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

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

BRISBANE

9.34 AM, WEDNESDAY, 7 AUGUST 2019

Continued from 6.8.19

DAY 44

MR P. GRAY QC, counsel assisting, appears with MR P. BOLSTER and MS B. HUTCHINS
MR G. KENNETT SC appears with MR J. ARNOTT for the Commonwealth of Australia
MR M. BORSKY QC appears for Japara Healthcare Limited

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Commissioners, I call the first witness for today, Ms Gwenda Darling.

COMMISSIONER TRACEY: Very well.

<GWENDA NOELENE DARLING, SWORN [9.34 am]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Ms Darling, you've prepared a statement for the commission?

MS DARLING: Yes.

MS HUTCHINS: Yes. And do you have a copy of that statement before you?

MS DARLING: Yes.

MS HUTCHINS: Have you had the opportunity to read over it before today?

MS DARLING: Yes.

MS HUTCHINS: And are its contents true and correct to the best of your knowledge and belief?

MS DARLING: Yes.

MS HUTCHINS: Thank you. Commissioners, for the transcript, that statement is WIT.0329.0001.0001 dated 26 July 2019. I tender that statement.

COMMISSIONER TRACEY: Yes. The witness statement of Gwenda Noelene Darling dated 26 July 2019 will be exhibit 8-23.

EXHIBIT #8-24 WITNESS STATEMENT OF GWENDA NOELENE DARLING DATED 26/07/2019 (WIT.0329.0001.0001)

MS HUTCHINS: Ms Darling, could you please read for the Commission from your statement commencing at paragraph 4.

MS DARLING: Yes.

MS HUTCHINS: Thank you.

MS DARLING:

My full name is Gwenda Noelene Darling. I'm 66 years old and I'm an Aboriginal woman and I live in [REDACTED], NSW. I've worked in a range of government roles, across areas including child protection, housing, juvenile justice, mental health and with Centrelink and the Department of Family and Community Services. I have primarily worked with the Aboriginal community in an advocacy context in these roles. In March 2015, I was diagnosed with behavioural variant frontotemporal dementia. I also have temporal lobe epilepsy which exacerbates the effects of the dementia. I have several other comorbidities both internally and externally, including inability to use my hands and restricted movement in my shoulder and elbow. I am awaiting further surgeries.

I was first approved to receive a home care package in January 2017 after having an ACAT assessment. From the outset, I was approved to receive a level 4 package and I'm still waiting to receive my level 4 package. It's 930 days. About 10 days after I was approved for a home care package and because there were no level 4 packages, I started on a level 2 package. In February 2017, I was able to move to a level 3 package, which is what I still receive today. The services that I currently receive are daily personal care and necessary hygiene, housekeeping, meal preparation, transport to medical appointments, cleaning and garden maintenance. I receive 14 hours of personal care per fortnight and around three hours of cleaning.

The funds in my level 3 package don't allow me to do some things like necessary home maintenance while maintaining the personal care hours I need. For example, I cannot use my front door. I don't have sufficient funds in my package to get an appropriate ramp installed. I'd also like to be able to increase my daily personal care and hygiene assistance to twice daily if possible. I do not have funds to allow me to attend local social events or outings like trips to the library. When I contacted My Aged Care in early July 2019, I was told it's been over 900 days that I've been waiting for my level 4 package. I had an ACAT reassessment over the phone about 15 months ago and I was assessed as a high priority for a level 4 package. I have been on the high priority list since then and I was told by My Aged Care in July 2019 that they estimate it will be a further three to six months before I receive a level 4 package.

I've had five different providers of my home care package since January 2017. I have chosen to change providers numerous times due to concerns about poor services and management of my package funds. My first home care provider I started receiving a level 2 home care package from my first provider in 2017. The provider is run by a church and when I started with them under the old home care system, you couldn't choose your own provider or change provider.

The first complaint I had was about the first provider was overt racism. I was called a "boong" on a couple of occasions by the care worker who had come to my house. I initially complained to the provider. I spoke to the local management and also to higher management. I sent a written complaint to the home care provider via email.

However, I felt that I was basically dismissed. The person who managed the care worker told me that I had to raise it with the care worker myself. I spoke to the care worker about it when she next came to my house and when I told her that, "When you called me a "boong", I found that really offensive". She said, "Oh, I always call you lot that". I thought the whole thing was totally unacceptable and I told her that. I made an audio recording of that conversation with the care worker on my telephone and I advised the provider that I had recorded it. I felt really strongly about the way I had been spoken to and I wanted to pursue the issue further. To me, calling a person a "boong" is one of the most offensive things you can say to an Aboriginal person.

I contacted the National Aged Care Advocacy Program. The man I spoke to said, "This is too big for us, we can't do anything, you have to go to Aged Care Complaints." I hadn't heard of the Aged Care Complaints Commission before then. As a result, I contacted the Aged Care Complaints Commission. The first time I contacted them by telephone I was really angry about the racist comment at that time. The woman that I spoke to said she couldn't talk to me when I was that angry and she hung up. I called the Aged Care Complaints Commission again at another time and the woman I spoke to said they didn't have any record of my previous call. I asked whether I could speak to an Aboriginal person because I thought they might understand how I felt. The woman I spoke to said they didn't have any Aboriginal people who I could speak with.

I explained my comment about the racist comment. She asked me whether I had contacted the provider and I said I had, I had complained to management, but they hadn't done anything. She then asked me whether I had any proof of the care worker making the comment. I told her about the recording on my mobile phone of the conversation with my care worker and she told me it was illegal to record the conversation in my own home. She said that I needed to take it up with the provider and the ACCC couldn't do anything. In the interaction with the woman at the ACCC, I didn't feel like there was any compassion for me or concern about my experience. I felt like the woman I spoke to had a script to read off and there was no personalisation. The woman didn't offer me any options about what I could do if the provider didn't give a satisfactory response.

As far as I'm aware, the ACCC didn't contact the provider about my complaint. I decided to pursue it further with the provider and I went to the church that operated the provider. The church operated a nursing home as well and I spoke to the chaplain who worked there. He told me that the comment was unacceptable "but there is nothing I can do, I'm just the chaplain". I had been

a member of that church for 45 years at that stage and I just felt that nobody cared. I contacted the management of the provider again. I did eventually receive a letter from the manager which contained a general apology that I was not happy with the service that I'd received. It didn't acknowledge the details of what happened at all and by the time I received that letter, I'd already changed providers.

I went to a meeting with my local federal member of Parliament and had a face-to-face meeting. I got a standard letter saying that they were looking into it, but I never heard anything further. In February 2017, the system changed, and it was possible for me to change providers. I gave notice of my intention to change provider and informed them I wanted to commence with a new provider on 7 March 2017. However, instead of moving my package to a new provider, my first provider cancelled my services completely on 25 February 2017. This meant that I was not eligible for services under the new system and it left me without any services relating to food, personal care and home cleaning. I was in the midst of surgeries at the time and was advised that I had to get another ACAT assessment completed and spend time on the waiting list before services recommenced.

Fortunately, My Aged Care were very helpful in sorting it out and a reassessment was not necessary. I started receiving home care services from my second provider in March 2017. I was only with that provider for about three weeks. As a company, the provider was okay. However, many of the girls who came as carers weren't very good. It didn't seem like they knew how to clean properly. I felt like I was living in squalor and no one cared. It seemed to me that they didn't want to do certain tasks like vacuuming or dealing with continence issues. They were also very unreliable. Staff often didn't turn up for services like showering that I needed assistance with. Sometimes no staff would come for a couple of days which meant I that received no personal care for a couple of days.

My package was sometimes charged for services that I had not received. Part of the services I received was assistance with going places like medical appointments and shopping because I'm not allowed to drive. On one occasion, it was very hot and my care worker said in her case notes it was too hot to go out. However, the cost of taking me out was deducted from my package. I saw this on my invoice. I contacted the provider and told them that it wasn't good enough. The person I spoke to told me, "If that's what she said you did that day, you must have forgotten." I know I did not forget, as I would not have gone to the shops in 46-degree heat and I did not sign a timesheet for that service. I was unhappy with the service and the response, so I decided to change providers again.

In April 2017, I changed to my third home care provider. Initially they were very good and I liked the couple that ran the company. I was their third client. However, within 12 months, they grew to have around 120 clients and things

deteriorated. I had two periods of receiving my home care package from that provider. The first period was from April 2017 to July 2018. Sometimes the care workers who came to my house wore thongs and had dirty hands and fingernails for food preparation.

One day one of my workers said to me, "I don't know why you're able to get a package. I know older people than you who don't get packages". I thought this reflected a lack of cultural competency and understanding that Aboriginal people are eligible at a younger age, due to a difference in lifespan. I raised it with the manager, who just said, "Other people give excellent reports about her. I'm not sending her back." The manager didn't do anything in response to me raising that issue with her.

Another issue I had with my first period with that provider related to a ramp installed at my back door which I needed to enable me to leave the house. The provider arranged for a builder to install a ramp. The initial cost from my package was $3850. However, the work wasn't done properly and the ramp was dangerous. For example, parts of the handrail didn't align. My care worker, who was employed by the provider and sent daily case notes, raised with management and I sent an email requesting the builder not be paid. Despite that, the builder was paid and a further 1850 was then paid for my package for more repairs for another builder. I felt they would rather just pay out money than follow up with people for services poorly done.

I had an ongoing issue with the financial statements that the third home care provider issued to me. The statements were, in my view, almost always incorrect, sometimes in my favour and sometimes in theirs. The amounts of money recorded for my package were often way out. I requested corrections verbally and in writing multiple times. It frustrated me, because the funds in my package were government money and I felt it was unaccounted for.

I contacted the Seniors Rights Service again and asked whether an accountant could audit the accounts for me. They said it wasn't something they could assist with and that I would need to pay my own accountant. I thought that even if I did pay an accountant to do an audit, I wouldn't be payable to do anything with that information anyway, so I didn't do anything about it. After the issues with both the financial statements and the ramp, I decided to switch to a different provider.

At the end of July 2018, I started with my fourth provider. I chose this provider because a lady I knew in the area had begun with them and told me they only charge 10 per cent as fees. My primary concern with my fourth provider related to my carer. My carer did things like showering, cleaning, helping me travel to doctors appointments and with shopping. One day she told me she had no experience or qualifications in aged care, she did not have any insurance and that she was working as a subcontractor with an ABN for the provider and being paid $25 for an hour directly from my package funds.

She is a local Aboriginal woman and I encouraged her to enrol in TAFE and complete her certificate 3 in aged care. I contacted the Seniors Rights Service about that and spoke to a man who was very nice. He told me he thought I should change providers. I also contacted the constituency officer of Minister for Aged Care Ken Wyatt, as well as my local federal member of parliament. Both offices told me to ring the department in Canberra. I felt like they weren't interested.

At that point, I felt like it was useless to keep trying to complain, so I didn't pursue it any further. I thought about contacting the ACCC, but, given the response to my previous complaint about the carer, I didn't know there would be any point. As a result of my issues with the fourth provider, I went back to the third provider from early November 2018 until April 2019. Once again, I had issues with financial statements. I only received two statements in the six months that I was with them. When I did receive statements, they contained errors. The accumulated funds that had been transferred from my fourth provider weren't credited to my package funds on the statements.

In around March 2019, after not having received a statement for months, I rang the provider and told them I hadn't received any statements. The woman working in the office told me the couple who managed the business were overseas and it would be done when they came back. It's very important to me to know how much money I have available in my package and accumulated funds. At that time, I needed to pay $500 for some rails for the toilet that my occupational therapist, who I funded privately, told me that I needed. Because I hadn't received a statement, I didn't know whether I had enough funds to order the handrails.

I decided to try the ACCC again. I contacted them by telephone. The man I spoke to said that he would have to speak to somebody else about the issue and would get back to me. It took them three weeks to contact me again. And, in the three weeks between when I contacted the ACCC and heard back from them, I contacted the provider again, both in emails and verbally by phone, as had my brother and my son. By the time I heard back from the ACCC, I had received a financial statement the day before from the provider.

The funds transferred from my fourth provider were finally reflected on that statement. The man from the ACCC who called back, apologised for the delay and said that he hadn't been able to contact the provider. He asked me whether the issue had been resolved and I told him it had. I decided in April 2019 to switch to a provider where I could self-manage my package. Even in the final statement that was prepared by my third provider in order to transfer my funds to my current provider, there was a payment error for a service that I did not receive. I raised it with them, but I never received a response.

With my current provider, I self-manage my package, which allows me to choose and employ all my own workers. The fees are lower than the other

providers I have used and I'm able to find workers who charge me less than I pay if I receive the services via a provider. If I'm not happy with a worker, I can make the decision not to employ them anymore. I sign a form at the end of each service to authorise a payment so I know that my package is only being charged for services that I've receive.

The workers enter a service agreement with my provider and the provider handles the payment from my package. The workers have to carry their own insurance, so there's no money coming out on top of my care charges. I get to interview the carers and check their qualifications. I have to look for people who have a disability care qualifications or who have cert 4 or higher in aged care, as I think they're better equipped to assist me with my personal care. However, those workers often don't want to do things like cleaning. So as part of my package, I hire a separate cleaner.

My only concern about my current provider is what will happen when I need more monitoring of my health and more care management, as I can't self-manage? There are no client case notes or home assessments. That's concerning to me, because the workers do not even have an authority to call an ambulance if necessary. One of my sons has said, "We will do it". I'm writing everything down now so they know what I expect when I can't organise it myself. One of the reasons I'm doing that is, in my experience, people who work in home care don't stay in the job long and they rotate between organisations.

There are still some issues with my current provider. The statements are often delayed. For example, I didn't receive my May 2019 statement until 28 June 2019. The provider told me that was because My Aged Care hadn't provided payment information. I'm currently waiting on some rails to be installed in my bathroom by a local CHSP provider under a service agreement, which were recommended by my occupational therapist over four months ago. But, overall, I'm happy with the arrangement with the current provider. It's a much better way to go.

From my professional background, I know how complaints mechanisms work. You start at the low levels and you go up. However, it's hard to know where to go to raise issues about home care. I've always started with the provider, because they're the ones who get the money and spend the money. Some providers give you information how you can pursue complaints. I believe when I started with my third provider I was given a booklet that set out options for raising complaints, including the ACCC. However, some of the providers that I've used have not provided that information.

I feel like no one cares about the waste of funds and out-of-guidelines misappropriation that I've seen in home care, because there's no one to raise those issues with. It annoys me, because it's government money, but it's also my money. The package providers get the money, which can be thousands of

dollars a month. It seems to me that home care is not supervised. No one is allocated to take care of it. Where do you complain about fees and charges? It seems to me that you take care of yourself.

I feel very strongly that there should be a fraud reporting and complaints process similar to the Centrelink fraud telephone line and online service. I like to be able to raise complaints in writing, because my thinking is clearer when I put things in writing. However, many older people like to phone in and be heard and then have it followed up in writing. So to phone in –

sorry –

So they know their complaint has been listened to. I'm aware that in residential care there is official visitor programme, but there's nothing like that for home care. After my first experience of having my service cut off by the provider after complaining, I've been a bit fearful that I could lose my package if I complain. The providers have a lot of power. I had to really fight hard to get my package reinstated. I felt hopeless and disempowered after that experience and it felt like there was no point raising issues or complaining.

I think one option would be to randomly – a random survey posted out to people receiving home care services to inquire whether people have issues. If I received a survey asking me about my current and previous providers, I would write my response down. That takes the fear away of initiating the process.

Based on my experience, I would be very reluctant to contact the ACCC again with a complaint. When I raised issues with the ACCC, it felt like they were not interested. When I contacted them, I never received any acknowledgement of my complaint, such as an email confirming my phone conversation. I did not feel any confidence that my complaint would be dealt with in any way that would get results. There was nothing done in response to my complaint about my care worker being racist towards me. The response was only to ask for proof, tell me that my recording is illegal and direct me back to the provider.

What is the point if the ACCC just tell you to go back to the provider when the problem is that the provider is doing nothing? It seems to me that if the ACCC does not act on a complaint, they just refer it to the providers to make them get their act together about the issue. When I complained about the late and incorrect statements, the delay in the ACCC being able to do anything about it meant that the issue had already been resolved as a result of my brother and my son all contacting the provider in the meantime.

For home care, it seems like there is no oversight. The ACCC doesn't provide an option for dealing with the issues that I've experienced with my home care package. In my experience, if you ring My Aged Care, you get told to go to the web site. They have their scripts and they work off their script. How many 80 year olds are internet-savvy and can go on to the website? They also tell you to

go to the Seniors Right Service or the complaints commission. I think they should be able to deal with complaints, as they're a government organisation and they are paying out the money.

The My Aged Care telephone line is the best of any government department that I've experienced. The phones are always answered quickly by an English-speaking staff member. The staff are pleasant and understanding. However, it's hard to get consistent information and sometimes you get different information from speaking to different people. On one occasion, I rang My Aged Care three times and got three different answers about changing package providers.

I think that there needs to be more options for researching home care providers. They need some kind of comparison service, particularly given that they all charge such variable rates. The lack of consistency is very confusing for me as a consumer. In my experience, some of the companies charge 48 per cent of the package's fees and others charge only 10 per cent. The fees are described differently across providers, as things like case management, administration, rostering or core components. My preference would have been to get my services from an Aboriginal organisation to have culturally appropriate workers.

