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TRANSCRIPT OF PROCEEDINGS

O/N H-1053324

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

BRISBANE

9.38 AM, TUESDAY, 6 AUGUST 2019

Continued from 5.8.19

DAY 43

MR R. KNOWLES, counsel assisting, appears with MS Z. MAUD and MS B. HUTCHINS
MR G. KENNETT SC appears with MR J. ARNOTT for the Commonwealth of Australia
MR J.R. SEWELL appears for MiCare

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

MR KNOWLES: Thank you, Commissioner. Yesterday the Royal Commission heard the case study into the regulation of People Care. Today we will hear case studies about the regulation of two further approved providers. First, MiCare and then, later today, Japara. Before making some brief opening observations about the MiCare case study in which I appear with my learned friend MS MAUD, there are some appearances for other parties with leave to appear.

MR J.R. SEWELL: Good morning, Commissioners. My name is Sewell, spelt S-e-w-e-l-l, initials J.R., solicitor from Mills Oakley for MiCare, its officers and employees.

COMMISSIONER TRACEY: Yes, Mr Sewell.

MR SEWELL: Thank you, Commissioner.

MR G. KENNETT SC: Yes. If the Commission pleases, I am with MR ARNOTT in this case study for the Commonwealth.

COMMISSIONER TRACEY: Mr Kennett.

MR KNOWLES: Commissioners, as you will recall, the circumstances of the MiCare case study were first considered by the Royal Commission at the hearing in Cairns. There Ms Johanna Aalberts-Henderson gave evidence about the experiences of her mother while a resident at the Avondrust Lodge facility in suburban Melbourne. The owner and operator of Avondrust Lodge is, as you know, MiCare. Other witnesses in Cairns included Mr Robert van Duuren who was the general manager, residential services, and Ms Petronella Neeleman, the executive director at MiCare. Now, the evidence in Cairns pointed to serious deficiencies in the standard of care in Avondrust Lodge in 2018.

Mrs Aalberts began living there on 24 May 2018. She walked into the facility, as the Commissioners heard, with the aid of a walking frame. At that time, she was cognisant and continent. By 19 August 2018, less than three months later, she had died and at the time of her death, she had a chronic right lower leg wound and serious pressure injuries on her sacrum and right heel. Now, seven days after the late Mrs Aalberts had entered Avondrust the service had been reaccredited on 31 May 2018 by the predecessor of the Aged Care Quality and Safety Commission, the Australian Aged Care Quality Agency, for the maximum period of three years. An audit by the Quality Agency in April 2018 had found that Avondrust met all 44 out of 44 expected outcomes including those for human resource management, specialised nursing care and clinical care.

But by 29 August 2018, a delegate of the secretary of the Department of Health had imposed sanctions on MiCare because there was an immediate and severe risk to the safety, health or wellbeing of residents at Avondrust. In imposing sanctions, the

secretary's delegate referred to an audit by the agency between 16 and 27 August 2018 that had, to use the delegate's words:

> *Identified systemic and pervasive failures to deliver appropriate care across the majority of the accreditation standards.*

That audit had resulted from a complaint earlier made by Ms Aalberts-Henderson to the then Aged Care Complaints Commission about the treatment of her mother at Avondrust. On having completed its audit in August 2018, the agency found that Avondrust now failed to meet 13 out of the 44 expected outcomes that had all previously been found to have been met in April 2018. Subsequently, in September 2018, the agency found that MiCare had placed the safety, health or wellbeing of 14 of the residents at Avondrust at serious risk. One of those residents was the late Mrs Aalberts.

In this hearing, one of the key issues for consideration is why the systematic and pervasive failures to deliver appropriate care, as described by the delegate of the secretary, that were uncovered in August 2018 had not been evident to the agency less than four months earlier when it found that Avondrust met all 44 expected outcomes and granted re-accreditation for the maximum period of three years. There are, therefore, questions about the adequacy of the regulatory approach of the agency in April 2018. Another key issue is the effectiveness of the imposition of sanctions as a regulatory measure. Here the sanctions included revocation of MiCare's approval as an approved provider under the Aged Care Act and, as such, termination of its entitlement to government funding for provision of its aged care services.

But that sanction was fashioned, as was the case in many other circumstances that the Royal Commission has heard of, in such a way such that it would not come into effect if, within a particular period, here one week, administrators and advisers were appointed for a period of six months. That begs the question, obviously, about how often revocation is utilised unconditionally. That question was put yesterday by senior counsel assisting the Royal Commission, Mr Gray QC, to Mr Anthony Speed and the answer is, "Seldomly, if ever." It also begs questions about what, if any, other sanctions measures should be available for aged care regulators. For instance, should they have powers in appropriate circumstances to ban or fine those responsible for the management of approved providers.

Returning to advisers and administrators, their selection has, since 2016, been almost entirely at the discretion of approved providers. Here MiCare selected, appointed and dealt with its nurse adviser and administrator, Ansell Strategic, as it saw fit. On the other hand, the dealings of the agency and the department with Ansell were relatively limited. They certainly had no particular statutory obligations or powers in that regard and that is arguably surprising given that the nurse adviser and the administrator are the people who might be expected to have an intimate knowledge of the affairs of a deficient approved provider and its progress, if any, back to compliance. The evidence in this case study suggests Ansell's core objective for

MiCare was the resolution of its regulatory issues, that is, to get sanctions lifted and to ensure that accreditation was renewed.

That objective was achieved in January 2019. Among other things, by then MiCare was again assessed as meeting 44 out of 44 expected outcomes. However, even after that objective had been achieved, Ansell expressed reservations to MiCare about the underlying quality and sustainability of changes to the provision of care to residents at Avondrust. As late as 12 February 2019, Ansell informed MiCare that – these are the words of Ansell:

> *The lack of robust clinical processes and reporting provides an ongoing risk for the home, including the risk of –*

in the words of the Ansell employee –

> *a possible catastrophic clinical event.*

That information was never shared with the agency or the department by Ansell or MiCare, and there was no obligation on them to do so by law. But one might have thought, nonetheless, that is the sort of information that should have been. The failure to share that adverse assessment emphasises how much, in the present regulatory regime, accountability depends on transparency and candour on the part of approved providers and their associates. It is reasonable to expect that such transparency and candour will be given. Unfortunately, however, it cannot be assumed as a given. That raises questions about the powers of regulators to compel production of documents and information and, to the extent that such powers exist, how often and effectively they are used.

Ansell's adverse assessment about MiCare's implementation of changes goes to one further final issue: other more recent evidence suggests that that assessment was not without some justification. Internal MiCare emails in February and March 2019 set out concerns of staff about the sustainability of improvements at Avondrust. Since then, complaints have been made to the Aged Care Quality and Safety Commission about various matters, including staffing levels and wound management at Avondrust. They were some of the aspects of Avondrust's operations that were found very wanting in August 2018. The recent complaints about the very same matters call into question how effective the regulation of MiCare since August 2018 has been.

I now turn to the witnesses who will give evidence at today's hearing. We will first hear from Ms Neeleman, the executive director from MiCare. We will then hear evidence from Ms Judi Coombe, a key member of the nurse adviser administrator team from Ansell. Thereafter, there will a panel of four witnesses. Three of those witnesses will be aged care assessors, each of whom was a team leader for a visit by the agency, or the commission as the case may be, respectively in April and December 2018 and January 2019. The fourth panel member will be Ms Catherine

Rosenbrock, the regional director for Victoria and Tasmania in the quality assessment and monitoring group at the Aged Care Quality and Safety Commission.

Finally, the Royal Commission will hear evidence from Ms Elsy Brammesan, the delegate of the secretary of the Department of Health who made the decisions to impose sanctions and then subsequently to lift them in respect of MiCare. Before asking Ms Maud to call the first witness, Ms Neeleman, I seek to tender, in accordance with the practice that was adopted yesterday, the documents in the tender bundle for the case study. The documents include documents that have been provided by the Commonwealth and MiCare. If I could call on the operator to display the MiCare tender bundle index which refers to some 257 documents. I'd ask for the documents comprising the MiCare tender bundle to be tendered into evidence, Commissioners.

COMMISSIONER TRACEY: Yes, the MiCare tender bundle will be exhibit 8-14.

EXHIBIT #8-14 MICARE TENDER BUNDLE

MR KNOWLES: Thank you, Commissioner. I note that there is a chronology at tab 252 of the tender bundle. We can indicate that its contents are agreed to by the Commonwealth and MiCare. I now invite Ms Maud to call the first witness, Ms Neeleman.

MS MAUD: Thank you, Commissioners. I call Petronella Neeleman.

<PETRONELLA DOROTHEA NEELEMAN, AFFIRMED [9.51 am]

<EXAMINATION BY MS MAUD

MS MAUD: Can you state your full name, please.

MS NEELEMAN: Petronella Dorothea Neeleman.

MS MAUD: Thank you. And have you prepared a further witness statement for the Royal Commission with the document ID WIT.0300.0001.0001?

MS NEELEMAN: I have.

MS MAUD: Do you have a copy of that there?

MS NEELEMAN: I do.

MS MAUD: Yes. Have you had an opportunity to read it recently?

MS NEELEMAN: I have.

MS MAUD: And are there any corrections that you wish to make?

MS NEELEMAN: Yes. On point 6, it should read that it was an announced visit, not an unannounced visitor.

MS MAUD: Sorry. For the operator, that's page at 0008. Can you just highlight the paragraph 6 at the very bottom. So the word "unannounced" should be "announced"?

MS NEELEMAN: That's correct.

MS MAUD: Yes. And could I ask you just to look over at the next page, and could you read paragraph (b), in particular the last sentence?

MS NEELEMAN:

> *There were no changes made to the staffing rosters or numbers of staff rostered on the week before or during the audit. As is our practice in all audits, all senior managers who have changeable commitments attend on site to support staff during the audit as an additional resource for the team when documentation is required to be located. However, this was only attended to after the arrival of the Australian Aged Care Quality Agency in April 2018 because we did not know about the visit in advance.*

So, no, that's not correct.

MS MAUD: You just want to delete those words from "because"?

MS NEELEMAN: Yes.

MS MAUD: Yes. And other than those changes, is your statement true and correct?

MS NEELEMAN: Yes, that's right.

MS MAUD: Yes. I tender that statement, Commissioners.

COMMISSIONER TRACEY: The amended further statement of Petronella Dorothea Neeleman dated 24 July 2019 will be exhibit 8-15.

EXHIBIT #8-15 AMENDED FURTHER STATEMENT OF PETRONELLA DOROTHEA NEELEMAN DATED 24/07/2019 (WIT.0300.0001.0001)

MS MAUD: Thank you. Now, Ms Neeleman, you're the executive director of MiCare Limited; is that right?

MS NEELEMAN: That's correct.

MS MAUD: Yes. And how many years have you been in that role?

MS NEELEMAN: 29.

MS MAUD: How many aged care facilities does MiCare operate?

MS NEELEMAN: Four.

MS MAUD: One of those is Avondrust Lodge in Victoria?

MS NEELEMAN: That's correct.

MS MAUD: Yes. Now, I just want to very briefly sketch with you the events from April 2018 until early this year. On 16 and 17 April, as you say in your statement, there was an announced accreditation audit conducted at Avondrust Lodge?

MS NEELEMAN: That's correct.

MS MAUD: The result of that was that the facility was found to meet all of the 44 expected outcomes?

MS NEELEMAN: That's correct.

MS MAUD: Yes. And a decision was then made on 31 May 2018 to re-accredit Avondrust Lodge for the maximum possible period of three years?

MS NEELEMAN: That's correct.

MS MAUD: Yes. Then from the period from 16 through to 27 August, there was a review audit and, as a result of that, it was found that Avondrust Lodge did not meet 13 of the expected outcomes.

MS NEELEMAN: That's correct.

MS MAUD: Yes. And on 29 August, a decision was made to impose sanctions - - -

MS NEELEMAN: Yes.

MS MAUD: - - - which required, among other things, MiCare to appoint a nurse adviser and an administrator?

MS NEELEMAN: That's right.

MS MAUD: Following that decision, there were then a number of site assessments conducted by the Quality Agency?

MS NEELEMAN: Yes.

MS MAUD: Leading up to an assessment on 6 December. And at that assessment, the finding was made that the 13 previously unmet expected outcomes were now met; is that right.

MS NEELEMAN: That's right.

MS MAUD: Yes. And MiCare was subsequently invited to apply to have the sanctions lifted.

MS NEELEMAN: Yes, that's right.

MS MAUD: It made that application and it was granted - - -

MS NEELEMAN: Yes.

MS MAUD: - - - on 11 January.

MS NEELEMAN: Yes, that's right.

MS MAUD: Yes. So the sanctions were lifted from 11 January this year?

MS NEELEMAN: That's right.

MS MAUD: Now, Operator, if you could bring up Ms Neeleman's statement, and in particular page 0009. The paragraph numbered 7 there is responding to questions that MiCare was asked in a notice to give information in relation to whether there were significant changes in relation to certain matters at Avondrust Lodge between the period 1 January 2018 to 14 August 2018, and your evidence to the Commission was that there were no significant changes to the number of residents during that period; that's right?

MS NEELEMAN: That's correct.

MS MAUD: And that there were also no significant changes to staff numbers?

MS NEELEMAN: That's right.

MS MAUD: Yes. During the period from 1 April – so not the period that's referred to in your evidence in the statement but the period from 1 April, are you able to say how many registered nurses were employed at Avondrust Lodge?

MS NEELEMAN: We had a seven-day-a-week coverage by a clinical care consultant, so one.

MS MAUD: Yes. So there was one registered nurse - - -

MS NEELEMAN: During the day.

MS MAUD: - - - who fulfilled the role of clinical care?

MS NEELEMAN: Yes. It was filled by two people but basically gave us seven days a week coverage.

MS MAUD: I see, two people. And how many enrolled nurses were employed at Avondrust Lodge at that time?

MS NEELEMAN: I don't know.

MS MAUD: I anticipate you might not be able to say how many personal care attendants - - -

MS NEELEMAN: I don't have that figure in my head, sorry.

MS MAUD: Was there also at that time from 1 April through to 30 August a nurse practitioner who was employed by MiCare?

MS NEELEMAN: She worked across the Victorian sites, so three sites. Yes.

MS MAUD: I see. And so during that period that we're discussing, 1 April to 30 August, was there a regular period of time that the nurse practitioner spent at MiCare?

MS NEELEMAN: She would spend at least one day a week but was on call for any other matters.

MS MAUD: Now, in your statement, you refer to the fact that there were five long-term staff retired and one medium-term staff member who resigned during that period 1 January to 4 August 2018?

MS NEELEMAN: That's right.

MS MAUD: Did any of those resignations that you are referring to there occur before 17 April 2018?

MS NEELEMAN: They all took place before 14 April.

MS MAUD: In the period from 17 April to 30 August, there were no further significant changes in the nursing or personal care attendants at - - -

MS NEELEMAN: No, there was not.

MS MAUD: So during that period, from 17 April to 30 August, were those positions filled?

MS NEELEMAN: Yes, they were.

MS MAUD: Right. And there was no change to the number of registered nurses employed at - - -

MS NEELEMAN: No, there was not.

MS MAUD: And the personnel stayed the same, as well?

MS NEELEMAN: Yes.

MS MAUD: Yes. I infer from your answer that there was no change to the rosters at - - -

MS NEELEMAN: That's correct.

MS MAUD: - - - Avondrust Lodge during that period, as well? And so, as I understand it, the registered nurse who filled the role of the clinical care coordinator worked 7.5 hours in the morning shift?

MS NEELEMAN: That's correct.

MS MAUD: And that was seven days a week.

MS NEELEMAN: Yes.

MS MAUD: And that remained the case from the start of April to the end of August.

MS NEELEMAN: It did.

MS MAUD: Yes. And, in addition to that, the registered nurse was on call for 16 hours for the afternoon and evening shift?

MS NEELEMAN: That's right.

MS MAUD: Now, you refer in your statement to the manager at Avondrust Lodge having commenced a period of sick leave on 4 July and returning part-time in August. Are you able to say when in August that person returned to work?

MS NEELEMAN: My understanding was it was the first week in August, but it was only one or two days a week.

MS MAUD: And then that person resigned in November. Are you able to give an approximate date in November?

MS NEELEMAN: It was mid-November.

MS MAUD: And – so that was – that's the facility manager that you're talking about there?

MS NEELEMAN: That's right.

MS MAUD: And you recruited a new person to fill that role and they commenced in January?

MS NEELEMAN: Yes. At the - - -

MS MAUD: Is that right?

MS NEELEMAN: - - - end of January, early - - -

MS MAUD: The end of January, did you say?

MS NEELEMAN: End of January.

MS MAUD: And during the period that the facility manager was on sick leave in July through to the first week of August, was there somebody appointed to act in that role?

MS NEELEMAN: Yes. We had an assistant unit manager. And Robert Van Duuren also stepped in to have a more – a bigger role in the facility. He spent more of his time.

MS MAUD: So the assistant unit manager, did they take on the role of acting as facility manager full-time - - -

MS NEELEMAN: Yes.

MS MAUD: - - - during that period?

MS NEELEMAN: Yes.

MS MAUD: Yes. So there was no absence of someone fulfilling that role?

MS NEELEMAN: No.

MS MAUD: Now, you say some things in your statement about changes to internal policies and procedures at Avondrust Lodge during the period 1 January to 14 August 2018 and I just want to ask you some more questions about that. I take it

from your evidence that, other than those changes that you specifically mention, there were no changes during the period from the start of April to the end of August 2018 to the policies at Avondrust Lodge for the conduct and review of internal audits. That process remained the same?

MS NEELEMAN: That remained the same.

MS MAUD: Yes. And there were no changes to the policies in relation to the education and staff development or monitoring of training of staff?

MS NEELEMAN: No, there were no changes.

MS MAUD: Similarly, no changes to the systems in relation to the delivery or monitoring of residents' specialised nursing care needs; those remained the same.

MS NEELEMAN: No change.

MS MAUD: No changes. And no changes to the systems for the management of medication?

MS NEELEMAN: No change.

MS MAUD: No changes to the procedure for the recruitment, selection or induction of new staff?

MS NEELEMAN: No change.

MS MAUD: And no changes to the system for managing residents with challenging behaviours?

MS NEELEMAN: No, there were no changes.

MS MAUD: And no changes to the call bell system that was in operation at the Lodge?

MS NEELEMAN: No changes. We're in the process of building a new building, which will be operational from January next year.

MS MAUD: Yes. And just the last question in relation to that. There were no changes to the programme for the management of infection control at Avondrust Lodge during that period?

MS NEELEMAN: Not that I'm aware of.

MS MAUD: During the period 1 April to 30 August, was there any significant deterioration to the environment or equipment in use at Avondrust Lodge?

MS NEELEMAN: It's an old building that we're replacing - - -

MS MAUD: Yes.

MS NEELEMAN: - - - but it hasn't substantially changed in that time.

MS MAUD: No. So there wouldn't have been any change, for example, to the condition of the blue vinyl nursing chairs that are present in the home?

MS NEELEMAN: No.

MS MAUD: Or to blankets that are supplied by the home?

MS NEELEMAN: No.

MS MAUD: Or to the carpets or bathrooms?

MS NEELEMAN: No.

MS MAUD: And did the practice change during the period from the start of April to the end of August for the use of Kylie mattress protectors?

MS NEELEMAN: I'm not aware.

MS MAUD: Were there any changes to the process for the continuous improvement of the physical environment?

MS NEELEMAN: There were no changes.

MS MAUD: No. Now, on about 5 September, you advised the department that MiCare had appointed Ansell Strategic to the role of nurse adviser. And you gave details of the people who would be fulfilling that engagement. So Judy Coombe was providing oversight of the engagement and Elspeth Brown was to be the primary nurse adviser?

MS NEELEMAN: That's correct.

MS MAUD: And Anne Collis was to provide support in relation to staff training and clinical assessment and care planning. Is that right?

MS NEELEMAN: That's correct.

MS MAUD: That was the initial plan. And then another person, who was not from Ansell Strategic, who I will just refer to as Sue, had been appointed as the administrator.

MS NEELEMAN: That's correct.

MS MAUD: Yes. What were the considerations that informed the decision to appoint Ansell Strategic to the nurse adviser role?

MS NEELEMAN: They have a good reputation in the industry. We've worked with them before in a strategic planning basis, but they have a good respect. And, in discussions with who was available, they seemed like the better team. And they were available.

MS MAUD: They were available.

MS NEELEMAN: There's very limited people available.

MS MAUD: What was the period that you had worked previously with Ansell Strategic? When was that, roughly?

MS NEELEMAN: Probably two or three years before that. And I had worked with Cam Ansell on a costs of providing CALD care, whether there was a difference in providing – the costs in providing care to people from a culturally and linguistically diverse background compared to just mainstream.

MS MAUD: So I think you said earlier that they had provided some strategic advice. Was that just one engagement?

MS NEELEMAN: That was one engagement where they worked with the board.

MS MAUD: Yes. And then was there a separate engagement in relation to the specific matters that you just referred to?

MS NEELEMAN: That wasn't engagement. That was through Laser. We were working on that cost. At the time I was chairing the LASA CALD committee.

MS MAUD: And what were the considerations that informed the decision to appoint Sue to the administrator role?

MS NEELEMAN: She was available, came as a recommendation from LASA.

MS MAUD: And I understand that one or two – a couple of days after you initially engaged Sue, her engagement was terminated. Why was that decision made?

MS NEELEMAN: It was made because Sue had been appointed as the administrator and we had had a discussion, Judy, Sue and I, about the responsibilities of each party. And when Sue arrived on site, she started addressing areas that were Ansell's responsibility. And I made a call that it was – it was not the approach we wanted to have where both the nurse administrator and the administrator were maybe in conflict about what they were doing. We wanted a cohesive team. We wanted to address the issues as quickly as we could.

MS MAUD: So when you referred in an email on 7 September to the Department of Health to that change and you gave an explanation of the difficulty to get alignment on the changes we needed to be making, is that what you're referring to there?

MS NEELEMAN: Yes.

MS MAUD: Yes. What's your understanding of the role of the nurse adviser?

MS NEELEMAN: Well, there were a lot of issues in our clinical practice and the nurse adviser was specifically meant to be dealing with that.

MS MAUD: So when you say "dealing with that", do you mean - - -

MS NEELEMAN: Working with those standards and the staff to address those issues.

MS MAUD: Right. So working with MiCare - - -

MS NEELEMAN: Yes.

MS MAUD: - - - to improve in those areas?

MS NEELEMAN: Absolutely. To give us advice.

MS MAUD: And during the period of the sanctions, Ansell Strategic reported to the Department of Health approximately fortnightly. You were aware of that?

MS NEELEMAN: Yes.

MS MAUD: Yes. And did you have an opportunity to review the reports before they were provided to the department?

MS NEELEMAN: In some instances, yes.

MS MAUD: What was your understanding of the purpose of providing those reports to the department?

MS NEELEMAN: It was to show our progress and where we were still lacking in areas that we needed to work on.

MS MAUD: All right. In November 2018, MiCare commissioned Mary Dunn to conduct an assessment of Avondrust Lodge's compliance with the accreditation standards; is that right?

MS NEELEMAN: That's right.

MS MAUD: Yes. And what's Ms Dunn's experience?

MS NEELEMAN: She has done those similar sorts of assessments for other providers.

MS MAUD: Had you worked with her before?

MS NEELEMAN: No, I had never worked with her before.

MS MAUD: No. Are you aware whether she had previously worked as an assessor for the Aged Care Quality Agency?

MS NEELEMAN: I believe she had, but I'm not sure.

MS MAUD: All right. And was the purpose of engaging Ms Dunn so that MiCare could gauge how it was progressing with the timeline for improvement that had been set by the department?

MS NEELEMAN: Absolutely. To get another fresh set of eyes across it.

MS MAUD: And Ms Dunn attended Avondrust Lodge on 20 and 21 November?

MS NEELEMAN: That's correct.

MS MAUD: And she undertook, in effect, her own assessment of how Avondrust Lodge was – whether it was complying with the 13 previously not met expected outcomes.

MS NEELEMAN: That's right.

MS MAUD: And, Operator, if you could bring up tab 105 of the tender bundle. And you see there at the top that Ms Dunn refers to having reviewed clinical files of six elders and selectively reviewed aspects of another six elders. And then she refers to having gathered information by observation, discussions with nursing and personal care staff and information interviews with some elders.

MS NEELEMAN: Yes.

MS MAUD: And she then expresses the view that Avondrust Lodge was not meeting eight of the 13 expected outcomes and they still had gaps. That was her assessment.

MS NEELEMAN: That was her findings.

MS MAUD: Yes. And she also expressed the opinion that two expected outcomes have some gaps, which may lead them to be assessed as not met.

MS NEELEMAN: That's right.

MS MAUD: Did Ms Dunn's report give you concern about Avondrust Lodge's ability to comply with the timeline for improvement?

MS NEELEMAN: Yes.

MS MAUD: Did you do anything in particular in response to that report?

MS NEELEMAN: Absolutely. We went back and made sure that things were covered and that staff understood their responsibilities.

MS MAUD: Is that what you understood to be the cause of the issues that Ms Dunn had identified?

MS NEELEMAN: We were still working with a number of agency staff. And that creates gaps in any aged care facility. And so it was about identifying where the gaps were, whether they our staff or whether they were agency staff and how were we going to address, when we identified an agency staff member had left a gap. It's also ensuring consistency of staff actions.

MS MAUD: All right then. About two weeks after you had received that report, on 6 December, three assessors from the quality agency conducted an assessment at Avondrust Lodge and they were present for one day.

MS NEELEMAN: Yes, that's right.

MS MAUD: And you received a copy of their assessment contact report and you provided some comments to correct a few errors in the report; is that right?

MS NEELEMAN: That's right.

MS MAUD: Could we bring up tab 111, please. And you can see you refer in that letter to page 6 in bold. And you identify in the last sentence that the nurse practitioner role has been in place for several years.

MS NEELEMAN: That's right.

MS MAUD: And that's the role that you mentioned earlier. There was one nurse practitioner engaged by MiCare who provided services across the three Victorian facilities. Yes. So that – I think it was slightly misunderstood in the report, that role was not a new role. So you're just pointing out that had been in place for several years?

MS NEELEMAN: That had been there – yes.

MS MAUD: Yes. Are you aware whether a revised assessment contact report was issued?

MS NEELEMAN: I can't remember.

MS MAUD: All right. And MiCare subsequently applied to have the sanctions lifted following the decision – or the report of the site assessment on 6 December which found that the previously unmet expected outcomes were now met.

MS NEELEMAN: That's right.

MS MAUD: And could we bring up tab 117, please. Before I ask you about that, you had a conversation with someone from the department, as I understand it, about what your application to have the sanctions lifted should include; is that right?

MS NEELEMAN: That's right.

MS MAUD: And you were told that, amongst other things, you should address what MiCare was doing to ensure the sustainability of the improvements that had been put in place. Do you recall that?

MS NEELEMAN: Yes.

MS MAUD: And so at the second page, page 5210, at the bottom, paragraph numbered 4, those are the matters that you're addressing there. And you refer to a process being under way to replace the facility manager, who would be an RN, but, at that stage, you hadn't filled that position, had you?

MS NEELEMAN: No, we hadn't.

MS MAUD: And you refer to having appointed a general manager of quality, risk and compliance.

MS NEELEMAN: That's correct.

MS MAUD: Yes. Was that a new role?

MS NEELEMAN: Yes, it was a new role.

MS MAUD: Was that person to be based just at Avondrust Lodge?

MS NEELEMAN: No. It was across all our sites.

MS MAUD: All sites. And when did that person commence in the role?

MS NEELEMAN: Started in February.

MS MAUD: And are they still employed in that role?

MS NEELEMAN: No, they are not, but we have just appointed a new person into that role who commences in September.

MS MAUD: And I think in one of your previous statements you said that that person resigned in March 2019.

MS NEELEMAN: Finished at the end of March, yes.

MS MAUD: So that was a short appointment.

MS NEELEMAN: Yes, it was a short – she - - -

MS MAUD: Yes.

MS NEELEMAN: - - - went back into facility management.

MS MAUD: And what was the date when the second person in that role commenced?

MS NEELEMAN: It will commence on 2 September.

MS MAUD: 2 September. So in that intervening time from March until they start on 2 September, there has been no one in that role; is that right?

MS NEELEMAN: No, but we have a quality manager who has also stepped in to assist us in managing the Melbourne sites but, in particular ..... so – and our community services manager, who's also an RN, has – our home care manager has also stepped up doing more clinical oversight at the facilities.

MS MAUD: So the quality manager that you just referred to then, is that a role that existed in the period April to August 2018?

MS NEELEMAN: No.

MS MAUD: So that was a new role, as well.

MS NEELEMAN: No. It was a post-sanctions role.

MS MAUD: Post-sanctions. I see. When did that person commence in the role of quality manager?

MS NEELEMAN: Sorry. The quality manager has been with us for four or five years.

MS MAUD: I see.

MS NEELEMAN: Sorry.

MS MAUD: But that person provides services across all facilities.

MS NEELEMAN: Across all facilities.

MS MAUD: Yes. And that was the position in 2018, during April to August?

MS NEELEMAN: Yes.

MS MAUD: Yes. And so does the role that that person has filled since March this year – has that changed or is that the same role that they were previously doing?

MS NEELEMAN: No. It's a much broader scope, and particularly looking at compliance and risk, as well as the quality aspects. And it's a role that reports through directly to me and to the board and to the quality and risk committee.

MS MAUD: I see. And so is that – they're the general responsibilities that the person who will take on the role of general manager of quality, risk and compliance will have; they'll take on that role - - -

MS NEELEMAN: Yes.

MS MAUD: - - - across all four facilities?

MS NEELEMAN: Yes.

MS MAUD: Yes. Now, you refer on the next page, but we don't need to go to it, to the creation of the quality, risk and compliance committee.

MS NEELEMAN: That's right.

MS MAUD: When was that committee created?

MS NEELEMAN: They met for the first time in October, from memory.

MS MAUD: October last year?

MS NEELEMAN: Yes.

MS MAUD: And how frequently do they meet?

MS NEELEMAN: They meet about every three months.

MS MAUD: So is that what has happened in the period since October 2018 until now, they've met about quarterly?

MS NEELEMAN: Yes, but they've changed the schedule now. They're meeting as frequently as they need to and minimally every six weeks. So if there's an issue, they will meet, but otherwise they're meeting six-weekly.

MS MAUD: Why did you decide to increase the frequency of those meetings?

MS NEELEMAN: I think we need to make sure that our organisations is performing well and the risks have been mitigated.

MS MAUD: Now, other than what is said in your letter that we just looked at, did MiCare provide any other information to the department in support of its application to lift the sanctions?

MS NEELEMAN: We provided the continuous improvement report, I think.

MS MAUD: And, other than that, nothing else?

MS NEELEMAN: I can't remember.

MS MAUD: No. All right. Could we turn now to tab 251, please. And if we could go to page 0634. So this is the report of a site audit that was conducted at Avondrust Lodge on 7 and 8 January this year. You've received a copy of this, I assume?

MS NEELEMAN: Yes.

MS MAUD: Yes. And what's set out here is the roster in place at Avondrust Lodge at that time. Is that – have there been any changes to that roster since then?

MS NEELEMAN: We've added some personal care hours recently and also an RN on the overnight shift.

MS MAUD: And in that period since 7 January, have there been any changes to the staff employed in the role of registered nurse?

MS NEELEMAN: We still have some agency shifts. We had a couple staff who were due to sign on and who pulled out after the 15 July hearing where we had recruited people and they said, "We're not coming any more".

MS MAUD: So the need for agency staff in the RN role, is that because you don't have sufficient permanent staff to cover the rostered spots or because you need coverage for unexpected leave?

