the attorneys-general across the States. It's like painting the Harbour Bridge. They keep changing. So actually talk to them about what they can do. One of the things that the Law Reform Commission recommends is to have harmonised powers of attorney.

40

It's impossible when you've got your mother living in Melbourne, your daughter in Sydney and your son in Queensland all getting advice from their public advocates and information that's all different. It shouldn't be beyond the wit of mankind to actually harmonise the legislation. There is – the national plan was one of the 45 recommendations. That was launched at the beginning of this year, but the recommendation regarding the harmonisation legislation, it's pretty mealy-mouthed and soft, and I'm determined to impress on people how important it is to protect



people, to be able to educate them. You can't educate them at a national level with seven or eight different systems in terms of enduring documents.

5 MR BOLSTER: Now, the fifth focus you identify it as combating ageism, and I'd like to spend a bit of time about that particular area and ask you this question: do we value older Australians?

10 DR PATTERSON: I don't think you can generalise in that way. I think that a large number of people value older Australians and respect them, but, sadly, they're not represented well in the press. Sadly, they're not represented well in various walks of life, and there is a lot of ageism in terms of people believing that older people are had it, dependent, a burden. I think sometimes, some of our policy affects it. Some of the language in the – in the – can't remember the name of the report. In terms of the inter-generational report - - -

15

MR BOLSTER: Yeah.

20 DR PATTERSON: - - - actually talks in language that is rather negative. So we use negative language, and we actually, in fact, not only influence the community in having negative effects, but older people themselves begin to feel that they're worthless and useless. We may appreciate what they do as carers, for grandchildren and for their partners and for children with a disability. We – we value what they do as – as volunteers, but we underestimate and devalue their other contributions to the community.

25

MR BOLSTER: You define ageism in these terms:

*Discrimination against people based on their age, manifested through negative stereotypes and perceptions.*

30

What's the best way for the Commission to understand ageism in the practical context, particularly with reference to aged care?

35 DR PATTERSON: Let me just answer it by saying ageism can also affect younger people as well, and that's why that is a very general comment, but when we're focusing on older people, it can influence – for example, if you see that somebody is – or believes that somebody is frail, incapable, not able to make decisions, then the balance between autonomy and the balance between people having a protection gets out of whack, and you end up with overprotection, and I will give you one example.

40

45 When I first came into the commission, somebody raised it with me, not as a complaint, but as an issue. An elderly gentleman wanted to go from a nursing home to an RSL function in Queensland. The manager of the facility thought that was not good for him, that was a risk. Two staff volunteered to go without pay, and – you know, go voluntarily, and he was prepared to pay for them, and there was still this tussle about that he shouldn't really go. Now, young people take risks. We all take risks, and I think, sometimes, we can overprotect old every people and we have to let

them make decisions for themselves that are controlled, but not overbearing, and I think ageism can lead to people being overprotected, “You can’t go out. You might fall in the garden.”

5 MR BOLSTER: You talk about negative beliefs about older people. What are some of those beliefs and how do we challenge them and how do we turn them around?

DR PATTERSON: I think one of the – one of the – one of the beliefs is that you’re not as capable of making decisions as you – as you once were, and I think that we  
10 need to do a lot more about assessing people’s capacity. Some of the neuropsychologists I’ve met with are now trying to look at, “Yes, I can make a decision about who’s my power of attorney, but I haven’t got the capability of making a decision about my investment of my superannuation or whatever else,” and they’re trying to actually refine and look at carefully how they change, that decision-  
15 making changes over time.

It sometimes can improve when you’ve got – when you’ve moved from an area where you’ve been, you know, victimised to where you’re being protected. So I think that we need a much better way, not this simple mini mental test of people’s  
20 capacity. It’s about saying we all need to be able to make decisions as far as we possibly can and to estimate that I’m able to make those decisions, and I don’t think that’s the case because people, if they assume that you can’t make a decision, they assume it about everything in your life.

25 MR BOLSTER: In paragraph 17, you say that:

*Ageism undermines the human rights of older Australians and is an obstacle to achieving an aged care system that respects and supports human rights.*

30 Could you speak briefly to that? What can we do to stop ageism undermining people in the aged care context?

DR PATTERSON: Well, as I said at the beginning, I believe education is absolutely  
35 vital. That you need deep changes exposing people in the educative process of the workers who go to work into – in aged care, the GPs who visit aged care need to actually have experienced and thought about the well older person, how they – how they cope, and the fact that when somebody, the day before, they go to an aged care facility is no different from the day after they re-enter an aged care facility, and that they have all the rights of anybody out in the community. Although, those rights  
40 wither away - - -

MR BOLSTER: Yeah.

DR PATTERSON: - - - when I lose some of my autonomy, when people make a  
45 decision about what I should do and where I should go or what I should eat or about my medication. That if we don’t have that deep change in education, then I think we will continue to see ageism affecting what happens to older people. I think, also, that

people should be reminded that one day, unless they have a premature death, they will be old, and I remind every group I talk to that the culture they set now is the culture they will inherit.

5 MR BOLSTER: All right. Can we turn to the prevalence of ageism, and you make some comments there about the fact that there is little evidence about it, but that the Law Reform Commission recommended a national prevalence study back in 2016. Are you familiar with where that study is at the moment?

10 DR PATTERSON: Well, just let me clarify something. We're talking about two different things. We're talking about ageism and elder abuse, and there isn't a study about ageism. I did actually refer to a – a piece of research that Susan Ryan  
15 undertook which was talking about how people perceived other's attitudes towards them, and a significant proportion of people, over 70 per cent, feel that they're discriminated against. So that's quite a different thing from the abuse. The Law Reform Commission recommended a prevalence study on – on elder abuse. They  
20 actually – the government has funded a – to look at a definition because there are quite different definitions and – to look at a definition. Australian Institute of Family Studies has been doing that. They looked at a scoping study, and they've just closed the tender for a prevalence study, and I believe it will be announced as to who will be having that in the near future who will be undertaking that prevalence study.

MR BOLSTER: Thank you for that. The prevalence data in relation to ageism, the Ryan study that you referred to, 50 per cent of people said that ageism was present in  
25 healthcare, government policy and access to services. What's your feeling about those statistics based on your experience?

DR PATTERSON: Well, I think many of these are older people, and they were experiencing what they've seen, and it doesn't just happen in aged care. I mean, you  
30 see people in – older people in public hospitals, and there was, in 2015, a very moving monthly quarterly essay by a doctor of general medicine at the Royal Prince Albert Hospital in Melbourne.

That's very sober reading about the treatment of older people in aged care, even to  
35 the point where somebody said to her, "Why on earth are you doing general medicine? You don't make money working with older people?" Now, that's the attitude that prevails amongst other specialists towards a general – a specialist in general medicine working with older people. Heaven help us because that's ageism at its worst, and that she talks about the treatment in hospital of people having meals  
40 presented to them and it being taken away with no recording. People being left in – inappropriately without receiving help when they called for help. So it's – it's prevalent in all aspects where older people are frail and needing care.

MR BOLSTER: Do you have a particular view about nutritional issues in aged  
45 care?

DR PATTERSON: I have a very strong view about nutritional – nutrition in aged care and medication in aged care. It is appalling that we have research which is reported by the Dietitians Association of Australia or whatever its formal name is that significant proportions of people in aged care are malnourished. How can that happen? That's a question I ask. How can you have people in the care of facilities where they are malnourished, and there's a second study which demonstrates that they have very low protein.

Now, we all know as we age – my physio reminds me constantly that I should have protein in every meal because, otherwise, our muscles waste. Why should somebody in a nursing home not have physical therapy, not have appropriate nutrition to maintain as much of their mobility as possible, and to see that we have malnourished residents in aged care is totally unacceptable.

MR BOLSTER: And - - -

DR PATTERSON: With regard to medication, I have a large number of general practitioner friends who are appalled and pharmacy friends that there isn't sufficient review of medication. There's some recent work that has been done using technology of putting in all the medication, and it puts up flags when there are counter or polypharmacy outcomes. That's the sort of advance we should have that people's medication is appropriate, that they don't come back from hospital where there's some medication that the GP doesn't realise what they're having, doesn't see it till the next visit, or doesn't even go through a medication review.

Those are simple things that can be fixed, nutrition, medication, to actually improve the lot and the life of people living in nursing home care. We're going to have the peak of aged care in the next 15 years of the baby boom going into aged care. We have no time to waste. I've been talking about this since 1976 when the baby boomers thought it was never going to get older. It's on the threshold of aged care, and I – I think we should be – I hope this Royal Commission will be acted on and the recommendations adhered to, to actually improve the lot of people in aged care because, at the moment, in some facilities it's totally inappropriate.

MR BOLSTER: Could we turn to the issue of unconscious bias which is something you make specific reference to in paragraph 10 of your report. How do we see unconscious bias in health and, more particularly, in aged care when it comes to older people?

DR PATTERSON: I think it's – that's part of the ageism that they're frail, they're incompetent. People don't see them as the person they are and have been and, for example, belittling comments, you know, "Dear. Sweetie," not calling somebody by their name, or some older people prefer to be called by Mr and Mrs Jones or whatever. Not respecting them as people who have a history, who still love, who still care about their grandchildren, who still are whole human beings and shouldn't be infantilised by an unbiased attitude of people thinking they're lesser persons because they're now in care.

MR BOLSTER: What about benevolent ageism? Is there such a thing?

DR PATTERSON: Well, there is. It's about overprotecting people. I maybe did that to my mother, I suppose, when I was looking after her. We often want to  
5 overprotect them. We want to surround them – what I was talking about before of getting that balance of autonomy and protection out of step and, sometimes, the benevolence can lead you to be overprotective and not actually taking into account the person's wishes for themselves.

10 MR BOLSTER: Closely related to that, you refer, as another basis for ageism, the fear and dislike that some people have for older Australians. Why is that?

DR PATTERSON: I think it's quite difficult for especially younger people who are dealing – and middle age and even at my age, it's very confronting that your life will  
15 come to an end, and – and so sometimes you end up with a dislike. And we've got a program – The Benevolent Society are doing a whole campaign on ageism, and they say that some people basically weren't very nice when they were young, and they don't turn into very nice older people. We're not all the same. And – I've forgotten your question.

20

MR BOLSTER: I was asking you about the fear and dislike that people feel for older Australians.

DR PATTERSON: That's right.

25

MR BOLSTER: It's difficult to go into a nursing home sometimes, isn't it? Confronting.

DR PATTERSON: It is confronting because you've got to confront your own  
30 demise.

MR BOLSTER: How should people approach that from your perspective as a Human Rights Commissioner?

DR PATTERSON: I believe it's absolutely vital that we expose people to lives well  
35 lived and, for example, I'm doing a project at the moment, assisting with it, or supporting a project of a young woman who has been doing a project of 100 young people in Melbourne, Sydney and now in Brisbane to be launched on 16 or 17 or 18 August. 100 young people, painting portraits of 100 centenarians. In 1976 there  
40 were 122 centenarians; there are now over 4000 centenarians. In 2040 there's going to be over 40,000 centenarians. Let's face it, a lot more people are going to be living a very long life. And what we're trying to do with this project is to get an army of young people who've sat, painted, talked to, befriended, written about these older people who have lived 100 years, and then to show examples of what you can do  
45 with intergenerational reports.

And there's research now that shows that intergenerational reports, combined with education – there's just been, only on 20 July, this is very up to date, the Public Health Journal of America has actually reported a method study of 63 pieces of research, commissioned by the World Health Organisation to look at what are the  
5 factors that can counteract ageism. And when they did this meta-analysis of these 63 studies of over 6000 people published this week, they found that together intergenerational activities and education have the greatest effect in reducing ageism.

10 MR BOLSTER: Let's talk about intergenerational activities. Can you give us some examples of the sorts of things that the Commission should be looking at to involve younger people in an engaged way with someone who's in aged care?

15 DR PATTERSON: I think there are a host of things that can happen. Aged care facilities aren't always very interesting places for young people to go. You know, sitting in a room with an elderly person is not everyone's idea of fun but if there are activities that they could join in. For example, one place I read – this is recently – has a pool table, and I watched a son and a father – the father with very, very severe dementia still able to play pool. What a better interaction, how more interesting for  
20 the son to visit, to be able to play pool with his father. I think people need to be creative about what can we do to make this place welcoming to the community and the families. We know that many families don't visit people in aged care.

The other thing that we've seen recently is colocation of kindergartens and day care – sorry, playgroups. There's a – the play group association is doing a very active  
25 program of bringing young people into – into the facility. The other thing that we've just recently – I've just recently heard about is in Holland, they're co-locating students in aged care, not to work in aged care but to actually do things with older people, playing chess, taking them out for walks, taking them down the shops to buy birthday cards for relatives, whatever, natural, normal activities. How much better is  
30 that for the resident and what is the young person, young student going to learn. I think we need to see much more creativity of bringing the community into aged care facilities.

35 MR BOLSTER: We then turn to the harder edge of ageism, which is elder abuse, and if we could just focus our attention on how it operates in the aged care context. Where do you see it either with people making the decision to go into aged care or moving from one aged care service to another or with decisions that have to be made about their finances or about their care. How do you see elder abuse in that context?

40 DR PATTERSON: I think the seeds of elder abuse are planted well before you go into aged care. I believe that we need a much greater concerted effort from many sectors, including the law, in encouraging people to have their enduring documents in place early. I would encourage everyone who's over 18 to have their enduring  
45 documents because you can have an awful accident and end up in care. I think that's important, that they aren't forced into doing – doing their documents without time to think about it when they're rushed and – they should be in place. So there should be a concerted effort and campaign to get people to have them in place.

The other thing is that they ought to be taught about what their rights are in terms of those, as I mentioned before. So they can revoke their power of attorney, they can change the documents. 50 per cent of people die without a will, and even fewer have an advanced care directive as you at the Royal Commission have now found, about  
5 three per cent. They need to be in place. The other thing is that I've talked to aged care assessors, assessment teams; many of them are very experienced, although we're seeing some changes in that, but some very experienced health professionals, who can wangle a time with a person on their own, saying "I need to test them at the office", or whatever else. But they've said they would like to be able to have  
10 mandated that they could actually have time on their own with the person they're assessing. Because often the person who's perpetrating elder abuse to get them out of the home and get their hands on the money are there while they're being assessed.

And I think one of the things – recommendations that I would like to see coming out  
15 of this is that consultation with the assessors is undertaken to ensure that they can have time alone with the person they're assessing. Then you get into the nursing home and not only the nursing home, one of my great concerns is aged care in the home where you don't have other staff observing and we've seen other staff reporting abuse. And I believe that attention has to be given to how do we protect  
20 people from their carers and from their professional services in the home where they're more at risk, but also making sure that they're not being abused either by their family or by providers. And I don't know but there is a lot of Twitter stuff about guardianship and the taking away of rights and I haven't investigated that but I think there's most probably some areas that need investigating there.

25 MR BOLSTER: That leads me to the issue of harmonisation of enduring documentation. Have you been talking to the legal profession about that, and what's your perception of the ease with which that can or cannot occur?

30 DR PATTERSON: As you know, I was a Federal Minister and did health agreements; it's like herding cats. But as I mentioned before, I think that to be able to educate people, especially in the CALD and Indigenous communities where we need – especially as older people have trouble with their – or revert to their first language, that they need to be able to have that sort of material. It's very hard for a  
35 State to do that, and also, as I said, there's enormous duplication of educational material because we've got all these different jurisdictions. But it's difficult managing families across jurisdictions and across borders. That's where it has been raised with me. Mum's is on one side of the river and the daughter is on the other side and the rules are different.

40 I think it's an absolutely vital recommendation of the ALRC and needs to be implemented and, as I said, I don't think the national plan is strong enough on it, and I could go feral at some stage and talk about the States that are reluctant to do it, but I actually believe it's absolutely vital, a vital recommendation of the commission.

45 MR BOLSTER: What about a national register of care workers?

DR PATTERSON: That's a bit out of my kin. Should it be only people who are convicted of abuse or maltreatment of an older person. I believe there should be some system in place that means that somebody can't do something in one State and move to another State with impunity.

5

MR BOLSTER: All right. In terms of the ALRC recommendations you highlight in paragraphs 33 through to 39 the education and awareness that's required on the part of medical professionals and carers about elder abuse and how to identify it and how to deal with it. Could you speak briefly to that? Where is the state of the law in Australia on that?

10

DR PATTERSON: Well, the ALRC report recommended education of health professionals and people dealing with older people. I actually had a meeting of 10 of the peak bodies, physiotherapists, speech therapists, occupational therapists only a couple of weeks ago. At two weeks notice they all turned up which I thought was amazing. They all said, we need material, we need to know, and they needed to know what are the flags. They said we need to know what we can do about it. We also need to know how it affects our patient/clinician relationship. We have - - -

15

MR BOLSTER: Privacy, it's a privacy issue then.

20

DR PATTERSON: We have a Commonwealth Privacy Act, we have State Privacy Acts. In some States the rules are different depending on whether you are in a public or a private hospital. How on earth can you educate the health professionals who feel - and banks tell me the same thing. You know, we've got a relationship with our clients; when can we tell people, and I think it's absolutely vital - again, at least if we can't get harmonisation, at least material people can go to say, "I'm in New South Wales, I've got a problem, I believe my client" - financial advisers are in the same position - "I've got a client, where can I go and not breach the privacy laws". They also talk about understanding how to deal with and where they can get assistance.

25

30

And I believe that we could put together some core educational materials and top and tail it with specifics for the particular professions. They're keen to do it. We don't have the money but I think it's an absolute - it wouldn't take a fortune but it would be an important tool for educating those who are dealing with older people.

35

MR BOLSTER: You've had an opportunity to read the submission lodged on behalf of the late Barney Cooney to the Commission, and you knew Mr Cooney?

40

DR PATTERSON: Yes.

MR BOLSTER: It's fair to say he was very widely respected, down to earth, respectful, talented senator for the State of Victoria from December 1984 through to June 2002, nearly 18 years, and for 15 of those years you sat across from him in the Senate.

45



DR PATTERSON: Yes.

MR BOLSTER: What are your reflections about what he's going to tell the Commission when his evidence is tendered later this week?

5

DR PATTERSON: Well, you caught me off guard because I was on the plane and I read the submission and I burst into tears on the plane; I thought I wasn't going to cry here. But Barney was a character. He and I met innumerable times in innumerable aged care facilities because when his party was in government he would be sent out to open a nursing home, and I would go along because I was visiting every nursing home in Victoria. And Barney would get up and say "I shouldn't be opening this nursing home; Kay Patterson should. She knows more about aged care than I do", to the horror of his State colleagues. And in the chamber he would always get up and say that I knew more about aged care.

