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TRANSCRIPT OF PROCEEDINGS

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

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

PERTH

9.34 AM, 27 June 2019

Continued from 26.6.19

DAY 29

**MR P. ROZEN QC, counsel assisting, appears with MR P. BOLSTER,
MS E. BERGIN and MS E. HILL
MR S. FREE SC appears for the Commonwealth
MS J.K. TAYLOR appears for Mr Leong
MR GILES appears for Mr Cohen**

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

MR ROZEN: Good morning, Commissioners. Before I open the Alkira Gardens case study, there are some appearances to be announced, Commissioners.

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MS J.K. TAYLOR: Commissioners, my name is Taylor, I appear for Mr Leong.

COMMISSIONER TRACEY: Thank you.

10 MR S. FREE SC: If the Commissioners please, Free, I appear for the Commonwealth which has leave to appear.

COMMISSIONER TRACEY: Yes, Mr Free, welcome back.

15 MR GILES: If it pleases the Commission, Giles, I appear for Mr Cohen.

COMMISSIONER TRACEY: Thank you.

20 MR ROZEN: If the Commissioners please. Shannon Ruddock lives in Sydney with her husband and two young children. Mrs Ruddock is the youngest child of the late Marilyn and the late Vincent Paranthoienne. Shannon Ruddock contacted the Aged Care Royal Commission through a public submission using the Royal Commission's website. She did so because she was concerned that her late father did not receive adequate or quality palliative care. I will shortly call Shannon Ruddock as the first witness in this case study.

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Ms Ruddock's mother passed away from cancer in 2006 in Calvary Hospital in the Sutherland Shire of New South Wales. Ms Ruddock's parents had been married 35 years at the time of her mother's death.

30 Ms Ruddock will share her family's experience with the Commission. She will give evidence about the steps she took to try and protect and care for her father and the impact this had on her and that effect is ongoing. After suffering a stroke at the end of January 2017, Ms Ruddock's late father, Vincent Paranthoienne moved from living independently at a retirement unit and into residential care and ultimately to Alkira Gardens in the Sutherland Shire of New South Wales. Mr Paranthoienne initially entered Alkira Gardens in April 2017 for respite but he became a permanent resident there in June 2017. During his time at Alkira Gardens, Mr Paranthoienne developed a large and painful lump on his chest near where he had previously broken some ribs. This was originally misdiagnosed in August 2017 as a haematoma. I should indicate that no criticism will be made of any medical practitioner in relation to that diagnosis for reasons that will become apparent.

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45 On 3 September 2017 Ms Ruddock and her sister took their father out for lunch for Father's Day. Ms Ruddock had not seen her father for a few weeks. She saw a noticeable decline in her father's presentation. She will describe him in her evidence as yellow in colour, and having lost a lot of weight. She took her father to the

emergency department of a hospital the following day. He was admitted, further scans of his chest and a biopsy led to the late Mr Paranthoienne being diagnosed with a malignant spindle cell tumour. The malignancy was advanced and Mr Paranthoienne was given a poor diagnosis. He was referred to the palliative care team at the hospital in preparation for his discharge back to Alkira Gardens. The hospital's discharge plan was sent to Alkira Gardens.

Our case study will focus on the period following Mr Paranthoienne's return to Alkira Gardens. Ms Ruddock will give evidence in that regard that she was concerned that her father's needs, particularly around his level of pain assessment and management and pain relief were not adequately managed by Alkira Gardens after her father's return on 18 September 2017. Josh Cohen of the community palliative care team at Calvary Health Care in Kogarah saw Mr Paranthoienne at Alkira Gardens on 20 September 2017. And Commissioners, you will be hearing from Mr Cohen who at the time was a transitional nurse practitioner and is now a fully endorsed nurse practitioner. His role was effectively as a consultant to Alkira Gardens, consulting to assist Alkira Gardens to understand what Mr Paranthoienne's palliative care needs were and how they could best be addressed.

He made recommendations to Mr Paranthoienne's GP at Alkira Gardens in relation to medication and pain relief. The GP attended on Mr Paranthoienne and prescribed certain pain medication. Mr Cohen will explain the role of the Calvary community palliative care team in relation to the delivery of palliative care in residential aged care facilities, and he will explain that about six months after these events his employer adopted a new model of care which he will be detailing for the Commission's benefit. Mr Cohen attended upon Mr Paranthoienne again on 27 September 2017 and he provided updated guidance on prescriptions for Mr Paranthoienne's pain management. He will give evidence about the steps he took in respect of the care of Mr Paranthoienne and, as I've indicated more broadly, about the role of the specialist palliative care provider working in an aged care setting.

John Leong is the compliance and development officer of The Sisters of Our Lady China Health Care Proprietary Limited. Our Lady of China, as that company will be referred to, operates the residential aged care facility, Alkira Gardens. Mr Leong has been employed by Our Lady of China since 2007 and has been involved with Alkira Gardens since it opened on 1 June 2015. He will give evidence about the care that Alkira Gardens provided to Mr Paranthoienne during the time that he was a resident at the facility and in particular he will address the provision of palliative care by Alkira Gardens to Vincent Paranthoienne. He will explain that he had no personal involvement in the delivery of that care. A little bit like case studies that the Commission has heard in Sydney, his evidence will be primarily based on his reading of the records that were maintained by the staff that were involved in the care. Most of those staff members are no longer working at Alkira Gardens and that's another matter that he will be asked about in his examination.

Commissioners, in this case study we will in summary explore, A, whether there was palliative care plan for Vincent Paranthoienne at Alkira Gardens; B, whether there

was adequate communication between Alkira Gardens, Vincent Paranthoienne and his family about the provision of palliative care services to Mr Paranthoienne, and we will explore whether Mr Paranthoienne's pain assessment and management were adequate and in particular whether the clinical governance arrangements at Alkira Gardens
5 were adequate. Commissioners, at this point I tender the Alkira Gardens case study tender bundle.

COMMISSIONER TRACEY: Yes, the Alkira Gardens tender bundle will be
10 exhibit 5-31.

EXHIBIT #5-31 ALKIRA GARDENS TENDER BUNDLE

15 MR ROZEN: The Commission please. The Commissioners will in due course see there are a lot of detailed progress notes maintained by nurses and care workers and others at Alkira Gardens included in the tender bundle. What the staff of the Commission in cooperation with lawyers representing Alkira Gardens have sought to do is to pull as much of that material together in the form of tables to be of assistance
20 to the Commission, summary tables which we would seek to hand up, each as an aide-mémoire for your purposes, rather than as an exhibit, the purpose being, as is probably obvious, to assist in understanding the material without necessarily have to wade through a lot of the documents in the form of progress notes.

25 So I can hand up at the moment two documents which those instructing me will ensure are in front of you. I'm grateful to Ms Hill. Once they're in front of you I will explain briefly what they are. Thank you. We're just handing them down the bar table. As I say, they've been the subject of detailed consultation and I should indicate on the record our gratitude for the cooperative spirit within which this has
30 been approached by the legal representatives of Alkira Gardens. So in no particular order – and I'm not sure which is on top in the pile – one of them is headed Alkira Gardens Case Study: Record of Regulatory Action, and that probably speaks for itself. It's a list of dates with events and cross-referencing to the tender bundle. There was significant regulatory input at Alkira Gardens, not solely related to this
35 case. In fact, there were other areas that were explored by the regulators. That material is all in the tender bundle and will be the subject of some brief reference in the course of the case study today.

The second document is headed Alkira Gardens Case Study: Chronology of Events,
40 and that is, as it describes, an attempt to just summarise the various steps that saw Mr Paranthoienne move from different hospitals back into Alkira Gardens, back to hospital, ultimately passing away on 16 November 2017 at a hospital. So I hope those documents are of some assistance to the Commission. And there is the third document which is a summary of the medical records, and I'm instructed that that's,
45 whilst it's agreed, we don't physically have it with us at the moment. It's being printed; it should be here shortly. When it is, I will make sure that that ends up in front of you. Commissioners, at this point I call Shannon Ruddock.

<EXAMINATION-IN-CHIEF BY MR ROZEN

5

MR ROZEN: Ms Ruddock, can you please state your full name for the transcript.

MS RUDDOCK: Shannon Marie Ruddock.

10

MR ROZEN: Thank you. Ruddock is the correct pronunciation, or – because I'm always saying Ruddock.

MS RUDDOCK: Ruddock. Ruddock.

15

MR ROZEN: Whatever suits you.

MS RUDDOCK: Ruddock.

20

MR ROZEN: And, Ms Ruddock, for the purposes of the Commission, have you made a witness statement dated the 31st of May 2019?

MS RUDDOCK: I have.

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MR ROZEN: All right. Is there a copy of that statement in front of you?

MS RUDDOCK: There is.

30

MR ROZEN: It's WIT.1132.0001.0001. Have you had an opportunity to read through your statement before coming along this morning to give evidence?

MS RUDDOCK: I have.

35

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

MS RUDDOCK: No, there's not.

MR ROZEN: All right. Are the contents of your statement true and correct?

40

MS RUDDOCK: They are.

MR ROZEN: Okay. I tender the statement of Shannon Marie Ruddock dated the 31st of May 2019, Commissioners.

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COMMISSIONER TRACEY: Yes, the statement of Shannon Marie Ruddock dated the 31st of May 2019 will be exhibit 5-32.

**EXHIBIT #5-32 WITNESS STATEMENT OF SHANNON MARIE RUDDOCK
DATED 31/05/2019 (WIT.1132.0001.0001) AND ITS IDENTIFIED
ANNEXURES**

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MR ROZEN: Commission pleases. Now, Ms Ruddock, I will ask you, please, to keep your voice up, essentially, because we've got some background noise from some of the equipment here, and if your voice drops off at any time, I might just gently remind you, if that's all right - - -

10

MS RUDDOCK: Okay.

MR ROZEN: - - - to try and speak loudly.

15

MS RUDDOCK: I'll move this closer too.

MR ROZEN: At the moment, it's absolutely fine, I should say.

MS RUDDOCK: Okay.

20

MR ROZEN: All right. Now, you made a submission to the Royal Commission about your experience involving your late father.

MS RUDDOCK: I did, yes.

25

MR ROZEN: All right. And we might just start by asking you a little about – a little bit about your childhood and your mother and father. Where did you grow up?

30

MS RUDDOCK: So I grew up in a suburb called Engadine in Sydney – in the south of Sydney.

MR ROZEN: Yes.

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MS RUDDOCK: We grew up in a pretty modest home. My mum and dad were – both had not finished high school, but worked very hard to give us a good life. I'm the youngest of three children. I have an older brother and an older sister. My parents also had another child, their second child who died of cot death at six months old, so that was a source of a lot of sadness for my parents. But we – you know, we generally, had a pretty good, happy life. My – you know, I spent a lot of time with my dad doing water activities. My dad had been a commercial abalone diver in his

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twenties and thirties in the south - - -

MR ROZEN: Yes.

45

MS RUDDOCK: - - - of Australia in Victoria and South Australia, and – and even though he wasn't doing that when I was a child, he still had a love of the water. So

even though we didn't live that close to the beach, it was about a half an hour drive, we – the beach was a big focus of our – of our life - - -

MR ROZEN: Yes.

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MS RUDDOCK: - - - and, in particular, for me and my father, I would spend a lot of time going on diving trips with him to catch fish and abalone, hiking through the national park to places that he knew had good fish and abalone and – and I would do those trips with him, snorkelling beside him. We also did a family holiday every
10 year camping which was a lovely experience. We went with the same group, same families and we'd go for three or four weeks and, again, more fishing, more diving, more catching abalone. So it was – you know, it was a happy Australian childhood.

MR ROZEN: You took the words out of my mouth. Now, we've got a photo here,
15 tab 21 in the tender bundle which I will ask to be brought up on the screen. No, sorry. That – can we remove that. Sorry. I'm sorry. It's tab 9. Can you tell us when this photo was taken.

MS RUDDOCK: This photo was taken, I believe, at the end of April. My dad had
20 just – had been at Alkira Gardens for probably a week by this point, so - - -

MR ROZEN: April 2017.

MS RUDDOCK: 2017, sorry.
25

MR ROZEN: Yes. Yep.

MS RUDDOCK: This is actually in the car park of the Alkira Gardens facility as
30 we – I was taking my father to a funeral for a family friend. So he – he was – you know, he was still quite skinny at this point. He'd not been long out of hospital and – but he was recovering and he was doing pretty well.

MR ROZEN: Right. Thank you. We will come back to that period and we will talk
35 about that in a little bit more detail in a moment. So after the three children left home, your parents lived together for some time; is that right?

MS RUDDOCK: That's right, yes.

MR ROZEN: And where were they when you'd all left?
40

MS RUDDOCK: They were still in our house in Engadine, but they did move – I
45 can't remember – probably about a year or two after I left home, they moved down to the south coast of New South Wales. My mum had been diagnosed with terminal cancer, and she retired and they decided to move down the south coast so they could be without a mortgage and just have some – a nice retirement together for as long as they could.

MR ROZEN: Your father had also retired at that point.

MS RUDDOCK: He did, yes. He'd retired about a year before that, but - - -

5 MR ROZEN: Right. I neglected to ask you - - -

MS RUDDOCK: - - - it was around about that time.

10 MR ROZEN: - - - a little bit more about your father's work. You told us that he did some abalone diving - - -

MS RUDDOCK: Yes.

15 MR ROZEN: - - - at one point. What other work did he do/

MS RUDDOCK: From what I can remember, he was a plumber's assistant at one point.

20 MR ROZEN: Yes.

MS RUDDOCK: As a child, he actually grew up helping his father with the family roofing business. So he put the roof on a lot of places in and around where we lived.

25 MR ROZEN: Yep.

MS RUDDOCK: And he also – before he retired, he was a community bus driver for aged care facilities.

30 MR ROZEN: Now, you told us a moment ago that your Mum was diagnosed with terminal cancer. That was in 1998. Is that right?

MS RUDDOCK: Yes. Yes. She was initially diagnosed with cancer in 1996 - - -

35 MR ROZEN: Yes.

MS RUDDOCK: - - - but we realised that she hadn't recovered from it and it was terminal in 1998.

40 MR ROZEN: Yes. And, ultimately, she passed away in 2006.

MS RUDDOCK: That's right, yes.

45 MR ROZEN: And can you tell us a little about the circumstances. Was that quite sudden?

MS RUDDOCK: She – she – in some ways, yes.

MR ROZEN: Yes.

MS RUDDOCK: It's hard to explain that to people when we knew that she had terminal cancer, but - - -

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MR ROZEN: Yes.

MS RUDDOCK: - - - she was living – she was quite healthy for quite a while after her diagnosis, and about two and a half months before she passed away, she – her colour began to change and she lost some weight. We realised she had some digestive issues, and she went into hospital and they discovered that the tumour had spread to her pancreas. The plan was for her to go in for day surgery to have a stent put in to enable her to still eat and digest food for a period of time, but she never actually came out of hospital. So her condition deteriorated. So she remained – she was at St George Hospital as well. She remained there for about two months, and then about three weeks before she passed away, she was transferred to Calvary Hospital when it became apparent that she was – she was quite terminal and was probably going to die soon.

20 MR ROZEN: And that's Calvary Hospital in Sydney.

MS RUDDOCK: That's right, yes.

MR ROZEN: In what suburb is that - - -

25

MS RUDDOCK: It's actually in Kogarah.

MR ROZEN: In Kogarah.

30 MS RUDDOCK: It's not in the Sutherland Shire. It's just outside - - -

MR ROZEN: Yep. Okay.

MS RUDDOCK: - - - the Sutherland Shire, yes.

35

MR ROZEN: And was that at the request of the family that she was transferred to Calvary, do you recall? Or was that – how did that come about?

MS RUDDOCK: It – my – my mum had been living down the south coast, and so she had an – an oncologist down there, but we managed to treat her old oncologist who did treat her when she lived up in Sydney, and she came to see Mum and – and decide – and – and – and suggested that mum was move down to Calvary Hospital at that point. So that was – that was how that happened. I – I don't – I was – I was only 28 at the time and because my dad was alive, he did a lot of the planning and care for my mum. So I wasn't really across all those decisions at that time, but - - -

45

MR ROZEN: Yep.

MS RUDDOCK: - - - that's my understanding of what happened.

MR ROZEN: Okay. And were you able to spend some time with your mum in the last weeks of her life - - -

5

MS RUDDOCK: Yes.

MR ROZEN: - - - in Calvary Hospital.

10 MS RUDDOCK: Yes.

MR ROZEN: How often would you – do you think you'd visit her at that time?

15 MS RUDDOCK: Probably every day, maybe every second day, sometimes. I was working at the time, but most of the time every day.

MR ROZEN: Yep. And what, in general times, was that experience – how – I mean, obviously, it was a very sad time in your life.

20 MS RUDDOCK: Yes.

MR ROZEN: In terms of the care that she received and that you saw, how would you describe the experience?

25 MS RUDDOCK: It was actually quite a nice experience, if I can say that. It was terribly sad, but it – the hospital itself just had a great atmosphere. They had a lot of private rooms for patients. Their staff just had such excellent knowledge of death and dying and what to expect. They could tell us things about – to look out for in terms of helping my mum. In the last – in the last week of her life, she was
30 unconscious and, you know, for example, they – they would tell us how to tell if she was in pain. For instance, if we went in and we picked up her hand and she resisted us, she was possibly in pain, and so we were instructed if that happened, we should go and see a doctor or a nurse and ask them to give her some more pain relief at that time.

35

Also, I mean, you are – we – on that level at Calvary Hospital, everyone is dying, and so there are a lot of family members visiting, and so we'd go into the tea room with the other families that we got to know over that time, and I suppose we could chat to them about our experiences. My mum had actually befriended a lady in St
40 George Hospital who ended up in Calvary Hospital. So we chatted to her family quite a lot, and they actually passed away on the same day. So I think, really, overall, it was just – it was a lovely quiet atmosphere. The staff are very knowledgeable. There are a lot of staff around. I really felt like she was well cared for. We didn't have to pre-empt anything. You know, the nurses and doctors would
45 come in to, you know, do mouth care and turn her and give her her medication. So I felt like we – she was in good hands and we – all we – all we had to deal with was – was our grief, not anything else.

MR ROZEN: Yes. Yes. What were the implications for your father's situation of your mother's passing? What then happened with your dad?

5 MS RUDDOCK: So my dad was devastated and remained so until he passed away. He – sorry. He remained living in his house down on the south coast for about a year afterwards, and then between my siblings and I, we decided to move him up to Sydney. He lived with my sister and her family for a period of time. We sold his house down there. We needed to get him back in his community where he had friends around him - - -

10 MR ROZEN: Yes.

MS RUDDOCK: - - - and family around him. So – so that – he – he lived there with my sister and her family for about five years, and then – and then for various reasons, we had to move him out of that house and into a new place. We moved him into an over 55s villa not far from there so he could still stay close to his – my niece and nephew and my sister and her husband and – and also his – his family and friends – well, his sister and his friends as well.

20 MR ROZEN: Yes. And the over 55 villa was in a retirement village. Is that the right term for it or - - -

MS RUDDOCK: No.

25 MR ROZEN: No.

MS RUDDOCK: It was just an apartment block where - - -

30 MR ROZEN: Okay.

MS RUDDOCK: - - - you have to be over 55 to live in there.

MR ROZEN: Yep.

35 MS RUDDOCK: So most people over 70. We wanted him to be in an environment where it could be a quiet environment, and he wasn't at risk of being – sharing an apartment with 20 year olds who were going to have loud parties. So that's why we made that decision.

40 MR ROZEN: All right. And how would you describe your father's general health at that – in – during that period?

MS RUDDOCK: Yes, he was in good health.

45 MR ROZEN: Yep.

MS RUDDOCK: He – you know, probably, his biggest concern was his depression. He – he'd suffered from depression most of his life, and that had become worse after my Mum died, but he – he was – and – and he also had type 2 diabetes which was relatively well managed, but he – he would go out every day. He befriended lots of
5 people in the local coffee shops. He caught up with friends, he would drive – I was 45 minutes away from him. He'd drive over to see me. I would drive over to see him. He was totally independent and – and in good health.

10 MR ROZEN: He was living alone, which was significant when he had a stroke - - -

MS RUDDOCK: That's right.

MR ROZEN: - - - in early 2017.

15 MS RUDDOCK: Yes.

MR ROZEN: And it was sometime before the family became aware that he had - - -

20 MS RUDDOCK: Yes. Sadly, that's true.

MR ROZEN: - - - a stroke; is that right?

MS RUDDOCK: That's true.

25 MR ROZEN: Yes.

MS RUDDOCK: Yes. I was away on a holiday with my family and – and my dad – we don't know how long he'd been there for. It was up to two days he was in the apartment on his own after having a stroke. We know he'd seen people on the
30 Friday, and he was found, I believe, on the Sunday, the Monday – can't remember.

MR ROZEN: And he was hospitalised.

35 MS RUDDOCK: Yes.

MR ROZEN: St George Hospital, at that time.

MS RUDDOCK: Yes.

40 MR ROZEN: And he remained there for some – some months - - -

MS RUDDOCK: That's right.

45 MR ROZEN: - - - whilst he recovered.

MS RUDDOCK: Yes.

MR ROZEN: And, unfortunately, whilst he was in hospital, he had a fall and broke several ribs; is - - -

MS RUDDOCK: That's right.

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MR ROZEN: - - - that right?

MS RUDDOCK: Yes. He – he got out of bed at night time and fell and broke those ribs, yes.

10

MR ROZEN: And, presumably, part of the reason for the length of time he was in hospital was that the ribs had to heal as well, I suppose, as well - - -

MS RUDDOCK: That actually wasn't the case.

15

MR ROZEN: Okay.

MS RUDDOCK: He – he initially was in hospital doing a lot of rehabilitation. He lost – as a result of the stroke, he'd lost – he was unable to walk and he'd lost movement on his right side of his hand, and so most of his time at St George Hospital was recovering from the stroke. The – he broke his ribs only – probably about two to three weeks before he left the hospital. So that's why when he went to the nursing home and he was still experiencing pain, it – it made sense that it was the ribs that were causing him problems.

25

MR ROZEN: Yes. And talk us through the family decision-making when he was to be discharged from hospital in April of 2017. What options did you consider about how to care for your father?

30

MS RUDDOCK: Right. So we considered – we knew that we needed to move him into a residential aged care facility. My sister and I, neither of us had a house that could – where he could live and be able to move around. So we – I initially considered moving him close to me. I was 45 minutes away from where my dad was living before he had his stroke. But we ultimately made a decision to keep him down in the Sutherland Shire in his community so that his family and friends could visit him, which they did do. It was – it was a very difficult decision as to which aged care facility to put him in.

35

MR ROZEN: Yes.

40

MS RUDDOCK: I feel like they're – you have to go by word of mouth as to whether a place is good or not. And also the hospital told us that he had to leave within a relatively short space of time. They did allow us time to find a facility but we really just felt like we were doing this quite blindly. We initially moved him into one facility, which I'm not naming, and it was a for profit facility in the area. He – he was quite lonely there. He – that facility mixed a lot of the advanced dementia patients with people who were still of quite good cognition, and I think there was a

45

shock for my father. It was a very busy facility. They – you needed a swipe pass to get between floors and – so it wasn't easy for him to get to the activities that the facility had on at the time and so he largely felt quite lonely and forgotten at that facility so we decided to move him.

5

We decided to move him to Alkira Gardens. We had heard good recommendations from a few different sources about Alkira Gardens, from our financial planner, from family friends in the area. Another friend told me a nurse that she knew had worked there and had recommended it as a good facility. So we – my sister actually went and visited that facility at the time and – and we agreed to move him there.

10

MR ROZEN: In relation to the information sources that were available to you in helping you to decide where to move your father, did you at any point consult the My Aged Care website?

15

MS RUDDOCK: I believe I did, but I was really looking for reviews and recommendations, and you don't find that on the My Aged Care website. I did look at the My Aged Care website, but it gave me an indication of what facilities there were in the area.

20

MR ROZEN: Yes.

MS RUDDOCK: But in terms of providing any real information that I was looking for, that's all it provided for me. I was looking for recommendations.

25

MR ROZEN: Okay. So some sort of indications of quality, presumably.

MS RUDDOCK: Yes.

MR ROZEN: Do you think a publicly accessible government-endorsed website that provided that information would be of assistance to people?

30

MS RUDDOCK: That would be very helpful. I think it would be difficult to do because people's experiences are subjective, I suppose, but it would be helpful, yes.

35

MR ROZEN: In the absence of that, you were reliant on word of mouth from friends and colleagues and family.

MS RUDDOCK: Yes.

40

MR ROZEN: So initially your dad went into Alkira Gardens for respite.

MS RUDDOCK: Yes. That was just while we got his financial – financials in order. The plan was always for him to go in there permanently, but he was in there on respite initially.

45

MR ROZEN: For some time, from April till about June?

MS RUDDOCK: Yes.

MR ROZEN: The paperwork wasn't actually finalised until July, but from June onwards he was a permanent resident there.

5

MS RUDDOCK: That's correct.

MR ROZEN: Of course, at this time there was no sense in which he was palliative.

10 MS RUDDOCK: No.

MR ROZEN: That wasn't the treatment – the care that he was receiving.

MS RUDDOCK: No.

15

MR ROZEN: And had he recovered? How would you say he had recovered from the stroke? He wasn't fully back to his pre-stroke self or - - -

MS RUDDOCK: No, he wasn't fully back to his pre-stroke self, but I don't think he
20 ever was going to be. He was walking with a walking frame. He was able to move
around. He – his cognition had been affected but it was – he was still – he still had
pretty good cognition. His short and long-term memory was still quite decent. He –
we got a phone connected in his room. He would pick up the phone and call people.
25 We had phone numbers beside the phone for him, and he would call people to chat to
them. He made friends with people in the facility. He participated in the activities
and he was – he was in pretty good shape given he had had a stroke, yes.

MR ROZEN: That sort of activities did they have that he enjoyed participating in?

30 MS RUDDOCK: Mainly internal activities that I know that he participated in. I
know they did do a couple of external activities. I'm not sure if he went on those.
Things like they would have a singer come in and sing. They had pets, dogs come
and visit the facility. They would take residents out to the garden and – I'm not sure
35 what activities, but they would take the residents out to the garden. But mainly it
was – and mainly it was also the church service that the facility provided. The sisters
from the order would come in and – and chat to the residents and I know my dad
really enjoyed that.

40 MR ROZEN: All right. I meant to ask you about that. Was your dad a religious
man?

MS RUDDOCK: We – he was a lapsed Catholic but after his stroke I think he – in
hospital he had been – my sister must have written down that he was a Catholic
because we had Catholic people come and see him in hospital, and he enjoyed that
45 attention and that spirit – spirituality that they brought with the visits that they gave
to him. So I think as his health was failing, it was something that became more
important to him.

MR ROZEN: Yes. Was it part of your decision-making in relation to Alkira Gardens that spiritual dimension?

5 MS RUDDOCK: In some ways. It wasn't really part of my decision-making but when I knew it was a Catholic facility I thought yes, I think – that just gave me some extra confidence that I thought he would be happy there.

10 MR ROZEN: Right. Okay. And to your knowledge how often did the nuns come in; was it once a week? Is that how it worked or more frequently, do you know?

MS RUDDOCK: So there was a bi-weekly church service but then on the other weeks there was some kind of religious activity so I'm not sure whether nuns came in every week or every fortnight but they were there regularly. I saw them on a few occasions.

15 MR ROZEN: And on average how often do you think you were visiting your father at this time?

MS RUDDOCK: At this point maybe twice a week, maybe three times a week.

20 MR ROZEN: Right. And did that become more frequent at a later period?

MS RUDDOCK: Yes, yes.

25 MR ROZEN: Yes. All right. We'll come to that in a moment. Now, in July, 11 July you tell us in your statement, you first noticed a lump on your Dad's chest.

MS RUDDOCK: Yes.

30 MR ROZEN: Do you want to just tell the Commissioners about that, what were the circumstances?

MS RUDDOCK: I came in to visit my father to take him to a friend's funeral. I brought him some clothes to get him changed, and when I took off his shirt I
35 discovered that he had developed a lump over the site of where I believe his ribs had broken. It was quite significant in size, and so I immediately went down to the nurses' station on that floor and – and asked whoever was there to come and have a look. I know that – I'm not sure if it was a registered nurse or what the qualifications of that person was, but someone came up. The physiotherapist came up to take a
40 look at it. People were feeling it. I could notice that he was a little uncomfortable and in pain when they touched it, but it was certainly something that I hadn't seen, probably two – what was it, two to three months prior, when I – when this photo was taken when I had also taken him to a funeral. So it was something that had grown in a very short space of time. And I dressed him and we agreed that a doctor would
45 come and visit him that evening after I brought him back from the funeral.

MR ROZEN: Okay. There was – sorry, I withdraw that. There was also a noticeable loss of weight at this time with your father.

MS RUDDOCK: Yes.

5

MR ROZEN: That was something that was clear to you.

MS RUDDOCK: Yes.

10 MR ROZEN: Can you expand on that for us? What did you observe?

MS RUDDOCK: It wasn't noticeable to my – to look at him but I dressed him in these same clothes that is he's dressed in here in this photo, and I noticed that they were bigger on him. You know, I had to tighten the belt quite a lot around his waist
15 and the shirt was – it appeared to be much larger on him.

MR ROZEN: Were you present at the facility when your father was fed at any time around this period? Were you there for meal times, I should say?

20 MS RUDDOCK: I had been there for meal times but I can't recall whether it was around this period or not, so I can't answer that question.

MR ROZEN: All right. That's okay. And were there any discussions between you or your siblings and the facility managers about the weight loss and about what was
25 causing it, what would be done about it and so on; do you remember?

MS RUDDOCK: Not with the facility managers but with the GP.

MR ROZEN: Right.

30

MS RUDDOCK: We spoke to him – I spoke to him about it.

MR ROZEN: Okay. And what was the outcome, if any, from those discussions?

35 MS RUDDOCK: The outcome was – well, it was investigated. So for a start, the GP recommended that my dad have a bedside scan to determine what this possibly could be.

MR ROZEN: Yes. This is the lump we're now talking about?

40

MS RUDDOCK: The lump, sorry.

MR ROZEN: Yes.

45 MS RUDDOCK: The lump, what that could possibly be. And from memory, I can't remember who gave me this information but it was concluded the ribs were still broken. And that the lump was probably a haematoma that had developed over the

site of the broken ribs, and the – we talked about my father being in pain and the GP suggested perhaps unmanaged pain was making him lose his appetite and causing weight loss and prescribed some high calorie drinks, I believe, around that time for my father to have at meal times.

5

MR ROZEN: And did you see your father having those high calorie drinks at any time?

MS RUDDOCK: No.

10

MR ROZEN: Okay. You're not saying he didn't, you're just saying you didn't see it?

MS RUDDOCK: Yes. I'm not saying he didn't; I just am saying I did not see that.

15

MR ROZEN: Okay. Right. And the first scan of the lump that you've just referred to, do you know what form that took? Was that an X-ray or what type of scan? If you don't know, I'm not asking you to guess.

20

MS RUDDOCK: I can't be sure. I thought it was an X-ray but I can't be sure.

MR ROZEN: Anyway, it was communicated back to you by the GP that it was likely a haematoma or a build-up of blood around the area of the broken ribs; is that right?

25

MS RUDDOCK: That's right.

MR ROZEN: Okay. And when you visited your father at this time – so we're now in about August – July/August of 2017, was he complaining of pain?

30

MS RUDDOCK: Yes, he was.

MR ROZEN: Right. And can you – was it constant or was it coming and going? How did it manifest itself?

35

MS RUDDOCK: It was intermittent, so he could be quite comfortable and then he would be sitting there quite comfortably and then be in pain in moments and it was quite significant pain that he could be in within moments.

40

MR ROZEN: Yes. And then it could pass quite quickly as well; is that right?

MS RUDDOCK: It could pass quickly, it could hang around but I think at this point it was passing quite quickly. And if my father then readjusted his position he could become comfortable again.

45

MR ROZEN: Yes. On Father's Day in 2017 which I think was 3 September - - -

MS RUDDOCK: Yes.

MR ROZEN: - - - you had arranged to have a family lunch.

5 MS RUDDOCK: That's right. Yes. I had been unable to visit my dad for about
three weeks because my husband had been sick and in hospital. So after we had been
through this process of trying to determine what this was, I felt comfortable that he
was being taken care of. My sister and I decided to take him out for lunch with our
10 children and husbands. And – and the plan was for my sister to collect him from the
facility and meet us at the restaurant.

MR ROZEN: And when you first saw your father at the restaurant, what was your
experience?

15 MS RUDDOCK: I was about 20 metres away from him. I was shocked. He looked
terrible. He – he had lost even more weight. From a distance he looked – like he
looked yellow. And I just – I said to my husband, “My God, he's dying”. I had seen
that before with my mum and I just knew.

20 MR ROZEN: Would you like a break, Ms Ruddock?

MS RUDDOCK: It's okay, I will just have a drink.

25 MR ROZEN: Are you sure? We very much appreciate how difficult this is for you
to relate to us and if at any time you want a break, there's no problem.

MS RUDDOCK: Thank you. So he – yes, he was about 20 metres away. I said to
my husband, “He's dying”. My children with me; I had a three year old and a seven
year old. I very much tried to not make it look – tried not to get upset in front of
30 them. They didn't really notice. As my sister came over to me with my father, she
said to me, “He's not making any sense either”, and that became apparent to me. We
sat him down at the restaurant. He wanted to be there with us, so we decided to go
ahead with the lunch. He was so happy to see everybody but he was a little bit
delirious. He was a bit confused at times and then at other times he would notice the
35 kids. He said to us – he said to us, “This has really lifted me up”, and just enjoyed
looking at the kids playing around but it was quite obvious to the rest of us that he
was very ill.

40 MR ROZEN: Was the afternoon cut short or what did you do in response?

MS RUDDOCK: We just – we pretended. We – we ordered lunch. We pretended
everything was okay - - -

45 MR ROZEN: Yes.

MS RUDDOCK: - - - but we noticed he was in pain. He had been given some
Panadol by the nursing staff at Alkira Gardens. I could tell he was in pain. So I

rummaged through my bag to try and find something else to give him. I had found some Nurofen so I gave him that as well. We – we – we ate and then we got him a wheelchair to take him back to the car because it was – while it wasn't very far for him to walk we felt like he was too weak to do that. So my sister took him back to the facility. In hindsight, I would have probably taken him to hospital straightaway. I think I was in shock and I wasn't making good decisions.