MS NEELEMAN: No. It has been mainly to do with filling the roster, so known. But we did have a number of agency staff in addition to that over the May, June and early July period, as we called all staff in for compulsory training on the new standards. And it was a two-day commitment to all staff to attend on the new standards and cultural intelligence training.

MS MAUD: So have there been – sorry – I withdraw that. You referred to not having been able to recruit some RN positions. Have there been resignations in the period since January this year to now?

MS NEELEMAN: Yes. There has been two resignations.

MS MAUD: So how many RNs did MiCare employ at Avondrust Lodge in January this year?

MS NEELEMAN: We had full 24-hour coverage. I don't know the exact number of RNs. The two clinical care coordinators that were at Avondrust at the time of the sanctions both resigned.

MS MAUD: When did that happen?

MS NEELEMAN: February.

MS MAUD: Late February?

MS NEELEMAN: Yes.

MS MAUD: And are those the positions that you've been unable to fill since?

MS NEELEMAN: One of them has been unable to be filled, but we've now filled that. The incumbent should start in a fortnight. And the other one has been filled with the RNs that we have anyway with the additional night shift person. And the people that we had on staff have picked up additional shifts to cover the other position. So we're back to a full 24-hour coverage plus, during the day, the CCC role has changed to a care manager role. As well as the facility manager is also a registered nurse.

MS MAUD: I see. And there was a site audit that was conducted by the now commission in April this year; is that right?

MS NEELEMAN: That's right.

MS MAUD: What was the outcome of that audit?

MS NEELEMAN: Whilst there were a few gaps, generally the outcome was good.

MS MAUD: Were there findings made in relation to expected outcomes?

MS NEELEMAN: I don't remember the details.

MS MAUD: And have there been any further assessment contacts at Avondrust Lodge by the commission since April?

MS NEELEMAN: There was one on Friday.

MS MAUD: Do you know the outcome of that? It might be too early?

MS NEELEMAN: I haven't received formal advice. We got some feedback Friday night which was not very encouraging.

MS MAUD: What was the feedback?

MS NEELEMAN: That there were gaps. And they resulted from a number of complaints, anonymous complaints. But all the complaints have been closed by the Complaints Commission with no further action required. They stemmed around wound management. And we were able to address all the concerns that everything was in place that needed to be in place.

MS MAUD: Yes. So, as I understand it, the complaints might give rise to an assessment, an audit assessment, but did you receive feedback in relation to the findings made in the actual assessment, rather than the complaints?

MS NEELEMAN: I haven't yet received a report from the agency.

MS MAUD: But the informal feedback that you got was that there were gaps?

MS NEELEMAN: The informal feedback was that there were gaps, yes. In one case the wound chart hadn't been completed, but the notes – it was there in the progress notes. So the wound care had been given, but it wasn't written in the right place. I haven't yet heard whether that was because there was an agency staff member – I don't know. I haven't - - -

MS MAUD: No further questions for this witness. May she be excused.

COMMISSIONER TRACEY: Yes, certainly. Thank you, Ms Neeleman. You're excused from further attendance.

MS NEELEMAN: Thank you.

<THE WITNESS WITHDREW [10.29 am]

MS MAUD: Commissioners, I now call Judith Coombe.

<JUDITH RAEWYNNE COOMBE , AFFIRMED [10.30 am]

<EXAMINATION BY MS MAUD

MS MAUD: Thank you. Can you state your full name, please?

MS COOMBE: Judith Raewynne Coombe.

MS MAUD: And have you prepared a statement for the Commission dated 22 July 2019?

MS COOMBE: I have.

MS MAUD: And does it have the document ID in the top right WIT.0301.0001.001?

MS COOMBE: That's it.

MS MAUD: Have you had an opportunity to read that recently?

MS COOMBE: Yes, I have.

MS MAUD: Are there any changes that you would wish to make to it?

MS COOMBE: No, not at this stage

MS MAUD: And is your statement true and correct to the best of your recollection?

MS COOMBE: Yes, it is.

MR KNOWLES: I tender that, Commissioners.

COMMISSIONER TRACEY: The witness statement of Judith Raewynne Coombe dated 22 July 2019 will be exhibit 8-16.

EXHIBIT #8-16 WITNESS STATEMENT OF JUDITH RAEWYNNE COOMBE DATED 22/07/2019 (WIT.0301.0001.001) AND ITS IDENTIFIED ANNEXURES

MS MAUD: Thank you. Now, Ms Coombe, you're a registered nurse; is that right?

MS COOMBE: Yes.

MS MAUD: You've worked in various roles in the aged care industry over 26 years both in New Zealand and in Australia?

MS COOMBE: Yes.

MS MAUD: Your current role is with Ansell Strategic; what's that position?

MS COOMBE: I'm the manager of operations.

MS MAUD: And what does it involve?

MS COOMBE: That involves coordinating and overseeing the teams in the operations area of the business. We're principally all nurses with the exception of one contractor that we use and we carry out a range of services in that sort of operational area for our clients.

MS MAUD: How long have you been in that position?

MS COOMBE: Since January 2018.

MS MAUD: Did you work for a company called EHC Inc prior to that?

MS COOMBE: ECH.

MS MAUD: What's that company?

MS COOMBE: That's an aged care provider in South Australia. Initially, when I was employed they had residential care, community care and retirement living.

MS MAUD: And you were employed with that organisation from 2000 to March 2017; is that right?

MS COOMBE: No. To May 2014.

MS MAUD: May 2014. You had a variety of roles which you've addressed in your statement and I don't need to take you to those. In paragraph 11 of your statement, you refer to the fact that, in your current role, you oversee Ansell Strategic's appointments by approved providers as nurse advisers and administrators. Does Ansell Strategic's work in that area, that is, filling the role of nurse adviser and administrator following sanctions imposed by the department, does that constitute a significant part of Ansell Strategic's business?

MS COOMBE: It's becoming more common. We do a range of other services as well so it's hard to say whether that's a significant part of the business. I haven't actually given that consideration.

MS MAUD: Are you able to estimate how many appointments of that kind you've overseen?

MS COOMBE: Three.

MS MAUD: Three. You refer in your statement to having worked for Ansell Strategic at an earlier time, from November 2014 to August 2015. Did you undertake similar roles of overseeing Ansell's appointment as nurse adviser or administrator during that period as well?

MS COOMBE: No. I was a contractor during that period for Ansell's.

MS MAUD: What would you do in that role?

MS COOMBE: I had roles such as preparation for accreditation, doing quality and risk identification reviews in instances where an organisation was looking to sell one of their facilities, for example, that type of thing.

MS MAUD: Does Ansell Strategic primarily provide consultancy services to providers of aged care services in Australia; is that their primary business?

MS COOMBE: Yes. So we only work in the aged care sector. We have two different parts to our business. There's the advisory service which is more around mergers and acquisitions, feasibility studies, development of service models for organisations who are looking to expand or rationalise their services. So looking at perhaps the number of residential care beds and facilities they might have in relation to the number of retirement living services that they might provide. So that type of service model.

A lot of work around strategic planning, capital investment. So that's the sort of thing that the advisory service does. And then we have the area which I oversee, which is the operations area and that's more in the clinical operations or the operations of community services and residential care services and support for providers.

MS MAUD: You refer in your statement to the work that Ansell does assisting aged care providers to prepare for accreditation visits or audits and your evidence is that Ansell has been engaged, in your time, by about 17 approved providers to provide those services; is that right?

MS COOMBE: Well, a range of services. Some of them are that accreditation preparation but I would say, for our clients, a number of them are really looking at that ongoing monitoring that we're able to provide so that they are always ready for an accreditation visit and having that independent set of eyes to identify where they might have gaps, opportunities for improvement, to provide support and guidance for different ways of working. So it's not just in the lead-up to an accreditation service. A lot of them now are looking for ongoing support in that area.

MS MAUD: In the situations where you're engaged in the lead-up to a known accreditation visit, what's the period prior to a visit of that kind that Ansell would be engaged from generally?

MS COOMBE: Probably in the last sort of two, three, four months. Generally, that's what's happened.

MS MAUD: Does the role in that context involve identifying potential issues and assisting the approved provider to address them? Is that the primary - - -

MS COOMBE: Yes, that's – that's one – that's one component of the assignment.

MS MAUD: In paragraph 42 of your statement, you say that you had not provided services to MiCare prior to September 2018. Do you know whether Ansell Strategic has provided services to MiCare before that time?

MS COOMBE: Look, I'm not aware of that. They may have done but certainly in the operations area and, personally, I haven't.

MS MAUD: Has Ansell been engaged by MiCare since the sanctions were lifted in relation to Avondrust Lodge on 11 January this year?

MS COOMBE: Our engagement with them finished shortly after that and we have not been engaged by them since.

MS MAUD: I just want to briefly ask you some questions about Ansell Strategic's appointment. The company was initially appointed to the nurse adviser role; is that right? And early on, there was a decision made to also have you, Ansell Strategic, hold the role as administrator. Were you involved in that decision?

MS COOMBE: Not the decision. I was involved in the discussion in that I was asked could we provide that additional service.

MS MAUD: Right. So you're not aware what led to the decision to appoint Ansell Strategic to the dual role?

MS COOMBE: That was the decision made by MiCare.

MS MAUD: In the context of an appointment to the role of nurse adviser following the imposition of sanctions, what do you consider the role of a nurse adviser to be?

MS COOMBE: They're there to provide guidance and support for the home, to address the non-compliances, in particular the clinical-related non-compliances and return the home to compliance and to support the staff with increasing their capability and capacity in order to address those things effectively in accordance with the standards and best practice.

MS MAUD: Is it fair to say that the outcome of a successful appointment as nurse adviser is that the provider will be subsequently assessed as meeting all of the previously unmet expected outcomes; is that the measure of success?

MS COOMBE: That's probably the first measure of success; that they achieve compliance.

MS MAUD: Are there other measures?

MS COOMBE: The second measure would be that the process is sustainable, that you can successfully hand over to an organisation and they can then move forward with the level of capability required to manage the service thereafter without that level of support.

MS MAUD: What's the role of the administrator?

MS COOMBE: Largely to do the same thing but that is in areas which are considered to not have a clinical component to them.

MS MAUD: Now, Ansell Strategic was appointed by MiCare in early September last year; is that right?

MS COOMBE: Yes.

MS MAUD: As nurse adviser and then shortly afterwards as administrator as well. That appointment, those appointments concluded on 11 January this year; is that right?

MS COOMBE: Yes, about that time as I recall.

MS MAUD: About that time, so around the time that the sanctions were lifted?

MS COOMBE: Yes.

MS MAUD: So Ansell Strategic was in the role for a bit over four months. In the first month of the appointment, how long would you and the other two Ansell staff have spent physically at Avondrust Lodge each week?

MS COOMBE: It varied. Usually, the other two staff would be there three, sometimes four days a week. Initially, I was there more often and then withdrew slightly as the engagement progressed and the project progressed but certainly three, four days a week initially.

MS MAUD: Were there issues that you identified during the period of the sanctions that were of concern to you in terms of the ability to comply with the schedule for improvements?

MS COOMBE: Typically, if I can say about the timetable for improvement, or the whole sanctions process, typically sanctions are awarded for six months. There is typically a three-month timetable for improvement placed on that. And I think it's worthwhile understanding that that three months is quite a tight timeframe in some

cases. When you look at the sanctions being imposed, a provider then needs to source a nurse adviser and administrator, which may take a week, and they've got a week to do that.

Then for a nurse administrator/adviser to be free to come to the site and start the work may take another week. You've then got a period of discovery, to work out what the non-compliances are and what has actually caused those non-compliances. That may take another period of time during which you are starting, of course, to address those serious risks initially because you've got that information in the information from the Quality Agency.

So if you look at a three-month period that you've got to address the non-compliances, you can spend four weeks actually starting the process and getting it going. You might then have some staff changes that are required throughout that, or people self-select out and decide to exit an organisation and then you can be eight weeks in before you've got that stability. You're perhaps using agency staff to replace staff. You've then got another four to five weeks to address the non-compliances. So it is a very busy time and, you know, there are – there are weeks taken up, really, establishing the process.

MS MAUD: Does the adequacy of that initial period of three months, though, depend on the nature of the issues that the particular facility has?

MS COOMBE: Yes.

MS MAUD: So in the case of MiCare, did you have particular concerns about the adequacy of that period of time?

MS COOMBE: No. We knew that we would have to keep moving fairly quickly and require significant changes by the staff, but we felt that it was manageable.

MS MAUD: All right. Could we bring up tab 88 of the tender bundle, please? You see there, there's an email from you to Petra Neeleman dated 24 October 2018. So probably somewhere between six to eight weeks into the appointment at that time. And at the bottom of the page there you see there you're discussing a staff member who was unhappy with – is it unhappy with what Ansell was doing in relation to the matters that you refer to there?

MS COOMBE: I think that's on the previous page that I'm looking at at the moment.

MS MAUD: Sorry. We've moved over. Can we go back to the previous page, right down the bottom. Without naming the person that you're discussing there, is that the person who was the facility manager at the time?

MS COOMBE: Yes.

MS MAUD: Yes. Did you have any particular concerns in relation to the facility's ability to improve in relation to the relevant expected outcomes because of the management staff that were in place at the facility?

MS COOMBE: We did have concerns with their responsiveness around some of the issues that we wanted resolved.

MS MAUD: And can we turn over to the next page, please. And the paragraph there where you identify concerns about the division of management responsibilities, is that a concern you had at the time about Avondrust Lodge? And, again, these are concerns about the facility manager. And you will see in the last sentence, "I have said to El" – is that a reference to Elspeth?

MS COOMBE: Yes.

MS MAUD: Yes. And she was in the role of the nurse adviser who was present at the facility?

MS COOMBE: Yes.

MS MAUD:

> *That if we are going to work around ..... so be it, because the focus is now on demonstrating compliance.*

So is that the focus of the work that you were doing with MiCare at that time, demonstrating compliance?

MS COOMBE: Yes. It was getting the home care back to compliance.

MS MAUD: Yes. But do you accept that, given the concerns that you've identified in that email, that if the facility manager was to remain there, although you might be able to demonstrate compliance, nonetheless, your concern might still be a real one?

MS COOMBE: Yes.

MS MAUD: Now, as part of the appointment as nurse adviser, you on behalf Ansell Strategic provided reports about fortnightly to the department; is that right?

MS COOMBE: Yes.

MS MAUD: And, in your experience, is that something that the nurse adviser always does?

MS COOMBE: Yes.

MS MAUD: And are the reporting requirements generally the same?

MS COOMBE: I've noticed that they can vary from department officer to department officer. So it's a matter of trying to work with them to understand what information – how they want the information and how to present it to them.

MS MAUD: And, in your experience, what's the information that the department wants to receive as part of that reporting?

MS COOMBE: It's information about the progress being made toward compliance around those areas that have been identified and identifying any additional risks or barriers that may exist.

MS MAUD: And what do you understand the purpose of the reports to be?

MS COOMBE: To provide that information to the department so that they can support the home in any way in order to achieve those changes that are required.

MS MAUD: Well, how might the department support a home?

MS COOMBE: Well, they might go back and speak with management and talk to them about ways in which they can get other resources or make some changes in order to get to a level of compliance.

MS MAUD: So if that's the purpose then, is one of the important things for those reports to do to identify issues so that the department can then provide support of the kind that you've referred to?

MS COOMBE: Yes.

MS MAUD: Do you know if there's an obligation to provide the reports or is it just something that's done as a matter of practice?

MS COOMBE: I believe that a request is generally made that those reports are provided to the department.

MS MAUD: Do you understand it to be a requirement that you report?

MS COOMBE: Yes. I take it to be a requirement.

MS MAUD: Right. Now, in paragraph 51 of your statement, you refer to the need for someone filling the role of nurse adviser to maintain communication with the department. And is the way that you maintain that communication through these regular reports?

MS COOMBE: In this case, yes, that was the way it was done.

MS MAUD: Is there sometimes other ways that the nurse adviser might communicate with the department in your experience?

MS COOMBE: Yes.

MS MAUD: How might that happen?

MS COOMBE: Teleconference calls, for example.

MS MAUD: In what circumstances would they occur?

MS COOMBE: Well, that's generally at the request of the department, as I understand it.

MS MAUD: And has that happened in your experience with Ansell Strategic filling the role of nurse adviser?

MS COOMBE: Yes.

MS MAUD: Will they tend to happen regularly or frequently, or will they be intermittent?

MS COOMBE: In an engagement that we are part of at the moment it's weekly.

MS MAUD: And so is that the preferred reporting format in that instance, via teleconference? Is that right?

MS COOMBE: Yes.

MS MAUD: So you're not also providing written reports?

MS COOMBE: We're very early in the engagement and I haven't to date, but I will be.

MS MAUD: And you say in your statement that, in your experience, appointments of advisers under the Aged Care Act are undertaken in consultation with the Department of Health. What do you mean when you say they're undertaken in consultation with the department?

MS COOMBE: So the names of the – the name of the organisation or the names of individuals is provided to the department so that they understand who is carrying out the role. And I spoke with the department at the time of our engagement.

MS MAUD: Yes, but the fact they might know who's filling the role doesn't necessarily mean that you're consulting. Do you mean something more when you say it's undertaken in consultation?

MS COOMBE: I believe that the organisation talks to the department about who they are appointing, as well.

MS MAUD: All right. So you're talking about the appointment process, then, not the actual fulfilment of the appointment? I might have misunderstood.

MS COOMBE: Yes, I think I am.

MS MAUD: You're talking about consultation in relation to the appointment?

MS COOMBE: Yes.

MS MAUD: Yes. I understand. So the fact that the department is consulted about the appointment, in your experience, would the department on occasions express an opinion that a person not be appointed as a nurse adviser?

MS COOMBE: I don't know that information.

MS MAUD: You don't know. Were there any teleconferences between you or anyone else from Ansell Strategic and the department in relation to MiCare?

MS COOMBE: I don't specifically recall. I was dealing with another engagement at the same time and I wouldn't like to make the wrong statement about the wrong client.

MS MAUD: Not that you can recall?

MS COOMBE: No.

MS MAUD: Yes. Do you consider it part of the nurse adviser's reporting function to provide their assessment of how the approved provider is progressing?

MS COOMBE: Yes.

MS MAUD: So it's not just providing factual information about what's being done; it's also providing some opinion about how things are progressing?

MS COOMBE: Yes.

MS MAUD: Yes. I will just clarify the question. Do you understand it to be part of the role of the nurse adviser to provide your opinion about how the approved provider is progressing to the department?

MS COOMBE: Can you state the question again, please.

MS MAUD: Do you understand it to be part of the nurse adviser's role to report to the department, not just facts about what is happening at the facility, but also your assessment of the progress that's being made?

MS COOMBE: I don't know that there is a stated obligation to provide that, but I think certainly if it wasn't progressing, that would be communicated to the department.

MS MAUD: So what would be the circumstance in which you might communicate that? Would there have to be no progress at all or just an assessment by you that the progress is insufficient?

MS COOMBE: I wouldn't go so far as no progress. I think you would alert the department to issues prior to that, but it's where, perhaps, advice is not being accepted and progress isn't being made accordingly. Different circumstances in different cases.

MS MAUD: Are there any circumstances other than advice not being accepted in which you might consider it appropriate to report your assessment to the department?

MS COOMBE: Without having specifics available, it's difficult to answer that question, because it's a case-by-case basis on what you might report.

MS MAUD: Was it a consideration for you when preparing reports to the department in relation to MiCare to manage the department's expectations of how MiCare was progressing?

MS COOMBE: I would say it's more about manage their understanding of how they are progressing, or inform their understanding.

MS MAUD: All right. Could we turn to tab 52, please. Do you see there an email from you. And it's the bottom email that I'm referring to, Petra Neeleman and others. Are the people there all employees of MiCare?

MS COOMBE: Yes. Anne Collis was one of our team members.

MS MAUD: I see. And can you see towards the bottom of that email the paragraph beginning, "I'm happy to have a bit more padding around", and then a second sentence, "We need to be careful, because there are still deficits in the care plan and we don't want to raise the agency's expectations too high". So do we accept, Ms Coombe, that there you're reporting to the department in a way that will manage their expectations of the progress that's being made?

MS COOMBE: What I was referring to there was that I didn't want to overstate what we were doing and, in that case, have the agency coming and thinking that we were at a more advanced stage than we were.

MS MAUD: And is it your practice to always give the approved provider an opportunity to comment on your report before you provide it to the department?

MS COOMBE: Sometimes I am asking for clarification where I have made a statement that I wasn't directly involved in and I wanted to be sure that I had that correct. I do the same with the team members. And so I get a range of opinions, just to make sure did I have that correct it was on that date or the information did go into that care plan, or whatever the situation might be, because it's important that these reports are factual and at times I just wanted the accuracy of it to be confirmed.

MS MAUD: Have you encountered instances where the approved provider has objected to information that you're proposing to provide in a report to the department?

MS COOMBE: No.

MS MAUD: Do you feel, when you're preparing the reports, in any way limited in the information you can provide because you know it's going to be also provided to the provider itself?

MS COOMBE: No.

MS MAUD: There were some changes at Avondrust Lodge in November 2018 to the personnel. Do you recall, in that month, the facility manager resigned?

MS COOMBE: Yes.

MS MAUD: Yes. And the deputy facility manager also resigned?

MS COOMBE: Yes. I'm not sure if that was November but, yes, she resigned.

MS MAUD: Was the resignation of the deputy facility manager anticipated, as far as you knew?

MS COOMBE: I wasn't surprised by it.

MS MAUD: You weren't surprised. Would the loss of those two people from MiCare have had a destabilising effect on the facility?

MS COOMBE: I think any resignation has an initial ripple effect as people hear about it and digest that information. Whether that results in destabilisation can be varied. Sometimes those resignations are – meet with approval of staff and are, therefore, not so destabilising. So, again, it depends on the circumstances.

MS MAUD: At the time, was it your view that the resignation of those two people would have consequences for the ability to bring Avondrust Lodge back into compliance with the standards?

MS COOMBE: No. I didn't feel that that would adversely affect the progress towards compliance.

MS MAUD: So the loss of the facility manager, which is a senior role, you didn't think that was going to hamper the time it might take to bring the facility back to compliance?

MS COOMBE: No.

MS MAUD: Can we bring up tab 136. Do you recognise that as a draft report that you prepared for Petra Neeleman?

MS COOMBE: Yes.

MS MAUD: As I understand, Ms Neeleman requested a report of that kind in about January that year and you prepared that, notwithstanding that your period as nurse adviser and administrator had finished by that time.

MS COOMBE: Mmm.

MS MAUD: Yes. So this was in addition to the role that you had been filling as nurse adviser and administrator.

MS COOMBE: Yes.

MS MAUD: And this report is, in general terms, a report about your assessment of the causal factors that had led to the problems at Avondrust Lodge; is that right?

MS COOMBE: Yes.

MS MAUD: Could we turn, please, to the last page, which is 0325.0003. You see there in the section numbered 5 Future Considerations, you express a concern that:

> *... the home has not yet achieved a sustainable level of performance in relation to leadership, lifestyle and clinical management at the home.*

Is that a concern that you held in early January of that year?

MS COOMBE: As I said before, typically a sanctions period is six months. The initial three months are targeting a return to compliance. The second three months are for sustainability, to really embed those processes down, make sure that any changes that you've made, changes to the structure or the systems or practices or whatever, have time to become embedded and to become business-as-usual and to become quite natural in terms of how the staff perform. And so, at the beginning of January, we are only just into that period of sustainability and getting to that point. So at that point, it's not unusual, in a sanctions project, to be concerned about that and how that sustainability is going to play out.

MS MAUD: Yes, so is the answer to my question that, yes, that was a concern you held in January?

MS COOMBE: Yes, yes.

MS MAUD: In your statement, you say that – sorry, I will just identify the fact that you subsequently issued a final version of that report which made quite significant changes to that section. If we could bring up, please, tab 140 in the MiCare tender bundle. Could we turn to the last page, which is 0491_0003. Is the only significant change that's made to this report from the draft report, this section 5 Future Considerations?

MS COOMBE: Yes.

MS MAUD: Yes, it's otherwise the same. You'll see there that your assessment is different now and you refer to a meeting held on 20 February. What was it that you were told at that meeting on 20 February that led you to change this section of your report?

MS COOMBE: We were told that they would be employing a registered nurse manager and that they were or had employed – I just can't recall at that stage – a quality, risk and compliance – I think it was the title – manager, who would then be overseeing that sustainability piece for the organisation.

MS MAUD: When you say you were told at that meeting and understood that they were going to employ a registered nurse manager, do you mean a facility manager who would be a registered nurse?

MS COOMBE: Yes.

MS MAUD: But that had been the intention of MiCare, hadn't it, since the resignation of the facility manager in November, to employ a registered nurse as the next facility manager?

MS COOMBE: Yes.

MS MAUD: So in early January, you would have already known that that wasn't a new fact?

MS COOMBE: No, but it was reiterated at that point that, yes – and I think at that time they had actually sourced somebody.

MS MAUD: They had employed somebody?

MS COOMBE: Yes. I'm just not sure if they'd started.

MS MAUD: So given that you already knew that an RN was going to be employed as the facility manager, is it fair to say that it was really the development of the employment of the quality manager that is what changed your assessment?

MS COOMBE: Yes. Those two functions together, that there were two fairly experienced people with – who were registered nurses and had experience in quality management and successfully managing a facility rather than a novice manager. So hearing that it was an experienced facility manager that they were sourcing and somebody who had a good quality background certainly decreased the concerns that we had.

MS MAUD: But as at 20 February, was it your understanding that they hadn't recruited someone to that position; it was just an intention to do so?

MS COOMBE: Yes, an – I can't recall whether they had already employed somebody but I did get the clear message that they were looking for an experienced manager, not a novice manager.

MS MAUD: So is it fair to say that, had it not been for the fact that that was MiCare's intention, that the concern that you had expressed in the draft report would have remained one that you held?

MS COOMBE: Can you ask that question again, please?

MS MAUD: Yes. I've asked that in a confusing way. Would you have continued to hold the concern that you had expressed in the draft report if you had not been told that they were going to employ a quality manager?

MS COOMBE: Yes.

MS MAUD: Yes. Were you asked, in December or January, by anyone at the department, for your opinion about the sustainability of the changes that had been made at Avondrust Lodge?

MS COOMBE: No.

MS MAUD: No. If you had been asked, would you have given your opinion?

MS COOMBE: Yes.

MS MAUD: You wouldn't have felt that you needed to get approval to do that from MiCare?

MS COOMBE: No.

MS MAUD: No. And so if you had been asked that in December or January, what would you have told the department?

MS COOMBE: That the home needs to use the period that has been given for sustainability to achieve that.

MS MAUD: Yes, what specifically would they have – I will ask the question in a different way. The concerns that you outlined in your draft report to Petra Neeleman, would you have told the department of those concerns if you had been asked?

MS COOMBE: Yes, yes.

MS MAUD: I have no further questions for this witness.

COMMISSIONER TRACEY: Thank you.

COMMISSIONER BRIGGS: Good morning, Ms Coombe. Thanks for your evidence. It has been quite interesting to hear it. Both this morning and in one of our earlier hearings on home care, we heard that an organisation who is having trouble then goes to a provider organisation to try and find the names of companies or people who might be nurse administrators and advisers. Is there normally a set of relationships that a company like yours has with those provider organisations so that they're at least aware of your existence and your capability in the area, or how does this work?

MS COOMBE: I guess, you know, we're fortunate that our managing director, Cam Ansell, has quite a high profile in the aged care sector so people are aware of the organisation and they come to us saying, "Is this a service that you can provide?". They might have heard us speak at conferences or have other ways of knowing that we exist or people might do sort of key word searches, if you like, you know, Google who has got something on their website that suggests that they do work in these areas, so there is a range of ways that people would find us or other providers of these services.

COMMISSIONER BRIGGS: Do you think it would be appropriate to have the department or the Quality Agency maintain a panel of possible providers of these services?

MS COOMBE: I think that could be helpful for providers. They have quite a short period of time in order to find somebody and we are not all out there waiting for the next job to come in, so I think it could reduce the amount of time that they spend using their own networks and their Google searches in order to find a provider who is able to do this for them.

COMMISSIONER BRIGGS: It certainly might be more effective than a Google search.

MS COOMBE: Yes.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Thank you, Ms Coombe, for your evidence. You are excused from further attendance.

MS COOMBE: Thank you.

<THE WITNESS WITHDREW [11.13 am]

COMMISSIONER TRACEY: The Commission will adjourn until 11.30.

ADJOURNED [11.13 am]

RESUMED [11.38 am]

COMMISSIONER TRACEY: Mr Knowles, I was looking in the wrong direction.

MR KNOWLES: Reconfigured position. A place I'm not accustomed to, I must say. We now call the witnesses from the Aged Care Quality and Safety Commission panel. If perhaps each of them might be given the oath or affirmation.

COMMISSIONER TRACEY: Yes, certainly.

<CATHERINE THERESA ROSENBROCK, AFFIRMED [11.39 am]

<GILDA D'ROZARIO, AFFIRMED [11.39 am]

<SUSAN WATERS, AFFIRMED [11.39 am]

<COLETTE MARSHALL, AFFIRMED [11.40 am]

MR KNOWLES: Can I ask each of you on the panel, starting with you, Ms Rosenbrock, and moving along the panel, to state your full name for the Royal Commission and indicate what your position is.

MS MARSHALL: So my name is Catherine Theresa Rosenbrock. And I am the regional director for Victoria and Tasmania in the quality assessment and monitoring group at the Aged Care Quality and Safety Commission.

MS D'ROZARIO: My name is Gilda D'Rozario and I am one of the quality surveyors at the Melbourne office at the commission.

MS WATERS: My name is Susan Margaret Waters and I'm a quality surveyor at the commission.

MS MARSHALL: My name is Colette Marshall and I'm a quality assessor with the Melbourne, Victorian office for the commission.

MR KNOWLES: Thank you. Now, can I ask each of you to indicate how long you've been in your respective present positions, as well, starting again with you, Ms Rosenbrock.

MS ROSENBROCK: So I've been in my current position since January 2019 when the commission came into existence. Prior to that, I had held similar roles with each of the two predecessor organisations, commencing at the Aged Care Standards and Accreditation Agency in July of 2012.

MS D'ROZARIO: I've been with the agency since August 2007 and, prior to that, I worked as a registered nurse with a psychiatric assessment and treatment team in Melbourne Health.

MS WATERS: I've been with the agency since May 2000. I've had a number of roles, including team coordinator in the first round of accreditation. Subsequent to that, I was education officer for two years and, since then, I have been a quality assessor.

MS MARSHALL: I've been employed by the commission and its predecessor since 2011 as a quality assessor. And, prior to that, my experience has been as a registered nurse in a variety of settings and roles.

MR KNOWLES: Thank you. Now, Ms Rosenbrock, you've prepared two statements for the Royal Commission, the first of which is dated 22 July 2019; is that correct?

MS ROSENBROCK: That's correct.

MR KNOWLES: And that is document WIT.0302.0001.0001. Do you have a copy of your statement - - -

MS ROSENBROCK: I do.

MR KNOWLES: - - - dated 22 July 2019 with you there?

MS ROSENBROCK: I do.

MR KNOWLES: Yes. And have you read that statement lately?

MS ROSENBROCK: I have.

MR KNOWLES: Yes. and I understand that there is a change that you wish to make to the statement.

MS ROSENBROCK: There is one small correction. In paragraph 91 of my statement, I refer to the assessment contact that took place on 24 September 2018 as being unannounced. It should say announced.

MR KNOWLES: I see. Subject to that one change to paragraph 91 of your statement, are you satisfied that the contents of the statement are true and correct to the best of your knowledge and belief?

MS ROSENBROCK: Yes, I am.

MR KNOWLES: I seek to tender the statement of Ms Rosenbrock dated 22 July 2019.