15

But having read the submission, if Barney were here I would be saying to him – and Barney was still alive – "Barney, you now know more from your lived experience about aged care than I ever hope to know". But how can it be that Barney didn't ring his bell because people didn't come when it was urgent, when he needed to be shifted in his bath chair or his bed chair because it seems so insignificant he didn't have his coffee or his tea. Isn't it the right of every single human being in care or wherever that those basic needs are met. I – Barney's voice is one that should be heard. It was articulate. It was sensitive. He understood the point of view of the staff.

25

But there he was, and very much like another friend of mine, who was made a quadriplegic in an awful car accident where somebody just putting shopping in the back of a boot. The car ran into her and she ended up a quadriplegic for the last 10 years of her life from 80 to 90. She had to use a typing machine. I went in and saw that she was trying to type stuff so made a sheet for her, I would like to go to my bedroom, the day room, outside, and put all the things she'd like to do frequently. We discussed it. I plasticised it – I've forgotten the word for it, and did two copies. I was appalled every time I went in, they were somewhere else, not near her, and it would have facilitated that she could ask for things very easily and quickly without having to type laboriously out, "I want to go to the day room"

35

Barney talks about using technology in the submission. And I'm referred to the medication, the technology, I think he would agree with, and we agreed on a lot of things. People see the nasty parts of the chamber but I was very fond as – Amanda Vanstone wrote the most amazing obituary about Barney. He was highly regarded by both sides. Barney writes about technology; isn't he talking about those medications that mean that somebody in aged care is not going to have an adverse effect from polypharmacy. Are there other technology things that can occur? We've got one nursing home I know of where the nurses wear a brooch – their name badge.

45

At night-time when somebody presses a bell, the person who owns this nursing home – she's got a couple of them – says to the nurse, "Mr Such and Such rang for your

assistance to go to the toilet and it took you 15 minutes to go and you weren't in any other room". When they walk into the room it registers they've gone in. Technology has got a part to play. Barney told us what it was like as lived experience. He also talks about some of the solutions and I dip my hat to him and I wish he were here to be giving the evidence himself.

MR BOLSTER: Finally, before we conclude, every witness is given an opportunity to indicate what should change. What's your wish list? What does the Commission need to know about to make the system better? Is there anything you wanted to say in that regard?

DR PATTERSON: Well, I think we need to reset the balance of power between protection measures and autonomy and independence. I've emphasised the need for workforce education. I would like to see the Royal Commission focus on best practice. There are some – many – aged care facilities which are giving world-class care to their residents. How can they do it on the same funding as another one which isn't? And I believe that we should have a ranking for best practice. And we should have a carrot for best practice. The aged care standards provide a minimum. We saw Oakden meet all of those old 44 standards and were failing. You can have the rights on a wall but if they're not in the hearts and minds of the staff, you may as well not have them.

You have the standards; unless they're upheld to the highest degree, again, they're failing. And Barney talks, and I hadn't read it when I wrote my submission, he talks about the tick-a-box approach. The tick-a-box approach in meeting standards is just good enough. But what we should achieve through the Royal Commission is more than good enough. Thank you.

MR BOLSTER: That's my examination. Thank you, Commissioners.

COMMISSIONER TRACEY: Dr Patterson, you mentioned in your evidence your concern for the care of the baby boomers in the not-too-distant future, and we've been asking the specialist gerontologists, I think you use the American term – geriatricians as seems to be the term still used in Australia about whether there's going to be enough people with that specialist knowledge available when they're going to be needed. And that has led to more questioning about whether there is an adequate provision within our medical system for the training places necessary if more are going to be needed, and we've been getting a lot of general reassurance from current practitioners that, yes, there's enough coming through the system. Is that your impression or do you have concern that we may be needing to train up more specialists and also, of course, in the nursing positions?

DR PATTERSON: Commissioner, there are two different disciplines. A geriatrician or a geriatric physiotherapist or a geriatric OT, occupational therapist, is about working with the elderly and sick elderly and treatment of disease in the elderly. The gerontologist, however, could be a biologist or a sociologist or a psychologist or even a statistician who looks at the changing nature of individuals as

they get older, not necessarily old and sick, but older, changes in cognition, changes in physical attributes. Or what does an older population mean when you've got a – dependent on a smaller youth population.

5 So it's two – quite different separate issues. I think I'm not up to date enough with –  
in terms of – of the trainings, but I will say that one comparison I used to make in the  
1970s was we had one professor of geriatrics in the whole of Australia and we had  
12 professors of paediatrics. I don't know whether that balance – that ratio is still the  
same, but it – we really do need to make sure we – and I don't know – I don't – I  
10 can't give evidence – give an accurate response because my education days are long  
behind me in terms of knowing the field that well.

COMMISSIONER TRACEY: Yes. Thank you. Dr Patterson, thank you very  
much for your evidence. It's been very enlightening to hear your views on the areas  
15 that we're considering and how they overlap with your responsibilities as the Age  
Discrimination Commissioner, and we're very grateful to you for coming all this  
way, and if I may say so, personally, I share your views of Senator Cooney. He was  
a wonderful man and a colleague at the Victorian Bar for many years so - - -

20 DR PATTERSON: And a wonderful character.

COMMISSIONER TRACEY: - - - that document that you've read has had a  
profound impact on this Commission and will, no doubt, guide our inquiries and the  
results of those inquiries as we progress. Thank you very much.

25 DR PATTERSON: Thank you. Thank you.

MR BOLSTER: Commissioner, I tender Dr Patterson's statement.

30 COMMISSIONER TRACEY: Yes. The statement of the Age Discrimination  
Commissioner, Dr Patterson, dated the 14<sup>th</sup> of June 2009 will be exhibit 5-27.

35 **EXHIBIT #5-27 WITNESS STATEMENT OF AGE DISCRIMINATION  
COMMISSIONER KAY CHRISTINE LESLEY PATTERSON DATED  
14/06/2009 AND ITS IDENTIFIED ANNEXURES**

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

**<THE WITNESS WITHDREW [1.08 pm]**

45 **ADJOURNED [1.08 pm]**

**RESUMED**

**[2.02 pm]**

5 COMMISSIONER TRACEY: Yes, Ms Bergin.

MS BERGIN: Thank you, Commissioner, I understand my friend would like to announce his appearance.

10 MR TRAN: If the Commissioners please, my name is Tran. I appear with the Commissioners' leave on behalf of the Silver Chain Group in respect of Ms Fisher's evidence.

COMMISSIONER TRACEY: Yes, Mr Tran. Thank you.

15 MS BERGIN: Thank you Commissioners. I call Dale Allyson Fisher.

**<DALE ALLYSON FISHER, AFFIRMED**

**[2.02 pm]**

20

**<EXAMINATION-IN-CHIEF BY MS BERGIN**

25 MS BERGIN: Thank you, Ms Fisher. You may take a seat if that's more comfortable for you. What is your full name?

MS FISHER: Dale Allyson Fisher.

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

MS FISHER: Yes, there is.

35 MS BERGIN: I'd just ask you to leaf through the pages and confirm for the Commissioners that that is your statement.

MS FISHER: Yes, it is.

40 MS BERGIN: Operator, could you please bring up document WIT.0210.0001.0001. Commissioners, I tender the statement of Dale Allyson Fisher dated 3 June 2019.

COMMISSIONER TRACEY: Yes. The witness statement of Dale Allyson Fisher dated 3 June 2019 will be exhibit 5-27.

45 **EXHIBIT #5-27 WITNESS STATEMENT OF DALE ALLYSON FISHER  
DATED 03/06/2019 (WIT.0210.0001.0001)**

MS BERGIN: Ms Fisher, I should start with your – by asking you if you have any amendments to your statement.

5 MS FISHER: Yes, I do. I have two corrections. The first correction is on paragraph 83 where the sentence reads:

*Our client base is split 70/30, non-malignant/malignant.*

10 That should be reversed and say 30 non-malignant, 70 malignant.

MS BERGIN: So the new sentence will read:

*Our current client base in PCS is split 30/70 non-malignant/malignant.*

15 Is that correct?

MS FISHER: That's correct.

20 MS BERGIN: Thank you, Ms Fisher. What was the next amendment?

MS FISHER: The second amendment is paragraph 11, the last sentence which reads:

*We employ more than 4100 people including more than 90 doctors.*

25 We do not currently employ more than 90 doctors. We employ 52. The reason for that amendment is when we were collecting the data we included our trainee doctors.

30 MS BERGIN: So in that case should we delete the words “more than 90” and substitute “52”?

MS FISHER: Yes.

35 MS BERGIN: And then your sentence will read:

*We employ more than 4100 people including 52 doctors.*

Are you satisfied with that amendment?

40 MS FISHER: Yes, I am.

MS BERGIN: Thank you, Ms Fisher. Could you please describe your current role and any prior roles that may be relevant to your evidence today.

45 MS FISHER: Yes, I'm currently the chief executive officer of the Silver Chain Group which is a national aged and health care organisation that focuses on home care. I have had held that appointment since December 2018, and prior to this

appointment I was the chief executive officer of the Peter MacCallum Cancer Centre and institute, and that's in Victoria. I held that role for five years. And prior to that I was the chief executive officer of the Royal Women's Hospital, again in Victoria in the Parkville precinct or nine years.

5

MS BERGIN: Thank you. You've mentioned that Silver Chain provides home care services. Could you tell the Commission a bit more about the services that Silver Chain provides.

10 MS FISHER: Yes. Thank you. The services that we provide are community-based services. So we provide health and aged care in the community and we have been in Perth for over 30 years in palliative care but the Silver Chain organisation has had a history of 110 years in Western Australia. And we also have services in South  
15 Australia which is the Royal District Nursing Service so we look after people in the community there. And we also have services in Queensland, which is around hospital in the home. We also have services in New South Wales, palliative care, and also in Victoria.

20 MS BERGIN: Where are home care services provided, Ms Fisher?

MS FISHER: Predominantly they are provided in the Perth area and we also have home services, aged care services in South Australia.

25 MS BERGIN: How many palliative care clients in Western Australia does Silver Chain look after?

MS FISHER: We look after 600 people a day and that's around three and a half thousand. That's in our palliative service in Perth – metropolitan Perth.

30 MS BERGIN: In Perth alone.

MS FISHER: Yes.

35 MS BERGIN: And do you have some numbers at a national level?

MS FISHER: Yes, we have over 100,000 clients across the nation.

40 MS BERGIN: The Royal Commission has heard about the importance of home care, particularly during Adelaide hearing two. In the context of this hearing which is in person-centred care, how is palliative care provided in the home by Silver Chain?

45 MS FISHER: As I said, Silver Chain is focused on assisting people to stay in their home, whether that – because that's the choice that they make, and in Perth in particular, by a decision of previous governments, it was determined from a policy perspective that – 30 years ago, that the community palliative care should be built up as opposed to building institutions. And so Silver Chain was able to develop a model

of care that over those years that's able to service such a large amount of people, so that people can choose to live and die in the home.

5 MS BERGIN: How does Silver Chain assist people to stay in the home through the provision of palliative care?

10 MS FISHER: We assist in many ways. We use a person-centred model of care which means that we work with the client, as we call – call them, within that domain of their home. Philosophically, we believe it's really important that we transfer the power and control of care to the person affected, and clearly the family as well are important in that definition. So we have developed a model over many years that we've drawn on international best practice, both in person-centred care, and palliative care, and we have a model where we can look after a person's end of life which in the community it's usually – is about 70 days that we will look after a person at the end of their life through palliative care. So initially the visits – if you would like me to expand? Yes.

MS BERGIN: Yes, please expand Ms Fisher. Thank you.

20 MS FISHER: Thank you. So initially there would be in the evidence, My Guidebook. So in the first interaction with a client and their family, the goals of care would be established. So what does that person who is in control and wants to make decisions about their care and their health outcome so that the person can stay well and the person can stay engaged and in control. Coming from tertiary institutions which is geared up to acute care, we have a legacy in the Australian health system where we're disease-focused and the – usually the medicalisation has taken away the power from the patient in an acute setting. And so Silver Chain, really, it's a small but seismic shift in giving the power to the person who is at the end of their life.

30 And so as the disease progresses – and in cancer it might be what we call a more rapid decline, or in chronic conditions, at end of life, the time can vary. So Silver Chain is able to draw on its multidisciplinary team, and by that I mean doctors, nurses, carers, allied health and other social support services to actually look after the person in the home. And – but the key is that the person is always in control. So it's an iterative process and we build up our services to support the client right up to the death. And so what that will mean is that we can bring equipment, oxygen. We can bring in instruments to, or to deal with pain and symptom control.

40 We can also bring in support for the carers because, as you could imagine, it's quite a stressful time. We have a psychosocial model so bereavement support, psychosocial, so in – at the end of life we will look after the carer for up to three months after the death. And so it's quite a complex and, may I say, unique model in – in Western Australia, in Perth in particular, that we would like to liberate across the country.

45 MS BERGIN: Thank you, Ms Fisher, you mentioned that Silver Chain has a history spanning some 100 years. Is the person-centred model part of a recent phenomenon or is it part of Silver Chain's long history?

MS FISHER: The person-centred in Silver Chain is around 20 years development and that came about at the same time when there was a movement into consumer choice and control. And so Silver Chain has, as part of its way of doing things, researches what the best practice is. And so person-centred care became a key  
5 feature of the Silver Chain model, not only in palliative care but in other models over 20 years ago.

MS BERGIN: You mentioned that Silver Chain services in palliative care include a range of aspects, such as allied health and medication administration. Could you  
10 inform the Commission a bit more about how palliative care is administered in the home?

MS FISHER: It is administered initially with, again, the multidisciplinary team and as the disease or end of life experience, if you can call it that, nears its ends, it draws  
15 on more specialty expertise. So specialist palliative care doctors will be, you know, looking after, and case managing that particular individual along with specialist palliative care nurses, general nurses and allied health, and depending on what the needs of the client is at any particular time.

MS BERGIN: Ms Fisher, how involved is the family in decision-making at this  
20 time?

MS FISHER: The family is key in assisting with decision-making. Usually it is the client's choice to stay at home, to die at home. That choice does need to be  
25 supported by a family member or a carer in some cases, and the carer play not necessarily be a family member, but family, however defined. But they are critical to supporting that client through the various stages of palliative care. And so we include, in our client, if you like, the carer as well. So we care for the carer to make sure that their psychological, you know, stress is minimised during what is quite a  
30 stressful time. And as the parent's cognitive ability may deteriorate through their disease process or, in fact, through medication, the dependency on a carer is – escalates. So we can provide respite care as part of our – as our model as well to give a rest, for example, for the carer.

MS BERGIN: So in the context of providing services, palliative care services in the home, what is the effect of not transferring control to the – to the family and instead  
35 keeping control and choice with the person?

MS FISHER: I'm sorry, could you repeat the - - -  
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MS BERGIN: I'm interested to explore with you the person-centred care model and to what extent the person receiving treatment retains control and makes choices, rather than perhaps a hospital setting where control might be transferred to others, the family or to clinicians.  
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MS FISHER: So, again, the tool that we use is the My Guidebook tool which is a – we also develop what's a care plan which is agreed goals. So when the client – and



we work with the client and the family to express those goals. So everything is understood initially. We also encourage as a form of an advanced care plan which we support so that everyone is clear about what the pathway is, and so while we don't go into what's called an advanced care directive, when we have those  
5 established and agreed goals, that the family and carer will honour those objectives of the care plan because it's all done upfront or during the process. And so that when, you know, if there is a crisis or there is an episode where, perhaps, the family isn't coping, the wishes of the client, supported by the carer, are fulfilled.

10 MS BERGIN: You mentioned the role of advanced care planning. Is Silver Chain involved in supporting the person to prepare to do advanced care planning or is that something that's left with the client and their family to take care of?

MS FISHER: No. Silver Chain will facilitate the advanced care plan and the  
15 manifestation of that is through the My Care Plan or My Guidebook.

MS BERGIN: Okay.

MS FISHER: We do have other models that are in my evidence where – a program  
20 called Integrum where we use advanced care planning in particular either through the patient's GP, or we have general medical officers and our goal is that everybody in that program would have an advanced – advanced care plan, and we're very keen to encourage more advanced care planning in the community.

25 MS BERGIN: Ms Fisher, what are the entry criteria to palliative care services at home through Silver Chain?

MS FISHER: The entry criteria is referral by a – a palliative care service in a  
30 hospital, for example, or a registered nurse or a GP can refer to the palliative care program.

MS BERGIN: Are clients able to receive palliative care through a home care package?

35 MS FISHER: The clients can receive a palliative care – sorry, a home care package as part of their palliative care. We – sometimes, however, the delay in receiving a package is such that the client doesn't receive a home care package, and we think that's – could be improved. For example, the palliative care, 70 days isn't a long time. So that's the average sort of length of time for palliative services with Silver  
40 Chain. So that even if a client is eligible for a home care package, the wait for a level 1 or 2 is three to six months, but a level 4 package can, you know, take a year, and so, clearly, that that doesn't add up. So it may be that the diagnosis is quite sudden, palliative care is required and so the ability to draw on care packages is not there. Silver Chain started as a charity, and we do provide services beyond those for  
45 which we're funded. For example, last year we provided \$1.8 million worth of care so that people who needed more complex care in the home which can be done, we were able to support them through Silver Chain funds.

MS BERGIN: Thank you, Ms Fisher. Your statement suggests – at paragraph 104, talks about the delay and – referral pathways and also the effect of delay and seems to suggest that clients who receive palliative care at home receive palliative care earlier than those in residential care. Why is that the case?

5

MS FISHER: The – the referral for palliative care services into aged care facilities and for this – can I talk about the Western Australian experience – is we believe that we are not referred to early enough, and so that referral can come from the aged care facility registered nurse, for example, or it can come from the – the – the client who's  
10 in the aged care facility's GP. But we believe that the referrals are not early enough because the rules aren't clearly defined. The referral pathways are not clearly defined. The staff in aged care facilities are not always trained. Aged care facilities don't necessarily have registered nurses, and so when Silver Chain are called in, we can respond, but it – usually, the end of life is – is usually only days left in that  
15 person's life. So, clearly, with 70 days in the community and only several days – that being said, I'm sure that, you know, people are supported, but not with specialist palliative care. So we think earlier referrals from the facility or from the providers of care or the GP needs to be more transparent and clear.

20 MS BERGIN: How can early referrals improve outcomes for clients?

MS FISHER: We believe specialist palliative care is fundamental in looking after people at the end of their life. So in symptom control, for example, of pain, and so the death process, you know, depending on the person, varies in different ways. So it  
25 may be that the cognitive ability of the person in an aged care facility is not such that they can express what they need, but I think we believe at Silver Chain that the discussion of, you know, the reality of the end of life, and we believe that, you know, death is part of the life cycle and needs to be talked more openly and so advanced care planning in aged care facilities, the conversation with the family that it is the  
30 end of the life, and I think even in Australia, we don't talk about death enough in our community. And so we think that there is these cultural barriers to people realising this is the end.