However, the only Aboriginal organisation near me charges 48 per cent, like many providers, which wouldn't leave me enough funds to get appropriate care. I think it would be good to have people in a role like a guardian when someone commences with home care as a contact, an advocate for them if they experience problems with their care.

I think the home care system is broken and it seems totally unregulated. The providers are running a free-for-all system. I want to stay living in my home but without good home care and honest providers, I will not be able to stay home. Like thousands of Australians, I'll be forced into residential care defeating the whole purpose of home care, which is to allow us to remain in our own homes. As a home care client, I feel like no one cares. I'm blessed to have family who care but many don't. It's important that we get it right for the people who are vulnerable and who can't look after themselves.

Thank you.

MS HUTCHINS: Commissioners, there is no further questions for this witness following from the statement.

COMMISSIONER TRACEY: Thank you very much, Ms Darling, for recounting these experiences. It's very important for us to know what happens on the ground when someone makes a telephone call or a complaint and how it's dealt with. You've had some mixed experiences and that's been very helpful to us to know

exactly what is going on and we are grateful to you for your evidence. Thank you very much.

MS DARLING: Thank you, Commissioner.

COMMISSIONER TRACEY: Please feel free to leave the witness box at your own pace.

<THE WITNESS WITHDREW [10.02 am]

MS HUTCHINS: Commissioners, I now recall Mr Peter O'Brien.

<PETER O'BRIEN, ON FORMER AFFIRMATION [10.03 am]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

COMMISSIONER TRACEY: Mr O'Brien, you are still on your former affirmation.

MS HUTCHINS: Mr O'Brien, you will recall yesterday, towards the end of your evidence, you had been providing a description about the types of actions that might be taken by officers as outcomes of the assessment process. We had gone through actions that might include, firstly, that no further action is required; secondly, that a referral is made to the Department of Health compliance centre; thirdly, that a referral might be made to the Aged Care Quality and Safety Commission and, fourthly, that a referral might be made to the Aged Care Complaints Commissioner. Operator, if you could please pull up tab 104 of the general tender bundle and please go to page 21. Another action that might be taken in the course of the decision-making process is a decision that the particular report needs to be escalated internally; is that correct?

MR O'BRIEN: Yes.

MS HUTCHINS: And here, under paragraph 11, at the dot points – if you could please pull those out, operator – it says:

> *Compulsory reporting notification should be escalated to the compliance section central office for the purpose of briefing the department's executive and the Minister's office.*

The reference here to the central office compliance section is a reference to the team within the prudential and approved provider regulation branch; is that correct?

MR O'BRIEN: Well, I'm not 100 per cent certain of the branch arrangements but they are in our central office and it is the aged care compliance branch.

MS HUTCHINS: In the aged care compliance branch.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes, that's the name of the branch that's provided in the glossary at the front of this document.

MR O'BRIEN: Yes.

MS HUTCHINS: But it may be that the branch has a different name now, do you think?

MR O'BRIEN: Yes, things have changed in the last month or so.

MS HUTCHINS: Okay. And are you aware of the name of the branch now?

MR O'BRIEN: We still refer to it as the aged care compliance branch. We have the same email address.

MS HUTCHINS: Sure. And who is the assistant secretary responsible for that branch?

MR O'BRIEN: Anthony Speed.

MS HUTCHINS: Thank you. So, in accordance with this document, are the types of matters that might be escalated up where the issue is considered contentious or concerns are held that the health, safety or wellbeing of care recipients are at high risk?

MR O'BRIEN: Yes.

MS HUTCHINS: So what is an example of the type of circumstances where an issue might be considered contentious?

MR O'BRIEN: Where a resident might have suffered injuries – significant injuries and has been hospitalised.

MS HUTCHINS: Yes. And where police have charged an individual in relation to the incident, is it usually the course that it will be referred if there has been a police charge or is it still a matter of discretion?

MR O'BRIEN: Generally speaking, if the police have charged somebody, we would refer that.

MS HUTCHINS: Yes. And the incident may or has resulted in media attention?

MR O'BRIEN: Yes. Generally it would be if it has resulted in media attention.

MS HUTCHINS: Yes. And so if the incident in question is something that wouldn't be considered serious in the normal scheme of things, say, for example, because it didn't result in the hospitalisation of a resident, like you gave evidence about yesterday, but nevertheless the family said that they were going to go to the media about the event; is that something that would then be escalated internally?

MR O'BRIEN: Potentially. But, generally speaking, it's because of a significant issue. Depending what the issue is and if it's unusual or severe, and sometimes – very rarely we'd know necessarily if the family are going to go to the media.

MS HUTCHINS: Yes. And the final dot point refers to if the incident is severe or unusual. Is that a different consideration to what's in the first dot point which you just explained being to do with the incident – the event being severe?

MR O'BRIEN: Well, it can be. It can be an incident that's completely different, like a few months ago in Queensland, there was a resident on a bus trip and the bus was hijacked by a couple of carjackers or bus-jackers and the police pursued the bus for a while. Whilst the resident wasn't injured, it was an unusual and severe incident.

MS HUTCHINS: Yes, I see, thank you for that explanation. We will turn now to the documents that have been provided by the Department of Health in relation to a number of Japara facilities. I appreciate that these reports cover a number of files that you weren't personally involved in.

MR O'BRIEN: Yes.

MS HUTCHINS: They also span a period of time which predates the time that you've been in the department?

MR O'BRIEN: Yes.

MS HUTCHINS: So as we go through them, I will be sure to indicate which ones you have been involved in personally and which ones you haven't and it will be apparent from the timeframes whether these are reports that are relevant to the systems and procedures that have been in place since you've been part of the team. The first report that I would like to take you to is at tab 65 please, operator. So this document here shows a screen shot from the national complaints and compliance information management system; is that correct?

MR O'BRIEN: That's correct.

MS HUTCHINS: Yes. And so this is, in effect, the electronic system that you use to record all the information and steps taken regarding the receipt and assessment of a report?

MR O'BRIEN: That's correct.

MS HUTCHINS: And is there any other repository for information that's to do with the reporting system that's not captured as part of these reports that will be generated?

MR O'BRIEN: All documents are recorded or kept in NCCIMS.

MS HUTCHINS: Thank you. We can see at the top of the screen here that there is a box second from the bottom that says, "Notification type", and you can see that it includes reportable assaults?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And so would the description in the notification change whether it's a physical or a sexual assault or would it always be a reportable assault?

MR O'BRIEN: I think there is more detail in the compulsory reporting entry on the second screen.

MS HUTCHINS: Sure. And it also includes, when you look along the top of the boxes in, say, the third column of boxes, your name is indicated there as the manager?

MR O'BRIEN: Yes.

MS HUTCHINS: We've also got a couple of boxes down from that, the date that the information was received. Is that the date that the report was made by the provider to the department?

MR O'BRIEN: That's correct.

MS HUTCHINS: Yes. And the created date being 29 August 2018 – what is that date?

MR O'BRIEN: That's the date the – one of the staff members actioned and started to assess the report.

MS HUTCHINS: Yes. We can also see on this front page, in the fourth column along here receiving office, owning office, which has got Hobart Health. You said yesterday that all of the reports now go to this one office; is that correct?

MR O'BRIEN: That's correct.

MS HUTCHINS: Yes. And so in the past, we can see some that go to other offices.

MR O'BRIEN: Yes.

MS HUTCHINS: But that would no longer be the case under the current procedures. If we go down on the page on the right-hand side, you can see the name of the facility that's made the report. Here it's Japara Bayview. Then if we turn over to page 2, this screen here shows the work flow actions that have been undertaken in relation to this assessment; is that correct?

MR O'BRIEN: That's correct, yes.

MS HUTCHINS: Here we see the first entry, "Add compulsory notification issue", that's 31 August 2018; is that correct?

MR O'BRIEN: That is correct, yes.

MS HUTCHINS: So is that the date that the assessor, at first instance, is assessing the report?

MR O'BRIEN: Well, when the report would have initially been received, initial assessment – risk assessment of the report would have been undertaken and if the report was considered high risk, if a resident had been hospitalised, somebody had been charged or it was a severe or unusual incident, that would have been actioned more timely but an incident like this wasn't assessed at that level. With – could you narrow the screen focus – just to go to the health screen again.

MS HUTCHINS: Yes, so to pull out the – sorry.

MR O'BRIEN: You've got – where you've got due date 31 August, it's got completed date along.

MS HUTCHINS: I see, yes. If we look at the completed date please, operator – actually, no, sorry, keep it in the view that it's currently in so we can see what the dates relate to. So we've got "Add the compulsory notification issues", so this is the time when the assessor starts looking at the report; is that correct?

MR O'BRIEN: Yes. So it was done on 29 August and the due date to complete it is 31 August. They've got a couple of days, I suppose, to complete the initial step.

MS HUTCHINS: Yes. And so you can see they've done the assessment on the – started it on the 29th and it's finished on the 30th?

MR O'BRIEN: They've done the notification assessment – they started on the 30th and – I think, the reading of that. If you go across, it says completed date on the 30th.

MS HUTCHINS: Okay. So this "add compulsory notification issue", which is the very top action - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - is that when they start the assessment?

MR O'BRIEN: That's when they create the record and file the basic – record the basic details of the record.

MS HUTCHINS: Okay. And then so the next entry down, "complete compulsory notification assessment" and then it says 30 August on the completed date. So that's the date that the assessor at first instance makes a decision?

MR O'BRIEN: Yes.

MS HUTCHINS: And then we see also on 30 August "manager approval of the notification assessment".

MR O'BRIEN: That's right.

MS HUTCHINS: Is that approval by you?

MR O'BRIEN: That's right.

MS HUTCHINS: Okay. Then after that we see, also on the 30th, that the scheme sent a notification acknowledge; is that a decision that's been made?

MR O'BRIEN: No further action.

MS HUTCHINS: No further action. Correct. So in instances where you approve a decision that there be no further action and then the letter sent out to the provider, is there further oversight of that decision by your manager that sits above you?

MR O'BRIEN: Not – there's not a quality assurance process in place if that's what you're trying to say but from time to time we do discuss cases and we try and reach some agreement or consensus and further understanding of policy. So, yes, some cases, if there was some concern or issue with them, would be discussed and a decision would be made. And occasionally cases are reviewed at later dates.

MS HUTCHINS: Yes. So in terms of your discussions about cases, is that somewhat of an informal kind of reporting arrangement where if there's a case that you think might be of particular interest, you will go to your manager and say, "This is one that I think is of interest"?

MR O'BRIEN: Yes. We do sit right next to each other, so we do talk every day about particular cases.

MS HUTCHINS: Yes. And so is there any, I guess, formal reporting requirements in terms of the type information that you need to give to your manager about the decisions that you're making?

MR O'BRIEN: Well, we do provide data on the number of referrals and the number of cases processed by the team.

MS HUTCHINS: Yes.

MR O'BRIEN: And there's other – and escalations and so forth.

MS HUTCHINS: Yes. And is that data something that you put together or someone else in your team puts together?

MR O'BRIEN: Someone in my team puts it together. Yes.

MS HUTCHINS: Yes. And that goes to your manager?

MR O'BRIEN: Yes.

MS HUTCHINS: And then does he need to report that to someone else – he or she, sorry.

MR O'BRIEN: Yes. She.

MS HUTCHINS: She.

MR O'BRIEN: But I send it off to Anthony Speed and to the national compliance centre.

MS HUTCHINS: Okay. Thank you. And so we can turn now, please, Operator, to tab 59. And so this here is an email from the provider that's attaching the notification, the reportable assault report.

MR O'BRIEN: Yes. That looks like the covering email, yes.

MS HUTCHINS: Yes. And then if we go to tab 60, please, Operator. So this here is a reportable assault report template.

MR O'BRIEN: Yes.

MS HUTCHINS: And this is the current template which I showed you yesterday, but this is a version that's been filled in.

MR O'BRIEN: Yes. Well - - -

MS HUTCHINS: I will give you the opportunity to look at the document, certainly.

MR O'BRIEN: Yes. I can't see the other pages to confirm it.

MS HUTCHINS: Operator, please go to page 4. And, Operator, if you could please display pages 4 and 5 at the same time. So these two pages are the details that's provided to the department in relation to the reportable assault at first instance.

MR O'BRIEN: Yes, that's correct.

MS HUTCHINS: Yes. And so we see down the left column the details of the providers. At the top it says it's making the report on behalf of the approved provider itself. Yes?

MR O'BRIEN: Yes.

MS HUTCHINS: It indicates that this report relate to an unreasonable use of force or assault at question 12. You see the date here is 16.07.2018.

MR O'BRIEN: Yes.

MS HUTCHINS: 14 – at number 14 it has got filled out that the report has been made to the police.

MR O'BRIEN: Yes.

MS HUTCHINS: And, in terms of whether the person has been arrested or charged, it says that they do not know. If we move across, Operator, please, to 16 – yes. Pull out the first question, which is "provide a brief description of the incident". The names have been redacted here, but the references to the resident at the first instance has said:

> *The resident asked another staff member, "Do you know that man that worked last night?" He pulled the blankets off me and touched me down below. I really don't like him." A staff member reported immediately to the EEN, who reported to the RN on duty. They contacted me via phone at 20.26 hours."*

So the description of this event appears to me to be a description of unlawful sexual contact.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes.

MR O'BRIEN: I agree with that.

MS HUTCHINS: Yes. And so in this instance the provider has ticked at 12 that it's unreasonable use of force or assault.

MR O'BRIEN: Yes.

MS HUTCHINS: I think you mentioned earlier in relation to the home screen that a fairly generic description is given, in any event, as to whether an event is a physical assault or sexual contact.

MR O'BRIEN: Yes. If you go back to the home screen - - -

MS HUTCHINS: Sure.

MR O'BRIEN: - - - if you go down the bottom, it does refer to a sexual assault.

MS HUTCHINS: Okay. And so – Operator, please go to tab 65 – I mean – sorry – to tab 65.

MR O'BRIEN: See, right down the bottom, it has got "key word: sexual assault". So the staff have assessed it as a sexual assault, not as a reportable assault.

MS HUTCHINS: Yes. Excellent. Okay. And so that would be important because, as you were saying yesterday, in instances of sexual assaults, department staff will make inquiries to see whether there is a pattern of sexual assaults.

MR O'BRIEN: We have since the start of this year.

MS HUTCHINS: Since the start of this year.

MR O'BRIEN: So this year. We have changed – gradually changed over the 17 months I've been in the department. We did about 30 referrals per month. And it was mainly focused on late reporting and low reporting. We're now much more focused on the care and wellbeing of the care recipients and that as a gradual change probably from late 2018. And we're now doing – last financial year we did 80 referrals per month, compared to 32 the previous financial year. So you can see that there's a lot more referrals done and much more focused on care and wellbeing of the recipients and that probably started late in 2018.

MS HUTCHINS: Late 2018.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And so the shift in focus to the care and wellbeing of residents - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - is that a shift from – what could potentially fairly be described throughout these reports, maybe, as more a focus on the strict compliance with the timing of the reports under the Act?

MR O'BRIEN: Yes. That's a - - -

MS HUTCHINS: Yes.

MR O'BRIEN: Yes. We have changed focus, yes.

MS HUTCHINS: Yes.

MR O'BRIEN: That's correct.

MS HUTCHINS: Okay. Thank you for that. And so when – if we could, please, go back to tab 60, Operator, to the pull out of question 16, the description of the assault. When you see a description like this, what's your immediate reaction in terms of whether you consider this to be a serious incident?

MR O'BRIEN: It's difficult to determine whether it's a serious incident, because the resident – well, the carer is providing some care, I suppose, in taking the blankets off them for some reason. So there may have been some touching of the resident in doing that action. So it probably wouldn't be considered high risk and it wouldn't be actioned straightaway.

MS HUTCHINS: Okay. Operator, please go to tab 61. Here we see an email from the department to the provider acknowledging the submission.

MR O'BRIEN: Yes.

MS HUTCHINS: And then we see a response from the provider saying that they have been in touch with the police and have advised that this is to be closed off with no outcome found.

MR O'BRIEN: Yes.

MS HUTCHINS: So what's the significance of a police charge? You were saying earlier that, in instances where there's a police charge, it's more likely to be escalated. Is that correct?

MR O'BRIEN: Well, depending when we find out when the police have charged the resident, if it's – or the carer, I mean. If it could be months down the track before we become aware that the police have charged somebody, so the escalation is probably not quite as, I suppose, as urgent, but a referral would probably be made on that basis.

MS HUTCHINS: Yes. And so in this instance, if there had have been a police charge against the alleged perpetrator, you would take that as an indication that this is the type of matter that should be elevated?

MR O'BRIEN: That's right.

MS HUTCHINS: Sure. And if at the time – I think you were just saying now that sometimes you don't know whether the police are going to charge the person or not at the time that the decision is being made; is that correct?

MR O'BRIEN: That's right.

MS HUTCHINS: Yes. And so if you don't know at the time, that's not something that will hold up the decision-making process?

MR O'BRIEN: No, not necessarily. We sometimes might wait, if the service indicate that they expect to hear back from the police if they're going to charge somebody in a day or two, we might hold off - - -

MS HUTCHINS: Certainly.