MR ROZEN: Yes.

10 MS RUDDOCK: We took him back to the facility. I think the plan was – it was a Sunday. I think the plan was to speak to the facility manager on the Monday and – but that night, I couldn't sleep and I woke up in the next morning, and I just – I – I just said I'm going to get him. I'm going to take him there myself. I didn't – I'd lost faith in the facility to – to do that.

15

MR ROZEN: So you went back there on the 4th on the Monday morning.

MS RUDDOCK: Yes.

20 MR ROZEN: Did you speak to the facility manager or anyone else that was in a position of authority?

MS RUDDOCK: I didn't. I don't believe I spoke to anyone in a position of authority. My – my primary reason for being there was to get my dad to hospital. So I walked in. I spoke to the nurse – whoever was at the nurses' station. I asked them to get me a wheelchair, I asked them to contact the registered nurse and – and get his records sent, brought up to the floor to give to me so I could take it to hospital with me, and – and I packed him a bag and got him ready to – to go to hospital. He was – he was in his room when I arrived that day lying on his bed. You know, all the other residents on that floor or most of the other residents that I could see were walking around and having dinner, and my dad's just lying on his bed looking dreadful. I walked in – to him, and I said, "Dad, I'm going to take to you hospital," and he said, "Thank God."

35 MR ROZEN: And you did. You took him to - - -

MS RUDDOCK: Yes. Yes.

MR ROZEN: - - - St George hospital.

40

MS RUDDOCK: Yes.

MR ROZEN: And he was there for about a fortnight.

45 MS RUDDOCK: Yeah, about two and a half weeks, I think.

MR ROZEN: Two and a half weeks at that time.

MS RUDDOCK: Yes.

MR ROZEN: And whilst he was there, there were further investigations done of the lump in his chest.

5

MS RUDDOCK: Yes.

MR ROZEN: And a biopsy was taken.

10 MS RUDDOCK: Yes.

MR ROZEN: Was that the first time that there was a biopsy taken as far as you were aware?

15 MS RUDDOCK: Yes.

MR ROZEN: And a diagnosis came back to you after that. Those investigations were conducted, that he had a – had what was described to you as a spindle cell tumour or sarcoma. Is that - - -

20

MS RUDDOCK: That - - -

MR ROZEN: - - - right?

25 MS RUDDOCK: That's correct. Yes.

MR ROZEN: All right. And what did you understand – sorry, I withdraw that. Were there – was a prognosis provided to you, what that meant for your father?

30 MS RUDDOCK: We – at that time, we were told that it was terminal. It was advanced. It was terminal. And at some stage in that time, we were told that he maybe had a couple of months – a few weeks, a couple of months to live.

MR ROZEN: I see, the people at the hospital told you that.

35

MS RUDDOCK: I believe so.

MR ROZEN: Yep. Was – he was still, of course, a resident at Alkira Gardens.

40 MS RUDDOCK: That's right.

MR ROZEN: Was there any consideration in your mind about whether the next stage of his life ought to be spent at Alkira Gardens or somewhere else? Was that something you considered as a family?

45

MS RUDDOCK: We did consider. I would have – yeah, we did consider moving him, but it's such a long and laborious process to go and find another aged care

facility, particularly at this point when we were really operating in crisis mode trying to take care of him, make sure that he was – you know, that he was comfortable - - -

MR ROZEN: Yes.

5

MS RUDDOCK: - - - and that we understood what was happening in the hospital. You know, I still had in the back of my mind that people told me Alkira Gardens was a good facility, and so I thought, perhaps, the lack of notice of his clinical decline that hadn't been noticed before, maybe that was unusual, and so I thought – my sister and I thought we would go and speak to the facility and complain about that, and – and ask them if they could take care of him as – with his new care needs as a palliative patient.

10

MR ROZEN: Yep. And that discussion with the facility managers about the provision by them of what was now palliative care to your father, did that take place before he returned to Alkira? In other words, in advance of his returning or was it once he'd returned? Do you recall.

15

MS RUDDOCK: It took place in advance.

20

MR ROZEN: Yes.

MS RUDDOCK: We – I made a phone call on the 18th of September to the facility to tell them that – about my father's condition, and I, at that point, verbally complained about the – them not noticing his clinical decline and asked – and said that I would need to meet with – with the facility manager. We didn't realise, at that point when I made that phone call, that dad would be discharged that day. He was – he was discharged – but he was discharged later that afternoon quite quickly. As these things go in hospitals, often, you don't know when it's going to happen. So when I made the phone call, when I found out he was going to be discharged that afternoon, my sister and I rushed down to have a meeting with them before he left the facility – before he left the hospital.

25

30

MR ROZEN: And as is the case when someone is discharged from hospital, there was a discharge report that was provided to Alkira Gardens.

35

MS RUDDOCK: Yes.

MR ROZEN: Is that right? Did you get a copy of that discharge report? Do you remember?

40

MS RUDDOCK: Yes, I did. I received it in the mail after the fact.

MR ROZEN: Yeah.

45

MS RUDDOCK: I remember going back to – after I had been – my plan was my dad was being discharged on the 18th of September. I went down to have a meeting

with the facility manager. My plan was to be back at the hospital before my dad left, but when I got back to the hospital, he'd already been discharged. I discovered he'd been discharged without his discharge papers, and they didn't get to the facility until the next day, and I remember being very upset about that because I knew that his
5 pain relief was a little bit complicated. His - - -

MR ROZEN: Yes.

10 MS RUDDOCK: - - - pain was complicated, and I was very concerned that the facility didn't have the information about his pain relief available to them on the day that he got back to the facility.

MR ROZEN: What was his pain relief – sorry, what was the situation with the pain whilst he was at hospital? Was he in pain during the - - -
15

MS RUDDOCK: Terrible pain.

MR ROZEN: Right.

20 MS RUDDOCK: Yes.

MR ROZEN: And did you discuss with hospital staff the management of that pain?

MS RUDDOCK: I did. I – I recall it took some time to get his pain under control.
25 That was a big part of his time in hospital, was - - -

MR ROZEN: Yes.

MS RUDDOCK: - - - getting his pain under control. There was a lot of trial and error in – in that. The tumour, my understanding was, involved some nerves and it was growing quickly. So my understanding was – or I was told by a number of different people that his pain would change. It would get worse, and the – his pain management would need to be adhered to very strictly in order to keep him as comfortable as possible.
30

MR ROZEN: Was the experience with the pain whilst he was in hospital similar to what you'd observed earlier before the diagnosis, that is, that there would be sudden peaks in the pain where it would be very intense?
35

MS RUDDOCK: Yes, I think – I wouldn't say that he was in that level of pain while he was at Alkira Gardens, but when he was in hospital, yes, there was – he would be – he could be laying there asleep, and then he could be – you know, that he could wake up in pain. He would say things to me like, "I want you to – you need to throw me under a bus." The pain – yeah, it was just terrible pain.
40

45

MR ROZEN: Could tab 23 of the tender bundle please be put on the screen. Various parts of that document have been redacted, as you can see, Ms Ruddock. So probably doesn't look exactly like it did when you received it.

5 MS RUDDOCK: Yes.

MR ROZEN: But do you recognise that as being a copy of the discharge referral note from the hospital that was sent to you that you described a moment ago.

10 MS RUDDOCK: I do, yes.

MR ROZEN: Yep. That's the first page of it. We can see at the top that it's headed Discharge Referral Note, and then the second line under that heading, Result Date 18 September 2017. Do you see that?

15

MS RUDDOCK: Yes, I do.

MR ROZEN: Yep, and that was the date that your father was discharged from the hospital.

20

MS RUDDOCK: That's right. That's right.

MR ROZEN: And if you got to the – if we can go to the second page of that which ends .0006, please, Operator. You see about halfway down the page, there's a heading Discharge Medications. It's just been highlighted for you, Ms Ruddock. Do you see that, Discharge Medications?

25

MS RUDDOCK: Yes.

MR ROZEN: Yep, and if we can just scroll down a tiny bit more so we can see what's under "analgesia", please. Without asking you to give expert pharmaceutical evidence, you understood that was the pain-killing regime that was in place when your father left the hospital on the 18th of September.

30

35 MS RUDDOCK: That's right, yes.

MR ROZEN: And was it explained to you that the Oxycontin and the Lyrican – I think it should be Lyrica - - -

40 MS RUDDOCK: Yes.

MR ROZEN: - - - were the drugs that would operate as the base level of pain control?

45 MS RUDDOCK: Yes.

MR ROZEN: And the Endone which we can see there is prescribed PRN which is – as needed, as I think you understand - - -

MS RUDDOCK: Yes.

5

MR ROZEN: - - - was a two hourly as needed prescription to deal with the sudden onset of pain.

MS RUDDOCK: Yes, that breakthrough pain.

10

MR ROZEN: Yes. That was how it was described, the breakthrough pain?

MS RUDDOCK: Yes.

15 MR ROZEN: Thank you. And - - -

MS RUDDOCK: They – they said the pain would break through the – the baseline medications occasionally and he - - -

20 MR ROZEN: Okay.

MS RUDDOCK: - - - should be given Endone when that happens.

25 MR ROZEN: Yes. And that was a discussion you had at the hospital, was it, before you – before the discharge?

MS RUDDOCK: Yes.

30 MR ROZEN: All right. Now, you told us a moment ago that, as far as you were aware – I don't think there's any dispute about this – Alkira didn't get the discharge referral until the following day, the - - -

MS RUDDOCK: That - - -

35 MR ROZEN: - - - day after your dad was there?

MS RUDDOCK: That's my understanding, yes.

40 MR ROZEN: Did you accompany your dad from the hospital back to Alkira>

MS RUDDOCK: No, I wanted to, but by the time I got back to the hospital after meeting with the facility manager, my dad had already been discharged. So I didn't transfer him. I – I was going to drive back to the facility that afternoon, but I was already halfway home. I needed to get home to my children, so I called the facility
45 to talk them through his – I believe I talked – to talk to them about his – his pain relief.

MR ROZEN: Okay. And was it at that point that you found out they hadn't received the discharge referral note? How did you - - -

5 MS RUDDOCK: I discovered that in hospital, so I went back to the hospital to see if I could accompany my dad back to the facility, and - - -

MR ROZEN: Yes.

10 MS RUDDOCK: - - - I found that he'd already left. I spoke to a nurse there and she told me the discharge papers hadn't been sent with my father, and they would go the next day.

MR ROZEN: Okay. Did you ask them whether that could happen on that day or – how did that conversation end? Do you remember?
15

MS RUDDOCK: I don't remember how it ended.

MR ROZEN: No, I won't ask you to guess.

20 MS RUDDOCK: Yes.

MR ROZEN: That's okay.

MS RUDDOCK: I believe he was still – I believe he was sent to the facility with medications, but I don't believe he was sent with the discharge plan that explained it.
25

MR ROZEN: Okay. Once your dad was back at Alkira Gardens, was there any discussion between you and the facility managers about what the accommodation arrangements will be?
30

MS RUDDOCK: Yes. So that – that all happened in the meeting on the 18th of September before my dad arrived back at the facility when we complained. My sister and I complained to the facility manager and the deputy facility manager about why they hadn't noticed his clinical decline, and at that point, we asked if they could care for him as a palliative patient with his new care needs, and they said yes. And we – I recall specifically explaining that his pain was very a large issue, and it would need to be managed very carefully. They suggested that we move – my Dad was in a low care ward at that point.
35

40 MR ROZEN: Yes.

MS RUDDOCK: And they suggested we move him to a high care ward which would have a higher staff to patient ratio. We were shown a room in one of the locked dementia wards which was a shared room. It's – I wasn't really against the shared room, but the – the residents in there appeared to have very advanced dementia. There were a lot of people wandering around. At one point, that – I think it was the deputy facility manager said to me that there was a person lying on
45

somebody else's bed, and I just didn't think that was a very safe place for my father who was almost bedridden at that point to be at risk of people with advanced dementia wandering around when he couldn't really defend himself if that - - -

5 MR ROZEN: Yes.

MS RUDDOCK: - - - was – if something like that was to happen.

10 MR ROZEN: Those terms “low care” and “high care”, were they terms that were used by the staff at the facility at Alkira Gardens, were they? Do you recall?

MS RUDDOCK: I don't know if I can remember there. Maybe they – that was my understanding. I'm not sure if they were the words they used.

15 MR ROZEN: Okay.

MS RUDDOCK: I believe so. I mean, the ward he was on initially - - -

20 MR ROZEN: Yep.

MS RUDDOCK: - - - was a – was award of people who were relatively good cognition and - - -

25 MR ROZEN: Yes.

MS RUDDOCK: - - - had very few physical disabilities, and the other wards, you know, my understanding, were locked, the dementia wards.

30 MR ROZEN: Yes. Okay. And what did you decide when they showed you that shared room. That you decided – I think you might have just indicated that that wouldn't be suitable for your father.

35 MS RUDDOCK: Yes. I – I said I – I was concerned for his safety there, and I asked if he could remain in his – on the low care ward.

MR ROZEN: Yes.

40 MS RUDDOCK: I appreciate that was probably not a good decision at that time but in the absence of any other better options I thought up in that ward he had friends up there who could look out for him. I thought it was more peaceful and so long as the nursing staff could go and attend to him I thought he would be safer there, as the better of two options.

45 MR ROZEN: Did he go back to his old room?

MS RUDDOCK: Yes.

MR ROZEN: Okay. And I think it was the next day that you first had some dealings with Josh Cohen, the specialist palliative nurse practitioner.

5 MS RUDDOCK: I don't – so that was the 19th. I think I spoke to Josh on the 20th.

MR ROZEN: Yes.

10 MS RUDDOCK: But I don't know if I had a conversation with him on the 19th. I'm not saying it didn't happen; I just don't recall.

MR ROZEN: No, sure. Had you been told, out of interest, at the hospital that there would be this external specialist palliative care provider that would be involved?

15 MS RUDDOCK: Yes.

MR ROZEN: Right. So that was part of the information given to you at discharge.

MS RUDDOCK: Yes.

20 MR ROZEN: All right. And do you recall what you were told about what the role would be of – you didn't know it was Josh Cohen at that time, but the person who turned out to be Josh Cohen; were you told what his role would be?

25 MS RUDDOCK: I didn't understand exactly what his role would be. I just understood that he would be in touch with us. We dealt with the palliative care nurses at the hospital and there had been a voicemail to my sister by one of them saying, "We will put you in touch with somebody like me out in the community when your father is discharged from hospital".

30 MR ROZEN: Right.

35 MS RUDDOCK: But I didn't – I didn't totally understand what the role was. I remember feeling very comfortable with it because I knew that the – that he or she at that time, because I didn't know it was Josh, was from Calvary Hospital, and I had a lot of confidence in their care. So I remember feeling quite happy that someone from that – from that hospital would be attending to my father in the community.

40 MR ROZEN: That confidence was based on your previous experience with your mother; is that right?

MS RUDDOCK: That's right. Yes.

45 MR ROZEN: And describe for us the first meeting on 20 September with Josh. How did that come about and what happened?

MS RUDDOCK: Okay. So the first conversation that I recall having with Josh I think was on the 20th and he called me. I had just picked my children up from school

and he called me to say he had visited my father and that one thing he had noticed is my father had not been administered either any PRN Endone medication or enough of it. I can't remember the exact conversation. I remember being very upset about it. I was very, very worried about my father's pain becoming uncontrolled. And I
5 remember at this point I was – I was so distressed. I remember hanging up the phone after speaking to Josh. I mean, my understanding was Josh had spoken to the facility about it.

10 MR ROZEN: Yes.

MS RUDDOCK: And I felt like he was advocating for my father but I still remember being quite angry that the facility hadn't been managing it well enough. And I hung up the phone and I was standing with a friend and I remember bursting into tears with her and I remember saying, "I don't know how hard it is to ask a
15 question; why can't they just ask him if he's in pain, why can't they do that". At that point, I think it was around about that time I was starting to think do we need to hire a private nurse for my father to take care of him in the hospital, mainly to ask him if he was in pain – in the facility, sorry.

20 MR ROZEN: Yes. Did you talk to the facility management about, apart from Josh Cohen, what they had by way of staff with palliative care skills? Was that something that you discussed with them?

25 MS RUDDOCK: I never asked them about their staff – if their staff had palliative care experience, but we had from the hospital been told that Alkira Gardens could provide palliative care.

MR ROZEN: Yes.

30 MS RUDDOCK: They were good at it.

MR ROZEN: Yes.

35 MS RUDDOCK: So I didn't ask those specific questions, no, but I allowed him to go back there with the knowledge that other people had told me that they could provide that care.

40 MR ROZEN: All right. Now, without going through day by day this fortnight that we're now talking about where your dad was back at Alkira Gardens before ultimately being re-hospitalised. How often did you visit during that period? You told us more frequently than had previously been the case.

45 MS RUDDOCK: Yes. Up to every day, maybe every second day. My sister and I made sure, between the two of us one of us was there every – each day. We also had – my dad also had family friends and his sister and so lots of people were visiting him and his friend – one of his friends who was on the low care ward would come down and see him every day. He had my phone number, and I would speak to him

relatively regularly, you know, so that he could tell me that he had seen my dad that day.

MR ROZEN: Yes, and - - -

5

MS RUDDOCK: I should actually note in terms of the room he was in – I’m not sure of we – my dad did actually end up being in a high care room in one of the wards. I’m not sure if we were going to get to that.

10 MR ROZEN: Yes, sorry, thank you for reminding me of that.

MS RUDDOCK: Yes.

15 MR ROZEN: Can you explain to the Commissioners how that happened because he was ultimately moved.

MS RUDDOCK: Yes, he was ultimately moved.

20 MR ROZEN: How many days did he spend in his old room?

MS RUDDOCK: He was back in his old room just for one night.

MR ROZEN: Yes.

25 MS RUDDOCK: The next morning I went in to see him and the deputy facility manager said to me again, “We can’t look after him in this room”, and suggested we move him to a high care room again. And I said, “Well, I didn’t like the room you showed me yesterday. Do you have any other rooms to show me?” And they showed me another room in a different locked ward which appeared to be much more peaceful. The patients – it was a locked dementia ward as well but the patients there seemed to – I didn’t see as many people wandering around looking as
30 much more peaceful. The patients – it was a locked dementia ward as well but the patients there seemed to – I didn’t see as many people wandering around looking as confused as they were in the other ward, and so I agreed to move my father to that room. So he was in a high care room as of the next day.

35 MR ROZEN: Did you notice, when you were visiting, any difference in the number of staff in that part of the facility compared to the lower care area? Was it apparent to you there were more or - - -

40 MS RUDDOCK: There were more people because some of the residents, particularly around meal times required people to feed them, so I did notice there were more people. I don’t know what their qualifications were, what level or what – level of staffing they were.

MR ROZEN: Yes.

45

MS RUDDOCK: But I did notice there were more people around, yes.

MR ROZEN: Just in relation to that, there were some qualified nurses working at the facility and then there were other people who were care workers, personal care workers. Was it possible for you to know from one day to the next whether you were dealing with a nurse or care worker? Was there anything to distinguish them, do you know?

MS RUDDOCK: Not that I remember. I remember there was a difference between the recreational officers and the caring staff but in terms of the caring staff I don't recall there being any significant obvious differences. So I would, if I asked to see the registered nurse she would come and see me.

MR ROZEN: Yes.

MS RUDDOCK: But I, in terms of the other staff, I wasn't sure what the mix was.

MR ROZEN: Was there any group meetings involving yourself, Josh Cohen, and the staff at the facility during this period that we're talking about?

MS RUDDOCK: Yes. So on 27 September – so in one of my phone calls with Josh, I can't remember how many times he visited my father but on 27 September we agreed to meet at the facility together and talk about my father. So we met in my father's room initially. Josh asked me any concerns that I had about my father's care. He at that point had a – the staff had told me there was a developing pressure wound. There was something developing on his back.

MR ROZEN: Yes, on your father's back.

MS RUDDOCK: It was – yes, it was a red mark at that point and their staff were aware of it, and they had put an air mattress on the bed which is meant to help prevent them. So I remember discussing that with Josh and – and then Josh said to me all right, let's go and – and talk to the staff about your father and about his care needs. There was another discussion that we had about the Endone, about the PRN Endone, about how my understanding, and I'm sure Josh will expand on this, but my understanding was that he – the Endone that was administered to my father would be charted and so that would allow Josh, when he came back to the facility to see my dad each time, to see how much Endone my dad had.

Then he would know how much to increase his Oxycontin by or his Lyrica – I'm not sure which one it was – and he would start from a new baseline. And the idea was that he would always be needing the extra Endone and the Oxycontin would slowly increase until he passed away – the Oxycontin or Lyrica. So we had – the two conversations were mainly about the pressure wound and about the medication. So we got together – the staff there at the time, Josh requested that the registered nurse on duty would come to that meeting too, so they called her down. I can't remember, there were a number of them but I can't remember how many people were there.

And, you know, the conversation, I was very grateful to Josh for expressing my concerns with authority because I felt like when I had expressed them to the staff they weren't really listened to or maybe they were listened to or people didn't really know what to do with what my concerns were.

5

MR ROZEN: Yes.

MS RUDDOCK: I also am not a clinical – I don't have clinical experience and so I needed someone with that clinical experience to speak to the staff on behalf of my father, so I was very grateful to Josh for doing that. I noticed in that meeting, the staff – I've used in my statement – that the staff appeared shocked in that meeting.

10

MR ROZEN: Yes.

MS RUDDOCK: I would like to say that had nothing to do with Josh's approach; he was very professional and respectful and polite to the staff. I believe that response that I subjectively saw was mainly because I didn't think the staff could answer his questions, they couldn't answer why he wasn't having pain assessments. They couldn't answer – Josh suggested that perhaps they could do a pain assessment every day when they showered my father. And one of the nursing staff said, "Well, we don't have time to shower the residents every day, we shower them every second day". And I remember Josh was quite forthright and said "Well, you why don't you shower them every day? You don't have to shower them just in the morning, you can shower them all throughout the day. This is a great time to do a pain assessment." So he really just spoke with his authority and gave some guidance, I thought, to the staff at the time. And I was very grateful for that.

20

25

MR ROZEN: Now, I should have asked you before that, you have already told us that you were visiting your father – between your sister and you, you were there every day during this period, and what was your experience of your father's pain?

30

MS RUDDOCK: I would go and visit him. He was – it was definitely better than when he was in hospital so I'm not making any complaints that he was in excruciating, out of control pain but he still was in pain. Every time I went to see him, I would say "Dad, are you in pain?", or at some point throughout my visit with him he would move and he would say he was in pain. So at that point I would go and ask the nurses to come and bring him some Endone. So he did have Endone. I remember in that meeting with Josh, Josh looked at the chart and said "That's great, your dad has been asking for Endone", and I looked at the chart and I said "Each of those times have been when I was here asking for it on his behalf." I don't know how often he was given Endone if I wasn't there or another family member wasn't there to advocate for him and ask for it for him. I don't know if pain assessments were taking place. I really don't know what they were doing.

35

40

MR ROZEN: Okay. The chart that you're referring to; this was accessible to you obviously.

45

MS RUDDOCK: I didn't – I didn't know I could ask for it. But I could have – I think in hindsight I could probably could have asked for it. This is the chart that Josh asked for when he went up to meet the staff and he looked at the chart.

5 MR ROZEN: Okay. So it wasn't at the end of the bed or somewhere that you could just look at; do you remember?

MS RUDDOCK: I don't believe so. I believe it was in – I believe it was in the nurses' station.

10 MR ROZEN: Right. Okay. And you mentioned a moment ago about the sore on your father's lower spine, the sacrum I think is the technical term.

MS RUDDOCK: That's right.

15 MR ROZEN: It was described to you as a reddish sore and I think from the records it first appeared on 24 September so three days before the meeting that you're talking about.

20 MS RUDDOCK: I think so, something like that.

MR ROZEN: And you were told around about then, were you, when it first appeared that there was a sore?

25 MS RUDDOCK: Yes. We – we were just – we were told there was a red area that could potentially become a pressure wound, and – and I felt confident because they told us that they were aware of it. I felt like they would keep an eye on that.

30 MR ROZEN: Were you given any further information about that any time before your father ultimately went back to hospital? Was there any further discussions about the wound after that first information?

35 MS RUDDOCK: Yes. About two days before he went back to hospital I went to visit him and I was told by someone, one of the staff, that the pressure wound had opened up and that the GP had attended to see my father. And he had been put on Keflex, which I understand is an antibiotic, as a precaution. I remember those words "as a precaution". And I wasn't told it was infected; I was just told that they were precautionally giving him antibiotics just in case.

40 MR ROZEN: Of course, we know ultimately that when your father went back to hospital on 4 October that the wound had, in fact, developed into a very serious infected wound?

MS RUDDOCK: Yes. Yes. Do you want me to talk about that day?

45 MR ROZEN: No, I will perhaps come back to that in a moment, if I could.

MS RUDDOCK: Yes. Okay.

MR ROZEN: Before I do that though, we've talked about the pain management and the sore. Your father also had a series of falls during this period whilst he was at
5 Alkira Gardens.

MS RUDDOCK: Yes.

MR ROZEN: Do you remember now – and once again I don't want you to guess if
10 you're not sure, but were you contacted more than once about him having fallen?

MS RUDDOCK: Definitely, yes.

MR ROZEN: Yes.
15

MS RUDDOCK: I felt like it was very regular. If not every day, every second day I felt like I was getting a phone call to say he had fallen. It may not have been that frequent but it did feel very frequent.

MR ROZEN: Yep. Well, I think it is common ground the records show a number
20 of falls occurred during this period.

MS RUDDOCK: Right.

MR ROZEN: And did you discuss with the facility management what they were
25 doing about that, either to stop the falls or to reduce the risk of injuries from the falls? What were you told?

MS RUDDOCK: Yes, we were told that he'd had a bed alarm put on his bed.
30

MR ROZEN: Yes.

MS RUDDOCK: And he had some socks that had a nonslip surface on them, so if
35 he tried to get out of bed that would help. That was my understanding of what was done.

MR ROZEN: Do you recall any discussion with Josh Cohen or anyone else about
40 the possible use of morphine as an additional pain-killing agent? Do you recall that at all?

MS RUDDOCK: I know that Josh left some medication at the facility to be used my
dad's pain got worse, but I don't know if it was morphine. I know there was some
other medications that were left there.

MR ROZEN: Okay. I will be a bit more specific. Was there any discussion at any
45 point that you remember of injectable drugs of a – you know, subcutaneous injections of drugs - - -

MS RUDDOCK: Yeah.

MR ROZEN: - - - whether it be morphine or anything else? Do you remember?

5 MS RUDDOCK: I believe the medications I was just referring to were injectable.

MR ROZEN: Yep.

MS RUDDOCK: Yeah.

10

MR ROZEN: Right. Okay. We know they weren't ultimately used at all. Do you remember any discussion about that, about why they weren't used?

MS RUDDOCK: I remember a discussion I had with dad's GP about his pain – not
15 very clear on this, but - - -

MR ROZEN: Okay.

MS RUDDOCK: - - - I remember we had a discussion about his pain, and I
20 mentioned that – those medications that were there, and I questioned the doctor as to whether they should start using them. He – ultimately, they weren't used, but the GP said that there was some scope to increase one of the medications, which I believe was the Lyrica, at one point. It was, I believe, doubled and my sister went into the facility the day after that happened and found my Dad very incoherent, and we called
25 the GP back and agreed that perhaps he couldn't handle the increase in the Lyrica, so it was – it was brought back down to its original dose.

MR ROZEN: Yes.

30 MS RUDDOCK: I believe, on that day, the doctor also – the GP also recommended to the facility that they did not give him any extra Endone just for that day, just to counterbalance the fact that he had had so much of the other drug.

MR ROZEN: There were a number of adjustments made up and down of the
35 various drugs during this period. How would you describe, overall, the management of your dad's pain? Was it – from your perspective, was it at any point under control, in that, he could have a pain free day, for example?

MS RUDDOCK: I don't feel it was under control. I don't – but I don't feel like he
40 was in excruciating pain like he was in hospital. It was managed to a point.

MR ROZEN: Yes.

MS RUDDOCK: But I feel like he – he was – he was always still susceptible to
45 quite strong breakthrough pain experiences because of what I thought was the lack of Endone given to him.

MR ROZEN: You mentioned earlier about the initial meeting that you had before your dad returned to Alkira Gardens, and then a subsequent meeting on the 27th a week or so later - - -

5 MS RUDDOCK: Yes.

MR ROZEN: - - - involving Josh Cohen. Was – at any point, was there a palliative care plan prepared by Alkira Gardens that you saw?

10 MS RUDDOCK: No. No.

MR ROZEN: All right. Was there any discussion about a palliative care plan; do you recall?

15 MS RUDDOCK: No.

MR ROZEN: Okay. So in terms of a documented, sort of, regime, it was really the medication in the hospital discharge report that was the document; is that right?

20 MS RUDDOCK: Yes, I didn't know that we were meant to have some kind of palliative care plan that was separate to that.

MR ROZEN: Okay.

25 MS RUDDOCK: I had discussions with Josh about how my wish was for my father to pass away at Calvary. We – I talked to Josh about it. Josh had said, “If your dad ever needs to go to hospital, you need to ask the ambulance to take him to Calvary,” but – so I had a number of discussions with Josh about things like that, but there was no discussion with the facility at all about a palliative care plan. The only – only
30 discussion with the facility was somebody asked me if I would like to change the Do Not Resuscitate form.

MR ROZEN: Yes.

35 MS RUDDOCK: That was it. That was the only acknowledgement of a change in documentation for my father at the facility.

MR ROZEN: Yep. Thank you. Excuse me, Ms Ruddock.

40 MS RUDDOCK: That's okay.

MR ROZEN: There was a discussion at some point about some radiation treatment.

MS RUDDOCK: Yes.

45

MR ROZEN: Was that proposed by Josh Cohen?

MS RUDDOCK: That was. That was after the meeting on the 27th. We talked about dad's pain and Josh suggested that perhaps my – my dad would benefit from some palliative radiotherapy which it was really – was not meant to prolong his life, but was meant to hopefully help with the pain.

5

MR ROZEN: Yes.

MS RUDDOCK: So I thought, fantastic, if we can do this, maybe we don't need to worry so much about if the medications are a bit out of control. So I agreed to him having that. It was – it was to be conducted at the hospital.

10

MR ROZEN: Yes. Any – do you recall which hospital that was going to happen at?

MS RUDDOCK: I'm not 100 per cent sure. It was either at hospital or at an imaging – I can't remember. I believe it was at St George.

15

MR ROZEN: Okay.

MS RUDDOCK: I'm not 100 per cent sure, though.

20

MR ROZEN: It was off site anyway.

MS RUDDOCK: Off site.

MR ROZEN: It would involve a trip.

25

MS RUDDOCK: Yes.

MR ROZEN: Was that a factor that you considered in deciding whether to do that, that it would involve your father having to be transported away from the Alkira Gardens?

30

MS RUDDOCK: I wasn't overly concerned about him being transferred at that point because I thought the – the benefits far outweighed – would – would have far outweighed any distress that he would go through being transported.

35

MR ROZEN: All right. As it turned out, of course, he had a fall just as he was about to be transported and that changed everything, didn't it?

MS RUDDOCK: Yes.

40

MR ROZEN: Is - - -

MS RUDDOCK: Of the morning of – that he was meant to go to have the palliative radiotherapy - - -

45

MR ROZEN: Yes.

MS RUDDOCK: - - - he fell at the facility that morning and banged his head very hard on a table and was rushed to hospital with bleeding on the brain.

MR ROZEN: Yes. You were contacted by Alkira Gardens about that.

5

MS RUDDOCK: Yes.

MR ROZEN: And they told you about the fall, that there was quite a significant injury on this occasion.

10

MS RUDDOCK: Yes.

MR ROZEN: And that he would be transferred to hospital.

15

MS RUDDOCK: Yes.

MR ROZEN: All right. Before I ask you some questions about what then happened at hospital, I would ask you to just have a look at tab 86 in the tender bundle which will appear on the screen in front of you. Do you see that Sisters of Our Lady of China Care Directive is the heading on the left-hand side?

20

MS RUDDOCK: Mmm.

MR ROZEN: And this is the – is this the Do Not Resuscitate document that you mentioned a moment ago?

25

MS RUDDOCK: I believe this is the Do Not Resuscitate document.

MR ROZEN: Yep.

30

MS RUDDOCK: Yes.

MR ROZEN: And that's your signature down at the bottom of the page.

35

MS RUDDOCK: Yes, so this was – this is the 28th of July.

MR ROZEN: July. Yes.

MS RUDDOCK: This was before – because I – hang on. I'm quite confused by this one.

40

MR ROZEN: Okay.

MS RUDDOCK: Because I know that when I was asked to change the DNR, I – I said he was not for resuscitation, so I think, here, this is saying he is for resuscitation.

45

MR ROZEN: Yeah. There was - - -

MS RUDDOCK: Yes.

MR ROZEN: - - - actually an update, wasn't there?

5 MS RUDDOCK: Yes.

MR ROZEN: I see. I'm sorry. We can see the update at the top of the – the top line; is that right, 24th of September?

10 MS RUDDOCK: Right. Okay. So, yes. But it's redacted there.

MR ROZEN: I think if you look at the second – is it? If – yeah, if - - -

15 MS RUDDOCK: Well, where it's – where I've ticked "no" and updated it - - -

MR ROZEN: Yes, that's actually your initials there on the – across from - - -

MS RUDDOCK: Yes.

20 MR ROZEN: - - - number 2, isn't it?

MS RUDDOCK: Yes.

25 MR ROZEN: Yep. Where you've changed it from yes to no.

MS RUDDOCK: Yep.

MR ROZEN: And that was what took place on this period on the 24th.

30 MS RUDDOCK: Yes. Yes.

MR ROZEN: Okay. Thank you.

35 MS RUDDOCK: Yes, so that – and that makes sense to me now.

MR ROZEN: Sorry. No, I probably confused you - - -

40 MS RUDDOCK: No, that makes sense to me. I was – I was asked to change that. Yes.

MR ROZEN: Yep. Yep, and that's when that occurred. All right.

MS RUDDOCK: Mmm.

45 MR ROZEN: Thank you. Now, your dad was transported back to St George Hospital for treatment for the head injury - - -

MS RUDDOCK: He went to Sutherland Hospital which was closer to the facility at the time. Yes.