COMMISSIONER TRACEY: Yes. The first witness statement of Catherine Theresa Rosenbrock dated 22 July 2019 will be exhibit 8-17 (WIT.0302.0001.0001)

EXHIBIT #8-17 FIRST WITNESS STATEMENT OF CATHERINE THERESA ROSENBROCK DATED 22/07/2019

MR KNOWLES: And you've prepared a supplementary statement, Ms Rosenbrock, dated 2 August 2019.

MS ROSENBROCK: Yes, that's correct.

MR KNOWLES: And that is document WIT.0359.0001.0001. Do you have a copy of that statement there with you?

MS ROSENBROCK: Yes, I do.

MR KNOWLES: And have you read that recently?

MS ROSENBROCK: I have.

MR KNOWLES: Yes. And are there any changes that you wish to make to the statement?

MS ROSENBROCK: No, there are none.

MR KNOWLES: And are the contents of the statement true and correct to the best of your knowledge and belief?

MS ROSENBROCK: Yes, they are.

MR KNOWLES: Thank you. I seek to tender that supplementary statement, Commissioners.

COMMISSIONER TRACEY: Yes. The supplementary statement of Ms Rosenbrock dated 2 August 2019 will be exhibit 8-18.

EXHIBIT #8-18 THE SUPPLEMENTARY STATEMENT OF MS ROSENBROCK DATED 02/08/2019 (WIT.0359.0001.0001)

MR KNOWLES: Ms D'Rozario, you've also prepared a statement dated 22 July 2019 for the Royal Commission.

MS D'ROZARIO: That's correct.

MR KNOWLES: And that's document WIT.0301.0001.0001. And have you got a copy of your statement there with you now?

MS D'ROZARIO: I do.

MR KNOWLES: Yes. And have you read your statement recently?

MS D'ROZARIO: I have.

MR KNOWLES: And are there any changes you wish to make to it?

MS D'ROZARIO: No changes.

MR KNOWLES: And are the contents of the statement true and correct to the best of your knowledge and belief?

MS D'ROZARIO: That's correct.

MR KNOWLES: I seek to tender the statement of Ms D'Rozario.

COMMISSIONER TRACEY: Yes. The statement of Gilda D'Rozario dated 22 July 2019 will be exhibit 8-19.

EXHIBIT #8-19 STATEMENT OF GILDA D'ROZARIO DATED 22/07/2019 (WIT.0301.0001.0001)

MR KNOWLES: Ms Waters, you've also prepared a statement for the Royal Commission dated 22 July 2019?

MS WATERS: I have.

MR KNOWLES: Yes. And that's document WIT.0303.0001.0001. Have you got a copy of your statement there with you?

MS WATERS: Yes.

MR KNOWLES: And have you read your statement recently?

MS WATERS: I have.

MR KNOWLES: And are there any changes that you wish to make to your statement?

MS WATERS: No.

MR KNOWLES: Are the contents of your statement true and correct to the best of your knowledge and belief?

MS WATERS: They are.

MR KNOWLES: I seek to tender the statement of Ms Waters.

COMMISSIONER TRACEY: Yes. The witness statement of Susan Waters dated 22 July 2019 will be exhibit 8-20.

EXHIBIT #8-20 WITNESS STATEMENT OF SUSAN WATERS DATED 22/07/2019 (WIT.0303.0001.0001)

MR KNOWLES: Ms Marshall, you've also prepared a statement dated 22 July 2019.

MS MARSHALL: Yes, I have.

MR KNOWLES: Yes. And that's document WIT.0304.0001.0001. And have you got a copy of your statement with you there?

MS MARSHALL: Yes, I have.

MR KNOWLES: And have you read your statement recently?

MS MARSHALL: Yes, I have.

MR KNOWLES: And are there any changes – I understand you've prepared a corrigendum to your statement.

MS MARSHALL: Yes, I have.

MR KNOWLES: Yes. And the corrigendum is document WIT.0304.0002.0001. Have you got a copy of the corrigendum there with you, as well?

MS MARSHALL: I do.

MR KNOWLES: Yes. Are they the only corrections that you wish to make in respect of your statement?

MS MARSHALL: Yes, that's right.

MR KNOWLES: And, subject to those corrections in the corrigendum, are the contents of your statement true and correct to the best of your knowledge and belief?

MS MARSHALL: Yes, they are.

MR KNOWLES: I seek to tender for Ms Marshall both the statement dated 22 July 2019 and the corrigendum dated 4 August 2019.

COMMISSIONER TRACEY: Yes. The witness statement of Colette Marshall dated 22 July 2019 and the attached corrigendum will be exhibit 8-21.

EXHIBIT #8-21 WITNESS STATEMENT OF COLETTE MARSHALL AND THE ATTACHED CORRIGENDUM DATED 22/07/2019 (WIT.0304.0001.0001 and WIT.0304.0002.0001)

MR KNOWLES: Can I start with you, Ms Rosenbrock. In your position as regional director of the quality assessment and monitoring group for Victoria and Tasmania, what is your overall role in that position?

MS ROSENBROCK: The main responsibility is to ensure that our office conducts its programme of assessments of residential and home care services. So we have an annual programme of re-accreditation audits, quality reviews of home care services and assessment contacts of residential services and home care services to schedule into a year. So in a lot of ways it's a resource allocation function is the primary one, to ensure that we get all of our activities completed within the timeframes that's required for them.

In addition to that, I manage the staff based in Box Hill and Hobart of the group. I'm also, as a regional director, a delegated decision-maker in relation to decisions made under the Quality and Safety Commission rules. So those would be the three main

functions. So managing the resources and ensuring the programme gets completed, managing the staff and decision-making in relation to the statutory rules.

MR KNOWLES: Thank you. Now, can I ask whether each of you were in the hearing room earlier today when evidence was given by, firstly, Ms Neeleman and then, secondly, Ms Coombe.

MS ROSENBROCK: We were not in the hearing room, but we watched the broadcast from outside the hearing room.

MR KNOWLES: So you have observed - - -

MS ROSENBROCK: We have.

MR KNOWLES: - - - the proceedings today thus far?

MS ROSENBROCK: We have.

MR KNOWLES: And you're familiar with the evidence that has been given thus far?

MS ROSENBROCK: Yes, I am.

MR KNOWLES: Yes. And does that apply to all of you on the panel? Yes. Thank you. So there's familiarity on your part, Ms Rosenbrock, with the factual chronology of events in the matter?

MS ROSENBROCK: Yes, there is.

MR KNOWLES: And I take it that is the same for all of you and extends beyond, in the case of the three of you who are assessors, to your particular role to the overall history of the matter from April of 2018 through to January of 2019? Is that correct? You're nodding.

UNIDENTIFIED FEMALE: That's correct.

MR KNOWLES: For the transcript, that's a yes.

MS D'ROZARIO: Yes.

MS WATERS: Yes.

MS MARSHALL: Yes.

MR KNOWLES: Thank you. Well, I won't rehearse those details then now. I will just proceed to the specifics that I wish to ask each of you about. Ms Rosenbrock, if I can start with you, the genesis of the review order that occurred between 16 and 27

August 2018 was a type 3 referral from the Aged Care Complaints Commission, wasn't it?

MS ROSENBROCK: That's correct.

MR KNOWLES: And that was a type-3 referral that was given on 14 August 2018.

MS ROSENBROCK: That's right.

MR KNOWLES: Now, type-3 referrals, they relate to major issues or concerns on what was then the Complaints Commission's part, don't they?

MS ROSENBROCK: They do.

MR KNOWLES: That is, where they think there is some sort of significant or immediate risk to residents.

MS ROSENBROCK: That's correct.

MR KNOWLES: Now, you were aware that, prior to this type 3 referral on 14 August, there had been two previous type 1 referrals since late 2017 in respect of Avondrust?

MS ROSENBROCK: That's right.

MR KNOWLES: Yes. And the first of those type 1 referrals occurred on 18 December 2017.

MS ROSENBROCK: That is correct.

MR KNOWLES: And the second was on 1 August 2018. Yes. And you've referred to those in your statement at paragraph 62 and 70 respectively.

MS ROSENBROCK: I will take your word for the paragraph numbers, but, yes, I have.

MR KNOWLES: Yes. Now, type 1 referrals, as perhaps distinct from type 3 referrals, they involve less serious issues or concerns as adjudged by the Complaints Commission as it was then?

MS ROSENBROCK: So in relation to the referrals, I believe that there was a type 1 referral from the Complaints Commission in December. And a type 1 referral from the Department of Health was the second of the two referrals. So they're two different sources of referrals, I believe. The nature of a type 1 referral is, as you correctly said, that there is – I'm sorry – the nature of a type 1 referral is that the referrer believes that there is sufficient information in the referral for us to follow it up at our next assessment contact, but that there is not an immediate need to schedule

a visit to that service. Both of those referrers know that we have at least one visit to each service per year and they will leave it up to us to determine whether or not we change our schedule to bring that issue to our attention sooner or later.

MR KNOWLES: So for a type 1 referral, it might be that once they've sent off that referral to you, they do so with the knowledge that it's a matter for you to decide when they will next be – when that will next be investigated by virtue of a site visit and it could be as long as 363 or four days later?

MS ROSENBROCK: It could be.

MR KNOWLES: They just wouldn't know.

MS ROSENBROCK: They wouldn't necessarily know. We certainly acknowledge the receipt of the referral. And if we have a visit in our forward schedules, whether it's a tentative visit or a planned visit, we will advise them when we acknowledge the referral that we have a visit planned for that month, which gives them an indication of when we might go. It's always possible that, if they think that the visit is too far into the future, that they might contact us and seek to have us go sooner than that. But the discretion and the timing of the visit is our decision.

MR KNOWLES: Yes, but you haven't, beyond receiving the referral, often got great detail of precisely why the referral was made?

MS ROSENBROCK: Generally, not in a type 1. So a type 1 might come to us, for example, on the strength of an anonymous telephone complaint made through either the then complaints commission or through our complaint line so the receiving agency isn't able to interrogate that information particularly well, they can't contact the anonymous complainant to get further information and so they might give us a fairly brief referral that contains the broad outline of the telephone message.

And, you know, a lot of the referrals that we get from the department, for example, are simple administrative matters like a change of bed numbers or a change of service name or something like that. Now, most of those are not going to prompt an immediate visit. So there's varying types of information but, generally speaking, type 1 is of lesser importance and so it doesn't prompt us to immediately respond by sending a team to assess the performance of the service against the relevant standards.

MR KNOWLES: The referring agency at this time formed the relevant opinion as to type 1 - - -

MS ROSENBROCK: Yes.

MR KNOWLES: - - - to a certain extent; you accept that as a given. Is that fair?

MS ROSENBROCK: Not necessarily. We take each referral on its merits and there are times where we think that perhaps the referral should have had a higher or a lower number attached to it. The number attached to the referral doesn't determine our response. The content of the referral determines our regulatory response, and we will go sooner if we feel there is a need to go sooner.

MR KNOWLES: So if you were faced with an allegation of assault on a resident, even it might be categorised as a type 1 referral, that would be a matter that you would seek to respond to fairly promptly?

MS ROSENBROCK: If we've got very detailed information in a referral, so if we've got a named care recipient, we've got a named perpetrator of the alleged assault, if there are concerns around whether or not the assault was reported within a reasonable time and within the legislative timeframes, then we might decide that that one is more important than simply, we received a notification, it was received within time, the service appears to have done everything that they needed to do. So there is different levels of detail in referrals around reportable assaults and so some of those will prompt us to go sooner rather than later.

MR KNOWLES: If they didn't meet their reporting requirements, though, that might be a matter that goes to having some concern about the particular service?

MS ROSENBROCK: Yes, it would. It would go to concern about the knowledge that they have about their reporting requirements, whether or not all of the staff are aware of what the reporting requirements are and whether or not there might be some further issues in relation to their understanding about what's reportable or what's not reportable.

MR KNOWLES: If I can take you then to the type 1 referral on 1 August 2018 from the Department of Health. This is the document at tab 14 of the tender bundle. This was, in fact, a referral in respect of an allegation of assault at MiCare.

MS ROSENBROCK: Yes.

MR KNOWLES: You see the allegation was made verbally on 5 June about halfway down the page and police were notified of it - - -

MS ROSENBROCK: Yes.

MR KNOWLES: - - - but reporting requirements were not met in respect of this allegation.

MS ROSENBROCK: Yes.

MR KNOWLES: So you've received that. Were you concerned about that insofar as it related, firstly, to reporting requirements but more generally to the fact that it was an allegation of assault?

MS ROSENBROCK: So I didn't personally receive the – this particular referral so I didn't action the referral once it came into our service. So even though it has my name on it, it doesn't mean that I personally action each referral that comes to us. I'm aware of the action that was taken by the decision-maker who determined that the action to take in relation to this one and their decision was to refer it to the next assessment contact visit.

MR KNOWLES: Yes.

MS ROSENBROCK: Which, at that stage, would have been sometime after 1 July because I see that it's - - -

MR KNOWLES: If we can go to the second page of the letter. You see there - - -

MS ROSENBROCK: We received it on 1 August, that's correct.

MR KNOWLES: So it's getting up towards two months after the events of the allegation?

MS ROSENBROCK: That's correct.

MR KNOWLES: Would that factor into a decision-maker's view as to what needed to happen and how quickly?

MS ROSENBROCK: It does to an extent. If the Department had been particularly concerned about this report, I think that they would have referred it to us sooner than two months after the fact. So it probably would have had some bearing on the decision that was made in relation to when to next visit that service.

MR KNOWLES: Well, on that, you say that you're aware of the decision. That was a decision that was made to look at it at the next site audit and that eventually – sorry, the next assessment contact and that eventually occurred on 24 September 2018?

MS ROSENBROCK: I believe that originally the visit that was originally in our schedule at that time, so on 1 August, we had a tentative visit in our system for the month of October. So we – that was when we had planned to conduct a visit to that service and the decision-maker indicated that this referral ought to be followed up at that visit.

Subsequent events intervened between 1 August and 1 October, which is when we were originally planning to go there, so this referral was – the issue of regulatory compliance and behaviour management was addressed by the team that conducted the review audit in August.

This referral was not included in the work papers provided to that team, unfortunately for – mainly an administrative oversight. It had already been attached

to a visit that was planned for October. So when we recognised that we had not specifically addressed this referral during the review audit, I asked for it to be followed up on the visit on 24 September.

MR KNOWLES: So, effectively, the first occasion where this allegation of assault was to be investigated by way of an actual attendance on site by the agency was about three and a half months after the allegation was first made?

MS ROSENBROCK: That's right. The team that did the review audit in August would have seen this incident on the mandatory reporting register when they looked at that document, so they would have been aware of this incident at that time or of this allegation of assault at that time. So they would have been aware of it. They didn't report it but they certainly would have been aware of it. But then for clarity I sent it back with a subsequent team.

MR KNOWLES: Yes. Well, I mean, you are speculating as to whether or not they would have seen this particular allegation - - -

MS ROSENBROCK: If it was on the mandatory reporting register, they would have seen it because their audit trail indicates that they looked at the mandatory reporting register.

MR KNOWLES: Well, they haven't mentioned it in their reports, have they?

MS ROSENBROCK: They haven't mentioned it. They don't necessarily mention everything that they see in every document that they look at during an audit.

MR KNOWLES: In terms of the assessment contact document for the 24 September visit, do you agree that that document doesn't mention this at all?

MS ROSENBROCK: It doesn't mention this incident, I agree with you on that.

MR KNOWLES: So one might readily infer that it wasn't even looked at on 24 September?

MS ROSENBROCK: You could assume that. It is not our practice – when we follow up a referral, if we find nothing on site, the teams do not necessarily report anything about that issue. It's unfortunate, I think, in this situation that we didn't give more specific instructions to the assessor to refer to it regardless of whether they found an issue of concern but, you're correct, it's not in the report.

MR KNOWLES: So what we have in sum is a three-and-a-half-month period before the scheduled site visit to investigate it and then no evidence, in the record at least, of any consideration of it at that time?

MS ROSENBROCK: It's not our role to investigate assaults at residential aged care facilities.

MR KNOWLES: There's no record of any consideration of it then.

MS ROSENBROCK: That's correct.

MR KNOWLES: Would you agree with sum - - -

MS ROSENBROCK: Yes.

MR KNOWLES: - - - subject to changing the word "investigation" for "consideration"; would you agree with that?

MS ROSENBROCK: That is – that is correct. There is no indication in any of the reports that this particular referral was followed up.

MR KNOWLES: Now, can I return to the review audit. As mentioned earlier, that was triggered by the referral on 14 August 2018.

MS ROSENBROCK: That's correct.

MR KNOWLES: And that was Ms Johanna Aalberts-Henderson's complaint about her mother's experience at Avondrust?

MS ROSENBROCK: That's right.

MR KNOWLES: It's fair to say, isn't it, that the August audit that was conducted by the then agency was triggered by that type 3 referral, wasn't it?

MS ROSENBROCK: Yes, it was.

MR KNOWLES: Would you agree that, but for Ms Aalberts-Henderson's complaint, there wouldn't have been that type 3 referral?

MS ROSENBROCK: That's – that's correct.

MR KNOWLES: And if there hadn't been the type 3 referral, there wouldn't have been the review audit at that time, would there?

MS ROSENBROCK: There would not have been a review audit at that time.

MR KNOWLES: And it was the review audit that ultimately led to sanctions being imposed on MiCare, wasn't it?

MS ROSENBROCK: That's correct.

MR KNOWLES: So but for Ms Aalberts-Henderson's complaint, it's unlikely that sanctions would have been imposed in late August 2018?

MS ROSENBROCK: It's unlikely that they would have been imposed at that time, that's correct.

MR KNOWLES: Now, the review audit was instigated – pardon me. And going beyond that, unless some other complaint were made, would you agree that sanctions might not have been imposed until much later? You had a visit that was scheduled for October?

MS ROSENBROCK: We were planning to go in October. I would hope that, had we gone and done an assessment contact in October, that the team that conducted that visit would have identified some or all of the issues that came to light during the review audit.

MR KNOWLES: So it might not have been identified until even October, is what you are saying?

MS ROSENBROCK: It might not have been identified until October.

MR KNOWLES: Okay. Now, the review audit that took place, that was instigated by yourself; is that right?

MS ROSENBROCK: That's correct.

MR KNOWLES: You assigned two assessors for a longer audit period than would usually be the case?

MS ROSENBROCK: That's correct.

MR KNOWLES: That is, over the period of 16 to, I think, 27 August, with in that period four days dedicated to being on site?

MS ROSENBROCK: That's right.

MR KNOWLES: So ordinarily for a review audit, how long would assessors be on site? Two days?

MS ROSENBROCK: No. Look, teams are generally on site during a review audit for three to four days, would be their normal time on site during a review audit. In this particular case, the timing of the commencement of the audit was a little tricky in terms of – ideally, I would have probably sent a larger team possibly for a shorter period of time but we had other teams assigned. I didn't have very many assessors available to me at the time. So we determined that we would rather have a team on site than wait until we had a larger team. So we sent a team of two and basically, their instructions when they commence a review audit is that they stay on site until they're finished. So normally they will take three to four days. It's rare but not entirely unheard of that they're there for longer.

MR KNOWLES: But I think you agreed with me a moment ago that this was a longer audit than would usually arise in respect of a review audit?

MS ROSENBROCK: Not in respect of a review audit. In respect of a re-accreditation audit, yes. In respect of a review audit, they usually run to three or four days on site.

MR KNOWLES: Compared with an accreditation or re-accreditation audit, would they typically take about two days?

MS ROSENBROCK: Re-accreditation audits typically take about two days on site and, as I said, review audits take longer than that.

MR KNOWLES: Now, can you say why, in this case, and perhaps why more generally, review audits take longer than re-accreditation audits?

MS ROSENBROCK: So review audits are scheduled when we have a reasonable belief that the service is not meeting the standards. So we have an indication, usually from a referral or from – we have an indication from either a referral or perhaps from an assessment contact that there is non-compliance at the service. We already have an indication of some individuals who may be at risk, so we've had a referral about a particular care recipient's wound or fall or an adverse event that has occurred in the home.

So we – the depth of the file reviews around those care recipients, particularly where we know that there is an adverse event, is deeper and it takes longer than for a file review of the care recipient for whom we don't have concerns. So when we go into a site where we've got serious wounds, as had been alleged to be the case at Avondrust, we are looking to identify the – all the care recipients with wounds and we are looking to do a comprehensive file review and the full range of interviews and observations that form part of our audit methodology in respect of each and every one of those care recipients. So the process takes longer.

MR KNOWLES: So review audits are more likely, in that sense, to commence with expectations on the part of the agency, as it then was, and now commission, that there are issues in the service that might well be identified in respect of the standard of care.

MS ROSENBROCK: That's correct.

MR KNOWLES: And is it fair to say that those expectations are not in existence, typically, when the agency, as it then was, and now commission, would conduct re-accreditation audits?

MS ROSENBROCK: That's correct.

MR KNOWLES: Okay. And you mentioned before getting referrals. In the main, is it fair to say that those referrals initially are derived from complaints from external sources?

MS ROSENBROCK: Around about a third of the complaints that come into my office come through complaints. Approximately a third come through the public health units, so they're outbreak notifications - - -

MR KNOWLES: Right.

MS ROSENBROCK: - - - for example. Around about a third come from the Department of Health, a combination of reportable assault notifications and administrative notifications, like changes to bed numbers or opening or closing services, those sorts of things. And at the moment probably about 10 or 15 per cent of our referrals come directly from the public. So in the form of pre-audit feedback that representatives are providing us with or information where a representative, a member of the public, care recipient, has made direct contact with us, because they've got concerns about a service. So about a third of them come from complaints.

MR KNOWLES: Complaints that are the subject of referrals and then - - -

MS ROSENBROCK: Yes.

MR KNOWLES: - - - an extra 10, 15 per cent - - -

MS ROSENBROCK: ..... come directly to us.

MR KNOWLES: - - - you were direct. So you're looking at somewhere between 40 to 50 per cent - - -

MS ROSENBROCK: Yes, around about.

MR KNOWLES: - - - are from external services?

MS ROSENBROCK: Yes.

MR KNOWLES: Directly or indirectly.

MS ROSENBROCK: Directly or indirectly.

MR KNOWLES: So do you agree that that would tend to highlight the importance of external sources, in terms of complaint making, for the purposes of indicating where poor care may exist?

MS ROSENBROCK: I think it's probably the most valuable source of information that we have available to us.

MR KNOWLES: Do you also agree, from the evidence you've given a moment ago, that, essentially, the audit methodology that is employed will differ depending on whether or not one is conducting a review audit or a re-accreditation audit?

MS ROSENBROCK: The methodology is the same, insofar as the same tools and the same approach is used to gather and analyse information. When we have a review audit and, indeed, when we find or when we identify non-compliance, whether it's in an assessment contact or during an audit, if you like, there are additional things that the assessors will do which is part of their methodology, but there are additional things that they will do while they are on site to dive deeper into a particular care recipient's experience.

MR KNOWLES: So is it fair to say that that translates to a greater degree of rigour in following through with all of the aspects of the audit methodology for the purposes of a review audit than a re-accreditation audit?

MS ROSENBROCK: No. I think that it's more about the application of rigour, as opposed to what you were suggesting, that they are more rigorous when they do a review audit. They are as rigorous as they need to be when they are on site. So the expectation is that, during the course of any visit, if they identify areas of concern, that they follow those through thoroughly and completely. The situation during most site audits is that they don't uncover issues that they need to interrogate further than the standard audit methodology. But if they identify it, we would expect them to follow through. When they do a review audit, they've already got a list of things that they need to follow through.

MR KNOWLES: Do you think, with a review audit, there is a heightened state of inquiry in the minds of assessors than they might otherwise have with an accreditation audit?

MS ROSENBROCK: They have prior knowledge of issues of concern and areas of concern. So I've no doubt that from the moment we assign them to do a review audit, they are thinking about what they might need to look at in order to understand the issues that are the subject of the information that they've been given. We certainly make sure when we're scheduling that we schedule very experienced and very capable assessors to conduct review audits. And we make sure that, if there are particular aspects of care that are the subject of the referral, that, wherever possible, we have the most skilled and competent assessors on the team to address those issues.

MR KNOWLES: All right. Well, in this case you had the review audit in August that has been referred to.

MS ROSENBROCK: Yes.

MR KNOWLES: And that was the document that you read before making your decision in September, on 12 September, to vary the period of accreditation, to shorten it.

MS ROSENBROCK: That's correct.

MR KNOWLES: Yes. And, apart from having regard to that review audit documentation, in particular the assessment information, you also had regard to MiCare's response.

MS ROSENBROCK: I did.

MR KNOWLES: MiCare, essentially, accepted the findings in the review audit, didn't they?

MS ROSENBROCK: Pretty much, yes.

MR KNOWLES: Yes. And did you also speak with Ms Gillian Blain, who was the team leader for that particular review audit?

MS ROSENBROCK: I certainly did. In fact, I asked Ms Blain – I sent Ms Blain back to the service after the review audit to do an assessment contact to gather some more information for me in relation to one of the expected outcomes, because I was not persuaded that all of the evidence had been put before me. So I actually scheduled another assessment contact with her to follow up with some further evidence-gathering for me, so that I could make my decision.

MR KNOWLES: Which expected outcome was that?

MS ROSENBROCK: It was in relation to behaviour management.

MR KNOWLES: All right. Okay. Now, can I take you to the audit assessment information document at tab 20 in the tender bundle. It will come up on the screen, Ms Rosenbrock.

MS ROSENBROCK: Okay.

MR KNOWLES: And can I take you then to page .0605. And you will see there what was said by the audit team in respect of human resource management, expected outcome 1.6.

MS ROSENBROCK: Yes.

MR KNOWLES: And, essentially, under the team's findings, where it says, "The home does not meet this expected outcome", it goes on to say:

While the home has a system for recruitment of staff, management could not demonstrate that there are sufficient skilled staff to provide appropriate care and services to care recipients.

So would you agree that, whatever system might have existed at Avondrust for recruitment of staff, the view taken was it didn't ensure that there were sufficient skilled and qualified staff to deliver services that met the standards, the accreditation standards, and the home's philosophies and objectives?

MS ROSENBROCK: Yes. I would agree with you on that.

MR KNOWLES: Okay. And you heard the evidence of Ms Neeleman earlier today when she indicated that there was no substantial change to the system for recruitment of staff between April and August 2018.

MS ROSENBROCK: That's correct.

MR KNOWLES: In fact, she gave evidence that there was no substantial change to any of the systems that she was asked about between April and August 2018. And you're not in a position to gainsay that?

MS ROSENBROCK: No, I'm not.

MR KNOWLES: Now, now, over the page at .0606, you will see there a heading Deficits In Management and Staff Knowledge Have Impacted on the Delivery of Care Recipients' Clinical and Personal Care. And you're familiar with those two paragraphs, the first of the two dot paragraphs that appear beneath that heading.

MS ROSENBROCK: Yes.

MR KNOWLES: They refer to materials that were available at the time of the accreditation audit; would you agree?

MS ROSENBROCK: .....

MR KNOWLES: Yes. Sorry. Could you just repeat that answer for the transcript.

MS ROSENBROCK: Yes, that's correct.

MR KNOWLES: So they were matters that could readily have been – I withdraw that. They were items of information that could have been available to the assessors as at 18 April of 2018.

MS ROSENBROCK: They could have been available, but they were not made available.

MR KNOWLES: Yes. Well, I will come back to that. Towards the bottom of the page, do you see the table that sets out the staffing levels? And that continues across on to the next page.

MS ROSENBROCK: Yes, I do.

MR KNOWLES: Now, in terms of the relevant shifts at that time, the only time that there was a registered nurse on site was for the morning shift, the am shift. And that was for seven and a-half hours each day?

MS ROSENBROCK: That's correct.

MR KNOWLES: And I don't know if you recall, but there was evidence given in the Cairns hearing of the Royal Commission that, for the 69-odd high-care residents, that would equate to about seven minutes per resident per day of time devoted by a registered nurse within a 7.5-hour block, too.

MS ROSENBROCK: Yes. I recall that evidence. Yes.

MR KNOWLES: Now, do you agree that that was insufficient in August 2018?

MS ROSENBROCK: I agree with the team's findings that the staff at the service at the time of this audit was – there were insufficiently skilled staff to meet the care needs of the care recipients who were residing in the service at that time. I don't have a view about whether or not the RN hours were sufficient in this particular case. I note that there are enrolled nurses on the register – on the roster, as well, and - - -

MR KNOWLES: But you would be aware that there are certain things that - - -

MS ROSENBROCK: That RNs can do that, and ENs cannot, yes.

MR KNOWLES: Yes. You would be aware of that.

MS ROSENBROCK: Yes, I'm aware of that. I'm aware of that. The majority of care that's delivered in residential aged care is delivered by care workers. And, certainly, enrolled nurses are more than capable of doing most of the day-to-day nurse-initiated care delivery in an aged care setting. The registered nurses' responsibility is to oversee the care delivery and to take responsibility for care planning and assessment. So in the sense - - -

MR KNOWLES: They might do other things. They might be involved - - -

MS ROSENBROCK: They might do other things.

MR KNOWLES: - - - in complex wound management - - -

MS ROSENBROCK: Exactly.

MR KNOWLES: - - - they might be administering - - -

MS ROSENBROCK: They might do all of that.

MR KNOWLES: - - - particular medications - - -

MS ROSENBROCK: But they would not necessarily attend - - -

MR KNOWLES: - - - syringe .....

MS ROSENBROCK: - - - to every care recipient on every day of the week or on every shift. But you certainly want to have registered nurses available to undertake those tasks that only registered nurses can perform.

MR KNOWLES: And you say they've got the responsibility of oversight for each resident as well - - -

MS ROSENBROCK: That's right.

MR KNOWLES: - - - which may take part of that seven minutes that they have?

MS ROSENBROCK: It would probably take up a fair chunk of that amount of time, yes.

MR KNOWLES: So what I'm putting to you is that that wasn't adequate at the time, in August 2018, and it wasn't adequate in April 2018 either?

MS ROSENBROCK: In April, the assessment team that conducted the audit in April did not receive negative feedback about staffing in the service. Their examination of care recipient documentation, their files, their notes, their plans did not indicate that there were gaps in the care delivery or in the assessment and planning that the registered nurse is responsible for undertaking in that service. And so at the time, with the acuity of the residents who were there at the time of the audit - - -

MR KNOWLES: They were all high care and there were 60 of them at that stage?

MS ROSENBROCK: They were all high care. The team concluded, and I have no reason to disagree with their findings, that, at the time, in April, the staffing mix was appropriately skilled and sufficient to meet the care needs of the residents who were in the service at that time.

MR KNOWLES: And you – well, I won't take it any further. You know that they subsequently, that is, MiCare subsequently increased its staffing levels quite significantly after the review audit, particularly in respect of RNs?

MS ROSENBROCK: The service, as far as I can tell, has increased the number of registered nurse hours on the roster. I don't believe that you can characterise it as a significant increase in staff because I believe that the – there has been some reorganisation of the mix of staff rather than necessarily an absolute increase in the number of staff.

MR KNOWLES: All right. Do you agree, then, that there was, subsequent to the August audit, a considerable increase in the numbers of hours of registered nurse contact on site and that would reflect an acknowledgement by MiCare that there was an inadequacy in the numbers of hours before then?

MS ROSENBROCK: I believe that the change in their roster was prompted by our findings in the August review audit and the subsequent sanctions.

MR KNOWLES: All right, well, can I take you to expected outcome 2.2, which appears at page .0611. Now, at this stage, the facility or the service had been found to not meet 13 out of 44 expected outcomes, and I think seven of them were in respect of clinical care. Is an expected outcome a regulatory requirement? It is, isn't it, really?

MS ROSENBROCK: That's a good question. We – I would have to say that we don't understand it in that way.