MR O'BRIEN: - - - a decision for a few days, but generally, no.

MS HUTCHINS: Yes. Operator, please go to tab 62. So here we see another email from the department to the provider where, if you go to the bottom of the page, please Operator, it says:

> *Thank you for your submission.*

Gives a reference number and says:

> *Can you please advise on the following. Have further actions been taken regarding this allegation? Were the care recipient's next of kin notified?*

MR O'BRIEN: Yes.

MS HUTCHINS: So of the lists that we went through yesterday of different actions that could be taken by the provider in response to an alleged assault, why is it that these are the questions you're interested to know the answers to?

MR O'BRIEN: Well, in terms of further actions, it's more regarding whether the care recipient – we assume – we treat all allegations as they may have happened, even though there's no definite proof. And what ..... says that the action has been taken to prevent the allegation or incident re-occurring, so we take – if there is insufficient information in the report, we request further information to clarify to make sure that actions have been taken to prevent reoccurrence of the incident.

MS HUTCHINS: Yes. Thank you. And so, Operator, if you please go to the email at the top of this page. This is the response from the provider where it details that the accused member was stood down from duty on full pay and posted a letter while the investigation was undertaken. The resident was assessed for injuries and nil were noted. The GP was contacted and reviewed the resident. The police were contacted.

Staff members were interviewed and witness statements were obtained. The resident's behaviour care plans were reviewed at this time.

And, following the investigation, the staff member was re-instated to his position and subsequent meetings was organised. HR advised the staff member of the allegations and the investigations and outcomes. The staff member has been required to complete additional training on elder abuse and compulsory reporting within a week, which he did. Further education on privacy and dignity was undertaken with him. The RNs were notified to monitor this staff member during his shifts to ensure that he was compliant with the education he was being given.

MR O'BRIEN: Yes.

MS HUTCHINS: So that's quite a number of steps, isn't it?

MR O'BRIEN: That is. Yes.

MS HUTCHINS: Yes. And, it also indicates that the care recipient's next of kin was notified and gives some fairly specific details about the involvement of the next of kin, the son and the daughter.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. So is that the type of level of information that you would be looking to receive from a provider when you're making your assessment?

MR O'BRIEN: We would prefer that level of detail, but sometimes we get far less than that and it's – yes – we get limited information, or no response at all.

MS HUTCHINS: Yes.

MR O'BRIEN: Or no response at all.

MS HUTCHINS: Yes. Okay. So, Operator, please go to tab 63. So this document here is a reportable assault assessment form; is that correct? And this is an internal document.

MR O'BRIEN: Yes.

MS HUTCHINS: And so this is what's used by the assessors when they're filling out, I guess, the outcomes of their assessment.

MR O'BRIEN: Yes.

MS HUTCHINS: And if you go to question 1, it asks about whether the report was made in the requisite timeframe. Two, you see here they've indicated yes. The second question is:

Has the approved provider taken appropriate action to ensure the health, safety and wellbeing of the care recipient involved in the reportable assault?

MR O'BRIEN: Yes.

MS HUTCHINS: And it has been ticked here yes.

MR O'BRIEN: Yes.

MS HUTCHINS: So then we see underneath that tick box – sorry, Operator – just the text immediately below the text box. It indicates a number of the actions that were taken as per the advice of the email from the provider.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And then number 4, you see, has ticked the box also and it says "as above"; is that correct?

MR O'BRIEN: If you bring it up.

MS HUTCHINS: Sorry, number 3. Yes. And so if you go to the text - - -

MR O'BRIEN: Yes. Yes.

MS HUTCHINS: - - - of question number 3, it says:

Has the approved provider taken appropriate action to manage the circumstances relating to this reportable assault and minimise the risk of recurrence?

MR O'BRIEN: Yes.

MS HUTCHINS: And we have got, "Yes," and it says "as above".

MR O'BRIEN: That's correct. Yes.

MS HUTCHINS: So you will recall yesterday when we went through the manual that what's given in the guidance is that there's different considerations or examples of actions by the provider that go towards the different considerations here, the different considerations being that question 2 is concerned with the health, safety and wellbeing of the care recipient involved in the reportable assault and number 3 is concerned with managing the circumstances which led to the assault; is that correct?

MR O'BRIEN: Yes.

MS HUTCHINS: So in circumstances like this where they're all lumped together, is that because the view is taken that, really, these steps apply to both considerations?

MR O'BRIEN: I think yes, that some of those outcomes could be applied to both questions. Yes.

MS HUTCHINS: Yes. And do you think there's a danger in not separating them out, that the assessor might not be sufficiently turning their mind to the question of what's being done in relation to each of these considerations?

MR O'BRIEN: There is possibly some danger, but I also know there was some problem with the forms, which is an IT issue but question 3 was – if they did complete question 3, there were some issues with it and it wrecked the whole form so they – and I couldn't read it. So question 3 was always a problem for completion. So we agreed that, while we were waiting for that issue to be fixed, that question 2 – put the details in question 2 but it is – it was a problem for us and I'd - - -

MS HUTCHINS: How long did that problem persist for?

MR O'BRIEN: Quite a few months. I wasn't aware of it but – and we didn't know what the problem was, but I couldn't read – if they changed question 3, it would then affect the visibility of the document. Some formatting issue which is beyond my expertise.

MS HUTCHINS: Yes. And I guess now reflecting on this document, do you think it might have been preferable to have perhaps had the staff members separate out which of the actions were in response to question 2 and which were in response to question 3 when they're completing these forms?

MR O'BRIEN: Some of them apply to both so I think – yes, I suppose they could complete – answer the question directly, yes.

MS HUTCHINS: Operator, please go to the next page, you'll see here it says "assessment" at the top and the boxes are ticked here that the approved provider has met all its responsibilities and has taken reasonable steps to address the issues. So that's been an assessment of questions 2 and 3. So I noticed in this particular assessment that there's no requirement of the officer to record the details of the staff member who allegedly sexually assaulted the resident; is that correct?

MR O'BRIEN: Was that provided?

MS HUTCHINS: Yes. It was provided in the description.

MR O'BRIEN: As I said yesterday, we don't record the names of the alleged aggressors or – or generally don't record the names of the alleged aggressors or victims on the screens but if we do look at a previous case, say of sexual assault, we would then look at the history and if there was previous sexual assault, we would look at the reports and see if similar names had been provided.

MS HUTCHINS: Yes. Okay. So if it's not recorded in a separate box would that require, say, if a sexual assault comes up in relation to a particular provider, that you would then need to go back, open up the original – you know, the full form - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - and then go to read the description of the assault and see whether that name has come up previously?

MR O'BRIEN: Yes.

MS HUTCHINS: So there is not, say, a central repository where you could type in someone's name and it's going to come up?

MR O'BRIEN: No.

MS HUTCHINS: Yes. Okay. I understand. I also note that there's no requirement on this form for the providers to disclose whether the staff member has been involved in any previous incidents; is that correct?

MR O'BRIEN: That's correct.

MS HUTCHINS: Yes. And then, operator, if you please go to tab 64. So the assessment has been completed by the initial officer and then it's been approved by you; that's correct in this instance?

MR O'BRIEN: That's right.

MS HUTCHINS: Yes. And so when you are approving an assessment by an officer, do you look at all of the materials available?

MR O'BRIEN: No, not necessarily. I would look at the description on the main screen. I would look at the compulsory reporting entry. Depending on the staff member, if they're a new staff member, I would look at all documents but the staff – or most of the staff were there – were employed well before myself so they have been around a while so I would check – but I would also check what response the provider has responded, like any emails in response to questions from the department. In effect, I do my own risk assessment and without reading the risk assessment from the staff member before I then look at the risk assessment.

MS HUTCHINS: Yes. Thank you. And so then this letter here is sent to the provider letting them know, in effect, that the case is closed?

MR O'BRIEN: We don't actually say it's closed because, as you said, if there was a repeated offence, this matter – this incident could be referred to the Aged Care Quality and Safety Commission. So the matter is never actually closed, it's just recorded and at this point in time we take no further action.

MS HUTCHINS: Okay. Thank you. Operator, we'll please now turn to tab 67 and go to page 4. This is a different reportable assault and is, again, one that you were the manager responsible for. Do you have any recollection of this assault in particular?

MR O'BRIEN: Not until I read it the other day because - - -

MS HUTCHINS: I appreciate you probably do a lot reports?

MR O'BRIEN: Yes. Well, there is about 7000 come in a year, so I don't often recall them.

MS HUTCHINS: 7000 how often?

MR O'BRIEN: Per – we had 7000 last financial year.

MS HUTCHINS: You had 7000 reports last financial year.

MR O'BRIEN: Yes.

MS HUTCHINS: And so now you're responsible for approving every one of those reports?

MR O'BRIEN: I don't – I haven't approved every one of them. My manager helped out when we had additional staff on to help clear the backlog. But most, I do.

MS HUTCHINS: Okay. So most of them you have.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And so, operator, if we please look at the text under question 16, the description of the incident. It says:

> *Wife reported bruising to the right eye to enrolled nurse. On investigation, right eye found to have been bruised and sclera noted to be red with broken capillaries in both eyes. When questioned –*

that's the resident –

> *he stated, "I was hit by a man in the night. I was hit in the face with a water bottle after I punched him". On questioning, the man was a staff member overnight.*

It says under 17 actions:

> *The staff member has been stood down until a full investigation can be undertaken.*

And the same response is effectively given response to question 18, that the staff member has been stood down. What's your reaction to the seriousness of this incident?

MR O'BRIEN: It's one of those cases where possibly it could have been considered high risk because of the nature of the incident and that the – there is injuries that correspond to the nature of the incident. I don't believe the resident was hospitalised, without seeing the next page but, yes, it's one of those ones where it possibly could have been escalated – not escalated but actioned in a more timely manner.

MS HUTCHINS: If it had been determined – if the decision had been made that this is a high-risk issue, who would you refer it to?

MR O'BRIEN: I would flag it for one of my staff to action straightaway.

MS HUTCHINS: What do you mean by "action"?

MR O'BRIEN: Well, they'd start the process of making an assessment of the report and contacting the provider within a couple of days.

MS HUTCHINS: Yes. And so if at the end of the assessment process you decided this is the type of matter that we should refer to someone else, who would you refer it to?

MR O'BRIEN: The Aged Care Quality and Safety Commission.

MS HUTCHINS: Aged Care Quality and Safety Commission. Thank you. And so when you read a description like this, does this give you cause to pause to consider whether there's issues within the provider, say, in terms of the culture of how they're treating the residents?

MR O'BRIEN: Yes, but we treat it as an allegation. So – and when the staff member looks at it further, they'll take further assessment and if they – if a detailed assessment is undertaken, they'll then look at the provider's history and other relevant matters.

MS HUTCHINS: Yes. So I don't wish to misquote you because I don't have the transcript reference - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - right in front of me here but I understood your evidence earlier to be something to the effect that you take the allegations as being correct, you proceed on that basis?

MR O'BRIEN: We proceed on that basis but we also proceed that they are only an allegation; they're not substantiated yet.

MS HUTCHINS: Yes. So it's bit of a difficult - - -

MR O'BRIEN: Yes. It's a bit each way but we do expect the service to treat them as if they may have happened and taken steps to prevent a reoccurrence.

MS HUTCHINS: Yes. So you treat an incident as though it may have happened.

MR O'BRIEN: Yes.

MS HUTCHINS: But you have to give a value judgment about how likely that may have been when you are determining whether to escalate?

MR O'BRIEN: Sometimes, yes, we do consider whether the reality of the situation and whether it might have occurred.

MS HUTCHINS: Yes. So operator, please go to tab 68. Here you see another example of an email to the provider requesting some further information. In response, the provider has said when the service was first notified and said that:

> *The staff member was initially suspended following the investigation with HR was dismissed from our services. The police are undertaking an investigation. However, the family did not want to press charges when they last discussed this with him.*

Does that type of response indicate to you that the assault is more likely to have happened because the provider has decided to dismiss the resident – sorry; the staff member?

MR O'BRIEN: I think there's some indication that the incident may have occurred and they've sacked the staff member as well.

MS HUTCHINS: Yes. And so, operator, please turn to tab 69. Here is the reportable assault assessment again. We see that the assessor is satisfied that the timeliness of the reporting is in order and that the approved provider has taken appropriate action to ensure the health, safety and wellbeing of the care recipient. So here it says, yes, the police were notified, the staff member was stood down and after an investigation, the staff member's employment was terminated.

MR O'BRIEN: Yes.

MS HUTCHINS: So, in circumstances like this, where someone is terminated following an event like this, do you find that that in itself is a sufficient step because they're dealing with that individual?

MR O'BRIEN: Not always. But it is in the policy guide that, if a staff member is terminated as one of their actions that the service is expected to take and considered to minimise the chance of recurrence.

MS HUTCHINS: And are there any efforts or steps taken to record that staff member's name in a register or somewhere else to flag that this person might be of concern?

MR O'BRIEN: Not that I'm aware of.

MS HUTCHINS: Sure. And if we please turn to the next page, operator. So you'll see here that there is a tick under:

> *Further information and/or detailed assessment is required to establish whether the approved provider has met its reporting requirements.*

So I understand from a response to a notice, that this was an error and that they didn't mean to tick this box?

MR O'BRIEN: No, it's down further the error occurs. Go down to the detailed assessment. Further down, page 4 or page 3 of the – page – no, page – back a page.

MS HUTCHINS: To page 3?

MR O'BRIEN: Yes. That page.

MS HUTCHINS: Sorry. I see. So this is indicating that a detailed assessment should take place?

MR O'BRIEN: Yes, this is the detailed assessment. And then under question 4, there's an error – under question 4, you've got yes/no, then you've got some words and then you've got proposed action. There is a contradictory statement there:

> *Should the information be disclosed to the Aged Care Quality and Safety Commission –*

or agency at the time. And they've ticked "yes". And down further under "proposed action", they've put "no further action".

MS HUTCHINS: Yes.

MR O'BRIEN: So that's the contradiction and that was a fault with the form.

MS HUTCHINS: Yes, I see. I see. And – sorry – after the detailed assessment, it was then determined that no further action was required.

MR O'BRIEN: That was the assessment, yes.

MS HUTCHINS: Yes.

MR O'BRIEN: It's probably one of those ones I'd look at now. And I'd probably, given that we've changed our – I suppose, our risk settings, it's probably one that I would consider probably would warrant a referral but at the time that was the appropriate risk standards for that report.

MS HUTCHINS: Yes. And I understand from your evidence earlier that this wouldn't be an example of one where you would escalate it internally because there's no media attention?

MR O'BRIEN: Well, the resident didn't have severe injuries, wasn't hospitalised, I mean, they still had injuries. We weren't aware of anybody being charged so there were other contributing factors.

MS HUTCHINS: Yes. And so in circumstances like this where the provider's own investigation suggests that there's something that has occurred, because the staff member has been stood down, but the family members elected that they don't want to – sorry, the victim has elected they don't want to press charges, the consideration about the charges still remains an important consideration in your determination?

MR O'BRIEN: Yes, that would have been of consideration. Even though the charges weren't laid, it suggests from the provider's email that charges may have been laid if the family had consented to it.

MS HUTCHINS: Thank you. So, Operator, please go to tab 28. This is a report that relates to a different Japara facility, Bayview Gardens. Sorry, no it doesn't. It relates to Bayview George Vowell. So this is located in Victoria. So this is an example of an assessment that was not allocated to you.

MR O'BRIEN: It was before I joined the department.

MS HUTCHINS: Yes. Yes. Because it's dated back in 6 January 2017. And if we please go to tab 27, Operator. And please turn to – so we can see here from looking at this form that this is a different form than the one used - - -

MR O'BRIEN: That's right.

MS HUTCHINS: - - - in the previous assessments.

MR O'BRIEN: Yes..

MS HUTCHINS: And if we go to page 2, please. We can see this is the information that was required at that point in time. We see that the allegation in question is written in text in the bottom right-hand column, where it says:

Allegation that the care recipient sexually assaulted carer. Entered his room and felt a hand touch his genital area.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. And then, under 17, where it says:

What action has been taken by the approved provider to manage or minimise the risk of the reportable assault occurring again?

It says:

Contacted the employment agency. Carer has nine years experience. Carer will not return to George Vowell.

So here, again, we're not told the name of the carer, but that's something that now you would look for?

MR O'BRIEN: Well, the form requests that the information be provided now. Yes.

MS HUTCHINS: Yes. And, under – for question 16, which says:

What action has been taken to the approved provider to ensure the health, safety and wellbeing of those residents involved in the reportable assault?

It says:

Care recipient provided with reassurance. Care recipient has continence and aids that require checking and this may be the cause of the alleged incident.

Do you consider that to be an adequate explanation of the action taken by the provider to ensure the health and safety and wellbeing of residents?

MR O'BRIEN: It's a bit hard for me to comment on previous staff's reports. And I would like – I don't know if there is any other documents associated with this thing. Without seeing the other documents, it's a bit hard to comment.

MS HUTCHINS: Sure.

MR O'BRIEN: If there's other documents that - - -

MS HUTCHINS: Sure. But, just on the face of this description, if you were provided with this today, applying, I guess, the policies and procedures that apply today - - -

MR O'BRIEN: No. That wouldn't be – we would follow up with that – on that report.