MR ROZEN: Right. As an emergency patient.

5

MS RUDDOCK: Yes.

MR ROZEN: And what happened there? They assessed that injury?

10 MS RUDDOCK: Yes, I was away at the time, so my sister was with my father and he – they assessed his head injury – it was quite significant. They said it was quite possible that, given his poor condition, he could probably – possibly die from the head injury within the next couple of days. They said if he survived the next couple of days, he would – it – the head injury wasn't going to be fatal.

15

MR ROZEN: Yes.

MS RUDDOCK: So we had about – a period of about two days where we weren't sure whether he would survive the head injury, but what became – after he survived that, what became more apparent was the pressure wound was very severe.

20

MR ROZEN: And how long was he in Sutherland, do you remember? Was it overnight or a couple of nights?

25 MS RUDDOCK: I believe he was there a couple of nights. I remember saying to my sister we need to get dad across to Calvary Hospital as soon as possible, and so she started making inquiries about that through the hospital to get him moved across.

MR ROZEN: Right. Your dealings with Josh Cohen, did they cease when your dad left Alkira Gardens to go to Sutherland Hospital?

30

MS RUDDOCK: Yes, they did.

MR ROZEN: Okay. And then he was ultimately moved to Calvary on the 6th of October?

35

MS RUDDOCK: That's right, yes.

MR ROZEN: Okay. And he remained ultimately at Calvary Hospital until he passed away.

40

MS RUDDOCK: That's right, yes.

MR ROZEN: All right. Tell us about that period. So that's from the 6th of October until the 16th of November, a little over five weeks.

45

MS RUDDOCK: Mmm.

MR ROZEN: How was – what was your experience there of your dad, particularly in relation to the control of his pain?

5 MS RUDDOCK: I felt his pain was totally under control. I wasn't concerned at all about his pain in the – in Calvary Hospital.

MR ROZEN: Yes.

10 MS RUDDOCK: I felt like he was very, very well cared for there, and I wanted him to stay.

MR ROZEN: All right. And did you convey your desire for him to stay there to the staff at Calvary?

15 MS RUDDOCK: Yes.

MR ROZEN: And what did they say about that?

20 MS RUDDOCK: So, initially, those conversations happened after, I think, dad had been there for about two or three weeks. They were getting his pain under control. They were caring for this pressure – terrible pressure wound.

MR ROZEN: Yes.

25 MS RUDDOCK: And there were conversations about him needing, once he – once he was considered stable, as he was not actively dying – which is the term I understand.

MR ROZEN: Yes.

30 MS RUDDOCK: They said he could not stay in the hospital, and he would need to go back to the facility until he was actively dying.

35 MR ROZEN: Just before we come to that, at paragraph 148 of your statement, if that could be brought up, it's page .0016. Whilst that's being done, you describe, there, the expert knowledge of the staff at Calvary Hospital.

MS RUDDOCK: Yes.

40 MR ROZEN: Paragraph 148, if that could please be highlighted. You say, there, that they had expert knowledge about the process of dying and what to expect. Can you expand on that or give us an example of how you formed the view they had such expert knowledge? You describe one there about the - - -

45 MS RUDDOCK: Yeah, I'm just wondering if I should read some – what I wrote in this statement.

MR ROZEN: Well, you can do that. That's probably – it's a good way of doing it.

MS RUDDOCK: Yeah. So I say here, for example, the staff – all of the staff to my knowledge, nurses, doctors, they all had expert knowledge about what to expect
5 when somebody was dying.

MR ROZEN: Yes.

MS RUDDOCK: So they could tell us things to look for like, you know, if their
10 fingernails or fingertips start turning blue, then we're – you know, we might be nearing death. Things like – there was one time when I went in, my dad was quite delirious and very, very teary, and I was able – and the doctor who was attending to my father at the time said to me, "While it's understandable your dad's upset, given the position he's in, this could be a sign of an infection somewhere in his system, so
15 let's check that out. Let's make sure that – that – you know, we understand if he has an infection or something of the like," and it turns out in that instance, he did have a urinary tract infection. The staff were also very conscious of the family and the – the distress that they were going through. They – they wanted to know about my Dad. They were asking questions about who he was as a person. You know, they – at the
20 moment – at that time, all they could do was look at a man who was very ill and unable to communicate with them.

MR ROZEN: Yes.

MS RUDDOCK: So they wanted to ask questions about him. They – you know, the
25 doctor, one day, suggested I get my dad outside and some fresh air and sunshine if we could to see if that would help him. So it was very holistic, the whole experience with the staff at Calvary Hospital. I felt like I could ask them anything, and they could tell me. Also, quite importantly, they can tell when someone is about to die,
30 you know, and they will call you in. So while that – there might be a few false alarms, I felt like with my dad, we were called in twice and he – the second time we were called in he did, in fact, pass away. So they – they know the signs of when somebody is nearing death and so I didn't feel like I had to second-guess them. I didn't feel like I had to hang around the hospital for days on end to support my dad.
35 I felt like he was cared for in the times that I couldn't be with him.

MR ROZEN: Now, after about three weeks or so there was a discussion about that your father hadn't reached the active dying stage, and therefore couldn't just stay in hospital indefinitely. You told us that you had that discussion.
40

MS RUDDOCK: Yes.

MR ROZEN: And then did you receive a letter about Alkira Gardens at that time?

MS RUDDOCK: Yes, so he was there, so I think he was there all up for six weeks.

MR ROZEN: Yes.

MS RUDDOCK: I think it was around about week 3 we started to have discussions with the staff about him needing to move back to the facility, and I was begging them, I said they can't look after him at Alkira Gardens; they've demonstrated that twice, I'm very worried about him moving back there. I was very worried about him
5 being hoisted out of bed because that's quite distressing and – well, I had seen him hoisted out of bed and it was very distressing and painful for him.

MR ROZEN: Yes.

10 MS RUDDOCK: And I felt like the chances of him getting sent back to the facility, I felt like the chances that he would then have to go back to hospital were very high, so he would need to be hoisted out of bed again, put in patient transport, sent back. So there were a lot of discussions about that. On the Friday – on the Friday we were
15 told he was to be sent back to the facility on the Monday. I went home and I received a letter by express post from the Department of Health to say that Alkira Gardens had been sanctioned by the government for failing their – an audit on their accreditation.

MR ROZEN: I just ask that tab 39 be brought up on the screen. The date on this
20 letter, which is on page 2, which we don't need to go to at the moment, but that's 25 October 2017. It's a letter from the delegate of the secretary of the New South Wales State office Department of Health. And we see the heading there The Australian Government Department of Health. Is this the letter, decision to impose sanctions on Alkira Gardens, that you're referring to?

25

MS RUDDOCK: Yes.

MR ROZEN: How did the receipt of that letter impact on the following events?

30 MS RUDDOCK: I felt like I had won some kind of perverse lottery. I felt like this is giving me a chance to keep my dad at Calvary. So as soon as I received it I called my sister and she had had some experience in health care and she said to me, we need to call the – I think the director of clinical nurse services at the hospital and tell them about this letter. So I called and spoke to – I think it was the acting director at
35 the time, and I said, "Please, you cannot send my father back. They can't look after him. This letter demonstrates that". You know, particularly, at that point I didn't realise what standards they had failed but the line which said something along the lines of there were, yes, serious concerns for the safety, health and wellbeing of residents, I discussed that with the clinical – director of clinical services, and she
40 agreed that my father could stay until such time as I had attended the meeting on 8 November which is the family and friends meeting with the Department of Health and the management of the facility.

MR ROZEN: And you said a moment ago, Ms Ruddock, that you begged the
45 hospital to keep your father at Calvary.

MS RUDDOCK: Yes.

MR ROZEN: Do you mean that? What did you say?

MS RUDDOCK: I remember speaking to – I think it was a manager at Calvary and a few of the other staff when we were talking about Dad having to go back to the
5 facility.

MR ROZEN: Yes.

MS RUDDOCK: And I feel like there was – they were really trying to reassure me
10 that it would be fine. Again, I had heard how Alkira Gardens are good at palliative care and I said, “Well, that may have been the case in the past but it’s not my experience”.

MR ROZEN: Yes.

MS RUDDOCK: So I remember – and I remember speaking to the staff at the time
15 and I – and they said, “Well, if you don’t want to send him back there, then you need to find somewhere else for him to go”. And I made an off-the-cuff statement like, “Well, my experience is they’re all as bad as each other”. I don’t believe that; I
20 know there’s a lot of good facilities so I would like that on the record.

MR ROZEN: Yes.

MS RUDDOCK: I was very upset and angry at the time. And I remember just
25 speaking to all these different people and saying, please don’t – I’m paraphrasing but I said, “Please don’t tell me that they’re good at palliative care because my experience is not, that they’re not good at palliative care and they cannot look after him and I really want him to stay here”. So I just remember having a lot of lengthy
30 conversations with different people about me just really to try and advocate on behalf of my father so that he could receive the care that they had at Calvary.

MR ROZEN: Yes, you attended the meeting at the facility.

MS RUDDOCK: I did.

35

MR ROZEN: On 8 November.

MS RUDDOCK: Yes.

40 MR ROZEN: And what happened at that meeting, in summary?

MS RUDDOCK: In summary, I didn’t say anything myself. I know there were a lot
of upset family members and residents. And I just listened, and there were a lot of
discussions about – so the Department of Health spoke and told us about the
45 sanction. We still at this point didn’t know what they had failed. And the – just a lot of upset family and friends at the facility and residents. At the conclusion of the meeting, I had resigned myself to the fact that if my dad had to go back to the facility

then he needed to have a private nurse to take care of him. And so I went up to one of the administrators that I think had been appointed by the – either by the government or by the facility and asked if it was legal or okay for me to have our own private nurse there for our father and she said, yes, that was fine. So I went
5 back to the hospital thinking if they're going to tell me he has to go back to the facility then I would make inquiries about a team of private nurses to take care of him.

MR ROZEN: Ms Ruddock, at paragraph 155 of your statement which is on page
10 0017, if I could ask that to be brought up. Para 155, please. You say there – as you can see it's highlighted on the screen. Referring to this period, under the heading My Emotional Experience, you say:

15 *I spent most of my time hoping my father's condition would deteriorate rapidly so that the hospital would be forced to keep him and he wouldn't have to go back to Alkira.*

That must have been a particularly difficult experience for you.

20 MS RUDDOCK: Yes. I feel very guilty for saying those words but I would go in and see him and I'd think – if the staff told me he was – he had had a good day, I was annoyed because I thought he can't have a good day because if you have a good day you're going to get better, and they're going to send you back there, and just knew I didn't want him to go back there. And so all I was looking for was for confirmation
25 from the doctors that he was deteriorating. And I feel that – I felt guilty and angry with myself for thinking like that. I felt like I couldn't support him in the way that I wanted to support him because I was just looking for signs of deterioration all the time. And I was hoping that he would have an infection. I was hoping that – that something had become worse. So – and this is all to protect him. It felt completely
30 incongruous with how you would behave around someone you love.

MR ROZEN: There was a sudden deterioration in your father's condition shortly after the meeting that you attended on 8 November, the meeting at the facility,
35 wasn't there?

MS RUDDOCK: Yes. So I went back to the hospital on the 9th and I met with my father's doctor at Calvary and I just looked at my dad and I just said to him – I said to the doctor, "Please, don't send him back, look at him". He was barely conscious at this point. And – and the doctor just took a look at him and did an assessment and
40 he said to me "No, he can stay".

MR ROZEN: And was it explained to you that he had reached that end of life stage at that point?

45 MS RUDDOCK: I think I asked him because I knew the – I knew the words that I needed to hear were that he was actively dying.

MR ROZEN: Yes.

MS RUDDOCK: And I think I did ask if he considered my dad was actively dying and I believe he said "Yes".

5

MR ROZEN: And you say, in relation to that, in your statement at paragraph 166 that you met with your sister, this is on 9 November, and you said, "It's over, we don't need to fight for him anymore."

10 MS RUDDOCK: Yes.

MR ROZEN: Is that how you felt?

15 MS RUDDOCK: Yes. I felt like I was in a battle for pretty much that whole time to take care of him so we felt – ultimately felt relief and just decided at that point that we needed to discharge him from the facility, just in case he improved again and he – the doctors decided he needed to go back. I just – I don't know, I was thinking, well, maybe if there's nowhere to send him then that throws another spanner in the works and we can help, you know, maybe keep him there for a little bit longer just in case
20 he improved. I think in the back of my mind I knew that he wasn't going to improve but at that point we just – I just wanted to end our relationship with Alkira Gardens, get my dad's things and so we could just focus on supporting him for the last few days of his life.

25 MR ROZEN: Tell us about that last week.

MS RUDDOCK: So he was – after that, when he was out at Calvary before he was actively dying, he was in a shared room. So they moved him into a private room which gave us an opportunity to just spend time with him in a peaceful environment.
30 It allowed me to bring my youngest daughter in to see him and she would sing songs for him. And it just – I don't know, it was just very peaceful. I really felt like he was being taken care of. I had no concerns at all about Calvary, about their ability to take care of him. I had total faith in them and they didn't fail me. They did look after him very well.

35

MR ROZEN: And ultimately your father passed away on 16 November.

MS RUDDOCK: That's right.

40 MR ROZEN: Now, Ms Ruddock you have included in your statement at its conclusion a section headed My Message to the Royal Commission.

MS RUDDOCK: Yes.

45 MR ROZEN: I think you've already given a very powerful message to the Royal Commission as it is, but I was wondering if you would like to read out that section of your statement to us.

MS RUDDOCK: Okay. It's quite long.

MR ROZEN: It can be highlighted on the screen or you can read it from a document if it's easier.

5

MS RUDDOCK: Okay. So my message is:

10 *I believe my father was neglected by Alkira and they could not provide him with adequate palliative care. My concerns are that there were not enough staff at Alkira to care for resident such as my father with complex needs and the staff that were there were not trained to provide appropriate palliative care, including how to administer PRN medications. I also believe that palliative care is specialised care and that residential aged care facilities that offer it should go through a rigorous accreditation process, and ensure that staff*
15 *delivering this care understand the care needs of each patient. I constantly felt like the staff at Alkira did not understand that they were caring for someone who was dying.*

20 *I also believe that because palliative care was not adequately provided at Alkira, my father was transferred into hospital and once in hospital, I was constantly concerned he would need to be transferred back to Alkira. I believe if this had happened it would not have been too long before he was sent back to a hospital as Alkira were not providing him with adequate palliative care. Hoisting patients out of beds, putting them in patient transport and then*
25 *hoisting them back into a bed in a facility is extremely distressing for end of life patients. I believe this is inhumane and unnecessary, and an unnecessary thing to do to an end of life patient.*

30 *My experience was also that there was not a sufficient recourse for residents and families to seek appropriate palliative care if it is not being delivered at the facility. As the time at the end of a person's life is emotional and time critical, it is often difficult to begin a complaints process.*

It's quite separate to palliative care but:

35

My father was assessed in his ACAT assessment as being a high care patient. I understand assessment as a high care patient means the facility receives more government funding for that resident than for low care patients. However, in my experience there seemed to be a discrepancy between how much the facility received to care for my father and the care he actually received. My concern is that the discretionary powers granted to facility managers to direct funds as they see appropriate is open to abuse and if abused can put high care residents at risk of neglect.

45 I would like to say that I don't believe all facilities do that, by the way, but it's open to abuse.

5 *Due to this I think specialist palliative care facilities should be considered to ensure that the needs of palliative residents can be met appropriately. I am glad that my father received wonderful care in his final days at Calvary and died with dignity as he deserved, however it was very distressing and exhausting to ensure he received this care because it was not available at Alkira.*

MR ROZEN: Thank you, Ms Ruddock.

10 MS RUDDOCK: Thank you.

MR ROZEN: Commissioners, that concludes my examination of Ms Ruddock.

15 COMMISSIONER BRIGGS: Ms Ruddock, thank you very much for that evidence. It is extraordinarily hard to give. I just wanted to ask a little bit, just one question, really, about the situation in hospital and how you felt in that engagement with the hospital about whether or not they must be transferred back to Alkira. And it's really about – I had a sense of powerlessness from your situation in negotiating this interface between the two, and was there anyone else there to help you in this, or
20 were you entirely on your own?

MS RUDDOCK: I can't recall - - -

25 COMMISSIONER BRIGGS: Apart from your sister, of course.

MS RUDDOCK: Sorry. Yes. Other than my sister, I can't recall if there was a social worker with me. It's possible there was but I can't recall. There were a few people from the facility – from the hospital. I did feel very powerless, and I consider myself as someone who was a pretty strong advocate. I know that there's a lot of
30 people who maybe don't speak English or don't feel they can question authority. I feel like they weren't problems for me, but even given that, I felt powerless. I felt like I had no control over whether he was going to be sent back or not. I was also told by one of the staff at Calvary that they – sometimes people transferred out of palliative care back to facilities die in patient transport. The – I believe that's
35 because the process of moving them is very distressing and can be painful and exhausting. So I was very concerned that that would happen to my father. So but, yes, definitely I felt powerless, in answer to your question.

40 COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Ms Ruddock, we're very conscious of the extraordinary courage that you have shown in engaging with the Commission. It has been very important to us to hear your story and understand how palliative care can and sometimes doesn't work in the community. And be assured that your story will
45 be well and truly in our minds when we come to make recommendations for improvements to a system that obviously needs improvement.

MS RUDDOCK: Thank you very much.

COMMISSIONER TRACEY: Thank you. The Commission will adjourn until 11.30.

5

<THE WITNESS WITHDREW [11.17 am]

10 **ADJOURNED [11.17 am]**

RESUMED [11.37 am]

15

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Commissioners, before I call Joshua Cohen, could I just make good on my promise to hand up the third of those documents, aide-memoires, if that's the right plural, which is entitled Alkira Gardens Case Study, Summary of Records, and this is an A3 document that's agreed between the parties which sets out a summary of pain assessments, prescriptions of medicine and administration of medicine.

20
25 COMMISSIONER TRACEY: Does it include a comparison about the pain management regimes at Alkira Gardens and at Calvary?

MR ROZEN: It does not, Commissioner. We don't have the Calvary records which would enable us to make that comparison, not to say that we couldn't acquire them if that was considered appropriate, but, at present, we don't have them.

30

COMMISSIONER TRACEY: Well, we will see how we go, but it was pretty plain from Ms Ruddock's evidence that whatever treatment was being provided was at a proper standard at Calvary, and not at Alkira.

35 MR ROZEN: Yes. Well, that's certainly something we - - -

COMMISSIONER TRACEY: It may be interesting to - - -

MR ROZEN: Yes.

40

COMMISSIONER TRACEY: - - - understand the difference between the two regimes.

MR ROZEN: Yes.

45

COMMISSIONER TRACEY: But, anyway, that's for the future.

MR ROZEN: Yep. That's not something we're in a position to do today, but it's certainly something which we can take on board. For the moment, we've provided this document to our learned friends and I hand up copies for you, Commissioners. That document may be of assistance in the examination of both Mr Cohen and Mr Leong will be the third witness. I call Joshua Bedford Cohen.

<JOSHUA BEDFORD COHEN, AFFIRMED

[11.40 am]

10

<EXAMINATION-IN-CHIEF BY MR ROZEN

MR ROZEN: You can take a seat, Mr Cohen, if that's more comfortable.

15

MR COHEN: Yes, thank you.

MR ROZEN: And, Mr Cohen, can you please state your full name for the purposes of the transcript.

20

MR COHEN: Yes. Joshua Bedford Cohen.

MR ROZEN: And Mr Cohen, have you prepared two witness statements for the purposes of the Royal Commission?

25

MR COHEN: Yes, I have.

MR ROZEN: The first of those statements is dated the 29th of May 2019, and our code here is WIT.0179.0001.0001. That document will be brought up on the screen in front of you, Mr Cohen.

30

MR COHEN: Mmm.

MR ROZEN: Can you confirm for us that that is, at least, the first page of the statement that you made for us?

35

MR COHEN: Yes, I can confirm that's the first page, yes.

MR ROZEN: Thank you. And have you had an opportunity to read through that statement before giving evidence today?

40

MR COHEN: I have read through that statement, yes.

MR ROZEN: Yep. Anything you'd like to change in it?

45

MR COHEN: No, I'm – I'm happy with the statement as it is today.

MR ROZEN: Okay. And its contents are true and correct?

MR COHEN: Correct.

5 MR ROZEN: I'll tender a statement dated the 29th of May 2019. Commissioners, before that gets marked, there are two statements of Mr Cohen. They could be separate exhibit or they could perhaps be - - -

10 COMMISSIONER TRACEY: Well, I will mark them separately.

MR ROZEN: Separate exhibits. Content with that. Thank you, sir. So I tender the – firstly, the statement dated the 29th of May 2019.

15 COMMISSIONER TRACEY: Yes. The witness statement of Joshua Bedford Cohen dated the 29th of May 2019 will be exhibit 5-33.

20 **EXHIBIT #5-33 WITNESS STATEMENT OF JOSHUA BEDFORD COHEN
DATED 29/05/2019 (WIT.0179.0001.0001) AND ITS IDENTIFIED
ANNEXURES**

MR ROZEN: In addition, Mr Cohen, for reasons which will become apparent shortly, you provided another witness statement to us, this one dated the 6th of June 25 2019, and that's WIT.0225.0001.0001. Can you confirm for us that the document on the screen is the first page of that statement.

MR COHEN: Yes, I can confirm that.

30 MR ROZEN: And have you had an opportunity to read through that statement as well before coming along to give evidence today?

MR COHEN: Yes, I have.

35 MR ROZEN: Anything you'd like to change.

MR COHEN: No, I'm happy with that statement as it is today.

MR ROZEN: All right. Contents true and correct.

40

MR COHEN: Correct. Yes.

MR ROZEN: I'll tender that, sir, please.

45 COMMISSIONER TRACEY: Yes, the second witness statement of Joshua Cohen dated the 6th of June 2019 will be exhibit 5-34.

**EXHIBIT #5-34 WITNESS STATEMENT OF JOSHUA BEDFORD COHEN
DATED 06/06/2019 (WIT.0225.0001.0001) AND ITS IDENTIFIED
ANNEXURES**

5

MR ROZEN: The Commission pleases. A little bit of explanation might be called for, Mr Cohen, which I will provide and you tell me if you agree with this: the first of those statements which is now marked 5-33 responds to a notice from the Commission asking to you give some general evidence about your role as a specialist palliative care medical practitioner.

10

MR COHEN: Yes. Yes. As – as a nurse practitioner, yes.

MR ROZEN: Yes.

15

MR COHEN: That – that is – that’s correct. That’s the first statement.

MR ROZEN: Yep, and I’ll ask you a number of questions about that - - -

20

MR COHEN: Mmm.

MR ROZEN: - - - during the course of your evidence this morning. The second statement is more specific and it deals with your role in relation to the case study that we’re examining today which is the Alkira Gardens case study involving the late Mr Paranthoene and your attendances on him in September of 2017.

25

MR COHEN: Yes, that’s right.

MR ROZEN: All right. Because there is quite a bit of overlap - - -

30

MR COHEN: Sorry.

MR ROZEN: - - - in the sense that the role you played at Alkira Gardens was pursuant to your general role - - -

35

MR COHEN: Mmm.

MR ROZEN: - - - we will, for convenience, deal with both statements and both general areas in the course of your evidence without having to recall you to deal with anything else. Do you understand that?

40

MR COHEN: I do, yes.

MR ROZEN: All right.

45

MR COHEN: Thank you.

MR ROZEN: Thank you. Now, before coming to that, I would like to ask you a little bit about yourself, if I may, and you deal with this in each of your statements in very similar forms. Firstly, you are an endorsed nurse practitioner.

5 MR COHEN: Yes, that's correct.

MR ROZEN: You were a transitional nurse practitioner at the relevant time in September 2017.

10 MR COHEN: Yes, when I first met Mr Paranthoienne, I was a transitional nurse practitioner.

MR ROZEN: Yes. Well, can you explain briefly to us that distinction. It's probably obvious, but better coming from you, I think.

15

MR COHEN: Yes. So a transitional nurse practitioner is when you are enrolled in a Masters of Nursing, Nurse Practitioner, and seated in a position that, once you're endorsed, you will become a nurse practitioner which has a much – quite well defined and broader scope of practice - - -

20

MR ROZEN: Yes.

MR COHEN: - - - to when you're a transitional nurse practitioner.

25 MR ROZEN: Okay. That scope of practice "well defined" is detailed in paragraph 11 of your statement.

MR COHEN: Mmm.

30 MR ROZEN: If that could be brought up on page 0002. It will be highlighted in front of us. This is a quote from the – what is it? The Australian College of Nurse Practitioners.

MR COHEN: Yes, that's right.

35

MR ROZEN: That's the professional association, is it - - -

MR COHEN: Correct. Yes.

40 MR ROZEN: - - - or the professional - - -

MR COHEN: It's a national association for nurse practitioners in Australia.

45 MR ROZEN: Right. And it defines a nurse practitioner – and, of course, we can all read it there:

As a registered nurse with the experience and expertise to diagnose and treat people of all ages with a variety of acute or chronic health conditions. Nurse practitioners have completed additional university study at master's degree level and are the most senior clinical nurses in our healthcare system.

5

And then it goes on and refers to APRA, and that's a definition – an explanation that you're comfortable with, I take it.

10

MR COHEN: It is. I find that a very helpful definition - - -

MR ROZEN: All right.

MR COHEN: - - - when explaining what I – what I do.

15

MR ROZEN: Whilst we're on that page, if we can just go up to paragraph 9, you detail your qualifications and you have a Bachelor Degree of Nursing from the University of Sydney.

20

MR COHEN: Yes.

MR ROZEN: And then so far as your postgraduate qualifications, I'd like to ask you a little bit about that.

25

MR COHEN: Mmm.

MR ROZEN: Firstly, a Graduate Certificate in Health Palliative Care from - - -

MR COHEN: Mmm.

30

MR ROZEN: - - - Flinders University.

MR COHEN: Mmm.

35

MR ROZEN: And, secondly, a Masters in Palliative Care at Flinders University.

MR COHEN: Yes.

40

MR ROZEN: We've having witnesses, as it turns out, later this afternoon – possibly one of the professors that you might have studied under, I imagine.

MR COHEN: Mmm.

45

MR ROZEN: What made you choose Flinders University as a place to study those areas?

MR COHEN: Flinders University was known within, you know, palliative care circles as being a university that (a) offered a Masters in Palliative Care. There – there was only one other to – which was my understanding at the time that offered it.

5 MR ROZEN: Yes.

MR COHEN: And I'd had some colleagues that had enrolled in that Masters of Palliative Care and were very happy with their level of education and the quality of the – of the courses within that master's degree. So I started off with a certificate in health and as a sort of, you know, wet my feet in the course, and then decided to progress that onto the masters.

MR ROZEN: Okay. Now, those two qualifications didn't elevate you to the nurse practitioner status, did they?

15

MR COHEN: No. No.

MR ROZEN: You had to do a Master's of Nursing.

20 MR COHEN: That's right.

MR ROZEN: You must be very fond of tertiary education, Mr Cohen.

MR COHEN: Yes.

25

MR ROZEN: You did your Master's of Nursing back at the University of Sydney.

MR COHEN: That's right.

30 MR ROZEN: And that's a – is that one year, full time?

MR COHEN: No, it's one and a-half year full time, three years part-time.

MR ROZEN: Yep. Okay.

35

MR COHEN: And I did that part time.

MR ROZEN: All right. Is there any dimension of that that deals specifically with palliative care nursing?

40

MR COHEN: No, it's a generalist degree.

MR ROZEN: Right. Okay.

45 MR COHEN: And the expectation is that you bring your specialist, you know, qualifications with you into that.

MR ROZEN: Okay. And then that was 2017, so it was – well, you completed that in 2017 - - -

MR COHEN: Yes.

5

MR ROZEN: - - - and do we understand, then, that in that experience in September of 2017 when you are working at Alkira Gardens, you're still completing your master's; is that - - -

10 MR COHEN: Correct.

MR ROZEN: - - - the connection?

MR COHEN: That's right.

15

MR ROZEN: All right. Okay. Thank you. In addition to those qualifications, you are, of course, employed in your present role at Calvary Hospital which you detail in paragraph 4 – rather, at Calvary Healthcare, Kogarah; is that right?

20 MR COHEN: That's right.

MR ROZEN: Yep. What's the role there? You're a palliative care nurse practitioner?

25 MR COHEN: Yes.

MR ROZEN: What does that involve, day to day?

30 MR COHEN: So I'm a palliative care nurse practitioner that sits within the community palliative care team at Kogarah.

MR ROZEN: Yes.

35 MR COHEN: And I work solely in the residential aged care space. So our community palliative care team works both within people at home - - -

MR ROZEN: Yes.

40 MR COHEN: - - - people living in their homes and people living within residential aged care. I do not visit people in their own homes. I visit people within residential aged care only.

MR ROZEN: There are other nurse practitioners who specialise in home based palliative care, do they?

45

MR COHEN: Not within our service.

MR ROZEN: Right. Okay. Calvary, we've already heard about from the evidence of Ms Ruddock, is a hospital which has a long experience in the - - -

MR COHEN: Mmm.

5

MR ROZEN: - - - provision of palliative care; is that right?

MR COHEN: Yes, it has a - it's a - has a long history in connection with the local community.

10

MR ROZEN: Right.

MR COHEN: With - so Calvary Hospital offers both palliative care and rehabilitation services.

15

MR ROZEN: Right.

MR COHEN: It has been doing so for some time.

20

MR ROZEN: And is that the extent of the medical services provided at Calvary or are they - are there other more general medical services provided as well?

MR COHEN: Well, the - the lion's share of medical services sit between those - sit within those two specialties. There are - - -

25

MR ROZEN: Yes.

MR COHEN: - - - pain clinics. There are rehabilitation clinics and other specialties that sit within palliative care as well that have developed over the years of that - of being there.

30

MR ROZEN: In addition to doing that work, you also are represented on a number of committees - - -

35

MR COHEN: Yes.

MR ROZEN: - - - associated with palliative care.

MR COHEN: Yes.

40

MR ROZEN: You detail those in paragraph 5 of your statement. I'd like to ask you a little bit about those. You're at the chair of the Palliative Aged Care Network.

MR COHEN: Yes, that's right.

45

MR ROZEN: What does that network do?

MR COHEN: So the Palliative Aged Care Network is a group of specialist palliative care health professionals, nurses and allied health who all work within residential aged care – work in that care setting, I should say. So it's either people like myself who are stepping into an aged care facility from an outside
5 organisation - - -

MR ROZEN: Yes.

MR COHEN: - - - or nurses, clinical nurse consultants coming from within the aged
10 care organisation itself, and we – we meet every three months and talk about the challenges and the innovation that we are all delivering within that space, and I've been chair of that committee – it will be two years in April of next year.

MR ROZEN: Right. And I assume that you can confirm for me that the evidence
15 you're going to give today is informed, not only by your clinical experience as a practitioner, but by the discussions that you hear through that network, I take it.

MR COHEN: Yes. Absolutely. It's been a very important space for me as a – as a
20 new nurse practitioner, and I really took advantage of – of being a part of that, you know, discussion. The group was well and truly established by the time I came on board, and I found it an invaluable place to – to have those discussions.

MR ROZEN: You also detail that you're a committee member of Palliative Care
25 Nurses Australia.

MR COHEN: Yes, that's correct.

MR ROZEN: And that's not a network. It's a peak body, is it?

MR COHEN: That's right. It's the peak body for palliative care nurses within
30 Australia - - -

MR ROZEN: Right.

MR COHEN: - - - and sits alongside Palliative Care Australia.

MR ROZEN: And you may not be able to answer this, but - - -

MR COHEN: Mmm.
40

MR ROZEN: - - - what sort of size membership does that organisation have; do
you know?

MR COHEN: I'm sorry. I couldn't answer that.
45

MR ROZEN: Okay. That's all right.

MR COHEN: I wish I could. I know it's quite substantial.

MR ROZEN: All right. All right. And you also have a teaching responsibility at the – or an appointment at the University of Technology in Sydney?

5

MR COHEN: Yes, I have – I have an honorary associate with UTS, and I have been the subject developer for a complex centre management within a new Master's of Palliative Care that UTS commenced this year, and the subject that I'm involved in will commence later in July of this year.

10

MR ROZEN: Can I ask you a little bit about the services that are offered by your employer – by Calvary at Kogarah. What's the principal work that is done?

MR COHEN: The principal work around palliative care, you mean?

15

MR ROZEN: Yes.

MR COHEN: So we are a palliative care service, a very substantial palliative care service - - -

20

MR ROZEN: Yes.

MR COHEN: - - - that sits in southern – in the Sydney – Sydney's southeast local health district, LHD. We offer inpatient services, so there's a 32-bed palliative care unit. We offer a very substantial community palliative care service that looks after people who are in their own home. Both of those services, there's a multidisciplinary team that services both of those – both of the – the different care settings.

25

30 MR ROZEN: Yes.

MR COHEN: So allied health – a full suite of allied health. Bereavement services are a very important part of what we do as well.

35 MR ROZEN: Yes.

MR COHEN: Medical services and – and nursing services within both of those care settings.

40 MR ROZEN: All right. Can I just stop you - - -

MR COHEN: There's - - -

MR ROZEN: Sorry, I was going to stop you there.

45

MR COHEN: Mmm.

MR ROZEN: It's a cliché, I know, but it sounds like that's a holistic model. Is that how one would describe that?

5 MR COHEN: I would describe it as a holistic model, yes.

MR ROZEN: Yes. Okay. And, sorry, I cut you off. You were - - -

10 MR COHEN: I was going to say there's also a motor neurone service that's attached to our palliative care service where we look after that very specific population as well.

MR ROZEN: And then there's the – or perhaps you'll get into it, there's the outreach service that you're a part of.

15 MR COHEN: Yes. Yes. Then there's the residential aged care nurse practitioner service that – that – that I'm a part of.

MR ROZEN: Yes, and can you tell us a bit how that – a bit how that operates, please.

20

MR COHEN: Yes. So I was employed as a transitional nurse practitioner in Calvary in May of 2017.

25 MR ROZEN: Yes.

MR COHEN: And then in November of 2017, we then employed another transitional nurse practitioner, and when I stepped into that role, the model of care that I thought would be an appropriate model for nurse practitioners to implement was the palliative – the – sorry, the – the palliative care needs round which was a model that was already up and running at Calvary Clare Holland House in Canberra, and I had read about that in the British Medical Journal of Supportive and Palliative care and made contact with that team - - -

30

35 MR ROZEN: Yes.

MR COHEN: - - - since the outcomes from their research were – were very encouraging, and there was a real lack of model of care that included palliative care, residential aged care and nurse practitioners.