MS BERGIN: Thank you, Ms Fisher. You mentioned in your evidence that Silver Chain was first established in Western Australia. Why – what was unique about the Western Australian context?

MS FISHER: What was unique? Silver Chain actually started as a children's charity to look after children's health, street children's health and education, and so  
40 from that charitable origin, it has developed to look after people as a not-for-profit organisation. So one of the great things about the not for profit is the – we don't have shareholders. We only have – we have stakeholders, but our major stakeholder is our client, and so it has built up in a service level over many years, but, really, the palliative care program started 30 years ago where I said that the government  
45 decided, instead of building facilities, it would build a community program, and I think that in Australia, we're a bit obsessed with institutions.

We have actually got rid of institutions for mental health. We've got rid of institutions for disability, and here we are still building institutions for our older Australians. And so I think with the foresight of the Western Australian Government at the time, they decided to build up the strength of the community palliative care. And so the Perth community, it's actually enshrined in their culture now that Silver Chain is a well-known brand and respected because we can support people in their home to die with dignity while they're in control.

MS BERGIN: Ms Fisher, we talked a little bit about access and I want to explore that with you further. What changes in – what changes such as changes in funding or other changes are required to improve access to specialist palliative care services in the home?

MS FISHER: Look, I think the – the – if I could start with the patient choice. I think that we know that 70 per cent of Australians want to die at home and only 20 per cent are able to do that, and yet 50 per cent of people living in Perth can die at home. So the change of policy needs to be Community Care Matters and community care not only matters to Australian people, but it also matters in terms of economics. So if you can't win in an argument, you know, the health economics is quite significant. The Grattan Institute prepared a report in 2014 highlighting the value of community care and the fact that it actually is – makes sense in a health economics sense. So I think that there needs to be a policy shift in each jurisdiction to support palliative community care. It can be done, that's what Australians want.

And then there is this Commonwealth/State divide, so perhaps there needs to be a requirement of the Commonwealth to require States to increase its support of community palliative care, but also, perhaps, you know, new money can be pooled together to come up with innovative models, and I think that we have a very interesting project in the west of Sydney using a social investment money to do a seven-year pilot project with the Sydney West Health Service where we're looking at a community palliative care and that's two years in. And so I will be very interested in the evaluation of that which is done independently to show the – economic value, this is what Australia wants, and we can provide good quality care. So I think that we do have some signature projects to demonstrate the value in other jurisdictions.

MS BERGIN: Ms Fisher, just continuing on funding, is funding an access issue in that you mention in your statement that the number of clients requesting or requiring home palliative care exceeds service provision. Is that partly a funding issue?

MS FISHER: Yes. Again, one of the reasons that palliative – community palliative care in – in Perth built up so strongly and on scale is because it was called what's – block funding, and so it wasn't capped. So the expertise, time has built up a very strong robust service. Usually, most of the health payment system is about output or throughput. So we even – you know, the GPs, you know, have to look after X amount of patients because they're paid by patient, and so even the GPs looking after people in the community perhaps should – we need to look at the funding of that to support people in the home to look after more complex patients in the home. So a

case management fee, for example. And so funding is a problem at the primary level, State level and the Commonwealth.

5 MS BERGIN: You mention in your statement that Silver Chain has self-funded \$1.8 million each year in additional palliative care services for Western Australian clients.

MS FISHER: Yes.

10 MS BERGIN: And, on average, this is the equivalent of 300 clients. Is it – what does that mean?

15 MS FISHER: That means that if someone is referred to us and we have met our targets we will not say no to them. It may be that the funding over X amount of life goes longer, we will not abandon our clients if they're still in need and they don't run to the 70-day cycle. So what we do is we have a safety net for those clients that either don't – aren't eligible for funding, funding's run out or their disease progressed in a way that we – where the system can't support it. So we, you know, that's one of the reasons I wanted to lead Silver Chain because of the amazing work  
20 it does.

MS BERGIN: Ms Fisher, you've mentioned the 70-day cycle a couple of times.

25 MS FISHER: Yes.

MS BERGIN: Could you tell the Royal Commission a bit more about that and what that means.

30 MS FISHER: That means that when a person first comes into palliative care services, their end of life duration is really not understood. It depends on the basic health of the client. It depends on the disease progress, and there is no – every individual experience is different, and so that – that 70 days is the average of – of a – the length of stay, if you like, in the Silver Chain – in the Silver Chain model in Perth.  
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MS BERGIN: Ms Fisher, you've also mentioned the role of a carer and the importance of caring for the carer. Can advanced care planning and having palliative care at home improve the experience for a carer?

40 MS FISHER: Yes, we believe it does. The carer is – is vital to the sense of care in the home and so the carer needs caring. The carer's burden, if you like, is better supported or managed if they – if the goals are very clear about what the person that they're caring for is expressed and understood. And while, you know, I've only been at Silver Chain for a – it's now seven months, I actually, you know, went out and –  
45 and visited with the Silver Chain staff, into people's home and watched the role of the carers, and I can tell you there's some amazing stuff happening. And the carer's role is – is vital and – and must be supported, and Silver Chain provides respite for

carers so that they can have a break, and we also provide some training for carers as well. So we include carers in – in – in our education and training of how to look after their loved one.

5 MS BERGIN: So how does Silver Chain provide respite in the context of its services?

10 MS FISHER: We have – for example, in Perth we have six social centres that really support our aged care program but what that also does is actually assist the carers to get a break. So we have transport as well, so we can pick up the client, take them to the social centre and in the social centre there are programs that range from nutrition to social engagements, and some physiotherapy, reablement and so that time that the client is in the social centre, that gives a break to the carer so that they can do some other things that fulfils their – their life ambition.

15 MS BERGIN: You mention in your statement, Ms Fisher, that Silver Chain provides coordination services for its clients and this seems to come through in one of the case studies, in particular case study three at the back of your evidence about Mrs A. Could you please provide the Commission with some further information  
20 about this example. Perhaps talk the Commissioners through the example.

MS FISHER: Yes, thank you so much and I can see that the case study as presented would have been understood. But with your indulgence I did get an update on that particular client to see what had happened - - -

25 MS BERGIN: Thank you, Ms Fisher.

MS FISHER: - - - with Mrs A; would that be okay?

30 MS BERGIN: Thank you, please.

MS FISHER: Yes. Thank you. So Mrs A had received Silver Chain palliative care for 12 months, so longer than the 70 days, and she's just about to be discharged, so she hasn't died as yet, to a level 4 home care package and the GP care and she's now  
35 in a stable phase. She has not been admitted to hospital through the whole time she has been with Silver Chain. In addition to what is provided in the witness statement – and she did give consent for me to share this with the Commission – we facilitated the complex adoption process for her six-year-old grandson. We communicated with her grandson about her future, including assisting to make a memory box. We  
40 supported her grandson directly managing the complex emotions associated with his grandmother's illness and we are providing ongoing bereavement support for Mrs A because her daughter died as well, and that is the mother of the grandson.

45 We provided medical nursing care to manage her symptoms and to stabilise her conditions. I said we organised a home care package but also importantly we developed plans for Mrs A to die at home and so she will come to Silver Chain for palliative care services when required. And I think if I could go back to the original

statement, Mrs A mentioned that she believes the same level of palliative care support in the social model as we expressed in her story, should be received by everyone in Australia.

5 MS BERGIN: How is Mrs A's grandson doing now, Ms Fisher?

MS FISHER: We are helping him with his – clearly he's got a very complex – I'm not aware directly but the fact that we're able to organise his impending adoption I think is a remarkable story.

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MS BERGIN: You mentioned earlier that Silver Chain has its own community social centres in response to one of my questions.

MS FISHER: Yes.

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MS BERGIN: Where are they and how do they operate?

MS FISHER: They're in various – we have six in metro Melbourne and we have seven around the Western Australia country. They have been around, I think, for well over 10 or 11 years. And the – they're either acquired or part donated and we run them as, as I said, social centres that are available to Silver Chain clients.

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MS BERGIN: And you also mentioned the integral model, could you tell the Commission a bit more about the integral – Integra model of care.

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MS FISHER: Silver Chain wishes to advance the models of care in order to support people to live and die in their homes, as is – to live their lives, you know, confidently as they choose. Silver Chain, as part of their innovative culture, not only on the technology but in research and development, has developed a new model called Integrum – which I had to look up when I started which is Latin for restore. And the idea of that Integrum program which is one centre in Perth is using a GP practice model where we look after, and currently we have around 160 clients who the eligibility, you must be over 65, you must have more than two chronic diseases. And you would have had multiple hospital admissions. And so this new model, and you don't – you only have to be 50 if you're one of Australia's first people.

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So these clients are being looked after in a general practice setting. As I said previously, GPs really aren't funded to look after complexity. So this case management model can look after clients in the home quite effectively and so it is a – like a GP practice. The client can come in. There is a general practice assessment. Each client has an advanced care plan so we know what their – the goals are of the care. Then the case is managed by a registered nurse and we can draw on allied health people to support, depending – we can use transport, we can assist people to go to clinics and we can actually – look, the system is very complex and hard to navigate and so the Integrum model is part – it is mostly case management but also navigating through the system so that people can get better support for their disease, so speciality support, medical support or general community support, and we believe

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it is – could be a model for the future to deal with complex people – complex conditions in the home and it can be done.

5 So we're really trying to pave the way for a new model of primary care to keep people in the home. And that has been funded but mostly about 60 per cent, 50 or 60 per cent by home care packages. We got a grant from Western Australia Primary Health Alliance, about 900,000, and then Silver Chain again is investing in this model as well so that we can prove the concept and the outcomes of preventing avoidable admissions to hospital in particular.

10 MS BERGIN: Ms Fisher, to what extent is access to Integrum privately funded?

MS FISHER: There is a percentage of private funding which is diminished and it is only one per cent of the current program this year.

15 MS BERGIN: Thank you, Ms Fisher. And does it include client outcomes to provide case management, in your experience?

MS FISHER: We believe it is – it helps with the actual experience. It prevents hospital admissions. The review and the assessment of the – those outcomes are in a report due at the end of June and that will be – that's being done by a university partner and a commercial partner to demonstrate the health outcomes are better for the client.

25 MS BERGIN: Thank you, Ms Fisher. Would you be able to supply that report to the Royal Commission if it's – when it's available.

MS FISHER: I will be very pleased to.

30 MS BERGIN: Ms Fisher, we ask all of our witnesses whether they could bring a wish list to the Royal Commission, and if you could change five or a few things about the current system, what would be on your list?

MS FISHER: The first thing that Silver Chain would wish for would be to increase advance care planning in the community and would believe that an MBS number for that – for the advance care for GPs would increase the amount of advance care planning in the community. The second wish to have – would be to have higher levels of home care packages, level 5 and perhaps 6, which means that you wouldn't have to rely on charitable arms to support older and vulnerable Australians in the home, that they could access specialist palliative care in the community. So the packages need to be flexible and look after – and draw on quite specialty expertise, specialist palliative care including medical and nursing so that clients can live and die in the community.

45 The third wish list which I'm actually quite passionate about is death literacy. We need as a society to talk about death more. We – death is a part of the life cycle and socially and culturally, you know, we don't have those conversations. So we could

have a national health literacy – public health literacy project where we start to have that conversation. I would like to see earlier referral and provision of palliative – specialist palliative care services and in-reach into aged care facilities, and I talked earlier about that. It’s really important that an aged care facility is someone’s home, and so they really do deserve to have specialist palliative care in the home and we would like to see that as a requirement.

And the fifth change, you know, is to see palliative care in the home be available in every jurisdiction, and I’ve said the statistics before, about that’s what people want, and case 3 – case study 3, Mrs A, does illustrate that point. And again, you know, we’re obsessed with building institutions and then, you know, one of my personal KPIs is when I can work out how to put a ribbon around community care and for someone to open community care as the new, you know, virtual institution health then that I would have done my job as a leader of Silver Chain providing health and aged care in the community so Australians can confidently live and die as they wish to.

MS BERGIN: Thank you very much, Ms Fisher. That concludes my examination, Commissioners.

COMMISSIONER TRACEY: Yes. Ms Fisher, you mentioned the figure, I think, of \$1.8 million that Silver Chain provides to support palliative care. Are you able to put a rough percentage on how much of that would not have been necessary had it been for timely government funding, to which the individual was otherwise entitled but there has just been a delay in the funding coming through?

MS FISHER: I do believe that the requirement for funding is due in part to the delay in packages for people in palliative care in the community. I wouldn’t want to guess a figure, but certainly that is a factor in us requiring to fund people in – in the home.

COMMISSIONER TRACEY: And do you find that GPs and other referrers of people to your services feel inhibited about making referrals if they think the person has got more than the 10 weeks yet to live?

MS FISHER: I think that may play out subtly.

COMMISSIONER TRACEY: And do you think that might also be a factor in aged care residential facilities delaying to the last minute referrals?

MS FISHER: I wouldn’t like to guess how the aged care facilities do operate, but again, I think that that is, you know, perhaps a – a factor.

COMMISSIONER TRACEY: So one of the things we need to be looking at is seeing whether that 10 week limit is appropriate in all circumstances and perhaps looking at creative ways of ensuring that people get the funding to which they’re



entitled a lot quicker when they're terminally ill than they might otherwise do when they apply for home care.

5 MS FISHER: Yes. Yes, I think, you know, some way of fast-tracking or bringing down the barriers at that time would be – I think would make a huge difference to Australians' lives.

10 COMMISSIONER TRACEY: Yes. Thank you, Ms Fisher. Well, thank you very much for taking the time to prepare a very detailed statement. The case studies are also very helpful for obvious reasons. And we will work our way through this as quickly as we can, and hopefully make some recommendations that will ensure that people get timely care and organisations such as yours are not bearing expenses that would otherwise be borne by the public system. Thank you very much.

15 MS FISHER: Thank you so much. Thank you.

MS BERGIN: Thank you, Commissioners. If this witness may please be excused.

20 <THE WITNESS WITHDREW [2.44 pm]

MS BERGIN: I now call Matthew John Moore.

25 MR TRAN: May I be excused, Commissioners?

<MATTHEW JOHN MOORE, SWORN [2.45 pm]

30 <EXAMINATION-IN-CHIEF BY MS BERGIN

35 MS BERGIN: Mr Moore, if you could take a seat if that's more comfortable for you. What is your full name?

MR MOORE: Matthew John Moore.

40 MS BERGIN: And what is your current role?

MR MOORE: General manager, Aged and Disability Services for the Institute of Urban Indigenous Health.

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

MR MOORE: I have.

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

MR MOORE: Yes, there is.

5 MS BERGIN: Could you just look through the pages and identify it as yours.

MR MOORE: Yes, that's mine.

10 MS BERGIN: Operator, could you please bring up WIT.0162.0001.0001. Do you have any amendments to your statement, Mr Moore?

MR MOORE: No, I do not.

15 MS BERGIN: Is it true and correct on the basis of your knowledge and belief?

MR MOORE: Yes, it is.

20 MS BERGIN: I tender the statement of Matthew John Moore dated the 30<sup>th</sup> of May 2019.

COMMISSIONER TRACEY: Yes, the witness statement of Matthew John Moore dated 30 May 2019 will be exhibit 5-28.

25 **EXHIBIT #5-28 WITNESS STATEMENT OF MATTHEW JOHN MOORE  
DATED 30/05/2019 (WIT.0162.0001.0001) AND ITS IDENTIFIED  
ANNEXURES**

30 MS BERGIN: Thank you, Commissioner. Now, I want to turn first to your experience, Mr Moore, and it is extensive. You've led the preparation of the Aboriginal and Torres Strait Islander Aged Care Diversity Action Plan which was commissioned by Ken Wyatt the former Aged Care Minister and the current Minister for Indigenous People; is that correct?

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MR MOORE: Yes, that's correct.

MS BERGIN: Could you describe your other relevant experience in this area.

40 MR MOORE: In this area – initially, when I finished grade 12 at school, I did a – a retail at Coles/Myer trainingship for about seven years. On completion of that, I then worked in a job placement agency getting young disabled kids into employment before taking on the role as the manager of a community controlled Aboriginal, Torres Strait Islander aged care service in the Scenic Rim region of south-east  
45 Queensland for all but 17 years. On completion of that, I went into aged and community care consultancy for a couple of years of which – that's the capacity in

which I then came to the Institute to establish community aged care services for the Institute of Indigenous Health.

5 MS BERGIN: Thank you, Mr Moore. Operator, could you please bring up paragraph 19 of Mr Moore's statement. In this paragraph, Mr Moore, you quote some statistics taken from the Australian Institute of Health and Welfare website; is that correct?

10 MR MOORE: Yes, I do.

MS BERGIN: Just want to take the Commissioners through that:

15 *Indigenous Australians are 2.3 times as likely to die early or live with poor health compared to non-Indigenous Australians. Indigenous Australians are 2.1 times as likely to have a profound or severe core activity limitation than non-Indigenous Australians, and Indigenous Australians are likely to experience dementia at three to five times the rate of non-Indigenous Australians. Indigenous Australians are 2.7 times more likely to live in disadvantaged areas compared to non-Indigenous people –*

20 based on the index which you quote. I'm also interested in taking the Commission to the statistics in the third dot point of your paragraph 19. You quote that:

25 *The data shows that the Indigenous, 50 plus years intercensal growth between 2011 and 2016 was the fastest growing Indigenous age cohort being 39 per cent which is double of that of non-Indigenous age population growth.*

Could you please put these statistics into its context for the Commission.

30 MR MOORE: Yeah. So the – the context is that Aboriginal and Torres Strait Islander people, you know, age earlier, and the burden of disease and chronic disease that – that impacts on their lives is more profound. And that whilst the Aboriginal and Torres Strait Islander highest growth is 50 plus, you know, it leads people to think that the Closing the Gap strategies must be working. Unfortunately, the  
35 Closing the Gap strategies are – they're being compared to general Australian population which are among the healthiest in the world and, unfortunately, that – that doesn't reflect that we are actually – whilst Aboriginals are living longer, the actual gap of life expectancy is not closing. So to say what of that is that there are no target strategies to deal with Aboriginal and Torres Strait Islander illness in the aged care  
40 system, and we're going to have to come up with some strategies to address that.

MS BERGIN: You also quote there:

45 *Growth rate of the Indigenous population aged 65 and over.*

What's the growth rate – the projection for - - -

MR MOORE: The projection is - - -

MS BERGIN: - - - projected growth rate?