MS HUTCHINS: Sure. And, as part of this process, would you ever make inquiries with the provider about the suitability of staff member?

MR O'BRIEN: Hiring and firing of staff is up to the provider. We don't tell providers who they can hire and fire. They have to comply with the Aged Care Act and make sure that their staff comply with the Aged Care Act, but they should have their own employment policies in place.

MS HUTCHINS: Yes. And would you ever make any inquiries about the type of training that's given to staff, say, in terms of the type of training that would be relevant to them undertaking their role of changing a continence aid, that, you know, if it is true that the care recipient – the incident might have arisen in these circumstances, are you then concerned to inquire about, you know, what's happening with that staff member in that facility when undertaking those types of duties?

MR O'BRIEN: No. I don't recall ever asking for staff members' training history or anything, if that's what you're after.

MS HUTCHINS: Thank you. And, Operator, please go to tab 29. So here we see question 1 – "Yes, completed"; question 2 – "Yes, no problem"; "Has the approved provider taken appropriate action? Yes". Then we see – we see, under these tick boxes, unlike the forms that you have been involved in recently, that there's no information provided about the responses given by the providers. Presumably, this is just done with reference to the assessment report.

MR O'BRIEN: And other documents, yes, if there is any other documents.

MS HUTCHINS: If there's any other documents - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - it would be to reference to those either. Well, I can tell you, from what we've been provided by the department, there are no other documents in relation to this assessment. Would you find that surprising, that there's no follow up?

MR O'BRIEN: I don't know the policies and procedures at this time - - -

MS HUTCHINS: Yes.

MR O'BRIEN: - - - and so it's a bit hard for me to comment.

MS HUTCHINS: Yes, but under current policy you would have expected - - -

MR O'BRIEN: It would be different now - - -

MS HUTCHINS: Yes.

MR O'BRIEN: - - - but I don't know what the policies and procedures were at that time.

MS HUTCHINS: Yes. Okay. Thank you. And then we see on the next page that the assessment is that the approved provider has met its responsibilities and has taken reasonable steps. Another reportable assault which we've been provided details with is at tab 34, please, Operator. This is another example of a report that you weren't involved in personally. It involves a report concerning George Vowell, again, in February 2017. So in relation to this form we note down the bottom on the right-hand column, it says "police station reported to". It says who the police station is. I note here that there's no number given of an incident report. And I've seen that across a number of - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - the reports. Is a police incident notification number something that you would require?

MR O'BRIEN: No, because police don't always provide it to a service.

MS HUTCHINS: Yes. And so you just, I guess, take it as given when the provider says that they've reported it to the police - - -

MR O'BRIEN: They've contacted the police.

MS HUTCHINS: - - - you accept that - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - without conducting independent inquiries?

MR O'BRIEN: That's right.

MS HUTCHINS: Yes. And if we please go to page 2, Operator, we can see the description of the alleged offence is that the care recipient alleged that they had been slapped in the face by a carer. It strikes me that this is quite a brief description of the incident. Do you think more information would have been relevant for you to be able to make a proper assessment?

MR O'BRIEN: Well, if you apply our policies – today's policies, yes, but, like I said before, it's a previous report that I don't know what the policies and procedures were at that time.

MS HUTCHINS: Sure. And the response to question 17, which asks:

> *What actions have been taken by the approved provider to manage or minimise the risk?*

The response is:

> *Unlikely to have occurred, due to cognitive impairment, confusion suffered in care recipient.*

Then it says:

> *The Service has initiated staff management process.*

What would you understand that this initiated staff management process means?

MR O'BRIEN: Not really certain, because, again, it's before my time.

MS HUTCHINS: Yes.

MR O'BRIEN: So bit hard to comment on stuff - - -

MS HUTCHINS: Okay.

MR O'BRIEN: - - - that's a couple of years old.

MS HUTCHINS: And then we go down and it says a number of other steps that have been taken, including that the incident allegedly occurred when two staff were with – assisting with ADL showering. The alleged offender denies allegation and other staff member substantiates that no assault occurred. "No previous concerns regarding professional conduct." Then we go to the response to question 16, which is asking what action has been taken by the approved provider to ensure the health, safety and wellbeing of those residents. And it says:

> *Care recipient had no redness or any sign of injury. Confusion associated with cognitive deterioration resulting from syphilis.*

So it seems that the information provided here is directed more towards explaining to the department why the assault did not occur. Would that be a fair assessment of that information?

MR O'BRIEN: Potentially, yes - - -

MS HUTCHINS: Potentially, yes.

MR O'BRIEN: - - - but without seeing if other information is available.

MS HUTCHINS: Yes. And do you think any of that information is focused on the safety of the resident?

MR O'BRIEN: Again, it's a bit hard to comment on an old case without knowing their policies and procedures at that time.

MS HUTCHINS: And where the alleged victim is someone with a cognitive condition, is that something that's taken up when you are weighing the seriousness of an alleged assault?

MR O'BRIEN: Not necessarily, no. It shouldn't have any real bearing on – a person with a cognitive impairment - - -

MS HUTCHINS: Yes.

MR O'BRIEN: - - - has the right not to be assaulted just like any other resident.

MS HUTCHINS: Yes. And so if it is someone with a cognitive incapacity or issue, is there more of an importance to understand details such as who has reported the assault, you know, whether there was another witness there or, you know, how it is that the – the circumstances surrounding the event.

MR O'BRIEN: Once an allegation is made, if a person – it doesn't matter if a person with cognitive impairment makes the allegation once, the service should report it. So that shouldn't have any bearing on it.

MS HUTCHINS: Certainly. So please go to tab 36, Operator. This is the reportable assault assessment. Here we see down the page again that the boxes are checked approving that these steps have been taken adequately. There's no details included again. Presumably, it's by reference to this form that the assessment has been made.

MR O'BRIEN: That's right.

MS HUTCHINS: Would you agree with that? Yes. And we go over the page. And, again, it says – the boxes are ticked that the approved provider has met all of its responsibilities and taken reasonable steps.

MR O'BRIEN: That's what it says.

MS HUTCHINS: Looking at this now – and I appreciate that you weren't in your role at this time – do you have some concerns with the way that this assessment has been performed?

MR O'BRIEN: As I said before, I don't – I wouldn't like to comment on stuff I don't know the history, because I don't know their policies and procedures and what the required processes were at that time.

MS HUTCHINS: Yes. But, in terms of, I guess, the adequacy of the approach to protect the safety and welfare of residents, are there further actions that you would think should be undertaken?

MR O'BRIEN: With our current policy settings today, yes. We would do it differently. Yes.

MS HUTCHINS: Yes. And what are some important factors that you think go towards protecting the safety and wellness of residents that we don't see in this assessment?

MR O'BRIEN: Potentially, they could have relocated the staff member. Potentially, they could have provided training and taken a more detailed investigation, but, without knowing the whole circumstances, it's hard to comment on.

MS HUTCHINS: Certainly. It is hard to know the whole circumstances - - -

MR O'BRIEN: Yes. So - - -

MS HUTCHINS: - - - off the face of that form.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. Okay. Thank you. Operator, please go to tab 41. Again, this is another reportable assault assessment which you were not involved in, again at George Vowell. The alleged description – sorry – the description of the alleged incident under question 16 on page 5, thank you, Operator, is that on 23.10.2017:

> *Agency staff member worked with another staff member. A resident became agitated during personal care and attempted to hit staff member multiple times. In response, the personal care worker slapped the resident back on the hand or the wrist. No injury was observed. The agency carer reported this incident to the manager and then that was, in turn, reported to the facility.*

So I think, based on your previous evidence, this would, again, be seen as an incident that's not that serious.

MR O'BRIEN: Yes. I would say not serious because they've indicated there's nil injuries observed.

MS HUTCHINS: Yes. Yes. And so, I think, as you've previously said, in instances where there's no injuries, the incident in question is unlikely to be seen as serious.

MR O'BRIEN: Initially, yes, that's right.

MS HUTCHINS: So when you read a report like this, is it of any relevance to you that it's an agency staff member that made the report?

MR O'BRIEN: No, not really, no. It doesn't matter who the allegation comes from.

MS HUTCHINS: Yes.

MR O'BRIEN: If the allegation comes from a family or another staff member, we just treat it as an allegation.

MS HUTCHINS: Yes. And if we go to tab 44, please, Operator. Here we see an email requesting further information. So here what's sought is whether there was notification to the GP, representatives, whether the recipient's care plan was reviewed or updated, whether there's additional updates from the investigation.

MR O'BRIEN: Yep.

MS HUTCHINS: And, in response, the provider has said there has been an examination and nil injury was found, so it was unnecessary to notify the doctor. So this is an examination by an internal staff member?

MR O'BRIEN: I think it reads the clinical care coordinator, yes.

MS HUTCHINS: Yes. Yes.

MR O'BRIEN: Yes.

MS HUTCHINS: So they've been given the okay by an internal staff member and it says:

> *However, should be noted that the resident fractured his hip a few weeks prior to the incident and possibly became agitated due to pain and frustration at now being able to mobilise.*

Is that relevant information to you when performing your assessment?

MR O'BRIEN: Well, depending – the service have provided that as part of their explanation for the incident, so we would look at that and consider that.

MS HUTCHINS: Yes. and it says:

> *Resident has a severe cognitive impairment and diagnosis of dementia.*

It says the behaviour care was reviewed on 26.10.2017 by the care coordinator. I understand from your evidence yesterday that the department is not concerned, as part of its inquiries, to understand what the scope of the current care plan is.

MR O'BRIEN: That's right. And we don't ask - - -

MS HUTCHINS: Is that correct? And what the nature of the assessment was.

MR O'BRIEN: No.

MS HUTCHINS: Yes. And so there was a meeting held and advised that the department is going to be advised of the outcome of the meeting that's going to happen the subsequent day. If we go to page 42 – tab 42 please, Operator. So this is the behaviour care plan which the provider has given to the department, even though this isn't something that the department was necessarily wanting to see.

MR O'BRIEN: No. Sometimes services do provide it, but we don't request it generally.

MS HUTCHINS: Yes. And so if you go to the second page of this document, please, Operator, you see down the bottom, it says 26th of the 10th:

> *Care plan reviewed post refusal of care with physical aggression. Nil changes to care plan.*

So, essentially, the provider advice, if it had been followed through, that they were updating the care plan, is really just them looking at the care plan saying, "No update necessary." And that's, I guess, the entirety of what this process is involved in this instance. Is that a fair description, do you think?

MR O'BRIEN: It reads that way, yes.

MS HUTCHINS: Yes. So if you go to tab 45, please, Operator. So here we see the assessment that's being undertaken. We see:

> *Was the report made within 24 hours? Yes.*

We see, under 2:

> *Has the approved provider taken appropriate action?*

We've got at the very bottom of this list of actions, we've got:

> *The staff member was stood down pending investigation.*

So, despite the email that the department was going to be advised of the outcome of the investigation the following day, it has been decided that it's sufficient – this action of standing down pending investigation is sufficient and the department is not concerned to know the outcome of the investigation.

MR O'BRIEN: Well, the service ..... and the police are responsible for investigating incidents, so we don't necessarily need to know the full outcome of the incident. But, generally, if there is a long delay in processing reports, which has occurred in the past, we would be advised of the outcome of the investigation. But depending if this report was processed close to the incident, the service would still be finalising their investigation, so we wouldn't necessarily know the outcome of the investigation until after the report was assessed.

MS HUTCHINS: Yes. But in the correspondence, as I understand it, and I'm paraphrasing, they say, "We're going to have a meeting with the staff member tomorrow and we will let you know the outcome of that meeting."

MR O'BRIEN: Yes, that's what it says.

MS HUTCHINS: So if that meeting had have ended in a finding that the relevant staff member confessed to the alleged assault and was stood down, would that be something that would be relevant to the determination of how you would assess this matter?

MR O'BRIEN: Possibly, but, I mean, the main thing is the staff – as long as the service has taken action to prevent a re-occurrence and they've taken some action to prevent a reoccurrence, they've assessed the resident - - -

MS HUTCHINS: Yes.

MR O'BRIEN: ..... assessed, they've reviewed the care plan as they've said, and they've also stood the staff member down pending investigation. So if the investigation indicated that the staff member had committed the offence, I would expect them to take further disciplinary action, but that's not recorded here.

MS HUTCHINS: Yes. Yes. Thank you. Operator, please go to tab 54. Again, this relates to a report by Japara George Vowell. The description under question 16 is:

> *Reported by student on clinical placement that PY was assisting IC with his lunch and shovelling large spoons of food into his already full mouth. When he expressed he didn't want any more food, the staff member quite forcefully slapped her hands on my face. I could hear it from my distance. And said, "I give up with you". This hand-face contact also occurred at lunch on the 13th.*

The actions that are detailed – sorry – just so that I'm clear, this was a report that you were the manager for. Do you recall this one?

MR O'BRIEN: Yes, I think I was. Yes.

MS HUTCHINS: Yes. And so, at this point in time, which is 12 June 2018, this is now the seventh reportable assault from this particular facility in the preceding six months. Is this something that would have been brought to your attention at the time you were doing the assessment?

MR O'BRIEN: The initial assessment, no, it wouldn't have been. We just go purely on the report.

MS HUTCHINS: Yes.

MR O'BRIEN: When a staff member is doing an initial assessment of the report, if in doing their initial assessment they determine that a more detailed assessment is required, then they would undertake a review of the service's reporting history.

MS HUTCHINS: Yes. So when an assessor is doing the initial assessment, they don't know how many – they don't know if there has been six – sorry – they don't whether there has been seven reports by that particular facility in the last six months, say.

MR O'BRIEN: No. Well, they can look at it and they do look at it if they remember the name or recall the name or want to look further at the service's reporting history or also look to see if the alleged aggressor or alleged victim have been previously identified in a report. But it's not a matter of course, simply because of time pressures.

MS HUTCHINS: Yes. So – yes. And so, just in terms of the facility name, there is no alert or anything of that nature that would come up when an assessor starts the assessment process, the initial assessment process, that would flag, "This is a facility that has had seven reportable assaults", say, in the last six months?

MR O'BRIEN: No, it wouldn't. No.

MS HUTCHINS: No.

MR O'BRIEN: When does six months start for the seven reports?

MS HUTCHINS: So the first report was on the – so, in relation to this particular facility, the first report was on 6 January 2017.

MR O'BRIEN: Right. It was six months after - - -

MS HUTCHINS: No. Sorry. You're correct. That's not six months. So it's seven reports since 6 January 2017, between that date and the date of this report, which is 18 June 2018.

MR O'BRIEN: Isn't that 18 months?

MS HUTCHINS: Sorry. 2018. It's more like the space of, say, a year and a-half?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. So is seven reports in a year and a-half concerning to you?

MR O'BRIEN: It can be, depending on the size of the service. We do have a notional average, which is a measure of average reports per 100 places per 12 months, which is around three. So we expect, for every 100 places, around three reports every 12 months, but it's very much a rough estimate and is a guide only.

You might find that – and I don't know the size of the service, how many beds they had, so how many residents they had. But we would also look at the type of incidents, whether they were a repeat – exactly the same or similar incidents, or they were completely different and whether they were care-on-care recipients or family members or different matters, depending on what the nature of the reports were. But, depending on the size of the service and how many were of similar nature, that would be taken into account.

MS HUTCHINS: Are you aware of the size of this service?

MR O'BRIEN: Not off the top of my head, no.

MS HUTCHINS: Now. So how would you know, if you were assessing a report, whether the amount is concerning?

MR O'BRIEN: It's available in – if we click on the provider in NCCIMS, it does bring up the number of beds in that first service. So the officer only has to click on a couple of buttons.

MS HUTCHINS: Yes. Okay. But, in any event, it's not something that's considered at first instance, anyway, the number of alleged assaults at a facility when the initial assessment has been performed?

MR O'BRIEN: Not necessarily, no.

MS HUTCHINS: Thank you. If we go to tab 56, please, Operator. This is another email with a request for some further information from the department, along with a response. The questions that are asked are whether there was a medical assessment, whether there was any injury and was the care recipient's family notified. If we go to the next page, please, Operator, there's a number of other questions that are asked there about the steps that have been taken, why was the service late in reporting the alleged assault and what was the outcome of the internal investigation, what actions have been taken to minimise the potential risk of occurrence. So it seems at this point in time more information is now being sought when you are undertaking the investigations - - -

MR O'BRIEN: Well - - -

MS HUTCHINS: - - - than what we see in the previous reports?

MR O'BRIEN: Yes, but the officer concerned decided it was insufficient information and had a few questions.

MS HUTCHINS: Yes. Thank you. And, in response, we see the provider, on the first page, please, Operator, details that the HR process has been gone through. You see here that, again, there was a GP review in this instance, there was no injury of the – sorry – no evidence of injury to the resident. The family – there was a family

meeting held on the same day. The staff member was suspended to allow no further contact with the resident during the investigation. The HR process – the description given for why the service was late in reporting the alleged assault is that the information was provided at the end of a student placement and written documentation forwarded late Friday and reviewed on the Monday morning where the issue was forwarded to yourselves and the HR department. Do you think that's an acceptable explanation about why the 24-hour time period wasn't met?