40 MR ROZEN: Yes.

MR COHEN: Really, that there – I had done a literature review before I had – I had brought a model to the table that I thought could work where we worked, which was obviously different to Canberra. There was a real lack of those - - -

45

MR ROZEN: Right.

MR COHEN: - - - and the one in Canberra was, to me, the one that – that made most sense.

5 MR ROZEN: Okay. That was ultimately implemented in about April of 2018 in Sydney?

MR COHEN: That's right. It was – it was implemented up. We had a model of care day which was a - - -

10 MR ROZEN: Yes.

MR COHEN: - - - discussion with, really, the whole organisation. Nurse practitioners are relatively new – new positions, whether they be palliative care, aged care, whatever the specialty. So there was – that was an opportunity to educate the people that I work with about what it is we do. I think we were all still figuring out how will these roles look in this service? How are they best placed to work?

MR ROZEN: Yes.

20 MR COHEN: And nurse practitioner's mandate is to – really to – to fill gaps in care where doctors, medical practitioners have difficulty getting into and accessing. And in a metropolitan palliative care service, the area that made most sense to me for that was residential aged care.

25 MR ROZEN: Yes. All right. I'll ask you a little bit more in a moment about the - - -

MR COHEN: Okay.

30 MR ROZEN: - - - palliative care needs rounds and how that model changed, but as at September 2017, which is the focus - - -

MR COHEN: Mmm.

35 MR ROZEN: - - - of our case study, that new model hadn't been implemented.

MR COHEN: No, it had not.

40 MR ROZEN: What was the model at that time, if you're able to describe it?

MR COHEN: So up until that time, before I had actually started at Calvary, we had already made a commitment to residential aged care through the appointment of a nurse specialist who was working point six which was, I think, over a fortnight. So three days a week servicing our very large geographic area which really goes from south of the airport in Sydney down to as far as Cronulla and those areas sort of before Wollongong. So it's quite a large geographic area.

MR ROZEN: Yes.

MR COHEN: And the referrals then – when I came along, obviously, I was a 1FTE,
so a full time nurse practitioner that other position and person had left. And we
5 would receive referrals – ad hoc referrals is what I refer to them in my
submission - - -

MR ROZEN: Yes.

10 MR COHEN: - - - where they come in either from a hospital – so an acute care
setting, making a referral to a palliative care service that someone will need their
services once they arrive home or into residential aged care. The referrals could
come from residential aged care facilities themselves and, usually, they came from
GPs.

15

MR ROZEN: Right.

MR COHEN: And they would be faxed into our service where our staff would then
allocate them to the appropriate person.

20

MR ROZEN: All right. Probably an appropriate time to ask you about your
involvement in the case study - - -

MR COHEN: Mmm.

25

MR ROZEN: - - - which we are examining, and I think you've been in the
courtroom this morning while Ms Ruddock gave her evidence.

MR COHEN: Yes, I – yes, I was.

30

MR ROZEN: I will ask you a little bit about some of the things that she raised
during the course of your evidence this morning.

MR COHEN: Mmm.

35

MR ROZEN: It's – so the statement which is now exhibit 534 deals specifically
with questions about this case study.

MR COHEN: Okay.

40

MR ROZEN: And I will ask you to agree with that.

MR COHEN: Yes.

45 MR ROZEN: Take my word for it.

MR COHEN: Mmm.

MR ROZEN: That's the statement dated the 6th of June 2018.

MR COHEN: Yes. Yes.

5 MR ROZEN: If that could be – I'm not sure if that's the one on the screen or not.
No. If that one could be brought up. Thank you, and I will ask you some questions
about this. We don't need to go through your background. You were asked, firstly,
what your recollections are of your involvement, and if I could summarise them,
they're next to none. You don't have any actual memory now of the work that you
10 did at Alkira Gardens.

MR COHEN: No, that's correct. I – I rely on the documentation that I made at that
time - - -

15 MR ROZEN: Yes.

MR COHEN: - - - to give me record of that event.

MR ROZEN: And so you were able to interrogate records maintained by your
20 employer, which you made - - -

MR COHEN: Yes.

MR ROZEN: - - - at the time.
25

MR COHEN: Yes.

MR ROZEN: And if I could just, before we go to those records, get some
understanding of the practice that you followed at that time - - -
30

MR COHEN: Mmm.

MR ROZEN: - - - in terms of record keeping. In other words, were you making
handwritten notes? Were you entering them on a database, and when were you doing
35 that relative to the events that you describe in the notes. What was your practice?

MR COHEN: So my practice is and remains that I document electronically on my
own documentation at that time, either – usually, you know, either directly after or
that afternoon when I get back to work but in the lion's share of cases it's directly at
40 that time. Every aged care facility I go into has a different way of keeping medical
records. Some of them are electronic, some of them are handwritten so – but I
always present an electronic document, whether that is put into their own, you know,
as a cut and paste, but I document contemporaneously, so at the time of the event.

45 MR ROZEN: Yes. So you travel, what, with a device, a laptop or something?

MR COHEN: I have a – yes, I have a portable laptop. It has access, you know, internet access and I can look at medical records and I can store documents on that computer.

5 MR ROZEN: All right. If we could bring up tab 104, please, in the tender bundle. This is a printout – or it's not a printout, it's on the screen, but it's based on the printout of the medical records that you provided to the Royal Commission; is that right, Mr Cohen?

10 MR COHEN: Yes, that's right.

MR ROZEN: All right. And if we can just, taking this, this is the first entry in your records that you were able to identify.

15 MR COHEN: Yes, that's the first entry.

MR ROZEN: All right. Just to help us navigate through that, we can see in the top right-hand corner, immediately under the Commission's coding which, of course, wasn't there when you provided it to us, is that right, that's something we've added
20 to the document.

MR COHEN: Yes.

MR ROZEN: LCM.222, and so on.
25

MR COHEN: Yes, that's right.

MR ROZEN: Immediately under that we see the late Mr Paranthoiene's full name and a number; what's that number?
30

MR COHEN: That's his medical record number that a person is given when they're registered with our service.

MR ROZEN: Right. And then if we look on the left-hand side, the first entry there is ACC. What does ACC stand for?
35

MR COHEN: Aged and chronic care.

MR ROZEN: Okay, that's the - - -
40

MR COHEN: That's the category of notes that I document under.

MR ROZEN: Notes that you're making.

45 MR COHEN: That's right.

MR ROZEN: Okay. Then we've got a date, 19 September; is that the date of the events being described or the date the note is being made, or what are we looking at there?

5 MR COHEN: That's the date of the actual event and the note there.

MR ROZEN: Okay. Were all of these notes made on the same day as the events they describe, do you know? If you're not sure, I'm not asking you to guess.

10 MR COHEN: Yes, look, I'm not sure. My usual practice is to document on the day.

MR ROZEN: Yes.

MR COHEN: So that is – that's what I would say to that.

15

MR ROZEN: Okay. Is it the case that occasionally you might make the notes the following day if you were particularly busy?

MR COHEN: No.

20

MR ROZEN: No. Okay. And then we've got a heading about a quarter of the way down the page, Aged and Chronic Care Progress Note, and there's some other information there, and you're identified as the person – is that the person who made the note or the person that provided the services described in the note or both?

25

MR COHEN: I'm sorry, where – whereabouts do you mean, Mr Rozen?

MR ROZEN: Do you see – it's centred and it's in bold.

30 MR COHEN: Yes.

MR ROZEN: It starts, Aged and Chronic Care and it ends with Cohen, Joshua and then NP in brackets, do you see that?

35 MR COHEN: Yes, yes. That's meaning that I am logged into the electronic medical record under my unique, you know, identification and I am the person making that note, that's right.

40 MR ROZEN: All right. Now, you've already told the Commission that you were a transitional nurse practitioner or I think a TNP is the acronym.

MR COHEN: That's right.

MR ROZEN: On the note you're described as an NP.

45

MR COHEN: Yes.

MR ROZEN: What's the explanation for that, Mr Cohen?

MR COHEN: The explanation would be that there was no place in the software to have TNP and my employment was always going to be as a nurse practitioner.

5 When you're in that transitional phase, sometimes the software doesn't keep up with the actual title.

MR ROZEN: Have you had that fixed in the meantime?

10 MR COHEN: I don't know, now I'm a nurse practitioner, it's an appropriate title.

MR ROZEN: Right. Someone else's problem.

MR COHEN: I've caught up. Yes. But, no, it's a good point that you make.

15

MR ROZEN: All right. Then we've got some entries which – I'm not going to ask you about each of these, but the key ones seem to be, we've got four lines under a heading Service Event. I don't need to ask you about any of those, but then there's a bit of a gap on the page and then there's an entry "CHR service delivery mode". Do you see that?

20

MR COHEN: CHR service delivery mode. Yes.

MR ROZEN: I will just get it blown up for you.

25

MR COHEN: Yes. Thank you, that's easier.

MR ROZEN: It's now at the top of that identifier.

30

MR COHEN: Yes, yes.

MR ROZEN: Do you see that?

MR COHEN: Yes.

35

MR ROZEN: Then we've got "telephone individual".

MR COHEN: Yes.

40

MR ROZEN: Telephone means it was a communication by phone, rather than face to face.

MR COHEN: That's right. That's right.

45

MR ROZEN: What does the individual mean?

MR COHEN: It means I was speaking to one other person. I think the other category there is telephone group, from memory.

MR ROZEN: Sorry, telephone?

5

MR COHEN: Group.

MR ROZEN: Group. I see. Okay. Then we've got some start time, finish time, all of which is self-explanatory and then "CHR duration". What does CHR stand for, do you know?

10

MR COHEN: I'm not sure.

MR ROZEN: All right. But we would understand that to mean that three minutes was the duration of the phone call, essentially.

15

MR COHEN: That's right.

MR ROZEN: Okay.

20

MR COHEN: That's right.

MR ROZEN: And we see from others, as we'll see in a moment, that if it's a face-to-face meeting, the time that's entered would be the time that the meeting took, presumably.

25

MR COHEN: That's right, the time that the meeting took and a consideration for documentation in that time as well.

MR ROZEN: All right. Now, from the records, are you able to tell the Commission with any certainty how you came to go to Alkira? In other words, was your service contacted by Alkira or was it contacted by the hospital or was there some other means by which you became involved in this case?

30

MR COHEN: The referral was made from St George Hospital.

35

MR ROZEN: Yes.

MR COHEN: Where Mr Paranthoienne had been discharged on the 18th to our service, and from the electronic registration of Mr Paranthoienne, he was registered on the 19th of September, and that's when I would have received the referral.

40

MR ROZEN: All right. Now, for completeness, what you've done for us is you've looked at the notes and then you've reduced them to a narrative, essentially, in your statement.

45

MR COHEN: That's right..

MR ROZEN: And I'm going to take you to the notes in relation to specific matters but otherwise, you obviously rely on your statement as accurately setting out the various steps that you've taken.

5 MR COHEN: Yes, that's right.

MR ROZEN: All right. The first of those steps as we've just seen from the record that is highlighted on the screen was a telephone contact on 19 September. We know from other documents, and we heard from Ms Ruddock earlier today, that Mr
10 Paranthoienne was discharged from hospital on the 18th, and your first contact with Alkira Gardens was on the 19th. That was initiated by you as a phone call.

MR COHEN: Yes.

15 MR ROZEN: It necessarily follows that you must have received the referral from the hospital before you made that call. Are we to read anything into the promptness with which you contacted Alkira Gardens; what does that tell us? Does it tell us anything about the urgency or does it tell us about your work habits or what?

20 MR COHEN: Look, one of our indicators of our service is the length of time it takes us to contact our referral, once we've received it from a referrer, and we always try to contact within the first 24 hours. So the trigger would have been the referral to me.

25 MR ROZEN: Yes.

MR COHEN: And I would have read the progress, the discharge summary as well.

MR ROZEN: Yes.

30 MR COHEN: And then that would have followed up with a call to triage, if you like, the urgency of the need for a review.

MR ROZEN: Yes, okay. And the discharge referral – I think you were in court
35 when the document was brought up on the screen.

MR COHEN: Yes.

MR ROZEN: That's the same referral.

40

MR COHEN: That's right.

MR ROZEN: It went to Alkira Gardens, a copy went to Ms Ruddock, the daughter of Mr Paranthoienne, and a third went electronically, presumably, to you.
45

MR COHEN: Yes, I – I would have had access through Mr Paranthoienne’s medical record number to his St George discharge summary within – we use the same electronic medical record.

5 MR ROZEN: I see.

MR COHEN: So I would have had access to his pathology, his discharge summary, his imaging; all of those things.

10 MR ROZEN: I see. Not just the discharge report?

MR COHEN: Not just the discharge summary.

MR ROZEN: You could go behind that and look at anything you needed to.

15

MR COHEN: That’s right.

MR ROZEN: Right. You may not know the answer to this but I assume that’s not access that Alkira Gardens would have.

20

MR COHEN: I do know the answer to that and that is not access that Alkira Gardens would have.

MR ROZEN: Okay. Just while we’re on that, is that a problem in your experience; would it be better if the facilities had such access?

25

MR COHEN: Look, I think that – and this is an opinion that I would make, you know, initiatives like My Health Record are going some way to try and fill that gap so that, you know, for example, discharge summaries from other hospitals that you wouldn’t have access to, you could potentially find through that record. So there’s an acknowledgement that communication across care settings needs to be improved electronically, but I think there’s a long way to go for that electronic record that I have access to and acute care does, being available in a primary care setting.

30

MR ROZEN: Now, you told us that this was a triaging exercise, this telephone call, and if we look at the – halfway down the page there’s a heading Progress Note. These are the records you made based on what you were told by Alkira Gardens; is that right?

35

40 MR COHEN: Yes, that’s right.

MR ROZEN: Okay, so we see a phone call to RACF, that’s residential aged care facility regarding urgency of review by your organisation:

45

Discharged from the hospital on 18 September. Assist with pain management spindle cell tumour.

In your experience, Mr Cohen, is that a common or an unusual tumour to have, from your clinical experience?

5 MR COHEN: From my clinical experience that would be an unusual cancer diagnosis to manage.

MR ROZEN: Right. Can you help us with what it means? What is a spindle cell?

10 MR COHEN: So it's the type of cell that has been identified through the, you know, the pathology from the cancer. It's a connective tissue type cancer.

MR ROZEN: Yes.

15 MR COHEN: And in the case of Mr Paranthoiene, in being on the left chest wall was going to be in an area where there are lots of nerves, so nerve pain was potentially going to be an issue with this particular presentation.

MR ROZEN: Right. And that was apparent from the outset for you.

20 MR COHEN: That's right.

MR ROZEN: All right. You then went on:

25 *Registered nurse feels patient more confused since discharge from hospital, for GP review later today, and then plan, CPC2 –*

That's CPC2; that's you?

30 MR COHEN: That's right.

MR ROZEN:

...review this week please.

35 MR COHEN: Yes.

MR ROZEN: Was that a request you were making to someone else or you were conveying what they were asking of you; is that right?

40 MR COHEN: I'm not sure if that's what that's saying but it's giving a time frame for review - - -

MR ROZEN: Within a week.

45 MR COHEN: Well, I think given the day, it's sort of middle of the week on the 19th. I can't remember what day that was but it was certainly within a short – within a time frame of a few days that this person would be reviewed.

MR ROZEN: Okay. Did you consider there was any particular urgency over and above like cases? Is there anything about what you were told which indicated that to you?

5 MR COHEN: I don't – I don't recall that.

MR ROZEN: Okay. I understand. And if I haven't already said this, I will say it now, I'm certainly not asking you to guess; if you don't recall then that's an entirely satisfactory answer. As it turned out, your next involvement was the following
10 day - - -

MR COHEN: Yes.

MR ROZEN: - - - when you attended at Alkira. Had you, at that time, had any
15 experience of working at Alkira Gardens residential aged care facility?

MR COHEN: I don't recall if I had been to Alkira Gardens before that date. I had started on the 2nd – you know, in May, so there may have been an instance of interaction but I don't remember if there was.
20

MR ROZEN: At this time, you've already told us a very large geographic area that you're responsible for.

MR COHEN: Yes.
25

MR ROZEN: Do you know either approximately or accurately what the population is of the area that you work in?

MR COHEN: Well, the number of beds that we have, so beds are referred to, the
30 number of residential aged care beds in a particular local health district, we look after 4000 beds, and at that time I was the only health professional from our service going into that care setting, and managing specialist palliative care need.

MR ROZEN: Right. And those 4000 beds are spread over how many facilities; do
35 you know?

MR COHEN: So I think it's around 66 facilities that we have.

MR ROZEN: And as you've already explained to us, at this time there was no
40 proactive element to the work you were doing, you were just responding to referrals.

MR COHEN: That's right. The model of care was as it was when I first started at Calvary.

MR ROZEN: Yes. And those referrals, you've already told us, could come from a
45 range of sources.

MR COHEN: That's right.

MR ROZEN: This one came from the hospital.

5 MR COHEN: Yes.

MR ROZEN: Are there other hospitals that were referring palliative care patients to you as well?

10 MR COHEN: Yes, so the other hospital within our district would be Sutherland Hospital, so they could refer people. Prince of Wales Hospital may refer to us, also other hospitals outside of the district, Concord, Royal Prince Alfred.

15 MR ROZEN: Now, if we could go in the notes to page 3, that's 0003, and if we could just scroll back down a little bit so that Mr – we can see the page number in the top right-hand corner, please. Thank you very much. This is – these are notes that you made in relation to your involvement on the following day, on the 20th.

20 MR COHEN: Yes, that's correct.

MR ROZEN: And we can see about a third of the way down the page that this was a face-to-face individual delivery mode, as it's described there.

25 MR COHEN: Yes, that's right.

MR ROZEN: And you were there for 90 minutes. Does the 90 minutes cover the time that you were delivering, or that you were providing care advice and services and the time it took to make the notes or – so it's both.

30 MR COHEN: It's both of those things.

35 MR ROZEN: Okay. And you explain in your statement that on the 20th you visited the site and – this is paragraph 28 of your statement that I'm looking at now – you detail that Mr Paranthoene was experiencing pain including during the assessment.

MR COHEN: Yes.

40 MR ROZEN: And is it significant that he was experiencing pain during the assessment; is there any particular reason why you make that point?

MR COHEN: So I can't recall exactly the context of that, but the way that I document, I list them as issues.

45 MR ROZEN: Yes.

MR COHEN: And you give as much flesh to the issues as you can. I think, yes, so that's what I would answer there.

MR ROZEN: Okay. I think it's the case that – you can correct me if I'm wrong if I'm wrong about this, Mr Cohen, but I think on each occasion you attended – and I think there were three - - -

5 MR COHEN: Yes.

MR ROZEN: - - - you record that Mr Paranthoienne was in pain.

MR COHEN: That's right.

10

MR ROZEN: Yes. In your experience, including your subsequent appearance, was this a difficult pain management case?

MR COHEN: When you say subsequent experience, do you mean experience I've had since this time?

15

MR ROZEN: I do, yes.

MR COHEN: Look, I would say that pain management in residential aged care can often be difficult to manage.

20

MR ROZEN: Yes.

MR COHEN: The care setting can be a tricky space. The – the lack of education and knowledge amongst staff around how to manage pain management, how to assess pain appropriately, how to manage the medications appropriately, both regular and as required medications, can present some barriers to good pain management. When it comes to cancer pain management in residential aged care, you know, that isn't often the type of pain that we're managing there. In the instance with Mr Paranthoienne that was absolutely the type of pain we were managing and it was, in this care setting, difficult to manage.

25

30

MR ROZEN: You mentioned earlier that the location of the tumour, being in the chest, where there are so many nerves as you explained to us, was that part of the complexity of the case here?

35

MR COHEN: Yes, that was part of the complexity. I mean, the medications that he was discharged on from St George Hospital with the Oxycontin and the pregabalin, which is the Lyrica, that's specifically for nerve pain. He was on a very low dose. Normally, he would start with 25 milligrams that night or – or twice a day in titrate or increase the medication up from there and the as required Endone was very standard practice. So looking at the medications, there's nothing to suggest this is going to be very difficult to control pain. They are fairly standard medications that would be used for the management of cancer pain.

40

45

MR ROZEN: Right. So to the extent that there were difficulties, it was contributed at least in part by the care setting as you've explained.

MR COHEN: That's right.

MR ROZEN: Right. And I take it from that that's not unique to Alkira Gardens. In your experience that's something you find in residential aged care generally.

5

MR COHEN: Yes, in my experience you could not say that that is unique to Alkira Gardens.

MR ROZEN: Okay. You mentioned the word "titrating", if I could just get you to explain a bit more about that because that's what happened, isn't it, over this period of time with your involvement.

10

MR COHEN: Yes. So titrating medications in palliative care means that you increase or decrease the dose according to response and according to the distress of the person. So for example, with the PRN or as required Endone that is something that we use; we ask people to utilise that medication when they – when they have break-through pain, and then the idea is you come back and evaluate the amount of use of that medication and that gives you an indication whether the background dose is actually an adequate dose, whether there's been failure of the background and it's not managing adequately, or – or whether there could be other reasons why someone is requiring the use of Endone.

15

20

MR ROZEN: Is another description of the interrelationship between the background dose and the Endone, so the background was the Oxycontin and the Lyrica, the as needed drug was the Endone; is another description of that that basal pain relief and could you refer to the Endone as being a bolus pain relief. Is that terminology used?

25

MR COHEN: You'd refer to the Endone as a short-acting pain relief, and the Oxycontin as a long-acting pain relief, so pharmacologically it works over 12 hours, hence why it's twice a day. And the Endone, you know, pharmacologically works over a four hour period, it takes around 30 to 45 minutes to actually have an effect, and then depending on the person's, you know, level of organ failure, it may be in the system anywhere four to six hours.

30

MR ROZEN: Yes.

35

MR COHEN: So it's no good treating acute sort of exacerbatory pain with a long-acting medication; you need something short-acting to get in there and relieve the actual pain in a short time frame.

40

MR ROZEN: All right. If we could have tab 28 brought up. This is an email that you sent on 20 September. And I just want to try and understand from you just so it's a bit clearer to you, obviously there's some email addresses that have been blocked out. I'm looking at the email at the bottom half of the page, the one that you sent and I will ask you to accept that it was sent to Alkira Gardens.

45

MR COHEN: Yes, I would accept that.

MR ROZEN: And it's addressed to the GP whose name has been blocked out and the residential aged care facility team. And you'll see you wrote:

5 *Please find review for Mr Paranthoienne, attached review attended 20
September 2017. Thanks, Josh.*

What's this communication; why did you make this communication?

10 MR COHEN: This communication was the documented notes that I had made or assessment that I had made for Mr Paranthoienne earlier that day, and it's so that the residential aged care facility were able to receive an electronic copy and that the GP was also part of that communication and knew that I had been there and suggestions that I had asked him to enact for Mr Paranthoienne.

15 MR ROZEN: All right. Now, the attachment is behind tab 29 or it certainly appears to be. I just ask you to confirm that if you could. Is that the attached report that was sent under cover of that email?

20 MR COHEN: Yes, that's correct.

 MR ROZEN: All right. And if we can just go halfway down that first page, or about a third of the way down, we've got the discharge medications listed there, and that's a lift from the – from the medications that were in the discharge report from St George Hospital?

25 MR COHEN: That's right.

 MR ROZEN: Okay. I just want to ask you about the PRN Endone, and see if I can understand what's conveyed in the report. It says PRN, which we know, you've told us means as needed.

30 MR COHEN: Yes.

35 MR ROZEN:

Endone 5 milligrams, Q two hours –
what does the Q stand for there?

40 MR COHEN: So that is referring to how often it would be available to the person that required it. And it's saying that every two hours, if required, Mr Paranthoienne could have 5 milligrams of Endone.

45 MR ROZEN: And who is to assess whether or not it's required? That's the first question.

MR COHEN: So that would be the assessment of the registered nurse in whatever the care setting was, in this instance Alkira Gardens, to make that assessment, to ask the question, and then to make an assessment of need and then to have that, ensure that that actually medication is prescribed, so legally they can administer it, and then
5 to give the medication and monitor the response.

MR ROZEN: Okay. And is there an assumption built into that prescription that an assessment is to be made every two hours? How is that meant to work?

10 MR COHEN: Yes, there is an assumption that that is what would occur.

MR ROZEN: Right.

MR COHEN: Yes, that's right. That the people who made that plan in the hospital
15 would be thinking that when he goes to the other care setting, when Mr Paranthoienne goes to the aged care setting, that there would be the expertise to then manage that – that intervention, that pharmacological intervention.

MR ROZEN: Expertise and resources.

20

MR COHEN: Correct.

MR ROZEN: All right. Assuming that assessment is made, however often it is made, presumably it's important from your perspective as the outsider coming in,
25 that it's properly recorded. Is that important?

MR COHEN: Yes, that's right. So any S8 medication like morphine, Endone needs to be recorded and two registered nurses need to sign it out of the locked cupboard so there's always quite detailed recording of when those medications are actually
30 administered so finding when they're given is not difficult.

MR ROZEN: Right. So that's the legal obligation to record them.

MR COHEN: Yes.
35

MR ROZEN: I'm more interested in the clinical importance of recording them.

MR COHEN: Yes.

40 MR ROZEN: Why is it important for you?

MR COHEN: So it's important to me as someone who's come in from an outside in-reach service. If I arrive in a facility and find that someone has been using a lot of extra medication on top of their background pain relief then the first thing that comes
45 to my mind, well, what's going on here, why are they using so much of this medication and what needs to occur. So having a good idea of that then directs some of the – directs my plan of care for that person.

MR ROZEN: If we can just go back to the entire page, I just want to ask you about the next entry which is headed Social, do you see that?

MR COHEN: Yes, I can see that.

5

MR ROZEN: You've recorded information provided to you, presumably by Mr Paranthoienne's daughters, Shannon and her sister, it would appear. Is that how we would read that record?

10 MR COHEN: That's how you would read that record, yes.

MR ROZEN: Yes. And why is that information important to record from your perspective, that social information, if we can call it that?

15 MR COHEN: I think providing context for the person that you are going to meet is an important part of any holistic assessment and so social is one of the key aspects to who needs to be involved in conversations, who needs to be present, you know, what – and obviously that's a very basic snapshot but it helps to consider the whole person.

20

MR ROZEN: Yes. One of the themes of the evidence we've heard this week, both in a negative and a positive sense, has focused on the importance of relationships in residential aged care. And I take it relationships are important in the provision of palliative care; is that a fair observation?

25

MR COHEN: Do you mean relationships with people that I'm assessing and their families or with facilities?

MR ROZEN: Well, both probably.

30

MR COHEN: Both. Yes, look, I think, especially an in-reach service then all of those relationships are critical to any successful, you know, implementation of plan.

MR ROZEN: Yes.

35

MR COHEN: For transparencies, you know, for the sake of transparency of care, you know, speaking with family and residents about their care plans, their wishes, their goals of care; all people need to be present for those conversations. So we are making or helping people make the choices that they want for their care.

40

MR ROZEN: Yes.

MR COHEN: And then obviously staff being present so that they can hear the plan of care because that's often where it falls apart, when the plans aren't passed on.

45

MR ROZEN: Do such plans need to be documented in your view or experience; are they ordinarily documented?

MR COHEN: Look, I think those conversations need to be documented, whether that's in documentation such as the notes that I made or a formalised document, advance care planning documents, those sorts of things that have been spoken about previously.

5

MR ROZEN: Yes, and drawing on your – the experience that we discussed earlier, just in relation to advance care planning, is that something you're seeing? Is there more of it in your experience?

10 MR COHEN: Look, I would say through our new model of care, the palliative care needs around advance care planning really features as quite a large part of that – of that intervention. In fact, it's one of the triggers that we use in identifying the people that we might discuss in an aged care facility whether there is a lack of care plan, no care plan, whether the care plan needs to be revisited and by care plan, I mean an
15 advance care plan, an advance care directive, a goals of care conversation, anything that will give you some information around what that is, so advance care planning is core to what we do. I think for the very reason that we've needed to put this into a model of care it's something that routinely hasn't been done and that we're very intentionally trying to facilitate.

20

MR ROZEN: So in the current model that's something that is being driven by your service in residential aged care settings.

25 MR COHEN: Yes, in our – in the model of the palliative care needs around case conferencing is a part of that model. Yes.

MR ROZEN: Right. Okay. We don't – and I'll stand corrected on this but we don't seem to see anything that could be described as a palliative care plan or an advance care plan in this case. Do you recall there being any discussion about that?
30 There doesn't seem to be anything floated by you.

MR COHEN: No, I don't recall.

35 MR ROZEN: Okay. If we can turn then to your next involvement which is 26 September. If we can go back to tab 104, I think we need to, please. And if we can go to page 0007. This is a further telephone contact, we see from the record.

MR COHEN: Yes, that's right.

40 MR ROZEN: Yep, and it's a 15-minute telephone conversation, and I take it this was in the nature of a follow-up to the document that you had emailed about a week or so earlier.

45 MR COHEN: Yes. Yes. And my understanding from these notes is it's two phone calls that I sort of group together - - -

MR ROZEN: Yes. Right.

MR COHEN: - - - as being 15 minutes.

MR ROZEN: Yeah, I see.

5 MR COHEN: Mmm.

MR ROZEN: And is – thinking about your practice at this time – I know you had - - -

10 MR COHEN: Mmm.

MR ROZEN: - - - only been there since May, but this level of involvement, is it unusual or is this pretty well the norm that you would experience?

15 MR COHEN: This would be standard practice.

MR ROZEN: Right. Yep. Okay. And if we can go back to the entire page, please, and we see under the heading Progress Note. Firstly:

20 *Family concern around patient drowsiness and increase in pregabalin.*

And that's the Lyrica.

MR COHEN: That's right.
25

MR ROZEN: And we heard Ms Ruddock talking about that earlier today.

MR COHEN: Yes.

30 MR ROZEN: And that was a concern that the increase which had been put in place was having an effect on Mr Paranthoienne's - - -

MR COHEN: Yes, cognition.

35 MR ROZEN: - - - cognition functioning, essentially.

MR COHEN: Mmm.

MR ROZEN: And that you were requested – there was a request to reduce it.
40

MR COHEN: Mmm.

MR ROZEN: And just so that I understand the dynamic here, because you were a transitional nurse practitioner, rather than an endorsed one - - -

45 MR COHEN: Yes.

MR ROZEN: - - - the ultimate call was with the GP.

MR COHEN: That's right. So the GP would need to do all the prescribing in this instance because - - -

5

MR ROZEN: Yes.

MR COHEN: - - - I had no endorsement to do so.

10 MR ROZEN: To do that.

MR COHEN: That's right.

MR ROZEN: Your role was really in a form of a recommendation, essentially.

15

MR COHEN: That's right.

MR ROZEN: I take it that's now different that you are a fully endorsed nurse practitioner?

20

MR COHEN: That's right. So, obviously, collaboration still occurs with the general practitioner, but I'm able to prescribe and de-prescribe as I see appropriate.

MR ROZEN: Yes, in relation to all of these drugs, for example?

25

MR COHEN: In relation to all of those drugs.

MR ROZEN: Okay.

30 MR COHEN: That's right.

MR ROZEN: I want to ask you about the next entry because it does seem to raise an important matter for us.

35 MR COHEN: Mmm.

MR ROZEN: So after the reference to reducing the medication, we read this entry:

40 *GP raised other concerns around medication administration in RACF and he's reluctant to chart injectable medication in instance of it being given inappropriately.*

Do you see that?

45 MR COHEN: Yes, I see that.

MR ROZEN: It's a matter you also deal with in your statement, but – in much the same terms as what appears in your notes.

MR COHEN: Mmm.

5

MR ROZEN: Are we to understand from that that you raised with the GP the possibility of some injectable pain relieving medication?

MR COHEN: Yes. So in my first assessment of Mr Paranthoiene, I had documented that access to injectable medications for – in anticipation of deterioration and potential end of life and dying, it would be very appropriate that these medications be prescribed so that they're there just in case - - -

10

MR ROZEN: I see.

15

MR COHEN: - - - a deterioration occurs out of hours or on weekends when access to a GP or an afterhours GP is going to make it difficult, and you wouldn't essentially – so, for example, if someone stops swallowing and weren't able to swallow their Oxycontin, but are still in pain, how are you going to manage that? You need to have an injectable version there to do so.

20

MR ROZEN: I see. And do you have any particular injectable drug in mind in this situation?

MR COHEN: In this particular case study?

25

MR ROZEN: Yes. Yep. There's a reference to morphine, we see, in one of the records.

MR COHEN: Yes. So, again, that he was already on Oxycontin then and a reasonable injectable version would have been the injectable morphine. That's right.

30

MR ROZEN: Yes. Okay. They're both opioids; is that right?

MR COHEN: Both opioids.

35

MR ROZEN: Yes. Okay.

MR COHEN: They're both opioids.

40

MR ROZEN: And is that the relevance of him already being on Oxycontin that he's had - - -

MR COHEN: Yes. So the - - -

45

MR ROZEN: - - - some exposure to opioids?

MR COHEN: Yes. So – yes, he – he had clearly – he was not opioid naïve, is what I would phrase it. He already was on substantial pain relief, and that – that has implications for the type of injectable morphine you would use and the amount that you would use. So you would do a conversion to an appropriate subcutaneous
5 dose - - -

MR ROZEN: Yeah.

MR COHEN: - - - of morphine.
10

MR ROZEN: The response as I'm understanding it, and correct me if I'm wrong about this, was - - -

MR COHEN: Mmm.
15

MR ROZEN: - - - that just wasn't going to be possible in this care setting because of the GP's concern.

MR COHEN: Yes. Well, I document there that the GP had concerns and a reluctance to chart those medications in the instance of it being given inappropriately. I can't record, other than my documentation at that time, that that's my memory of it.
20

MR ROZEN: Yes.
25

MR COHEN: If you would like me to talk to my experience of it since that time, generally, I'm able to do that.

MR ROZEN: I will, but just in a moment.
30

MR COHEN: Okay.

MR ROZEN: Just in relation to this case, if I could.

MR COHEN: Yes.
35

MR ROZEN: Was that, did that mean that, to use a colloquial expression, effectively had one hand behind your back in relation to pain management here.