5 MR MOORE: - - - over 200 per cent in the growth rate, yeah.

MS BERGIN: Well, again, like I just said, I think that it means that we're going to have come up with strategies to address the Aboriginal people living longer. I think we're going to have come up with targeted strategies to address how we're going to deal with them within the aged care system.

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MS BERGIN: So when you talk about the strategies that we need to develop, are you seeing that the existing strategies are deficient?

15 MR MOORE: Absolutely. I don't think there is targeted strategies to address Aboriginal and Torres Strait Islander aged care. The action plan which is just in the – has been presented by the Minister, and there's been no evidence it's been rolled out yet, that it's made any difference, but apart from that, I don't think there is targeted strategies for - - -

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MS BERGIN: Yes.

MR MOORE: - - - Aboriginal aged care.

25 MS BERGIN: So in terms of the implementation plans that exist at a Commonwealth level, is your point, really, that there's a lack of evidence of implementation, rather than a lack of planning?

MR MOORE: Yes.

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MS BERGIN: Okay. So you quote in your evidence some work that's been done by a centre at ANU.

MR MOORE: Yep.

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MS BERGIN: And I'd just like to bring up tab 43 of the tender bundle, please, Operator. I think that's the Broome tender bundle.

MR MOORE: Yeah.

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MS BERGIN: Thank you. So you might be aware, Mr Moore, that we had a hearing recently in Broome – well, last week in Broome where - - -

MR MOORE: Yes.

45

MS BERGIN: - - - we had a focus on delivery of aged care services to remote communities - - -

MR MOORE: Yep.

MS BERGIN: - - - including Aboriginal and Torres Strait Islander communities.

5 MR MOORE: Yes.

MS BERGIN: And we're particularly interested in hear from you – hearing from you on the experience in the urban setting as well as to complement the evidence that we've heard today. Now - - -

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MR MOORE: Yeah – sorry.

MS BERGIN: Sorry.

15 MR MOORE: No, I was just going to say that the CAEPR report clearly shows – as – as the Commissioners would be aware, I don't have lived experience in the rural – in the remote areas. However, I think that, you know, broader Australia, actually, when we talk about Aboriginal and Torres Strait Islander, their minds go straight to the remote communities. So what the CAEPR report actually reflects is that more  
20 than 80 per cent 0 actually close to 85 per cent of Aboriginal people now live in urban and large regional settings.

So – so whilst it would never – you know, the – the issues of the problems that our brothers and sisters have in those remote communities shouldn't never be  
25 downplayed and – and not just geographic. They've got some significant stuff that they need to deal with, but I think that people need to understand that if we're going to make a difference for the broader Aboriginal community, we're going to have to have some urban strategies as well as those remote strategies. An example is in south-east Queensland where – where we operate, the fastest growing Aboriginal  
30 community in Australia, in – in that pocket of south-east Queensland corner, three hours drive one way and an hour the other, there's more than 80,000 Aboriginal people live there, and so I – I suppose the reason that I – in – in my – that I highlight this, is that there needs to be an urban strategy. It can't just be that we generally look after the remote strategy.

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COMMISSIONER TRACEY: One thing we were told in Broome was that there wasn't a significant difference between health outcomes for urban Aboriginal communities and rural Aboriginal communities, and the evidence seemed to suggest that one possible reason for that is that urban Aboriginal people are reluctant to seek  
40 services that are available for cultural and other reasons. Is that your experience?

MR MOORE: That – that is my experience. I think it's a fallacy to think that just because they live in an urban setting, they have good access, good pathways. I – I think that there's – and part of my paper goes to talk about some of the reasons why I  
45 think that is. But, yeah, absolutely, that's my experience that – the – the same outcomes across the country.

COMMISSIONER TRACEY: And just one related issue, and it's sort of counterintuitive, but one of the figures you quote in your statement is that it's anticipated that there will be a significant increase in the number of Aboriginal people over the age of 65 in the coming years which would seem to suggest that there has been or will be anticipated improvement in health provision for these people who, for that reason, are going to live longer than might have been the case on average in the past. Is that a contradiction or - - -

MR MOORE: No, I don't think it's a contradiction, and I think that if you just looked at the Aboriginal statistics in population, it - it - it would lead you to that - their life expectancy is they're living longer and their health outcomes should be better, but when it's compared to a normal Australian who's also living longer and their health outcomes are better, the actual - the gap that we talk about, I don't think is closing, but it would be true to say that, yes, they will live longer, their health outcome should be better, but it - they just won't catch up to mainstream Australia at the rate - with the changes - with what's happening currently.

COMMISSIONER TRACEY: Thank you. Yes, Ms Bergin.

MS BERGIN: Thank you, Commissioner. Operator, could you please bring up figure 5 of the report. Figure 5. Just - Mr Moore, just while the operator is bringing up the figure that you wanted to take the Commission to - that's it, figure 5. Thank you, Operator. I wanted to ask you about - just on the point you were making a moment ago in discussion with Commissioner Tracey about age specific disability rates. Are they higher among the Aboriginal and Torres Strait Islander population than non-Aboriginal and Torres Strait Islander people?

MR MOORE: Yes. The work that we did before, the NDIS work that we're doing currently now, taking the - the - the data from the last census about Aboriginal people that identified that they need assistance with an activity in daily living that are under 65 years of age, yeah, the - the work that we did actually demonstrated that they're up to five times more likely to have a disability and that the actual rates of disability as per stated, we think, should nearly be doubled, if not tripled, they reflect what really is.

MS BERGIN: Would support be better delivered by the Commonwealth to Aboriginal and Torres Strait Islander people who need care through the NDIS, rather than through the aged care system?

MR MOORE: I think that the aged care system is still catching up now about the rollout, as the Commissioners would be aware and the Commission, that the - the changes to the aged care system did not - have not taken the most vulnerable into account through the - the reforms and through the changes. I think that the aged care system itself is still catching up with dealing with the most vulnerable in our community, but which Aboriginal and Torres Strait Islander people are, and I think that the - the NDIA and the disability sector is even further behind, and that is they rollout these huge reforms and huge changes. I don't think that they are designed to

assist the most vulnerable people as well. So whilst there's that area of 50 to 65 which actually the – the Aboriginal cohort sit in between both, I actually think that aged care – I think that I would be recommending that they try to hand – try and gain access to both systems and have a look - - -

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MS BERGIN: Okay.

MR MOORE: - - - at which one they can actually get into, yeah.

10 MS BERGIN: And are there other criteria that should be applied in assessing which model of care provision is most appropriate in a particular community? I'm talk - - -

MR MOORE: Well, I – yeah, I – I was going to say the health – yeah, the success of the Institute has been that the basis for our assessed need of a client, whether it's in the disability or the aged care sector, is based on health need first.

15

MS BERGIN: Yes.

MR MOORE: So ..... health assessment which actually then points to whether it's a health related issue, it's a aged care related issue, it's a disability related issue, I think would be essential. I don't know where, across the country, other communities do that very, you know, thoroughly.

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MS BERGIN: Mr Moore, could you tell us about the Institute's model of care.

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MR MOORE: So the Institute's model of care is an integrated primary health care/aged care model, and it's based on the premises. I just alluded to that comprehensive health check underpins everything we do. So the Institute's model is that if there – there are needs, assessed needs or identified needs, particularly in a health system, then there's internal communication through referral pathways to make sure that appropriate services are provided by the appropriate bits of the – of the – the services that are provided. It's a comprehensive model of care, and if – we are fortunate enough for the Institute to have multiple income streams. So everything from aged care is one funded stream, but we've got clinical care, we have chronic disease management, we have family wellbeing, we have mums and bubs, we have health prevention, health promotion. So we've got a suite of services that actually wrap around the client, and it's not just a scheme, loan or isolated aged care service.

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MS BERGIN: You talk in your statement about person-centred care and consumer directed care - - -

40

MR MOORE: Yeah.

MS BERGIN: - - - at paragraphs 28 and 29. What are the key differences between the two in the context of service delivery to Aboriginal and Torres Strait Islander communities?

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MR MOORE: For us, fundamentally, I think person-centred care is where you put the person in the centre of the whole – of their – their required needs and then their assessed needs, and consumer-directed care is where you put the person in the centre of either a goods or services – a suite of service, say. So as – for us, if, like I said,  
5 aged care is just one part of the actual make-up of a client’s needs, so for the integrated model of care and the holistic model that we have, if that client has chronic disease and has some clinical requirements, maybe have some family wellbeing services happen. To make it person-centred for them we refer and get services that are appropriate for that level and so the aged care bucket is not left to  
10 pick up the tab for a clinical care requirement or for a chronic disease management requirement or whatever.

So aged care just becomes part of the suite of services that actually can address the needs of that client. So we put the person in the centre of their holistic needs. Now,  
15 for consumer directed care it only puts them in the centre of their aged care requirements and – and I think my experience is that more often than not a lot of their aged care dollars are spent actually for them getting primary health care or getting chronic disease management or getting other transport. So their aged care money is being spent on other services, yes.

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MS BERGIN: Are these labels helpful?

MR MOORE: No, I don’t – well, for a good service like ours – we have a no wrong door approach that our clients, I would say, don’t necessarily know all the work that  
25 goes in the background to actually unpick the silos of funding and to actually refer and make sure that we triage appropriately to the appropriate bucket of money that we get, you know. Allied health is a classic example. Allied health is funded in aged care, it’s funded in clinical care, it’s funded in primary health care, it’s funded in a chronic disease management. It’s funded in a whole heap of areas. So for us  
30 when one of our clients comes in and actually access their entitlement to some allied health services through their clinical care, then we don’t have to allocate that out of their aged care package. That aged care money can be spent on their aged care itself.

So I think for a good holistic service, where the client is in the middle and it’s  
35 consumer directed care, they don’t need to actually label whereabouts the money is coming from; they just need to get the care that they require in the way that they require it.

MS BERGIN: You talk about the relationship of trust and respect in provision of  
40 care to your clients, including gender and age of the care worker and matching up gender and age wherever possible. Why is that important?

MR MOORE: For Aboriginal and Torres Strait Islander communities again, there’s  
45 the cultural considerations around, you know, an elderly Aboriginal female really does not want – or maybe it’s not culturally appropriate to get a young Aboriginal male to come and do the personal care or the, you know, any of those sort of requirements. But the trust relationship is Aboriginal people in my experience want



Aboriginal community to service them. You know, some of the barriers that are broken down by having an Aboriginal person that understands community, understands culture, understands whatever when they're doing their caring role gives us access into their lives, gives us access into their homes, their families and the willingness to accept services.

I think it's a real barrier and I think that part of the issue around mainstream aged care providers not being able to understand and address that, because I don't think that there's an understanding that that's not just a slight thing, that it's quite – it's ingrained in culture and it actually assists to break down barriers to provide service care.

MS BERGIN: How else might Indigenous status be relevant to care for your clients?

MR MOORE: Indigenous status be relevant to care; can you - - -

MS BERGIN: So I'm thinking whether or not a worker and a care recipient both identify as Indigenous and Torres Strait Islander or not. For example, can a non-Indigenous care worker provide care to an Indigenous care recipient?

MR MOORE: Yes, they can. I think that understanding the culture and being accepted within the community and by the client and whatever is an essential part of that and like I alluded to before, I think that if you are of Aboriginal and Torres Strait Islander descent and you have an understanding of that stuff it breaks down some barriers to do that. If you are not Aboriginal and Torres Strait Islander, and you need to have an understanding, you need to be able to demonstrate the understanding and it's just another consideration for the employee to be able to gain trust and be able to access the clients, yes.

MS BERGIN: Mr Moore, how long does it take to build up trust with your clients?

MR MOORE: It can take a long time – it can take a short time, it can take a short time. I think that's variable but in my experience, you know, for all engagements or most of the engagements we have with our clientele, a high touch, low impact sort of approach is taken. So – so again, you know, I think part of the issues and part of the problems with the way that the assessment system works within aged care for Aboriginal people at this stage is that on first engagement with an Aboriginal person, you know, a professional person is going to ask a whole series of questions all of which have huge impacts for that person that they have to, you know, provide information about not just their personal requirements but sometimes about their family situation, about some other things.

And so to do that the first time if you don't understand around those cultural nuances around that, you know, I think that whilst the ACAT teams and the assessment teams are really quite a professional workforce and are very good at what they do, I think they try and hide behind the fact that everyone is vanilla and it's consumer directed

care and if we ask these question that people will tell us what they need. If they there's no understanding or inherent understanding of these cultural barriers first, I don't think they understand that these clients will tell them what they think they want to hear to get them out of their face, to get them out. The result of that is  
5 inappropriate assessments, lower levels of care that are approved or the clients walk away from the system altogether.

So that high touch, low impact stuff for us is that we tell the clients enough information, that they need to mull it over, think about it, talk to people to come back  
10 and ask for the next bit. So the more interaction we have with the lower – the smaller chunks of bite-size information for understanding, then down the path, three, four, six months down the track is when they're actually – when the trust is built and that's when you can actually get to the real issues of what's happening. Another  
15 good example of that is that typically for block-funded CHSP services for Aboriginal and Torres Strait Islander communities in my experience have been at the lower level, lower impact ones are usually the first ones that are agreed upon, some transport services, maybe some yard maintenance, maybe whatever.

But the next level up is when – then there's an acceptance that you can come inside  
20 the home and you can actually do some domestic assistance and maybe some personal care or some meal preparation because that then – we then start knowing that we've built some trust because we then get access into their family situation, into the life, into some – and it's usually then, you know, at the second or third review of actually what the care plan or what the care might be that the clients open up about,  
25 well, actually what's going on here is that my daughter doesn't do this for me. I actually do need some personal care, I do have some continence issues. That's the sort of level; so it can take three months, it can take 12 months, and obviously it's, you know, it's different.

30 But that's for an Aboriginal organisation that have an Aboriginal workforce to go in and that's still the level of – that we sometimes engage. So, again, for a mainstream service provider that doesn't have the appropriate staff or the appropriate understanding of culture there's significant barriers for people to access appropriate care or get the quality of care that they require.

35 MS BERGIN: Does the high touch and low impact also talk about – you're also talking about taking things at the pace of the client?

40 MR MOORE: Yes. Absolutely. And again, the mantra that – one of the mantras that we at the institute is that under-promise and over-deliver because, you know, again if Aboriginal people they're upfront that you can do the world for them and then you don't deliver, well, then they're more likely to walk away from that. And I don't even know whether that's a cultural thing; maybe it's just an aged care thing in general but absolutely if we over-promise and can't deliver then it resonates through  
45 the community. It does whatever, so we've got this – a couple of mantras. One is high touch, low impact. The other one is under-promise and over-deliver, yes.

MS BERGIN: Thank you, Mr Moore. You mentioned the role of Indigenous staff and the role of an Indigenous or an Aboriginal-controlled and owned entity. How important is it that a facility with Indigenous or Torres Strait Islander care recipients also has Indigenous staff?

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MR MOORE: Yes, it's vital, I think. Our experience as we roll services out, the aged care services in the south-east Queensland ..... and Indigenous health came about, you know, in, you know, because there was a gap in that service system for elders in that community. So when we first rolled services out into the northern suburbs of Brisbane there was no community-controlled aged care providers. There was a couple of welfare programs run by some faith-based organisations but less than 50 Aboriginal people out of a population of 35,000 in that catchment were receiving care. The scary part was the 12 months prior there was only four ACAT assessments for Aboriginal people in that same catchment and only two of them were actually approved for a service. So there was significant lack of services there.

The first time we rolled services out or attempted to recruit staff into the region, the first three times actually we only had two people from Aboriginal and Torres Strait Islander background that had the qualifications to actually – that applied for the roles so very quickly we realised that we had to build a workforce, given that Aboriginal people want community to service them and given that because there was no community-controlled services in the region and there was no Aboriginal and Torres Strait Islander community targeted aged care service, none of the community was skilled up to be able to provide the services to them. So very quickly that's – we targeted that contextualised training, getting skills, qualifications for community in that area and we've been quite successful in doing that over the five years now. I think in excess of 100 Aboriginal people have been put through the certified training and, you know, I think a success rate up around 90 per cent and employment rate up of about 85 per cent which is really quite successful.

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MS BERGIN: Has the institute been supporting workers to complete certificate III?

MR MOORE: Yes. Yes, absolutely. So we applied for and were lucky enough to receive some cert III guarantee for the aged care training skill sets. What we did do though was we negotiated with the RTO in Queensland, a local one, to actually – to contextualise the training material to our model of care, and actually to employ the trainers internally and the mentors internally so that we could work with community members to actually get them their skills, skill sets up and which – and the model that we used was pretty much guaranteeing a job on completion of the qualification and what we have done successfully is that once the first five core subjects are done we've actually been able to offer some casual work on – until the students completed their training to which place then we could employ them wherever necessary.

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MS BERGIN: To what extent has this been successful for the institute and for the workforce?

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MR MOORE: Yes. So for our aged care business unit we've got in excess of 70 per cent Aboriginal and Torres Strait Islander employment and so, again, Aboriginal elders wanting community members to service them has been integral to us actually rolling out and growing as successfully as what we have.

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MS BERGIN: To what extent do you find that staff once they've completed a certificate III to what extent has the institute been able to retain and continue to train the workforce?

10 MR MOORE: Yes, so like I alluded to, I think we've got about 70 per cent Aboriginal and Torres Strait Islander employment now. Of those 70 per cent, in excess of 50 per cent have come through our own training systems. Where now the institute has a leadership program internally, built in, some whereby some of those people now are doing some middle management training with a view to be able to  
15 have a look at career pathways for them. Yes.

MS BERGIN: As I mentioned, this is – this hearing partly has a theme of person-centred care and if that label is not helpful we can just talk about good quality care. In your – does dignity and self-management carry a particular importance for  
20 Aboriginal and Torres Strait Islander elders when you talk about provision of aged care services?

MR MOORE: Yes. I think so, and I think the broader Australia, too, also recognise that for Aboriginal and Torres Strait Islander culture elders are held in high regard  
25 and dignity and respect for elders is absolutely appropriate. I would say at the institute – and the leadership team at the institute often refer that we think that our model of care actually demonstrates practically how we deal and respect our elders by breaking down barriers to access the complex by actually providing services that were never there before, by allowing them to tap into the holistic care and person-centred care is fine in that context. Consumer directed care, probably not so much.  
30 That language is a bit problematic and the fact that we then move in consumer directed care into a business relationship with an Aboriginal elder who, you know, a lot of the time hasn't had a life experience of having to make informed choices and live with consequence of choice, when they are at their most vulnerable. I think that  
35 that can be problematic, that conversation sometimes about moving from a community-based block-funded welfare sort of program into an individualised business arrangement with an Aboriginal elder, some of that language is sometimes difficult.