MR O'BRIEN: Yes. It was a student who, from what I read from that, provided feedback on their placement. So – and it was sent on the Friday afternoon or Friday evening – late on Friday. So I suppose it didn't have reportable assault. And if the student hadn't – might not be fully aware of the reporting requirements of an aged care facility. So, under those circumstances, I think that's acceptable that the service can't be held responsible for that.

MS HUTCHINS: And, at the bottom here it says:

> *Through the HR process, the staff member was suspended. However, there was a determination made that the staff member did not behave in the manner alleged and, as such, there was no further risk of reoccurrence.*

So, in circumstance like this, you've got a student in placement that said an event occurred, has alleged an event occurred. Internal processes has decided that it did not occur.

MR O'BRIEN: Yes.

MS HUTCHINS: And that's taken at face value by the department, is it?

MR O'BRIEN: That's right. That's correct. They say the HR team investigated thoroughly and could find no evidence to substantiate the claim.

MS HUTCHINS: Yes. But no further information is provided by the provider detailing what that investigation actually involved.

MR O'BRIEN: No, that's right.

MS HUTCHINS: All right. And no independent inquiries were made, say, with the student to see what her side of the story is?

MR O'BRIEN: Well, I don't know what the HR department did exactly, so I can't determine – I can't advise that.

MS HUTCHINS: No. But, say, from the department's perspective - - -

MR O'BRIEN: No.

MS HUTCHINS: - - - you wouldn't make independent inquiries about that?

MR O'BRIEN: We deal with the service provider.

MS HUTCHINS: No. And so if we then go to tab 55, please, Operator. So you see here that section 1 is ticked as being compliant. Section 2, again, a decision that the approved provider has taken appropriate action. The information given is that it was reported by the student, that the staff member was stood down, there's no injuries, and the next of kin was notified of the assault. So that's considered to be appropriate action to ensure the health, safety and wellbeing of the care recipient in that situation?

MR O'BRIEN: Yes. That's some of the steps that are outlined in the policy documents that we would consider reasonable, yes.

MS HUTCHINS: Yes. And so here, if we go to page 2, we see, under the response to circumstances regarding the reportable assault, we see that it was:

> *…witnessed by a student on clinical placement, staff member stood down with pay pending investigation. Service provided limited responses.*

Why would that last sentence be included?

MR O'BRIEN: We do consider if a service has provided limited responses and it's a comment the staff make. And it's more of a flag that if we find another case of the service providing a limited response in a report further on, or even a provider level, we might refer that matter.

MS HUTCHINS: Yes, that makes sense. So if you've come across an instance where a service provider has given limited responses, is that then put somewhere in the system so it will create a flag or something to an assessor when they're performing their assessment so they're aware of it?

MR O'BRIEN: No, they'd have to go back and look at previous documentation.

MS HUTCHINS: Yes, I see. Finally, I'd like to turn quickly to Japara Bayview. There's a number of alleged assault reports that were made here which, again, is before your time. I'm interested to hear just your view on a couple of matters in relation to this. Operator, if you could please go to tab 2. This is an incident report form. Again, this looks like a different report form than what's currently being used?

MR O'BRIEN: Yes, it is.

MS HUTCHINS: Yes. And here we've got the description of the incident is:

> *That received had your save form written for –*

this is a resident –

by a staff member alleging that staff member was changing into her nightie. He forced her head down and neck down causing terrible pain again.

Here there's no injury noted and nil complaints of pain; is that right?

MR O'BRIEN: Yes.

MS HUTCHINS: Does that seem to you, just on the face of it, to contradict the description that there's nil complaints of pain after the injury was said to cause terrible pain?

MR O'BRIEN: Well, I suppose what they're referring to there – and it's only – this is an assumption, but that the incident, when it was occurring, when they were dressing the resident, that it caused terrible pain at the time but there was no long-term pain after the incident. But that's an assumption.

MS HUTCHINS: Yes, yes. Yes, rather than – nil ongoing pain is what that can be assumed to mean.

MR O'BRIEN: Yes, yes.

MS HUTCHINS: Yes. And then so we see in the assessment form, in relation to this incident – which is at tab 3, thank you, operator – this is a different form that appears again, to the one that is currently being used by the department. If you could please go to page 2, operator. So we see here the questions that were required of assessors at this point in time which is around January 2016. If we please go to page 3, operator, we can see here that there is a requirement to collect details of the alleged offender where these details are included here, "Was the alleged offender a member of staff?" At 9, if it's yes, "Do they have a current police check?" Is a police check something that you currently investigate?

MR O'BRIEN: No.

MS HUTCHINS: No. So that's not something you need to look at now.

Has action been taken to minimise any risk?

That's something that you still look at now.

Has the AP disclosed the staff member or volunteer being identified as an alleged offender in a previous or similar reportable assault?

And – so here what we can see is that:

Yes, this AO was the alleged offender in case –

and it gives the case number which was in March 2015. Now, this question isn't included in the current - - -

MR O'BRIEN: No, it's not.

MS HUTCHINS: - - - set of questions that the providers are required to provide.

MR O'BRIEN: Is it – was it included in the current – in this form of this case or was it provided at a later date?

MS HUTCHINS: So in the one that we're currently looking at?

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. So you'll see here - - -

MR O'BRIEN: I mean, it's – yes.

MS HUTCHINS: Sorry. I'm not quite sure of your question.

MR O'BRIEN: Well, the – "When did the AP disclose that the staff member or volunteer had been involved in a previous assault"; was it on the form or was it disclosed at a later contact with the service?

MS HUTCHINS: That's an excellent question which is not apparent to me on the face of the document.

MR O'BRIEN: No, it wasn't apparent to me. Yes.

MS HUTCHINS: So that information's not – from my reading, cannot be ascertained from the incident report form, although please correct me if I am wrong. What can be ascertained from this form is the name of the alleged – of the staff member that allegedly committed the alleged assault.

MR O'BRIEN: Yes.

MS HUTCHINS: And also the name of the resident. Well, one would have to guess because it's not recorded in the records whether this information is obtained from a telephone call or independent inquiries but, in any event, you would agree that it appears to be part of the assessment process at this time that that information needs to be considered by assessors?

MR O'BRIEN: If that was the form they used, I suppose so. But, as I said, I wasn't around in that period, so I can't necessarily comment on the policies and procedures.

MS HUTCHINS: Yes. And so if you received a notification today that an alleged assault of this nature had occurred and you were advised that the alleged offender in

the case had been the subject of a previous alleged assault, is that something you would consider relevant to your determination about whether the provider is taking sufficient steps to manage the risk to residents?

MR O'BRIEN: Well, we'd look at the actions taken and also look at the previous actions taken. We sometimes get reports – two reports in the one email about the same staff member assaulting residents and they're actioned straightaway, but if – the same staff member had been involved in two separate incidents of a similar nature, that would probably result in a referral to the Aged Care Quality and Safety Commission in today's processes.

MS HUTCHINS: In today's assessments. Yes, your Honour. And if you go over, operator, please, to page 4, you see, under section F:

AP history and actions taken by the AP in relation to the alleged offender –

as part of the tick boxes that were needing to be completed by assessors at this time. It includes a question about strategies in place to minimise the risk which remains today. Here we've see that the action was that the AO was suspended pending investigation. Then we see, the next question:

Has the scheme had any similar cases at the service in the last six months? If yes, has the scheme had any similar cases with the AP in the last six months?

Sorry; that's the same question – sorry, no, it's not. As part of the inquiry, they had to check what was happening with that particular provider. That's not a question that is currently required of assessors in the process?

MR O'BRIEN: Well, they would look at – if they were undertaking a detailed assessment, they would look at the service's reporting history in the last six months as part of a detailed assessment.

MS HUTCHINS: In the detailed assessment?

MR O'BRIEN: Yes.

MS HUTCHINS: But if it's just in the initial assessment which doesn't require the more detailed assessment - - -

MR O'BRIEN: It doesn't require it, but sometimes they do do a review of the service's reporting history.

MS HUTCHINS: Yes. And you would agree that in this instance the vast majority of these reports are just the subject of the initial assessment?

MR O'BRIEN: I don't know – in terms of this report you're talking about?

MS HUTCHINS: Just in terms of all of these reports – these Japara reports that are the subject of the discussions today?

MR O'BRIEN: One – I think one had a detailed assessment. The others that we looked at today were all initial, but I don't know if this is what – in that time that they called an issue – the – this one we're looking at currently, if that's an initial assessment or a detailed assessment; I don't know the policies and procedures at that time.

MS HUTCHINS: Sure. I understand. So it might be that this is not the standard initial assessment form.

MR O'BRIEN: Yes.

MS HUTCHINS: It might be that this is the detailed assessment at the time - - -

MR O'BRIEN: It could be, but I don't know.

MS HUTCHINS: - - - but we're not sure. Thank you. That is clear. So in the circumstance the assessor is satisfied that the action of the provider is sufficient in relation to the alleged assault and the case is finalised. If we go to tab 7 please, operator, this is another report in relation to the same facility. This is an incident which is dated 12.2.2016, being, on my calculation, 28 days since the previous incident that we were just looking at. The description of this incident here on the first page is that, it was:

> *Reported that on 10.2.2016, the alleged offender –*

which is the same staff member as in the previous report –

> *...threw the call bell at her and hit her leg. She had pain to the right knee, nil bruising.*

So it seems that this – I know the names are redacted here but what the schedule will show is that it's the same personal care worker as the previous report but it's a different resident.

MR O'BRIEN: Yes.

MS HUTCHINS: So would that be a cause of concern to you if you were looking at a report and you were aware that the same personal care worker had committed – well, had been alleged to have committed an assault in such a short time period?

MR O'BRIEN: That would, and it probably would mean that we'd undertake – would do a referral to the Aged Care Quality and Safety Commission.

MS HUTCHINS: Yes. And under the heading towards the bottom of the page, Possible Cause/Action Taken/Recommendations, it says that the action was that:

Reassurance was given. Actioned per mandatory reporting guidelines.

What does that mean to you?

MR O'BRIEN: I don't know what the service's mandatory reporting guidelines are because that would be their own document, but I assume it means reporting to the department, but I don't know.

MS HUTCHINS: Yes. One can only assume.

MR O'BRIEN: Yes.

MS HUTCHINS: Yes. So if you go to tab 8 please, operator. Here we see the assessment report – I mean – sorry – yes, this is the reportable assault report. This has got – if we go to page 2, we see that on this page, there's no description in the document about what the alleged circumstances of the alleged assault were, assuming that's gleaned from the incident report that the provider has given. In terms of the actions taken, we've got that the alleged offender has been suspended and that there's been an investigation into the incident. This description seems significantly less than what we've seen in the more recent assessment reports, would you agree with that?

MR O'BRIEN: I suppose so, but they at least have taken some action and they've – which probably means that there probably should be follow up, if we were following current policies today but I don't know the processes that occurred back then.

MS HUTCHINS: Yes. And so in relation to the provider response, again, it says that there's been an investigation into the incident and the alleged offender has been suspended. Noting that the alleged offender was suspended and that was the action last time, is there any consideration made about the fact that, if that's the action that the provider's taking for, say, two reports in a row without further action, is that something that would cause you to inquire about whether they should be taking further steps?

MR O'BRIEN: Well, I think if the alleged offender is a care recipient or a staff member and if there's repeat allegations and they've taken some steps and their steps haven't worked, it's an indication that the steps they've taken haven't worked so that a referral is possibly warranted but a bit hard to comment on previous reports.

MS HUTCHINS: No. But in this instance, it appears all that can be ascertained from the incident report is that reassurance was given to the alleged victim and that action per mandatory reporting guidelines, which you have said to the effect, "We don't know what that say, what that means" and then the only other action taken is

that the alleged offender has been suspended and investigation into incident. You'd agree with that?

MR O'BRIEN: Yes.

MS HUTCHINS: So on the face of that information, would you feel comfortable making a determination the appropriate steps have been made to ensure the health, safety and wellbeing of the residents?

MR O'BRIEN: Again, I don't know the policies and procedures at that point in time. With our current lens on it, I wouldn't put that through in its current form.

MS HUTCHINS: Certainly. Thank you. And we see at tab 9, just for the sake of completeness, the assessment process, we just see the boxes are ticked or checked yes, yes, yes. On the other page yes, yes, in response to all the questions with no description given in relation to the assessment. A further example I'd like to take you to quickly is at tab 14. This is dated 16.4.2016. If we go to page 2 please, Operator, we see – we cannot tell from looking at the form what the actual alleged assault was.

We have not been provided with any separate documents from the department which indicate what the assault was. You can take that as given. What it does say on the front of this page is that unreasonable use of force or assault is what this relates to. But we cannot see any details about what the alleged assault was, who the alleged offender is. Would you agree with that?

MR O'BRIEN: Yes. No. The report lacks detail.

MS HUTCHINS: And we see that there has been some reviews to see whether there's a review by a registered nurse that there's no injury, the general practitioner has attended and the police officers have been notified. And, again, here the staff member has been suspended from duty pending the outcome of the investigation. That's the entirety of the information provided, along with, you know, standard kind of strict compliance information on the front page.

Again, we see, at tab 15, please, Operator, all of the boxes are ticked – checked yes in relation to fulfilment of all the obligations, the approved provider is taken to have met its responsibilities and to have taken reasonable steps. Again, do you think this is insufficient detail applying today's policies and procedures as to how you would approach an assessment?

MR O'BRIEN: Well, I suppose for starters, the form we use now is different, so we get more information initially from the service provider. But if you're using today's policies and procedures, the answer is no, that's not sufficient at the – not sufficient.

MS HUTCHINS: Yes. I mean, one would expect that you need to know the details - - -

MR O'BRIEN: Yes. Exactly.

MS HUTCHINS: - - - or at least the circumstances of the alleged event - - -

MR O'BRIEN: Exactly.

MS HUTCHINS: - - - to at least attempt to make an – you know, at least attempt to make an appropriate decision in relation to whether appropriate measures have been taken.

MR O'BRIEN: Yes.

MS HUTCHINS: And you would need to know what the details of the actions taken by the provider were with reference to those circumstances to be able to make a proper assessment about whether proper steps have been taken.

MR O'BRIEN: That's the current policies, yes.

MS HUTCHINS: Yes. But even back at this time, just as a matter of - - -

MR O'BRIEN: Again, I don't know the policies and procedures and, also, if there was any other contact with the service provider and the individual, but it's a bit hard to comment.

MS HUTCHINS: Sure. I think – you can take it as given that the assessment that was required of the assessors, at this point in time, was that they needed to check whether the provider had been taking adequate steps to ensure the safety and wellbeing of residents.

MR O'BRIEN: I don't – I can't comment. I don't know the policies and procedures at that time. I can't really comment.

MS HUTCHINS: Sure. But you can see - - -

MR O'BRIEN: I assume it was, but I don't know.

MS HUTCHINS: - - - here on the form that what has been asked of the assessor - - -

MR O'BRIEN: Yes.

MS HUTCHINS: - - - is whether appropriate steps have been taken.

MR O'BRIEN: Yes.

MS HUTCHINS: And do you think it's possible to know whether appropriate steps have been taken if you don't know the circumstances of the alleged incident?

MR O'BRIEN: That would be a reasonable assumption, yes.

MS HUTCHINS: Thank you. Finally, please, Operator, bring up document – in the bundle of documents that have already been tendered, please bring up the document at tab 12. Yes. Thank you. And please go to page – I'm just finding the relevant page number here. So on the form that we were just looking at, it was not possible to tell who the alleged offender was. You can take that as an assumption.

MR O'BRIEN: Yes.

MS HUTCHINS: But what we have seen in the two previous reports was that it was the same alleged offender. And then, in a document which – we're having some difficulties identifying the correct page, but you can take it as given that in the Perth hearing Japara provided the Commission with a summary of alleged – on page 5. Thank you. That during the Perth hearing Japara provided the Commission with a summary of alleged incidents and, as part of that description, they've identified that, within this facility, there was a staff member that was the alleged – that was alleged to have assaulted residents on three separate occasions. If this was information that was brought to your attention, is this something that you would consider to be relevant in your decision as to whether a report should be closed pending no further action or whether it would be escalated or referred elsewhere?

MR O'BRIEN: If a staff member is alleged to have assaulted a resident on three separate occasions, as I've said before, that would most likely result in a referral to the Aged Care Quality and Safety Commission.

MS HUTCHINS: Most likely?

MR O'BRIEN: Well, depending – I'm 99 per cent certain it would, but it depends if the staff member has been terminated or something else has happened. Without knowing the whole story – the general rule, I think it would happen, but without knowing the whole story and all the facts and the circumstances - - -

MS HUTCHINS: Okay. Thank you. I have no further questions, Commissioners.

COMMISSIONER BRIGGS: Mr O'Brien, I just want to ask a follow-up question around the media being one of the reasons you might refer something to the commission. In several of our community meetings that the Commission has had, it has been apparent that action has only occurred after these people have gone to the media. And I find that rather disturbing. Why is it necessary for somebody to have to go to the media to get action?

MR O'BRIEN: It's not necessary for people to go to the media, in my experience. Generally, the media are interested in a significant issue, severe injury to the resident, staff member being charged or a severe or unusual incident, which is similar to what we are – generally speaking, they don't – media aren't interested in, I suppose, a rough handling issue which results in no injuries or no charges.