MR COHEN: Yes, it meant, in effect, that with no injectable medications prescribed, if this gentleman deteriorated and was unable to swallow his Oxycontin, then there was nothing there to manage his pain.
40

MR ROZEN: Yes. Now - - -
45

MR COHEN: So it would never have been possible in that care setting - - -

MR ROZEN: As - - -

MR COHEN: - - - without those.

5 MR ROZEN: Sorry. As events turn out, a fall on the 4th of October

MR COHEN: Mmm.

10 MR ROZEN: - - - about a week or so later meant that Mr Paranthoieni was back in the hospital system. So is it the case that in a practical sense, this didn't matter in this case because he never got to a point where the morphine would have been used; is that right?

15 MR COHEN: Yes, certainly, he – he was still swallowing - - -

MR ROZEN: Yes.

MR COHEN: - - - and managing his oral medications up to that point.

20 MR ROZEN: Okay.

MR COHEN: So the idea of if needed medications or anticipatory prescribing, is how I would phrase it - - -

25 MR ROZEN: Yes.

MR COHEN: - - - is something that we use to ensure that these things are there because it's a very unpredictable population as we found.

30 MR ROZEN: Yes.

MR COHEN: You – you just don't know what's going to happen at any particular point. So you try and – and plan and communicate and implement things as wholly as you can to avoid distress.

35

MR ROZEN: Yep. Experience teaches you what's foreseeable.

MR COHEN: That's right.

40 MR ROZEN: And you act in advance of the foreseeable event; is that right?

MR COHEN: That's right. That's right.

45 MR ROZEN: Now, I cut you off as you were offering - - -

MR COHEN: Mmm.

MR ROZEN: - - - a broader observation about this issue, that is - - -

MR COHEN: Mmm.

5 MR ROZEN: - - - the unpreparedness of GPs in residential aged care settings to make such prescriptions.

MR COHEN: Mmm.

10 MR ROZEN: Could you expand on that in your experience.

MR COHEN: Yes. So in my experience, that's not the first time that I've heard GPs have that apprehension around prescribing, and, you know, I think these are strong medications.

15

MR ROZEN: Yes.

MR COHEN: There – there needs to be a level of safety and governance around these medications. They can cause harm if used inappropriately, but, also, they can
20 relieve distress if used appropriately, and that's really at its core. These medications are there to manage distress. So it's really vitally important that we ensure the capacity within residential aged care facilities to manage these injectable medications is there, so that we feel confident prescribing them. I mean, I must – I will say for my own practice, it doesn't prevent me from prescribing these medications because I
25 feel as though I give enough instruction to them to ensure an amount of safety, and I – I put parameters in around the prescribing of those medications. So, for example, if you say you were speaking about Endone before, Q2 hourly, an equivalent of subcut morphine, two and a half milligrams every two hours, then you say if you're getting more than four within a 24-hour period, then you stop at that point. You
30 don't give any further. You don't give any – they're not authorised to give more past that point.

MR ROZEN: Yes, thank you. And just for completeness - - -

35 MR COHEN: Mmm.

MR ROZEN: - - - if we go back to page 5 in your notes, that is – I should have taken you to this a moment ago. That's where we see the reference to morphine. This is something you raised – it's point 3 about a quarter of the way down the page.
40

MR COHEN: Sorry, which notes, Mr Rozen?

MR ROZEN: Yeah. We're now looking at your notes - - -

45 MR COHEN: My notes.

MR ROZEN: - - - from the 20th of September.

MR COHEN: Yes. Yes.

MR ROZEN: I'm taking you back in the narrative. I apologise for that.

5 MR COHEN: I see what you mean now. Yep.

MR ROZEN: Yep, but that's the point at which – it's point 3:

Option for PRN, S/C.

10

What does that stand for?

MR COHEN: Subcutaneous.

15 MR ROZEN: Subcutaneous. Thank you:

Pain relief, five-milligram morphine, Q4, hourly, PRN.

So that was the point at which you raised the possibility of morphine.

20

MR COHEN: That's right.

MR ROZEN: And then there was a subsequent discussion with the GP that you've recorded in the notes - - -

25

MR COHEN: That's right.

MR ROZEN: - - - that I was just asking you about.

30 MR COHEN: Yes.

MR ROZEN: Thank you. If I can take you then to the next involvement which is the 27th of September and the notes are at page 0009. Just before I do that, if I can just pick up on a matter you raised a moment ago, and that is your own personal preparedness to prescribe subcutaneous medications.

35

MR COHEN: Mmm.

MR ROZEN: You said that the way you address questions of risk is through information provision and oversight.

40

MR COHEN: Mmm.

MR ROZEN: Is it important for you to have some previous relationship with a facility and the staff at the facility to have a level of confidence and trust about that?

45

MR COHEN: Yes, absolutely. That – that would be seen as the ideal. It's not always the case.

MR ROZEN: Yes.

5

MR COHEN: And I'm sure that we will get to this detail later. The palliative care needs round, we're doing them in a quarter of the facilities - - -

MR ROZEN: Yes.

10

MR COHEN: - - - and I would say they're the facilities where there is a growing relationship - - -

MR ROZEN: Yes.

15

MR COHEN: - - - and you can, you know, be more assured of, for example, the triage information you're getting from a nurse about level of distress. Whereas, if you're walking into a facility that you haven't been into for some time, there could be different staff and you're prescribing subcutaneous medications, and you – you would be in a situation where you'd need to think carefully, if I'm prescribing this, who's going to give it, will they give it appropriately for the right indication at the right time, and will they come back and evaluate that later? You can't always guarantee that.

20

25 MR ROZEN: What information sources do you have – as a general question, what information sources do you look for in relation – or to inform decisions that you make about increasing or decreasing medications? We know you did that during the course of your involvement here.

30 MR COHEN: So, at its core, it would come from my assessment of the patient.

MR ROZEN: Yes.

35 MR COHEN: And if there was an assessed need, then I would need to find the means to manage that need, and if it was a pharmaceutical option, then that would be what I would need to pursue, and then that sort of creates a whole cascade of activity where you're speaking to family and making sure that they're aware of the things that you are wanting to prescribe - - -

40 MR ROZEN: Yes.

MR COHEN: - - - because, very often, families aren't told, and are surprised when they receive their letter from the pharmacy and all of these medications that they had no idea their loved one was on – is on - - -

45

MR ROZEN: Yes. Yep.

MR COHEN: - - - and I think that would be a very distressing thing to find. So I always make it a point to make sure that they're not going to be in that situation of – of – of not knowing what someone's taking. But then to engage in the conversation with the care staff and, usually, that means you need to speak to someone senior
5 within a facility who can hand over and hand on messages. Some of the electronic medical records that you do with – you can actually ensure your note is going to be at handover so it's highlighted in red with a very prescriptive plan. That gives me some confidence that will occur.

10 MR ROZEN: Yes.

MR COHEN: Other – other software, you don't have that capacity, so it's close follow-up with a phone call or – or something to that effect.

15 MR ROZEN: All right. And if I can turn then to the – your next involvement which was the 27th of September - - -

MR COHEN: Mmm.

20 MR ROZEN: - - - and this was the last of your face-to-face involvement at the facility. I think I'm right.

MR COHEN: Yes, that's right.

25 MR ROZEN: And we can see – and the note is on page 0009 which I think is on the screen in front of you. We focus on the progress note part of that which is halfway down the page on the left-hand side. You have, there, recorded medications largely unchanged since the last assessment.

30 MR COHEN: Mmm.

MR ROZEN: Sorry, just above that:

Re-review of Vince with daughter Shannon present.

35 What does re-review mean in that context?

MR COHEN: So I'm coming back for the second time.

40 MR ROZEN: Yes.

MR COHEN: So I had already met Mr Paranthoiene the week before, and I was coming back this week to reassess interventions that had been suggestions, and if they'd made any difference to, in this instance, his pain.

45 MR ROZEN: All right. You then talk about:

Medication largely unchanged, pregabalin remained at 25 milligram BD.

BD - - -

5 MR COHEN: Twice a day.

MR ROZEN: Twice daily.

MR COHEN: Yes.

10

MR ROZEN: After concern about drowsiness. So it'd gone up to 50 and was back down to 25.

MR COHEN: Mmm.

15

MR ROZEN: Then:

Pain remains main issue –

20 and that's a constant feature, it seems, of the - - -

MR COHEN: Yep.

MR ROZEN: - - - notes and, of course, the evidence that Ms Ruddock gave earlier.

25

MR COHEN: Yes.

MR ROZEN: Is it fair to say that Mr Paranthoienne's pain was never really under control during his time at Alkira?

30

MR COHEN: I think that's a fair thing to say.

MR ROZEN: Yeah.

35 MR COHEN: Yes.

MR ROZEN: Is that a matter of – should that be a matter of concern to the Commission? Should it have been able to be controlled better, in your view?

40 MR COHEN: Look, I think – yes. I think if – if you have adequate pain assessments, they're there.

MR ROZEN: Yes.

45 MR COHEN: Mr Paranthoienne could easily articulate he was in pain. He was someone who could easily give you a score of, you know, mild pain, severe pain, no pain at particular points in time.

MR ROZEN: Yep.

MR COHEN: And then when you had that response and that answer then, there was medication prescribed that could be given in the instance of assessment, and then if
5 there's capacity within the staff to then re-evaluate after that, then there is potential for better pain management.

MR ROZEN: Yes.

10 MR COHEN: I think, as I also documented on that day, it's important to also note that, you know, Mr Paranthoienne was never going to be pain free.

MR ROZEN: No.

15 MR COHEN: There was always going to be an amount of pain, but that's not to say that it can't have been better.

MR ROZEN: Yes. In your – in this note at the very bottom of the page, the last
20 little paragraph:

Plan discussed with RACF team to treat Vincent's pain with PRN Endone prior to meal times to see if this helps.

25 And if I could just stop there; do we read that as meaning moving to three times a day, one with each meal? Is that - - -

MR COHEN: There had been – there had been a correlation between eating and pain for Mr Paranthoienne.

30 MR ROZEN: Yes.

MR COHEN: So the idea was that if eating causes pain, I guess it's a type of incident pain which is common, also with cancer, where a certain activity we know will cause pain so you anticipate the pain with the activity, be it eating, movement,
35 showering, and you give pain relief prior to that activity. And when I say "prior" it needs to be given with an oral formulation, you know, 30 minutes prior for it to actually be working at that you need it to work. So I wouldn't say that the inference is it would be a three times a day dose. Still in the spirit of PRN it's as needed, but to say that this particular time is a trigger for pain so anticipate that.

40

MR ROZEN: You've already explained to us that the appropriate response to the PRN Endone prescription is to do frequent assessments of pain; that's how one determines whether or not it is required. We know from the records that there were pain assessments utilising the Abbey Pain Scale which is something that you would
45 be familiar with.

MR COHEN: Yes.

MR ROZEN: That's a – I don't know if gold standard is quite the word but it's certainly an industry standard of pain assessment.

5 MR COHEN: The Abbey Pain Scale is a pain scale for people with dementia so you're looking at a whole series of things. It's really built around people that potentially can't communicate their pain.

MR ROZEN: Thank you.

10 MR COHEN: Yes.

MR ROZEN: That wasn't Mr Paranthoienne's case, so that difficulty, as you've already indicated, didn't really present itself here. He was quite able to articulate whether or not he was in pain.

15 MR COHEN: Yes.

MR ROZEN: Is asking someone if they're in pain, a pain assessment, from your perspective?

20 MR COHEN: It absolutely is. Yes. That is a pain – that's a screening for pain which then anticipates care.

MR ROZEN: Okay.

25 MR COHEN: Prescribes care, so yes.

MR ROZEN: All right. So if we go to your notes, after the reference to meal time you say:

30 *Suggested ongoing daily pain assessments.*

Are we to read that as saying there should be a pain assessment once a day and that's adequate or how should we read that note?

35 MR COHEN: Look, I'm not sure how to read that but I would say my experience in the aged care setting to this time, when you ask a facility to do a pain assessment it's almost that then – I'm surprised with the plan that needs – planning that needs to go around that because the first question I'm often asked "Do you want it for three days or five days?" and I'll go, "Well, I just want you to ask if they're in pain as regularly as you needs to, but if I need to give you a time then I will say five days". But I would expect a registered nurse to be of a standard where you assess need at the time based upon what's occurring. I know that's not the case because there isn't the capacity to do that, but yes, so does that answer the question?

45 MR ROZEN: I think it does although if I could perhaps explore a little further - - -

MR COHEN: Yes

MR ROZEN: - - - to understand whether what you're suggesting there is that a daily pain, as in once every 24 hours, whether that would be adequate in this case?

5

MR COHEN: I would say at the very least but clearly Mr Paranthoienne had triggers for pain more frequently than daily so the pain assessments, the numerical pain scale can be done at the bedside very, very quickly. You know, a score of zero, no pain; 10, the worst possible pain or somewhere in between it. It literally takes that long to do. But that, you know, that also means that there's a level of insight and usefulness around those tools that they're used, you know, regularly within a service, familiarity with that and then knowing what do I do with that information once I have it.

MR ROZEN: You see, what – I'll tell you where I'm going with this; what jars from a reading of the records is that there are no days during this two week period where Mr Paranthoienne is given any more than two doses of Endone in a 24 hour period. There are days when he's only given one, there are days where he's given none. We combine that with the evidence we've heard both from Ms Ruddock and now from you about there being real pain issues here. How is the Commission to make sense of those two bits of information? Is it – is a conclusion that should be drawn that not enough Endone was given, perhaps because not enough assessments were made, or is there another explanation? Or are you not in a position to express a view?

MR COHEN: I'm not sure that I'm in a position to express a viewpoint but I – I would think that that – that the pain assessment occurring was not adequate.

COMMISSIONER TRACEY: Does it follow that treatment was inadequate?

MR COHEN: Yes. It would follow that that's the case, Commissioner.

MR ROZEN: Your next involvement at Alkira was on the 29th, if I could take you to the progress notes, 0011, please.

MR COHEN: Yes.

MR ROZEN: This was, as we can see, a telephone follow-up by yourself and it's at this point in the narrative that the question of the radiation – palliative radiation therapy arose which we heard Ms Ruddock talking about earlier. Can you just explain to us the clinical judgment behind that.

MR COHEN: Yes, so it had been documented in Mr Paranthoienne's discharge summary the conversations that had been had with a radiation oncologist, and that there was a window there for perhaps a fraction of radiotherapy if required further down the track. And as Ms Ruddock said earlier, you know, you balance burden versus benefit and what's going to be most beneficial for a person at a particular time in their illness trajectory and I think – so that's where the idea for the conversation

with radiation oncology to revisit what had been documented previously, and see if this was, indeed, something that was possible.

5 MR ROZEN: And can you explain to us clinically how that would work in a case like this; why would you do it?

10 MR COHEN: So it would be one single fraction for – to the site of the tumour in the hope that that would manage pain in a fairly timely way, knowing that someone may not have months and months to live and that may benefit from that in a short period of time. If you like, it's almost a gold standard-type option that you could offer somebody if they were able to benefit from it and if the judgment was that that could potentially make a difference in a short time frame.

15 MR ROZEN: And is the application of the radiation, is that intended to reduce the tumour in size, is that how it would operate or what's the - - -

MR COHEN: Look, it – it's intended to reduce the symptom of pain, so whether that is a reduction in tumour size, then yes, that's what would occur.

20 MR ROZEN: Right, okay.

MR COHEN: But certainly not to prolong life. It's not to prolong, in this instance, Mr Paranthoienne's life; it's for symptom management is how that would be framed.

25 MR ROZEN: Yes. Okay. And the inconvenience and potential pain of transferring Mr Paranthoienne to a facility where that could be done is obviously one factor to be weighed into the assessment of whether it's a good idea or not.

30 MR COHEN: That's right, you would need to factor all of that in, you know, a person's ability to transfer from bed to chair or, you know, from the facility into the ambulance, what effect that would have. You would factor all of those things in.

MR ROZEN: Yes. In this particular case, with that factoring, your judgment was it was something that was worth pursuing.

35

MR COHEN: After a conversation, so obviously I'm not prescribing the treatment. I need to say, "I think this may be beneficial", and then the radiation oncologist would then say "Yes, I think that's a suitable plan" and then admit Mr Paranthoienne for, in this instance, the planning and the intervention on the one day.

40

MR ROZEN: Yes. Preparations were made for that to take place on 3 October.

MR COHEN: Yes.

45 MR ROZEN: And we know from the evidence, we've heard from Ms Ruddock that an event intervened where Mr Paranthoienne had a fall and that didn't then happen but

other events did. So far as your involvement in this matter was concerned that was really it, wasn't it, at that point?

MR COHEN: That's right.

5

MR ROZEN: There is a further note – a follow-up note on 4 October by a colleague of yours, but that records – it's self-evident what it records – that wasn't any further involvement by you personally.

10 MR COHEN: No, that's correct. So once someone goes into another care setting – in this instance, hospital, we then discharge that person from our community service. You can't be registered in two places at the one time.

MR ROZEN: I see. All right. Thanks very much. That's all I want to ask you
15 about your involvement here. Commissioners, I note the time. I'm about to go on to a different topic with Mr Cohen. I wonder if it might be an - - -

COMMISSIONER TRACEY: How long do you think you will need?

20 MR ROZEN: I think I'll need about 20 minutes, and on that basis I was going to suggest perhaps a slightly shorter luncheon break than we've been having, if possible, bearing in mind we do have a pretty full afternoon still.

COMMISSIONER TRACEY: Well, if we come back at half past 1?

25

MR ROZEN: I mean, quarter to 2 would probably meet the concern.

COMMISSIONER TRACEY: Would that be all right?

30 MR ROZEN: I think so.

COMMISSIONER TRACEY: All right.

MR ROZEN: Thank you.

35

COMMISSIONER TRACEY: All right. The Commission will adjourn until a quarter to 2.

40 **ADJOURNED** [12.55 pm]

RESUMED [1.47 pm]

45

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Thank you, Commissioners. I recall Joshua Cohen. Just make yourself comfortable there, Mr Cohen.

MR COHEN: Yes.

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MR ROZEN: We had reached the point before we broke for lunch where I had concluded asking you about your experience at Alkira Gardens and as foreshadowed I now want to ask you a bit about the new model of care that was implemented by your employer in April 2018 which you deal with in your first statement which is exhibit 5-33. And at the outset, can I just ask you to reiterate some of the evidence you gave earlier about the genesis of the new model. I understood the evidence you gave earlier to be to the effect that you were involved in the development of the new model based on an assessment that was done of work in Canberra. Is that right?

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MR COHEN: That's right. So our model of care was a replication, really, of the model that had been implemented as a pilot study down in Calvary in Canberra. Clare Holland House was the name of the team that implemented that model of care, and they had published some evidence in 2016 and that was evidence that I was aware of when I came into my position as the transitional nurse practitioner at Calvary, and brought that idea of that model to the Kogarah site.

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MR ROZEN: Yes. And do you know whether the pilot study in Canberra was in turn based on some work that had been done overseas or - - -

MR COHEN: No, it was original research that had been conducted in Canberra.

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MR ROZEN: Right. Okay.

MR COHEN: It was their – the kernel of the idea came from them.

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MR ROZEN: The new model, as we keep referring to it, is palliative care needs round.

MR COHEN: Correct, the palliative care needs round.

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MR ROZEN: PCNR, everything has to have an acronym in the health world.

MR COHEN: Yes.

MR ROZEN: And you've detailed that from paragraph 26 onwards in your first statement which is exhibit 5-33. Can you just give us a sketch overview of how it works.

40

MR COHEN: Yes, so the palliative care needs round is an intervention. It's a clinical meeting that occurs monthly within an aged care organisation that is led by the nurse practitioner in this instance, and in the instance in Calvary, where you discuss and identify palliative care need amongst the people that are living within

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that residential aged care facility. So before you begin the needs round process you provide education, usually two or three sessions, a fairly short education to a facility, and you give them a set of triggers and the triggers – which were also developed by the team in Canberra, and they later published that after their first pilot result – the triggers are – there are a set of five triggers, so you provide education around these triggers, and I can tell you what those five triggers are if that would be helpful.

MR COHEN: You're guessing my next question. I think they're detailed at 37, are they, of your statement, and we're talking about the same thing.

MR COHEN: That's right. That's 37, yes.

MR ROZEN: Perhaps if that could be brought up, this is exhibit 5-33, so it's top of the page there, isn't it. Yes, back to you, Mr Cohen.

MR COHEN: This is a critical part of the process because, as I've discussed, the identification of palliative care need within residential aged care at times is lacking so you can't just say we want you to identify a need in your facility without actually providing them with a vehicle to do so. And this is one of a few that are out there, but this is one that is attached to this particular model, the palliative care needs round. And the triggers are – as you can see listed there, they're in no particular linear order but they are a deterioration or an exacerbation in a resident's condition, the absence of a care plan or a current advance care plan being in place, family conflict or disagreement around the goals of care for that particular resident, residents that have been brought from an acute care facility, so hospital to a residential aged care facility for end of life care.

The literature tells us that that group is at particular risk of dying in short months, usually within three months of admission if you come from hospital, as opposed to coming from the community or home. And then with the use of those first four may lead you to the surprise question which is done internationally in palliative care which is "Would you be surprised if this person died within six months?". That's not an easy question to answer, but the other triggers give you some flesh and information behind that.

MR ROZEN: Am I to understand by the footnote that you've included at paragraph 37 that the article cited there by Forbat et al, 2017 is some evidentiary basis for the five triggers?

MR COHEN: That's right.

MR ROZEN: Okay. And that – I don't need to take you to this but that article is in our tender bundle, so it's part of the evidence before the Commission, you will be pleased to know.

MR COHEN: Yes.

MR ROZEN: So with those triggers, I wonder if we could just go back a step, though. The needs round involves you or perhaps another nurse practitioner or is it at the moment just you?

5 MR COHEN: So within our service there are myself, a nurse practitioner, and a transitional nurse practitioner, so we never do them together, they're always done individually so we've divided our area in half geographically. So I'm running a set of needs round and my colleague is doing the same thing. The people who might attend from an aged care facility, when we begin the education we say anybody who
10 has anything to contribute around patient resident care needs is welcome. In practice, we usually get a fairly small number of attendees which are usually senior clinical nurses from within the site. Occasionally we will get some allied health, that may be pastoral care, it may be staff that are involved in leisure activities or carers, assistants in nursing may also participate, directors of nursing are welcome to come.

15 But the group – the groups that I attend usually between number between – anywhere between three and five people with the registered nurse coming off the floor to present the patients that they've identified with palliative care need, and that would number four – four to five residents discussed within that hour.

20 MR ROZEN: Right. Okay. So you've included a table in your statement – this is at paragraph 33, where you tell the Commission that the PCNR process there, the needs round, have been successfully implemented in 16 facilities included in the outreach program. And you list the 16 there in the table in the two areas, Sutherland and St
25 George; is that right?

MR COHEN: That's right. So there's a – divided into the current and the facilities where education has commenced and we plan to commence the needs round in that site.

30 MR ROZEN: Those 16 are of the – was it 66 that you told us about earlier; is that right?

MR COHEN: Yes, so roughly they represent around a quarter of the sites within our
35 area.

MR ROZEN: How have they been selected or were they self-selected? How did it work?

40 MR COHEN: So when I – when we were deciding which sites to go into, because I was new to the district and hadn't worked in that particular care setting, I didn't really have any idea, so we used the – the aged care in-reach teams in our district known as the geriatric flying squads, they were very present in that space and when we told them about the model that we were interested in implementing, they assisted
45 us in identifying aged care facilities where they had the perception of palliative care need, where they felt that the aged care team would benefit from our input. So we used that.

Also Calvary Kogarah had done some research previously in the aged care space. There was some research in 2016 where they had done a survey to around 78 per cent of the sites within our district, around their expectation of our service and their future expectation of our service. So that also provided information as to what would be appropriate.

MR ROZEN: Yes. Now, it won't be lost on anyone that Alkira Gardens is not one of the facilities listed there.

10 MR COHEN: No.

MR ROZEN: Has there been any discussion with Alkira Gardens about participating in this process?

15 MR COHEN: Yes, so Alkira Gardens were selected initially on the Sutherland side and I would state that I was looking after St George and my colleague was looking after the Sutherland side, so whilst I wasn't directly involved I was aware that they were on our list. We had attempted to implement the palliative care needs rounds there on more than one occasion. Unfortunately, we were unable to get the traction that we needed to sustain that model there.

MR ROZEN: Okay, because you weren't the person dealing with them you're probably not in a position to indicate what the problem was, I take it.

25 MR COHEN: Yes, I didn't have direct involvement. Certainly, I had discussions with my colleague as to her perception as to why it wasn't successful in that particular facility.

MR ROZEN: Can you share that with us?

30 MR COHEN: Yes, so the – and this is something that we couldn't have known before we started. When we had a red flag with facilities that – where – there's a quick turnover of staff or where management – we haven't got suitable buy-in or interest from directors of nursing or senior executive staff on the site who can then hand over that information to other nurses within the facility to say, actually, this is something that we're interested in pursuing. We didn't ever garner that interest in a month-to-month sustained way from Alkira Gardens.

40 MR ROZEN: Okay. Now, I want to ask you about four discrete topics which probably overlap to some extent that you deal with in your statement. The first of them is at paragraph 43 of your first statement, exhibit 5-33, under the heading Challenges in Offering Palliative Care Services. You identify funding as a key challenge in offering palliative care services into residential aged care. Do you mean by that funding at your end or funding in the aged care setting or both or something else?

MR COHEN: I would only have an opinion about funding from our end, from a public service coming into a residential aged care setting. And also from my position as chair of palliative aged care network, I'm aware of what interventions there are, particularly in New South Wales, some of the funding arrangements, whether they be
5 recurrent or flexible funding, pots of money that are there for a few years with the hope that an intervention would continue after that time.

MR ROZEN: All right. Am I to take it from that that your concern is the absence of ongoing recurrent funding which seems, I must say, to bedevil the area of palliative
10 care programs, there's lots of pilots.

MR COHEN: Yes, so that is certainly an area of concern when you want to implement a model but you're unsure how long you will actually be present to do it.

15 MR ROZEN: Yes.

MR COHEN: And when we were starting our model we were – could confidently say we can keep coming back because the funding for both of our positions is recurrent funding for these nurse practitioners from the State government, so we're
20 not going anywhere. So that was actually a selling point to the aged care facilities to say we will be coming every month and we plan to continue doing that, there's no threat to the ongoing, you know, ability to do that from a funding point of view.

MR ROZEN: Yes. Is part of your role an educative one?
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MR COHEN: Part of the role – so nurse practitioners' primary, you know, role is around clinical care.

MR ROZEN: Yes.
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MR COHEN: Part of the needs round, the palliative care needs round, a component of the needs round in the clinical conversation is education, so case-based education, that occurs at that time.

35 MR ROZEN: And can you tease that out a little bit. In what form does that take? Is that by example or - - -

MR COHEN: So - - -

40 MR ROZEN: - - - is it more a didactic sort of model?

MR COHEN: No. Well, we've been keeping some data on the type of education that we give in the needs rounds, and we've been doing them for 18 months now. It's often around opioids and the use of opioids, the assessment of pain, the
45 appropriate conversion of drugs from an oral to a subcutaneous – a subcutaneous equivalent, advanced care planning. So we've kept fairly good information around the type of education that we give in the context of residents being presented to us.

It's very much education, at that moment, relevant to that person, symptom management and so on.

5 MR ROZEN: Does that link in any way back to our discussion earlier about the concern the GP had at Alkira about subcutaneous medication?

MR COHEN: Mmm.

10 MR ROZEN: Is one of the potential outcomes of this process to lessen those concerns on the part of someone like you as a prescriber?

MR COHEN: I think so.

15 MR ROZEN: Yes.

MR COHEN: I think so because you can really drill down on the detail of – of that process – the process of the use of PRN medication, the process identification of need and then the use of subcutaneous equivalents. What's safe, what isn't as the person giving – giving the – giving the drugs. So you get not only familiar with the people working in the sites through the needs round, but then you can deliver that really useful information regularly.

20 MR ROZEN: Slightly different approach to it. You heard Shannon Ruddock this morning talking - - -

25 MR COHEN: Yes.

MR ROZEN: - - - about the importance of a member of the public like her being able to make sensible judgments about where a loved one should go, particularly in relation to the provision of good palliative care.

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MR COHEN: Mmm.

35 MR ROZEN: Is there any way a member of the public can know which of the facilities in these two shires are the ones where this service is being offered? Is that publicly available information other than from reading your witness statement and it ends up on our website?

40 MR COHEN: Look, I don't know if it's information that's publicly available. The sites that we're involved in – that we're involved in, I know, cite the fact that we're there doing these rounds.

MR ROZEN: Yes. Yes.

45 MR COHEN: Whether that's verbal or documented, I couldn't – I couldn't say.

MR ROZEN: Do you see any benefit, looking at it from the point of view of a member of the public, in knowing?

5 MR COHEN: As a consumer, yeah, I – I think that would be something that would be of use to someone helping to decide on the quality of the care within a facility, yes.

10 MR ROZEN: Yeah. At paragraph 61, you respond to the question that you were asked by the Commission which is to detail what, in your opinion, is appropriate palliative care in aged care services. And you very helpfully set out what you consider to be the elements of appropriate palliative care and best practice in aged care services in the list that we can see on the screen at the moment. If you had to pick your key two, which would they be?

15 MR COHEN: Key two.

MR ROZEN: It's like trying to pick your favourite child, probably, is it?

20 MR COHEN: Look, I would base some of that on – on Ms Ruddock's information this morning when she was talking about care that was holistic and being in a situation where a family member felt they could ask anything and had an answer competently given. So I guess the first one, adapting the care to the individual and the family, would have to be number one - - -

25 MR ROZEN: Yes.

30 MR COHEN: - - - and keeping the resident at the centre of that care and, obviously, the family is with that person in that centre. So it – being adaptable to that. And I think being familiar with the literature around the delivery of specialist palliative care in aged care settings, no matter what the model, no matter whether – whether capacity is within a facility or not to manage their care, the requirement for access to specialist palliative care actually doesn't change. It always needs – those linkages are vital to good outcomes in palliative and end of life care.

35 MR ROZEN: A question that sort of comes across a lot of the evidence you've given, is this, Mr Cohen: there's evidence before the Commission, and we will hear a bit more of it later this afternoon, about the importance of palliative care of a high standard being provided in residential aged care facilities.

40 MR COHEN: Mmm.

45 MR ROZEN: If for no other reason than because so many people die in residential aged care facilities and they're not unexpected deaths, generally speaking. As against that, there's the evidence the Commission has heard about the real challenges for residential aged care facilities to provide quality palliative care. Whether it's numbers of staff, whether it's access to appropriate drugs, whether it's training of staff, there seem to be a number of obstacles or challenges, if we put it that way.

From your perspective, is the best and most practical model a mixture of some development of capacity within residential aged care facilities, but supplemented by services such as yours providing specialist palliative care services?

5 MR COHEN: I think that you are very correct in that. I think it's never one solution. It's – residential aged care is a very, you know, difficult space with a lot of complexity to it. So, yes, I think it's a combination of – of – of many things to arrive at that point where you can be sure of good outcomes for people who require a palliative approach in residential aged care.

10 MR ROZEN: Playing the devil's advocate a little bit.

MR COHEN: Mmm.

15 MR ROZEN: Is there a risk in the model that the presence of the Josh Cohens of the world coming in from outside can lead to, perhaps, some residential aged care facilities saying, "Well, there's not really part of our core business. We have experts come in to do that. So we don't need to develop that capacity here." Is that a real risk and, if it is, how do you address that?

20 MR COHEN: Look, I'm not sure if they're asking themselves that question, and I feel as though there will always be a role for specialist palliative care coming in, no matter the capacity within the site. There are some models where there is specialist palliative care coming from within, very substantial models coming from within
25 residential aged care organisations, and even in that, linkages with specialist palliative care is an appropriate resource to use. So I would never say that having us on-site lessens capacity. We like to think that we encourage capacity building.

30 MR ROZEN: Yes. Is part of that answer coming back to the question about education and skills transfer - - -

MR COHEN: Part of that.

35 MR ROZEN: - - - that we spoke about.

MR COHEN: Yes. Yes.

40 MR ROZEN: Two more topics. One concerns the workforce which is a topic we just don't seem to be able to get away from in this Royal Commission.

MR COHEN: Mmm.

45 MR ROZEN: It pops up in every area that we look at. You were asked about whether there are successful work force models for delivering palliative care services in aged care, and if so, what makes them successful, and you deal with this at paragraph 98 of your statement, and I'd ask that be brought up, page 18. And you talk at 99 about the wonderfully named Geriatric Flying Squad Team - - -

MR COHEN: Yes.

MR ROZEN: - - - about which we are going to hear a bit more in our Darwin hearing, as it turns out, in a couple of weeks time.

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MR COHEN: Mmm.

MR ROZEN: Can you expand on what you say at 99 about the combination of the work you do with theirs. Is this Peter Gonski's team that we're talking about?

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MR COHEN: Yes.

MR ROZEN: Yes.

15 MR COHEN: Yes. One of – one of - - -

MR ROZEN: Professor Gonski, I should say. Yes.

MR COHEN: There's Peter Gonski's team and there's a team at Sutherland as well. So, yes.

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MR ROZEN: Right. And how has that been working and what are the future plans there?

MR COHEN: So both of those teams existed before we were running our particular model.

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MR ROZEN: Yes.

MR COHEN: Both of those teams had nurse practitioners as core parts of their team, and they have a geriatrician or part of a geriatrician position attached to those services as well. It's been, for me working with that team, a very interesting space to work in. Our articulation, we have been figuring out as we – as we – as we go along.

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MR ROZEN: Yes.

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MR COHEN: Because they had far more capacity than we did when we first started, they were managing a lot of palliative care, and I make the point in the statement that the palliative care given in residential aged care is not necessarily specialist palliative care that you would see in a specialist palliative care unit. We're often identifying palliative care need because there's a lack in facilities to do so themselves. Back to the question about the flying squad, so they were managing a lot of the advanced care planning and doing a lot of the palliative care.

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MR ROZEN: Yes.