40 MS BERGIN: Thank you, Mr Moore. Do you think that mainstream providers and the mainstream workforce can be trained in the provision of culturally safe or culturally appropriate care for Aboriginal and Torres Strait Islander elders?

MR MOORE: I think they could be but I don't think they will be. Our experience  
45 when we went through the consultation process for the diversity action plan was pushed back from mainstream with a lack of understanding. I don't know – even know it was a lack of understanding. I think that the difference between consumer

directed care now is that – and maybe some of the issues within the aged care system currently is that, for me, is that – that it’s a needs-based assessment but I think very quickly the market is driving a wants-based service delivery product and so even though you need to meet some criteria to be eligible to join in, to get a key to the services, once you’re in the services it actually is changing to a wants-based system.

So clients now actually – the needs assessment is not necessarily the driver for the market. And the marketplace itself is now becoming competitive and there are providers who are trying to – you know, clients who build up large amounts of – of, you know, surplus in their budgets are actually targeted for – to actually transition across so they can actually, you know – and it’s not necessarily based on the needs that they have. So it’s – it’s more of a wants based system than it is a needs based system. Does that answer your question?

MS BERGIN: I think so.

MR MOORE: Mmm.

MS BERGIN: I’m interested in what you said about the surplus in client budget. Are you talking about home care packages then?

MR MOORE: Yeah, the home care package side of it, yes.

MS BERGIN: What has been your experience of the creation of surplus since the home care package allocation has changed under consumer directed care?

MR MOORE: I think it’s a communication error up front – right up front. I think, you know, the elders that we deal with and – and, more broadly, in the broader aged care industry, initially, you know, consider – I – I think there’s a consideration that money is their money. It’s not government allocated money. I think that because of their age and because of their life experience, they want to save it for a rainy day. They want to save it for when they really need it. They want to – whatever. And so I think that, of late, five years in now for ours, anyway, and some – some communication and some work with our team, with our clients is that we’re actually getting the staff spending the money and not – and not saving it for a rainy day. But I – I just think that was a – an oversight initially as it – that rolled out in the communication strategy about the way that it was targeted was it’s their money when, you know, we’ve changed all the language for us. That the – it’s government money which can be allocated against care needs, you know.

MS BERGIN: To what extent did bulk funding provide more flexibility in your experience?

MR MOORE: For Aboriginal and Torres Strait Islander, I think block funding is absolutely key to – you know, the viability path for the providers that – that want to provide some work, but, again, like, I alluded to before, to build trust and rapport with clients who are at their most vulnerable, to try and – and get them services that

they require, I think you need to have that flexible approach to doing it. The one-on-one business relationship straight-up front is a stretch too far for Aboriginal people, I think, to jump into. So the block funded, you know, low level supports to build that trust and rapport, and then to actually get a real picture of their needs, I think leads to  
5 – to more comprehensive and appropriate assessments for higher level complexity. And I think that for Aboriginal and Torres Strait Islander specific providers, it – it’s essential.

10 MS BERGIN: How might quality care or person-centred care in remote areas versus city differ for Aboriginal and Torres Strait Islander people?

MR MOORE: Again, it’s – I wouldn’t presume because with no lived experience of remote, I wouldn’t presume to – to try and say the difference, specifically, but – but generally, like I said, I don’t – I don’t think that there’s a targeted strategy for urban  
15 aged care at this stage. I think that a lot of the conversations around Aboriginal aged care and about Aboriginal disadvantage and whatever move straight to remote areas. The Commissioners have had, you know, the hearings in Broome which I’m sure would have had some ideas about how to maybe address that. But, absolutely, the urban and large regional settings need to – to break down the – the assumption that  
20 Aboriginal people have access to good health care and good aged care just because they live in an urban setting.

MS BERGIN: How might life experiences of Aboriginal and Torres Strait Islander people differ such that quality care might have a particular or a different meaning,  
25 and how might it be the same?

MR MOORE: I think we’re moving into a whole new area of quality at the moment with the – you know, as of 1 July and we move into the new common standards. It – it was a shame that we couldn’t get diversity as a standalone standard in the new  
30 common care standards, even though I know that it is embedded throughout. But – but, again, I – I think that the wants based service delivery system at this stage and, now, with the change of focus for quality actually being a – a personal thing for a client, it – I think that quality itself is going to be challenged in a whole heap of ways around the aged care system moving forward. That – you know, that providers  
35 actually absolutely have to try and look after their services and the intent of the – the – the assessed needs for clients and – and – and the way that they actually, you know, care for the clients. When a client – on the other hand, you know, wants based system may – may see quality completely differently. So I think that’s the same for Aboriginal and mainstream aged care services.

40 MS BERGIN: Why is that, Mr Moore, that a wants based system might see completely different quality outcomes to what funding model?

MR MOORE: Well, I – I just think that a wants based system then is – is open and  
45 – and it just gets – with more limited parameters about what you do. You know, quality from a consumer’s perspective may be about whether someone says yes and somebody says no, not necessarily about the quality of what they get and what they

don't get. Again, the – I think the Institute's success has been based on the needs assessment is – underpins all of our care plans, our care requirements, and we have an ability to triage to other buckets of funding and to other service systems to be able to get appropriate care. I'm unsure if I can comment further on other stuff.

5

MS BERGIN: Thank you, Mr Moore. If you could provide a wish list of things you would like to change to the Royal Commission, what would you include on your list?

10 MR MOORE: I've got a few things. I think the first thing that I would like – I would love for the Commission to be able to – or the Commissioners to be able to recommend to COAG around – to refresh the Closing the Gap strategies, that, actually, aged care targets are embedded in that. There are a significant number of indicators and performance stuff that's – that's been added to – to the Closing the Gap refresh where aged care has missed the boat. They have – there – there is no  
15 targets in there. Disabilities is another one that isn't in there, but I know that's not your remit.

I think, you know, given that the Commission really, potentially, is looking at some structural reform as well, the success of the Institute in an integrated primary  
20 healthcare/aged care model, I think, demonstrates that there is potential for a different funding model for these most vulnerable people. That, you know, because health and aged care and even disabilities, again, to that extent, are so intertwined, you know, an – an Aboriginal person who's 50 plus that actually, you know, presents with assistance with activity or daily living is – is going to have a chronic disease, is  
25 going to have some health issues, and – and the fact that they are intertwined and that – we could potentially have some savings for the aged care system and leverage some – some health care and mental health and chronic disease management and other things in there, it would be interesting to see if – if there was a possibility to potentially fund separately for these most vulnerable cohorts.

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There's a – you know, I'm unsure how to – to say this. The Aboriginal medical services across the country already have about 150, you know, Aboriginal community controlled health organisations funded. They already have a platform there that potentially could be leveraged in that space. That, you know, they already  
35 connected to the community. They have trust already. They employ Aboriginal people. They have solutions for this stuff of Indigenous ..... and that – whilst I'm not saying that we need to go and ..... another 150 niche Aboriginal and Torres Strait Islander markets potentially, but there is a platform there that could be leveraged. But, however, I think that it would need to be a regional approach to that. I don't  
40 think that you could do it in an isolated approach.

I think, again, success factors for the Institute have been that we've done it on a regional level. We've brought together four Aboriginal medical services who have commonly agreed that as a regional solutions and – and – and addressed targets and  
45 to do stuff. I think that – that a regional solution to some of this stuff in urban and large regional settings could potentially work. Again, the Institute's success was based on planning of a – a master plan of a three or five-year plan for that region

about where the gaps are, proper environmental scan, having a look at where existing services lay, bring in the – the existing Aboriginal and Torres Strait Islander community care aged care providers, having a look at the health, doing – and the reason for success in the Institute, I think, is because there was comprehensive  
5 planning done upfront to really clearly identify gaps and then commonly come up with some solutions.

And I don't think that that needs to stand alone for ours. I think that absolutely would be replicable across the country. And so I think that that, potentially, is – is something that I would ask the Commissioners to consider. Another thing –  
10 potentially appropriate targets, the work that we did in the environment – in the environmental scan for the Institute clearly cross-reference demographic data with what actually was on the ground for Aboriginal people. We had a look at the – you know, the complexity of care. We had a look at the large numbers of Aboriginal  
15 people, where the population shifts were moving to, where we should be sitting up services, how we tap into those services. Again, you know, we use the Aboriginal medical service as a basis because our clients were already there, and we could tell what their needs were by their chronic disease level – whatever. So that – that could be again.

20 I've already alluded to, I think, that block funding is essential for Aboriginal people, and I think that, potentially, quarantine block funding which targets Aboriginal, Torres Islander specific community controlled organisations could well be a way to – to doing that. I think another thing that I would ask the Commissioners too is  
25 mandating that reporting of Aboriginal and Torres Strait Islander engagement throughout the whole of the aged care sector. Again, I – I know I spoke at the round table with the Minister, but – with the commissioners, but, you know, numerous occasions over my time in aged care where I know that business is one within the aged care sector by actually – by engagement with Aboriginal community controlled  
30 organisations, by demonstrating in an application or in a tender document that you can cover that population. You can cover everywhere.

Once the business is won and once the service – the money is provided to the service, there's never an obligation for them to report against what they've done in that space.  
35 And so, you know, it – and I know it's five years ago now, but, you know, there's no data comes out that actually clearly identifies where Aboriginal people are getting service too, they're getting service from and what level of service they do get. I use an example. When the regional assessment tenders went out for the regional assessment services, it was mandated in that tender that everybody had to  
40 demonstrate their ..... their relationships with Aboriginal and Torres Strait Islander and their ability to cover the whole region. As soon as the tenders were won, the majority of regional assessment services because of their – their business requirements just get their assessor to do all the assessments.

45 There's no engagement with the people who actually underpin their application to get that – to win that business. So – so as you would be aware, what gets measured gets done, so I actually think we should measure what everybody does across the



broader aged care sector with Aboriginal people at this stage. And – and the last thing is, I think, that we – I haven't really alluded to it again because I'm not an expert in residential aged care, but I think that there is a significant gap in – for Aboriginal people to move from their community and their – their community care services. You know, there's less than one per cent of the Aboriginal population in residential aged care. Actually, it's only point eight or whatever it is, and of that point eight, more than half of them are in remote regional settings.

So it actually says that Aboriginal people aren't going into residential aged care and I think there's reasons to for that. I think there's an opportunity, potentially, to actually do something which is in the middle which could leverage off some high level aged care complexity, married in with some health services, and that – also to build that trust and rapport about actually people moving out of their homes into an accommodation site setting to get their care. And that, you know, there's already examples in the NATSIFLEX and the state based multipurpose services where that happens, but they are geographically fenced into regional remote areas. I think there's a real opportunity to potentially have a look at that in – in urban and more larger settings to actually have some locations and facilities that can build trust for Aboriginal people to move into those supported accommodation settings. So I - -

20

MS BERGIN: Thank you, Mr Moore.

MR MOORE: Is that enough?

25 MS BERGIN: I – thank you. It's very informative.

MR MOORE: Yeah.

MS BERGIN: There were two questions I realised I had omitted which I would like to ask you, and I'm sorry for not asking this earlier.

30

MR MOORE: .....

MS BERGIN: What does it mean – you talk in your evidence about – I think at paragraph 93 about the concept of a thin market. What does it mean to say that Aboriginal and Torres Strait Islander aged care services are a thin market?

35

MR MOORE: Yes. So from – I alluded to before, I think that under a consumer directed care model, it – you know, it is to drive the marketplace so the market is the competition that should drive down, you know, prices, should create competition, should do all the things that a market should do. But the problem is – for Aboriginal and Torres Strait Islander people is that for them to make informed choice and for them to have confidence in the choices they do make, there needs to be options. So there need to be a suite of providers that they can choose from. There needs to be a suite of services that they can choose from, and they need to have all the information at their hand to make that informed choice.

45

And I think that for Aboriginal people – Aboriginal and Torres Strait Islander people, there is a lack of good quality information that gives them – you know, without the assistance of navigation in the system. You know, again, that My Aged Care portal itself doesn't work for you – one of my ..... is on the service finder in the My Aged Care portal. There is a specialist button which you can just self-tick. There's no – it's not controlled by the department. It's not cross-referenced by the quality agency. You just tick it to say you specialise in something. So, you know, this is on a government endorsed website for when people are at their most vulnerable to try and make a choice about what they want, and people can just self-select that they're a specialist and something.

It's really just a marketing tool and it is not there to actually provide that information for vulnerable people to make, you know, decisions that they're – at that point. So, for me, a thin market, I just think that no matter whether you live in an urban setting, where there's a whole heap of aged care providers, but very limited Aboriginal and Torres Strait Islander specific providers, or whether you're in a remote community, I think that we should treat Aboriginal and Torres Strait Islander aged care as a thin market no matter what the geographic location.

MS BERGIN: Thank you, Mr Moore. And my other question relates to something you just touched on about the importance of system navigators or advocates. How important are they in the context of delivery of services to Aboriginal and Torres Strait Islander?

MR MOORE: Absolutely. Aboriginal and Torres Strait Islander people cannot interact with the system if they don't have somebody that's an advocate for them to navigate their way through the system. Again, the success of the institute has really been based on the fact that we understand the My Aged Care system, we understand the portal and we've been able to put in things to navigate clients around the pressure points and the barriers to their access. So for instance the Institute of Urban Indigenous Health have skilled up their chronic disease management nurses in all 20 of their clinics to be able to provide referrals to aged care through regional assessment services, the ACAT teams, because those nurses work with that community in that local environment, understand what's going on. They can explain and give them the information they need about what has to happen, where the pressure points are, what the triggers are, what the mandatories are.

And so what we do then is get a consent form from the client for us to advocate for them through the process. We have a really clear precise text about that this is an Aboriginal person that's known to us, that does not want to have a cold call, does not want to have a screening ..... does not want to but that wants us to advocate for and engage for them through the system and it's a web-based referral. It's not a phone contact referral. So if we have to speak to somebody at the call centre in My Aged Care on behalf of an Aboriginal person we've failed in our processes to get them through to break down the barriers to access.

But yes, absolutely, if Aboriginal and Torres Strait Islander people don't have appropriate advocacy and don't have somebody who is accepted and trusted that can provide the information they require to get into the system the barriers are just too many for them and they will walk away from the system. So moving forward, I think an appropriate navigation system is an absolute essential. I might also say, I also think that the appropriate navigation stuff needs to be highlighted but I don't think again a vanilla navigation process for every person in Australia will do for these marginalised complex ones at the bottom, targeted.

10 MS BERGIN: Thank you Mr Moore. We've covered a lot of ground today. Is there anything that you wanted to add to your evidence that I haven't already asked you about?

15 MR MOORE: I don't think so. I think I've covered all of it. The last thing I would like to say is just thank the Commissioners for, you know, giving me this opportunity to actually talk and to hear my views and my thing and just have an open invitation either formally or informally that if ever you're in Brisbane you come and have a look at the deadly work that the institute is doing in that space. The offer is there for you guys to come any time. So thank you.

20 MS BERGIN: Thank you, Commissioners, that concludes my examination of Mr Moore.

25 COMMISSIONER TRACEY: Can I just follow-up one point that you made. A number of our interlocutors have advocated a recommendation that a government-funded panel be set up to provide advocacy generally for vulnerable people who, left to their own devices, couldn't negotiate the system. And obtain benefits to which they were entitled. Now, plainly Aboriginal people fall well within that category. I'm just thinking of the practicalities. Would you see it best if there were Aboriginal people on such a panel or would it be better for the government to be funding people who are doing that sort of work within organisations such as yours to provide those services specifically to Aboriginal people?

35 MR MOORE: Yes, I think it has to be on the ground. I actually – I see the relevance of a panel and the higher level advocacy and making sure that the broader, yes, I think that – that there should be Aboriginal representation on a large panel like that. I actually think that – that it needs to be on the ground and it needs to be a nuance to the different communities and different geographies, the different issues there are for the different Aboriginal communities across the country. I think that it needs to be – I don't know how you do it if it's outside of at least a region at the widest. I'm unsure about how you would actually get a panel of people nationally to have a look at the differences between the Cape, between, you know, Western Australia, between inner city Brisbane. I think it has to be local Aboriginal people that give those messages and do that navigation.

45

COMMISSIONER TRACEY: Mr Moore, thank you very much, both for your evidence today and your earlier participation in discussions with the Commission and I don't think you've heard the last of us.

5 MR MOORE: Okay.

COMMISSIONER TRACEY: Thank you very much for coming and assisting our inquiries. Ms Bergin, I gather there's a desire for a short adjournment before we continue.

10

MS BERGIN: Thank you, Commissioner.

COMMISSIONER TRACEY: Yes. The Commission will adjourn shortly.

15

**<THE WITNESS WITHDREW** [3.35 pm]

20

**ADJOURNED** [3.35 pm]

**RESUMED** [3.52 pm]

25 COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Thank you, Commissioners. I call John Michael Rungie.

30 **<JOHN MICHAEL RUNGIE, SWORN** [3.53 pm]

**<EXAMINATION-IN-CHIEF BY MR ROZEN**

35

MR ROZEN: Take a seat, Dr Rungie.

DR RUNGIE: Thank you.

40 MR ROZEN: You have been waiting very patiently today, and we're sorry to have held you up for as long as we have but your moment has arrived. Can you tell us your full name, please.

DR RUNGIE: John Michael Rungie.

45

MR ROZEN: You are an ageing well specialist.

DR RUNGIE: I am.

MR ROZEN: A self-conferred title.

5 DR RUNGIE: Yes, I invented the title because a title didn't exist for what I do.

MR ROZEN: Okay. And you have a long and storied career in the aged care sector.

DR RUNGIE: I do.

10

MR ROZEN: First, we can just start with some qualifications. You've got a PhD in biological sciences.

DR RUNGIE: Yes.

15

MR ROZEN: And your thesis topic?

DR RUNGIE: I can almost not remember. It was ATPase activity in membranes in plant tissue. That's not exactly the title.

20

MR ROZEN: All right. You worked in the disability and aged care sectors for 40 years.

DR RUNGIE: Correct.

25

MR ROZEN: And you hold a range of current positions which are set out in detail in paragraph 4 of your statement that I will tender in a moment but if I can just identify a handful of them. You're the director of the Global Centre for Modern Ageing.

30

DR RUNGIE: I am.

MR ROZEN: And what does the Global Centre for Modern Ageing do?

35 DR RUNGIE: It's an organisation that's involved in encouraging and enabling the business of ageing well. So it's become very familiar with the new narrative in the hearts and mind of older people about how they want to live their lives well in their 70s, 80s, 90s and then encourages businesses to understand the new narrative and build product and services to meet their needs.