MR KNOWLES: Shouldn't you?

MS ROSENBROCK: That's a very good question. Yes, I really can't answer it. It's the first time it's been put to me in that way.

MR KNOWLES: I guess what I'm getting at is, with all of the failings that were identified in respect of expected outcomes, wouldn't it follow then that one would expect the regulatory compliance expected outcome also to be not met?

MS ROSENBROCK: Our understanding in relation to expected outcome 2.2, in terms of how that regulatory compliance expected outcome was interpreted, was that particular regulations that providers need to meet in relation to clinical care were met. So we would be looking in respect of standard 2 to ensure that, for example, their registered and enrolled nurses were, in fact, registered and enrolled with AHPRA, and that they had processes in place to ensure that they monitored the registration of their registered staff, that they were complying with relevant legislation around medication management and the regulations that exist at the state level in relation to who can and cannot administer, and the safe storage of scheduled medications and, in relation to requirements under the Aged Care Act, that was the – that standard was where we evaluated whether they were meeting their regulatory reporting requirements in relation to care recipients who were missing from the service.

So we had a set list, if you like, of regulations in relation to clinical care that we would assess compliance against. But assessment of compliance against the standards in general would generally be reflected in expected outcome 1.2, which is also a regulatory compliance outcome so if you were - - -

MR KNOWLES: Which they met.

MS ROSENBROCK: Which they also met.

MR KNOWLES: But just on this, though, if you look at that, the expected outcome at the top of the page is described as:

> *Requiring that the organisation's management has systems in place to identify and ensure compliance with all regulatory requirements about health and personal care.*

MS ROSENBROCK: That's right.

MR KNOWLES: So how is – how could it be said that there were systems in place to identity and ensure compliance with all regulatory requirements about health and personal care when there was a lack of compliance with the expected outcomes relating to health and personal care?

MS ROSENBROCK: The service had systems in place to manage its compliance with the standards. The fact that they have failed to comply with the standards is, in some ways, secondary to that. So, for example, the service was accredited. The service had plans for continuous improvement in place. The service believed, and it certainly had policies and procedures in place, that had they been applied and monitored and consistently evaluated, ought to have enabled them to meet the standards. I understand where you're coming from - - -

MR KNOWLES: The systems didn't ensure compliance though, did they?

MS ROSENBROCK: The systems did not ensure compliance, that's correct. So the question, I suppose, is whether or not those systems were effective and we could – we could argue, in this case, that they most likely were not.

MR KNOWLES: Now, you said before that one of your roles is as a delegate, making decisions.

MS ROSENBROCK: That's correct.

MR KNOWLES: That would include decisions, as was the case here, about varying a service's accreditation period?

MS ROSENBROCK: Yes.

MR KNOWLES: That power to vary an accreditation period also extends to revocation of accreditation?

MS ROSENBROCK: That's correct.

MR KNOWLES: How long have you been making those decisions as a delegate in the exercise of that power?

MS ROSENBROCK: Seven years.

MR KNOWLES: Okay. And have you ever, in that time, exercised the power to revoke accreditation?

MS ROSENBROCK: On a number of occasions.

MR KNOWLES: You have. Can you estimate how many times?

MS ROSENBROCK: Possibly 10.

MR KNOWLES: Okay. And aside from varying the accreditation period, you also imposed a timetable for improvement?

MS ROSENBROCK: That's correct.

MR KNOWLES: And there were to achieve those – they being MiCare were to achieve those improvements by 26 November 2018?

MS ROSENBROCK: That's correct.

MR KNOWLES: Can you explain how that process of achieving the timetable for improvement was to occur?

MS ROSENBROCK: So when we do a review audit, we have two decisions that we can make, basically. We can revoke the accreditation or we can choose not to revoke the accreditation and, in the event that we choose not to revoke, we can vary. Whenever – whenever we have a decision around non-compliance, we impose a timetable for improvement which is a period of time, usually, and certainly at that time, the standard timetable for improvement was three months in which time the service must make improvements to bring the quality back up to the standard required to meet the expected outcomes that were not met.

MR KNOWLES: And what was the statutory context of MiCare not meeting the timetable for improvement – that is, by not achieving full compliance with the expected outcomes by 26 November 2018?

MS ROSENBROCK: So had they not met their timetable for improvement, there's a couple of things that we can do. So we evaluate – so we assess their performance

at the end of the timetable for improvement by way of an assessment contact. Occasionally we'll do it by way of a subsequent review audit but generally it's by doing an assessment contact. When we do an assessment contact, we don't have available to us the revocation power, if you like. We can only, at that stage, make a determination around compliance and, if there's continued non-compliance, we can then make two decisions.

We can decide to impose a further timetable for improvement. If there's – so if they've made progress – so in the case of this service where there were 13 "not mets", initially, if they'd had two or three at the end of their timetable for improvement, they would probably have been placed on a subsequent timetable and given some further opportunity to make the necessary improvements to bring them back to compliance.

And that would be particularly the case if we had seen evidence of improvement but not sufficient to meet the standards at that time. If there was substantial failure to meet the expected outcomes at the end of a timetable, then I would have scheduled another review audit, which again would have brought revocation into the possible range of outcomes.

MR KNOWLES: What about involving the Department of Health? In terms of the secretary's enforcement powers, does anything flow from a failure to meet the timetable for improvement in that regard?

MS ROSENBROCK: So the Department can do a number of things when there's a non-compliance service. They can choose to issue a notice of non-compliance, or not to issue a notice of non-compliance. In the case of Avondrust, it was under sanction at the time so – and the sanction period was scheduled to end sometime after the timetable for improvement. I think it was initially placed on a six-month sanction and a condition of that sanction being lifted was that they return to compliance. So in the event that they had not met their timetable for improvement, there would have been options within the sanction that the Department could have exercised, if you like, at that point.

MR KNOWLES: Now, you made a finding, I think on 19 November 2018, that, at that time, so far as you were concerned, there was still non-compliance with 13 out of the 44 expected outcomes. So you were satisfied, one week out from the conclusion of the timetable for improvement, that 13 out of the 44 expected outcomes were still not met?

MS ROSENBROCK: Let me explain to you a little bit about that visit and the decision that flowed from it. So in November, we did a visit to the service, an assessment contact to the service, while it was on a timetable for improvement, for the purposes of monitoring their progress against their plan for continuous improvement. It was not an assessment contact for the purpose of assessing performance. So the assessor was not asked to make recommendations about whether or not the service had met any of the expected outcomes that were currently

not met. So if you like, the only decision that was available to me after that visit, in the absence of an assessment of performance against the expected outcomes, was to continue to – continue their non-compliance as an open non-compliance.

MR KNOWLES: So the assessment of performance that subsequently occurred was on 6 December?

MS ROSENBROCK: That's correct.

MR KNOWLES: And prior to that, when do you say there was any assessment of performance by the agency as to meeting any of the 13 previously not met expected outcomes?

MS ROSENBROCK: At the review audit.

MR KNOWLES: So there was no assessment of compliance between 27 August and 6 December?

MS ROSENBROCK: No. We had given them three months to make improvements. They had provided us with a plan for continuous improvement. That had a number of activities on it, most of which had end dates sometime in November. So, for us to assess compliance – so when they give us a plan for continuous improvement, we accept the plan and we accept the timetable that they have given us within that plan. So if they tell us that they're going to have something completed by November, you could say that it would be unfair of us to go in October and assess them knowing that they won't have completed the improvements.

MR KNOWLES: Well, I'm just saying you didn't actually form any views, though, about how close or far away they were from meeting the relevant expected outcomes between the review audit and 6 December.

MS ROSENBROCK: No. We did two visits subsequent to the review audit decision. So we did a visit in September, on 24 September. We did a visit in early November. Both of those visits documented progress against the plan for continuous improvement. So had there been any anything in either of those reports that alarmed me, I could have sent a team to assess performance. But the November visit in particular indicated steady progress against the plan for continuous improvement, that there was work happening across all of the non-compliances. We follow up each of the care recipients that we have concerns about from the review audit, so any of the care recipients who were named in the serious risk report were checked up on each time we went to the service. And we didn't have any ongoing concerns about those people. So - - -

MR KNOWLES: But as at 1 November when that assessment occurred, it was still found to be not met? That's right, isn't it?

MS ROSENBROCK: It was not - - -

MR KNOWLES: That's the formal position that occurred as a result of that assessment contact.

MS ROSENBROCK: That's correct.

MR KNOWLES: Yes. Now, Ms D'Rozario, can I turn to you. You were the team leader in the April audit on the 17th and 18th of that month in 2018, weren't you?

MS D'ROZARIO: That's correct.

MR KNOWLES: Yes. And you and one other assessor, a Ms Rosemary Pace, attended the facilities on those dates.

MS D'ROZARIO: Yes.

MR KNOWLES: And your visit was announced to MiCare in advance.

MS D'ROZARIO: That's correct. It was an announced re-accreditation audit.

MR KNOWLES: Yes. And you knew at the time, obviously, that your report would inform the decision-maker as to re-accreditation, not only whether it would happen but also the period of re-accreditation.

MS D'ROZARIO: That's correct.

MR KNOWLES: And if you gave a 44 out of 44 expected outcome pass mark, so to speak, then there was a higher likelihood they would be re-accredited for three years.

MS D'ROZARIO: Correct.

MR KNOWLES: And that's the maximum period.

MS D'ROZARIO: Yes.

MR KNOWLES: And that's what happened here, wasn't it?

MS D'ROZARIO: Correct.

MR KNOWLES: Yes. Now, in advance of your visit, you say in your statement you received a work pack.

MS D'ROZARIO: Yes.

MR KNOWLES: And that included a self-assessment tool that was completed by MiCare. Do you recall that?

MS D'ROZARIO: Yes. Yes.

MR KNOWLES: Yes. And they gave themselves 44 out of 44, didn't they?

MS D'ROZARIO: Yes, they did.

MR KNOWLES: Yes. How often do you see an approved provider admitting previously unknown non-compliance in such a self-assessment?

MS D'ROZARIO: I haven't seen any.

MR KNOWLES: No. And you were also given a previous – documents relating to a previous assessment contact on 5 March?

MS D'ROZARIO: Yes, that's correct.

MR KNOWLES: And you would have been aware from that that some residents had previously complained about staffing levels?

MS D'ROZARIO: Yes.

MR KNOWLES: Yes. Now, in your statement at paragraph 26, you set out a chronological description, broadly speaking, of the process of the audit visit, would you agree?

MS D'ROZARIO: Yes.

MR KNOWLES: And the first day, as I understand it, is devoted to interviews with residents, representatives, staff and management.

MS D'ROZARIO: That's correct.

MR KNOWLES: In the main.

MS D'ROZARIO: Yes.

MR KNOWLES: And then at the end of the first day and the second day, you focus on document review.

MS D'ROZARIO: Yes.

MR KNOWLES: Okay. So, in terms of document review, at subparagraph (h) in paragraph 26, you refer to some of those documents. And in the second part of that subparagraph – pardon me – the second part beginning with the words "I recall". Towards the end of that you refer to general business records that were relevant to the assessment, focusing on the management, systems and governance of the facility:

This included, by way of example, the provider's plan for continuous improvement and its policies in relation to infection control and medication management.

So you looked at all of those documents at the time. You were satisfied with them, that the infection control policy, medication management policy were satisfactory at the time.

MS D'ROZARIO: I was, yes.

MR KNOWLES: And, in terms of the continuous improvement plan, was that something that would have included the improvement register?

MS D'ROZARIO: It would have included the examples that was provided in our report.

MR KNOWLES: Right. Would it have included the improvement register document? Are you familiar with that - - -

MS D'ROZARIO: Yes.

MR KNOWLES: - - - as a separate document?

MS D'ROZARIO: Yes. It would have included that.

MR KNOWLES: Okay. And so you've heard earlier the evidence that, as at August 2018, there was a reference to an entry in the improvement register on 17 April 2018 about staffing issues?

MS D'ROZARIO: I don't recall that.

MR KNOWLES: Well, I will come back to that in a moment then. But you say that you would have looked at the improvement register at that time?

MS D'ROZARIO: Yes.

MR KNOWLES: Okay. Now, can I take you to tender bundle document tab 6. That's the re-accreditation audit assessment information that you and your team member, Ms Pace, prepared; is that right?

MS D'ROZARIO: That's right.

MR KNOWLES: Okay. And, as I understand it, you mostly dealt with the clinical care, expected outcomes and she dealt with the other ones.

MS D'ROZARIO: That's correct.

MR KNOWLES: Yes. And, in terms of the actual wording in the document, were the words that appear under the findings of whether or not an expected outcome is met or not met, were they your own words or are they someone else's words?

MS D'ROZARIO: So part of some of the rationale words are part of the CAT generated report, however we do add on to - - -

MR KNOWLES: Pardon me. Sorry. What was that, a what generated report?

MS D'ROZARIO: So it's the computer-generated report.

MR KNOWLES: Computer-generated report.

MS D'ROZARIO: Yes.

MR KNOWLES: Okay.

MS D'ROZARIO: But surveyors have the opportunity to add to the rationales, for example, the responses of the consumer experience report. So we would add on to those rationales.

MR KNOWLES: You can, but you might not add to what is, in effect, a template. Is that a fair comment?

MS D'ROZARIO: Yes.

MR KNOWLES: Okay. And what's the source of the template rationales as you describe them? They're, effectively, the reasons, aren't they, for the finding?

MS D'ROZARIO: Yes.

MR KNOWLES: As to "met" or "not met". What's the source of that template?

MS D'ROZARIO: What do you mean, sorry? I don't understand the question.

MR KNOWLES: Where do you the get the template from?

MS D'ROZARIO: So it's from our electronic CAT – it's called a CAT. So it's computer assisted template which surveyors use to formulate the reports.

MR KNOWLES: Okay. And, so, for example, can I take you to expected outcome 1.4 at page .1392 in this document – pardon me. I might have that page number wrong. Expected outcome 1.4, which is about, I think, four or five pages in. Pardon me, Operator. Yes. Thank you. So and that extends over to the next page. Is that sort of template reasoning that one sees there at the bottom of the page and then moving across to the top of the following page?

MS D'ROZARIO: Yes.

MR KNOWLES: And, in terms of what you or Ms Pace added, is that something that just appears from about the word:

> *…majority of care recipients and representatives interviewed are satisfied staff follow up.*

MS D'ROZARIO: Yes.

MR KNOWLES: Did you add that or is that also part of the template that you've adapted?

MS D'ROZARIO: No, we have added that.

MR KNOWLES: Okay. And when you say "majority", you interviewed, I think, was it 19 people?

MS D'ROZARIO: We interviewed 19 consumers - - -

MR KNOWLES: Yes.

MS D'ROZARIO: - - - at that time of the audit.

MR KNOWLES: So one wouldn't know, though, whether this was 10 or 18?

MS D'ROZARIO: No.

MR KNOWLES: Okay. Now, in going through the reasons, if I can take you then to expected outcome 1.5, that's also, I take it – is that template reasoning there?

MS D'ROZARIO: Yes.

MR KNOWLES: And I will come back to 1.6. Can we go to 1.7 and 1.8. Is that all template reasoning, as well?

MS D'ROZARIO: Yes.

MR KNOWLES: And similarly for expected outcomes 2.4 to 2.6? Would you agree - - -

MS D'ROZARIO: So these rationales would have been validated with the observations we made on the day in the interviews.

MR KNOWLES: But this is template reasoning, though, isn't it?

MS D'ROZARIO: Yes. Majority. Yes.

MR KNOWLES: Yes. So, in terms of – and I'm not taking you to all of it, but would you agree a large proportion of the document is cast in that form - - -

MS D'ROZARIO: That's – yes.

MR KNOWLES: - - - that is, picking up on the template reasoning that is a bank available to assessors?

MS D'ROZARIO: Yes.

MR KNOWLES: Okay. Now, can I take you back to expected outcome 1.6. And this is the human resource management expected outcome, which you and Ms Pace found was met at the time. And, in terms of that reasoning, is that by and large template reasoning, save for perhaps the last section relating to two care recipients interviewed?

MS D'ROZARIO: Commencing from:

The majority of care recipients and representative interviews - - -

MR KNOWLES: Okay.

MS D'ROZARIO: Yes.

MR KNOWLES: So that's the last two sentences have been – three – pardon me – sentences have been added.

MS D'ROZARIO: Yes.

MR KNOWLES: Okay. And just that sentence preceding the majority of care recipients says:

Care recipients and representatives interviewed are satisfied with the availability of skilled and qualified staff and the quality of care and services provided.

MS D'ROZARIO: Yes.

MR KNOWLES: Then the very next sentence seems to be at odds with that, because it simply refers to the majority of care recipients and representatives interviewed are satisfied with the same things, the availability of skilled and qualified staff.

MS D'ROZARIO: So the yellow highlighted area would have been in reference to the result of our consumer experience interviews.

MR KNOWLES: Yes. And but in terms – how do you reconcile the pink with the first yellow sentence? One relates to the majority; the other one suggests that all care recipients and representatives were satisfied who were interviewed.

MS D'ROZARIO: I don't know.

MR KNOWLES: Okay. Now, you've heard the evidence of Ms Neeleman that she gave today that there was no change to the system for recruitment of staff between - - -

MS D'ROZARIO: Yes.

MR KNOWLES: - - - April and August 2018 and there was no change to the system, I think, for education of staff and, in particular, clinical staff during those times.

MS D'ROZARIO: Yes.

MR KNOWLES: Okay. And, in that regard, given the findings that were made in August of 2018, how did you come to the view, back in April of 2018, that the systems and processes – and this is at the top of that paragraph:

> *…were in existence to ensure there are sufficient skilled and qualified staff to deliver services that meet the accreditation standards and the home's philosophy and objectives.*

MS D'ROZARIO: Okay. So at the time of the audit, we followed our methodology. Documentation reviewed – the team reviewed that was available to us showed that care plans were being reviewed regularly. Consumers were being referred to appropriate allied health and medical officers. Observations that were made during the audit show that there were numerous staff on site. Call bells were being responded to at a timely manner. And the interviews, the feedback that we got from consumers and representative, they had told us that the care were being met and that they were satisfied with the way the staff were attending to their needs and preferences.

MR KNOWLES: You say that was the information that was made available to you. You acknowledge that there was information that went to dissatisfaction by staff and residents that was not available to you but that was subsequently uncovered during the review audit?

MS D'ROZARIO: At the time of our audit, documentation that we had requested management at the time were provided to us, so we based our findings on those documentation that was available to us on the day.

MR KNOWLES: So you didn't get the residents' survey that was dated from February of 2018?

MS D'ROZARIO: I don't think that documentation was reviewed at our visit.

MR KNOWLES: All right. And you didn't receive any indication – you looked at the improvement register but you didn't see that there was an entry for the day before, on the 17th, when you were looking at documentation on the 18th - - -

MS D'ROZARIO: No, I didn't.

MR KNOWLES: - - - that related to a failure to keep clinical records up to date?

MS D'ROZARIO: I don't remember.

MR KNOWLES: Now, can I take you to, in the same expected outcome, expected outcome 1.6, the bottom of the page, there is a table and going over the page, you see there that there is essentially registered nursing staff on for seven and a half hours a day on site?

MS D'ROZARIO: Yes.

MR KNOWLES: Now, at that time, you regarded that as satisfactory?

MS D'ROZARIO: We did.

MR KNOWLES: Did you consider that that would lead to there being only seven minutes per resident per day of registered nursing attention?

MS D'ROZARIO: No, we didn't.

MR KNOWLES: Do you think that that is an adequate amount of time for a registered nurse to deal with 60-odd high-care residents?

MS D'ROZARIO: At the time, because of the feedback that we received from consumers, and representative and the staff that were rostered on that day, they didn't indicate any risks regarding staffing, they were happy with the levels of staff on site and the way that the care was being provided at that time.

MR KNOWLES: All right. You agree, though, that there was no change to the staffing between April and August, do you understand that's the evidence that's been given by Ms Neeleman?

MS D'ROZARIO: Yes.

MR KNOWLES: And there was no change to the arrangements for rostering of registered nurses?

MS D'ROZARIO: Yes.

MR KNOWLES: Yet, in August of 2018, a very different finding was made?

MS D'ROZARIO: That's correct.

MR KNOWLES: So when would it get too little? If there was a situation where there was a registered nurse on site but only once every two or three days, but no residents were complaining about it, when would you find that that was a problem in terms of staffing levels?

MS D'ROZARIO: So, as surveyors, we look for impact for consumers and, as I said before, during the time of the audit, we couldn't – we didn't identify any risks or any impact on the consumers regarding the staffing. We did get some feedback from a few consumers regarding delays in call bell response and we had provided this feedback to management who had then informed us that they will review the process and ensure that the consumers were satisfied in the current care that they were receiving.

MR KNOWLES: And you accepted that at face value?

MS D'ROZARIO: We did. Yes.

MR KNOWLES: Okay. Do you think – you do review audits as well, Ms D'Rozario?

MS D'ROZARIO: Yes, I do.

MR KNOWLES: Do you take a different approach in an accreditation audit to a review audit?

MS D'ROZARIO: There is a different approach in terms of the visit is a little bit more focused and you know what expected outcome you will be looking at and what documentation you will be reviewing.

MR KNOWLES: Yes, but do you take a different approach where you are perhaps more mindful of looking for non-compliance at a review audit than you might otherwise at an accreditation audit?

MS D'ROZARIO: Yes, I do.

MR KNOWLES: Now, going to document 20 in the tender bundle, this is the audit assessment information for the August assessment, and at page .0606, those two dot points refer to deficits in management and staff knowledge on the delivery of care recipients' clinical and personal care, but they appear under expected outcome 1.6 going to human resource management. Now, do you see that there are two items of information referred to in the two dot points. The first is from 17 April 2018. That is an entry in the improvement register.

MS D'ROZARIO: Yes.

MR KNOWLES: So can you explain why you didn't see that when you were undertaking a document review on 18 April 2018?

MS D'ROZARIO: I don't remember.

MR KNOWLES: Okay. And the second is a survey conducted in February 2018 which identified dissatisfaction with staffing, with not enough staffing to meet all care recipients' needs. Can you recall whether or not you saw that?

MS D'ROZARIO: We didn't see that survey.

MR KNOWLES: Why do you think you didn't see that?

MS D'ROZARIO: It wasn't made available to the assessment team.

MR KNOWLES: Right. And do you think that identifies perhaps a difficulty in the sense that there is a great deal of dependence on the part of an assessment team on the transparency of the approved provider in terms of what material is given to you?

MS D'ROZARIO: Yes, I agree.

MR KNOWLES: I notice the time, Commissioners. I still have a way to go. I don't know whether it's an appropriate time.

COMMISSIONER TRACEY: How long have you got with this witness?

MR KNOWLES: With this witness I am almost finished, but then we still have two more members of the panel.

COMMISSIONER TRACEY: Well, I am conscious of that. I'm just trying to work out what the best course is. We will certainly finish this witness, we are not going to leave her part-heard.

MR KNOWLES: Yes.

COMMISSIONER TRACEY: How long do you estimate you will need to deal with the remaining two witnesses?

MR KNOWLES: They will be quicker, but I've still got a bit of time to go, probably about half an hour to 35 minutes, I'm afraid.

COMMISSIONER TRACEY: Yes, we'll sit on and complete the evidence.

MR KNOWLES: Yes. Thank you. Now, Ms D'Rozario, you've said in your statement, I think, at paragraph 33 that one of the suggestions that you have for

improvement of the regulatory process or framework is that assessors ought to be given greater access or even unrestricted access to electronic systems of providers during on-site visits?

MS D'ROZARIO: That's correct.

MR KNOWLES: Is that something that you think has been informed, at least in part, by your experiences in this case?

MS D'ROZARIO: Yes.

MR KNOWLES: And in terms of that, in particular the matters to which I've just taken you to?

MS D'ROZARIO: Yes.

MR KNOWLES: If you had reviewed those documents going to dissatisfaction with staffing levels, is it possible that it might have had an impact on the view that you took about whether or not that particular expected outcome was met or not met?

MS D'ROZARIO: Definitely.

MR KNOWLES: Now, I think at paragraph 31 of your statement, if I can take you to that, you refer to:

> *...a guiding principle that there should be transparency between the assessment team and the approved provider.*

Do you think that's a realistic expectation in every case?

MS D'ROZARIO: It doesn't always happen.

MR KNOWLES: Well, you referred earlier to the fact that you've never heard of a case in which a self-assessment by an approved provider was anything less than 44 out of 44 outcomes.

MS D'ROZARIO: Yes, that's correct.

MR KNOWLES: That would tend to suggest a lack of awareness or a lack of - - -

MS D'ROZARIO: Transparency.

MR KNOWLES: - - - desire to provide information of non-compliance; would you agree?

MS D'ROZARIO: I would agree with that.

MR KNOWLES: Can I, lastly, just take you back to the document at tab 6 of the tender bundle. This is expected outcome 2.1 and, in particular, at the page directed to expected outcome 2.1 in this document. This is your audit assessment information document. You, under the continuous improvement expected outcome, in the first dot point - - -

MS D'ROZARIO: Yes.

MR KNOWLES: - - - described one aspect of continuous improvement as being the purchase of a syringe driver?

MS D'ROZARIO: Yes.

MR KNOWLES: That's for the administration of certain medications?

MS D'ROZARIO: Yes.

MR KNOWLES: And you stated that management had implemented staff education and established documentation to support the implementation?

MS D'ROZARIO: Yes.

MR KNOWLES: And management advised the feedback from staff has been positive.

MS D'ROZARIO: Yes.

MR KNOWLES: Are you aware of the findings that were made in respect of the syringe driver in August of 2018?

MS D'ROZARIO: As a result of the review audit? Yes.

MR KNOWLES: Yes, indeed.

MS D'ROZARIO: Yes, yes.

MR KNOWLES: You are?

MS D'ROZARIO: Yes.

MR KNOWLES: Perhaps if I can just take you to that, it is at tab 20. If we can keep that on the screen and put it on the left of the screen – that page – and, at tab 20, in respect of expected outcome 2.3, which I think is at page .0611, at the bottom of the page, there's a reference to the purchase of the syringe driver early in the year. Do you see that - - -

MS D'ROZARIO: Yes.

MR KNOWLES: - - - in the third dot point towards the bottom of the page? But it said:

> *However, only one registered nurse has attended training on how to use it and that nurse said they are not confident to use it and require support. Management said they plan to implement training and competencies for the syringe driver but this has not commenced.*

How does that reconcile with what you have found in your previous report in April of 2018?

MS D'ROZARIO: It doesn't.

MR KNOWLES: All right. Ms Waters, perhaps if I can now turn to you. You came to be involved with Avondrust in December of 2018.

MS WATERS: That's correct.

MR KNOWLES: Yes. And you were the team leader for the assessment contact on the 6th of that month?

MS WATERS: I was.

MR KNOWLES: Yes. And you attended with two other assessors on that day?

MS WATERS: I did.

MR KNOWLES: Was that the usual number of assessors in your experience for an assessment contact?

MS WATERS: The number of assessors is determined, to some degree, by the complexity of the issues that we have to follow up and also the numbers of consumers in the home. So I thought that three of us was a sufficient number.

MR KNOWLES: Yes. And you were there just for the one day?

MS WATERS: We were.

MR KNOWLES: And it was an announced visit, was it?

MS WATERS: It was.

MR KNOWLES: Yes. And prior to that attendance on site, I think you said the day before you got a work pack. That would have had a lot of material in it, with all of the review audit and other documentation relating to Avondrust?

MS WATERS: Well, I received it about 10 to 5, and I didn't notice that the review audit report wasn't in it, in my pack. It was just the audit report, which is quite different. So a review audit report has the supporting documentation relating to a not met outcome. I discovered during the audit on the 6th that my two colleagues, who were registered nurses, they got it, so it was an oversight in what was put into the work pack.

MR KNOWLES: So you didn't have - - -

MS WATERS: I didn't get it. I only got the rationale statements.

MR KNOWLES: So you didn't get the assessment information document that has the additional matters that are added to the rationale?

MS WATERS: That's right, I didn't get it. I did wonder why but I didn't ring the office and ask for it. I just assumed maybe they didn't want me to know all the additional information.

MR KNOWLES: But you knew, obviously, there had been findings of 13 of the 44 expected outcomes - - -

MS WATERS: I did.

MR KNOWLES: - - - not met?

MS WATERS: Yes.

MR KNOWLES: And that subsequent assessment contacts hadn't deviated from that assessment?

MS WATERS: And I got those reports, two in September and one in November.

MR KNOWLES: Yes. And there hadn't been any assessment contact to your knowledge between 1 November 2018 and 6 December 2018.

MS WATERS: Not to my knowledge.

MR KNOWLES: Okay. And do you know why that was?

MS WATERS: No.

MR KNOWLES: Perhaps that's a question for you, Ms Rosenbrock.

MS ROSENBROCK: It's not our normal practice to schedule visits with greater frequency than was the case with Avondrust. So we scheduled a visit – we scheduled two visits during the timetable for improvement, approximately six weeks apart. So they were on a relatively short timetable; they were on a three-month

timetable. And we visited them approximately every four weeks after the audit and then the end of TFI visit on 6 December. So it's not our usual practice to visit more frequently than that.

MR KNOWLES: Right. And, Ms Waters, returning to you, you say in your statement at paragraph 21 that you had a discussion with your fellow team members before going on site, as well as with Ms Rosenbrock?

MS WATERS: Yes.

MR KNOWLES: And had you ever gone to Avondrust before this time?

MS WATERS: No.

MR KNOWLES: Right. And, other than looking at the documents that you had received – and, as you say, some of them were incomplete – you didn't, therefore, have any distinct reference point, from direct experience, for your assessment of purported improvement, did you?

MS WATERS: No.

MR KNOWLES: And was it usually the case that you would speak with Ms Rosenbrock before conducting an assessment contact?

MS WATERS: No.

MR KNOWLES: So why did it happen on this occasion?

MS WATERS: I think because the late advice the night before, in terms of when I got the assignment request – and I can't actually remember what I discussed with Catherine, but it was just something to do with the impending audit that we were going to do.

MR KNOWLES: Right.

MS ROSENBROCK: Could I add to - - -

MR KNOWLES: Sure.

MS ROSENBROCK: - - - Susan's response? So Susan was not the original team leader for the assessment contact on 6 December. On 5 December, the original team leader, who had her work pack well and truly before then, advised us that she had a personal emergency that needed to be dealt with, and so at short notice we needed to re-team a visit. It was an end of TFI visit, so it had to be conducted. So we called upon Susan, as an experienced and competent assessor, to jump into the breach, so to speak.

And, for that reason, her work pack was prepared at short notice by our admin staff, after 5 pm the day before the visit was scheduled to occur. And I felt it was only fair to Susan to, on the morning of the visit, provide her with some instruction and guidance on how to go about the conduct of that visit, given that she had had so little time to prepare.

MR KNOWLES: So what instruction and guidance was that?

MS ROSENBROCK: So, basically, I advised Susan that, when we're writing – basically, that when we're doing an end of TFI visit – so at the end of a timetable for improvement, that we expect the report to reflect not only the compliance status of the home, so whether or not the team believes that the service is met or not met, but also to include details of what actions the home has completed in order to bring it back to compliance. So the structure of the report is a little bit different than a normal assessment contact. And so I just wanted to make sure that Susan, as the team leader, understood what was expected in the report, so that she would be able to appropriately direct and lead the team.

MR KNOWLES: Did you express any view yourself, having looked at it on the 19th, as to whether or not they were moving towards compliance on your assessment?

MS ROSENBROCK: I don't believe I would have done that.

MR KNOWLES: Okay. Now, obviously, by the time of the visit, the actual timetable for improvement had expired.

MS ROSENBROCK: It had. It had.

MR KNOWLES: How does that work in all of the circumstances, where they haven't met the timetable for improvement and you only go to assess it after it has expired?