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MR COHEN: When we started we knew we had to articulate with them. What we found is that – and Geriatric Flying Squads managed more acute conditions than we do. Their purpose is to really prevent admissions, if it's appropriate to do so, from coming into a hospital emergency room. They can intercept the call that a site has made to an ambulance and have a conversation with the facility and say. "Is there anything we can do to avoid this admission or is it absolutely essential?" And then they make that decision. So, oftentimes, it will be the situation where they turn up, and they may be identifying someone who is either dying or requires a palliative approach to care, and admission is not in their best interests, and they can negotiate that with – with the – the resident and family. So it's been – we've discovered that it's a shared care model. Sometimes, their care is appropriate; sometimes, my care is appropriate; sometimes, it's a combination.

MR ROZEN: Yes.

MR COHEN: For example, on a Friday, I may hand over to the flying squad and say – because we don't work on the weekends, unfortunately.

MR ROZEN: Yes.

MR COHEN: We don't have that capacity. They do. They can continue symptom management, Saturday, Sunday and then hand back to us on the Monday.

MR ROZEN: Yes.

MR COHEN: So it's something that we're working out and articulating more as we are working together more.

MR ROZEN: What about at the aged care facility level? You've been exposed to lots of facilities. Some, presumably, provide better palliative care services than others.

MR COHEN: Mmm.

MR ROZEN: What do you think distinguishes the ones that are doing it better?

MR COHEN: The sites that are doing palliative care better - - -

MR ROZEN: Yes. Yes.

MR COHEN: - - - what distinguishes those sites?

MR ROZEN: Yeah. What is it about those that you've identified?

MR COHEN: Staff that – their – staff that have a solid employment at that site. So that they're regular. They're – it's not a high turnover of staff, sorry, is what I'm trying to say.

MR ROZEN: Yes.

MR COHEN: Not a high turnover of staff. So you can build a relationship with that facility and site because it's the same people that are there. That would be one of the
5 first things that I would say. I actually think I have documented that somewhere in here.

MR ROZEN: You may well have done, and I apologise if I've missed it.

10 MR COHEN: Sorry.

MR ROZEN: I think it's at 102, if I'm right.

MR COHEN: Yes. No, no, that was a successful workforce model.
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MR ROZEN: Maybe not. Anyway, that – I mean, it's interesting you make that observation.

MR COHEN: Mmm.
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MR ROZEN: The evidence – and, once again, I don't think any of this is in dispute. There's very high staff turnover at Alkira Gardens.

MR COHEN: Mmm.
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MR ROZEN: Most – nearly all of the staff that were involved in providing care to Mr Paranthoene two years ago are no longer working at the facility.

MR COHEN: Right.
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MR ROZEN: So it's that continuity of staffing.

MR COHEN: Mmm.

35 MR ROZEN: What about the – is it anything to do with staffing numbers, for example? Is that a significant thing or more about quality, rather than quantity?

MR COHEN: Look, I – I – it's certainly about quality over quantity, but I – I don't actively engage in the number of staff - - -
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MR ROZEN: No.

MR COHEN: - - - that are assigned to a particular patient load. There are times where I may ask, "How many people are you looking after today," to the registered
45 nurse. Normally, it's an overwhelming amount, and I know that when I ask them to accompany me on – on an assessment, I'm aware that they're stretched in the

capacity to do that. That spending that time with me really takes away from the rest of the tasks that they need to do and that they're time poor around that.

5 MR ROZEN: Last topic I want to ask you about, you deal with at paragraph 115 on page 21 of your statement, under the heading Opportunities for Improvement and Reform. This is the equivalent of what other witnesses have had the experience of a wish list at the end of their evidence.

10 MR COHEN: Yes. Yes.

MR ROZEN: Which is a service we're happy to provide here. You've listed a number of areas. I wanted to ask you about one in particular, but feel free to expand on the others, and that is the one you've referred to at (c), and it's good to see you think there should be more nurse practitioners in aged care organisations. I'm sure none of us are surprised.

MR COHEN: Mmm.

20 MR ROZEN: But also pharmacists, other professionals, building that, what, expertise. Is that the idea?

MR COHEN: Yes, that's right. I think it's the idea of a – you know, a conversation between specialists, providers, all the services sitting at a table together to say how are we going to best manage, in this case, palliative care within this site? I have colleagues that are nurse practitioners working within aged care organisations, not in New South Wales, but that have very successful models.

MR ROZEN: Yes.

30 MR COHEN: I've always thought that when you're coming from within an organisation, you clearly have more authority to make change as opposed to someone coming out.

35 MR ROZEN: Yes.

MR COHEN: We know that the scope of practice of a nurse practitioner is so suited to the aged care environment where they can assess, they can diagnose, they can do appropriate diagnostics to lead to that, and then implement the actual medications, prescribing or de-prescribing. That is gold in that space. As is, you know, other roles coming from within aged care organisations: clinical nurse consultants in the particular specialty that are familiar with how the organisations works, with the care plans that they use, more so than we would be as an outside organisation coming in. So I don't think you can underestimate the effect that that would have from within the industry to feel as though there was, you know, that interest in it.

45 MR ROZEN: Commissioners, that concludes my examination of Mr Cohen.

COMMISSIONER TRACEY: Mr Cohen, thank you for sharing your considerable experience of palliative care with us. We are very grateful to you for coming all this way to do that.

5 MR COHEN: Thank you.

COMMISSIONER TRACEY: And we thank you very much for your evidence.

10 MR COHEN: Thank you. I'm very grateful to be asked, Commissioners.

COMMISSIONER TRACEY: Thank you.

MR ROZEN: Thank you, Mr Cohen.

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<THE WITNESS WITHDREW [2.16 pm]

MR ROZEN: Ms Hill will take the next witness.

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COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: Commissioners, I call John Leong.

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<JOHN LEONG, SWORN [2.16 pm]

<EXAMINATION-IN-CHIEF BY MS HILL

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MS HILL: Thank you, Mr Leong, please take a seat. If I could ask you to keep you to keep your voice up, and could you please state your full name.

35 MR LEONG: I am John Leong.

MS HILL: You are the compliance and development manager of Our Lady of China.

40 MR LEONG: Correct.

MS HILL: The Sister of Our Lady of China are the approved provider for Alkira Gardens; is that right?

45 MR LEONG: Correct.

MS HILL: You've prepared two statements for this Royal Commission, haven't you?

MR LEONG: That's right.

5

MS HILL: Operator, could I ask you to please display document ID WIT.0244.0027 – sorry, 0022.0001. Mr Leong, is that the second statement that you've made to the Royal Commission dated 25 June 2019?

10 MR LEONG: Yes. Correct.

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

MR LEONG: Yes.

15

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

MR LEONG: Sorry, can you repeat that?

20 MS HILL: Are there any changes that you seek to make to the statement of 25 June?

MR LEONG: No, the correction I wanted to make already in the supplementary statement.

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MS HILL: And that's in that statement?

MR LEONG: That's that. Commissioners, I tender that.

30 COMMISSIONER TRACEY: Yes, the witness statement of John Leong dated 25 June 2019 will be exhibit 5-35.

35 **EXHIBIT #5-35 WITNESS STATEMENT OF JOHN LEONG DATED 25/06/2019 (WIT.0244.0002.0001)**

MS HILL: Operator, could you please display document ID WIT.0244.0022.0001. Mr Leong, do you see the statement dated 14 June 2019?

40

MR LEONG: Yes.

MS HILL: And that's the statement that you've made.

45 MR LEONG: That's correct.

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

MR LEONG: Correct.

MS HILL: You have some changes that you wanted to correct in this statement that you made in the supplementary statement; is that right?

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MR LEONG: That's right.

MS HILL: Commissioners, I tender that statement.

10 COMMISSIONER TRACEY: Yes. The second witness statement of John Leong dated 14 June 2019 will be exhibit 5-36.

15 **EXHIBIT #5-36 WITNESS STATEMENT OF JOHN LEONG DATED
14/06/2019 (WIT.0244.0002.0001)**

MS HILL: As the Commission pleases. Mr Leong, you're a qualified registered nurse.

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MR LEONG: I was but I'm not registered to practice currently.

MS HILL: The care that residents can expect from Alkira Gardens is set out in the resident and accommodation agreement between the resident and The Sisters of Our Lady of China; is that right?

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MR LEONG: That's correct.

MS HILL: And in Mr Paranthoienne's case that's the subject of an agreement that you provided to the Commission dated 22 June 2017 when Mr Paranthoienne becomes a permanent resident.

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MR LEONG: That's correct.

35 MS HILL: Mr Paranthoienne, we've heard, has been a resident of Alkira Gardens since 20 April 2017 having entered Alkira Gardens initially on a respite agreement; is that right?

MR LEONG: That's right.

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MS HILL: And palliative care and the palliative care expectations of a resident and Alkira Gardens is set out within that permanent resident agreement that we've referred to, isn't it?

45 MR LEONG: That's right.

MS HILL: You've been present in the hearing room throughout course of the day.

MR LEONG: Yes, I have.

MS HILL: And you've had the opportunity to read Ms Ruddock's statement before attending the hearing today.

5

MR LEONG: Yes, I have.

MS HILL: In those circumstances you aware that before Mr Paranthoiene was a resident at Alkira Gardens, he had suffered a stroke, had been hospitalised, had had a fall subsequently when he was in rehabilitation, and had fractured six to eight ribs and he was on pain relief at the time that he moved into Alkira Gardens.

10

MR LEONG: Yes, I'm aware of that.

MS HILL: Mr Leong, you would agree, wouldn't you, that lots of people die in residential aged care, don't they?

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MR LEONG: Yes, they do.

MS HILL: And you agree that people who are dying in Australia expect good quality palliative care, don't they?

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MR LEONG: Yes.

MS HILL: Our Lady of China, as the approved provider for Alkira Gardens, has a palliative care policy and procedure.

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MR LEONG: Yes, we do.

MS HILL: And your lawyers have provided that to the Commission, haven't they?

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MR LEONG: That's correct.

MS HILL: Our Lady of China also has a pain management policy, don't they?

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MR LEONG: Yes, we do.

MS HILL: And your lawyers have also provided that to the Commission, haven't they?

40

MR LEONG: That's correct.

MS HILL: In that pain management policy, it sets out the clinical protocol for the pain management guideline; is that correct?

45

MR LEONG: Yes.

MS HILL: That clinical protocol – that guideline which sets out the task for the staff of Alkira Gardens, doesn't it?

MR LEONG: That's right.

5

MS HILL: If I could pause there to clarify with you, Mr Leong. You were not involved, and you don't say you were involved in providing care to Vincent Paranthoene at any time he was a resident at Alkira Gardens, do you?

10 MR LEONG: No, I don't get the direct involvement in that.

MS HILL: And those statements – those two statements that you prepared, you've prepared them by reference to the records that are available to you, haven't you?

15 MR LEONG: That's correct, and plus interviewing the two RNs which still remain working there, who looked after Mr Paranthoene.

MS HILL: In your statement, Mr Leong, in your first statement, you express medical opinions at paragraph 89 and 96, and I can have those brought up for you.

20 That's a statement dated 14 June, so I could perhaps start with paragraph 89. So paragraph 89 at the top of the page which is just being highlighted now, at paragraph 89 you express a medical opinion, don't you?

MR LEONG: Yes.

25

MS HILL: And you've done so based on your view and what you understand from the documents and those people you've spoken to, haven't you?

MR LEONG: That's correct.

30

MS HILL: You've done the best you can to understand what's happened here.

MR LEONG: That's correct.

35 MS HILL: But you're not qualified to give a medical opinion, are you, Mr Leong?

MR LEONG: No.

MS HILL: Operator, if I can ask you to turn to paragraph 96. If you could take a look at that paragraph that's highlighted before you, I suggest, Mr Leong, that in that paragraph you express a medical opinion? I'm referring explicitly to that second sentence there.

40

MR LEONG: This was – I asked the RN and that's the opinion they gave me.

45

MS HILL: So you formed that view to the best of your ability on the basis of those people you had spoken to.

MR LEONG: Correct.

MS HILL: You're not otherwise qualified to give a medical opinion as to that second sentence.

5

MR LEONG: That's right. I am not.

MS HILL: Operator, can I ask you please to display tab 24 of the Alkira Gardens tender bundle. Mr Leong, could I ask you to take a look at that document on the monitor before you. That's a discharge referral note for Mr Paranthoienne on 18 September 2017, and I can tell you that's the discharge referral note that your lawyers provided to the Commission.

10

MR LEONG: That's correct.

15

MS HILL: Can you see there that it sets out that Mr Paranthoienne had a diagnosis of a spindle cell tumour with advanced malignancy and a poor prognosis.

MR LEONG: Yes.

20

MS HILL: It said a palliative care team has been engaged by the hospital.

MR LEONG: Sorry, what are you asking me, sorry?

25

MS HILL: So perhaps if I – turning over that page, you will see it says:

Issues in this admission –

and they set out at 1 and 2, there's a chest wall malignancy.

30

MR LEONG: Yes.

MS HILL: Followed by anaemia at 3. There has been a heading Issues – following that there's a heading Discharge Medications. If I can ask the operator to zoom back out, please. They are the discharge medications, aren't they, Mr Leong?

35

MR LEONG: That's correct.

MS HILL: And there is a discharge plan that follows that, isn't there?

40

MR LEONG: That's correct.

MS HILL: Could I draw your attention to the discharge medications that are there on page 2. Do you see the ticks next to those medications?

45

MR LEONG: Yes, I do.

MS HILL: Do you know whose handwriting that is?

MR LEONG: No, I cannot comment on that.

5 MS HILL: Are you in a position to say with any certainty what those ticks refer to?

MR LEONG: I cannot explain.

10 MS HILL: The Commission has heard that there was a delay with Alkira Gardens getting the discharge papers from the hospital, and you were present in the hearing this morning and heard that.

MR LEONG: Yes, I was.

15 MS HILL: Are you able to say why that was?

MR LEONG: So can I – did you ask - - -

20 MS HILL: Why would there have been a delay with Alkira Gardens receiving the discharge papers?

MR LEONG: I wouldn't be able to explain that, no.

25 MS HILL: What is the typical process, Mr Leong, of Alkira Gardens receiving discharge papers from hospitals?

30 MR LEONG: From what I understand they normally accompany the resident, the discharge summary, yes. As I don't have direct interaction with that in the facility. I just go by like in the documentation.

MS HILL: You would agree that it's unfortunate that in Mr Paranthoiene's case there was a delay that we've heard about this morning.

35 MR LEONG: That's correct.

MS HILL: Could I ask that the witness be shown the document that has been prepared by solicitors for the Commission and your lawyers, Mr Leong. And I've got a copy.

40 MR LEONG: Thank you.

45 MS HILL: Mr Leong, that's the document that's agreed by your lawyers and the lawyers for the Commission. I'm going to ask you to take a look at several entries. Staying on the first page, could I ask you to go to 19 September 2017 which is the second entry there.

MR LEONG: Yes.

MS HILL: Could I ask you to move along to the column that says Endone prescribed.

MR LEONG: Yes.

5

MS HILL: And do you see what it says written there?

MR LEONG: Endone prescribed on the 19th. Five milligram every two hours PRN.

10 MS HILL: Are you able to say what that means to your staff at Alkira Gardens?

MR LEONG: I wouldn't be able to comment on that as I was not there.

MS HILL: Could I turn your attention then to the entry 23 September 2017.

15

MR LEONG: Yes.

MS HILL: I suggest to you if we follow the detail for that entry along, there is paracetamol, Oxycontin and Lyrica that's administered at 8 am to Mr Paranthoienne.

20

MR LEONG: Yes.

MS HILL: At midday, Mr Paranthoienne received paracetamol again.

25 MR LEONG: Midday, yes.

MS HILL: At 5 pm, Lyrica is administered.

MR LEONG: Five pm, Lyrica. Yes.

30

MS HILL: At 8 pm, Oxycontin's administered.

MR LEONG: Eight pm, Oxycontin, yes.

35 MS HILL: There's no Endone administered.

MR LEONG: Endone was administered, 9 am, five milligram, and 11.45 am, five milligram on 20 September.

40 MS HILL: I apologise, Mr Leong. I'm referring to the 23rd of September.

MR LEONG: Oh, sorry. Sorry.

45 MS HILL: So on the 23rd of September, I suggest you can see that at 8 am, there's paracetamol, Oxycontin and Lyrica.

MR LEONG: Yeah. Correct.

MS HILL: At midday, there's paracetamol.

MR LEONG: Mmm.

5 MS HILL: Five pm, Lyrica is administered.

MR LEONG: Yep.

MS HILL: Eight pm, Oxycontin is administered.

10 MR LEONG: Yep.

MS HILL: There's no Endone administered.

15 MR LEONG: Correct.

MS HILL: And there's no pain assessment, is there?

MR LEONG: No.

20 MS HILL: Where's the pain assessment for that date, Mr Leong?

MR LEONG: Based on the evidence available, I really couldn't explain why – I couldn't find it.

25 MS HILL: Can I turn, then, to the 24th of September, the date that follows.

MR LEONG: 24th?

30 MS HILL: The 24th.

MR LEONG: Yep.

MS HILL: There's a pain assessment on the 24th at 11 am. Do you see that there?

35 MR LEONG: That's right.

MS HILL: And it's recorded five to six, and a 10 at back.

40 MR LEONG: Ten, that's right.

MS HILL: At 8 am, paracetamol, Oxycontin and Lyrica is administered.

MR LEONG: That's correct.

45 MS HILL: At midday, paracetamol is administered.

MR LEONG: That's correct.

MS HILL: At 11 am, Endone is administered.

5 MR LEONG: Eleven am, that's correct.

MS HILL: At 5 pm, Lyrica is administered.

MR LEONG: That's correct.

10

MS HILL: At 8 pm, Oxycontin is administered.

MR LEONG: That's correct.

15 MS HILL: And then if we go back to the Endone prescribed column, there's a note there that says:

Cease for 24 hours from 2.30 pm.

20 MR LEONG: Yes.

MS HILL: Could I ask you, then, to turn the page, and I will draw your attention to the 25th of September which might be slightly obscured by that staple in the top left-hand corner.

25

MR LEONG: Mmm.

MS HILL: Do you see that there's no pain assessment on that date?

30 MR LEONG: On the 25th of September, there was a physio assessment conducted and - - -

MS HILL: There's no record of any - - -

35 MR LEONG: No record of a pain assessment.

MS HILL: Are you able to say why that is?

40 MR LEONG: I mean, I can't explain why, but there's no record to say whether he was in pain, then they didn't document, or there was no record of pain assessment done because there was no pain. So I can't explain why it wasn't done.

45 MS HILL: I suggest, Mr Leong, that it's an unusual practice to stop Endone for a period of time, which has been done on the advice of the GP, and then not conduct a pain assessment or have any record of a pain assessment the following day.

MR LEONG: Sorry, can you repeat that question again. Sorry.

MS HILL: On the 24th of September - - -

MR LEONG: Mmm.

5 MS HILL: - - - we've seen that Endone has been ceased for 24 hours, and there's no dispute that is at the direction of the GP, and then when we turn to the 25th of September, there's no pain assessment on that date, no record of anything about Mr Paranthoiene's pain.

10 MR LEONG: That's right.

MS HILL: And I suggest to you that it's unusual to remove Endone, remove a medication that has been considered for pain relief, and then not conduct a pain assessment.

15

MR LEONG: I mean – correct, and like I mentioned earlier, it could be because, like, there's no document to say whether he did have pain and didn't document, or he – he didn't have pain, that's why it wasn't done so. I can't explain why.

20 MS HILL: Can I ask you to stay on that A3 document that's in front of you and draw your attention to the date starting with the 30th of September.

MR LEONG: 3rd of – 30th of September?

25 MS HILL: Yes. And focusing on that column, Pain - - -

MR LEONG: Mmm.

30 MS HILL: - - - there's nothing recorded about Mr Paranthoiene's pain, is there, on that day?

MR LEONG: No.

35 MS HILL: And that's true of the 1st of October.

MR LEONG: Correct.

MS HILL: That's true of the 2nd of October.

40 MR LEONG: Correct.

MS HILL: That's true of the 3rd of October.

45 MR LEONG: Correct.

MS HILL: I suggest, Mr Leong, that Alkira Gardens is not in a position to say what Mr Paranthoiene's pain level was on those dates?

MR LEONG: I – I can't answer that. There's just no documentation to indicate whether – like I mentioned, whether he was – he was in pain, it wasn't document, or he wasn't – he wasn't in – he wasn't in pain and wasn't – been completed.

5 MS HILL: You can't say what's going on, on those dates, can you, because of the absence of records?

MR LEONG: That's correct.

10 MS HILL: Or the fact that there were no records, can you?

MR LEONG: There were no records and I can't make a – a – a comment on whether – why it was no record, whether because that – he didn't have any pain or he did have pain. So I can't make a comment on that one.

15

MS HILL: I suggest to you, Mr Leong, that Alkira Gardens has kept inadequate records of Mr Paranthoiene's pain, pain management during this time, haven't they?

MR LEONG: I disagree with that because when you look at from the 18th of
20 September, there were records of the registered nurse doing a – conducting,
informally, using the Abbey Pain Scale or the document in the progress note to say,
“Can you rate your pain? We will give a rating either six to 10 out of – I mean, six –
five tom six out 10 or eight out of 10.” Those are the informal numerical type of a
pain scoring, and in the progress note, they even mention something I read:

25

Resident is comfortable lying in bed watching TV and nil complaint of pain.

I have seen those evidence in the progress note.

30 MS HILL: I suggest to you that what this summary of records demonstrates is that,
sometimes, Alkira Gardens knows - - -

MR LEONG: Mmm.

35 MS HILL: - - - what Mr Paranthoiene's pain is and, sometimes, they don't.

MR LEONG: I don't know for that. There's just no document to say, like, they
didn't do it because – because they were – I mean – let me rephrase that. I can't
explain that because, like, there was no documents saying, like, they didn't do it.
40 And – or could it be, like, he didn't have pain. That's in the progress note that when
they ask him whether he was comfortable, and he – he would say, look, he's
comfortable watching TV or no pain.

MS HILL: You would agree, wouldn't you, Mr Leong, that Alkira Gardens has kept
45 inadequate records of Mr Paranthoiene's pain during this time?

MR LEONG: Yes, I agree there were, unfortunately, some occasions. There's shortfalls in that, and we have rectified that problem and all the staff been trained in that to make sure they're assessing pain, they – they would document that for each occasion.

5

MS HILL: I suggest to you, Mr Leong, that Alkira Gardens – the staff at Alkira Gardens did not have control of Mr Leong's pain during this time.

MR LEONG: Sorry, can you explain whose pain?

10

MS HILL: You've been present in the hearing room throughout the course of the day, and you've heard the evidence - - -

MR LEONG: Yes.

15

MS HILL: - - - of Ms Ruddock and you've heard the evidence of Mr Cohen.

MR LEONG: Mmm.

20

MS HILL: Alkira Gardens didn't have control of Mr Paranthoienne's pain management, did they?

MR LEONG: I – I – like I mentioned, there are some shortfalls and, on some occasion, they would have done it, like, better.

25

MS HILL: Why were there shortfalls, Mr Leong?

MR LEONG: That, I couldn't explain. There's – there's no documentation in the file that I could see.

30

MS HILL: I suggest to you, Mr Leong, that the treatment of Vincent Paranthoienne at this time, 18 September to 3 October, was inadequate, wasn't it?

MR LEONG: Sorry. Can I just go through and look through that.

35

MS HILL: Certainly.

MR LEONG: Yes, it was inadequate, but, at the same time, they – they were giving him the pain analgesia as charted by the doctor.

40

MS HILL: After Mr Paranthoienne was discharged by the hospital on the 1st of September, he was assessed by Josh Cohen from the community palliative care team, wasn't he?

45

MR LEONG: Yes, he was.

MS HILL: And we see that in the progress notes that you've referred to in your evidence earlier, and Josh Cohen emailed Mr Paranthoiene's general practitioner and Alkira Gardens his review of Mr Paranthoiene, didn't he?

5 MR LEONG: Yes, he did.

MS HILL: Operator, could I ask you to please display tab 28. That's the email that Alkira Gardens received, isn't it, Mr Leong?

10 MR LEONG: That's correct.

MS HILL: Operator, could I ask you to display tab 29. That's the review that Mr Cohen emailed the GP in Alkira Gardens, isn't it?

15 MR LEONG: That's correct.

MS HILL: Now, on that recommendation – on that review of the 20th of September, the notes show that the GP had a reluctance to chart injectable medications in the instance of it being given inappropriately by staff at Mr Paranthoiene's aged care facility. You've heard that evidence this morning.

MR LEONG: I did, yes.

MS HILL: And you've seen that referred to in the documents.

25

MR LEONG: That's right.

MS HILL: It suggests a pretty dim view of the staff at Alkira Gardens, doesn't it?

30 MR LEONG: Sorry, can you repeat that. Sorry.

MS HILL: The fact that the GP is reluctant to chart injectable medication because of the concern of it being given inappropriately, that suggests a dim view of the staff of Alkira Gardens, doesn't it?

35

MS TAYLOR: I object. The witness can't answer what sort of view the GP had of the staff at Alkira Gardens. The documents really speak for themselves.

40 COMMISSIONER TRACEY: I'm sorry. I'm having - - -

MS TAYLOR: I'm sorry. You can't hear me.

COMMISSIONER TRACEY: - - - difficulty hearing you.

45 MS TAYLOR: I object to the witness being asked what the GP's view of the staff at Alkira Gardens was. The documents speak for themselves. Mr Cohen was asked

about it, and that went through, but, really, the witness can't assist the Commission on what the GP's views of the staff care was, in this regard.

5 COMMISSIONER TRACEY: Is there anything suggestion, Ms Hill, that there was some communication between the GP and the witness?

MS HILL: No, Commissioner.

10 COMMISSIONER TRACEY: No. So you're really asking him to speculate.

MS HILL: I don't pursue the question, Commissioner. Operator, could I ask you to turn to tab 30. Tab 30 is an example of the progress notes that we've been referring to, isn't it, Mr Leong?

15 MR LEONG: Correct.

MS HILL: And if you turn to the 21st of September 2017, 1900, do you see, there:

20 *LMO, R/V meds as per palliative care team recommendation.*

MR LEONG: Yes.

MS HILL: And that's on the first line.

25 MR LEONG: That's right.

MS HILL: And we've heard evidence this morning, Mr Cohen then conducted a further review on – that was the further review Mr Cohen conducted on 27 September.

30 MR LEONG: Correct.

MS HILL: And operator, if I could ask you to please display tab 34. That further review was emailed and that's the email, isn't it, Mr Leong?

35 MR LEONG: Correct.

MS HILL: And operator please display tab 35. That's the attachment to that email.

40 MR LEONG: Correct.

MS HILL: Operator, could I ask you to please display tab 33. On that first half of the page, could I draw your attention to the entry for 27 September 2017, 1345. You see there that it says the LMO was informed.

45 MR LEONG: Yes.

MS HILL: And then the second last line:

LMO faxed the recommendation. Care plan updated.

5 And then there's a reference to PRN Endone given at - - -

MR LEONG: Correct.

10 MS HILL: - - - that time. Where is that care plan, Mr Leong?

MR LEONG: I mean, from reading that, I'm not clear which care plan the RN was referring to.

15 MS HILL: Is there a care plan for Mr Paranthoene in place by Alkira Gardens this time?

MR LEONG: There – yes, there's a care plan. There's a care plan.

20 MS HILL: And what document are you referring to when you talk about a care plan?

MR LEONG: It's about the dietician been and make some recommendations about some diet changes and that was updated.

25 MS HILL: In your palliative care policy you agree that reference is made to there – to an advance care directive being identified.

MR LEONG: Sorry?

30 MS HILL: In The Sister of Our Lady of China's palliative care policy, reference is made to identifying advance care directives, if able; do you agree with that?

MR LEONG: Yes.

35 MS HILL: Is an advance care directive the same as a palliative care plan, in your view?

MR LEONG: In my view, no.

40 MS HILL: What makes them different?

MR LEONG: I can't explain the difference but from what I hear Josh Cohen was saying this morning about the difference, that's how I interpreted it.

45 MS HILL: Do you know whether an advance care directive was prepared for Vincent Paranthoene at this time, Mr Leong?

MR LEONG: When he first came in he did have an advance care directive from what I saw in his file and later it was updated and – but there was changes and the daughters discussed with the staff about it and the doctor. That was updated, yes.

5 MS HILL: Between 18 September and 3 October 2017, are you aware of any plan of any description?

MR LEONG: Sorry, I didn't understand that question.

10 MS HILL: Between 18 September - - -

MR LEONG: Yes.

15 MS HILL: - - - and 3 October of 2017 are you aware of any palliative care plan for Vincent Paranthoienne by Alkira Gardens?

MR LEONG: From looking at his documentation, I couldn't find any specific care plan saying palliative care plan.

20 MS HILL: I suggest to you, Mr Leong, that between 19 September – sorry, 18 September, Mr Leong, and 3 October, the staff at Alkira Gardens were not able to know what care Mr Paranthoienne required, were they?

MR LEONG: I disagree with that.

25

MS HILL: How are they able to know what care he required, Mr Leong?

30 MR LEONG: The medication chart charted for his pain. There was a medication chart for his bowels to prevent constipation, and the directive by the RN to commence a repositioning and there's a repositioning chart for his comfort as well, and there are directives there.

35 MS HILL: What direction did Alkira Gardens provide their staff between 18 September and 3 October 2017 about Vincent Paranthoienne's palliative care needs?

40 MR LEONG: The answer in the progress notes I could recall seeing different days there was documentation or communication, written down in progress notes to say who – Josh Cohen was being – I mean, Mr Paranthoienne was being seen by Josh Cohen and they made – made some adjustment with medication and then they would have consulted doctors to make those adjustments, titrate the medication to make sure he's as comfortable as possible.

MS HILL: Was there a standalone document of any description?

45 MR LEONG: You mean as in terms of a form?

MS HILL: A form, a specific document that sets this out in the one place?

MR LEONG: No.

MS HILL: Operator, could you please display tab 25. Can I draw your attention to the monitor, Mr Leong, and ask you to look at the lower third of the screen, 20
5 September 2017, 19.40.

MR LEONG: Yes.

MS HILL: Could I ask you to read that entry to yourself, please.
10

MR LEONG:

Resident seen by LMO yesterday, 19 September '17. Charted Oxycontin 25 milligram BD. However, only 20 milligram in stock. Supplied by pharmacy but still administered as resident was in pain, 8 out of 10 score. Lyrica 25 milligram BD. And PRN Endone 5 milligram every two hourly charted. Pharmacy – pharmacy supplied stock today. Received Oxycontin 20 milligram – sorry, 10 milligram and 15 milligram tablets. T/F to B8 to continue monitoring pain.
15
20

MS HILL: You agree that that entry that I've taken to you refers to issues with the pharmacy twice?

MR LEONG: Correct.
25

MS HILL: Operator, could you please display tab 30. If I can draw your attention to the entry of 21 January 2017 at 1900.

MR LEONG: 21 September, did you say?
30

MS HILL: Yes. That's on the second half of the page commencing "Nursing."

MR LEONG: Yes.

MS HILL: Have you read that?
35

MR LEONG: I'm reading it now. Yes. I've read it.

MS HILL: Mr Leong, you agree that that entry refers to Lyrica being increased to 50 milligrams.
40

MR LEONG: That's correct.

MS HILL: And that's after Mr Cohen has attended and then after the LMO, the GP, has charted.
45

MR LEONG: That's correct.

MS HILL: And the pharmacy is informed and that entry says “Awaiting stock”.

MR LEONG: Correct.

5 MS HILL: Operator, could you please display tab 33. Could I draw your attention to the entry of 28 September 2017 at 1600.

MR LEONG: Yes.

10 MS HILL: And if you could read that, please. I’ve got the wrong page for you there, Mr Leong.

MR LEONG: Yes.

15 MS HILL: Just bear with me. I will put that to one side for now, Mr Leong. You had the opportunity to review the progress notes.

MR LEONG: Yes, I did.

20 MS HILL: In addition to those two entries that I’ve taken you to, I suggest to you that there’s a further entry that’s details that the pharmacy has rung and supplying stock to Alkira Gardens.

MR LEONG: Correct.

25

MS HILL: In your first statement that you’ve made to the Commission you refer to various issues and explain the licensing of certain types of prescription medication, don’t you?

30 MR LEONG: Yes, I did.

MS HILL: And you also set out the need for pharmacy orders to be in by a certain time, by 10 am, so that they could be delivered to Alkira Gardens.

35 MR LEONG: That’s correct.

MS HILL: In your statement, your first statement at paragraph 86, you refer to the GP prescribing medication and the fact that Alkira Gardens doesn’t receive the Oxycontin or the Lyrica until 20 September.

40

MR LEONG: That’s correct.

MS HILL: So two days pass and Alkira Gardens doesn’t have the prescription medication that it needs for Mr Paranthoiene, do they?

45

MR LEONG: That’s correct.

MS HILL: What policies did Alkira Gardens have in place to ensure that Alkira Gardens could meet Mr Paranthoienne's needs for different types of pain medication?

5 MR LEONG: I couldn't explain why they have not rung up to request the pharmacy to provide that medication urgently. But in the progress note I noted the RN gave the 20 milligram in place of the 25 milligram of the medication ordered by the GP.

10 MS HILL: I suggest to you, Mr Leong, that between 18 September and 3 October 2017, Alkira Gardens did not have the pharmaceutical resources to provide palliative care to Mr Paranthoienne, did they?

MR LEONG: Sorry, can you repeat? Sorry.

15 MS HILL: Between 18 September and 3 October 2017, I'm suggesting to you that Alkira Gardens did not have the pharmaceutical resources to be able to provide palliative care to Mr Paranthoienne?

20 MR LEONG: They didn't because they're not allowed to stock additional medication which is not prescribed by the doctor, not ordered by doctor. They cannot stock additional or spare medication, like – especially schedule 8 medication.

25 MS HILL: We've looked at that table, the summary of records, and I suggest to you when you see that table you will see that there are times when there's no record of any Endone being given.

MR LEONG: Yes. I agree.

30 MS HILL: And have you heard – you've read Ms Ruddock's statement and you've heard her evidence this morning that Ms Ruddock was concerned that her father needed Endone.

MR LEONG: Correct.

35 MS HILL: Have you been able to locate any record of any discussion between the staff of Alkira Gardens and Ms Ruddock about her father's pain relief?

MR LEONG: No, I couldn't.

40 MS HILL: If there was a discussion between Alkira Gardens and Ms Ruddock about her father's pain relief, would that have been recorded?

MR LEONG: I would expect so.