40

MR ROZEN: Right. I might just ask you if I could to just slow down your speaking a little only because someone has the task of transcribing every word you and I say, and it's a challenge at the best of times. You're also a member of the Aged Care Financing Authority.

45

DR RUNGIE: I am.

MR ROZEN: We've heard quite a bit about ACFA and we will be exploring it in a bit more detail in later hearings. And you're a member of COTAs South Australian Policy Council.

5 DR RUNGIE: I am.

MR ROZEN: The Council of the Ageing.

DR RUNGIE: Council of the Ageing, yes.

10

MR ROZEN: How long have you held that position, Mr Rungie?

DR RUNGIE: Three years, and in fact, I have held all those positions for about three years. In fact, approximately from the time that I left my mid-life career as CEO of ACH Group.

15

MR ROZEN: Okay. We'll come to the ACH Group in a moment. For the moment, though, can I just confirm that you have made a statement for the Royal Commission dated 11 June 2019.

20

DR RUNGIE: I have.

MR ROZEN: It was, in fact, a revised version of an earlier statement that you provided to us; is that right?

25

DR RUNGIE: Correct.

MR ROZEN: And for our purposes, the coding is WIT.0158.0002.0001 which should appear on the screen in front of you, I hope, in a moment.

30

DR RUNGIE: It's not currently there.

MR ROZEN: It's coming, I think. It's arrived. Is that – with a little bit of redacting of some personal details, is that a copy of the statement or at least the first page of it that you have made for the Royal Commission, Dr Rungie.

35

DR RUNGIE: Yes, it is.

MR ROZEN: And have you had chance to read through your statement before coming along today.

40

DR RUNGIE: I have.

MR ROZEN: Is there anything that you wish to change in your statement?

45

DR RUNGIE: No, there isn't.

MR ROZEN: And are its contents true and correct?

DR RUNGIE: Yes.

5 MR ROZEN: I tender the statement of Dr John Michael Rungie dated 11 June 2019, Commissioners.

10 COMMISSIONER TRACEY: The witness statement of John Michael Rungie dated 11 June 2019 will be exhibit 5-29.

**EXHIBIT #5-29 WITNESS STATEMENT OF JOHN MICHAEL RUNGIE  
DATED 11/06/2019 (WIT.0158.0002.0001)**

15 MR ROZEN: If the Commission pleases. You mentioned a moment ago, Dr Rungie, that before these various positions that you presently hold and that you've held for the last three years or so, you had a full-time position with the ACH Group.

20 DR RUNGIE: Correct.

MR ROZEN: ACH standing for?

25 DR RUNGIE: Well, it originally stood for Aged Cottage Homes and then Aged Care and Housing but it's actually now registered as ACH Group.

MR ROZEN: ACH Group. All right. Can you tell us about your time with the ACH Group, maybe working backwards. So when you concluded your time there you were the CEO.

30 DR RUNGIE: I was. I had been the CEO there for 20 years, and before that for about 15 years I was the operations manager.

35 MR ROZEN: All right. You've detailed a bit about the ACH Group in your statement from paragraph 6 onwards. I might just ask you, if you could, to just summarise the services provided by the ACH Group and some of the initiatives that were implemented there during your tenure as the CEO.

40 DR RUNGIE: It's a fairly typical not-for-profit aged care organisation in Australia. It had eight residential aged care facilities. It had about 600 packages. I mean, we now know that varies a little bit from time to time. It supported about another 9000 older people in smaller health and community service-type programs and had about 900 independent houses that were both resident-funded and IUs, but the majority were IUs, in other words, housing for people with limited financial means. The  
45 interesting thing about this organisation is that right from its beginning it's always been very interested in the clients of the service thriving and in the eighties, we started to collect information about – just about how people were using their time in

the day and that became very clear to us that people were not very engaged, that they had – there were good programs in the organisation but, in fact, they tended to be more entertainment and they tended to be for not very long amounts of time in the person's life. And that's - - -

5

MR ROZEN: This is the resident's life.

DR RUNGIE: This is the resident's life and that's a real theme about the way we understand quality of life in aged care today is that while a lot is on offer, in most cases people don't access that stuff for very long and, in fact, have very large periods of disengagement or boredom or isolation. So we started looking at ways that we might deal with that and one of the things we did quite early was to start to use a program that measured quality of life in the services. And that initial program was called Passing. In 2004, we redeveloped that, but not substantially just to make it easier for people to use, into a – a review program called Customer Impact Statement. In other words, we're measuring the impact of the service on the clients.

That particular program works across all aged care types. It's a peer review process, so it engages a staff member's understanding the point of what it's about. It can be done a number of times, so we can benchmark and we can measure whether an improvement works or not. And in many of our improvements, in fact, didn't make much difference and, particularly, I reference entertainment programs that can often take quite a lot of time and even have people going to them for periods of time, but didn't seem to make much difference to the quality of life when we measured it using the customer impact statement that we called CIMPACT.

But what it has done over that time, it has led the organisation to a variety of really exciting and interesting things to do that do measure much better using CIMPACT and they are, particularly, an aged care facility where everyone gets a house, not a – not a room. In other words, if you visit someone in this aged care facility – there's the high care aged care facility. You go in the front door of the person's house, their house and no one else's, into their lounge room and dining room, kitchen, laundry, and services come in the back door. And what we found with that, that it dramatically reduced the losses that people suffered on moving into residential aged care.

We also built a facility that focuses entirely on short-term care and re-enablement in partnership with the State Department of Health in South Australia, and that was targeting people who were coming out of hospitals and, inevitably, were going into residential aged care, often improving a bit after a bit of time, but never going home. So it picked those people off, put them into this short-term care service with goals for each person and a very high percentage of those people going home and not representing.

In addition, we set up a number of programs that specifically targeted quality of life and – and for us, that meant that they had to have a role, a membership in something. They had to learn something. They had to make a commitment to it over time. So,



for example, we set up a number of community choirs which were run, not by an activities officer, but by someone who was qualified in the area, and these particularly worked well for people with dementia who hadn't lost the ability to learn a tune and remember a tune and be able to sing quite complicated music in a choir, and surprising to us, also became very popular with people with Parkinson's disease because it taught them a whole lot of breathing techniques.

MR ROZEN: Thank you. You mentioned – I think you said re-enablement, re-ablement – it's the same thing essentially. It's a bit of a funky word, but, nonetheless, perhaps – you tell us. What are you talking about when you talk about re-ablement in relation to elderly people in residential aged care?

DR RUNGIE: It's – if I go back a little bit to the story of ViTA which is the facility specifically built for encouraging people to recover when they come out of hospital.

MR ROZEN: Yes.

DR RUNGIE: A lot of the – just as an example, a lot of people come out of hospital still needing – really, often, in a weakened state from their time in hospital and needing anything from just convalescence, a recovery period right through to needing to relearn a skill or – or even to learn a new skill.

MR ROZEN: Can I just pause – I just interrupt there. I'm sorry, but are we talking, for example, about an elderly person who was living at home, had a fall, they've broken their hip, they've gone into hospital which we know is a very common path into residential aged care, and then they don't come out or, at least, they don't come out till they die. That's a very common - - -

DR RUNGIE: Correct.

MR ROZEN: - - - pattern.

DR RUNGIE: Correct.

MR ROZEN: You're offering a different pathway for such a person.

DR RUNGIE: A very different pathway, yes, yes.

MR ROZEN: Yes. Thank you.

DR RUNGIE: So that – and that's a good example because that might require some specific work around – around physio, around building strength again, being able to walk. It might require also, though, some specific work around a number of other things that the person can no longer do so that they need to relearn to do things in a different kind of way because they now have some kind of a disability they didn't have before. And it might also require us to take the person through some time in their own home as part of the program to make sure they can reorientate to it in this

new stage of life. And, in addition to that, the person may have had to give up some things because of the accident they've had, and so that we can work out what kind of new things the person can take up so that the person is able to continue to live a – a – a good life when they go home, given that we know that quality of life is the really significant indicator to people recovering and doing well wherever though live. So just using that as an example - - -

MR ROZEN: Yes.

10 DR RUNGIE: - - - there are a whole lot of other examples that go back into quite small re-enablement and enablement processes. We particularly notice, as people become frail, they have to give up things, and so a lot of our re-enablement effort has been about working with people to repurpose, if you like, to work out what a new purpose in life might be, and then a – and then a new activity or a new role that you might be able to take up and build the things around that to enable that to happen. In 15 a sense, it is like rehabilitation, but rehabilitation is a state effort and more specifically targeting very, quite specific issues around people's injuries. This tends to build out the rest of people's lives where they might need recovery as well.

20 MR ROZEN: Yep, and what sort of success rate did you experience with that initiative with ACH?

DR RUNGIE: I would say extraordinary. We were able to use these processes in home care to enable quite a lot of people not to have to move into residential care.

25

MR ROZEN: Yes.

DR RUNGIE: Certainly through ViTA, we managed to have large numbers of people go nowhere near residential care, and we had some success in having people move out of residential care. We would have liked a lot more, but as you would know from my statement, there are really, at the moment, currently a lot of barriers to people moving out of residential care even if we've managed to get them to recover.

30

35 MR ROZEN: We will come to those presently. From your experience, Dr Rungie, do you think there are a significant number of people who are currently going into residential care, including within the scenario that I described to you of the elderly person having a significant injury and then going from hospital to residential care. Are there many people for whom that sort of initiative might – it would prevent them going to residential care at all or maybe see them going into residential care briefly and then coming back to some type of home care? Do you think there are significant numbers of people who would benefit from such programs if they were more widely available?

40

45 DR RUNGIE: I would love to be able to give you a number.

MR ROZEN: No, I'm not seeking a number, but I'm trying to get a sense, if I can.

DR RUNGIE: I personally think there are very large numbers of people - - -

MR ROZEN: Yes.

5 DR RUNGIE: - - - but – but we don’t have any evidence – much evidence about it at the moment; right. So the accumulating evidence for unnecessary institutionalisation is the waiting lists on home care, people clearly preferring home care.

10 MR ROZEN: Yes.

DR RUNGIE: The possible reduction of demand for residential care. I mean, I’ve now seen another report from StewartBrown suggest maybe those numbers aren’t quite as accurate as – as we originally thought. The very strong preference of older  
15 people themselves to stay home if they possibly could. So this needs – ViTA has been a good test of this, but this needs a lot more testing, and my sense is that if we have a much larger number of home care packages, perhaps some higher level home care packages and some really good use of those packages to help people reconsider their lives as frailer people and how they could manage that, that we might find a real  
20 lessening of the demand for residential care, and my sense is that we should work incredibly hard to make that happen.

MR ROZEN: You mention, in the context of re-ablement and rehabilitation, the role of physiotherapy – the importance of physiotherapy in assisting people to regain  
25 movement and the like. I think you were in the hearing room when we heard the evidence of Ms Urwin, the young lady who was a physiotherapist, and her descriptions of the role of physiotherapy and the very limited role of physiotherapy in her experience, largely driven, it seems, by the funding arrangements. Is that a barrier to the sorts of initiatives that you’re talking about? Is there a connection  
30 there?

DR RUNGIE: That was an extraordinary story this morning and – and, personally, to me, just a great disappointment. I might mention a couple of times the work of Professor Hall Kendrick. He – he sadly died earlier this year so is not able here to  
35 give evidence at – at this hearing but his work in this area – his research work in this area was extraordinary. One of his pieces of work, work with a large number of frail older people to try and understand what their life goals might be, and that piece of published work describes six life goals of frail older people. That from my – I can’t work out why they haven’t become the basis of the way we think about designing  
40 aged care.

What’s interesting about those is, firstly, that they – none of them make a reference to care. So this is about people describing the kind of life they want to live as their goals with care being the thing that you get to enable you to live that life. That’s a –  
45 a real distinction between the way providers think about aged care which is care – care is the end point, “We provide good care and, in a sense, bad luck if that doesn’t deliver you with a good life.” Right? Which is completely different to the way that

– that older people – frail older people would describe that. When you do look at what those life goals are, they are things like, wanting – fiercely wanting to stay independent; right? Fiercely wanting to stay in their own home. So older people are really up for physio and other treatments that will just even improve their functioning  
5 just a little bit so they can do something more they can't do at the moment so they can do it for themselves, and to have physios like the one we heard this morning available to aged care and not doing that is really sad.

MR ROZEN: You refer in your statement to the notion of growth, and I want to try  
10 and understand, if I can, whether growth as you describe it, in the context of aged care, is something different to re-ablement and rehabilitation? I understand it to be a somewhat broader concept more related to general quality of life, if I'm understanding it correctly.

15 DR RUNGIE: Mmm.

MR ROZEN: Could you assist us there.

DR RUNGIE: It is part of – of re-enablement. Although, re-enablement tends to be  
20 thought of more in terms of more physical - - -

MR ROZEN: Yes.

DR RUNGIE: - - - ability and independence to do things; right. And why we –  
25 why I included personal growth in my – in my statement is that we know that older people tell us that they want to keep learning things and experiencing new things, partly because they have done that all their lives and partly because, as you age, things drop away and you do have to replace them with other things. So personal growth to older people is – is really very important, and it's often at this point that  
30 people – and so as an example, I'm going back to the choir I was talking about earlier, learning to sing with other people very complex musical pieces in a group is a – is a new skill. It's something you're learning. It's good personal growth; right.

What we certainly notice in – in both residential aged care and in home care is  
35 there's almost no focus on working with people to encourage them to think about personal growth and, therefore, what kind of activity they might take up in this – in that space to learn something, and very little effort to connect older people to other old people who've successfully done that, so people can learn from one another by word of mouth - - -

40

MR ROZEN: Yes.

DR RUNGIE: - - - and those kind of things; right? I do think that abandoning the  
45 notion of personal growth in people is very dangerous for the person and very likely to result in people becoming much more dependent, much more quickly.

MR ROZEN: A theme that runs through much of your statement and I think the evidence that you've been giving to the Commission this afternoon is the notion of innovation, and you make the point that there's no incentive to innovate in our current aged care system. Can you expand on that, please. Big topic, I know.

5

DR RUNGIE: If I – I just – one things I would like to talk about, at some stage, is the transformation of the sector; right. And one of – and there are a number of habits in how a sector transforms; right? One of the habits is around co-invention.

10 MR ROZEN: Yes.

DR RUNGIE: So recently the Global Centre for Modern Ageing worked with a local community in South Australia that had won some new bed licences and was about to build a new aged care facility. And they came to us and the process that the  
15 Global Centre set up was a co-invention process to co-invent the new facility. So they worked with a group of frail older people, some of whom already lived in residential care and some who didn't, and the first question they asked was, if you could design your own facility what would it look like. And people tend to have two answers to that question: one is I prefer not to move in at all but if I had to, then they  
20 start improving the current system. I'll have a bigger room, for example, I'd like a door outside to the garden, things like that, right.

When the co-invention question is asked, which is describe your current life and then – and people do. And then say what are the things you're happy to give up when you  
25 move into residential care. People on the whole say, "Nothing, I want to continue all those things. I want to keep my dog, I want to keep my garden, I want to stay with my husband, I like the fact my daughter comes round and cooks the roast every Monday afternoon". Whatever the bits of their life are, they want to keep them. You can do almost none of those things in the current residential aged care model. So that  
30 then requires the service provider and other product developers, often start-ups – new start-ups to come together with the clients and design a new service and then test it.

And those services tend to look nothing like the current institutional communal-based residential care. I think that's innovation. Really serious innovation. Another  
35 example is that we have heard of a number of ageing well start-ups in Australia that are designing products that are based on knowing some older people very well and then designing a product that relieves the pain point that the person currently has, whatever that might be.

40 MR ROZEN: Can you give us an example of that.

DR RUNGIE: Yes, so we know that older people, when they become frail, often start to lose a lot of their networks because they were going out to clubs and joining things and they can't go out as much so that they lose those networks. And those  
45 networks then either don't get replaced at all or they get replaced by paid staff out of the aged care system. Now, there's a problem with using paid staff out of the aged care system to fill those networks, partly because we can't afford it, there aren't

enough of them, and partly because they are in the end paid so they always come at this thing slightly differently. So there are a number of – I know of three product developers in Australia, a care app, Care Connect and Compargo, so there are three companies in Australia at the moment that build products that build – that use an electronic package to build a network around a person, right.

And what's clever about them is that they also enable you to connect, if you want, to a whole lot of the care information if the person is connected to a care service or health information if they're connected to the health service into that same package, right. Easily accessible. So you appoint a webmaster, you invite people into the network. Those people can communicate with one another whenever they interact with a person, and they often will start by improving the care but very quickly move into things they notice about the person's life quality. "I notice she said the other day she liked playing cards but nobody comes." "Does anyone know someone who plays cards?" "Yes, my son can do that" and so someone else gets invited in to do something. And they're clever products. They're very cheap and they're doing something that currently nothing else does.

MR ROZEN: Yes. And is there enough existing incentive in the system to encourage more of that sort of innovative thinking or is it rather the other way around that there are disincentives to thinking outside the square, if I can put it that way?

DR RUNGIE: Perhaps I should start by saying, I see almost no innovation in the aged care sector.

MR ROZEN: Yes.

DR RUNGIE: Right. So I don't think it is existing and when it does happen, the filters to work out even if it's very good or very – or not very useful innovation is struggling a bit at the moment, right. So now, why is that not happening: I think there's a range of reasons why that's not happening. There certainly aren't a lot of incentives, but – but there are a number of other things going on. You heard from Kay Patterson about the – about ageism.

MR ROZEN: Yes.

DR RUNGIE: There's substantial ageism in aged care, right, and it's not hard to see. I mean, where else do you solve a problem of looking after a person who needs a lot of care by putting them in an institution. It's – the ageism in the aged care sector is very strong. And – and – and starts much earlier than the aged care. I think, as Kay said, it starts right back in the early stages of making fun of people when they're older which means then your application for a job is taken less seriously which means you're then unemployed which means then that you don't have as much money which means you don't have a house which means that – so you finally get positioned in a place where the world thinks it's okay to stick you in an aged care facility without trying really hard to see whether we could keep you at home with a package, and the world thinks it's all right for you to be doing nothing all day and

bored and that you ought to be able to cope with that or whatever it is. So I do think ageism is a real problem.

MR ROZEN: Yes.

5

DR RUNGIE: I do finally think this is not a sector that has not decided it needs to transform, that it currently doesn't serve people well, that it's really hard to work in and it's not affordable. And at some point then you say we can fiddle with the edges of this or really start to try and change this into a sector, and that's where, if you don't have that view of the world then the need to have a lot of innovation in there just – it just doesn't present itself.