MS ROSENBROCK: At that time – and so we're not talking very long ago, but at that time it was our practice to schedule a visit, an end of TFI visit, within 14 days of the expiry of a timetable for improvement. So that was the business rules that we operated under at that time. We've subsequently amended that. So we now go and do an end of TFI visit the day after the TFI expires.

The Quality and Safety Commission rules, which came into effect on 1 January, have a requirement for us to have made a decision on compliance within 14 days. So we have adjusted our timeframes to reflect that change. But, up until that stage, it had always been the practice, for as long as I had been at the commission and its predecessors, that you visited within 14 days of the timetable expiring.

MR KNOWLES: So the deadline was a little bit of a soft deadline, would you agree?

MS ROSENBROCK: It was a bit of a soft deadline. It's certainly a harder deadline now, but it was somewhat more fluid at that time.

MR KNOWLES: Returning to you, Ms Waters, your assessment contact was just to look at the 13 - - -

MS WATERS: That's right.

MR KNOWLES: - - - previously not met expected outcomes?

MS WATERS: That's right.

MR KNOWLES: You didn't look beyond that. You weren't forming a view as to whether or not accreditation or, you know, other expected outcomes were met.

MS WATERS: We were not.

MR KNOWLES: No. And you came to the view that the 13 – you and your colleagues came to the view that the 13 previously not met expected outcomes should now be found to be met?

MS WATERS: We recommended that.

MR KNOWLES: Yes. Now, you've set that out with your colleagues in the assessment contact report, which is at tab 109 of the tender bundle. That refers, I think at page .2429, to the interviews that you conducted.

MS WATERS: Yes.

MR KNOWLES: You haven't referred there to the nurse adviser and administrator, Ms Coombe.

MS WATERS: Well, if it's not there, we didn't interview her.

MR KNOWLES: Yes. And she was there on site, though, wasn't she?

MS WATERS: I can't recall.

MR KNOWLES: Well, Ms - - -

MS WATERS: The nurse practitioner was there. The nurse administrator, I don't recall who that was.

MR KNOWLES: The nurse adviser, you mean?

MS WATERS: The nurse adviser.

MR KNOWLES: Yes.

MS WATERS: I do not recall meeting her or interviewing her.

MR KNOWLES: Right. Okay. So if Ms Rosenbrock has said, at paragraph 110 of her statement, subparagraph (e), that a nurse adviser was present during the December 2018 assessment contact, you're not in a position to depart from that?

MS WATERS: I can't comment. No.

MR KNOWLES: But, to the extent that such a person was there from Ansell Strategic, you didn't speak with them yourself.

MS WATERS: No. And my two colleagues, obviously, didn't speak to her, because it would have been in the audit trail.

MR KNOWLES: Yes. Now, in the documents that are – pardon me. Now, would you have wanted to speak to that person in assessing the return or no return to compliance?

MS WATERS: In retrospect, if I had known she was on site, I would have been interested in speaking to her.

MR KNOWLES: She has been there all along from the time of the sanctions having been imposed.

MS WATERS: That I was not aware of.

MR KNOWLES: If you had been aware of that, wouldn't you have thought, "This is a person who may have considerable intelligence and information about the facility's ability to return to compliance"?

MS WATERS: Yes.

MR KNOWLES: Now, in terms of documents, you've referred to some sample documents at the bottom of that page and then, across to the next page, .2430, you refer to other documents that were considered. And, again, there's no reference to any documents that were prepared by the nurse adviser and administrator, Ansell Strategic?

MS WATERS: No.

MR KNOWLES: Do you think those documents, to the extent that they might have contained details of their assessment of the ability of the service to comply, might have been a useful thing for you to have regard to?

MS WATERS: That I'm not sure. A nurse adviser is probably someone I would not have – if I had known she was on site, I don't know whether I would have interviewed her.

MR KNOWLES: But you've just said a moment ago that that's the sort of person that may actually have some useful information for you.

MS WATERS: Yes. Yes. Well, the fact is we didn't know she was on site, so - - -

MR KNOWLES: All right. Can I take you to the document at tab 105 of the tender bundle. Do you recall this being shown earlier today to witnesses? This is the summary of gap analysis findings at MiCare Avondrust Lodge prepared by Ms Mary Dunn.

MS WATERS: Yes. I did watch.

MR KNOWLES: Yes. And that was prepared on 20 and 21 November 2018.

MS WATERS: Yes.

MR KNOWLES: So that's pretty contemporaneous with your assessment of the service, would you agree?

MS WATERS: Yes.

MR KNOWLES: Yes. And you've seen that she says, on or around the 21st, under the heading Findings:

> *I believe that eight of the 13 not met expected outcomes still have gaps which will not be remedied by next week when the TFI expires.*

And then, a little bit further below, in those enumerated expected outcomes, there's then a reference to another two expected outcomes that have some gaps which may lead to them being assessed as not met. So, all up, potentially up to 10 expected outcomes, in Ms Dunn's opinion, would be found to be not met at the time of the expiry for the timetable for improvement.

MS WATERS: Yes.

MR KNOWLES: Is this the sort of document you would have liked to have been aware of?

MS WATERS: We're there to independently assess the 13 outcomes on the day.

MR KNOWLES: Sure.

MS WATERS: And we had three individuals who had complementary skills and my colleagues were two registered nurses and were more than capable of assessing the clinical and care outcomes. And I was – I assessed the non-clinical outcomes.

MR KNOWLES: Yes. I understand that, but if you go further on in this document, you will see, for instance, that, just under Human Resource Management, towards the bottom of the page, it directs attention to the fact that handover processes are ineffective or non-existent. Now, that's her opinion and you may form a different opinion, but this type of document would draw attention to specific matters, wouldn't it?

MS WATERS: It may have.

MR KNOWLES: Well, I put to you that it would have and it might have then brought matters to your attention that you otherwise might not have been aware of.

MS WATERS: Well, that's right.

MR KNOWLES: So do you agree that this is a document that, while it sets out someone else's opinion, would have been of some assistance to you in terms of identification of issues that you might wish to have regard to yourself?

MS WATERS: We can only assess on what we read and review on the day.

MR KNOWLES: I understand that.

MS WATERS: And we triangulate with the feedback we get back and the observations we make. So it's – that's what we did on the day.

MR KNOWLES: Yes. And you didn't get this document from the approved provider.

MS WATERS: We didn't get this document. I can't comment.

MR KNOWLES: If you had got this document, is it possible that you might have made contact with Ms Dunn to understand why she formed the views that she had?

MS WATERS: I'm not sure. I can't answer that, because we were there as a unit of three to actually undertake the audit on behalf of the agency.

MR KNOWLES: Do you think the absence of provision of documents like this to the agency could potentially undermine the agency's assessment function?

MS WATERS: No. I stand by the integrity of our report.

MR KNOWLES: I'm not asking about your report specifically, Ms Waters. What I'm saying is do you think the failure to provide documents like this, in a candid

fashion by an approved provider, can undermine the assessment function of what was then the agency and is now the commission?

MS WATERS: I can't comment on that.

MR KNOWLES: Now, Ms Dunn has, would you agree, referred to problems there in respect of handover processes that would be properly regarded as systemic. Would you accept that?

MS WATERS: I can't - - -

MR KNOWLES: She is describing the fact that the processes for handover are ineffective or non-existent. Assuming that were correct – and just take it that that is correct for the moment. I'm not asking you to express your own view about that, but assuming that were correct, would you agree that that represents a systemic failing?

MS WATERS: I can't comment on that.

MR KNOWLES: I put to you that it does and, if you had regard to this document, it might have had a bearing on your own views that any deficiencies that continued at the service were not systemic.

MS WATERS: I can't comment.

MR KNOWLES: All right. Ms Marshall, can I turn to you, and the re-accreditation audit on 7 and 8 January 2019. You, like Ms Waters, attended the premises; there were also two assessors with you as well in your team?

MS MARSHALL: That's correct, yes.

MR KNOWLES: It was a team of three?

MS MARSHALL: Yes.

MR KNOWLES: Was your audit visit also announced in advance?

MS MARSHALL: No. It's unannounced

MR KNOWLES: It was unannounced. Okay. And obviously you knew that your report would inform the decision-maker as to, firstly, whether or not there was to be re-accreditation and, secondly, the duration of it?

MS MARSHALL: Yes. That's what happens, yes.

MR KNOWLES: You'd agree that, in those circumstances, the audit report, and any reference to evidence going to the conclusions in the audit report, would be important because it informs the decision-maker, who is making an important

decision, as to accreditation for potentially a considerable period of time; it may only be a year but that's a considerable period of time?

MS MARSHALL: Yes, that's right.

MR KNOWLES: Now, in that regard, can I ask you, had you been to Avondrust Lodge yourself prior to January of 2019?

MS MARSHALL: No, I don't believe I'd been there in the past.

MR KNOWLES: So like Ms Waters, you didn't have any direct experience by which you could compare how things were in January 2019 to some other time vis-à-vis improvements?

MS MARSHALL: The information – we use the information in the reports to guide that.

MR KNOWLES: Yes. So it was a documentary – you had to compare your own views with a documentary view – a view set out in the document from the past?

MS MARSHALL: Yes.

MR KNOWLES: Yes. Thank you. You also spoke with a superior before going out on the audit; that was the assistant director of the now commission, not Ms Rosenbrock but another staff member?

MS MARSHALL: Yes, I would have spoken to one of them. Yes.

MR KNOWLES: Yes. And what was discussed in that discussion at that time?

MS MARSHALL: That wasn't – that hasn't been recorded but because I knew the history of the home's non-compliance, I just wanted to check to see if there was anything else I needed to be informed about.

MR KNOWLES: Okay. And were you given some additional information?

MS MARSHALL: No.

MR KNOWLES: Okay. Now, you and your team made findings that went to recommendations that 44 out of 44 expected outcomes were now met?

MS MARSHALL: That's correct.

MR KNOWLES: Yes. And having read those documents provided in your work pack that went to the background of what had occurred over 2018 - - -

MS MARSHALL: Yes.

MR KNOWLES: - - - you'd accept, wouldn't you, that there had been considerable changes at Avondrust between April 2018 and January 2019?

MS MARSHALL: Yes, there had been. Yes.

MR KNOWLES: And can I ask you this, did you and your team speak with Ms Coombe from Ansell Strategic at the time?

MS MARSHALL: Somebody on our team spoke to the nurse adviser, yes.

MR KNOWLES: Well, when you say the nurse adviser, that was – was that the lifestyle activities program person from Ansell Strategic, or was there an actual discussion with Ms Coombe?

MS MARSHALL: I didn't speak to Ms Coombe, no. And I know that one of the team members spoke to one of the nurse advisers. That's recorded in our notes. That's all I can say to that.

MR KNOWLES: Yes. Can I take you to document at tab 241 of the tender bundle. Does that look like your notes, by the way, Ms Marshall?

MS MARSHALL: Yes.

MR KNOWLES: Yes. And your fellow team members' notes?

MS MARSHALL: That's correct, yes.

MR KNOWLES: Can I take you to, in that document, .8691. In terms of the contact with the nurse adviser that you refer to, is that the person – I don't need you to say their names – that is referred to towards the centre of the page, "Lifestyle plan" and then their name and then in brackets after that nurse adviser?

MS MARSHALL: Yes, that's right. Yes.

MR KNOWLES: So the discussion that was had with the nurse adviser went to lifestyle activities for residents; is that right?

MS MARSHALL: It was in relation to standard 3 which covers a range of leisure and lifestyle expected outcomes including care plans which was the main – which was one of the main topics.

MR KNOWLES: So it wasn't in relation to clinical care - - -

MS MARSHALL: No.

MR KNOWLES: - - - and it wasn't in relation to staffing levels in terms of expected outcome 1.6?

MS MARSHALL: No.

MR KNOWLES: So going back, is that the only contact that you're aware of between your team, on the one hand, and the nurse adviser team on the other?

MS MARSHALL: That's correct, yes.

MR KNOWLES: Yes. So aside from that, there was no contact with them where discussion was had about clinical care outcomes or staffing levels?

MS MARSHALL: No.

MR KNOWLES: No. Thank you. Now, in terms of the documents that you prepared, and your colleagues, you had a site audit report. Then as well as that you also had an evidence record for the site audit report?

MS MARSHALL: That's right.

MR KNOWLES: Was this a new form of documentation prepared by what was now the commission? Sorry to put you on the spot.

MS MARSHALL: Yes, I think it was. Yes, that's when that commenced.

MR KNOWLES: Yes. So instead of having an assessment information record, you now had, firstly, the report and, secondly, the evidence that was behind the report; is that right?

MS MARSHALL: That's right, yes.

MR KNOWLES: Both those documents go to the decision-maker to look at?

MS MARSHALL: Yes.

MR KNOWLES: So the decision-maker sees the findings as to whether or not you think there is a meeting or not meeting of the expected outcomes?

MS MARSHALL: Yes.

MR KNOWLES: Under that, the rationale statements that we've referred to earlier in Ms D'Rozario's evidence?

MS MARSHALL: Mmm.

MR KNOWLES: And then otherwise, in terms of specific matters that go to the satisfaction of those rationale statements, are they set out to some extent in the site audit report but, to a large extent, in the evidence document?

MS MARSHALL: Could you repeat that?

MR KNOWLES: Perhaps I will show you the documents.

MS MARSHALL: Yes, I know what documents you're talking about.

MR KNOWLES: Yes.

MS MARSHALL: But any specific evidence - - -

MR KNOWLES: Where's that referred to?

MS MARSHALL: - - - goes into the evidence report.

MR KNOWLES: The evidence record. Okay. Well, can I take you to that document which is at tab 251 of the tender bundle. Is that the one that you're referring to?

MS MARSHALL: Yes. That's correct, yes.

MR KNOWLES: Yes. All right. Are you familiar with the quality surveyor handbook? Obviously, it was created at the time of the agency but I assume it still, in substance, applies to your activities now for the commission?

MS MARSHALL: Yes.

MR KNOWLES: From October 2018 and perhaps, unsurprisingly, the document states that these types of records have to contain sufficient and relevant evidence considered by an assessment team to assess performance against standards?

MS MARSHALL: Yes.

MR KNOWLES: You'd accept that that, as a matter of commonsense, is what ought to occur?

MS MARSHALL: Yes.

MR KNOWLES: All right. Now, at that page, do you see, in respect of regulatory compliance expected outcome 1.2 - - -

MS MARSHALL: Yes.

MR KNOWLES: - - - it says that:

> *The evidence that has been considered in order to assess performance against the standards is the team was not presented with any evidence indicating that the expected outcome is not met.*

MS MARSHALL: Yes.

MR KNOWLES: And it's fair to say, isn't it, that that approach is one that is taken for a very large number of the expected outcomes that are referred to in your evidence record?

MS MARSHALL: That's right.

MR KNOWLES: Yes. Would you agree that well over half of the expected outcomes simply have a statement to that end?

MS MARSHALL: Yes, they do.

MR KNOWLES: Yes. So the positive finding as to whether or not the expected outcome is met depends upon a mere absence of negative evidence that's been presented to you by, say, the approved provider? Yes, is that right? You're nodding.

MS MARSHALL: We write our explanation of how the expected outcome is met in the other report and if there is any evidence to suggest that there are gaps or issues is detailed under this heading. That was how we were required to write our reports at the time.

MR KNOWLES: Right so in other words - - -

MS MARSHALL: If there wasn't any evidence to suggest any issues or gaps, we were required to write that we were not presented with any evidence, indicating that the expected outcome was not met.

MR KNOWLES: When you say you were required to write that - - -

MS MARSHALL: That's how we were instructed to write it.

MR KNOWLES: You were instructed to write it that way. Right. Essentially, you're only referring to evidence, you say, if it's adverse; is that right?

MS MARSHALL: That's right, yes.

MR KNOWLES: Okay. And in that regard, you don't refer to the evidence that led you to be positively satisfied that a particular expected outcome was met?

MS MARSHALL: Not in this report; in the other one.

MR KNOWLES: Right. But that's just the rationale template statements a lot of the time, would you agree?

MS MARSHALL: That's how our reports are recorded.

MR KNOWLES: But that doesn't refer to evidence per se, does it?

MS MARSHALL: Yes, I would say that the rationale - - -

MR KNOWLES: You are looking at Ms Rosenbrock.

MS MARSHALL: All right, I won't do that. Our rationale statements in the report includes information that we have found while we've been on site to support that finding.

MR KNOWLES: Well, for many of them it doesn't, would you agree? It's just simply the rationale statement? I'll come to those in a moment, perhaps.

MS MARSHALL: I can't – I can't really comment any further.

MR KNOWLES: How do you think – do you think that simply saying, in this document, there's a meeting of the expected outcome by reason of not being presented with evidence indicating that the expected outcome is not met; do you think that promotes good regulation, that type of reasoning? I'm asking for your personal opinion as an experienced assessor.

MS MARSHALL: I – yes, I think that that's okay.

MR KNOWLES: All right.

MS MARSHALL: When you – yes.

MR KNOWLES: Can I take you to the document at tab 123 of the tender bundle. That's the site audit report. So that's the document, I think, that you were referring to before?

MS MARSHALL: That's right, yes.

MR KNOWLES: All right. And can I bring up, on the left-hand side of that, the audit report from the April 2018 audit, which is the document at tab 6 of the tender bundle. Now, you've already given evidence that, so far as you're aware from your reading of the documents, there'd been a considerable change at Avondrust over the time from April 2018 to January 2019?

MS MARSHALL: That's right.

MR KNOWLES: Yes. Okay. Now, can I take you to, firstly, expected outcome 1.6 in each document. Do you agree that when you look at the paragraphs under the heading The Home Meets This Expected Outcome in one document, in the other, The Service Meets This Expected Outcome, that they are – large parts of those paragraphs are substantially the same. Maybe the word "home" has been replaced with "service"?

MS MARSHALL: Yes, that's correct.

MR KNOWLES: These are the standard reasons and rationales that are provided to assessors in terms of stating compliance - - -

MS MARSHALL: Yes. That's right. And we were required to use those statements at the time.

MS ROSENBROCK: So, if I may, at the time of each of these audits, a large part of the audit report was computer-generated and so the similarity in words is a product of the process by which the report was created and I advise you that, under the current methodology that has been applied, and the report writing process under the new quality standards, we no longer use computer-generated reporting. All reports are written from scratch. And we use the computer auditing tool to gather and store our evidence but that we no longer use it to generate reports, and that assessors are now required to write and produce evidence for the decision-maker in relation to mets as well as to not mets.

COMMISSIONER TRACEY: What puzzles me, Ms Rosenbrock, is how you as the delegate, with both these documents in front of you and required to make a decision, can have any confidence that what you're looking at is the considered opinion of the author because you knew, when you did, that this was simply template writing.

MS ROSENBROCK: The output of the audit tool was based upon assessors validating, within the software, that they had considered the relevant information to support their finding.

COMMISSIONER TRACEY: Do you seriously suggest, word-for-word, the findings are identical, months apart? Different people writing it?

MS ROSENBROCK: I have to tell you that, as a decision-maker, the computer-generated reports made me feel quite uncomfortable.

COMMISSIONER TRACEY: Yes, Mr Knowles.

MR KNOWLES: Thank you, Commissioner. Do you agree that there are large parts of your document which, if they were to be compared with the April document, would be substantially the same or similar?

MS MARSHALL: Yes. A larger portion would have been except for those instances where we made alterations that reflected our findings. And they were under some of the expected outcomes.

MR KNOWLES: Okay. So just in terms of this example, is that towards the end where one sees a reference to the – in the bottom box on the screen, do you see the words:

The majority of care recipients and representatives who participated in consumer experience interviews.

Is that an example of something that you have entered in?

MS MARSHALL: That is an example, yes.

MR KNOWLES: That's something you've taken from the consumer experience interviews, which are effectively like a tick-box survey of residents; is that right?

MS MARSHALL: Yes, it's a questionnaire, a set of questions that we ask consumers and there's a range of answers they can provide, and it's also supported by their own comments, which is recorded in a different document.

MR KNOWLES: Some of the answers are yes/no. Some are, "strongly agree" down to "strongly disagree".

MS MARSHALL: Yes.

MR KNOWLES: They're the types of answers that can be provided in terms of the survey that's conducted. Okay. Now, obviously, in terms of – if I can take you then to expected outcomes 2.4 in each document; now, that's for clinical care.

MS MARSHALL: Yes.

MR KNOWLES: And, again, do you agree that, largely, those paragraphs are substantially the same?

MS MARSHALL: They look like they are.

MR KNOWLES: There might be one or two sentences that are different. And that is despite - - -

MS MARSHALL: Yes, there is – there is one sentence that's not in the January report.

MR KNOWLES: Yes, thank you. Is that the last sentence?

MS MARSHALL: The last sentence and – is the top one the April - - -

MR KNOWLES: The top one is April and the bottom one is the January one.

MS MARSHALL: Yes, it's essentially the same thing.

MR KNOWLES: Yes. So there's – if you look at the January one, the sentence before:

Changes in care needs are identified –

has been removed in your report, the one that refers to:

The home regularly reviews and evaluates the effectiveness of the clinical care system and tools used.

MS MARSHALL: Yes, that's right.

MR KNOWLES: So do you recall any particular reason why that sentence was removed from the later version of template reasons?

MS MARSHALL: Most likely because it's covered under "Continuous improvement" in expected outcome 2.1 continuous improvement so we didn't refer to it there as well.

MR KNOWLES: You knew that – I understand you say this was how you were instructed to complete your reports, so I'm not intending any direct criticism of you at all but you knew at the time of preparing this document that, in terms of clinical care, the home had not met that expected outcome between August of 2018 right up to 6 December 2018?

MS MARSHALL: That's right.

MR KNOWLES: There's no indication in that as to how they've got back from that period of non-compliance, is there?

MS MARSHALL: Well, in the December report there was extensive information recorded in relation to that, and if you go to the evidence report, I think there may be something in that in relation to it. But we would not normally provide further extensive information if it had been provided in the end of TFI report, which was only done a month before.

MR KNOWLES: Okay. Can I just go to that in the evidence report. I might come back to these documents in a moment, but in the evidence report, which is tab 251, and at the page dealing with clinical care, .0636, you said earlier – this is a document that sets out adverse evidence?

MS MARSHALL: Yes, that's right.

MR KNOWLES: Okay. So 2.4, the two things that are referred to, the evidence as to why clinical care is now met is not an absence of any evidence but that:

Staff provided positive feedback regarding a new handover process and said it's working well.

MS MARSHALL: Mmm.

MR KNOWLES: So that's not necessarily a negative comment as to the circumstances in existence at the service for clinical care, is it?

MS MARSHALL: No, it's not a negative statement.

MR KNOWLES: And, likewise, the following dot point is the same, would you agree?

MS MARSHALL: That's right, yes.

MR KNOWLES: Okay. But that's all there is in terms of evidence that supports the rationale statements other than your reference to responses to consumer CERs, consumer experience reports. That's all there is, in terms of the documentation to justify the position that was reached in terms of the rationales and meeting the expected outcome?

MS MARSHALL: So those rationales are also based on our methodology. When we're on site we can't – we can't populate the report with that rationale statement unless we've got evidence to support that, which we do when we're on site and it gets recorded in our notes. So yes.

MR KNOWLES: I'm curious about this. Do you go through each single line of the rationale statement and say, "That one I can accept on the evidence", "That one I can"?

MS MARSHALL: We can do that, yes.

MR KNOWLES: Well, do you do that?

MS MARSHALL: Yes.

MR KNOWLES: And if you are not satisfied with it, what do you do? Do you start removing lines out of the rationale statement?

MS MARSHALL: If we don't agree with a sentence in a set rationale statement, we wouldn't be putting it in, no, but we may need to write something different in our own words to replace that, depending on what our findings are.

MR KNOWLES: That's pretty rare in terms of where there's a finding of meeting the expected outcome, isn't it?

MS MARSHALL: Not in my experience it's not, no.

MR KNOWLES: Okay. All right. Do you agree that what this tends to become in terms of the rationale statement is a checklist of items that become a substitute for all circumstances that might be relevant to meeting an expected outcome?

MS MARSHALL: Sorry. I'm not quite sure I understand what you mean. Sorry.

MR KNOWLES: I phrased that poorly. Do you agree that the rationale statement effectively calls you to have a checklist of items to go through to ascertain whether or not an expected outcome was met or not met?

MS MARSHALL: Probably the best way to explain that is that, for every expected outcome, we have – at the time we had a set of results and processes that we followed to determine how we would assess that expected outcome. And our standard methodology for every outcome is that we do interviews which includes consumer and representative interviews, a wide range of staff and management and we do a wide range of observations which would cover a lot of expected outcomes and we look at a wide range of documents including clinical files.

MR KNOWLES: I understand that. But do you see much of that referred to in the actual documentation that goes to the evidence that was reviewed to support the findings that led to the conclusion of an expected outcome being met or not met?

MS MARSHALL: The depth of what we look at, no, is not reflected in the rationale statement, no. That's right.

MR KNOWLES: Okay. Lastly, can I just ask you, Ms Rosenbrock, you've seen earlier the document which was at tab 136 of the tender bundle. Perhaps if that can be brought up now. You might not have seen it actually, but you might have heard evidence about this document which was the draft potential sanctions causation factors report prepared by Ansell Strategic for MiCare.

MS ROSENBROCK: I've seen it.

MR KNOWLES: Do you recall that document being the subject of evidence?

MS ROSENBROCK: I've seen it, yes.

MR KNOWLES: Yes, and you've seen it as well?

MS ROSENBROCK: Yes.

MR KNOWLES: Yes. Okay. When you say you've seen it, that's only in more recent times, take it?

MS ROSENBROCK: Yes.

MR KNOWLES: Neither you nor anyone from the agency, as far as you are aware, saw that around the time of February 2019?

MS ROSENBROCK: Not at all.

MR KNOWLES: You heard Ms Coombe's evidence earlier today that that was a view that she held then – sorry; pardon me. If we go to the last page and the passage relating to future considerations about:

> *...the lack of robust clinical processes and reporting providing an ongoing risk. This is not only in relation to a catastrophic clinical event but also in relation to meeting the new Aged Care Quality Standards –*

and so on. I mean, that's the sort of thing that you'd want to know about if you're a regulator, wouldn't you, that a person who is on site, and has been on site regularly for months at the facility, holds those views?

MS ROSENBROCK: It would absolutely have been very useful to see this document at the time it was written.

MR KNOWLES: She's given evidence too today that she held those views back in January at the time of the accreditation audit, so it would have been useful to speak with her at that time as well, presumably?

MS ROSENBROCK: It would have been. We don't always get access to nurse advisers on site. It's unusual for them to be on site during an audit post a TFI. So that was quite an unusual scenario. We held similar concerns about the sustainability of the improvements at MiCare Avondrust Lodge which is part of the reason why we only accredited them for a short period of time in January.

MR KNOWLES: How often does somebody come back from sanctions to getting three years' accreditation immediately? It would be never, wouldn't it?

MS ROSENBROCK: Never. Never. Not in my experience, anyway.

MR KNOWLES: To the extent that you gave them one year, it was unlikely they were ever going to get more than that?

MS ROSENBROCK: They would never have got more than one year.

MR KNOWLES: Regardless of your concerns or otherwise.

MS ROSENBROCK: And the reason we do that is because we understand that continuous improvement is an ongoing process. We expect to see a service – we expect to see every service with open improvements on their plan for continuous improvement. There is always something that can be improved no matter how good the service is and if a service has just come off a sanction, there are still plenty of improvements that are still to be made, and you want to see that they are ongoing and you want to see that they reflect the learnings that the service has made during the course of their sanction and their period of non-compliance.

MR KNOWLES: So they were accredited in early January – pardon me. They had the accreditation audit on 7 and 8 January - - -

MS ROSENBROCK: Correct.

MR KNOWLES: - - - and a decision was made in early February - - -

MS ROSENBROCK: That's right.

MR KNOWLES: - - - to grant the extra year's accreditation?

MS ROSENBROCK: That's right.

MR KNOWLES: You say around that time there were still some concerns about – that reflect these concerns, about the sustainability of the changes?

MS ROSENBROCK: Yes. And there – and there was still evidence in the report that Colette and her team provided to us about some ongoing issues in relation to staffing and so we went and did another visit fairly soon afterwards. We visited again at the end of April.

MR KNOWLES: Yes, 24 April.

MS ROSENBROCK: Yes. A home that is on a short period of accreditation can usually expect to have more than the usual number of visits in the intervening period of time, so the service was visited in – at the end of April. They were visited again last week.

MR KNOWLES: Just before we leave off the April visit, though, that's still a period of months after holding these concerns perhaps in January as to the sustainability of improvements. Do you think that's a satisfactory period of time between the two events?

MS ROSENBROCK: It's been our usual practice for as long as I've been in the agency or its predecessors to schedule a visit around about three months after the resolution of a non-compliance. So to schedule a visit in April following an audit in January would be the usual kind of timeframe.

MR KNOWLES: But you might not usually have the same concerns that you had here?

MS ROSENBROCK: They'd had a lot of visits in the previous six months. We felt that it was reasonable and safe to schedule three months after the audit.

MR KNOWLES: Just in terms of that visit in April, you were only looking at two particular expected outcomes?

MS ROSENBROCK: That's right.

MR KNOWLES: They were both found to be met?

MS ROSENBROCK: That's right.

MR KNOWLES: Other expected outcomes were – there was some information in the assessment contact report.

MS ROSENBROCK: That's right.

MR KNOWLES: But they were not the subject of any findings or recommendations as to findings vis-à-vis being met or not?

MS ROSENBROCK: That's correct.

MR KNOWLES: You know that one of those related to having yellow plastic chains across the doors of people's rooms?

MS ROSENBROCK: That's correct.

MR KNOWLES: And the other related to the use of chemical restraints.

MS ROSENBROCK: That's correct.

MR KNOWLES: Why wouldn't you investigate that a bit more thoroughly to ascertain whether or not concerns about sustainability of changes were well-warranted?

MS ROSENBROCK: So with both of those – with both of those issues, the assessor has drawn them to our attention while not finalising an assessment of the relevant expected outcome. Assessors will use that approach where there are issues that they may not have time themselves to fully assess on the day that they're assessing it but it is sending a flag to a decision-maker that these issues need to be followed up at the next visit. If the assessor had had significant concerns about either of those issues, then I would have expected them to call the office, advise us that they had concerns and either receive instructions about assessing those outcomes or seeking an additional person to come out and assist them with the assessment or, possibly even, in a worst-case scenario, prompting us to extend the visit or call a review audit. So there's a variety of things that assessors can do if they have significant concerns on site - - -

MR KNOWLES: Yes.

MS ROSENBROCK: - - - but this particular assessor clearly felt that it was – these were matters that could be followed up at a further visit, rather than needing an immediate increased response.

MR KNOWLES: But just taking the chemical restraint issue, she observed on her findings that the number of residents there using – having dispensed to them anti-psychotic medications equated to 41 per cent of all residents. That's very high, isn't it?

MS ROSENBROCK: That's at the higher range of the levels that I've seen reported, yes.

MR KNOWLES: But so what follows from that observation is that there is then another assessment, but not for another three months.

MS ROSENBROCK: That's right.

MR KNOWLES: And that assessment, though, occurred, it's true, in response to complaints that were made, isn't it?

MS ROSENBROCK: The April assessment or the - - -

MR KNOWLES: No. No. The subsequent one - - -

MS ROSENBROCK: The subsequent assessment.

MR KNOWLES: - - - in more recent times.

MS ROSENBROCK: That's correct.

MR KNOWLES: Yes

MS ROSENBROCK: That's correct.

MR KNOWLES: So it wasn't even – it might have been scheduled not as soon had it not been for those complaints that have been received.