45 MS HILL: On your observation of the records available to us, what do you say Alkira Gardens is doing during this time to communicate Vincent Paranthoienne's care needs to Mr Paranthoienne and his family?

MR LEONG: The – on observation of the documentation in the file, and there are occasion like staff documenting important interactions between the daughter and the staff, the example would be, in July, they spoke to the next of kin and states she wants to be contacted wherever the doctor visit or when there's any investigation.
5 That was documented there, and in around about September, early September, there was a talk about the weight loss and the pain management, and – and then the deterioration. And later around about 21st of September, there's another documentation about the morphine subcut discussed with the daughter, and then on the 26th of September, there was a documentation about the advance care direct been
10 updated not for resus.

MS HILL: Which is the document that we've seen earlier in the course of today's evidence.

15 MR LEONG: That's right. About the interaction, yep.

MS HILL: Mr Leong, I want to take you to some progress notes, and if I could ask the operator to please display tab 19. I apologise. That's the wrong tab. Tab 20, please, Operator. And perhaps if we can have the top half of the page there zoomed
20 in on, Operator, please. Do you see there that there's an entry for 25 August 2017?

MR LEONG: Yes.

MS HILL: And then it jumps to 28 August 2017?
25

MR LEONG: Correct.

MS HILL: Are you able to say why there are no progress notes for 26 and 27 August?
30

MR LEONG: I can't explain.

MS HILL: Can I take you, then, staying on that section of the document, to the entry of 28 August at 1800 hours.
35

MR LEONG: Yes.

MS HILL: And the next document – next entry that follows is the 3rd of September.

40 MR LEONG: Yes.

MS HILL: Are you able to explain why there's no entries between those dates?

MR LEONG: I don't know.
45

MS HILL: Alkira Gardens was – received a sanction, didn't they - - -

MR LEONG: Correct.

MS HILL: - - - around this time? And those sanctions concerned a review of what was happening in Alkira Gardens from 16 to 23 October by the department?

5

MR LEONG: Correct. Correct.

MS HILL: These sanctions reflect very poorly on Alkira Gardens, don't they?

10 MR LEONG: Yes. Yes.

MS HILL: I suggest to you that there wasn't enough staff working at Alkira Gardens when Mr Paranthoienne was a resident there?

15 MR LEONG: Correct.

MS HILL: Operator, could I ask you, please, to display tab 38. And if I could ask the operator to move through to section 2.14, .3296. Do you see Mr Paranthoienne's name there?

20

MR LEONG: Yes.

MS HILL: And, Operator, could I ask you to return to the page previous. In fact, I will ask you to go back to that page you were just on, .3296. That's in respect of a finding in the audit assessment information, isn't it, that the expected outcome had not been met for mobility, dexterity and rehabilitation?

25

MR LEONG: That's correct.

30 MS HILL: And Mr Paranthoienne is used as an example of that on that section which is displayed in front of you.

MR LEONG: Correct.

35 MS HILL: And it sets out that Mr Paranthoienne had five falls while living at Alkira Gardens between the 21st of September and the 3rd of October 2017.

MR LEONG: Correct.

40 MS HILL: Are you familiar with the audit information report?

MR LEONG: Yes.

45 MS HILL: You're aware that Vincent Paranthoienne is referred, under the section on skin care – which is, Operator, at .3290, and that – what's displayed in front of you there is Mr Paranthoienne's prescription and the fact that, in respect of skin care, that

outcome that requires that care recipient's skin integrity with their general health has not been met. Do you agree with that?

MR LEONG: Correct.

5

MS HILL: And you would be aware that the Department of Health corresponded with the families and residents of Alkira Gardens about these sanctions?

MR LEONG: Yes. Correct.

10

MS HILL: And you've heard Ms Ruddock give evidence this morning of that friends and family meeting at Alkira Gardens on the 8th of November 2017.

MR LEONG: Yes.

15

MS HILL: Were you at that meeting?

MR LEONG: I was.

20

MS HILL: What do you recall of that meeting, Mr Leong?

MR LEONG: It's – there was – the department was there and there was the director from the agency then – that's what they call – and we had the consultant there to explain what the sanction is – what – why we were sanctioned. And then what we –
25 how we addressing from a company point of view.

25

MS HILL: Were there any records kept of that meeting?

MR LEONG: I believe there was, yes.

30

MS HILL: And where are they, Mr Leong?

MR LEONG: At our office.

35

MS HILL: I call for those records, Commissioner.

COMMISSIONER TRACEY: Yes. I will ask that your instructor speak with instructors for the company with a view to having those records produced.

40

MR LEONG: In Sydney at our head office, not at Alkira Gardens.

MS HILL: Thank you, Mr Leong. Mr Leong, in your statement, you give evidence at paragraph 35 that the facility's manager and the deputy facility's manager at the time that Mr Paranthoene was living at Alkira Gardens are no longer at Alkira
45 Gardens or employed by sisters of Our Lady of China.

45

MR LEONG: They, indeed, are employed by Alkira or the company. They're no longer – both of them are no longer with us.

5 MS HILL: Was their departure related to the sanctions imposed by Alkira – by the department at that time?

MR LEONG: The facilities manager then, he – he was on leave when the full review audit was done, and when he came back, we told him about the sanction, and he mention to the pace – it will – because he was only recently employed two months
10 there, and when he went on holiday, he came back, he knew there was a sanction, and he made a point that it would be too hard for him to continue work, so he resigned. And as he was there, the deputy facility manager, she resigned round about January 2018, that's right.

15 MS HILL: In your statement at paragraph 40, you give evidence of and describe the staff turnover at Alkira Gardens in this time that we've been talking about.

MR LEONG: Yes, I went through the progress note, and identified there were 13
20 RNs involved in the care. One of them was from the agency, 12 of them were employed by Alkira Gardens, and out of the 12, 10 have resigned. Only two remain working there.

MS HILL: What does that say to you, in your view, about the culture at Alkira
25 Gardens at that time?

MR LEONG: I can't comment that they were – as far as I know, they resigned because – due to reasons other than because of Alkira Gardens. It's – like I mention, it was – they – some of them were applying for permanent residence in Australia. They were – need to relocate to our – to work in remote areas to satisfy the criteria.
30 And others, like, finding jobs which matched their more personal situations.

MS HILL: With that level of staff turnover, complete and accurate record keeping is critical, isn't it, Mr Leong?

35 MR LEONG: You meant during that period?

MS HILL: During that period of time.

MR LEONG: They didn't all – they didn't all – from my understanding, they did
40 not all resign at the same time. It was up till when I start looking at the document which is recent they were – people were – I mean, registered nurses all those between the 2017 and up till now. It's not in one – one period.

MS HILL: Do you have a view about what's happening at Alkira Gardens at the
45 time that we've been talking about, Mr Leong?

MR LEONG: Well, what's – sorry, what specifically did you mean?

MS HILL: What observations do you make of the culture of Alkira Gardens?

MR LEONG: I mean, every time I went in and the staff were there and – I don't – I can't make any comment about what the culture of that, internally.

5

MS HILL: Now, you've agreed that there weren't enough staff working at the time that Ms Ruddock's father was living at Alkira Gardens?

MR LEONG: That's right. That was identified, yep.

10

MS HILL: And in paragraph 119 of your statement, you describe that, as a result of being sanctioned, Our Lady of China increased the nursing staff by 23.5 hours per day.

15 MR LEONG: Correct.

MS HILL: How is that number arrived at, Mr Leong?

MR LEONG: Okay. At that time, we engaged the Minister which is appointed by the – recommend by the department, and then the nurse adviser, that they were the one who calculate that and make those figures and propose the – to make those change and it was implement. I was not involved with this calculation.

20

MS HILL: Did you have any involvement in the calculation of the description of the skill mix?

25

MR LEONG: At that time during the sanction, no. It was the administrator, appointed administrator and the nurse adviser did all that.

MS HILL: Did you have any involvement in determining the number of staff and the nature of staff at Alkira Gardens presently?

30

MR LEONG: There was a discussion about it. I was not the – involved in making that decision. It was – I was sitting in there and she was – both of them were saying we need those staff, we need those staff and that was implemented.

35

MS HILL: And that's in 2017 at the time of the sanction.

MR LEONG: During the sanction, yes.

40

MS HILL: What about now? Do you have any involvement these days about how many staff should be working?

MR LEONG: Yes, if it's escalate to our head office, then I would be involve.

45

MS HILL: Are you involved in the recruitment of staff at all, Mr Leong?

MR LEONG: Not currently.

MS HILL: Do you provide any direction to your facilities as to what sort of staff you're looking for?

5

MR LEONG: I – we don't – I don't personally give them that advice. It's stipulated in the job description what type of criteria they should be meeting and, say, if a facility manager needed support and that they were escalated to head office, then we will get involved, and, sometimes, that's on a monthly basis. We do have an executive manage meeting. They can bring that – those type of issue to discuss, and we have a collective discussion on that.

10

MS HILL: Commissioners, that concludes my examination of Mr Leong.

15 COMMISSIONER TRACEY: Mr Leong, I'm troubled by your evidence about the holding of medications in facilities that are used to alleviate pain.

MR LEONG: Mmm.

20 COMMISSIONER TRACEY: And am I correct in understanding your evidence that some of the medications that were required properly to treat Mr Paranthoiene whilst he was in the care of your organisation at Alkira Gardens were not available because you weren't allowed to hold those medications on-site?

25 MR LEONG: Correct. We're not allowed to hold scheduled – if it's not prescribed by a doctor, but we're allowed to hold medication like Panadol in stock.

COMMISSIONER TRACEY: We're only talking about the medication you have said you're not allowed to hold. Do you understand my question?

30

MR LEONG: Not exactly, sorry.

COMMISSIONER TRACEY: Well, I understood your evidence to be that there was, on occasions, inadequate medicine available to be administered - - -

35

MR LEONG: Mmm.

COMMISSIONER TRACEY: - - - to palliative care patients at Alkira Gardens because of limitations placed on your organisation as to the holding of such medications on-site.

40

MR LEONG: That's correct. That was at that time, but, recently, the Poisons Regulation chance and we could hold emergency medication, including those for palliative.

45

COMMISSIONER TRACEY: Yes. Well, you see, what troubles me, firstly, is what was the source of those constraints?

MR LEONG: Sorry, I didn't - - -

COMMISSIONER TRACEY: Well, why weren't you able to hold those medications on-site? What stopped you?

5

MR LEONG: The legislation wouldn't allow us to - - -

COMMISSIONER TRACEY: What legislation?

10 MR LEONG: The Poisons and Therapeutic Goods.

COMMISSIONER TRACEY: Well, you see, I'm just looking at the medication charts, and there was a prescription which would have allowed the administration to Mr Paranthoene of five milligrams of Endone every two hours if that was necessary for him to be freed of pain.

15

MR LEONG: Mmm.

COMMISSIONER TRACEY: Now, that's up to 12 doses a day.

20

MR LEONG: Yeah.

COMMISSIONER TRACEY: How could it be that that could be prescribed, and, yet, you weren't able to hold that quantity on-site to meet the need?

25

MR LEONG: Sorry, I – I must have – I didn't make clear what I was saying. I thought Erin was referring to the additional, like, Oxycontin that it was more than what it was prescribed earlier, and we're not allowed to hold those extra, like, Oxycontin or Endone in stock to – really to increase the dosage. That's what I was trying to explain.

30

COMMISSIONER TRACEY: Well, I'm still puzzled because some of the medication that he could have been given, after it was clear on assessment that he was in pain, was Endone and he wasn't given it. Now, is there any explanation as to why he wasn't given it, other than you weren't able to hold enough?

35

MR LEONG: I couldn't explain why they didn't ring the pharmacy and say, "Look, it's an urgent delivery. Can you deliver," because they miss out on the 10 o'clock round from what I could gather in the progress notes.

40

COMMISSIONER TRACEY: All right. Now, you've said that whilst that was the position back in 2017, that has since changed.

MR LEONG: That's correct.

45

COMMISSIONER TRACEY: So can we be reassured that the necessary amounts of these important drugs are held on-site so that they can be administered when needed.

5 MR LEONG: Yes. It'll be – with the changes, yes.

COMMISSIONER TRACEY: Thank you, Mr Leong.

MR LEONG: Okay.

10 COMMISSIONER TRACEY: Anything arising?

MS HILL: No, Commissioner.

15 COMMISSIONER TRACEY: Yes. Thank you, Mr Leong, for your evidence. You are excused from further attendance.

MR LEONG: Okay. Thank you.

20 <THE WITNESS WITHDREW [3.20 pm]

COMMISSIONER TRACEY: We will adjourn shortly so that the room can be reconfigured for the panel.

25 **ADJOURNED** [3.20 pm]

30 **RESUMED** [3.36 pm]

COMMISSIONER TRACEY: Yes, Mr Rozen.

35 MR ROZEN: Commissioners, I call Dr Jane Fischer, Professor Jennifer Tieman and Dr Elizabeth Reymond.

40 <JENNIFER JOY TIEMAN, AFFIRMED [3.36 pm]

<JANE FISCHER, AFFIRMED [3.36 pm]

45 <ELIZABETH NANCY REYMOND, AFFIRMED [3.37 pm]

MR ROZEN: In no particular order, I assure you, could I start with you, please, Professor Tieman, could you confirm for the transcript your full name, please.

PROF TIEMAN: Jennifer Joy Tieman.

5

MR ROZEN: Professor Tieman, you're a professor in the College of Nursing and Health Sciences at Flinders University.

PROF TIEMAN: I am.

10

MR ROZEN: And you're also the director of the Research Centre in Palliative Care, Death and Dying at Flinders University in Adelaide.

PROF TIEMAN: I am.

15

MR ROZEN: Flinders University is known for its palliative care postgraduate education and research program.

PROF TIEMAN: It is.

20

MR ROZEN: And we had one of your alumni as witness earlier today.

PROF TIEMAN: Yes.

25

MR ROZEN: You're an experienced academic.

PROF TIEMAN: Yes.

30

MR ROZEN: And prior to commencing employment at Flinders University in 2004 you relevantly worked as a project officer in palliative care at the Repatriation General Hospital.

PROF TIEMAN: I did.

35

MR ROZEN: Is that also here in Adelaide – sorry, in Adelaide. It's been a long week.

PROF TIEMAN: Yes, it is in Adelaide.

40

MR ROZEN: And how long did you work there?

PROF TIEMAN: I worked there for about three years.

45

MR ROZEN: All right. And for the purpose of the Royal Commission you made a witness statement dated 22 May 2019.

PROF TIEMAN: I did.

MR ROZEN: And the code for that, for our purposes, is WIT.0173.0001.0001. And hopefully that will appear on the screen there to your left, or at least the first page of it. Is that the witness statement or a copy of it that you made for us?

5 PROF TIEMAN: It is.

MR ROZEN: I note that the statement is made in your personal capacity and not on behalf of your employer; is that right?

10 PROF TIEMAN: That is correct.

MR ROZEN: All right. Is there anything you wish to change in your statement?

PROF TIEMAN: No.

15

MR ROZEN: And are the contents true and correct?

PROF TIEMAN: Yes.

20 MR ROZEN: I tender the statement of Professor Tieman.

COMMISSIONER TRACEY: Yes, the witness statement Jennifer Joy Tieman dated 22 May 2019 will be exhibit 5-37.

25

**EXHIBIT #5-37 JENNIFER JOY TIEMAN DATED 22/05/2019
(WIT.0173.0001.0001)**

30 MR ROZEN: Dr Fischer, can you state your full name for the transcript.

DR FISCHER: Yes, Jane Fischer.

MR ROZEN: You're a medical practitioner, Dr Fischer, and a palliative specialist.

35

DR FISCHER: Yes, I am.

MR ROZEN: And you are the medical director and CEO of Calvary Health Care in Melbourne.

40

DR FISCHER: Yes.

MR ROZEN: That's a position you've held since 2007.

45 DR FISCHER: Correct.

MR ROZEN: You've worked for many years as a clinician in rural, remote and metropolitan settings both in Victoria and Western Australia.

DR FISCHER: Yes.

5

MR ROZEN: You've been the board chair of Palliative Care Australia since 2017.

DR FISCHER: Correct.

10 MR ROZEN: And a member of the board since 2012.

DR FISCHER: Yes.

15 MR ROZEN: Palliative Care Australia is the nation peak body for palliative care in Australia. And you've made a statement dated 29 May '19 which is on behalf of Palliative Care Australia.

DR FISCHER: Yes, correct.

20 MR ROZEN: Is there anything in your statement that you would seek to change?

DR FISCHER: No.

25 MR ROZEN: For our purposes, it's WIT.0159.0001.001. That should be on the screen in front of you. Can you confirm for us that that is your statement?

DR FISCHER: Yes, I can confirm, counsel.

30 MR ROZEN: And are the contents of the statement true and correct?

PROF TIEMAN: They are true and correct.

MR ROZEN: I tender the statement for Dr Fischer, Commissioners.

35 COMMISSIONER TRACEY: Yes. The witness statement of Dr Jane Fischer dated 29 May 2019 will be exhibit 5-38.

40 **EXHIBIT #5-38 WITNESS STATEMENT OF DR JANE FISCHER DATED 29/05/2019 (WIT.0159.0001.001)**

MR ROZEN: Dr Reymond, could you please state your full name for the transcript.

45 DR REYMOND: Elizabeth Nancy Reymond.

MR ROZEN: Dr Reymond, you're an experienced palliative care physician.

DR REYMOND: Yes.

MR ROZEN: You've worked solely in the field of palliative medicine since 2003.

5 DR REYMOND: Yes.

MR ROZEN: And you're one of the first medical cohort to obtain fellowship of the Australian Chapter of Palliative Medicine within the Royal College of Physicians.

10 DR REYMOND: That's right.

MR ROZEN: You're a Deputy Director of the Metro South Palliative Care Service in Queensland.

15 DR REYMOND: Yes.

MR ROZEN: And you're a director of the services, research, education and development arm.

20 DR REYMOND: Yes.

MR ROZEN: And you're the director of a number of funded palliative care projects about which we will be asking you presently

25 DR REYMOND: Yes, that's correct.

MR ROZEN: You're also an adjunct professor of palliative medicine at Griffith University's School of Medicine.

30 DR REYMOND: Correct.

MR ROZEN: And you've been kind enough to make a witness statement for the Royal Commission dated 30 May 2019; is that right?

35 DR REYMOND: Yes.

MR ROZEN: And once again, you make clear in that that that's not made on behalf of your employer but rather in your personal capacity.

40 DR REYMOND: That's correct.

MR ROZEN: All right. That is WIT.0173.0001.001. Is there anything in your statement you would like to change before it's tendered?

45 DR REYMOND: No, thank you.

MR ROZEN: All right. And its contents are true and correct?

DR REYMOND: Yes.

MR ROZEN: I tender the statement of Dr Elizabeth Reymond.

5 COMMISSIONER TRACEY: Yes. The witness statement of Dr Elizabeth Nancy Reymond dated 30 May 2019 will be exhibit 5-39.

10 **EXHIBIT #5-39 WITNESS STATEMENT OF DR ELIZABETH NANCY REYMOND DATED 30/05/2019 (WIT.0173.0001.001)**

MR ROZEN: In addition to those very comprehensive statements for which the
15 Royal Commission is very grateful, you've also been prepared together with your own staff and the staff of the Royal Commission to engage in a process of trying to reduce the great deal of material in your statements into a series of agreed propositions. And you don't all have to answer yes to that, but that's a process that we've been through and I've played some role in that as well. Perhaps I'll just address myself to you, Dr Fischer, at this point if I could. That process has been
20 successful in that a document setting out 22 agreed propositions covering the area in your witness statements has emerged from that process.

DR FISCHER: Yes, and I think that all three of us certainly agreed to that; there was common agreement to those. Yes.

25 MR ROZEN: What I propose to do, Commissioners, is now tender that document as a separate exhibit. It is actually already in the tender bundle so I probably don't need separately to tender it. I think a hard copy should have found its way to you. Okay. It might be some assistance. For the record it's tab 65 in the general tender bundle.

30 What I propose to do, ladies, is read out a couple of – or a number of those propositions, and identify one of you to address a question about them. And then it will be open for the others to add anything that they wish to. I might not always identify you by name, but I don't think any of you are particularly shy so please feel
35 free to chip in and add anything that you want to which will be of value to the Commission. The first point that a number of you – that each of you have made, in fact, in your statements goes to a basal proposition which seems an important one in the context of palliative care, and that is death is a natural part of life, and that most people die an expected death at an older age due to complexities of frailty and other comorbidities. That's proposition one.

40 And then a related proposition seems to be that Australians pay little attention to death and Dr Reymond, in your statement, you make the observation that, perhaps understandably, we tend to focus on living rather than on dying. Where we do
45 discuss death many of us express a preference to be cared for and die at home, just as most of us want to receive aged care services at home and that's something that has come through in a lot of the evidence in the Commission. Perhaps starting with you,

Dr Fischer, what's the significance of those observations about death for the Commission's consideration of palliative care?

5 DR FISCHER: The – well, obviously ensuring people die well is critical to
palliative care. But we would actually be saying that within the aged care setting it's
actually been associated very much just with end of life care. So we're really just
focusing, in fact, on the last days or weeks of someone's life and yet what palliative
care is about is ensuring that people are actually – we know that they have a life-
10 limiting or life-threatening disease. We know that they're going to die from it, their
certain condition, but what we're wanting to ensure is that we are making sure that
they live well knowing that they are going to be dying at some point in their disease
trajectory.

15 MR ROZEN: That point you make about the distinction between palliative care and
end of life care seems to be a very important one. Dr Reymond, I can see you
nodding. Can you assist the Commission with a better understanding of that
distinction.

20 DR REYMOND: Yes. It can get very confusing and it's been very confusing
across the literature. Can I just please add another thing to what Jane was saying.

MR ROZEN: Of course you can. Certainly.

25 DR REYMOND: I think the important thing about dying an expected death is that
death can be planned for in a proactive way, so that as needs emerge from people, we
can, after you see so many deaths, you can actually proactively plan for them, and
that can increase both the quality of life and the quality of death. So sorry, then it
goes back to your next one about the difference between palliative care and end of
life care. I think the – the Commission for National Safety and Quality now regards
30 end of life care as about the last year of life, whereas – and so that puts a time frame
on it. Whereas for palliative care, it tends to be more needs-based rather than time-
constrained. And I know that later on we get into the problem with ACFI, the way
ACFI talks about end of life care and palliative care and for ACFI, end of life care is
about the last seven days of life.

35 MR ROZEN: Can I just pick you up on that point because it seems an important
one, that that time frame over the last year of life for end of life care, I see you're all
nodding. Is that an agreed parameter for end of life care in the palliative care – in
relation to palliative care?

40 PROF TIEMAN: I think it is less, that it is actually 12 months or six months and
there is a lot of variability. But what it is saying we need to move to recognise not
just active dying but actually recognise that there is a period between being say well-
ish with a chronic disease and actually moving to seeing that death will inevitably
45 occur, and it is that recognition that enables, as Liz was saying, the possibility of
actually planning and putting in place supports, the ability to have appropriate place
of care, families to be involved and aware across those elements.

And if I could add one more element to that, I think it is the question we were talking about, death is a natural part of life so I think for me the question about building awareness that death is actually part of life and will inevitably come to all of us can normalise it to the point where we can have discussions and actually enable that
5 planning to occur because without a continuum that goes from death is normal, we should think about death as a possibility, we talk about it with people, we should look at care planning, advance care planning, we should recognise that something is changing, moving through to what is the care that is provided is part of a continuum that needs to be discussed.

10

DR FISCHER: Can I add?

MR ROZEN: Yes, please, Dr Fischer.

15 DR FISCHER: I think we need to be careful about not prescribing time frames for people because palliative care is actually about – as we said, it's person-centred, it's needs-based and there's actually evidence that shows that access to palliative care services which may be in conjunction with acute services actually produces better
20 outcomes for patients. It actually can reduce hospitalisations. It can actually reduce inappropriate treatments, particularly as people are approaching more the end of life. So it is about the needs-based and I – the problem that we have in Australia is that we have a whole range of different definitions in relation to what is end of life care. So from a aged care context, it's days and weeks. If we go to the national quality safety, the commission, it's considered within an acute hospital setting and they're
25 using it as a trigger for people who may be in the last 12 months.

So they use as triggers for us to try and pick up that people should be receiving palliative care and what we need to be doing is really adopting the WHO definition of palliative care across our health and aged care system.

30

PROF TIEMAN: And I agree and I think the first part of that is actually recognising the need for palliative care and recognising that the need for palliative care is actually real and needed.

35 MR ROZEN: I need to ask you, particularly Professor Tieman to keep your voice up if you are able to. We're fighting with a noisy gadget which is just sitting in front of you and you just need to project your voice if you could a bit. I want to move on to the question of quality of palliative care and what that means. We deal with that – you deal with that rather in proposition 6 and 7 of the agreed propositions.
40 Proposition 6 is that a tenet of quality palliative care is that it is always adapted to the individual needs and identity of the person receiving care, that is, that it's person-centred. And then a related proposition in 7 is:

45

Palliative care extends the concept of person-centred care beyond the patient as palliative care recognises a unit of care, usually composed of the person and their family or significant others.

With particular emphasis on the aged care setting, I wonder if I could ask you, Professor Tieman, to expand on that, particularly the notion of the unit of care and why that's significant in our considerations.

5 PROF TIEMAN: So often particularly for older people, they will actually be – have a caring unit around them and so that will be the family and that will be self-defined as to who is important to them in those areas. In home care but also in residential aged care, care still is provided predominantly by family, particularly in the home care setting, and even in a residential aged care, there tend to be very continuing
10 bonds that lead to caring across the period that people are in residential aged care. One of the aspects in providing care, palliative care to enable quality care is to recognise what resources are available to the person, and obviously the family is critical in that, for emotional, psychological, physical care support to the person. It also means that we need to think about it in terms of how we plan care that actually
15 recognises the role of the family in those components. And also we need to look at it in terms of what are the needs of the family and the carer in terms of supporting the person and in recognising that death will be approaching and what that will mean to them in terms of bereavement

20 MR ROZEN: Dr Fischer, anything you want to add to that?

DR FISCHER: No, I would just – I would totally agree with that. I think though when we're talking of supporting family in terms of grief and bereavement though that then also flows on to other carers and includes also your care workers or staff
25 within your aged care facility or people who are providing aged care services into the community or into people's homes.

MR ROZEN: Yes.

30 DR FISCHER: Because it is an essential sort of part of certainly what specialist palliative care would be looking at and if we're providing good palliative care that should be a core component.

MR ROZEN: That role of the workforce is a topic we will be coming back to, but
35 certainly one thing I wanted to ask about – and this really arises from something you said, Professor Tieman, about the breadth of services that are required in a holistic palliative care approach, there is, I think it's fair to say, a common misconception that palliative care is essentially about the management of pain, the alleviation of pain when someone is in that life-limiting illness. It's clear from your reports and
40 what you've just said to us that there are other dimensions to palliative care. Perhaps if you could expand on that Dr Fischer, maybe to start off with.

DR FISCHER: Yes. So apart from like the physical symptoms, what is also really important is people's psychosocial issues, issues of social issues, what are their –
45 what are their cultural beliefs that we need to have – pay attention to. There may be financial issues that both the patient resident, and family are dealing with. So there is that – it is very much that person-centred, truly holistic approach and if we are going

to deal with all of that in a holistic way, that is – that requires a team approach, and a range of skills to deliver that because it's not just one – one health professional who can deal necessarily with all of that.

5 I think the other thing I would say, though, is that there are a number of people who
won't have very complex symptoms or psychosocial issues and who could be
receiving a level of what we would just call general palliative care, they're not
necessarily needing specialist input. We still need to be addressing what are all of
the things to make sure we're providing good holistic care. It's that the specialist
10 palliative care services are there for those who have particularly complex issues that
are beyond the scope of your other health care providers.

MR ROZEN: I might just ask you perhaps to expand on that. I was going to come
back to that but now you've raised it, this interrelationship between specialist
15 palliative care and what we call a non-specialist or - - -

DR FISCHER: General.

MR ROZEN: General palliative care, I think particularly you were all present when
20 we heard the evidence of Josh Cohen earlier today - - -

DR FISCHER: Yes.

MR ROZEN: - - - who is very much involved in that specialist palliative care
25 provision. The Commission is very interested to understand better the relationship
between that form of external palliative care provision and what might be expected at
the general level. Maybe Dr Reymond, given your day-to-day involvement in doing
this, if I could ask you, firstly, to tell us a little bit about the services provided by the
organisation for which you work, and then if you're perhaps able to identify if there
30 are any differences between that and the service that Josh Cohen's facility provides.
Just for a bit of context, you do deal with this at paragraph 22 of your statement.
And maybe if that could be brought up at this point. Dr Reymond's statement,
WIT.0187.0001.0001, and this is at page 5.

35 DR REYMOND: So to answer your question about the relationship, I think our –
sorry, first of all our service provides services probably equally to, well, into
hospitals and also palliative care units but also into private homes - - -

MR ROZEN: Yes.

40

DR REYMOND: - - - where people are living with their family and also into
residential aged care facilities. Just as Jane said, we're a specialist palliative care
service so we tend to only look after ourselves on our own. We only look after very
complex people with complex needs and complex families, complex family needs.
45 In the – in the community setting in people in their own homes, particularly in aged
care, we work as a team, what we call share care, generally with the person's GP,
and also with the domiciliary services or other aged care services that may be

moving into the person's home and helping them. So in that way, we tend to be more consultative. We suggest things. And we work out roles and responsibilities between the general practitioners, the other parts of the team who's doing what, and to get the best outcome for the person. That takes quite a bit of communication.

5 What we're finding more and more is that GPs tend to be moving away from providing home care services for palliative patients, both in the community and in residential aged care facilities, but I will get to that. So the way we try, then, to provide care for people at home is we would – we would work out our responsibilities with the GP, if you can see the patient when they're well, if they can
10 come to your facility. Also for after-hours, it's really important for people who are dying to have access 24 hours a day to a clinician who can guide their care and make suggestions for their symptom control.

15 So, often, what we do with GPs is say, if you, sort of, do the daytime shift, we'll take over at night, and if people need to call, we can look after them. Similarly, with the domiciliary nurses, we can help provide them with equipment and other services going into the home. In the residential aged care facilities, we've got 93 – 92, 93. In our catchment area, over 9000 beds. We have few more staff than what Josh has for his service, and we – we aren't nurse practitioner led there. And we – again, we
20 work with a shared care, with the GP, but, again, we tend to take over the night-time arrangements for those people so that we can avoid unwanted hospitalisations for them because what GPs are doing more and more now – and this is not a criticism of GPs. It's just how it is.

25 And so how do we get a system that works for everyone? Generally, for after-hours, they swap over to a deputising or a locum service where they don't come in to see the patient, but they – the – the deputising service will be contacted. The problem – and the deputising services can do very good jobs in various areas, but we tend to take over the night time call because the deputising services seem to be quite scared
30 of opioids, using opioids for good symptom control, and the other thing is they don't tend to be too keen to go into residential aged care facilities. So, fairly quickly, will say over the phone to the nurse in charge, send the person to hospital. Now, if the person wants to go to hospital, that's tickety-boo, but most people don't want to go to hospital. They want to be cared for. So we tend to work that with them.

35 MR ROZEN: Thank you. I wonder if I could just unpack a little of that if I might. The Metro South Palliative Care Service, is it attached to a health network or a hospital or – what's its status?

40 DR REYMOND: It's a part of the Metro South Health Local Hospital and Health Service within Queensland - - -

MR ROZEN: Right.

45 DR REYMOND: - - - and there's 16 of those.

MR ROZEN: And there's 16 of those. This is in one of those; is that - - -

DR REYMOND: Yes. Correct.

MR ROZEN: - - - right?

5 DR REYMOND: Correct.

MR ROZEN: And what geographical area do you cover?

10 DR REYMOND: We cover Brisbane south. We abut onto the Gold Coast and then a little bit west as well.

MR ROZEN: Right.

15 DR REYMOND: It contains about 25 per cent of the population of Queensland.

MR ROZEN: So that's north of a million people, I'm guessing.

DR REYMOND: North of a million people.

20 MR ROZEN: Yes.

DR REYMOND: About – I think it's about 1.4 million.

25 MR ROZEN: Okay. And within that catchment area, how many residential aged care facilities?

DR REYMOND: Ninety-two.

30 MR ROZEN: And how long has the service been operating?

DR REYMOND: Metro South Palliative Care Service?

MR ROZEN: Yes. Yes.

35 DR REYMOND: It's been operating since 2003.

MR ROZEN: Okay. And what sort of numbers of full time staff do you have working within that service?

40 DR REYMOND: I think – I think we started off with three. Now, we have about 72.

45 MR ROZEN: Right. And in general terms, if you can't be too precise, but what's the make-up of the 72? Like, how many nurse practitioners, for example, do you have - - -

DR REYMOND: Okay. We have, I believe, four nurse practitioners. The majority of staff are – clinical nurse consultants or clinical nurses. In addition, we have six consultants, medical consultants, seven registrars, and then we have allied health staff, including occupational therapists, counsellors and social workers, and then
5 administrative staff which really glue us all together.

MR ROZEN: And the medical consultants, are they geriatricians or general physicians or - - -

10 DR REYMOND: They are – the bulk of them are specialist palliative care service – specialist palliative care physicians.

MR ROZEN: Physicians, and you're - - -

15 DR REYMOND: Sorry. We don't have any geriatricians.

MR ROZEN: Okay. Would that be a useful augmentation, do you think, to the service, or is that not so necessary?

20 DR REYMOND: It's – the average age of our patient is well over 65. However, we work closely with the geriatricians within Metro South Health. So we've always got that expertise available to us if we need it.

MR ROZEN: All right. Now, are you able to say what proportion of the time that
25 the workforce within the unit spend – what proportion would be in residential aged care facilities, do you think? You know, would it be half the time or nowhere near that - - -

DR REYMOND: No, less than - - -
30

MR ROZEN: No.

DR REYMOND: Less than half.

35 MR ROZEN: Less than half the time.

DR REYMOND: Less than half. The – I'm sorry. I should have said we're also running palliative care specific units - - -

40 MR ROZEN: Yes.

DR REYMOND: - - - in public hospitals, and we have a very special arrangement with a residential aged care facility which is working very well to increase capacity. So we have a – a consultant and a team down there. I – my guess, I would have to
45 say, overall, 20 per cent in residential aged care facilities, and it is not enough.