10

MR ROZEN: Are there untapped opportunities for further technological advances in this area?

15

DR RUNGIE: We've hardly started. We've hardly started. And the sooner we move into that space – we've hardly started. Certainly – I mean, South Australia, just for example, there are, to the best of my knowledge, about 30 ageing well start-ups that I know of in South Australia, which probably means there are three or four hundred of them in Australia, and if we did nothing – and most of those have got a technology base to them. If we did nothing more than learn from them, they're paying for their own R & D at this stage, it would cost nothing for aged care organisations to partner up with these people and learn about the way they innovate and learn about the way they use technology, at no cost to them. That would be a good start.

20

25

MR ROZEN: Is that something the Centre for Modern Ageing is involved in?

DR RUNGIE: Yes.

30

MR ROZEN: Can you just expand a little bit on that on how that works in a practical sense; what does the centre do?

DR RUNGIE: So particularly the centre either spots opportunities and goes to businesses and says would you be interested in working with us, or businesses come to it and say we've got a product we're interested in either, in testing it with older people, inventing it with older people, whatever it is. For example, a company came to the Global Centre recently that had a device that monitored a whole lot of your fitness and health habits when you were exercising, and charted those out and they were interested in seeing whether it would work with older people or not so they came in and tested it and modified as a result of that.

35

40

Now, they're not the kind of things that are currently an aged care provider would think of as important to an older person but I have to tell you they are things older people are thinking are very important because older people prize their health very, very highly as we saw from the latest national COTA census of older people – prize their health because they know it's a cornerstone to independence.

45

MR ROZEN: Yes. Now, as advertised, Dr Rungie, we like to give witnesses an opportunity to advance a wish list. I suspect you will be quite eager to take up that opportunity.

5 DR RUNGIE: Yes. Can I first just say one thing about CIMPACT which represents  
to the wish list, right. The interesting thing about CIMPACT is that it measures  
quality of life according to five dimensions. And those five dimensions would be, in  
fact, highly appropriate for anyone in this room to use, so we haven't modified them  
because you're an older, frailer person. What we found is that a good service rates  
10 well on three of them, right. Only an excellent service rates well on all five, right,  
and the two that excellent services rate on that good services don't get are building  
roles for people and building community safeguards for people, networks and  
safeguards in the community, right.

15 So you can rate well as a good provider if you're providing good – you're meeting  
people's basic needs, you're providing basic relationships, usually through the staff  
and things like that, and you're doing some kind of support to independence, right,  
will get you to be a good provider. What we found – sorry, what ACH Group found  
in using CIMPACT on its services that sometimes a service turned up as quite a poor  
20 service. It wasn't doing well in any of those areas. Sometimes it turned up as a good  
service, it was doing well in three areas which makes it a good solid service but not  
good enough to really meet the needs of an older person, and rarely did we get a  
service to turn up in the area of all five of them which really was our goal.

25 The thing that we learnt most from this is that increasing the amount of entertainment  
and the amount of staff and those kind of things in – in residential care didn't  
actually improve the CIMPACT score. And how we improved the CIMPACT score  
mostly was by keeping people out and providing all kinds of roles to people and all  
kinds of community safeguards to people, right. Occasionally, we were able to get  
30 good CIMPACT scores inside a residential service but it is very, very hard to do in a  
communal residential – it's very hard to do. This is a very unfamiliar environment in  
which it's very hard to treat people as individuals. So that's a long way of getting to  
the point of me answering your question.

35 MR ROZEN: Sure.

DR RUNGIE: I think my ask would be that we saw the – we saw the aged care  
sector as ripe for transformation and that transformation has a set of – so this is a big  
leap, right, that fiddling the edges of aged care is not going to make enough  
40 difference. We will be sitting here in five years time; we will be doing much better  
in residential aged care and it still won't be very good, right. So a sector that's up for  
serious transformation, right. So one of the things if you're going to do serious  
transformation, I would pay a lot of attention to home care being as good as it  
possibly can be. That will mean government will need to be clearer about what it  
45 wants from this. If it's going to create a market, it's got to be clear about what it  
wants because it's not a real market.



It does mean that we will want growth and re-enablement and support for older people living at home to think about how they grow and re-enable and stay independent and stay out of aged care, right. Secondly, I think we should make very – a really strong effort to keep people out of residential care that we stop seeing it as  
5 an alternative to home care and see it only as a – as a last resort, right. And so I would start making a very special effort to – when people are applying to see if there's any way we could support them to stay at home.

10 The third thing I would do is I would engage older people in large numbers in co-invention, get them together and get them talking about the lives they want to live and get them then working with product and developers to develop new products. Now, I think if we do that we will see a dramatic increase in the amount of use of technology products and things like that. I think we will see the specialisation of residential care so that it's either housing plus care, not a communal facility or it's a  
15 short-term facility of some kind. And the last thing I would do is I would engage the whole community in a really serious conversation about what is a good frail life, right.

20 So if any of us sitting in this room knew we were going to be frail in five years time we would talk about how we would want to live that frail life and we would want to start setting up a way of living that life, right, so the community will expect a good frail life and then we will start to make demands on providers who are currently not playing in that space to really start playing that space.

25 MR ROZEN: Thank you. Commissioners, that concludes my questions of Dr Rungie.

30 COMMISSIONER BRIGGS: Thank you, Dr Rungie for that evidence and for your witness statement which I found very compelling. I'm interested in when the work was done with the frail older people to design new arrangements that might suit them better than residential care, what sorts of things did they say?

35 DR RUNGIE: That project is still only in its first stage so the – so it's, we finished the consultations and the – really the summary finding of the consultations is that people do want their current lives to continue as much as possible. And they can't see any reason why you couldn't have a residential aged care facility that enabled that and they currently appreciate that the current facilities don't do it, right. Now, that's really all I can tell you at the moment, although we can – we could provide the Commission with some additional detail under that, if that's useful to you.  
40

MR ROZEN: I think we'd be grateful for that.

DR RUNGIE: Right. Good.

45 MR ROZEN: Thank you, Doctor. Yes.

DR RUNGIE: What I can tell you is the next stages of that will be that a combination of those findings with some product developers to see – so what – how could you design a facility that would enable you to do that; right?

5 COMMISSIONER TRACEY: You're obviously also very much aware of the cost of providing services for people in aged care, either at home or in institutions. In suggesting the various creative alternatives to the present arrangements, have you factored in the question of whether the revised alternatives are going to be more or less expensive than the present arrangement? I mean, I have in mind, for example, 10 that one would think that keeping people in their own homes, rather than in institutions would be better from a funding point of view, but I may be wrong about that.

15 DR RUNGIE: This is not, in the first instance, driven as a cost-saving conversation.

COMMISSIONER TRACEY: No.

DR RUNGIE: But we have no doubts that, in most cases, there are cost savings in it. I can point to a number of examples around Australia, for example, with the 20 Silver Chain who were here earlier today who invested a – a higher cost earlier on in a home care program in exchange for much lower use of services ongoing into the future that certainly demonstrated that that was the cheaper thing to do; right? Certainly, ViTA demonstrates that significant numbers of people are – are bypassing long-term expensive residential care to go home. Sometimes, on much cheaper – 25 cheaper packages.

I do also think that this whole debate about asking people to pay for more is, at least, in part predicated on people wanting what it is they're buying, and so that – for example, a – a program run by ACH Group where they offered people support to 30 take holidays, rather than go into respite in an aged care facility almost always resulted in the person expecting to pay for the holiday. Whereas, they were getting highly funded respite care. So this – clearly, this has to be tested, and I note that the earlier reference to date of use of social investment bonds in which the whole argument is that you invest in a change on the assumption that it's going to produce 35 lower costs down the track, I think we will see more of that sort of testing of some of these ideas going forward.

COMMISSIONER TRACEY: Thank you.

40 COMMISSIONER BRIGGS: Doctor, you're not alone in thinking that the sector lacks a bit of impetus to transform. It's certainly apparent to us, as we read regularly in the paper, further claims against the government for not stopping the reforms while this Royal Commission sits. And it leads me to wonder, why is it that this sector isn't reforming themselves? Is it because they are so reliant on government 45 funding that they expect the government to do it for them?

DR RUNGIE: This will be an opinion – an opinion piece, rather than backed up by a lot of data. My sense is that most aged care providers do think they are government subcontractors and, therefore, they will simply do what the government asks them to do and make some money along the way, and I think that’s evidenced a lot by the activity of boards of aged care organisations that often don’t know much about, for example, the quality of what they’re providing. Just as example because they, really, in a sense, delegated all that to the government that does quality in aged care.

10 I – I do think that aged care providers have taken their eye totally off the ball of their mission statements; right? So it – it’s interesting that their mission statements are often full of things about people living good lives, and their services are usually the opposite of that. And – and – and I think they’ve just, somewhere along the line, stopped noticing that difference between what they – why they were originally set up and what’s actually going on, and that – it’s almost a blindness to the reality of – of what’s happening in aged care at the moment. Not really answering your question. I’m just telling you what I’m noticing here.

COMMISSIONER BRIGGS: I think you are. I think - - -

20 DR RUNGIE: So that something that causes – that takes the glasses off people here, I think will be useful which is why I like the co-invention process, that the provider gets together with the – with the – with the older person, but with a very different set of questions to the one we’ve asked in the – the – the collection of client satisfaction data is not helpful because we have very high numbers of people saying they’re actually satisfied with the service and, yet, we have very different conversations with people in CIMPACT in which they tell us they’re not. We – we have collected, over a number of years, losses that we’ve noticed people suffer when they move into residential care. We now hold in that list 20 losses. So we think there are now 20 things you lose when you move into residential care which are not a result of being a frail older person. They are a result of the service model that you’re moving into.

35 Now, when I talk to providers about those 20 losses, it feels to me like people have never noticed them and, yet, there are – they’re enough to do you serious harm, that – that amount of loss going on without a conversation about what would it take to reduce those losses. So I’m not sure, Commissioner, if I’ve answered your question, but there – when this is driven by ageism or – or people being too far away from the issue that the – from the people they’re trying to serve or their just belief that they’re now just government subcontractors, there’s a set of things going on here which are, in a sense, colluding just to not any longer have this sector strongly aligned to the needs of people.

45 COMMISSIONER BRIGGS: It certainly has been the case in the discussions that I’ve had with people working in the sector that the thing that they notice most when somebody moves into residential care, that they go into a grieving process and that is because of these losses, loss of independence and everything that goes with it. So they’re certainly aware of it. The question is, is the sector sufficiently active to do

something about it, and I will leave my questioning and commenting there. Thank you.

5 COMMISSIONER TRACEY: Anything arising?

MR ROZEN: There's nothing arising. Thank you, Commissioner.

10 COMMISSIONER TRACEY: Dr Rungie, you've given us a lot of food for thought, a lot of thinking outside the square, as they say, and we're enormously grateful to you for that, and be assured that we will be taking on board all that you've told us orally and in your statement. Thank you very much for your attendance and your assistance.

15 DR RUNGIE: Thank you for the opportunity.

**<THE WITNESS WITHDREW [4.38 pm]**

20 MR ROZEN: Thank you, Dr Rungie. Ms Bergin will take the last witness for the day.

COMMISSIONER TRACEY: Very well. Yes, Ms Bergin.

25 MS BERGIN: Thank you, Commissioners, and thank you for sitting on this afternoon. I call Dr Craig Sinclair.

30 **<CRAIG BOWMAN SINCLAIR, AFFIRMED [4.39 pm]**

**<EXAMINATION-IN-CHIEF BY MS BERGIN**

35 MS BERGIN: Dr Sinclair, please take a seat if that would make you more comfortable. What is your full name?

DR SINCLAIR: Craig Bowman Sinclair.

40 MS BERGIN: And what is your current role?

DR SINCLAIR: I'm a research fellow at the University of New South Wales.

45 MS BERGIN: What are your qualifications?

DR SINCLAIR: I have a PhD in following from the University of Western Australia, and approximately 10 years experience as in postgraduate research or post-doctoral research.

5 MS BERGIN: Have you prepared a statement for the Royal Commission, Dr Sinclair?

DR SINCLAIR: Yes, I have.

10 MS BERGIN: Is there a copy of your statement in front of you? Could you just identify it as yours.

DR SINCLAIR: Yes, it is, yeah.

15 MS BERGIN: Operator, could you please pull up WIT.0218.0001.0001. Do you have any amendments to your statement, Dr Sinclair?

DR SINCLAIR: No. No.

20 MS BERGIN: Is it true and correct on the basis of your knowledge and belief?

DR SINCLAIR: Yes.

MS BERGIN: I tender the statement of Craig Bowman Sinclair. The date of the  
25 statement is the 28<sup>th</sup> of May 2019.

COMMISSIONER TRACEY: The witness statement of Craig Bowman Sinclair dated the 28<sup>th</sup> of May 2019 will be exhibit 5-30.

30

**EXHIBIT #5-30 WITNESS STATEMENT OF CRAIG BOWMAN SINCLAIR  
DATED 28/05/2019 (WIT.0218.0001.0001) AND ITS IDENTIFIED  
ANNEXURES**

35

MS BERGIN: Dr Sinclair, I just want to start with your expertise and your key works of research. You have written extensively and your witness statement contains extensive references to your work and that of others. What are your key works of research?

40

DR SINCLAIR: Okay. So I completed my PhD in 2009 and, from 2010, that was when legislation passed in Western Australia that allowed for advanced health directives and people to make enduring powers of guardianship, and with some colleagues, I began work in that area of advanced care planning. We were really  
45 interested in understanding what people thought about these approaches to planning for their future care and why so few people were actually going through that process. So it was social science based research. And as that research program developed, we

also had the opportunity to work at a more systemic level in our local region which was in the great southern region of Western Australia to better understand the processes in terms of storing and communicating advanced care planning documents to – to transition them between organisations, and that culminated in a – in a trial  
5 where we worked with people with serious lung disease and had trained nurses assisting them in – in the advanced care planning process.

As – as we were undertaking that research, I also became aware that there were – it was working less smoothly in the context of aged care and particularly for people  
10 with cognitive impairments, and that got me and – and other colleagues interested in rights based approaches which were looking at supporting a person’s ability to make decisions about their own care, and that – that led us to the work on supported decision-making which is listed in the statement as well.

15 MS BERGIN: Thank you, Dr Sinclair. What is supported decision-making? Can you offer a definition.

DR SINCLAIR: So supported decision-making is a rights based approach to decision-making, and the United Nations defines it as the process of enabling a  
20 person with a disability to make or communicate decisions about their personal or legal matters. That’s obviously a very broad definition, and I think it reflects the diversity in people’s impairments and the decisions they face and also the different types of support that may or may not be available to them. The practice of supported decision-making emerged in Canada in the 1990s, and I think some of the  
25 requirements around the, sort of, legal frameworks that would support this – this process are laid out in the convention on the rights of persons with disabilities, particularly article 12.

But I think it really boils down to an understanding that we develop and maintain our  
30 capacity for autonomous decision-making in the context of relationship. It’s not something that is a purely independent thing. Our decision-making capacity is not an all-or-nothing thing. In reality and particularly for people with an age related cognitive impairment, it’s a progressive and very gradual change, usually, which can also fluctuate. So the idea of – of people having capacity or not having capacity is –  
35 is problematic and supported decision-making engages with that and – and, particularly, the idea that, across that spectrum of decision-making abilities, we can provide tailored supports that help a person to exercise their legal capacity, even as cognition might be declining.

40 And the final aspect would be to see substitute decision-making, really, as something of a last resort, and so that has been a challenge, I guess, in terms of thinking about systems that are set up around substitute decision-making, and it’s really called into question the basis on which substitute decision-making happens and – and  
45 prioritising the person’s will and preference in that substitute decision-making.

MS BERGIN: Dr Sinclair, what is substituted decision-making on the – in the context of that spectrum that you were just talking about earlier?

DR SINCLAIR: I think broadly we could talk about it as when somebody else is making decisions on a person's behalf. It certainly does intersect with some of the aspects of supported decision-making in some areas. The legal frameworks, I'm sure the Commission are aware, in Australia are different in different jurisdictions but  
5 basically you can nominate somebody to be a substitute decision-maker for you through an enduring guardianship or enduring power of attorney. You could be assigned into the role of substitute decision-maker under the hierarchy of persons responsible particularly for medical treatment decisions, or in some cases that substitute decision-maker could be appointed by a tribunal.

10 And so I think while the supported decision-maker thing can be set up in contrast to substitute decision-making this is a very important process and it's particularly important for people with a progressive cognitive impairment, and at the moment we see that substitute decision makers have quite little guidance and support in actually  
15 understanding what their role is, and how they should be going about, you know, making a decision for somebody else.

MS BERGIN: What supports might be appropriate, Dr Sinclair?

20 DR SINCLAIR: At – I think at the initial stage we could just think about even, you know, understanding of the legal requirements of the role. So very often people are – are setting up these powers while they're maybe thinking about their will and often there's not even really a proper conversation between the person who – who's giving the power and the person who's taking it on about what those requirements are and  
25 more to the point I guess about what the person would want. So if you were in that role, what would be of great importance to the person in – in making a decision on their behalf.

MS BERGIN: Dr Sinclair, while you were waiting patiently to give your evidence  
30 this afternoon you might have heard some of the evidence of Dale Fisher.

DR SINCLAIR: Yes.

MS BERGIN: She mentioned advance care planning. Could you describe for us –  
35 could you offer a definition of an advance care plan and what an advance care plan would ordinarily contain.

DR SINCLAIR: Sure. So in the research field we tend to talk about the process of advance care planning as in the verb of doing this process rather than just the  
40 outcome in terms of documentation. So it does entail a process of, you know, within a person of being ready for a conversation that is sometimes quite emotionally difficult about facing potential future incapacity and also issues about death and dying as well. That's not all of what advance care planning is, but I think sometimes practically that's how people think of it and that's where there can be a barrier in  
45 terms of people engaging with the process. It does potentially lead to documentation and ideally that's a great way of communicating a person's wishes if they're unable to speak for themselves and so an advance care directive is typically where

somebody would write down their own wishes and that would have legal effect through the – the laws in the person’s jurisdiction.

5 Or they could nominate a substitute decision-maker and also there’s a proliferation of other non-statutory forms that would be considered, I think, less legally binding but which people often use because of their flexibility or if the – the advance care planning discussion or the advance care planning is happening by a family member rather than by the person themselves, which we do see happening sometimes as well.

10 MS BERGIN: You might have talked about this a little bit already but can I ask you how the concepts of supported decision-making and advance care planning sit together?