MS ROSENBROCK: That's not quite the case. So the visit that was to follow the April visit was scheduled tentatively for August. In fact, it was scheduled tentatively for July, but we didn't have the resources with the changeover to the new standards to do that visit in July. Subsequently, when we received the referrals at the end of July, I determined that the visit had to go ahead even if that meant interrupting other activity to ensure that we got a team out there to look at those issues.

MR KNOWLES: And those referrals, you're referring to complaints that have been referred to the agency.

MS ROSENBROCK: Yes.

MR KNOWLES: And the complaints related to a range of matters, but they included staffing levels and clinical care issues including wound management.

MS ROSENBROCK: That's correct.

MR KNOWLES: And they were matters that were, obviously, the subject of grave concerns back in August of 2018.

MS ROSENBROCK: That's correct. So those complaints were – they're not actually referred to the agency. They're actually – we're now one commission, - - -

MR KNOWLES: Yes .....

MS ROSENBROCK: - - - so they're complaints that came into the complaint resolution group of the commission.

MR KNOWLES: Yes.

MS ROSENBROCK: They did some initial follow-up with the service in relation to the subject matter of those complaints and then they provided that information to us. As soon as I saw that information and I saw it was about staffing and it was around wound care, which were the similar issues that we had had a year ago, we scheduled another visit as soon as we possibly could.

MR KNOWLES: And it tends to suggest that these complaints arise, that the concerns that were expressed by Ms Coombe back in February 2019, that she held in January 2019, were warranted.

MS ROSENBROCK: Correct.

MR KNOWLES: And that was despite the fact that, a matter of a month before that, the service had been adjudged to be compliant with 44 out of 44 expected outcomes.

MS ROSENBROCK: That's correct.

MR KNOWLES: I have no further questions for the witnesses, thank you, Commissioners.

COMMISSIONER BRIGGS: I'm not going to follow up that particular issue, but, Ms Rosenbrock, you might call me a bit naïve, but, in my long history of public service, I've never come across before computer-generated responses given to regulators as part of their day-to-day work. That's not my question. My question is what led to that system of computer-generated responses?

MS ROSENBROCK: I'm probably not the best-placed person to answer that question. When the computer assisted audit tool was introduced, there were two main reasons provided to us as to why it was being introduced. The first of those was to gain greater consistency in reporting across the agency. You can imagine with 200 different people all writing reports, sometimes they look different. And so

the first motivation was consistency of report writing. And the second consideration was in order to reduce report writing time.

COMMISSIONER BRIGGS: So, fundamentally, the system was to address known and apparent deficiencies in the then agency, together with manage resources. Thank you.

MS ROSENBROCK: That's correct.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising from that?

MR KNOWLES: No. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you, all, for your evidence. You're excused from further attendance at the Commission.

MR KENNETT: Commissioner – I'm sorry to interrupt, Commissioner.

COMMISSIONER TRACEY: Yes.

MR KENNETT: I don't have a microphone either, but I'm just taking some instructions as to whether there's anything that we might need to ask these witnesses.

COMMISSIONER TRACEY: Well, if you're going to do that, you will need to talk to Mr Knowles. We will do it immediately after the luncheon adjournment. The commission will adjourn until quarter to 3.

<THE WITNESSES WITHDREW

ADJOURNED [2.06 pm]

RESUMED [3.00 pm]

MR ARNOTT: Commissioners, there's nothing the Commonwealth seeks to ask by way of re-examination of the four witnesses.

COMMISSIONER TRACEY: Welcome back.

MR ARNOTT: Thank you.

COMMISSIONER TRACEY: Yes, Mr Knowles.

MR KNOWLES: Thank you, Commissioners. Ms Brammesan is in the witness box. If she might take the oath or affirmation.

<ELSY BRAMMESAN, SWORN [3.00 pm]

<EXAMINATION BY MR KNOWLES

MR KNOWLES: Ms Brammesan, can you tell the Royal Commission your full name.

MS BRAMMESAN: Elsy Brammesan.

MR KNOWLES: Yes. And do you have a copy of a witness statement that you have prepared for the Royal Commission before you there?

MS BRAMMESAN: I do.

MR KNOWLES: And that is the statement dated 22 July 2019?

MS BRAMMESAN: That's right.

MR KNOWLES: The statement is document WIT.0306.0001.0001. And have you read your statement lately?

MS BRAMMESAN: I have.

MR KNOWLES: Yes. Do you have any changes that you wish to make to your statement?

MS BRAMMESAN: I don't.

MR KNOWLES: And are the contents of your statement true and correct to the best of your knowledge and belief?

MS BRAMMESAN: It is. Thank you.

MR KNOWLES: If the statement of Ms Brammesan dated 22 July 2019 could be tendered.

COMMISSIONER TRACEY: Yes. The witness statement of Elsy Brammesan dated 22 July 2019 will be exhibit 8-22.

EXHIBIT #8-22 WITNESS STATEMENT OF ELSY BRAMMESAN DATED 22/07/2019 (WIT.0306.0001.0001)

MR KNOWLES: Ms Brammesan, can you tell the Commission your present position.

MS BRAMMESAN: I'm the director for Compliance Centre East within the Department of Health.

MR KNOWLES: And what does that role entail?

MS BRAMMESAN: So my role as a delegate for the secretary is managing the operations of the compliance work under the Aged Care Act.

MR KNOWLES: Yes. And when it refers to east, that is Queensland - - -

MS BRAMMESAN: The five states.

MR KNOWLES: - - - New South Wales, Victoria - - -

MS BRAMMESAN: ACT and Tasmania.

MR KNOWLES: - - - Tasmania and the ACT.

MS BRAMMESAN: That's right.

MR KNOWLES: Okay. And you held the same position in 2018?

MS BRAMMESAN: I did.

MR KNOWLES: And what are some of the responsibilities that you have in discharging that role?

MS BRAMMESAN: So in the role, my job is to understand if there is a non-compliance by a provider and – around the standards. I have to take the action to mitigate the risk for the carers and work with them about bringing them back to compliance.

MR KNOWLES: All right. And is part of your role, on occasions, to be a delegate of the secretary of the Department of Health - - -

MS BRAMMESAN: That is my role.

MR KNOWLES: - - - to make decisions under the Aged Care Act?

MS BRAMMESAN: It is.

MR KNOWLES: Yes. And does that include being a delegate to make decisions to impose sanctions and to lift sanctions that have been imposed?

MS BRAMMESAN: That is correct.

MR KNOWLES: Now, I take it that you are aware of relevant events that occurred at Avondrust Lodge in 2018 and early 2019.

MS BRAMMESAN: Yes, I am aware.

MR KNOWLES: So I won't go over those in detail. Have you been present in the hearing room during the evidence that was given by the Aged Care Quality and Safety Commission witnesses?

MS BRAMMESAN: No, I wasn't here.

MR KNOWLES: No. Have you seen that evidence on any webcasts?

MS BRAMMESAN: No, I haven't.

MR KNOWLES: No. Okay. Thank you for that. All right. Now, obviously, in this case your familiarity with the circumstances at Avondrust stems from the fact that you were the delegate - - -

MS BRAMMESAN: I was.

MR KNOWLES: - - - who imposed sanctions - - -

MS BRAMMESAN: That's right.

MR KNOWLES: - - - on MiCare in respect of Avondrust. And you were also the delegate that lifted those sanctions subsequently.

MS BRAMMESAN: That's correct.

MR KNOWLES: Yes. Now, can I ask about what a couple of circumstances prior to the imposition of the sanctions which occurred late in August of 2018. Before August of 2018, what, if any, knowledge did you have of compliance issues at Avondrust Lodge?

MS BRAMMESAN: I did not have any knowledge.

MR KNOWLES: You had no knowledge before then?

MS BRAMMESAN: No.

MR KNOWLES: No.

MS BRAMMESAN: Yes.

MR KNOWLES: And I take it that, to the extent that you found out about compliance issues relating to Avondrust Lodge, that was something that you learned of via the then agency.

MS BRAMMESAN: Yes. There was a type 3 referral sent to the commission and I became aware of the referral on 17 August.

MR KNOWLES: Yes.

MS BRAMMESAN: And that's when I became aware of the non-compliance issues.

MR KNOWLES: Yes. So that type 3 referral to the agency on 14 August 2018, that came from what was then the Aged Care Complaints Commission.

MS BRAMMESAN: That's right.

MR KNOWLES: They sent it to the agency. Why didn't they send it to the Department of Health, as well?

MS BRAMMESAN: They did. We received it on the 17th.

MR KNOWLES: I see. So that referral was sent to both places, but you didn't get it until - - -

MS BRAMMESAN: The agency got it on the 14th - - -

MR KNOWLES: Yes.

MS BRAMMESAN: - - - and I got it on the 17th.

MR KNOWLES: I see. Thank you for that.

MS BRAMMESAN: Yes.

MR KNOWLES: Now, in terms of that type 3 referral, was that something that was then discussed at the subsequent Department of Health liaison meeting with the agency on 21 August 2018?

MS BRAMMESAN: Not particularly sure if it was discussed on the 21st. I do know that a review audit commenced soon after they received - - -

MR KNOWLES: Yes.

MS BRAMMESAN: - - - that type 3.

MR KNOWLES: By the agency assessors.

MS BRAMMESAN: By the agency assessors at that time.

MR KNOWLES: Yes. Did you find out about that at the time that was happening?

MS BRAMMESAN: Yes, I did.

MR KNOWLES: Yes. And how did that occur?

MS BRAMMESAN: Through a phone call.

MR KNOWLES: A phone call, did you say?

MS BRAMMESAN: Yes, because I received – when I got the T3, I know a T3 is a significant referral. And I read the information that contained in it. I contacted the commission to find out what's happening about that. And I became aware a review audit has commenced at that time.

MR KNOWLES: Did you contact Ms Rosenbrock?

MS BRAMMESAN: I did.

MR KNOWLES: Yes. Okay. And is that an example of the informal information sharing mechanisms that I think you've referred to in your statement?

MS BRAMMESAN: That is one example.

MR KNOWLES: One example. Yes. Okay. And would you agree that those informal information-sharing mechanisms depend, at least to some extent, on the discretion of the individual officers?

MS BRAMMESAN: It does. However, we do have other mechanisms to share information, as well.

MR KNOWLES: Yes. I understand that. But, in terms of where they are not formal, you would accept that there is a degree of variance depending on the individual discretion of the person who - - -

MS BRAMMESAN: Yes. Receives that information.

MR KNOWLES: - - - decides to share or not share information.

MS BRAMMESAN: I agree.

MR KNOWLES: Yes. And in terms of the formalised information-sharing mechanisms, are they the ones you've referred to in your statement, I think, at – is it paragraphs 36 to 37?

MS BRAMMESAN: There is. And there should be one more statement, as well.

MR KNOWLES: Sorry? Pardon me? Is it 38, is it?

MS BRAMMESAN: Yes, that's right.

MR KNOWLES: Thank you. Yes. So 38 refers to informal or ad hoc - - -

MS BRAMMESAN: That's right.

MR KNOWLES: - - - information sharing. That's of the kind that you've just described between yourself and Ms Rosenbrock.

MS BRAMMESAN: That's right.

MR KNOWLES: But 36 and 37, are they the extent of the formalised information sharing mechanisms that you're aware of, at least?

MS BRAMMESAN: There is a monthly – every three weeks we do have an agency liaison meeting, as well.

MR KNOWLES: Yes.

MS BRAMMESAN: And I have mentioned it. I'm not sure which number .....

MR KNOWLES: Yes. Well, I will come back to that. I was about to go to that - - -

MS BRAMMESAN: Sure. Okay.

MR KNOWLES: So that's useful. But both of those matters there that are referred to in paragraphs 36 and 37, they're things that have been introduced from April 2019. Is that right?

MS BRAMMESAN: The SPoC – information – the commission started joining the SPoC at that time in April.

MR KNOWLES: Yes. That's what I mean.

MS BRAMMESAN: And the MOU has been – there was a different MOU before that with the agency.

MR KNOWLES: I see.

MS BRAMMESAN: This is the new MOU.

MR KNOWLES: I see. Okay.

MS BRAMMESAN: For the newly formed – yes.

MR KNOWLES: Okay. Thank you. But in terms of the Service Providers Of Concern Committee meetings prior to April 2019, so at the relevant time that we're dealing with here, the commission or its predecessor, the agency, didn't have a seat at the table.

MS BRAMMESAN: Not for the SPoC.

MR KNOWLES: No. Okay. Thank you. Now, can I turn to what I'm taking to be one of the informal mechanisms. Or perhaps it's a formal and it's not mentioned there, but that's the liaison meetings to which - - -

MS BRAMMESAN: That's right.

MR KNOWLES: - - - you've made some mention earlier.

MS BRAMMESAN: Yes.

MR KNOWLES: If I take you to tab 22 in the tender bundle. And these are the liaison minute meetings – pardon me. I have got the wrong ones. If I can take you back to – yes. Pardon me. I have got the right ones – tab 22. And these minutes related to the meeting on 21 August 2018.

MS BRAMMESAN: This is a different meeting to the one that I was referring to a little while ago. This is at the national level.

MR KNOWLES: I see.

MS BRAMMESAN: Because I can just see the people that are mentioned in there. So that's a national level meeting. There is also a state-based three-weekly meeting.

MR KNOWLES: I see. Right.

MS BRAMMESAN: Yes. Agency liaison meeting at - - -

MR KNOWLES: Right. I see.

MS BRAMMESAN: Yes.

MR KNOWLES: Okay. Well, in this meeting, if you turn to the second page, which is .2963, one sees the Homes Of Interest List heading.

MS BRAMMESAN: Yes.

MR KNOWLES: So I take it that an agenda item that was discussed at the meeting on 21 August 2018 was homes of interest. Now, I will come back to that terminology "homes of interest" in a moment, but if you proceed two more pages to the page ending .2965, do you see there, about four-fifths of the way down the page, MiCare Avondrust is mentioned. And the agency is recorded as having indicated that it's considering early release, many not met EOs, expected outcomes.

MS BRAMMESAN: I do see that.

MR KNOWLES: So what's reported, as I understand it, correct me if I am wrong, is that the agency is considering a release of a draft assessment information record in respect of a review audit, so that it will be provided as promptly as possible after the review audit has concluded.

MS BRAMMESAN: That's right.

MR KNOWLES: Okay. Now, in terms of that Homes of Interest list, can you tell the Royal Commission what the agency's Homes of Interest list is. I mean, it's evident from its name, but - - -

MS BRAMMESAN: Yes.

MR KNOWLES: - - - can you provide some details about that.

MS BRAMMESAN: They will be the services that are under TFI, timetable for improvement. So if an unmet was discovered, they will be on that list. And we discussed those homes of interest.

MR KNOWLES: Right.

MS BRAMMESAN: Yes.

MR KNOWLES: And how – the list was generated, do I take it from what you have just said, by reference to all aged care facilities that are subject to a timetable for improvement?

MS BRAMMESAN: That's right. The homes of interest list would have - - -

MR KNOWLES: All of them.

MS BRAMMESAN: - - - all of them.

MR KNOWLES: Okay. So it's an automatic scenario. There's no discretion for inclusion on the homes of interest list; it just happens by reason of you being on a timetable for improvement.

MS BRAMMESAN: I don't generate that list, so I can't tell you in detail exactly what's the consideration that goes in there. From my knowledge, the services that are - - -

MR KNOWLES: That's your understanding.

MS BRAMMESAN: That's my understanding.

MR KNOWLES: Yes. Thank you.

MS BRAMMESAN: Yes.

MR KNOWLES: Now, the Department of Health doesn't have a homes of interest list.

MS BRAMMESAN: We don't have a homes of interest.

MR KNOWLES: It has what you mentioned before, the service providers of concern list.

MS BRAMMESAN: That's right.

MR KNOWLES: So that doesn't relate to homes per se, but, rather, the service providers - - -

MS BRAMMESAN: Services.

MR KNOWLES: - - - that are running those homes.

MS BRAMMESAN: That's right.

MR KNOWLES: How is the service provider of concern list generated?

MS BRAMMESAN: So if a provider has got multiple areas of non-compliance, not just in the quality site, say, for example, there's a ..... non-compliance, there's an ACFI non-compliance or other matters or they have two or three homes at the same time under quality non-compliance, service will end up in a SPoC list - - -

MR KNOWLES: Right.

MS BRAMMESAN: And because it's - - -

MR KNOWLES: Who makes that decision? It sounds as though it's not as automatic as - - -

MS BRAMMESAN: It's not - - -

MR KNOWLES: - - - a homes of interest - - -

MS BRAMMESAN: It's not an automatic thing.

MR KNOWLES: It's a matter - - -

MS BRAMMESAN: And - - -

MR KNOWLES: - - - of discretion - - -

MS BRAMMESAN: That's right.

MR KNOWLES: - - - for somebody in a position - - -

MS BRAMMESAN: To - - -

MR KNOWLES: - - - what, such as yours.

MS BRAMMESAN: That's right. Yes.

MR KNOWLES: Yes. Do you decide who goes on the service provider of concern list?

MS BRAMMESAN: I do, in consultation.

MR KNOWLES: In terms of the area that you're responsible for.

MS BRAMMESAN: That's right. Yes.

MR KNOWLES: Okay. And you've mentioned some of the matter that go to the exercise of your discretion just now - - -

MS BRAMMESAN: Yes.

MR KNOWLES: - - - but there could be a whole range of factors.

MS BRAMMESAN: That's right. Yes.

MR KNOWLES: Okay. It's not as simple as whether or not somebody is on a timetable for improvement.

MS BRAMMESAN: It's not. Yes.

MR KNOWLES: No. Okay. MiCare was never on a Service Provider of Concern list?

MS BRAMMESAN: They were not on a service provider of concern list; they were on homes of interest list that goes along with the SPoC committee meeting, so - - -

MR KNOWLES: Yes. But that's not your list, is it?

MS BRAMMESAN: It's not my list.

MR KNOWLES: No.

MS BRAMMESAN: It's considered in the same meeting.

MR KNOWLES: Okay.

MS BRAMMESAN: Yes.

MR KNOWLES: But you're, obviously, by virtue of this, drawing attention to the fact that there can be differences between the two lists in terms of the approved providers that are subject of them.

MS BRAMMESAN: That's right.

MR KNOWLES: Yes. And can you explain, in principle, why the Department has a different list to that which the agency, as it then was, and commission now, has?

MS BRAMMESAN: The aim for the Service Provider of Concern is for us to look at is there going to be a wider or a bigger issue for the provider, not just at a service level. So as a Department, I think we do have to consider is this, you know, a systemic issue across this – you know, several services for this provider or is it just a concern for that service which happened at that time and it was rectified. So I really believe that Service Provider of Concern list is very different – for a different purpose.

MR KNOWLES: Does it reflect the fact that, in some respects, the Department's – I should say the secretary's function in terms of enforcement goes to sanctions against approved providers - - -

MS BRAMMESAN: Absolutely.

MR KNOWLES: - - - whereas the agency's function goes to particular services running particular homes?

MS BRAMMESAN: Yes. And the Department looks at the provider status and the accreditation agency – then accreditation agency was looking at individual services' accreditation, so the SPoC list is very different.

MR KNOWLES: Do you understand the agency and the Department, from what you've just said, as to what leads to an entity being on the list, to undertake a different assessment of risk for each of the lists?

MS BRAMMESAN: Do you mind repeating the question, please?

MR KNOWLES: Do you understand the agency and the department to take a different approach to the assessment of risk on those two lists?

MS BRAMMESAN: It is two different tests for the purpose of managing the risk because the SPoC list is of a higher risk compared to a Homes of Interest list. It is a different test.

MR KNOWLES: Why do you say that; are you referring to the statutory tests that accompany the exercise of power?

MS BRAMMESAN: Yes.

MR KNOWLES: One is for the secretary, immediate and severe risk, whereas the other for the agency, as it then was, now commission – well, one of the tests is serious risk? Is that what you are referring to?

MS BRAMMESAN: SPoC is not about immediate and severe test. SPoC is about having knowledge of a provider with multiple areas of non-compliance.

MR KNOWLES: I see.

MS BRAMMESAN: So it is a test about the provider rather than the service.

MR KNOWLES: Yes. Now, you've given evidence – and this is at paragraph 50 of your statement that, in your view, there are some disadvantages of having two aged care regulatory bodies having two – perhaps if it can be brought up, at paragraph 50 – having two approaches in respect of these risk assessments. You've expressly referred to the potential for that to cause unnecessary duplication for providers in their dealings with regulatory bodies. Can you think of any other potential disadvantages that apply by reason of having two bodies responsible for regulatory functions?

MS BRAMMESAN: I do think the timeliness of, you know, taking action to get an outcome for the care recipients would be one of the concerns as well, because the providers do have to respond to two different agencies and, you know, I would like to see the outcome for the care recipients come quicker so the timeliness would be an issue as well.

MR KNOWLES: Do you think that there is the potential for inconsistency between the two bodies, given their two different regulatory functions?

MS BRAMMESAN: I wouldn't say inconsistency because the outcome that two different agencies are trying to reach is very different. So the regulatory process for the commission is about the, you know, accreditation and the department is about the approved provider status so it is two different outcome, but you could be prosecuting the same issue in two different ways.

MR KNOWLES: Indeed.

MS BRAMMESAN: Yes.

MR KNOWLES: And at paragraph 52 of your statement, you've referred to what you understand to be an expected scenario whereby the commission:

> *... will assume responsibility for compliance functions following proposed legislative change –*

overall, I take it?

MS BRAMMESAN: That's right. Yes.

MR KNOWLES: And you say that you think that that would be something that would increase transparency and consistency for approved providers?

MS BRAMMESAN: Yes. Definitely.

MR KNOWLES: So does that go to the point that I was just asking about in terms of the potential being there - - -

MS BRAMMESAN: Yes, yes.

MR KNOWLES: - - - for inconsistency presently between, on the one hand, the Department's approach and that of the commission on the other?

MS BRAMMESAN: I agree.

MR KNOWLES: Would you agree that good decision-making depends, at least to some extent, upon having good sources of information?

MS BRAMMESAN: I do.

MR KNOWLES: Is it the case that the commission, albeit not the only source of information for the Department, is the main source of information for the Department in respect of exercising its regulatory functions?

MS BRAMMESAN: It is the main source of information. However, we do get information from the complaints area of the commission, which used to be a complaints commissioner before, and anyone can raise concern with the Department

as well. You could, you know, become aware of issues through other mechanisms but I do agree with you that the main source of information at this point is from the commission.

MR KNOWLES: In effect, the Department is somewhat removed from the actual gathering of information and the information that comes to it is second-hand, isn't it?

MS BRAMMESAN: The difference is that when the commission was not a Commonwealth agency before, the Department did go out and do our own investigation and now we do have another Commonwealth agency actually being present at a service gathering the information, so that's the difference that we have at the moment.

MR KNOWLES: Right. But as you've, I think, already acknowledged, the agency has different functions.

MS BRAMMESAN: They do.

MR KNOWLES: Different priorities, different assessments of where the risks lie and what the risks relate to so they're gathering information with different priorities to those which the Department would have?

MS BRAMMESAN: Yes. And it doesn't stop us from sourcing those information if I need further information from other areas.

MR KNOWLES: But would you accept that there's some perhaps potential disadvantages there by virtue of – and this might go to the question of consolidation to which you referred a moment ago - - -

MS BRAMMESAN: Yes.

MR KNOWLES: - - - that you wouldn't otherwise have if it was a consolidated body?

MS BRAMMESAN: Yes, I agree.

MR KNOWLES: Now, in terms of other sources of information, I think at paragraph 39 of your statement, you refer to the Department having:

> *...regular contact with approved providers, administrators and/or advisers appointed by an approved provider as a result of the sanctions process.*

To what extent does the Department or anybody from the Department, in connection with the sanctions process, have direct contact with residents or their representatives?

MS BRAMMESAN: So if I can just talk through a little bit about MiCare, if that's appropriate?

MR KNOWLES: MiCare?

MS BRAMMESAN: Is that - - -

MR KNOWLES: Yes. You want to answer it by reference to what happened with MiCare?

MS BRAMMESAN: Yes. That's right.

MR KNOWLES: Sure.

MS BRAMMESAN: So in the case of that, and in any instance when there is a sanction process, we do hold a forum called resident/relative meeting, and once I have made a decision about the sanction, sanction was imposed in this particular case, I wrote to every single family member and the care recipients and held a resident/relative meeting. That's a common feature that we have. And what it does is – in that forum, we also invite the complaints area of the commission to attend. We invite the Public Trustees and guardian and OPAN, the advocacy network, also to attend. So in this instance, there were up to 80 or 100 family members that attended.

So we are able to inform the families and the residents about what are the defects that were ..... that we discovered and what actions have been put in place and what actions are expected to happen before – through the process. So there is an engagement with – directly with the residents and the families and the letter that we write, too, also gives them direct contact for the compliance officer, so throughout the sanction process, the families can contact us and talk to us about any of their concerns that they have.

MR KNOWLES: Yes. That's after the decision is made, though.

MS BRAMMESAN: That's right.

MR KNOWLES: But what sort of direct contact is there with the Department – sorry with residents by the Department before the sanctions decision is made?

MS BRAMMESAN: Not any direct contact like in the complaints area or with the agency we don't - - -

MR KNOWLES: Yes. Its' all coming through other agencies?

MS BRAMMESAN: That's right.

MR KNOWLES: Yes. Okay. Do you see that as a potential deficit in terms of having good information sources for the purposes of good decision-making?

MS BRAMMESAN: I do, you know, believe another Commonwealth agency is giving the information and so we do get that information so - - -

MR KNOWLES: All right. Now, can I turn to the events immediately prior to the imposition of the sanction and if you go to tab 23 in the tender bundle, this is an email chain between – well, I won't say her name but a compliance officer and yourself.

MS BRAMMESAN: Yes.

MR KNOWLES: And she has said at the bottom of that page that there are two cases that she can see may be immediate and one of them is MiCare. This is on 22 August.

MS BRAMMESAN: Yes.

MR KNOWLES: What did you take that to mean when she said that they may be immediate?

MS BRAMMESAN: We have – by that time, we have read the type 3 referral and I have discussed with the team about the, you know, concerns that I have from that information and so - - -

MR KNOWLES: You thought – she is signifying that this may be an immediate and severe risk justifying sanctions?

MS BRAMMESAN: No, not at all. That the information when it comes needs to come to me immediately.

MR KNOWLES: I see.

MS BRAMMESAN: Yes.

MR KNOWLES: So in other words - - -

MS BRAMMESAN: Because an immediate and severe decision can't be made without having that information. She's not indicating it's an immediate and severe risk. She's saying this can be immediate, so when that information comes in, it needs to be brought to my attention immediately.

MR KNOWLES: I see. So it has got nothing to do with the statutory test - - - in respect of - - -

MS BRAMMESAN: No.

MR KNOWLES: - - - in respect of - - -

MS BRAMMESAN: Yes, I need to make the decision.

MR KNOWLES: - - - the imposition of sanctions.

MS BRAMMESAN: Yes.

MR KNOWLES: Okay. Now, turn to tab 26; this is another email from the same compliance officer to you. And this is later, this is on 28 August 2018. She says:

> *Without pre-empting the delegate's decision, I think it is looking immediate and severe at this end.*

Did she know you were the delegate at that stage?

MS BRAMMESAN: Where are you looking at, sorry?

MR KNOWLES: Pardon me. So if you look at the email, it's the second paragraph at the top of the page beginning with the words, "Without pre-empting".

MS BRAMMESAN: Yes, yes. Sorry, I can see it.

MR KNOWLES: Did she know you were the delegate at that stage, on 28 August?

MS BRAMMESAN: She would know that I'm the delegate, yes.

MR KNOWLES: She would have known?

MS BRAMMESAN: Yes.

MR KNOWLES: Yes. Okay. Now, you then made the decision on the next day and that's at document 30 in the tender bundle. The sanctions – and I'm paraphrasing here, Ms Brammesan, but essentially there was a freeze on payment of subsidy for new care recipients at Avondrust for six months and, on top of that, there was revocation of approval as an approved provider under the Aged Care Act, therefore, termination of funding for existing residents - - -

MS BRAMMESAN: Not existing.

MR KNOWLES: Pardon me. Termination of funding.

MS BRAMMESAN: No. So the number one sanction was subsidy, there will not be subsidy for the new care recipients.

MR KNOWLES: Yes.

MS BRAMMESAN: Yes.

MR KNOWLES: And number two is, though, if it was revocation, just unconditional revocation - - -

MS BRAMMESAN: Yes.

MR KNOWLES: - - - that would lead to an inability to claim funding?

MS BRAMMESAN: That's right.

MR KNOWLES: Do you agree with that?

MS BRAMMESAN: I do.

MR KNOWLES: Okay. But the revocation of approved provider status was conditional?

MS BRAMMESAN: It was.

MR KNOWLES: It was conditional on them – it wouldn't apply if they appointed an administrator and nurse adviser within seven days?

MS BRAMMESAN: That's right.

MR KNOWLES: Yes. Now, at that time, if one goes to the fifth page in the decision, which is .0209, the only information that you had then was the agency's draft audit assessment information report; isn't it?

MS BRAMMESAN: That's right.

MR KNOWLES: Yes. And your decision in fact largely sets out information from the report?

MS BRAMMESAN: Absolutely.

MR KNOWLES: Obviously analysing it as well but large takes that as accurate and as read?

MS BRAMMESAN: That's right.

MR KNOWLES: Okay. And is that one of the reasons why you would say at paragraph 52 of your statement that it might be preferable for the commission to exercise this function, in that they can then have an end-to-end role in the approach from gathering information right through to decision-making?

MS BRAMMESAN: That's correct.

MR KNOWLES: Now, how long have you been a delegate for the purposes of making decisions to impose sanctions?

MS BRAMMESAN: For this compliance centre east, for two years.

MR KNOWLES: For two years?

MS BRAMMESAN: For the compliance centre east, but I have done short stints of compliance director's role in the past.

MR KNOWLES: Yes. How many decisions do you think you have made over that time?

MS BRAMMESAN: During the two years?

MR KNOWLES: Yes.

MS BRAMMESAN: I currently have 20 sanctions that I'm managing at the moment.

MR KNOWLES: Yes. And have you ever provided revoked approved provider status without the ability for it to be avoided by appointment of an advisor and administrator?

MS BRAMMESAN: I haven't revoked the approved provider status.

MR KNOWLES: No.

MS BRAMMESAN: The providers have always been – the purpose of the sanction is to, you know, rectify the non-compliance, therefore, provide good care for the care recipients. I haven't had an instance where the provider has refused to appoint an administrator or an adviser.

MR KNOWLES: There may be circumstances, wouldn't you agree, whereby revocation is the – unconditional revocation is the appropriate course, because the counter-factual scenario is that aged care recipients would be worse off staying in a place that is trying to manage itself back to compliance when that appears very unlikely?

MS BRAMMESAN: That's right. And I do turn my mind to the fact it is someone's home and we do need to manage these things very safely. And, just to give you an example, when the scenarios that you're explaining has happened, where we do believe that service should not continue to operate because the provider is not showing interest or improvement to the service, in the period that I have been the delegate for the compliance centre east, I have managed closure of five services. And, therefore, the revocation takes effect after.

But you do need to always come back to securing the safety and welfare of the care recipients. You don't go and revoke approved provider status, because it is someone's home and you need to relocate them safely before you go and revoke. And that's why you want to put measures in place to protect the welfare of the care recipients.

MR KNOWLES: Ms Brammesan, do you think, just from your personal experience as a person - - -

MS BRAMMESAN: Yes.

MR KNOWLES: - - - who makes decisions in this area, do you think that the range of measures available to decision-makers is satisfactory on the whole or would you prefer to have some greater suite of tools to use in your decision-making for the purposes of regulatory function?

MS BRAMMESAN: I think, for the purpose of protecting the welfare and safety of the care recipients, there are enough tools to achieve that.