So their issues or attention is probably similar to what we would be interested in terms of an escalation and/or referral. And sometimes we're not aware of the media until later. Sometimes a service will tell us the media has told them about something. And that's when they report it to us. So it can – the media might provide information to a service that an incident has occurred and then that's the first the service may be aware of the incident. But, generally speaking, the media involvement, from our perspective, isn't significant. So normally it's the same issues we're interested in.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Mr O'Brien, you will be pleased to know that you're second time lucky.

MR O'BRIEN: Thank you.

COMMISSIONER TRACEY: You're excused from further attendance.

MR O'BRIEN: Thank you.

<THE WITNESS WITHDREW [11.38 am]

COMMISSIONER TRACEY: I just want to correct an exhibit number. I recorded Ms Darling's statement earlier this morning exhibit number 8-23. In fact, 8-23 was tendered yesterday. It's the second Japara tender bundle. And Ms Darling's statement should have been 8-24. The Commission will adjourn until midday.

ADJOURNED [11.38 am]

RESUMED

<ANTHONY DAVID SPEED, ON FORMER AFFIRMATION [12.05 pm]

<EXAMINATION-IN-CHIEF BY MR GRAY

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. I recall Anthony Speed, who is in the witness box.

COMMISSIONER TRACEY: Thank you.

MR GRAY: You are under your former oath or affirmation.

COMMISSIONER TRACEY: Yes. Mr Speed, you remain on your former oath or affirmation. I forget which it was that you took.

MR SPEED: Okay. Thank you.

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. Mr Speed, you have made three witness statements for the Royal Commission and you are relying on two of them. Can I just outline all three of them and explain what's happening with them. The first witness statement you made was dated 10 July 2019 but we're not proposing to tender that statement. You then made a witness statement dated 23 July 2019, WIT.0337.0001.0001. Now, if we look at the document on screen, do you recognise that to be the first page of your statement of 23 July, Mr Speed?

MR SPEED: Yes, that's correct.

MR GRAY: In paragraph 8, there is a reference to your 10 July statement which I understand you wish to replace with a statement we'll come to in a moment dated 2 August 2019; is that right?

MR SPEED: That's correct.

MR GRAY: So do you wish to amend the reference to your statement of 10 July so that it refers to your statement of 2 August 2019?

MR SPEED: Yes, please.

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

MR SPEED: No.

MR GRAY: To the best of your knowledge and belief, are the contents of your statement dated 23 July 2019 true and correct?

MR SPEED: That's correct.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The witness statement of Anthony David Speed dated 23 July 2019 will be exhibit 8-25.

EXHIBIT #8-25 WITNESS STATEMENT OF ANTHONY DAVID SPEED DATED 23/07/2019 (WIT.0337.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR GRAY: Thank you, Commissioner. Next, if we could bring up WIT.0261.0002.0001. Mr Speed, do you recognise that to be the first page of your statement dated 2 August 2019?

MR SPEED: Yes, I do.

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

MR SPEED: That's correct.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The second witness statement of Anthony David Speed dated 2 August 2019 will be exhibit 8-26.

EXHIBIT #8-26 SECOND WITNESS STATEMENT OF ANTHONY DAVID SPEED DATED 02/08/2019 (WIT.0261.0002.0001) AND ITS IDENTIFIED ANNEXURES

MR GRAY: Thank you, Commissioner. Mr Speed, you've given evidence on two other days before the Royal Commission. First, on 21 March 2019 in Adelaide and, secondly, on Monday, 5 August in Brisbane. That's right, isn't it?

MR SPEED: That's correct.

MR GRAY: In your evidence in Adelaide on 21 March 2019, you referred to a risk register and a service provider of concern list and you gave some evidence about that topic.

MR SPEED: That's correct.

MR GRAY: In your statement – in the evidence encompassed in your statement, you address some of these things. I just want to ask you about that topic, this risk register and service provider of concern list. With respect to your statement dated 23 July, which is exhibit 8-25, in paragraph 9, you say that:

> *The Service providers of concern or SPoC list, is circulated to regulatory staff of the department.*

And in effect, paraphrasing, you say it identifies providers of concern when non-compliance has been identified by the relevant regulator. Later in your statement at paragraph 13 you say that the list doesn't include all non-compliant service providers. Those two facts are correct, aren't they?

MR SPEED: I believe that to be the case, yes.

MR GRAY: In your 21 March evidence, you said that the meetings of the SPoC committee, if I can use that expression, were not minuted, but you have clarified or corrected yourself in your statement of 23 July at paragraph 25, and you've said that those meetings are minuted; is that right?

MR SPEED: I believe so, yes, and I've provided detail about the inquiries that I've made and the fact that I had only ever received one copy of the draft minutes to the best of my knowledge.

MR GRAY: That one was in June 2018 before you became the acting assistant secretary of the compliance branch?

MR SPEED: That's correct.

MR GRAY: You became the acting head of the compliance branch, or – can I say the acting head of the compliance branch, is that a reasonable - - -

MR SPEED: Assistant secretary.

MR GRAY: As acting assistant secretary of the compliance branch, are you, in effect, the head of the branch?

MR SPEED: Yes. That's correct.

MR GRAY: Thank you. You assumed that position on 29 October 2018. That's right; isn't it?

MR SPEED: That's correct.

MR GRAY: On that date, you also became chair of the SPoC committee meetings; is that right?

MR SPEED: Yes, I did. In practice, I did not attend any meetings, to the best of my knowledge.

MR GRAY: Yes. You say in paragraph 27 – you use that expression, "to the best of my knowledge" in the last line. To the best of your knowledge you didn't attend any meetings. Can't you remember whether you attended any of those meetings?

MR SPEED: No. At that time, I don't believe that I attended any. I attended meetings subsequent to 1 April, which was one meeting and that was with the – under the arrangements where there were new terms of reference operating following the new memorandum of understanding that operated with the Quality and Safety Commission.

MR GRAY: My question was can't you remember whether you attended any meetings in the period you've referred to in your statement, that is, between 29 October 2018 and giving evidence on 21 March 2019?

MR SPEED: That's correct.

MR GRAY: You can't remember?

MR SPEED: I can't remember.

MR GRAY: Is that because the meetings of the SPoC committee weren't important to you?

MR SPEED: No. It was because the meetings of the SPoC committee, most likely if I was not available, would have been chaired by the deputy chair who is the director of the compliance area in the branch.

MR GRAY: When you say you can't remember whether you attended any, aren't you telling the Commissioners that you don't have a recollection whether or not you attended?

MR SPEED: That's correct.

MR GRAY: Surely, if the meetings were important to you, you would be able to remember whether or not you attended?

MR SPEED: No, the meetings of the SPoC committee are one of several points of information sharing around compliance matters and so it may be that my diary schedule did not allow me to attend meetings that were scheduled during that period from the end of October to the end of March.

MR GRAY: If the SPoC committee had been important to you, you would have remembered whether or not you attended them, I suggest.

MR SPEED: I can't recall attending any meetings during that time.

MR GRAY: You've said that you received one set of minutes in June 2018. Have you reviewed the minutes of the SPoC committee since the date you assumed chairmanship of that committee, up to the present time?

MR SPEED: I have seen copies of risk registers, but I have not reviewed copies of minutes.

MR GRAY: So you haven't checked whether your name appears on any of the minutes of the SPoC committee over the period from 29 October to the present time; is that right?

MR SPEED: I've made inquiries and I understand that I did not attend any of those meetings, therefore, my name wouldn't appear on those minutes.

MR GRAY: All right. You also say, in paragraph 25(c) that you didn't receive any notes or minutes in the period 29 October 2018 to 21 March 2019 of the SPoC meetings. That's right, isn't it?

MR SPEED: That's correct.

MR GRAY: This also suggests, in my suggestion to you, that you didn't consider the meetings important.

MR SPEED: I consider the meetings important at an operational level to understand compliance matters, but it may be that I was unavailable to attend meetings.

MR GRAY: So let's get this right. You were – it may be, you're saying, that you were unavailable, even though these are important at an operational level, and you are the chair, to attend for a period of about five months? You were busy all that time. Is that what you're trying to suggest to the Commissioners?

MR SPEED: No. I would suggest that if I wasn't available to attend, the deputy chair would attend in my stead.

MR GRAY: Yes, but a minute ago you said it may be that you were too busy to attend because of other things in your diary. Are you suggesting that on each and every occasion there was a meeting, you turned your mind to whether to attend or not?

MR SPEED: I would need to understand the dates of the meetings that occurred in that period and whether I was available to attend.

MR GRAY: So you don't have a recollection whether you turned your mind to the question of whether or not to attend any of these meetings?

MR SPEED: I don't have a recollection, no.

MR GRAY: Well, that also suggests that you just didn't consider the SPoC meetings important. You considered them to be beneath your notice.

MR SPEED: I don't agree with that statement you made.

COMMISSIONER TRACEY: Does your name appear in any of the minutes as an apology?

MR SPEED: I would need to review that, Commissioner. I don't believe that - - -

COMMISSIONER TRACEY: What does need to review mean?

MR SPEED: I don't believe that it does.

COMMISSIONER TRACEY: You're not answering my question. What does "need to review" mean?

MR SPEED: If I attended the meeting, my name would appear in the meeting as an apology or as an attendee.

COMMISSIONER TRACEY: You're not answering my question. Does your name appear in any of the minutes as an apology?

MR SPEED: Not to my knowledge, no.

COMMISSIONER TRACEY: Well, again, you're prevaricating. Am I to understand you have not taken the trouble to go back and look at the minutes?

MR SPEED: I understand that my name does not appear in any - - -

COMMISSIONER TRACEY: No. You're again – would you please answer the question. Am I right in saying that you have not taken the trouble to go back and look at the minutes of those meetings?

MR SPEED: I have made inquiries and I understand ---

COMMISSIONER TRACEY: No. Yes or no. Have you looked at the minutes? It's a simple question.

MR SPEED: No, I didn't receive any minutes. I haven't - - -

COMMISSIONER TRACEY: Well, why didn't you say no in the first place?

MR SPEED: I'm sorry, Commissioner. I'm trying to provide context as to - - -

COMMISSIONER TRACEY: It's a very simple matter. Listen to the question and answer it, please. Answer it truthfully and do not prevaricate.

MR SPEED: Okay.

COMMISSIONER TRACEY: You are on your oath or affirmation. Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. Mr Speed, over this period of 29 October to at least 21 March, that is 29 October 2018 to 21 March 2019, when you were the chair of the SPoC committee and you were also the head of the compliance branch of the Department of Health, the fact that you didn't attend any of the meetings or monitor the minutes suggests that the SPoC committee and the SPoC list has not been treated by the department as a serious risk-monitoring tool within the department over that period. What do you say to that?

MR SPEED: I say that the – and, as I say in my statement, that the SPoC committee is an operational committee for monitoring compliance and it is only one of several forums. There are liaison meetings that occur with the Quality and Safety Commission. There are case meetings that occur in relation to particular aspects or cases of non-compliance. And the SPoC is not the key forum for monitoring compliance and, therefore, is not the critical forum for me to attend.

MR GRAY: Well, let's move past monitoring of non-compliance to a broader appreciation and assessment of the risk that might be presented by approved providers. Wasn't it the tenor of your evidence in March that a risk list was maintained by the department?

MR SPEED: That's correct.

MR GRAY: And wasn't it the tenor of your evidence in March that the risk list was the SPoC list?

MR SPEED: That's correct.

MR GRAY: Now, I want to ask about the processes or criteria involved in decisions to include an approved provider in the SPoC list. And I understand from your statement at paragraphs 11 and 12 that there's a nomination process to the committee, but it seems, from your statement as a whole, that there is limited guidance and considerable discretion around nominating a provider for inclusion in the SPoC list; is that right?

MR SPEED: That's correct.

MR GRAY: Now, we heard evidence yesterday from Ms Elsy Brammesan that she didn't consider it necessary or worthwhile to nominate MiCare in respect of the matters that were raised with her about MiCare Avondrust during the period August 2018/2019 to the SPoC list. Did you monitor that evidence? Have you reviewed that evidence?

MR SPEED: I saw that evidence, yes.

MR GRAY: Yes. MiCare was never placed on the SPoC list; is that right?

MR SPEED: I would need to check that. I'm not aware of that.

MR GRAY: Is there an arbitrary element to whether an approved provider gets entered on the SPoC list?

MR SPEED: As I noted in my statement, there is an element of discretion associated with that. The critical point here is that the case management system, the NCCIMS information management system, that the department maintains, is the critical point of knowledge and record of non-compliance.

MR GRAY: Yes, but I'm going to ask about questions that are broader than merely non-compliance and about, for example, risk of cessation of services, risk to the wellbeing of residents presented by approved providers across the organisation of a particular approved provider and not necessarily limited to the compliance or non-compliance of a particular facility. You understand what I'm saying, don't you?

MR SPEED: Yes, I do.

MR GRAY: Yes. So I'm asking – when I ask about risk, unless I say otherwise, I'm intending to ask a question about a broader appreciation of risk and not just an assessment of non-compliance at a particular facility or service. Is the SPoC list now, and back in the period October 2018 to March 2019, intended to list the highest risk providers known to the department?

MR SPEED: It was intended to capture risk known to the department, including some of those high-risk cases, yes, is my understanding.

MR GRAY: So I'm not sure if that's an answer to my question. Is it intended to list the highest risk providers?

MR SPEED: If the committee nominated and included those providers on the list, yes.

MR GRAY: That's just a statement of consequence, if the committee has taken a particular decision. I'm asking you, as the head of the compliance branch and the chair of the committee over the period that I've referred to, to give some evidence about the purpose of the list. Do you understand my question?

MR SPEED: Yes.

MR GRAY: Is it intended to list the highest risk providers known to the department?

MR SPEED: Yes.

MR GRAY: Thank you. Do you take steps, both in the period October 2018 to March 2019 and then since March 2019 to the present day, to assure yourself that the SPoC list in fact reflects the highest risk providers?

MR SPEED: No. There are other forms in which I provide that assurance to myself. So that could be through the weekly engagement with the directors in my branch, for example.

MR GRAY: Okay. So you're saying you don't personally take steps to assure yourself that the SPoC list reflects or includes the highest risk providers, but you're saying you ask other people to take steps?

MR SPEED: I take steps to assure myself through regular engagement with those staff in my branch. And that could be through information that has come through the SPoC or it could be through other sources.

MR GRAY: All right. And what steps do you ask them to take to enable yourself to be assured that the list reflects the highest risk providers?

MR SPEED: In relation to the SPoC list?

MR GRAY: Yes.

MR SPEED: The SPoC list – SPoC would operate according to the process that's described in 13, 14 of my statement and more – and during this time, the director of the compliance section would have taken steps to assure herself and then by reporting to me the inclusion of those risk – high-risk providers.

MR GRAY: I will come to 14 in a minute but, in 11 and 12, you've described a process, and you've already agreed with the characterisation I put to you about it involving discretion. And I suggested to you that there was an element of arbitrariness in it. And I don't know if you disagreed. You repeated your reference to discretion. There isn't a very robust process for deciding whether a service provider gets included or not. Would you agree with that?

MR SPEED: I would agree with that, yes.

MR GRAY: All right. Now, in paragraph 14 that you just referred to, you refer to a change in the process for inclusion of service providers in the SPoC list. And that change occurred in April 2019. That's very soon after you gave your evidence on 21 March. Was there any connection with you having turned your mind to the SPoC list on 21 March and this change in April 2019?

MR SPEED: No, none whatsoever. The terms of reference for the SPoC were reviewed and amended in the first – early part of the year as a response to the new memorandum of understanding that had been drawn up with the then – with the new Aged Care Quality and Safety Commission.

MR GRAY: All right. Now, you refer to this change in April 2019 and you say that there used to be a number of specific factors that were considered by the committee in deciding whether or not to include a service provider in the SPoC list. And you

enumerate those old factors, if I can call them that. Is that how we're to understand your paragraph 14?

MR SPEED: Yes, that's correct.

MR GRAY: Yes. And the old factors included, for example, at (b):

> *Evidence of actual or potential non-compliance across multiple service provider responsibilities.*

So, for example, that would mean if you had a service provider non-compliant in home care and also residential care, that would be a contributing factor to inclusion in the SPoC list; is that right?

MR SPEED: Yes, that's correct.

MR GRAY: And, (d):

> *Identified concerns in relation to the service provider's services being delivered under a contractual arrangement.*

So up until April 2019, it was meant to be a factor to be considered, on the issue of whether or not to include a service provider in the SPoC list, whether or not there was a subcontracting arrangement in place; is that right?

MR SPEED: That relates to the Commonwealth Home Support Programme where there would be a contracting arrangement in place.

MR GRAY: It only relates to Commonwealth Home Support Programme, does it, CHSP?

MR SPEED: Or at that time, prior to the establishment of the home support programme, when SPoC has been operating for a long period of time, it may have related to other grant programmes, as well.

MR GRAY: Well, you wrote the – you've written, presumably, the statement – I'm not saying you've literally typed it out but it's your statement and you've adopted it as your evidence, haven't you, Mr Speed? Do you know what it relates to?

MR SPEED: That's what I'm suggesting it would relate to, grant programmes.