MR ROZEN: Right.

DR REYMOND: There is an enormous need, both in the community and in residential aged care facilities for more capacity.

MR ROZEN: Right. And one final question for you, if I may, in relation to that.
5 The model that Josh Cohen described earlier, the needs rounds - - -

DR REYMOND: Yes.

MR ROZEN: - - - is that something you do?
10

DR REYMOND: No, it's not something we do, though I am aware of it and I think it probably works well. Because our service has been going a bit longer than his, also because we have a few more staff members in it, we actually have fairly good relationships with the residential aged care facilities. So they can – whenever needs
15 arise, they can call us, and we also have ongoing projects with our residential aged care facilities in collaboration with our primary health network which is a Commonwealth funded – the primary health networks look after GPs and primary practice.

MR ROZEN: Yes.
20

DR REYMOND: So we work with our PHN to introduce new projects into the residential aged care facilities, specifically for building up capacity there in terms of advance care planning or case conferencing or terminal care manager.
25

MR ROZEN: Thank you. Dr Fischer.

DR FISCHER: I just wanted to sort of add to what Liz is saying in terms of that, really, across Australia, there are a range of – or – or varying models of specialist palliative care and particularly community based. However, all of them should be
30 providing – you know, seeing complex patients, providing consultation and advice to residential aged care workers, to other primary health providers, to GPs because it's also about them building that capacity in your primary health workforce.

And – but the specialist palliative care services should also be providing that 24 after
35 hours support, and what that looks like – because that might often be just even by phone, but it's about – it's really critical about having that access to specialist advice if it's needed after-hours. There are then other issues that arise though across Australia because there is not equitable access, as I'm sure you're aware of, and, in
40 fact, even within – across jurisdictions or within jurisdictions even, there will be differences in terms of specialist palliative care services interacting with aged care services. And so that is – that is a significant issue.

MR ROZEN: Did you want to add anything to that, Professor Tieman?
45

PROF TIEMAN: I think most of it has been covered. Really, I think there are very many different ways that people are engaging with aged care at the moment, and that

they vary, potentially, by state. The relationship of specialist palliative care is – as Jane has indicated, it is both just a delivery of a complex care and adviser and a support for primary care and for other components of care, and, also, it does have a role in both research and education in building capacity across the whole of the workforce.

MR ROZEN: Yes, I will come back to that if I may. For the moment, can I just clarify the notion of a complex palliative care case. What – are we talking about the presence of comorbidities – is that the sort of thing that makes a palliative care case complex? Was the case study we’ve looked at today, some of you may have heard Josh Cohen talking about it, would that fit the description of a complex palliative care case? Dr Fischer, are you able to - - -

DR FISCHER: I – I think it – it can be very much broader than that. So it’s not necessarily about just having a number of comorbidities, though that, obviously, will increase your chance of having additional symptoms and then what – what those symptoms are due to. But I – so there’s the physical symptoms, pain, either nausea or vomiting. I have to say, as having worked as a specialist in palliative care, often, what is really complex are the psychosocial issues and conflicts between family and patient. So it’s not always like that, but I think that there is certainly – from my perspective, there is a level of complexity – if we’re talking of the holistic approach, it’s often beyond that of just pure physical symptoms.

MR ROZEN: Could you give us an example of – that you’ve had of a complex family dynamic? I’m sure you’ve all had them. You’re all smiling. Is it family members having different views about - - -

DR FISCHER: Yep.

MR ROZEN: - - - death?

DR FISCHER: Yes. So – so from a cultural perspective, we might have – you might have a patient who, we know – we know what their disease trajectory is and, normally, we would be having discussion with that – that patient about what – what might be happening and what sort of treatments or – would they like or not like, and what are the things we need to take into account to provide the care that’s going to meet their needs. We will then, you might – because of cultural tradition, the family are saying, “We don’t want you to have those discussions with the patient because we have” – you know, there’s usually a hierarchy and there’s someone who’s identified as the decision-maker and, yet, we can see that the patient is actually distressed and has symptoms and their pain or other symptoms could be exacerbated because of what’s happening from a spiritual or psychosocial issue, and it’s very difficult to deal with those if we’re not dealing with what’s underpinning those – those concerns.

So then it is about how do we negotiate a situation that – where we are respecting someone’s traditions, but are still trying to look after the needs of the patient. You

can then have complicating family dynamics where a – and this happens reasonably frequently – where some members of the family want all measures to be taken which is quite contrary to what the patient themselves might want or even what their decision-maker might want. So you have to then negotiate all those sorts of things as well.

MR ROZEN: Dr Reymond.

DR REYMOND: I guess that, pragmatically, a complex patient could be described as someone who's – whatever the situation is, it's beyond the skills of the treating team to cope with that. So then they would ask us to consult or to care.

MR ROZEN: Yes. Yes, thank you. We're interested in this notion of capacity enhancement and the role that specialist palliative care service providers can enhance the ability of a residential aged care facility to provide palliative care services itself. Is that an important part of the interrelationship? Perhaps, Dr Reymond, if we could - - -

DR REYMOND: I think it's – I think it's absolutely essential. I don't think that – and I've said this before, more than 98 per cent of people exit aged care systems through death.

MR ROZEN: Yes.

DR REYMOND: And given that death is the universal health outcome, the aged care system, whatever the aged care service is, they should have a level of competency, a capacity for palliative care.

MR ROZEN: Yes.

DR REYMOND: And my concern is that we're not there, even in – either in the residential aged care facilities or in the home care situation. The actual home care situation, with the deregulation of care in the community with level 3, level 4 packages and who can be an aged care provider, I think that's becoming more critical that we start to build that capacity.

MR ROZEN: Could I just ask you to expand on that? I'm not sure I understand exactly what you mean about the impact of the deregulation there. What's the significance of that for the provision of palliative care in the home setting?

DR REYMOND: Okay. We are – there are more and more home care providers now - - -

MR ROZEN: Yes.

DR REYMOND: - - - coming into the area and that's coupled with where people get home care packages, and effectively they can say where they want to spend their money on - - -

5 MR ROZEN: Consumer directed care. Yes.

DR REYMOND: Thank you. Consumer directed care.

MR ROZEN: Yes.

10

DR REYMOND: Which I think theoretically is a good thing but sometimes it can lead to difficult situations. So that the capacity of – they're coming from a low base, they are new to the area. In the past we used to have just the domiciliary nurses, really, and, you know, I'm not sure what they have in Western Australia. We have
15 Blue Care, Anglicare, many different types in Queensland. We would have a relatively close relationship with these people where they would call us and say, you know, "What should I do now?" or, "Can you suggest?" But with this deregulation, that is becoming more difficult. Further, I've come across situations in homes where I've been called to see someone, and I ask them who's their aged care provider and
20 they told me, "Oh, it's somebody in South Australia". This is from Queensland.

How can somebody from South Australia possibly provide patient focused palliative care - - -

25 MR ROZEN: Yes.

DR REYMOND: - - - to someone in a Queensland suburb? But it just makes a situation that much more complex because then, if we need to get other nurses to go in, then we need to broker for them and to pay for them, which we're not – we're not
30 funded to do, but you can't leave the person unsupported. They've given their money to another provider who isn't appropriate.

MR ROZEN: Yes.

35 PROF TIEMAN: Could I just say something?

MR ROZEN: Yes, please, Professor Tieman.

PROF TIEMAN: Because I think one of the considerations is the aged care
40 provision is not necessarily occurring for palliative care.

MR ROZEN: Yes.

PROF TIEMAN: In essence it is – it has been assigned because of aged care needs,
45 needs associated with ageing. One of the issues that is confronting us all is the fact that, inevitably, for people who age, death will be a foreseeable outcome with it. And so if people are on packages, how do we recognise when your relationship may

be primarily with a home care provider who is maybe cert 3 trained, that actually change is occurring that needs to trigger? And so we're making assumptions about how care is going to organise into the future and we need to look at how we form our relationships into the future models that aged care is looking at, to say that we can
5 identify when people will have palliative care needs and how that will work between specialist care, primary care and aged care. And I think that's the consideration. And it is also a consideration within residential aged care as well.

MR ROZEN: Dr Fischer.

10

DR FISCHER: I just – I mean, we are touching on actually, I think, a lot of issues here. There's the issues of poor data and understanding demand, and how services are being provided. We're touching on workforce issues and within aged care primary care, including the GP. We're also – it sort of touches on, in fact, the
15 availability of the specialist palliative care workforce. Given as in my statement there's only 226 specialist physicians across Australia and, what is it, three and a half thousand nurses with specialist palliative care, you know, qualifications. So there's a whole – it's quite complex and there's a whole lot of issues that we're going to address if we're really going to ensure that we are identifying and providing good
20 palliative care to our aged care population.

MR ROZEN: Could I perhaps just tease out the workforce issues, because we've sort of addressed them or, well, mentioned them in passing. At its heart seems to be the issue of whether presently we have a residential aged care workforce that has the
25 capacity to deliver quality palliative care in the aged care – residential aged care setting. And I think across the board the three of you would say that that might be present in patches but it's certainly not present across the board.

DR FISCHER: Yes.

30

MR ROZEN: What's missing? Why is the capacity not there presently? Is it about numbers of workers? Is it about skill levels? What is it? Dr Fischer, perhaps I could start with you.

35 DR FISCHER: So once again, I think there is a number of – there is a number of issues.

MR ROZEN: Yes.

40 DR FISCHER: So we're touching on what's the right – what's the right mix and balance of skills within – within aged care. Currently there are – there's a number of different education programs that are out there, but nothing is mandated. And so it really relies on your aged care provider, the leadership of those services, to be really looking at what education and what level of competency do their staff have. So
45 we've got the skill mix. We've then got the whole sort of issue of that it – palliative care training is really not embedded from an aged care worker perspective. And we would argue, PCA would argue, that it should be core for people working in aged

care. And, in fact, that even in our undergraduate programs for nursing, allied health medical, palliative care should be core and should be mandatory if we're really going to ensure a good level of general palliative care and to meet the future demands of our – of the population.

5

MR ROZEN: Thank you. Can I perhaps ask that the discussion in your statement, Dr Fischer, be brought up about this because I think it provides a useful setting for us to talk about the workforce issues. So this is WIT.0159.0001 at page 25, and it's paragraph 108 towards the bottom of the page that we might have to start our examination. The question you were asked there was how – or that you're answering, is:

10

How can the aged care workforce be improved to facilitate their access to high quality palliative care services both in residential aged care facilities and home care?

15

And just to clarify, we're talking about that general – the ability to provide that general level of palliative care.

20

DR FISCHER: Yes. Yes.

MR ROZEN: You all say that that provision of that level of care ought to be core business, I think is the expression that is used.

25

DR FISCHER: Yes.

MR ROZEN: And then the question, the obvious question is, if the capacity is not there presently, then what's needed in the future? And you've partly addressed that about, you know, the training that's provided to care workers, nurses, allied health professionals. Why is palliative care not part of the core curriculum for the training of those people? What's – why isn't it there now, would you say?

30

DR FISCHER: Well, yes, good question.

35

MR ROZEN: It seems so obvious, I guess, is what I'm saying, and yet it's not.

DR FISCHER: Well, I think palliative care has not always had perhaps the priority that it should across our health and aged care system. And I think that there have been, you know, a number of different inquiries, reports, that are all, in fact, identifying similar issues to what we're actually talking about today. And so – and as I've sort of stated, there are some really good pockets and there's some really great examples of programs, but it's not systematic and it's not right across the system. I don't know if Jen – yes.

40

45

PROF TIEMAN: I'm happy to have a go at elaborating a little more. I think it is around a number of issues. One that we're actually not terribly good at talking about death and dying.

MR ROZEN: Yes, comes back to that first point where we talked about it, doesn't it?

5 PROF TIEMAN: Yes, yes. I think the other is that we've actually been very, very good at keeping people healthy and living longer. And, actually, with wonderful public health interventions and medical interventions and so in a way we've been pushing out the dying. And I think, actually, as a population we're now facing the idea. Everything is catching up with us. We're actually getting more people who are older and more people who are dying older. So the problem is becoming more
10 manifest I believe.

MR ROZEN: Yes.

15 PROF TIEMAN: And that's actually part of the issue that also concerns us. And I think there's also this question that to some extent there has been a lot of discussion, is palliative care normal health care? It's something every health professional can provide and therefore to some extent they do it anyway so we don't need to think about it. And I think what's happening is we're starting to recognise that it is not always leading to the outcomes that we want. And we're actually also dealing with it
20 in a process where there is greater complexity, comorbidity, multimorbidity, progressive diseases, longevity. Issues that we haven't really seen are coming through, and so there's a whole complex of things that are coming together that are making palliative care a fairly significant discussion and which perhaps may explain why it was there, but it was there for a relatively small proportion of the population
25 and maybe didn't have a profile.

MR ROZEN: Dr Fischer, you mention in your statement – this is at paragraph 110 – that the aged care workforce strategy task force has – as we all know, has been doing work in this area. And one of the things that has been identified through the task
30 force's work is the gap in relation generally to skill levels and training, and specifically in relation to palliative care. I suppose my question is, there doesn't really seem to be the sense of urgency one might expect from that process.

35 DR FISCHER: Yes. And we would - - -

MR ROZEN: Would you agree with that?

DR FISCHER: We would definitely.

40 MR ROZEN: Yes.

45 DR FISCHER: We would definitely agree with that, so that urgent implementation is definitely needed. However, the other thing I would make too is that the implementation of looking at the aged care workforce cannot be just taken in isolation. We need to also look at it in terms of our – the health workforce and particularly that of GPs, because I think they are absolutely critical for us to provide good care to our aged population. There's also a national health work force strategy

that's being developed. So we need to really make sure that there's really good linkages between both of those strategies and there is some urgency around it as well.

5 MR ROZEN: Professor Tieman, is there anything you wanted to add? Particularly from a slightly different area of the skilling up of the specialist palliative care workforce, are we doing enough in that area?

10 PROF TIEMAN: Skilling up of the specialists? In terms of working in aged care specifically?

MR ROZEN: Well, yes. Yes.

15 PROF TIEMAN: So I think, obviously, the specialist palliative care workforce has got specialist skills that actually enable them to deliver complex palliative care to people with complex needs. I suspect there's also a need to look at how this workforce is going to engage with both the primary care workforce and the aged care workforce and provide leadership so that it's not always that they have to be delivering care. It is about them actually developing the skills that will enable the care to be delivered in different settings. I think it is also about contributing to the research that is going to actually inform models that are going to work across the whole of the systems that are going to be involved with it. And I think that in itself for specialist palliative care means it's going to have to expand its brief to take on those areas and to develop skills. So we have seen increasing interest in postgraduate studies in relation to specialist palliative care, which is very promising. And I think we've also seen it in regard to academic and research activity in the field, so that they can actually contribute to the actual issues that need to be examined, that need to be researched and that will need to be implemented.

30 DR REYMOND: Can I - - -

MR ROZEN: Sorry, can I just – if I could just ask a question to follow that up and then I will come to you, Professor Reymond. How many tertiary institutions are now providing postgraduate palliative care studies, do you know?

35 PROF TIEMAN: Look, offhand I couldn't, because part of it is depending watching the postgraduate studies to some extent. Look, there will be at least a dozen, at least a dozen, and then there would be more universities, for example, that also take on PhDs - - -

40 MR ROZEN: Yes.

45 PROF TIEMAN: - - - with people, say, within medical schools who would be looking at a palliative care issue in that. And so it depends to some extent. There would also be allied health people who would be looking at specialist development through other avenues. So there's a range of different ways in which people are developing skills.

MR ROZEN: Now, Dr Reymond, I'm sorry I cut you off.

DR REYMOND: That's just fine, counsellor. With the specialist palliative care services there simply isn't enough of them. They're not funded. They need more
5 funding, in particular I think one way of overcoming the urgency of upskilling the generalist palliative care workshop – workforce, is that if we had – if every specialist palliative care service was funded to have an educator.

MR ROZEN: Yes.

10

DR REYMOND: The workforce anecdotally, and also I know they've just done some surveys around Ipswich, the thing that people value the most in health care in terms of learning, is when you say to them, if you've got a problem, what do you do, "I call a colleague". That's the first thing. We have – we have all these modules,
15 we've got all this electronic stuff, but really what they want to do is phone a friend, "What should I do now?". If we can get the specialist level of palliative care services up, with educators in each, making relationship with the generalist palliative care workforce then we have a very good mechanism to increase skills. That will also allow for some residential aged care facilities where you've got a relatively high
20 turnover of staff, until that problem gets fixed, to allow upskilling within those facilities as well. But I think with the facilities, the associated problem there are the numbers of staff. We're still coming back to numbers and skills all the time.

MR ROZEN: Yes.

25

DR REYMOND: But the numbers of critical. Until somebody is prepared to make the investment and regulate the staff/resident numbers, then we're always going to have case studies like we saw this morning. It's inevitable. People can only do so many tasks before some of them fall off. Some of these nurses are looking after 60
30 beds with these complex – complex people living there. It's an impossible task.

MR ROZEN: Two hourly pain assessments are a pipe dream in that scenario.

DR REYMOND: Yes, it is a pipe dream. It's a pipe dream and then the other
35 problem is you try – and I think as Josh was pointing out, you try and work all of our pharmacological interventions around what you know is a substandard workforce in terms of numbers. So for instance if you want to give a subcutaneous morphine injection you have to have two people to administer the injection. You've got one nurse across 60 beds, that's it, or they're not even on-site, they're at home with the
40 phone. So how are you going to get two people together to be able to administer that medication, and what's happening to the rest of the people in the facility while that happens. So we just – somebody has got to bite the bullet.

MR ROZEN: Just before I come to you, Dr Fischer, sorry, I'm doing this again, Dr
45 Reymond do you have a specialist educator or - - -

DR REYMOND: No.

MR ROZEN: You don't.

DR REYMOND: No. No, but through our business – our palliative care collaborative we apply for short term grants and a part of those grants, usually from
5 the – from the Commonwealth Department of Health through the national palliative care grants we apply to get money and a part of that is about educating either, you know, with the palliative approach toolkit or with our caring at home safely and so we sort of do it that way. But you really need the relationship to get the ongoing sustainable increase in capacity.

10 MR ROZEN: Yes. We'll come back to the toolkit in a moment. Dr Fischer, you are very eager to answer.

DR FISCHER: I just was going back to actually from Jen's comments in relation to
15 the skill of the specialist workforce, in terms of that palliative care originally arose out of looking after people with cancer, and it's really now extending to those with chronic non-malignant diseases, and there are different issues, understanding some of those, are the disease symptoms arising out of that. So there is still a need for us to be continually upskilling our specialist palliative care providers and that they're
20 working quite closely with specialists in those relevant areas. But also really important that we start to generate evidence around what are the right models for those other disease groups or diagnostic groups. So it wasn't really further to Liz's comments, it's really around that specialist health care upskilling.

25 COMMISSIONER TRACEY: I notice there are a lot of oncologists who, on their name plates, say they are oncologists and palliative care specialists. That's, I take it, a phenomenon that has grown out of the history which you've just referred to.

DR FISCHER: Yes. And I think when – when palliative care originally became a
30 medical – like a specialty, there was sort of a grandfathering clause where people who had been practicing for a certain amount of time could actually gain the qualification of a fellow of the chapter of palliative medicine. What we are seeing now though is that where people are starting to do dual training, so that you actually might see that they have a palliative medical specialty and we're seeing people with
35 pain, geriatric, geriatric rehab, oncology, so yes, which is a – which is a positive thing actually, yes.

PROF TIEMAN: Could I please make one more comment about education because
40 so far and I specifically asked if it was about specialist palliative care education that your question was addressed to. I think we also need to acknowledge that the specialist palliative career is actually contributing to quite a lot of those national and State education for the generalist workforce in a variety of ways, obviously in direct input into clinical training and into the actual service provision and the type of things that Josh Cohen was talking about. But also they are contributing to the development
45 of programs that are actually looking at education and providing opportunity.

There are opportunities for people from both primary care and aged care to engage with palliative care services, so the PEPA palliative care experience program in Australia actually provides an opportunity for clinical experience in the palliative care setting which I think is a very valuable resource that can be looked at. And then
5 they have been engaged in many other different programs and give very generously of their time in developing resources to support these workforces.

MR ROZEN: Can I raise a different related matter I think and it's in agreed proposition number 20, if that could please be brought up from tab 68. Agreed
10 proposition 20 which I will read out is:

*Early completion of advance care planning documents by a patient strongly contributes to delivery of patient-centred palliative care. This should not be confused with completing an advance care directive which only comes into
15 effect when someone loses capacity.*

Why is the early completion of advance care planning documents a strong contributor to the delivery of patient-centred palliative care. Maybe Dr Fischer, if I
20 could start with you.

DR FISCHER: Well, I – I know we've agreed to this statement.

MR ROZEN: Right. You're backing away from it now?

DR FISCHER: No, no, the concept of advance care planning is really important. I think the thing – what's really critical is the conversations and, you know, that because these – they should be starting early. They should be ongoing because people's needs and wishes will change. And if – if they're documented that is great and if there is – you get to a point there's an advance directive that's really helpful as
30 well as guiding a health professional. But especially in the context if you – if there's no conflict within the family unit of care, with the patient, then actually having the right conversations and that people are aware of that. Someone might – they may have a decision-maker who's appointed. But that can be just as effective. I think it's more important that if there's conflict that it's actually documented to help guide. So
35 to me it's the early discussions and ongoing discussions but I don't know if either Liz or Jen want to add to that given we've signed off - - -

MR ROZEN: Maybe if I could start with you, Dr Reymond. At a practical level, is this an area of controversy? Are there practical issues about the honouring of
40 people's wishes in this regard?

DR REYMOND: Yes. Clinically this is a very complex area.

MR ROZEN: Yes.
45

DR REYMOND: And it is a fine paragraph but I think we all had a little bit of concern around it. For me, the early completion of advance care – we are a death-

denying society. If we can increase awareness of we really are all going to die, it will help us all plan for our inevitable death. I think the advantage of early completion of advance care planning documents is that it can raise people's awareness of – of their mortality. Often people say, if you say have you spoken
5 about your death, “Yes, I did a will 10 years ago”. And that's fine, that's just about your stuff, you know, what about you, what about your care. So I think that's where there's great advantage in having these advance care planning discussions and I agree with Jane, it's absolutely about the discussion. Documents can be problematic. There's no doubt about that. Especially with the advance care directives.

10 Now, the advance care directives lock people into a point in time and as you as lawyers would understand much better than me, it is as if the person is giving consent in their own voice, even if they're not there to consent to something. So they may have written an advance care directive on the advice of their GP or their
15 lawyers, five, six, years ago, and have locked in for themselves to the end of their lives a type of care. And if – we know from the work that we've done, the average age that people complete an advance health directive is 72 years, and they're rarely revisited. There is a big physiological difference in the human being between 72 years and, say, 82 years which is the average age of death for men. So whatever they
20 said they wanted there, may not be at all what they want here, but if they lose capacity, they're locked in with that.

There tends to be more of a global movement now towards the conversation, towards moving away from legal set in stone documents to having a conversational
25 approach about what you want for your care and advance care planning fits very well with that, whether they're a values-based document or not. For some people, and it's up to the person, none of this is compulsory. Some people who have a very strong internal locus of control, if they need to have the feeling that they are in control, then by all means the advance care directives probably suit them the best, really.

30 MR ROZEN: Yes.

DR REYMOND: But if not, if they want this conversational approach then I think they're better off leaving it open. For me, probably I'm on my hobby horse, but for
35 me probably the most important thing that anybody could do is choose an appropriate enduring power of attorney, however named, so that if you lose capacity you know that you have someone who understands you and knows how to advocate for you against this extraordinary health care juggernaut that you will be up against at some stage.

40 PROF TIEMAN: Could I just make one point. Because I think advance care planning is part of a societal perspective which is around consumer choice as well. So it is a way for the consumer voice to be heard. I totally agree with the idea that advance care planning is a conversation and is an ongoing conversation with health
45 professionals about your care needs and, in fact, you know, your advance care directive shouldn't come into play while you're actually talking and hopefully for many, many people their advance care directive never has to be enacted because

they're actually involved in the discussions about those about their health care at the end.

5 I think it is important though when we look particularly at ageing and we look at cognitive decline that we do actually start those conversations in a timely way and I think advance care planning has been an approach that we have developed to try and remind people that we do need to plan for our future. And part of our future is about dying, and so conversations, documents, all important. Do I think one is better than another? Not necessarily. Do I think we need to have better ways of capturing
10 people's wishes so that when they are needed they are there? Yes, I think we need much better systems as well, so a slightly different perspective.

MR ROZEN: Dr Fischer.

15 DR FISCHER: Sorry, so just building on all of that, we have to have health professionals who have the skills to have those conversations, even at a primary health care level and we also need a much greater focus around the community education and awareness so that we normalise death and dying, they understand what is advance care planning, they start talking about, but they also understand what is
20 palliative care.

MR ROZEN: Now, I'm very conscious of the time and it's been a long day, but Professor Tieman, if I could just go to you and ask about ELDAC which is something that you discuss in some detail and is of considerable interest to the
25 Commission. To give us a bit of context, this is paragraph 89 of your statement which is WIT.0173 at page 22, and you refer to it as:

A project that seeks to improve the care of older Australians through palliative care connections and advance care planning activities.

30 Can you just explain to us briefly, if you could, the nature of the project and its current status and what you see as its principal achievements, I guess.

35 PROF TIEMAN: So the End of Life Directions for Aged Care is – has been funded by the Department of Health, so it's a – a national program that's trying to – and it's a program of work, so it's trying to look at a number of initiatives that would actually take more of a system and a sector approach than just a project that might look at a single, for example, service.

40 MR ROZEN: Yes.

PROF TIEMAN: It actually has three streams of – sorry, four streams of work that are going on. So the first two is really built about – online capability building, so making information and evidence and toolkits available online so that they can be
45 there when they are needed and used by people in the residential aged care and the home care setting. There are five toolkits that are being developed. So one for residential aged care, one for home care, a legal toolkit, a working together toolkit

and a primary care toolkit. And so what they're all doing is trying to look at different aspects of what would be a comprehensive aged care setting.

5 The second stream of work is looking at technology innovations. So, at the moment, the primary piece of work being undertaken there is trying to create a digital dashboard that will look at trying to say how can we track how groups are going with regard to performance against a series of palliative care activities which range from advance care planning, through to recognising end of life, through to providing care, working together, bereavement and managing dying.

10 The third stream of work is a series of policy round tables and that's actually being led by Palliative Care Australia, and so the idea is to look at some of the complex issues that are confronting aged care and palliative care and to try and find ways to look at information that could inform policy directions, which could inform service thinking, and a number of other activities. And the fourth stream of work is about 15 trying to look at the relationship between specialist palliative care services and primary care and aged care through a – a program of service partnerships. So where facilitation occurs to actually help link services, residential aged care and home care services with palliative care services and, also, to look at the primary care involvement between those.

20 Where we're up to, we've actually developed, obviously, what we believe is a model that will inform and be comprehensive enough and simple enough to be understood that goes from advance care planning through to bereavement in that activity. We 25 have established the website and that is probably, at the moment, attracting around 3000 visits a month in those areas. We've actually built up a group of people who are either engaging through various newsletters, social media activities as well. The digital dashboard, we are having a meeting with the reference group before we start an industry discussion around that activity. The policy round tables, three have been 30 completed and three are in the process of being planned. And the services is well under way with signups in every State and Territory.

MR ROZEN: Thank you very much for that. Now, we're in the habit here of asking witnesses such as yourselves if you could convey to the Commissioner – the 35 Commission, a wish list of areas that you'd like to see addressed to address the many concerns that you've raised in your statements. Now is your chance. It doesn't come along too often, I suppose. So, maybe, Dr Fischer, I could start with you.

40 DR FISCHER: Thank you. So if I could be so bold, I've actually got an eight-point plan, aged care policy should align with the WHO definition of palliative care, and it should not be restricted to end of life being days and weeks. So we have touched on that.

45 MR ROZEN: Yes.

DR FISCHER: Palliative care must be included and clearly articulated in the aged care quality standards, and they aren't. All – and I touched on this, all undergraduate

nursing, allied health, medical certificate courses for care workers must include mandatory units on palliative care. We need to establish a minimum – a national minimum dataset for palliative care which includes both health and aged care if we are going to plan and deliver services for the future. We need funding to fully
5 implement the national palliative care strategy ensuring aged care is included in that. We need investment and the development of innovative models of care, as we've heard, to ensure older people have equitable access to specialist palliative care. We need an increased focus on community awareness around death, dying, advance care planning and palliative care and, lastly, we feel that palliative care should actually be
10 a COAG priority and actually supported by the appointment of a national palliative care commissioner so that we could actually address the aged care and health interface issues which are significant.

MR ROZEN: Professor Tieman, would you like to add to the wish list?
15

PROF TIEMAN: I'm sorry, you did provide us with this opportunity.

MR ROZEN: I did.

20 PROF TIEMAN: So mine are somewhat similar and somewhat different in orientation to Jane's. The first thing is think we do need public health promotions and campaigns, and we need them in, I think, three areas. One is normalising death as part of life. I think we need to have a second which will look at building and understanding what palliative care is and how it contributes to health and healthy
25 dying, and I think we need one which will also look at all lives (all deaths) are important which speaks to both diversity and ageism in a sense. I think we need to look at developing capability in aged care and in the primary care workforce which is independent to changes in structures and whatever capacity, structural capacity changes occur, and I think we need to look at it around several issues.

30 One is recognising end of life so that we actually can actually think about palliative care needs because we've actually recognised death will be occurring. We need to look at the skills associated in providing care and this will include both referral and shared care arrangements as well as the more classic symptom issues. We need to
35 look at communication skills because if we're not able to talk about death and dying with dignity and with compassion we will not be able to provide appropriate care, and we do need to look at advance care planning but also terminal care planning and delivery and I think these are knowledges that we need across the sector.

40 I would agree that workforce redesign is needed and in this we need to think of palliative care as core business for the activity. I would like to suggest that research is needed on pathways to death for older Australians across the various care and community systems so that we can actually look at effective supports at points of need along those trajectories. I think we need to ensure that bereavement is
45 considered and we also need to enable self-care for direct care providers who will be engaging with increasing rates of dying. This will help support a healthy workforce in both primary care, aged care and also, of course, in health care. And I think we

need to recognise that multi-system change is needed so that the person themselves doesn't experience fragmented dying.

5 We must anticipate the impact of population changes, societal changes and policy reform so that we can future proof whatever decisions we are making about palliative care provision and we need to make sure that person-centredness permeates all planning at all levels, policy, service design, consumer engagement and planning and evaluation and that will be the test of us actually being person-centred. And finally, we haven't discussed it very much in, I think, either my submission or across today is
10 really the need to explore technology and digital opportunities. I think these could look at issues such as prompts for clinical care, community monitoring, self care, advance care planning processes, support transitions and enable consumer feedback. End of my wish list.

15 MR ROZEN: I did ask so – and Dr Reymond, the last word.

DR REYMOND: Three points. I think that – I think we are in a palliative care crisis at the moment, especially with all the baby boomers coming through. In the short to medium term, what I think we really need are systematised models of care
20 that are led by specialist palliative care services and that can coordinate care across all of the care environment interfaces. We saw in our case study this afternoon the problems with the communication between the RACFs and the hospital. So those services – those models of care need to integrate all of that, and those services need to be evaluated by a clinical care standard that I think needs to be developed in
25 conjunction with the Commission on Safety and Quality for Health Services. And that – that standard should be developed by the content specialists, the specialists in palliative care, patients and carers and then that will allow those services to be appropriately evaluated to see whether they're delivering the standard of care that's required.

30 Those models – my second point is that those models need to be adequately funded. They should not rely on opportunistic grants coming up or some money that's fallen off the side of the budget. And finally, I think what we desperately need for aged care is optimal staff resident ratios that are mandated to ensure care for people.

35 MR ROZEN: Thank you Dr Reymond. Commissioners, that concludes my questioning of the panel.

40 COMMISSIONER BRIGGS: Thank you for your evidence. It's hard to know where to go with that. And I suppose I want to come back to the practicality of the fact that nobody wants to know or talk about death and dying, but you would prefer that those conversations happen. Let's be practical, how do you do that?

45 DR FISCHER: Well I think if – I guess there's something similar in terms of like if we look at mental health now, and if we go back 10 years, no-one was really talking about it till we actually had a national program, you know, it started with Beyond Blue but there is now such a focus around mental health so – but it's probably not

just one – one program, and, yes, certainly there’s a theme, you know, we have been building on trying to run – run awareness programs but yes, I think – but to me some of that is almost coming back to the training of your health workforce and that being core in their undergraduate because it’s all about how you’re normalising it right
5 across, you know, your whole community. And it’s not just a community awareness but it is, there are many elements to it.

PROF TIEMAN: I think there is an opportunity to leverage on the very fact that we’re sort of seeing play out today. I think nearly every Saturday night dinner party
10 I go to, discussions occur about ageing, about aged care, about “How will I support my mum” and I think that these give us ways into having community-based campaigns that perhaps were not possible 20 years ago for palliative care support. So I think there’s a recognition in the community that ageing is real and that would be one way into the discussion I think with that. I think perhaps sometimes the
15 community is ready to talk in certain ways about certain aspects of death and dying and perhaps we’re not ready to talk about it.

DR REYMOND: I think if we put a focus on our GPs, if we had a Medicare item for advance care planning, I think that would do an enormous amount to help educate
20 the public. At the moment the GPs are moving or don’t want to embrace advance care planning discussions because they can take quite a while and there’s no Medicare item for them.

COMMISSIONER TRACEY: All I can add to what Commissioner Briggs has said
25 is that I am very grateful that we have a transcript. There has been so much information, helpful, useful, important information that we’ve heard in the last hour and a half. It will require some time to sit back and read through it, consider it, but we’re enormously grateful to you for coming here and sharing your expertise. It’s been very, very helpful. Thank you all.

30 DR FISCHER: I think on behalf of all of us I would say thank you for giving us the opportunity to come and talk to you. I think as we’ve heard, you know, there is some urgency and reform that’s needed given what is current demand but also what’s ahead of us into the future.

35 COMMISSIONER TRACEY: Thank you. 9.30? The Commission will adjourn until 9.30 tomorrow morning.

40 <THE WITNESSES WITHDREW [4.59 pm]

MATTER ADJOURNED at 4.59 pm UNTIL FRIDAY, 28 JUNE 2019

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