MR KNOWLES: What about sanctions that affect directors or others involved in the management of approved providers?

MS BRAMMESAN: That would be amazing.

MR KNOWLES: So you think there are enough, but that would be amazing? Is that what you're saying?

MS BRAMMESAN: That would be the next step, taking to the next step. Yes.

MR KNOWLES: So why do you say that?

MS BRAMMESAN: There could be instances where the providers don't understand – the directors may not understand the responsibilities under the Act. And so that could be challenging or impediment to returning the service back to compliance.

MR KNOWLES: Yes. Now, you will recall in this case that the condition as to – to avoid revocation as such was, effectively, complied with by MiCare by appointing, initially, Ansell Strategic to be the nurse adviser.

MS BRAMMESAN: That's right.

MR KNOWLES: And a person called – I won't say their name, but another person called Sue, I think she has been identified as – as the administrator.

MS BRAMMESAN: That's right.

MR KNOWLES: And the Department had absolutely no say in the selection of those people, did it?

MS BRAMMESAN: No, we didn't.

MR KNOWLES: No. And you know, obviously, that MiCare and the administrator, Sue, parted ways soon after that.

MS BRAMMESAN: That's right.

MR KNOWLES: Again, the Department had no say in that.

MS BRAMMESAN: No, we didn't.

MR KNOWLES: And that didn't affect your view of compliance with the conditions to avoid revocation?

MS BRAMMESAN: They did bring on another person immediately.

MR KNOWLES: Yes.

MS BRAMMESAN: And it was a straight swap, rather than having a period without an administrator. So that didn't - - -

MR KNOWLES: And that was somebody from Ansell, as well?

MS BRAMMESAN: I believe so, yes.

MR KNOWLES: So does that mean one can avoid that difficulty with the condition to avoid revocation provided that there's continuity of an adviser or administrator?

MS BRAMMESAN: It is the provider's responsibility to find appropriately skilled and suitable person. And as long as they can meet that and continue to fix the, you know ..... of the service, it does meet the criteria.

MR KNOWLES: But that means from these circumstances, I take it, that the provider could continue to replace the nurse adviser or administrator as often as they liked –

MS BRAMMESAN: I wouldn't agree with that.

MR KNOWLES: - - - provided they keep continuity of – it might affect their ultimate prospects of having the sanctions lifted down the track, but that is conceivably possible?

MS BRAMMESAN: That is possible, but it hasn't happened.

MR KNOWLES: Yes. But the Department has, I think you've agreed, no say in any of that.

MS BRAMMESAN: If there was more than one time someone had to be changed, due to ill health or lack of availability or some emergency for them, there had to be change, that is agreeable. But if it was happening – even a proposal was happening soon after, I would like to understand what the was reason for that.

MR KNOWLES: Did you find out what the reason was for the administrator Sue leaving?

MS BRAMMESAN: At that time, yes.

MR KNOWLES: And what were you told?

MS BRAMMESAN: That, like the witness said this morning, the alignment and two different companies doing the work was difficult for them.

MR KNOWLES: Two different – sorry – pardon me.

MS BRAMMESAN: Two different organisations trying to do the administrator/adviser role was challenging.

MR KNOWLES: Okay. Now, just in terms of advisers and administrators, under the Aged Care Act, the only thing that restricts a person as to their eligibility for that role is that they mustn't be a disqualified individual?

MS BRAMMESAN: A disqualified person. That's right.

MR KNOWLES: They don't have to have any training under the statutory scheme, at least, at all.

MS BRAMMESAN: That is correct, but we do discuss what type of person will be required to return the provider back to compliance. We do, you know, explain the role of the administrator/adviser. And it is pretty serious being in sanction. And so it is one of the last resorts you go to, sanctions. So I have very detailed discussions with the provider at the time of imposing the sanction as to - - -

MR KNOWLES: Yes.

MS BRAMMESAN: Yes.

MR KNOWLES: But the point is, despite whatever the Department's explanation or expectation is, it's really ultimately a matter for the provider to decide who they choose.

MS BRAMMESAN: I agree with you.

MR KNOWLES: And if that person gets results, it doesn't matter what their qualifications are.

MS BRAMMESAN: To be a nurse adviser, you need to have clinical background. And I don't think someone without a clinical background will be able to do a nurse adviser's role and engage with the doctors and allied health professionals and conduct case conferences. For an administrator, I agree with you that they could, you know – we don't stipulate specifically what qualification they need to have.

MR KNOWLES: Now, in terms of the nurse adviser and administrator's role, they don't have any obligation to provide information to the Department, do they?

MS BRAMMESAN: They don't have an obligation, but we do discuss with the provider about their expectations.

MR KNOWLES: Yes. And they don't have to comply with the Department's expectations, though, do they?

MS BRAMMESAN: I haven't had an instance where they don't.

MR KNOWLES: No, but what I'm getting at is - - -

MS BRAMMESAN: Sorry.

MR KNOWLES: - - - let's just say they don't provide information, but then they satisfy the agency that they're back to compliance, 44 out of 44 – well, in the times of this case study - - -

MS BRAMMESAN: Yes. 13.

MR KNOWLES: - - - expected outcomes, it may be that the Department thinks, "Well, even though they haven't told us or shown us anything of what they're doing, here is the result from the agency, such that the sanctions ought to be lifted."

MS BRAMMESAN: The way we set up the sanction right from the beginning is one of the expectations is that we have either weekly or fortnightly update. So it is set out right up-front.

MR KNOWLES: Yes. And, in this case, I think the Department initially proposed weekly and MiCare and Ansell simply did fortnightly.

MS BRAMMESAN: They did fortnightly, and they chose to give detailed written response, rather than weekly smaller succinct information. So, as long as we were able to keep in touch and understand the improvements that was happening, that was satisfactory.

MR KNOWLES: When you say "detailed", you're referring to the reports, are you?

MS BRAMMESAN: The written report, that – yes.

MR KNOWLES: Yes. Well, the first report was relatively detailed, but do you accept the latter reports were one or two pages?

MS BRAMMESAN: Yes, that's right.

MR KNOWLES: All right. Now, the current arrangements were introduced – you refer to this in your statement at paragraphs 40 to 42 in 2016 to cut red tape. Can you describe how the system now differs from what existed prior to 2016?
MS BRAMMESAN: Yes. So in – before 2016, there was a panel that - - -

MR KNOWLES: Yes.

MS BRAMMESAN: - - - the department had. And that list will be provided to the approved provider and they could choose from the panel. And it had its own, like anything, positive and defects, as well. What we have currently is a system where the provider is able to choose advisers/administrators of their choice and make sure that they have the right skill and knowledge and available to do the job.

MR KNOWLES: And so previously there was some quality vetting by the department. Is that a fair assessment?

MS BRAMMESAN: That's correct, yes.

MR KNOWLES: And now there is no such quality vetting.

MS BRAMMESAN: That's right.

MR KNOWLES: Do you regard the current arrangements as preferable from a regulatory perspective?

MS BRAMMESAN: The challenge with the previous panel was that the people on the panel didn't have a varied type of knowledge. You know, someone who is a registered nurse may not have the particular skill of behaviour management if it was needed for a certain site. So there were a lot of limitations. And often they were not available and the list was quite smaller. And, you know, particularly interstate challenges and everything. And the cost was quite high, because they were on a government panel. So they were not only not available; the cost was very high, as well. So there were challenges and limitations in accessing them.

MR KNOWLES: Now, can I ask you then, in relation to the sorts of materials that the department has available to it provided by administrators and advisers, you get the reports, but that's a formalised arrangement that is set up towards the beginning of the period of the appointment of the adviser and administrator. Is that right?

MS BRAMMESAN: That's right, yes.

MR KNOWLES: Are you aware of more informal measures in this case in terms of MiCare than those fortnightly missives from the adviser?

MS BRAMMESAN: I'm not aware of other informal arrangement, but when we set up, it's not just the written report; usually there is a weekly teleconference where the provider is also involved. But, you know, every service is very different and the hours and days that advisers work might be different. In some cases, they have to work more of a weekend or afterhours depending on the issues they're dealing with. So we do need to work in such a way that we get the information.

MR KNOWLES: Now, you also were the delegate, as we've previously heard, that made the decision to lift sanctions in January of 2019.

MS BRAMMESAN: That is correct.

MR KNOWLES: Prior to that, you had, obviously, had regard to the fact of the agency's assessment contact in December of 2018, hadn't you?

MS BRAMMESAN: That's correct, yes.

MR KNOWLES: At that time – so you were aware that, where they had had – 13 certain expected outcomes that were previously not met, they had now been found to be met.

MS BRAMMESAN: That's correct.

MR KNOWLES: Yes. But that, obviously, didn't say anything about being fully met, so to speak, in terms of the whole suite of 44 expected outcomes, did it?

MS BRAMMESAN: That's correct. The sanction was about five outcomes that caused me to concern about the immediate and severe, so at the time when I considered lifting the sanction, those five were met.

MR KNOWLES: Yes. But - - -

MS BRAMMESAN: Including the others that were not in the sanction notice were met.

MR KNOWLES: Right. But that's a matter, though, that would be pertinent, wouldn't it, for your decision-making in respect of lifting sanctions, particularly - - -

MS BRAMMESAN: In terms of - - -

MR KNOWLES: - - - if you have concerns about the – previously about the systems that exist or don't exist at the particular aged care facility.

MS BRAMMESAN: Yes. I did get the report with 13 mets, so it did address the concerns that we had for the sanction, for the notice of non-compliance. So it did satisfy.

MR KNOWLES: That goes to those matters of past non-compliance.

MS BRAMMESAN: Yes.

MR KNOWLES: But were you satisfied in respect of other matters that hadn't been found yet to complied?

MS BRAMMESAN: Yes. So during the course of the sanction, the commission or I didn't become aware of any other matters that caused a concern or needed a different type of review. And I have, as I said, personally met with family members and the care recipients and brought their awareness to all the other mechanisms that are available during the sanction process.

MR KNOWLES: Yes.

MS BRAMMESAN: And so I was satisfied at the time when I lifted the sanction that I had considered the information in front of me.

MR KNOWLES: All right. Can I take you to tab 114 of the tender bundle. And this is, at the top of the page, an email from yourself to another couple of officers, one particular officer in the Department of Health, and you refer to the assessment contact report from the agency dated 14 December 2018 there.

MS BRAMMESAN: Yes.

MR KNOWLES: Do you see that?

MS BRAMMESAN: Yes.

MR KNOWLES: You say:

> *You can give a sentence in writing to DSS.*

Who is that, DSS?

MS BRAMMESAN: Department of Social Services - - -

MR KNOWLES: Social Security. Yes. That MiCare has fully met – it wasn't fully met though, was it?

MS BRAMMESAN: It was fully met with the unmets that we had, the 13 mets were fully met - - -

MR KNOWLES: Okay. So that's what you don't mean there; you don't mean fully with the accreditation standards?

MS BRAMMESAN: No.

MR KNOWLES: Okay. And then you see the next sentence:

Emily will talk to the provider on Monday regarding applying to have the sanction lifted.

MS BRAMMESAN: Yes.

MR KNOWLES: Yes, perhaps if I could just ask you to speak up a little bit or - - -

MS BRAMMESAN: I'm so sorry.

MR KNOWLES: - - - speak into the microphone a bit – move more closely – closer to the microphone.

MS BRAMMESAN: Sorry, Commissioner.

MR KNOWLES: Was that the case of you having told Emily to talk to MiCare the next business day about applying to have the sanction lifted?

MS BRAMMESAN: The providers – even, you know, the providers know their rights and one of the things they can have is to have the sanction lifted and they did have the unmets that were in the sanction that was met and it is the role of the officer when they contact the provider at the time when they get the report to let them know what are the other steps that are available for them.

MR KNOWLES: Right. Is that to encourage them to apply to have sanctions lifted?

MS BRAMMESAN: No. We have all sorts of requests from the providers sometimes when the unmets are met, the providers would say, "We are going to continue to keep the adviser/administrator, so we are going to leave the sanction in place or we would like just one item lifted." So they need to meet the criteria even in the lifting sanction, in the letter, it's not automatic lifting.

MR KNOWLES: And can you see what you say is a possible sentence that you might give to the DSS about what your – presumably what you regard the position to be vis-à-vis MiCare's compliance, and you say – this is the second sentence:

As the home has addressed the identified deficiencies and is now compliant with the accreditation standards, the department's compliance case will be finalised.

MS BRAMMESAN: That's correct.

MR KNOWLES: But it wasn't necessarily compliant with all the accreditation standards at that stage, was it?

MS BRAMMESAN: It was compliant with the 13 unmet, therefore – and I didn't have non-compliance against any other standards so – and that's what I'm referring to.

MR KNOWLES: Well, it was unknown what the position was at that particular time vis-à-vis the other expected outcomes, wasn't it?

MS BRAMMESAN: That is correct. But what I am saying is the unmets that I had in front of me were met at that time.

MR KNOWLES: Now, in terms of your decision to lift sanctions, which is at tab 130 of the tender bundle, you, save for the application to lift sanctions, only had regard to material from the agency; that's correct, isn't it?

MS BRAMMESAN: And from the provider's response as well. In terms of lifting the sanction, the provider had to write to me addressing certain criteria plus the commission's report.

MR KNOWLES: That is the provider's application to lift the sanctions.

MS BRAMMESAN: That's right.

MR KNOWLES: Save for that application, which was a matter of pages, a couple of pages with a continuous improvement plan attached to it - - -

MS BRAMMESAN: That's right.

MR KNOWLES: That's all, you otherwise just had the agency records?

MS BRAMMESAN: I had both, yes.

MR KNOWLES: And the agency records went to the fact of previously unmet expected outcomes now being met but said nothing about the other expected outcomes, whether they'd fallen into unmet territory or not met territory, did it?

MS BRAMMESAN: It didn't.

MR KNOWLES: And in terms of the decision to lift sanctions, you didn't make contact, I take it, with Ansell Strategic or particularly Ms Coombe from Ansell Strategic about her views - - -

MS BRAMMESAN: I didn't.

MR KNOWLES: - - - as to the improvements at Avondrust and the sustainability of those improvements?

MS BRAMMESAN: I didn't.

MR KNOWLES: You didn't?

MS BRAMMESAN: No.

MR KNOWLES: No. That would have been a useful source of information, wouldn't it, for your decision-making?

MS BRAMMESAN: The responsibility of sustaining the mets is the provider's responsibility, so I hold the provider responsible for that.

MR KNOWLES: You might hold them responsible but in terms of evidence about sustainability, wouldn't the adviser, a person who's been in there day in, day out since September be a useful source, and a good source of information about that?

MS BRAMMESAN: They would be. I did have the commission's report as well that indicated that the concerns identified in the beginning were addressed.

MR KNOWLES: Yes. Now, whether or not they'd been addressed in a way that was sustainable into the future, that is a question you could have asked the administrator and adviser, isn't it?

MS BRAMMESAN: Yes.

MR KNOWLES: Most probably they would have given you a helpful assessment in that regard, do you agree?

MS BRAMMESAN: I agree. I did have enough information, though, from everything in front of me to make the decision to lift the sanction at that time.

MR KNOWLES: You've no doubt seen the report from Ansell Strategic dated 12 February 2019?

MS BRAMMESAN: I have.

MR KNOWLES: At tab 136 of the tender bundle?

MS BRAMMESAN: Yes, I did.

MR KNOWLES: You've seen the last page of that report and the section under the heading Future Considerations. Now, as I say, this is a person who's been in the facility on a very regular basis for a sustained period of time, expressing a view that:

The lack of robust clinical processes and reporting provides an ongoing risk for the home.

And in the preceding sentence:

That the home has not yet achieved a sustainable level of performance in relation to leadership, lifestyle and clinical management at the home.

And then it goes on in the third sentence:

This is not only in relation to a possible catastrophic clinical event but also in relation to meeting the new aged care quality standards –

and so on. So that sort of opinion would have been something you would have put some stead in, I take it, if you'd known about it?

MS BRAMMESAN: I would have. However, in saying that, a Commonwealth agency has – who assessed the unmet, have gone back and assessed that those areas were addressed and I did have information from the provider to tell me what measures they were putting in place going forward, and I did know that there was going to be a re-accreditation visit soon after, within three months, and that will also test whether the measures that were put in place were going to be sustained at that time.

MR KNOWLES: Do you think it would have been preferable to make inquiries of the adviser and administrator about their own views as to the sustainability of the improvements that were said to have occurred at Avondrust?

MS BRAMMESAN: In reflection, I would think so and I still need to consider that it is their opinion at that time and I need to consider how I would use that information in regards to all the other information I have in front of me.

MR KNOWLES: You would know that the sanctions principles make this question of sustainability - - -

MS BRAMMESAN: Definitely, yes.

MR KNOWLES: - - - something that you have to take into account - - -

MS BRAMMESAN: That's right.

MR KNOWLES: - - - in terms of whether or not you are to lift sanctions. This was an opinion from a person who had first-hand knowledge on that very topic, wasn't it?

MS BRAMMESAN: That's right. If you look at the submission from the provider, they had given a number of items they were putting in place which they didn't have before.

MR KNOWLES: That is at tab 117, their submission.

MS BRAMMESAN: I don't have the tab, sorry.

MR KNOWLES: Perhaps if I take you to that.

MS BRAMMESAN: Sorry.

MR KNOWLES: So you were saying they indicated a number of matters that they had put in place, did you say?

MS BRAMMESAN: Page 2 of that documentation.

MR KNOWLES: Yes. What's that, the proposal for sustaining compliance?

MS BRAMMESAN: That's right.

MR KNOWLES: If you look at the proposal in the third paragraph, it simply says – the numbered heading Proposal For Sustaining Compliance, and if you look at the third paragraph:

> *We are in the process of recruiting a replacement facility manager who will be an RN.*

So that's one of the things that's said to underpin the sustainability of changes but it's something that hasn't even come into effect?

MS BRAMMESAN: That is one of the items of several others that they are proposing.

MR KNOWLES: In terms of the next paragraph, the appointment of a general manager of quality, risk and compliance, did you ask when that appointment was due to commence?

MS BRAMMESAN: It says "has appointed" so I would have taken that it was –

MR KNOWLES: You assumed that they were already on board at that stage?

MS BRAMMESAN: That's right.

MR KNOWLES: Okay. In making your decision in respect of the lifting of sanctions, am I right in thinking that, given what's referred to in that decision, there was no direct contact with any residents, their representatives, nor was there any contact with staff at Avondrust?

MS BRAMMESAN: That's correct, yes.

MR KNOWLES: I have no further questions for Ms Brammesan.

COMMISSIONER BRIGGS: Ms Brammesan, just going back to your earlier evidence about you working on the closure of five services.

MS BRAMMESAN: That's right.

COMMISSIONER BRIGGS: Just by way of fact, when a service like that closes, do they automatically lose their approved provider status?

MS BRAMMESAN: They don't automatically. That's a separate process that needs to be initiated to revoke the approved provider status.

COMMISSIONER BRIGGS: Do you normally initiate that? How does it happen?

MS BRAMMESAN: That process will be done in the Canberra-based office.

COMMISSIONER BRIGGS: In Canberra.

MS BRAMMESAN: Yes.

COMMISSIONER BRIGGS: And is it then recorded, should that provider seek to be a provider again, that their status has been – not revoked but removed because of the merger arrangement, or maybe it's revoked, I don't know, but I want to know, if they apply again, whether it's apparent to people in a year or five years' time, that they've lost this status and the reasons they have?

MS BRAMMESAN: Yes. The reasons are recorded, and it would be absolutely apparent to another person making an assessment for approved provider status that someone was – someone's status was revoked as an approved provider.

COMMISSIONER BRIGGS: In your experience, have providers who have had their status revoked ever been able to become a provider again?

MS BRAMMESAN: Not in my 22 years I haven't seen that.

COMMISSIONER BRIGGS: I'm pleased to hear that. Thank you.

COMMISSIONER TRACEY: Part of the need for intervention in this matter was because there was a serious complaint - - -

MS BRAMMESAN: That's right.

COMMISSIONER TRACEY: - - - that was made about the conduct of the home.

MS BRAMMESAN: That's right.

COMMISSIONER TRACEY: In making your decision, was there a reason why you did not consult the complainant?

MS BRAMMESAN: The complainant?

COMMISSIONER TRACEY: Yes.

MS BRAMMESAN: So in terms of – if I can just take one step back and explain the process itself for the benefit of everyone. When the T3 referral was received from the complaints area, you can see there were three different organisations working with this matter and so the complaints area was working on a particular person's concern and even the T3 very clearly outlines they are still sourcing information but they had enough concerns to raise a T3 referral, and within two days the commission had been out and started the review audit and that shows that process worked and showed the concern was taken seriously and looked at systematically, and as soon as I received the information, within 24 hours I have imposed the sanction.

And I was aware that the complaints area was working with this particular family member and I did not make any contact because my focus was about welfare of the care recipients in the entire service. And usually when I attend the resident/relative meeting, I make sure every time there's a sanction I hold a resident/relative meeting and I attend the residents/relative meeting, I do come in contact with the family members that have originally raised the concern. I did not in this matter. I do not remember seeing or talking to this family member. So I knew there was an agency dealing with that particular concern.

COMMISSIONER TRACEY: Well, at the end of the process, all that the complainant would know was that sanctions had been lifted.

MS BRAMMESAN: That is, yes, correct.

COMMISSIONER TRACEY: Well, do you regard that as a satisfactory position?

MS BRAMMESAN: Not from the complainant's perspective.

COMMISSIONER TRACEY: Well, from the perspective of good public administration.

MS BRAMMESAN: Yes. So, in terms of lifting the sanction, Commissioner, the provider, where they did have to meet all the unmets, it wasn't lifted without any of the unmets being met.

COMMISSIONER TRACEY: You're not answering my question. Do you regard it as good public administration, at the end of a process like this, which was instigated by a complaint - - -

MS BRAMMESAN: Yes.

COMMISSIONER TRACEY: - - - for the complainant to be left with no more than the knowledge that the sanctions had been lifted?

MS BRAMMESAN: I could have contacted her knowing that it was generated from a person. That would have been better.

COMMISSIONER TRACEY: I'm sorry. You're avoiding my question. It's a very simple one. Do you regard that as good public administration?

MS BRAMMESAN: No.

COMMISSIONER TRACEY: No. What steps have you put in place since to ensure that there is no repetition?

MS BRAMMESAN: We are going through a continuous improvement process. There are several things that we're looking at in terms of refining the process for sanctions and communicating with families. And I will take your consideration, as well, into that.

COMMISSIONER TRACEY: Has some thought been given to the prospect of appointing a liaison officer or somebody like that to keep a complainant informed about what is being done in response to serious complaints?

MS BRAMMESAN: In some of the sanctions, the department has appointed an adviser that we have appointed. It didn't happen in this case, but that is something that we could consider going forward.

COMMISSIONER TRACEY: In the course of making your decision, you would have read the various reports put in by assessors.

MS BRAMMESAN: That's correct.

COMMISSIONER TRACEY: Did you notice any similarity between them?

MS BRAMMESAN: My focus would be on – there were some – often there are reports that have similar sentences. If there are, I would call the commission to find out, you know, why does it say the same thing? Say, for example – a sentence doesn't come to my mind right now, but I would seek clarification.

COMMISSIONER TRACEY: We are not talking about occasional sentence; we're talking about great slabs that appeared in multiple reports.

MS BRAMMESAN: Yes. I did not notice in this regard.

COMMISSIONER TRACEY: You didn't notice that?

MS BRAMMESAN: Not in this case.

COMMISSIONER TRACEY: I see.

MS BRAMMESAN: No.

COMMISSIONER BRIGGS: I want to follow up the issue of the responsibility of liaising with the families.

MS BRAMMESAN: Yes.

COMMISSIONER BRIGGS: In our hearings, but particularly in the community meetings we've had, it's very clear that many people who speak complain of a lack of transparency and, as well, an absolute inability to understand how facilities that have done what they appear or are alleged to have been serious things to their family members, can be accredited with 44 out of 44 and then, seemingly quite quickly, have another review and they're not deemed to have met all the standards and then, shortly thereafter, to have another review and they've met all the standards.

The issue is that the community at large doesn't see the system as responsive to people making complaints, doesn't see them providing feedback to those people and certainly doesn't see it as transparent to them in terms of a fair process of review, sanctioning and so on following. Is it your view that something could be done to improve the transparency and the effectiveness of that liaison with families in order to enable them to regain some trust in the system?

MS BRAMMESAN: Yes. I do agree, Commissioner. One of the things is in terms of conducting this resident/relative meeting, like I was saying, there is nothing in the Act that stipulates that we have to conduct that meeting or the provider has to, but I take it upon myself that, absolutely, in every instance, I do conduct those meetings, write personally to the family members, so they know what the unmets are and they can hold the provider responsible. And we make sure there's regular meetings held. But in listening to you, we can go a step further and, possibly at the end of a process, we could have another meeting with the same family members to say what has been done and is there remaining issues. And so I think that is something that we should absolutely consider doing.

COMMISSIONER TRACEY: Anything arising, Mr Knowles?

MR KNOWLES: No, Commissioners.

COMMISSIONER TRACEY: Thank you very much for your evidence, Ms Brammesan. You are excused from further attendance.

MS BRAMMESAN: Thank you.

<THE WITNESS WITHDREW [4.05 pm]

MR KNOWLES: That concludes the evidence for the MiCare case study, Commissioners. I understand that it will be at the end of the week, I'm instructed, that there will be submissions made about directions coming out of the case studies. And we would propose to make submissions at that time in respect of any directions that arise out of the case studies. If it pleases the commission.

COMMISSIONER TRACEY: Thank you.

MR KNOWLES: So I now turn to the next case study, which is the Japara case study, which Ms Hutchins will be taking.

COMMISSIONER TRACEY: Welcome back.

UNIDENTIFIED MALE: Thank you, Commissioner.

COMMISSIONER TRACEY: Yes, Mr Hutchins.

MS HUTCHINS: Thank you. Commissioners, the next witness to be called is Mr Peter O'Brien of the Department of Health. Before calling Mr O'Brien, I will provide some short opening remarks regarding the context of the evidence that will be given this afternoon by Mr O'Brien.

The evidence that you will hear this afternoon concerns the mandatory reporting requirements pursuant to the Aged Care Act. As Peter Gray QC outlined in his opening address yesterday, this case study follows from the evidence heard by the Commission during the course of the Perth hearing regarding Mr Clarence Hausler, who was a resident of an aged care facility operated by Japara Health Care Limited in Mitcham. In the Perth hearing, the commission inquired into Japara's response to allegations of abuse by staff of Mr Hausler. It also explored whether Japara had met its obligations to report these allegations to the Department of Health.

Commissioners, the obligation to report assaults to the Department of Health arises pursuant to part 4.3 section 63-AA of the Aged Care Act. The mandatory reporting requirements apply to providers whose care recipients are receiving residential aged care. They do not apply to home care services. Subsection (2) of section 631AA provides that:

> *If an approved provider receives an allegation of, or starts to suspect on reasonable grounds, a reportable assault, then the approved provider is responsible for reporting that allegation or suspicion as soon as reasonably practicable and within 24 hours to the Department of Health.*

A reportable assault is defined in subsection (9) to include unlawful sexual contact, unreasonable use of force and an assault that constitutes an offence against the law of the Commonwealth or State or Territories. By operation of subsection (3), together with section 53 of the accountability principles, assaults committed by residents with

a diagnosed cognitive or mental impairment are not required to be reported, provided that a number of requirements that are set out in the accountability principles are met.

Pursuant to subsection (5) of 631AA, an approved provider is also obliged to take reasonable measures to require all staff members to report suspicions of reportable assaults as soon as reasonably practicable. For the purpose of the mandatory reporting provisions, staff members of approved providers are defined within subsection (9) to mean an individual who is employed, hired or retained or contracted by the approved provider. This is whether directly or through an employment or recruiting agency, to provide care or other services.

This scheme for compulsory reporting I've just described was inserted by the Aged Care Amendment Security and Protection Act 2007. In the Second Reading Speech on 8 February 2017, the Assistant Minister for Health and Aging described the purpose of the scheme for compulsory reporting as follows:

> *When the issue of physical and sexual abuse became a public issue last year, the major stakeholders within the aged care sector, namely the residents and their families, urged the introduction of a formal system of compulsory reporting as an obvious response to the issue. The government listened very carefully and consulted widely and today the bill that I am introducing establishes a requirement for approved providers to report allegations or suspicions of unlawful sexual contact, unreasonable use of force on a resident in residential aged care services.*

The department of Health's reportable assault form, which I will take you to later today, at tab 131 of the general tender bundle, states in answers to the question:

> *Why do reportable assaults have to be reported?*

It says as follows:

> *The Act specifies that it is an approved provider's responsibility to ensure care recipients live in a safe environment. Reporting reportable assaults to the department and to the police aims to ensure that any care recipients receives timely help and support and that the operational and organisational strategy is put into place to prevent the situation from occurring again.*

The Department of Health have provided the Commission with a document entitled, Compulsory Reporting Manual, which is tab 104 of the general tender bundle. This manual sets out the department's policies and processes in relation to receiving, escalating and referring compulsory reports. It states at the outset that the legislative changes introducing the requirements to make compulsory reports, along with further requirements relating to missing resident responsibilities:

…acknowledge the government's priority to provide assurance to the Australian community that providers are providing a safe environment for care recipients.

So what happens when a provider reports to the Department of Health that an alleged assault or a suspicion of an assault has occurred at that facility? What are the steps taken by the department of Health officers who receive those reports and what are the assessment criteria that they apply? What is the basis of a decision that a reportable assault does not require action by the department or, rather, that it should be escalated internally or referred to an external body such as the Aged Care Quality and Safety Commission? These are questions that will be explored this afternoon with Mr O'Brien, a manager with responsibility for assessment decisions under the compulsory reporting programme within the Department of Health.

The adequacy of the mandatory reporting scheme will be explored further during the course of this week with witnesses appearing on behalf of the Commonwealth. The examination of how the department deals with the compulsory reports it receives will be undertaken with reference to reports made by Japara in relation to three of its facilities, being Japara Bayview, Japara Bayview Gardens and Japara George Vowell. The Commission has obtained documents from the department relating to 20 reports made by Japara pursuant to section 63-AA of the Act in relation to reportable assaults at these facilities between 1 January 2016 and 1 February 2019.

The types of incidents covered by these reports include allegations of both physical and sexual abuse. The nature of the alleged physical assaults include instances of a staff member throwing a call bell at a resident, a staff member hitting a resident in the face with a water bottle, a number of incidences of staff members slapping residents on the face. One of these incidents including a circumstance where a resident was slapped when a staff member was putting large spoons of food into their mouth which was already full when the resident did not want any more food.

The nature of the alleged sexual assaults also appears serious, including an instance of staff members touching residents on the genitals. The response of the department for each of these reports was that no further action was required by the department. There was not one report where the alleged circumstance was escalated within the department or referred for further consideration by another body.

Through the evidence this afternoon, Commissioners, we seek to inquire into the question of whether the approach by the department is sufficient to ensure that providers are providing a safe environment for the people in their care. I now ask the operator to please display the Japara case study tender bundle index. Commissioners, his is consisting of 98 tabs. And I tender the bundle of documents in that index.

COMMISSIONER TRACEY: Yes, the Japara – was there an earlier tender bundle relating to Japara?

MS HUTCHINS: Yes, in the Perth hearing there was.

COMMISSIONER TRACEY: Yes. So perhaps this had better be described as the second Japara tender bundle.

MS HUTCHINS: Yes, thank you, Commissioners. Before I call Mr Peter O'Brien, would my friends like to announce their appearances.

MR BORSKY QC: Thank you, Ms Hutchins. Borsky is my name, for Japara Health Care Limited. May it please the Commissioners.