MR GRAY: Well, it doesn't say that. It just says, without qualification, "Identified concerns in relation to the service provider services being delivered under a contractual arrangement"; doesn't it?

MR SPEED: It does.

MR GRAY: Why doesn't that encompass, for example, an outsourcing arrangement to a management company in the residential care context?

MR SPEED: Because it was intended to capture the program – aged care programs that are delivered through grant contracts, is my understanding of that sentence.

MR GRAY: Are you saying that, actually, it's never been a factor considered by the SPoC committee on the question of whether or not to include a service provider in the SPoC list to address concerns in relation to a service provider's services in a residential care setting being delivered under an outsourcing arrangement?

MR SPEED: It may have been. I would need to look at the records of the SPoC to understand that.

MR GRAY: Well, you're the chair since October. If you just confine your answer to the period since 29 October 2018, can you answer the question?

MR SPEED: I'm not aware of any instances where that was captured.

MR GRAY: Howsoever that may be, these factors are no longer explicitly considered by the SPoC committee in deciding whether or not to include a service provider, as of changes made in April 2019; is that right?

MR SPEED: That's correct. There were new terms of reference drawn up and implemented from April 2019.

MR GRAY: In paragraph 14, you say this has been a streamlining exercise?

MR SPEED: That's correct.

MR GRAY: Does that mean that the SPoC committee just has to work more quickly and there aren't explicit factors, there are just factors that it can consider in its own discretion; is that right?

MR SPEED: No. It was in response – the streamlining reference is in response to a number of examples of information sharing that were occurring across the branch including with this staff in the state offices of the department, and it was an attempt to create efficiencies in how we worked together at that time.

MR GRAY: So what are the explicit factors that the SPoC committee – I'll just pause there – do you still chair it?

MR SPEED: I have attended one meeting since 1 April.

MR GRAY: Are you the ex officio chair of the SPoC meeting?

MR SPEED: I'm noted in the current terms of reference as the chair and the deputy chair is noted as the director of the quality compliance area.

MR GRAY: Okay. So what are the explicit factors that the SPoC committee is required now to consider under its terms of reference?

MR SPEED: The terms of reference includes as an attachment a risk matrix which describes issues such as intelligence around low-impact concerns such as concerns identified through financial reporting, for example, in a grant program, through to more severe issues around an early release of information regarding an impact on care and safety of a resident in a nursing home.

MR GRAY: Are outsourcing arrangements included?

MR SPEED: I would need to check the matrix.

MR GRAY: Perhaps you'll have an opportunity to do that over lunch. Can I ask you whether you're aware of any circumstance, whether inside the SPoC process – I think you said you don't recall inside the SPoC process – or outside, where the department has taken note of an outsourcing arrangement as a potential risk factor and has inquired into the detail of that outsourcing arrangement to determine whether there's a risk of cessation of services?

MR SPEED: I'm aware there have been instances but I would need to – to corroborate that information before wanting to give you a definitive answer on that.

MR GRAY: All right. Well, based on whatever inquiries or information you have in your mind when you give that answer, are you able to say how is it that the department identifies whether the provider's services are being delivered under a contractual arrangement if the provider hadn't filed a change in material circumstances form but has just provided the information by email?

MR SPEED: It may be that that information has come to the department through staff located in the state offices who are in contact with an aged care provider or hear that information on the ground, so to speak. It may be that that information comes to the department through the contacts that the Quality and Safety Commission has with a provider.

MR GRAY: And if it is picked up by the department having been informed by the Quality and Safety Commission, what's your view, as head of the compliance branch – should that be escalated some way into a more central area in the department? That information, should that be escalated?

MR SPEED: I think it would depend on a case-by-case basis. There is – it is not uncommon, for example, for contractual arrangements to operate, for example, with laundry services. That's a common feature. However, if there is a contractual

arrangement around something to do with care and services, that would possibly be something that should be escalated within the department, yes.

MR GRAY: If it seems, on the face of the information, that it's the entire management of the aged care facility in question, that should be escalated, shouldn't it?

MR SPEED: I would suggest that that's certainly information that should be known to others, yes.

MR GRAY: It should be escalated within the department?

MR SPEED: Yes, yes.

MR GRAY: To those areas that might be able to consider whether to include that information in the SPoC list, for example?

MR SPEED: Or some other forum, yes.

MR GRAY: And what would the other forum be?

MR SPEED: It could be through case liaison meetings with the commission. It could be in relation to a forum that exists around a particular case to share information about risk to do with a particular case.

MR GRAY: All right. I just want to keep asking you about the SPoC factors. In the list prior to the streamlining in April 2019, I don't see any reference to information from complaints. Is that right? There wasn't any consideration of the content of complaints as a factor for inclusion in the SPoC list?

MR SPEED: That's correct.

MR GRAY: Yes. And is that still the case?

MR SPEED: Yes. At this point in time, yes.

MR GRAY: Okay. And what about information about non-cooperation with inquiries, wherever those inquiries may be situated contextually, for example, prudential inquiries, complaints inquiries – what about non-cooperation with inquiries; has that ever been a risk factor considered by the SPoC?

MR SPEED: I would need to check specific circumstances but if there was a reluctance for example, for an approved provider to participate in its obligations under the Act, then that would most likely be considered.

MR GRAY: Because that's an obvious risk factor, the attitude of an approved provider on cooperation with inquiries would be a critical risk indicator, wouldn't it?

MR SPEED: It would certainly be a risk indicator, yes.

MR GRAY: But that's not included in the list you've given in paragraph 14 and that suggests that it wasn't considered in the SPoC processes up to April 2019; is that right?

MR SPEED: That's my understanding.

MR GRAY: You think I'm right?

MR SPEED: I think you're right.

MR GRAY: Do you know whether it's been considered since April 2019?

MR SPEED: I don't know whether specific examples have been considered, no.

MR GRAY: Now, with reference to an element of your evidence on Monday, I just want to ask you about prudential compliance and you made the distinction between operational compliance and a broader appreciation of prudential risk. Do you remember that passage of your evidence?

MR SPEED: .....

MR GRAY: I put to you that, when you were referring to operational compliance in the prudential context, you were referring to whether forms – that is prudential compliance returns and annual financial reports, aged care and general purpose, had been filed in due form and within time and that was what you were referring to as operational compliance; is that right?

MR SPEED: I would need to see the context of the – or the transcript but I would be referring to operational compliance in the sense that teams were managing specific case issues, I would expect.

MR GRAY: Okay. Well, forget what you said on Monday because I don't think it was entirely clear, with respect. I'll just ask you now: is there a distinction made within the compliance branch or within the department as a whole, between whether financial reports and prudential compliance statements have been filed in proper form and within time, on the one hand, and a qualitative, substantive analysis of the contents of those forms, whether they're filed in proper form and within time or not. Is that distinction a relevant functional distinction within the department?

MR SPEED: Yes, in terms of whether the provider has met its obligations under the Act. Yes.

MR GRAY: Has met its obligations under the Act?

MR SPEED: That's correct.

MR GRAY: Yes. Because the question whether the provider has met its obligations under the Act is relevant to that first category of matters; correct?

MR SPEED: Yes.

MR GRAY: Whether the returns are in due form and filed on time. And if they are in due form and filed on time then, relevantly, the prudential requirements have been met – the prudential obligations have been met; is that right?

MR SPEED: If – if all of the information has been provided on time, yes.

MR GRAY: In contradistinction to that subject matter, the substantive and qualitative analysis of what appears in the returns is a different function and it really involves considering whether there's prudential risk or financial risk presented by the information in those forms; correct?

MR SPEED: Yes.

MR GRAY: Now, are those two functions done in different parts of the department?

MR SPEED: Yes, they are.

MR GRAY: All right. Now, could we bring up the organisational chart at RCD.9999.0168.0001. Thank you, operator. Now, Mr Speed, you appear in the purple column under Aging and Aged Care. David Hallinan is said to be acting in that part of the department, and you appear in the left-hand column, second from the bottom, aged care compliance Anthony Speed; is that right?

MR SPEED: That's correct.

MR GRAY: Does this organisational chart, which is available on the internet, provide sufficiently precise detail for you to be able to point to where the two functions that we've just been discussing are performed within the department?

MR SPEED: Yes. I can point you to where the other function is undertaken if you'd like me to.

MR GRAY: Thank you. So let's just be clear: the question of whether the prudential forms are filed in due form and on time is within your branch; is that right?

MR SPEED: No. My branch is responsible for the operational response to a prudential compliance matter.

MR GRAY: I see. So where is the function of deciding whether the forms are filed in due form and on time to be found?

MR SPEED: That would be in the funding policy and prudential branch which is in the second column along from that.

MR GRAY: Nigel Murray?

MR SPEED: That's correct.

MR GRAY: So that's the second column, second from the top?

MR SPEED: That's correct.

MR GRAY: Under David Hallinan's overall direction?

MR SPEED: Yes.

MR GRAY: And that's Nigel Murray – is that a branch?

MR SPEED: That's correct.

MR GRAY: Yes. So Nigel Murray is the leader of that branch. So that's the question of compliance with manner and form requirements and timing requirements.

MR SPEED: That branch manager's funding policy but, in relation to prudential, it manages the relationship with the outsource provider to whom all approved providers are required to submit.

MR GRAY: Thank you for that but is that the branch where an assessment is made about whether the forms have been filed in due form and on time?

MR SPEED: Yes.

MR GRAY: Thank you. Now, where's the function performed about assessing whether the substance of the form reveals risk?

MR SPEED: In that branch.

MR GRAY: Both of those functions - - -

MR SPEED: That's correct, with the outsource provider that I mentioned.

MR GRAY: Okay. So when you said they're performed in a different part of the department, you just meant in a different part of the department from your branch?

MR SPEED: That's correct.

MR GRAY: Right. Are those functions both performed within the same team of people within Mr Murray's branch?

MR SPEED: Yes, I believe so.

MR GRAY: Okay. Thank you. Which is Ms Theresa Creamer's area?

MR SPEED: Theresa works in my branch, in aged care compliance.

MR GRAY: Right. And it was Ms Creamer who was the delegate who made the decision to take no further action on 13 June 2019 in relation to People Care. That's under your direction, is that right?

MR SPEED: That's – that's correct. Theresa sits in the aged care compliance branch.

MR GRAY: So why is that decision made within your branch as opposed to Mr Murray's branch?

MR SPEED: Because there were – following the process that you alluded to earlier in terms of the assessment, the non-compliance was referred to my branch, which is why a notice of non-compliance was released to People Care in January regarding their failure to provide that information and why Ms Cramer managed the decision regarding no further action in June.

MR GRAY: That no further action be taken?

MR SPEED: That's correct.

MR GRAY: Yes. Now, when the decision was made, was there consideration of whether previous reports from People Care had presented, as a substantive matter, a financial risk or a potential financial or prudential risk?

MR SPEED: When the decision for no further action was made?

MR GRAY: By Ms Cramer.

MR SPEED: I believe so, yes.

MR GRAY: Okay. And did that involve getting the opinions of people in Mr Murray's branch on that topic, did it?

MR SPEED: Not to my knowledge. We would have been managing the compliance issue as a case at that point.

MR GRAY: Does that mean it's really over to your branch and you decide it without reference to whether earlier reports reveal, in substance, the presence of financial risk? Is that right?

MR SPEED: The financial risk assessment is undertaken in Mr Murray's branch. We would be managing the compliance response in relation to that failure to submit.

MR GRAY: Well, my question is do you try to take into account whatever assessment might be available in Mr Murray's branch about financial risk when your branch within the department makes a decision about compliance?

MR SPEED: Yes, that would be true.

MR GRAY: Okay. That's what I thought you said to begin with. So was there a process by which your branch communicated with the officers of Mr Murray's branch to obtain their views on whether earlier reports from People Care had revealed financial risk?

MR SPEED: The earlier reports would have informed the original assessment of low-to-severe risk, which is determined in Mr Murray's branch.

MR GRAY: So - - -

MR SPEED: The earlier history of compliance, which I think is what you're getting at.

MR GRAY: They would have been taken into account at some earlier point before it was referred to your branch. Is that what you're saying?

MR SPEED: That's correct.

MR GRAY: Well, my question is when your branch, having been seized of the matter for some months, between at least January and June 2019; correct?

MR SPEED: That's correct, yes.

MR GRAY: Over some months during that period, is your branch trying to obtain the views of the people in Mr Murray's branch about whether this approved provider presents a financial risk?

MR SPEED: When the case came to my branch, there would have been an assessment of risk which – and when the provider submitted the information at the end of January, there would have been a subsequent assessment of risk. And for the period after that where there were questions about that information, my branch was following up with the approved provider regarding that information.

MR GRAY: Yes, but before deciding in June to take no further action on the notice of non-compliance that was issued in January 2019, did the delegate, to the best of your knowledge, turn her mind to whether Mr Murray's branch had informed your branch whether or not this approved provider might present a financial risk?

MR SPEED: In providing information to the compliance branch, that assessment would have come to us when the information was received from the approved provider. So - - -

MR GRAY: Okay. So you're speculating. You keep saying "would have". You don't know. Is that the answer?

MR SPEED: Well, I'm saying that when the approved provider submitted the information at the end of January, it's my understanding there was an assessment of risk at that time which indicated a level of risk which was not severe, which then subsequently informed the delegate's decision for no further action.

MR GRAY: So it sounds to me as if – I keep asking the same question. I'm not – you know, I'm not going to waste any more time on it, but I keep asking you the question whether, before taking the decision in June, there was an opinion obtained, but you keep referring to the opinion that came with the referral at a much earlier point in time. Is that the gist of your evidence?

MR SPEED: Well, I'm referring to the assessment that was undertaken when the provider eventually submitted their return at the end of January.

MR GRAY: All right. Now, I just want to put up an old form SPoC list, 1 April 2017, CTH.4000.1024.2492. And we've redacted the references to all of the other providers except for People Care. This is a SPoC list before the streamlining you've referred to. But, to your knowledge, has the format of the SPoC list changed since that streamlining?

MR SPEED: I wouldn't – I understand that the risk register looks slightly different to what this version does.

MR GRAY: All right. There's 16 or perhaps 17 approved providers on the list as at 3 August 2017. Now, the SPoC list has substantially more providers on it. Is that right?

MR SPEED: I believe so, yes.

MR GRAY: Yes. And do you know why that's the case, why are there so many more approved providers on the list?

MR SPEED: There has been an increase in findings of non-compliance and response taken in relation to that non-compliance since August 2017.

MR GRAY: Is that the reason why it was necessary to streamline the SPoC process in April 2019?

MR SPEED: The branch is constantly looking for opportunities to be more efficient in its operation to make better use of our resources, which is part of a decision to look at how we were working on a SPoC.

MR GRAY: So I will just ask my question again. Is the increase in numbers of service providers of concern, because of the increase in non-compliance findings, a reason for the streamlining of the SPoC procedures in April 2019?

MR SPEED: Yes.

MR GRAY: Yes. All right. Now, if we go to the next page, please, and the page after that. Right. Thank you. In relation to People Care, we – I'm sorry – that's another entity with a redacted name. But, in any event, there are three headings in the grey boxed area towards the bottom of the page. State Health Network. Is that a reference to the Health Department's state office?

MR SPEED: That's correct.

MR GRAY: All right. It's not the relevant jurisdiction's health authorities?

MR SPEED: No.

MR GRAY: No. And PAPRB, is that the prudential compliance and risk area?

MR SPEED: In Mr Murray's branch.

MR GRAY: That's Mr Murray's branch. And what's PAPRB accountability, as opposed to PAPRB prudential risk? What's the difference?

MR SPEED: That's the structure that operated before my time. I can't give you precise information on what its functions were.

MR GRAY: All right. We will just – just bear with us for a minute. If we go, please, to page 2504. That's the section of the SPoC list relating to People Care, isn't it?

MR SPEED: That's correct.

MR GRAY: And if we go over the page, please, we see the same headings for it. These are really standard form headings; is that right?

MR SPEED: That's my understanding.

MR GRAY: And are those headings, in effect, the indicators of the sort of sources of information that inform whether the provider is included on the list in addition to non-compliance information?

MR SPEED: From this template, it's my understanding that that represents the structures of the people participating in the SPoC at that time.

MR GRAY: All right. And there's also, for completeness, a reference to the CHSP and the NATSI Flex programmes, isn't there?

MR SPEED: That's correct. Yes.

MR GRAY: Okay. So would you put that document away. In paragraph 33 of your statement of 23 July, again on the topic of the SPoC list, you say that the regulatory approach does not change with inclusion of a service provider in the SPoC list of itself. So you're saying that there's no particular action that's triggered by inclusion in the list; is that right?

MR SPEED: The list does not and is not intended to replicate the regulatory framework is the intent of that statement.

MR GRAY: It's an information tool. It's not - - -

MR SPEED: That's - - -

MR GRAY: It doesn't lead to any particular action.

MR SPEED: That's correct.

MR GRAY: All right. It may, but not necessarily, lead to a particular action being taken under the compliance framework?

MR SPEED: That's a fair assessment, yes.

MR GRAY: All right. Is there anything outside the strict legal steps under the compliance framework that is triggered by inclusion in the list as a matter of general policy and procedure or usual practice?

MR SPEED: Is there anything outside of the regulatory framework?