15 DR SINCLAIR: They do intersect in practice and I think sometimes that brings up some challenges for people in terms of the terminology. Particularly in the context of an age-related cognitive impairment which I’ve mentioned previously has a particular course that’s sometimes hard to predict. I think it’s helpful to look at this as a spectrum rather than, you know, three very distinct things, and the value of that is that we can then think about doing everything practically possible to support the person’s ongoing involvement and agency in their decision-making. Where that’s  
20 not possible to look at what they might have documented in the past or what directions they might have made or what’s been planned out, and then if that’s not available or isn’t relevant to the situation, as a last resort, going to a substitute decision-maker and applying, you know, the standard for substitute decision-making that’s relevant to that jurisdiction.  
25

MS BERGIN: So Dr Sinclair, you mentioned before that cognitive decline isn’t necessarily static. So is it the case that someone may need a substituted decision-maker but only temporarily?  
30

DR SINCLAIR: Yes, absolutely. And certainly that’s the case in other areas. For example, in the mental health sector where conditions are very much fluctuating and a person may regain full capacity. We also see it in terms of age-related conditions as well. So where a, for example, a condition like dementia has on top of it a more acute insult like a delirium or some other form of temporary frailty, that can be – if  
35 the person then recovers from that episode, they can then go back to making those decisions. And so there’s a process of transition either way.

MS BERGIN: What assumptions are inherent in advance care planning?  
40

DR SINCLAIR: I think one of the assumptions that’s inherent is that we all want to make our own decisions and anticipate a future and make decisions for the future. And I don’t think that’s necessarily the case. It certainly – there are a lot of people in the community who do feel very strongly about this and do want to make those  
45 decisions in that way but it doesn’t apply for everybody and I think that needs to be taken into account. In the context where I’ve been conducting my research which is



particularly with people living with dementia we – I think that there is an assumption that's around it being premised on the loss of future capacity.

5 So if it's framed in the narrow way just about end of life medical treatment, it then becomes a discussion really about decline in capacity and death, rather than a discussion about what is it that you want to live well and what would you want people to be saying on your behalf if you couldn't communicate at one point in time. So I'm always taken to Kate Swaffer's writing and her testimony to the Commission as well, where she noted her experience and I think it's actually quite a normal  
10 experience of, at the time of diagnosis, being told to give up work and to go home and get her affairs in order. And so at a very difficult time when she was coping with that, taking on that diagnosis and accepting what it meant, there was sort of superimposed on that a discussion about end of life planning.

15 And I think that we can do a better job of it than that. Because if, you know, if it is framed within a broader process of post-diagnostic support we could understand how the person is actually coping with that diagnosis and putting some things in place that enable a person to preserve their identity as well as adjusting to the changes that they're experiencing, so in the background paper that the Commission put out last  
20 week, the research by Hilgeman on preserving identity in advance care planning, I think is quite useful to look at as a model and they did find in their pilot work that people with dementia had reduced depression following that intervention.

25 MS BERGIN: Thank you, Dr Sinclair. We've been talking a bit this afternoon about palliative care. How is advance care planning relevant to palliative care?

DR SINCLAIR: So I note the opening comments from this hearing which were about the breadth of palliative care and it not just being focused at the end of life or terminal stage. And I think certainly that advance care planning is very relevant all  
30 the way through that process of palliative care. If we think about, you know, using it as a process of valuing the person and individualising the care to their needs then it is a way of learning more about what their needs are and understanding, you know, what would be really important for a person to live well and then also what should be done if they were unable to speak for themselves.

35 MS BERGIN: What is the relationship then between advance care planning and palliative care? Have the two historically gone together?

DR SINCLAIR: I think they have and the palliative care sector has certainly been  
40 very interested in advance care planning and heavily invested in promoting it in the community and also facilitating it with individuals. And that's a good thing in one sense because they see the results, the very difficult situations that they face when a person is referred late into palliative care in the terminal stages and really the discipline can't deliver all that it's able to because of that process being somewhat  
45 unplanned. So I think they have an interest in it working well, but I also think that it needs to be bigger than just something that happens in the palliative care sector because this is really about a person's rights and their consent and their capacity to

make a decision at a certain time and that can be an issue even aside from palliative care, it relates to a range of situations.

5 So making it more mainstream I think would actually assist in raising the community's awareness about advance care planning and also reducing some of the barriers to actually engaging in the process.

10 MS BERGIN: Dr Sinclair, who is advance care planning and supported decision-making important for in aged care? Is it primarily for people with illness or are there others that it's important for as well?

15 DR SINCLAIR: Potentially if it's done well, it's important for everyone. And – and certainly the person should be at the centre of that process and what their wishes are for their care. But the research and particularly the work done by Dr Karen Detering in the respecting patient choices group showed through their trial that family members actually had significantly better outcomes in bereavement as well so reduced depression and anxiety in bereavement, and I think that's because having a clearer understanding of what the person wants enables them to hold on to that and to have clarity in their role. And also when those difficult decisions come up, to not be facing such a – you know, such a difficult process because they're enacting what their loved one wanted rather than what they think is best at the time.

25 MS BERGIN: What role does advance care planning play then for family members?

30 DR SINCLAIR: It has a really important role and part of it is starting a conversation that often hasn't been held within that family. So when this is brought up and sometimes it does need to be brought up by health professionals because the family have never found a way to actually broach that discussion. I, you know, hypothesise maybe that it gets tied up with a sense of duty to family and that this might signal some sense of abandonment for a parent and people are very scared of losing that relationship or endangering the relationship. So in some cases health professionals or other service providers do need to broach the discussion in order that the family can come together and have that communication, and through that, they tend to learn more about the person's needs.

MS BERGIN: Can nurses facilitate advance care planning? Is training of nurses appropriate?

40 DR SINCLAIR: I think it's important for all health professionals to be familiar with what sort of requirements there are in advance care planning but we've certainly found that while GPs are often identified as the ideal target, you know, in terms of a profession to introduce the discussion because of their long-term relationship with the person, their medical knowledge, their understanding of the person's conditions and the trust between them, but they often don't have the time and they're also not reimbursed for time that they spend on advance care planning as well. So trying to actually implement advance care planning in practice has often meant nurses

working in collaboration with the person's primary doctor and other allied health and social workers have also been effective in that role as well.

5 We undertook a trial in Western Australia where we were looking at a nurse-led approach and that was certainly effective in increasing the uptake of advance care planning and these nurses did require additional training but that has been taken up more broadly. There are other projects in Australia now that are upskilling practice nurses in particular to introduce advance care planning was part of the over 75 health assessment.

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MS BERGIN: I appreciate, Dr Sinclair, that your evidence is that advance care planning as a process is important. What should an advance care plan as the instrument include, once it's written down?

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DR SINCLAIR: Yes, so in that question you're asking not about what the government should – how they should set up the form but actually what people should write in their advance care plan.

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MS BERGIN: More about people – how people can plan for discussions and perhaps write down their goals and values and beliefs and their preferences for - - -

DR SINCLAIR: Sure.

25

MS BERGIN: - - - so that they can be known.

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DR SINCLAIR: Sure. Yes. That is an interesting question and obviously it's unique to the individual and is a product of the quality of that process of discussion. We do see that the type of advance care planning seems to be different across different settings. So – and it perhaps makes sense, you know, that if it's developed in a more acute hospital setting there does tend to be more of a focus on life-sustaining treatments and medical treatments. The – the forms that we see in the aged care context sometimes deal with – have a greater focus on personal care and activities and, for example, the involvement of family members in personal care which is highly valued for some people and is quite distressing for other people.

35

So – so I guess in responding to that, I think it's really useful to try to encourage people to make a broad statement about their goals and values because no advance care directive or plan can accommodate every possible scenario. There should be some, if possible, some preferences about, you know, particular treatments or cultural and spiritual practices or lifestyle decisions that are really important to that person. And an indication in which situations they would be particularly important. Identifying a preferred substitute decision-maker and/or the way that substitute decision-making should be approached, whether that be, you know, through a family approach or one particular individual could be valuable. And identifying how and when such a document should be enacted. So in what situations does this actually apply.

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As an example of just how to reframe that into this broader process, I guess the cognitive decline partnership centres work around advance care planning felt that, or reported that it was important to – for people living with dementia to plan for the rest of their life rather than just the end of their life and that was particularly because of  
5 the potential for there to be a long period of time where the person was functionally impaired and unable to make all of those decisions for themselves. So that really required a broad focus on lifestyle as well as just specific medical treatments.

MS BERGIN: Dr Sinclair, is special attention required to be paid to potential  
10 barriers for access for those who might be unfamiliar with what an advance care plan is or reluctant to enter one?

DR SINCLAIR: Yes, and I think we should design the programs and the interventions that support this process with these groups in mind. So the particular  
15 barriers that do seem to come up often are around literacy and understanding the requirements of the forms. People often talk about medico-legal language being a difficulty for them and needing help to understand what the form requires, but also how to put their wishes into the language that they think is needed. And the practitioners I've worked with have tended to find more success when they make it  
20 more about function for the person rather than medical treatment. So what about a situation where you couldn't walk, you couldn't talk, eat, think.

These are things that people are familiar with, they live with those experiences every day, as opposed to talking about dysphasia or immobility, those sort of medical  
25 terms. So explaining it in a way that people can understand and then assisting them in the process of expressing their wishes. And sorry if I can just add one more thing.

MS BERGIN: Yes, please continue.

DR SINCLAIR: It's also – you know, for these groups who are potentially facing  
30 barriers to engaging, I think it's really important to not see it as a one-off event. For example, at the time of admission to residential care is sometimes seen as a sentinel event where advance care planning might be raised. And if the person expresses concern at that point it doesn't mean that they're not going to not want to do it ever  
35 in the future. It might come up in six months time with the hairdresser and so people who that person is really comfortable with will probably get the signals as to, you know, the person expressing some wishes and need to be able to respond to those.

MS BERGIN: Thank you. What is important for culturally diverse communities?  
40 Are there special or additional barriers for access to advance care planning for those communities?

DR SINCLAIR: It is something that has been explored in the literature and I think it's really important in just – I will just put a few caveats on what I'm saying, and the  
45 first is that we all have culture, not just culturally diverse communities. I guess for those of us in the cultural mainstream, we sometimes don't notice the things we take for granted which are actually cultural beliefs, that inform what we think is

appropriate and our values, and also that we're more than our culture. So there's significant variation within cultural groups and we can't sort of set stereotypes or generalise. And finally, that even where advance care planning is, you know, has a lower prevalence for a certain cultural group it doesn't necessarily mean that it's an insurmountable cultural barrier, if you like.

I mean, it could be associated with that group's lesser access to education, migration experiences potentially, or trust in institutions which are potentially modifiable factors. Having said that, there is a pattern in the literature that suggests that cultural minority groups tend to engage in advance care planning less and they certainly seem to have less, lower rates of documentation of formal advance care directives and that has been explained with reference to language barriers and also in some cases taboos about discussing the topic of dying. So in some cultural groups that's seen as not appropriate.

And I think more broadly, if we think about collectivism as an idea where there's a process of a preference for making decisions as part of a family or a community, rather than as an individual, that feeds into this as well, and it does require the advance care planning process to be broad, flexible and responsive, rather than focusing on a legal document written by an individual.

MS BERGIN: Thank you, Dr Fisher. Your statement refers to Dutch and Italian communities, and the Royal Commission is interested in this research in the sense that post-World War II migrants are now – the first wave after World War II are now entering aged care. What research have you been involved in?

DR SINCLAIR: Yes. So that work was – I mean, as a social scientist, there's often – it's quite rare that I'm able to, you know, conduct experiments or manipulations, I guess, to test things, but we can observe things, patterns in the environment in society and compare and contrast. And these are two groups who are prominent migrant groups in the area that I was researching and they also have interesting differences in terms of how their particular nations and societies have progressed along these lines. So the Dutch system is seen as one that's highly geared towards individual autonomy. There's legal support for advance care directives, there's also legal support for euthanasia in the Netherlands. And these people who came to Australia came in large numbers after World War II.

In the Italian context, there's, I think, a range of economic development across the country and it tends to differ from the north to the south. There's much greater focus on family-based decision-making and there's relatively less use of residential care because family groups tend to live very close together. Children often don't move far away from their parents and it's quite normal and appropriate for older people to live with their families and to be cared for at home. So these groups were interesting in their difference and when we interviewed migrants from these groups in Australia, we certainly saw differences in how they felt about advance care planning and they were along those lines of the preference among the Italian groups in general for more family-based approaches to decision-making.

But this was also tempered by their experiences as migrants and so some people talked about, you know, experiences of internment in the Second World War or experiences in Europe in the Second World War and those leading to long-term effects on their trust in institutions. And there was also, you know, a desire for some people to actually migrate back to their native country as well. So it really brought up a range of issues that we weren't otherwise aware of.

MS BERGIN: Dr Sinclair, sometimes you hear it said in reading about advance care planning, the earlier the better. Is that your view; when is it timely to consider supported decision-making as part of advance care planning?

DR SINCLAIR: I think if we're going to do – I heard you mention both of those concepts there, supported decision-making and advance care planning. I think both of them, if they're going to be done well, people need access as early as possible. For many people who are in aged care and living with a cognitive impairment of some sort, that progress over time will make it more difficult to fully engage in the process, so the earlier that we can start the better. I think also we need to look at key events in a person's care trajectory as well as times to revisit these discussions as well. The supported decision-making work does need to be more tailored and intensive for people as they – as their impairments increase and so what we saw when we talked with people living with dementia about supported decision-making was that it actually brought up a range of relationship issues.

It wasn't just a matter of providing some practical assistance with getting something done, just the idea of opening up to receiving some help from, say, a family member or a care provider required a lot of trust and familiarity and really hinged on the quality of that relationship with the person. So if we are going to be promoting this, I think we do need to do it in a way where we can support all of the people involved and give them time to develop that relationship and work together in a productive way.

MS BERGIN: Dr Sinclair, what are the risks associated with advance care planning?

DR SINCLAIR: I think there are some risks and in general advance care planning would be consistent with the idea of person-centred care in its best form. It is a way of implementing person-centred care. There are some risks in the sense of premature implementation and that's, I think, particularly an issue where you have a system that is under stress in terms of providing services and care and people are rushed for time, and that if an advance care planning has been written down it sometimes becomes then more convenient to just go to that rather than to talk to the person, and see if they can understand the issue in the moment and assist them to make that decision. So there is that issue.

I think there's a risk around it becoming something that's systematic and enforced as opposed to being really an instrument for a person to express their own wishes, and that can really become an issue at key care transitions. So when it becomes

something that is part of the system, if it doesn't have flexibility, it then, you know, becomes something that adds to the stress of a care transition, rather than reflecting the person wanting to go through that process. An example, and this is in the area of financial planning, but there are aged care facilities where they will require an  
5 enduring power of attorney to be set up before they will admit the person into residential care and I think that that is actually missing the point of – of the person expressing their own wishes, one of which could be I want to make my own decisions at this point in time.

10 MS BERGIN: Dr Sinclair, is there a risk that an advance care plan could be used in ways that are inconsistent with a person's rights?

DR SINCLAIR: Yes. Yes. I think there are. And – and that needs to be monitored in terms of the quality of the discussion at the time the planning is taking place and  
15 having some mechanisms for overseeing it. Currently that's predominantly through the witnessing requirements for advance care directives and also then the recourse to tribunals in the case where a person involved in that person's care is expressing some concern that, for example, a substitute decision-maker is making decisions that don't seem to be reflecting the person's wishes or aren't ideal in their best interests.

20 MS BERGIN: Thank you, Dr Sinclair. We've asked all the witnesses that have appeared in this Royal Commission to come along with a wish list for improvement to the system; what do you have on your wish list?

25 DR SINCLAIR: Okay. Thanks. Some of these will just sort of deal with the issues that I've talked about already, but I think we do need – in advance care planning we do need to start early, maintain a broad focus and be ready when the person is ready. So that doesn't sound really like a specific wish but it asks the system that is  
30 implementing advance care planning to be able to be responsive and flexible to the person's needs, and also that this becomes embedded across the whole system, and part of the culture of wanting to know what's important to the people who are receiving care rather than just doing it to avoid issues or disputes, and, you know, to make things easier for the – for the practitioners.

35 I would like to see training and resourcing for advance care planning and I think a particular area where we can have a good deal of impact there is around the Medicare item billing for GPs to actually have the time and to be reimbursed for their time in broaching advance care planning discussions and assisting patients. The systems for  
40 storing and communicating advance care planning are not well developed so, you know, I mean, I'm talking from personal experience here but having recently moved interstate my advance care directive, I need to review that and also make my own efforts to then make that available within the system that I'm now living in. So there's no national system. There's even very minimal in terms of local and State-based systems for registering advance care planning and that was something that did  
45 come up in the elder abuse inquiry from the Australian Law Reform Commission.

And my final wish, it's the fourth one but it's the biggest one, so maybe it counts for two, is about national consistency in this area. So there are significant barriers for people in terms of engaging with this issue because of the complexity of the laws being different across different States and that becomes actually I think a risk of  
5 harm to the person when they live near State boundaries and are receiving care across State borders. It's also very difficult for people when they move interstate. And in terms of generating resources, a lot of the time is actually spent making the resources to – that are supposed to assist the community relevant to each of the seven jurisdictions rather than having something that could be generic across all  
10 jurisdictions.

And so I would propose to the Commission that the Australian Law Reform Commission's national decision-making principles, which were raised in their 2014 report on equality, capacity and disability in Commonwealth laws would be a very  
15 useful model for working towards consistency in our laws that would relate both to supported decision-making and also advance care planning and substitute decision-making. And also that bodies like Advance Care Planning Australia – I have to disclose that I'm involved in that group – but that's a non-government body that has an Australia-wide focus and is potentially well-positioned to provide resources and to  
20 be, I guess, a way of upskilling the community as a whole and moving towards a consistent approach to practice as well as just at the legal level, so a big one. Yes.

MS BERGIN: Thank you very much, Dr Sinclair. Commissioners, that concludes my examination of this witness.  
25

COMMISSIONER TRACEY: Dr Sinclair, thank you very much for sharing with us your deep learning and research results in the area of advance care planning. It is plainly an area that we're going to have to consider and that the community will need to come to grips with in forthcoming years. And the evidence that you've provided  
30 this afternoon will be of great assistance to us when we come to make our recommendations. Thank you very much for coming.

DR SINCLAIR: Thank you.  
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**<THE WITNESS WITHDREW [5.19 pm]**

COMMISSIONER TRACEY: 9.30?  
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MS BERGIN: 9.30. Thank you very much, Commissioner.

COMMISSIONER TRACEY: The Commission will adjourn until 9.30 tomorrow morning.  
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**MATTER ADJOURNED at 5.19 pm UNTIL THURSDAY, 27 JUNE 2019**



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