COMMISSIONER TRACEY: Yes, Mr Borsky. The second Japara tender bundle will be exhibit 8-23.

EXHIBIT #8-23 SECOND JAPARA TENDER BUNDLE

MS HUTCHINS: Thank you, Commissioners. I call Mr Peter O'Brien.

<PETER O'BRIEN, AFFIRMED [4.16 pm]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Mr O'Brien, you have not prepared a statement for the Commission in relation to this afternoon?

MR O'BRIEN: No.

MS HUTCHINS: You weren't required to do so. So the discussion today will be based upon the documents that have been produced in the Japara tender bundle and also the manuals which I understand you are familiar with.

MR O'BRIEN: Yes.

MS HUTCHINS: You are currently a compulsory reporting manager within the Department of Health?

MR O'BRIEN: Team leader.

MS HUTCHINS: A team leader.

MR O'BRIEN: Yes.

MS HUTCHINS: And is that role different to the level that would be categorised just as a manager?

MR O'BRIEN: The manager is an EL1, but it does that as part of other functions.

MS HUTCHINS: Yes. And so how many compulsory reporting managers are there within the team?

MR O'BRIEN: There's only one compulsory reporting manager. There's a team leader, myself, and then there's a number of staff under that.

MS HUTCHINS: Yes. And are you – is that the structure that applies across all of the different locations that people undertaking your role within the department do?

MR O'BRIEN: Compulsory reporting has been centralised in Hobart for a number of years, for the whole country.

MS HUTCHINS: So the whole team is based in Hobart?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And how long have you been in your current role for?

MR O'BRIEN: About 17 months.

MS HUTCHINS: When you began in your role as a team leader, was that your first role in relation to the compulsory reporting?

MR O'BRIEN: It was.

MS HUTCHINS: Had you previously been elsewhere within the Department of Health?

MR O'BRIEN: No.

MS HUTCHINS: What was your background before this role?

MR O'BRIEN: I worked for the public service in education and employment, social services for about 30-odd years, then I worked as a contractor for about 18 months and then I joined the Department of Health.

MS HUTCHINS: Thank you. And in your role as team leader, what are the types of tasks that you're responsible for?

MR O'BRIEN: Generally, staff management, assessing reports as they come in, approving or recommending compulsory reports that have been submitted by my

team, coordination of contact with other teams, other parts of the department, other agencies, and general follow-up with service providers.

MS HUTCHINS: Sorry. Did you say previously that there's only one team manager?

MR O'BRIEN: Yes, I've got a manager who's an EL1.

MS HUTCHINS: Yes. And so all reportable – all of the assessment reports would now be approved by that one manager?

MR O'BRIEN: No, the assessment reports are approved by me.

MS HUTCHINS: Yes, so they are all approved by you now?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. So we can see throughout the Japara documents, which we'll go to shortly, that there's a number of different managers, say, that sign off on the reports that are done by the assessors.

MR O'BRIEN: Yes.

MS HUTCHINS: Is that no longer the case where now they are fed more centrally through one - - -

MR O'BRIEN: Yes, they were done before 2017 – July 2017, they were done at a State level, so there would have been a different person in each State.

MS HUTCHINS: Yes. And so from that time, it's become more centralised where rather than having different people in different locations, everyone is sitting together?

MR O'BRIEN: Yes. That's correct.

MS HUTCHINS: I understand. I'd like to ask you a few questions about the process, really, that you undertake when you are looking at the mandatory reports that you receive. Just as a matter of practicality, when a provider lodges a report with the Department of Health, can that be done electronically or also by telephone?

MR O'BRIEN: Our preference is for electronically, but they can do both.

MS HUTCHINS: So if someone calls up and makes the report on the telephone, it will be entered into the system?

MR O'BRIEN: Sometimes it would be entered into the system. It depends if they have provided enough information. Sometimes we'd request them to complete an online report and follow up with the online report.

MS HUTCHINS: Yes. And so if it's done over the telephone, would you always request a written follow-up as well or if sufficient information is provided, is that telephone call enough?

MR O'BRIEN: We wouldn't always request a written report.

MS HUTCHINS: And where the notification does come to you in writing, say through one of the provider report forms, is that something that the provider will fill out independently or is that something that department members might be able to assist with?

MR O'BRIEN: No, the provider or service provider will complete that themselves and submit that themselves.

MS HUTCHINS: Operator, please bring up tab 131 of the general tender bundle. So this here is the reportable assault report form; is that correct?

MR O'BRIEN: That's correct.

MS HUTCHINS: Does this – I might ask the operator to just give Mr O'Brien an opportunity to see each of the pages. Does this look to you like it's the most current version of the form that's being used at the moment by the department?

MR O'BRIEN: Yes, that looks like the current version.

MS HUTCHINS: Okay. Thank you. If we could please go to page 4 of the document. This page shows the type of information that the providers are required to give to the department?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And so when we go down the left-hand column, you can see that details are to be given of the provider, who they are, who's making the report.

MR O'BRIEN: Yes.

MS HUTCHINS: Are those details that are included there, is that the person that generally, if department staff have a query about a particular instance, they'll get in touch with the person that's listed in these details?

MR O'BRIEN: That's correct generally, yes.

MS HUTCHINS: Here we see the details at 8, 9 and 10 for the facility. Then we have over at 12, 13 and 14 requirements to do with the timing of the receipt - - -

MR O'BRIEN: Yes. That's correct.

MS HUTCHINS: Sorry. The provision of the report both to you and also to the police. Then when we go over the page, you see at 16, 17 and 18 details about the description of the alleged incident and provision at 18 for the alleged offender, 20 the alleged victim and also 21 and 22, questions about actions that have been taken by the providers.

MR O'BRIEN: Yes.

MS HUTCHINS: Just pausing on a couple of these requirements for what's being asked of the providers here – operator, if we could please go to question 12 first:

> *Is this report related to unreasonable use of force or assault or unlawful sexual contact?*

What do you understand "unlawful use of force" to mean for the purposes of this question?

MR O'BRIEN: Well, I suppose, some – it could be an assault or a suspicion of an assault or contact – unwanted contact in terms of sexual contact. There is broad definitions in the guide, and I'm sorry, I can't quote them, but there is some broader definitions in the compulsory reporting manual that might give a further definition, yes.

MS HUTCHINS: Yes. Thank you. Yes, I've seen those, and I can take you to those as well in due course if that might assist. Do you know, as a matter of practicality, whether there is much difference in the understanding of what unreasonable use of force is compared to, say, an assault?

MR O'BRIEN: I suppose unreasonable use of force might apply more generally to care or rough handling in terms of a staff member providing care, but any assault or unreasonable use of force is considered a reportable assault, so - - -

MS HUTCHINS: Yes. And the term you used just then "rough handling", that's an expression that the Commission has heard often.

MR O'BRIEN: Yes.

MS HUTCHINS: What do you understand that to mean?

MR O'BRIEN: Well, when care staff are providing care to residents, they do it in an inappropriate manner or way that causes some pain or distress to the resident.

MS HUTCHINS: Would rough handling, you think, fall within this idea of unreasonable use of force?

MR O'BRIEN: It can do, yes.

MS HUTCHINS: It can do. Okay. And in relation to unlawful sexual contact, what is it that you understand that to include?

MR O'BRIEN: Sexual contact or unwanted sexual contact or touching or inappropriate touching – yes – it's again, clearer definitions in the manual than what I can give here from memory but it's where permission is not granted. The other thing is where you've got people with cognitive impairments, they can't give consent, so where no consent is provided but, by the same token, residents still have a right to have a sex life if they choose to do so, so there is – it's a bit of a grey area for services.

MS HUTCHINS: Sure. When you receive a report from a provider, when you look at the description of the circumstances which is included, will you try to make an assessment whether you think it does fall into the category of an unlawful sexual contact or unreasonable use of force or assault?

MR O'BRIEN: Well, the service provider ticks that box themselves. So, generally speaking, we assume they've got it right and understand the difference between the two. Sometimes they might tick both, if there is force as well as sexual contact but that is generally filled out by the service provider.

MS HUTCHINS: Would you make an assessment about whether the contact or the circumstances described does actually reach the level of what's identified here, being an unreasonable use of force or assault, or is it just taken at face value that, if it's been reported, it's going to be treated?

MR O'BRIEN: Yes. It's generally taken at its face value. If they've reported – decided to report it, we'll take it on – treat it on its merits.

MS HUTCHINS: Yes. And moving to the next question, which is 13:

> *Provide the date and time the allegation or suspicion was made known to the person responsible for reporting the assaults.*

MR O'BRIEN: Yes.

MS HUTCHINS: And then number 14 which relates to reporting the assaults to the police. Why is this important?

MR O'BRIEN: Providers have an obligation to report reportable assaults and sexual assaults to the department within 24 hours of once the key personnel or authorised officer becomes aware of the incident, and also within 24 hours to the police.

MS HUTCHINS: Yes. And so in relation to, say, the key personnel becoming aware of the incident, if, say, a nurse on the floor became aware of an incident, does the obligation – the time obligation start then or does it start when, say, they report that to a manager?

MR O'BRIEN: A nurse is probably considered one of the key personnel under the definition of the Act, under section 8 of the Act, so we would consider when the nurse was informed that the 24 hours would start then.

MS HUTCHINS: Yes. And, say, if it was a kitchen worker?

MR O'BRIEN: Not necessarily in that case.

MS HUTCHINS: Yes.

MR O'BRIEN: But it depends when they advised the nurse or facility manager or somebody else, that's when the 24-hour timeframe would start. But all staff in an aged care service facility are supposed to understand that they are supposed to report reportable assaults and sexual contact.

MS HUTCHINS: Yes. And the provider has obligations in that regard?

MR O'BRIEN: Yes, to train their staff.

MS HUTCHINS: Yes. And so if you saw an instance where, say, there was a bit of a lag, say, a week between a staff member knowing – say, a kitchen hand – and the report being made, as part of the inquiries would you be making inquiries about whether the provider is taking adequate steps to encourage their staff members to be reporting any kind of reportable assaults to the responsible people?

MR O'BRIEN: Yes, we might ask the provider why the report was so late after the alleged incident and, depending on their response, that might gauge how we respond.

MS HUTCHINS: Yes. And then if we move to question 17, which is on the next page, Operator. It says:

Provide a description of the alleged incident.

Sorry – at question 16:

Provide a description of the alleged incident.

What type of level of detail are you looking for in the descriptions that are provided?

MR O'BRIEN: Well, when, I suppose, exactly what has happened, if somebody has – the allegation that somebody has hit somebody or allegation that somebody has

pushed somebody or touched them inappropriately, whatever the nature of the actual assault is or unlawful sexual contact.

MS HUTCHINS: Yes. And would you request – or expect the details of, say, who the alleged perpetrator is and who the alleged resident is in terms of their names?

MR O'BRIEN: Yes. They're questions further down.

MS HUTCHINS: Yes. And, also, do you expect to receive information about how it is that the alleged assault or unlawful conduct came to the attention of the provider?

MR O'BRIEN: Generally they include that but, yes, that's quite often part of their statement. And that does help us in processing. It might be that – and if it's not included, we might do a follow-up question on that, how did they became aware of it. But, generally, the services include that information.

MS HUTCHINS: Yes. And, in relation to question 17:

> *Is the alleged offender a staff member, another care recipient or unknown/other.*

MR O'BRIEN: Yes.

MS HUTCHINS: Why is that a relevant consideration?

MR O'BRIEN: Well, it helps us look at the history, gives us more details on the service's reporting history. We only introduced that late last year, the staff members and the names of the residents and staff members – or alleged offenders and alleged victims, because it helps us build up, if there is repeat offences involving the same alleged aggressors or alleged victims. So it gives us a bit more information about the service and what's happening at that service. But it does help us – sometimes it's a visitor, a family member, but, also, it just helps us quantify the level of assault, the number of assaults committed by whom.

MS HUTCHINS: Yes. When last year was that introduced, do you recall?

MR O'BRIEN: I'm not going to be able to give you a definite date, but it was October/November. And some of the services don't – we use an old report when they submit their reports, so they – and we still get the old reports today. So even though the new report might have been available on the system, on the website, from October last year, or November last year, even today we're still getting the old reports.

MS HUTCHINS: And by "old reports" you're referring to - - -

MR O'BRIEN: Previous version. Yes. Previous versions.

MS HUTCHINS: - - - a previous version of the template?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. Okay. And so, in terms of the requirements to name the alleged offender, what are you doing with that information?

MR O'BRIEN: We don't record it anywhere. It's just in the report. But if we do do a referral to the Australian Safety and Quality Commission, we would include the name of the alleged offender, if appropriate, and the alleged victim.

MS HUTCHINS: Yes.

MR O'BRIEN: They have requested that on a regular basis, so it's part of – one of the reasons why we introduced that was to meet their needs.

MS HUTCHINS: Okay. There's nothing, say, as part of your internal processes where, say, you're faced with a report that has got a particular person's name, inquiries don't extend to, say, looking in a database and seeing if that person has come up a number of times before?

MR O'BRIEN: We would only be able to look at that particular service's history if they were, say, an employee or resident of that service that had previous reports for that service, but, in terms of if they were another service or whatever, we wouldn't be able to determine if they were on the system at all.

MS HUTCHINS: Yes. I see. So, just to be clear, say if there was a particular person who was an alleged offender and they had worked at several different facilities, if you wanted to see whether that person had been – that alleged offender had been the subject of a report previously, you would be able to go in the system and look that up?

MR O'BRIEN: No, only if they stayed at the same service.

MS HUTCHINS: Yes. So if you went to look it up and you would be able to check against the provider that they're currently working with?

MR O'BRIEN: Yes.

MS HUTCHINS: But not several others?

MR O'BRIEN: No. That's right.

MS HUTCHINS: Yes.

MR O'BRIEN: Yes.

MS HUTCHINS: And, as a matter of course, when you receive a reportable assault report, would you go into the system and check whether the person has previously been the subject of reports at that provider?

MR O'BRIEN: My staff will – depending on the actual case – and it's part of our assessment process an initial assessment is completed – they wouldn't necessarily look at the reporting history of the service. But if a more detailed assessment is warranted, then they will look at the reporting history of the service.

MS HUTCHINS: Okay. And, Operator, if we please go to 21. Here we see a requirement that the provider tell you what action has been taken to ensure the health, safety and wellbeing of those care recipients involved in the reportable assault and/or other care recipients at the service. And then the next question down, 22, asks the provider to explain:

> *What action has been taken to manage or minimise the risk of the circumstances relating to this reportable assault occurring again?*

Now, I understand from the compulsory reporting manual which we've referred to a couple of times already, that there's quite a bit of guidance given in relation to this. Operator, if you could bring up tab 104 of the general tender bundle. This here is a copy of the reporting manual. Is this the document as you recognise it?

MR O'BRIEN: Yes.

MS HUTCHINS: If we go to page 2 here, you can see that this is a document released 23 August 2017 and this version, 6 December 2018. Is this the most recent copy of this manual?

MR O'BRIEN: As far as I know, yes.

MS HUTCHINS: Yes. And so – and you're familiar with this document, I take it?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And so if we go to page 17 please, Operator. This provides some detail about the reportable assault form.

MR O'BRIEN: Yes.

MS HUTCHINS: If you please pull out the first paragraph and bullet points under that heading, Operator, you will see here it says:

> *When assessing a reportable assault, the compulsory reporting officer needs to consider the actions taken by the provider to ensure the health, safety and wellbeing of the care recipients. These actions may include –*

And then we see there there's a list of the types of factors that might be considered as part of your assessment. Are there any other types of considerations that you usually take into account that aren't included on this list?

MR O'BRIEN: Well, it depends on the nature of the allegation. So at the top it said "these actions may include". So we don't necessarily – we don't provide advice to a service on what actions they should take, but if we believe they've taken some steps to ensure the health and safety of residents, including some of the steps that are there, but I would have seen – we would see more than that's on that list.

MS HUTCHINS: And say, for example, if you receive a report from a provider which has only got one of these things listed - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - would you write to the provider and say, you know, "What are you doing in relation to X, Y, Z?", say?

MR O'BRIEN: Possibly, depending what the incident was.

MS HUTCHINS: Yes. And so you said you don't give advice on what types of steps they should be taking.

MR O'BRIEN: No.

MS HUTCHINS: Why is that the position that's taken?

MR O'BRIEN: Because we're not trained to provide clinical advice. We're not trained in aged care services delivery. We're, I suppose, generally administrative staff, so we don't have the skillset necessarily to provide that advice.

MS HUTCHINS: Yes. And so when you receive this information and you look over the list of what the providers told you they're going to do, do you just make a bit of a judgment call about whether that looks like a sufficient amount of steps that they've taken?

MR O'BRIEN: Yes. It's mainly if they've taken steps to make sure that the resident is not potentially at further risk of – and the care and wellbeing of the resident has been taken into account. Plus, we also look at if they've met their reporting obligations and the nature of the allegation and other matters. Like, the incident could be quite nasty and they might have taken four or five steps to prevent a re-occurrence, but we might still take further action simply because of the nature of the incident.

MS HUTCHINS: Yes. Yes. And so the types of steps that are included here include things like conducting a medical assessment.

MR O'BRIEN: Yes.

MS HUTCHINS: Reviewing the residents by the GP. So these are the types of steps you're talking about to - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - see the impact on the resident - - -

MR O'BRIEN: Yes. If the resident has suffered any injuries, that sort of thing. Yes.

MS HUTCHINS: And so how does it impact your decision-making if, say, the resident has suffered a severe injury?

MR O'BRIEN: Well, if the resident has suffered a severe injury and required hospitalisation, generally that matter would be referred to the Australian Aged Care Quality and Safety Commission.

MS HUTCHINS: Yes. Yes. And then other types of actions that are listed that might be included is to review a resident's behaviour, manual handling management plan.

MR O'BRIEN: Yes. Again, depending on the nature of the assault.

MS HUTCHINS: Yes. And so would you be inquiring into the details of what the review has involved and whether there has been any updates to the plan?

MR O'BRIEN: Generally speaking, the service would provide, but as we've got down the bottom, "Care plan reviewed and/or updated", but we don't seek evidence of that.

MS HUTCHINS: Yes. Or the details of what the - - -

MR O'BRIEN: Or the details.

MS HUTCHINS: - - - update involved.

MR O'BRIEN: Not necessarily, no.

MS HUTCHINS: No. So it's sufficient just to understand that they've done the review?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And then "Placing the residents on sight monitoring charts." Is that a similar type of thing, again, where you wouldn't actually want to see the charts?

MR O'BRIEN: That's right.

MS HUTCHINS: Yes. And you don't need to know necessarily to know the details of how long that's happening for or - - -

MR O'BRIEN: No.

MS HUTCHINS: - - - what it involves. No. It's a matter of just receiving the indication from the provider that's what they're going to be doing.

MR O'BRIEN: That's right.

MS HUTCHINS: Yes. And:

> *Providing more meaningful activities for the resident and informing the resident's next of kin or guardian of the incident.*

In relation to informing residents' next of kin or the guardian, is that something that's considered to be important out of these steps?

MR O'BRIEN: Generally, we ask the service, if they haven't indicated in the report that they haven't contacted the resident's family member. It's not mandatory, but it's something that we think would be preferable if they did contact that resident's family so they're aware of the situation at the service. Because sometimes the resident involved, the victim, doesn't have – is not cognitively intact or unable to convey their feelings.

MS HUTCHINS: Yes. And so do you make any inquiries independently of the provider with the next of kin or family members of the alleged victim, you know, just to check whether, I guess, what the provider has said is in line with how they saw the situation or - - -

MR O'BRIEN: No, we make no inquiries with family members.

MS HUTCHINS: And, as far as offering and providing access to counselling or pastoral care, reassurance given to the resident by care staff, again, are these the types of indications that you would be after trying to see, but you don't necessarily need to inquire into the details of what they involve?

MR O'BRIEN: No. We believe the service. If they tell us they've done these things, we believe what they've advised us.

MS HUTCHINS: Yes. Yes.

COMMISSIONER TRACEY: For what it's worth, Mr O'Brien, when rewriting of this section next comes round, there's considerable ambiguity in these dot points about the use of the word "resident". Sometimes it's clearly referring to the victim, sometimes it's clearly referring to the assailant.

MR O'BRIEN: Yes.

COMMISSIONER TRACEY: And sometimes it's not clear.

MS HUTCHINS: Yes. And the situation that Commissioner Tracey has raised just now, is this something that may have occurred as a consequence of the fact that the facility is obliged to report assaults that might involve – or they may report assaults that involve resident-on-resident aggression?

MR O'BRIEN: Yes. Well, it does have to cover that category, yes.

MS HUTCHINS: Yes. And in relation to the next set of guidance that's given in this document, Operator, if you go to the next paragraph and the dot points underneath those – that photograph, this states that:

> *The compulsory reporting officer also needs to consider the action taken by the provider to manage or minimise the risk of circumstances relating to the reportable assault. Examples of the action that the approved provider may take, where the alleged offender is: A staff member –*

If you go over the page it says "another care recipient or a visitor". So you can see here that, depending on who the alleged offender is, different actions might be considered.

MR O'BRIEN: That's right.

MS HUTCHINS: I note, just in relation to this section of considerations, as opposed to the ones that we've just been through previously, these differ. Is that because they're aimed at achieving different goals?

MR O'BRIEN: Well, I suppose – you mean the difference between the treatment for a staff member, a care recipient and a visitor?

MS HUTCHINS: Sorry. No, I mean the difference between the first set of bullet points that I just took you to in relation to needing to consider whether the actions taken ensure the health, safety and wellbeing of the care recipient as in so the first lot of bullet points that I took you through are designed at achieving that outcome?

MR O'BRIEN: They are different, yes.

MS HUTCHINS: Yes. And then the second set of bullet points is designed to manage or minimise the risk of the circumstances relating to the reportable assault happening again; is that right?

MR O'BRIEN: I suppose you could say that generally, yes.

MS HUTCHINS: In relation to steps taken – well, in relation to what the manual gives as guidance as to what steps or actions might be appropriate in terms of a provider trying to manage or minimise the risk of circumstances relating to the reportable assault occurring again, the types of activities that are identified here at the bullet points at the bottom of page 17 is suspensions pending the results of an investigation. And so in relation to that measure, we see this often across the documents.

MR O'BRIEN: Yes.

MS HUTCHINS: Does the department concern itself with understanding what the results of an investigation are before making a determination?

MR O'BRIEN: Not always but depending on the nature of the assault and if injuries have been suffered by the resident but if – it is in our manual that we are not required to investigate an incident so we rely – it is up to the job of the police and/or the service to undertake that investigation. So we rely on them to provide us that advice if, at the time of the report, or alternatively we might follow up with an email asking for information about the outcome of any investigation undertaken by the police and/or the service.

MS HUTCHINS: Yes. And in relation to the other potential activities that are listed, are there any that are listed there that you see as being of particular importance or ones that you feel you receive greater comfort from when you see them listed?

MR O'BRIEN: Well, the direction to attend retraining in manual handling is probably not one we'd prefer. We'd prefer to see that retraining in manual handling is probably not one we'd prefer. We'd prefer to actually see that the manual handling training has occurred. Depending on when we action the report. If it was actioning it within a day of the incident, it's probably – that's fair enough but if we're actioning it a few weeks later, we might have followed up to see if any – what action they've taken and we would expect to see something like that have occurred. Staff moved to different training or staff warnings or termination of employment depending on what the nature of the event is. And the other – two care staff to always attend, those sort of things are common things that we see.

MS HUTCHINS: Okay. And when you are conducting your assessments, is the potential seriousness of the alleged assault something that's taken into consideration when determining the appropriateness of the action proposed by the provider?

MR O'BRIEN: Yes.

MS HUTCHINS: So the more serious – you would view the circumstances of an alleged assault to be kind of the more steps you would expect to see?

MR O'BRIEN: Yes, well – even if we don't see enough steps, it might determine our action in terms of making a referral to the Australian Aged Care Quality and Safety Commission.

MS HUTCHINS: Yes. And so in terms of making a referral, what are the types of circumstances where a referral will be made?

MR O'BRIEN: Generally if a resident is hospitalised, police have charged somebody or may charge somebody, coroner involvement and death, that would definitely be referred. If repeated allegations against the same alleged offender, whether it's a staff member or a resident. Low levels of reporting and late reporting. If there's a bit of a combination. If the service does one late report we probably won't do a referral but if there is a couple in a row that would probably warrant a referral. If the service hasn't reported for five or six years, that might warrant a referral. The particular incident might not but the particular late reporting history for that – or low reporting history for the service might warrant a referral. Sometimes it is just the content or the nature of the allegation or the report that would warrant a referral.

MS HUTCHINS: Yes. So in the manual at page 19, it provides some information about referrals. It commences with the heading Department's Proposed Actions. The first heading there is, "No further action". So this is what happens where the decision is made that the assessors are satisfied that the reporting requirements have been met and that the requisite satisfaction has been obtained, that the provider is meeting its obligations in terms of providing a safe environment and making sure the circumstances aren't going to arise again?

MR O'BRIEN: Yes.

MS HUTCHINS: So, in that situation, what happens with the report after that?

MR O'BRIEN: After I've assessed it and no further action, I'd send – staff would send an acknowledgement letter to the service or an acknowledgement email to the service and then that matter would notionally be closed but we can refer back to it if, like I said before, there's – if that same alleged offender was involved in another incident, we might then reference that report in a referral to the agency.

MS HUTCHINS: Yes. And so if the report was made by a provider off the back of them being notified of an alleged incident by, say, a family member or another staff member, would there be any contact with that person directly about the outcome of the investigation, or is that through the provider?

MR O'BRIEN: No, not generally. Unless – unless the staff member involved was the one who submitted the report.

MS HUTCHINS: Yes. Then we have, next heading down, refer to compliance which says:

> *Where a provider has not complied with its responsibilities under the Act by more than two days or a systemic issue has been identified the case should be discussed with an appropriate jurisdiction compliance centre.*

MR O'BRIEN: Generally, we haven't done in the 17 months that I've been in the department. We've never made a referral to compliance.

MS HUTCHINS: Okay.

MR O'BRIEN: And I don't fully understand what the policy is around that but I think the information we provide wouldn't provide enough evidence for them to go down the compliance framework so – but I'm not an expert in that area and you probably need to refer that question to somebody else in our department.

MS HUTCHINS: Okay. Thank you. Commissioners, I've just been notified that we might need to finish at 5 pm tonight; is that correct?

COMMISSIONER TRACEY: Yes.

MS HUTCHINS: I might take a further five minutes and then we can adjourn until tomorrow. With apologies, Mr O'Brien, you'll be required back.

COMMISSIONER TRACEY: No, if it needs to be done, it will be done.

MS HUTCHINS: Thank you, Commissioners. So thank you for that, Mr O'Brien. Going next to referrals to the quality agency, it says here that:

> *A referral to the quality agency may be considered where –*

and then there's a number of instances identified here when a referral may occur. The first couple of dot points relate to compliance within the 24 hour timeframe and, again, the third dot point does as well. The third one relates to where a trend of reports has been identified which suggests possible systemic issues within the service or organisation?

MR O'BRIEN: Yes.

MS HUTCHINS: What are the type of systemic issues that's referred to there?

MR O'BRIEN: Well, it could be a history of manual handling reports for a service. So there might be a large number in a row that are very similar. It could be that the service or the provider isn't providing much information and providing generic responses. It could be that the service has a history of late reporting and has a variety

of different reasons and there seems to be a systemic issue that they are not meeting their reporting timeframes.

MS HUTCHINS: Yes. And so in terms of identification of systemic issues, when an assessor first picks up the report file to assess it, will they go and do some searches of the computers to ascertain whether there have been a number of recent reports or how does that feed into their - - -

MR O'BRIEN: Not necessarily, no.

MS HUTCHINS: How would they be aware of systemic issues?

MR O'BRIEN: Generally if they're doing a detailed assessment, they would look at the service history. Sometimes staff notice reports from a particular provider have similar issues and that then might trigger a further line of inquiry but due to staffing resources, it is limited, the amount of inquiries we can do about provider systemic issues.

MS HUTCHINS: Certainly. The next bullet point is:

> *If the issues in the report are severe and particularly concerning, for example, the report outlined a real or potential harm to care recipients.*

What are the type of reports that you might receive that would strike you as falling into this category of severe and particularly concerning?

MR O'BRIEN: If there's repeated sexual assaults of a resident at a service by the same resident and – or staff member, but if nothing seems to be done, so there's ongoing care – the care and wellbeing or the psychological health of the residents at the service - - -

MS HUTCHINS: When you say "a number of", how many is it that you really start to feel there is a problem? Two or three or four or - - -

MR O'BRIEN: It depends on the timeframe and over what period but with all sexual assaults in the last six months, we look at the history. That's one area where we will look at the history of a service and look at any, if there's been any similar allegations or similar incidents so we go back over the service's reporting history.

MS HUTCHINS: Yes. And before the most recent six months of undertaking that back checking, that wasn't standard practice?

MR O'BRIEN: No.

MS HUTCHINS: In terms of physical assaults, could you just give us some examples of the types of things that might - - -

MR O'BRIEN: Where somebody – a resident has been assaulted and they have to go to hospital for treatment for their injuries, that's always pretty concerning and that's – or it generally results in a referral to the Australian Aged Care Quality and Safety Commission.

MS HUTCHINS: Yes. And so, say for example, if a resident was punched in the face but they didn't need to go to the hospital, would that meet this type of requirement?

MR O'BRIEN: Possibly. It could be considered but not necessarily.

MS HUTCHINS: Okay.

MR O'BRIEN: Hospitalisation is probably a threshold but that's not the only reason we still might look at a referral in the instance you describe.

MS HUTCHINS: Yes. Okay. So hospitalisation is really the kind of common threshold of what's considered - - -

MR O'BRIEN: Yes. Residents who haven't been hospitalised, the incident still may have been referred to the Australian Aged Care Quality and Safety Commission.

MS HUTCHINS: Okay. Thank you. And finally, and just in relation to referrals, there might be referrals to the Aged Care Complaints Commissioner which, operator, is on page 20. And it says here:

> *A referral to the complaints commissioner would likely be in regard to issues that the department considers more appropriate for the complaints commissioner to address and resolve for individual care recipients through its resolution process. This may include where concerns are held about the provider's response to the individual.*

What do you understand this to mean here "the provider's response to the individual"?

MR O'BRIEN: To the individual complainant. We've only done one in the 17 months that I've been there - - -

MS HUTCHINS: What were the circumstances of that?

MR O'BRIEN: I'm not fully across that one off the top of my head because we've done 900 referrals this year, so I can't remember them all unfortunately

MS HUTCHINS: No. So if – are you able to think of a hypothetical example of what type of response by a provider might cause you to think, "This is something we may need to consider referring to the Aged Care Complaints Commissioner?"

MR O'BRIEN: No, I'd have to take that on – I wouldn't be able to answer that off the top of my head.

MS HUTCHINS: Okay. No, that's fine. Commissioners, if that's a convenient time, we can stop there for today. May I suggest a 9.30 commencement for tomorrow morning?

COMMISSIONER TRACEY: Am I right in assuming that Mr O'Brien will be required in the morning?

MS HUTCHINS: That is so, Commissioner.

COMMISSIONER TRACEY: Yes. Well, that's all right. It's just that I won't excuse him from further attendance. Mr O'Brien, I think, if you haven't already got one, will need to find a bed in Brisbane tonight.

MR O'BRIEN: I've got one for the night.

COMMISSIONER TRACEY: If you could be here in the morning, please, at 25 past 9 ready to resume your evidence.

MR O'BRIEN: Yes.

COMMISSIONER TRACEY: Very well. The Commission will adjourn until 9.30 am.

<THE WITNESS WITHDREW [4.59 pm]

MATTER ADJOURNED at 4.59 pm UNTIL WEDNESDAY, 7 AUGUST 2019

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