MR GRAY: Of serving notices and taking formal steps under the compliance framework.

MR SPEED: Yes. So I mentioned the home support grant programme earlier. So if there was a failure to report under those grant obligations, an officer might draw that to the attention of the SPoC team.

MR GRAY: Yes. No. I'm asking once the service provider is actually included in the list, assuming a decision is made, on whatever criteria that is done, what then follows? Is there heightened monitoring as a matter of course?

MR SPEED: No. It's an information-sharing activity. So there's an awareness from, for example, prudential participants, quality compliance participants and the State Health Network that there is, using my example, a grant management issue for that particular provider.

MR GRAY: Okay. Now, based on your knowledge from your involvement in the SPoC committee, although it sounds like you might have only been to one of the meetings on 1 April, nevertheless, since – at least since March, have you been apprising yourself in some way of what the SPoC committee does?

MR SPEED: I apprise myself of what issues the SPoC committee is considering, because then a director will inform me of those.

MR GRAY: All right. Based on your knowledge of what the SPoC committee does and then what is done with the SPoC list, is there, as a matter of usual practice, increased monitoring once a service provider is included in the SPoC list?

MR SPEED: That may occur. If there's increased awareness of risk, that may occur.

MR GRAY: Have you directed that that should occur?

MR SPEED: No.

MR GRAY: Okay. So it's, essentially, left open whether or not it will occur; is that right?

MR SPEED: No. The monitoring of a provider will occur in the context of the regulatory framework in the Act. So that's the correct procedure that all officers should follow.

MR GRAY: And going back to your answer a minute ago, you've said that it actually doesn't result in anything different from the compliance – I think you said compliance framework or compliance regime under the Act.

MR SPEED: Through inclusion on a SPoC?

MR GRAY: Yes.

MR SPEED: Yes. The SPoC, as I mentioned earlier, is an information-sharing forum predominately.

MR GRAY: All right. So that suggests, doesn't it, that there is not increased monitoring as a result of inclusion in the SPoC list?

MR SPEED: Not always. It may be the information that comes to SPoC has also been presented elsewhere and a case conference, for example, decision may be made to increase or escalate a response to that example.

MR GRAY: Well, again, these are speculative answers, are they? You don't know whether there's increased monitoring as a result.

MR SPEED: I'm speculating because it will depend on the individual circumstances of a case.

MR GRAY: And you haven't made any direction, and you're the head of the compliance branch, that there should be increased monitoring as a result of inclusion in the SPoC list.

MR SPEED: There would be increased awareness of an issue as a result.

MR GRAY: Well, I just asked did you make a direction. And I think you said earlier that you haven't.

MR SPEED: My direction and involvement in the SPoC, I would have seen the terms of reference and signed off on the terms of reference in April. That would have been - - -

MR GRAY: So you don't know whether you've made a direction that there should be increased monitoring as a result of inclusion of a service provider in the SPoC list.

MR SPEED: Like – again, it would come to the individual case and I would need to be - - - - - -

MR GRAY: Have you made a general direction that if a service provider is included in the SPoC list there should be increased monitoring? Yes or no; have you made such a direction?

MR SPEED: Not in so many words, no.

MR GRAY: Well, not in any words?

MR SPEED: Well, not in that regard, no.

MR GRAY: Have you made a direction that there should be – that the agency, now the commission, should be requested to survey a greater number of residents to obtain their customer experience reports than usual during visits?

MR SPEED: I don't have the authority to direct the commission to undertake an activity.

MR GRAY: What about a request?

MR SPEED: We can refer information to the commission, yes, and we do.

MR GRAY: Have you requested the commission to administer a larger number of CERs than would usually be the case if the service provider in question is on the SPoC list?

MR SPEED: No.

MR GRAY: Have you requested the commission to visit – that is to perform unannounced assessment contacts – during night-time hours or on the weekend if a service provider is on the SPoC list?

MR SPEED: Not if they're on a SPoC list, no.

MR GRAY: Have you directed the relevant team within your branch to conduct a review of the suitability of a provider to be an approved provider with a view to potential 10-3 revocation if the provider is on the SPoC list?

MR SPEED: I have directed that but not because they're on a SPoC list.

MR GRAY: All right. So in respect of particular cases - - -

MR SPEED: That's correct.

MR GRAY: - - - you have but there is no standing direction to consider 10-3 revocation if a provider is on the SPoC list.

MR SPEED: Because a provider is on a SPoC list would not be a reason to direct a 10-3 notice.

MR GRAY: All right. But it would be a reason to find out more and to apply enhanced monitoring and scrutiny of the provider, I suggest; wouldn't it?

MR SPEED: Yes.

MR GRAY: And ways in which that could and should be done include the ways I mentioned to you: unannounced visits in the night-time and on the weekend, that would be a good idea, wouldn't it?

MR SPEED: It could be, yes. Yes.

MR GRAY: Greater number of CERs – consumer experience reports – to see what the recipients of the care actually say about the care they're receiving?

MR SPEED: There could be, yes.

MR GRAY: That would be a sensible thing to do for a provider that's included on the list?

MR SPEED: Yes.

MR GRAY: They shouldn't just be administered during site audit visits but also during assessment contacts, shouldn't they?

MR SPEED: Potentially. It will depend on the circumstances of the case.

MR GRAY: Now, contractual outsourcing arrangements, if the department is apprised of, in some informal way, from the agency or commission, of a contractual outsourcing arrangement whereby management of the care services has been outsourced, that would be a reason for greater scrutiny of the approved provider, wouldn't it?

MR SPEED: Yes.

MR GRAY: One of the key things to find out would be the details of the roles and responsibilities under those arrangements; correct?

MR SPEED: Yes, I'd agree.

MR GRAY: Unless the department finds those details out, it doesn't know whether it should be making contingency plans in case those roles and responsibilities are unclear; agreed?

MR SPEED: Yes, that's fair.

MR GRAY: If those roles and responsibilities are unclear and it becomes apparent to the department that they're unclear because further inquiries reveal that, then it would be necessary for the department to make contingency plans for the possible cessation of services; do you agree with that?

MR SPEED: If that information became apparent, yes.

MR GRAY: If we think about the HelpStreet and People Care scenario, the Earle Haven case study, the department was apprised, informally through the commission by emails, not in a notification form, but it was apprised of an outsourcing of management, wasn't it?

MR SPEED: I believe so, yes.

MR GRAY: In March 2018?

MR SPEED: I believe so, yes.

MR GRAY: The department failed to follow up and clarify what the roles and responsibilities of People Care, on the one hand, and HelpStreet on the other were?

MR SPEED: That would seem to be the case, yes.

MR GRAY: And that meant it was impossible for the department to make contingency plans in case of a cessation of services at Earle Haven?

MR SPEED: That seems to be the case, yes.

MR GRAY: People Care was removed from the SPoC list on 17 October 2017. Were you able to satisfy yourself of that fact from the documents in the Earle Haven tender bundle?

MR SPEED: Yes, I'm aware of that.

MR GRAY: And as far as I know, People Care was never reinstated to the SPoC list at any time until 11 July 2019; that's right, is it?

MR SPEED: I don't know that it's - - -

MR GRAY: I beg your pardon, is that fact right? That's my understanding, and I'm asking you is that fact right.

MR SPEED: I don't know that it's been reinstated, but it would appear to the case that it was taken from the list in October - - -

MR GRAY: October 2017.

MR SPEED: 2017.

MR GRAY: We don't have any documents produced by the department suggesting that it was thereafter reinstated to the list at any time up to and including 11 July 2019?

MR SPEED: No.

MR GRAY: So that suggests that People Care was not reinstated to the list at any time until 11 July 2019 at least; do you agree with that?

MR SPEED: I would point to the fact that a case meeting was established from 11 July regarding that provider and that case meeting replaced any SPoC conversation that might occur.

MR GRAY: Did that occur as a result of the cessation of services around the middle of the day on 11 July?

MR SPEED: Yes, that's – that's correct.

MR GRAY: I'm really asking about whether the red flags prior to the middle of the day, 11 July, were picked up by the department and acted upon. One way in which that perhaps could and perhaps should have occurred would have been inclusion of People Care in the SPoC list; do you agree with that?

MR SPEED: That would have been one way, yes.

MR GRAY: But the department failed to include People Care in the SPoC list up to and including the middle of the day on 11 July; do you agree with that?

MR SPEED: Yes, that's correct.

MR GRAY: Do you agree with the following facts: People Care had a long history, known to the department, of persistent non-compliance on quality standards straddling both residential and home care?

MR SPEED: From a review of the information, that appears to be the case, yes.

MR GRAY: People Care's services had been the subject of serious risk decisions and sanctions. That is, People Care had been the subject of sanctions as well; do you agree with that?

MR SPEED: Yes.

MR GRAY: In June 2016, there was an adviser appointed pursuant to a conditional revocation sanction; do you agree with that?

MR SPEED: That appears to be the case, yes.

MR GRAY: Appears based on your review of the file?

MR SPEED: That's right, yes.

MR GRAY: That adviser was in place for some months after June 2016. In the course of the adviser's appointment, the adviser raised concerns about the sustainability of improvements. Do you agree with that?

MR SPEED: I haven't seen that concern raised.

MR GRAY: All right. If we have a letter referring to that matter, I take it you don't have any information to the contrary?

MR SPEED: That's fair.

MR GRAY: All right. After that adviser had finished assisting People Care, in May 2017 further sanctions ended up being imposed on People Care?

MR SPEED: Yes.

MR GRAY: The fact that, in spite of having been sanctioned under a conditional revocation and had an adviser appointed, within a year or so, or within less than a year, the approved provider had again become subject to sanctions; that suggests that this approved provider, at that point, was unsuitable to remain an approved provider, that is, May 2017. What do you say to that?

MR SPEED: I would say to that that there would be – it's not necessarily the case that because a provider has had a sequence of sanctions that they remain unsuitable. It may be that there has been issues that they have now resolved and have returned to compliance and, therefore, are suitable.

MR GRAY: All right. Let me ask you about a few more facts. That approved provider, People Care, had, on multiple occasions up to that time, shown poor capacity on governance, management and human resources issues. Do you agree with that characterisation of what the file shows?

MR SPEED: That appears to be – yes.

MR GRAY: Yes. When you add those matters to the fact that, in spite of being helped by an adviser in 2016, the approved provider slipped back into a position of such poor service provision that it was again sanctioned in 2017; when you put those things together, you have an approved provider who should have been in a deliberate and careful manner, phased out of the sector by ultimately having its approval revoked after some sort of orderly transition of its residents. What do you say to that?

MR SPEED: There are examples where providers have had similar circumstances, have returned to compliance and continued to – and provide quality care. There are also examples where, I concede, there are issues that, if all the information had been put together, indicate that there may have been systemic issues that warranted a more immediate response.

MR GRAY: Well, when we look at what ultimately happened in 2019, where there was some sort of a contractual dispute ending up in a confrontation between – that is, a commercial confrontation between the approved provider and the contractor, and that ended in the abrupt cessation of services to the residents, you'd agree with me, wouldn't you, that the fact that that occurred suggests that I'm right that this approved provider should have been managed out of the sector back in 2017?

MR SPEED: I'd agree that there was information that occurred immediately prior to 11 July that the department was not made aware of by the approved provider, which

led to those circumstances of 11 July and pointed to significant concerns about the suitability of that approved provider.

MR GRAY: But you're not quite agreeing with me that this approved provider should have been managed out of the sector and had its approval revoked when it showed that improvements in its services was unsustainable after its initial sanctions in 2016?

MR SPEED: I'm agreeing with you in that information could have been sought earlier in relation to the approved provider and its suitability.

MR GRAY: You're the head of compliance in the department, aren't you?

MR SPEED: At a branch level, that's correct.

MR GRAY: Are you the delegate for making decisions under 10-3?

MR SPEED: I am a delegate. There are other delegates, yes.

MR GRAY: Are you telling the Commission that, if you'd known all the facts that I enumerated and you agreed with, that you wouldn't have revoked the approval of that approved provider?

MR SPEED: I'm speculating that if I'd known all the information that I'm now aware of, earlier intervention and requests for information would most likely have been provided.

MR GRAY: Mr Speed, you sound very hesitant in answering my question. Are you being guided by an overarching consideration that, really, the purpose of the compliance regime is to manage approved providers back to compliance at all costs?

MR SPEED: The overarching purpose of the regime is to ensure care and safety for residents. We do that through, in the first instance, supporting providers to return to compliance. Where that doesn't occur, or is not a result, then we have a range of tools, including the 10-3 notice that you've referred to, to facilitate a change of provider.

MR GRAY: And it hadn't occurred on a number of occasions for this approved provider. There'd been opportunities for the approved provider to be managed back to approved compliance with the assistance of external assistance, external adviser, for example, and the approved provider had failed. So by 2017, it was obvious that they were no longer suitable. Are you saying that you are hesitant about whether there'd be a revocation of approval, even in those circumstances?

MR SPEED: I'm saying that if all of that information had been known to the department at that time, there may have been an earlier response such as the issuing of a 10-3 notice.

MR GRAY: Well, I'm not conceding, in leaving the issue, that those facts weren't known to the department. I think they were known to the department, weren't they, Mr Speed? I won't go back over it. Now, I suggest to you that an appropriate and responsive approach to regulation, in the overall interests of vulnerable receivers of aged care services, necessitates a willingness on the regulator to go to the highest level of its regulatory powers and to revoke approval in cases such as People Care where there's such abundant evidence of the unsuitability of the approved provider; do you agree with that?

MR SPEED: Yes.

MR GRAY: Yes. If a regulator isn't willing to do that and to signal that it will do that, it's in the longer run not protecting the interests of receivers of care and it is not providing a sufficient signal to deter approved providers from providing substandard care; would you agree with that?

MR SPEED: If that were the case, yes, I would agree with that.

MR GRAY: There are other matters. Not only was the outsourcing arrangement notified to the department in relation to People Care in March 2018, albeit in an informal manner through emails, but, also, there was the matter of the prudential return non-compliance between January – or between, possibly, late 2018 all the way through to June 2019. That's so, isn't it?

MR SPEED: Yes.

MR GRAY: And that's an additional reason why suitability should have been considered, I suggest. What do you say to that?

MR SPEED: I would agree with that.

COMMISSIONER TRACEY: It's an explanation, is it not, of why the delegate didn't refer the matter to Mr Murray, because there would have been nothing to report on.

MR SPEED: There was some information provided to report on, but the information was incomplete.

COMMISSIONER TRACEY: Well, the accounts weren't there.

MR SPEED: That's correct.

COMMISSIONER TRACEY: So there was nothing for Mr Murray's people to tear apart and give advice to the delegate on and yet the delegate went ahead, on the eve of what happened on 11 July, and lifted sanctions.

MR GRAY: Commissioners, the facts are not Clear, but it is possible that, although there was a complete failure referred to January 2019, certain returns - - -

COMMISSIONER TRACEY: Yes.

MR GRAY: - - - were provided after that time, albeit they were incomplete or had errors in it.

COMMISSIONER TRACEY: Well, that's the point. They weren't complete accounts. And – but the point is, for whatever reason, according to the document you put up earlier, there was no reference to Mr Murray's branch before the decision was taken to lift sanctions.

MR GRAY: No. Well, our friends for the Commonwealth can draw attention to any such document if there was one. And, in addition – Commissioner, may I proceed?

COMMISSIONER TRACEY: Yes.

MR GRAY: I'm going to finish this topic - - -

COMMISSIONER TRACEY: No. No. You go on.

MR GRAY: In addition, the prudential compliance section was encountering a lack of cooperation with its inquiries about the outstanding prudential information, in particular from Mr Lang, who was said to be the approved representative, or, to use their expression, delegate of the approved provider, in that period of January to June 2019; do you agree with that?

MR SPEED: Yes, I do.

MR GRAY: And you've already agreed that lack of cooperation with inquiries is – I said a critical red flag or a critical risk factor. You said it was a risk factor. That also suggested unsuitability, I suggest to you.

MR SPEED: Yes.

MR GRAY: And this may not have been a matter that the department was apprised of, but complaints officers of the commission were in communication with the contractor HelpStreet about complaints, at least by 4 April 2019. And then the commission learnt, in a meeting of 30 May 2019, that communications about complaints were not being transmitted by the contracted management company, HelpStreet, to the approved provider People Care. Now, do you know whether either of those facts was conveyed to the department?

MR SPEED: No, I do not know that.

MR GRAY: All right. If they had been conveyed to the department, those would have been matters that should have been taken – that should – had they been conveyed to the department, they should have been considered in a review about whether approval should be revoked on ground of suitability. Would you agree with that?

MR SPEED: I would agree with that, yes.

MR GRAY: Could we bring up – and this is the last subtopic just before lunch and then I've got two topics to address after lunch, Commissioners. If we bring up tab 101, please, Operator. This is an email authored by the Aged Care Quality and Safety Commissioner, Janet Anderson, dated on the evening of 11 July to – not to you, Mr Speed. And I'm not suggesting you would have seen this before, save in reviewing the tender bundle in preparation for giving your evidence. This is a document from the Earle Haven tender bundle, of course. In respect of the five questions Ms Anderson is asked, I will ask you your opinion responding to each in turn. Firstly:

> *When a provider seeks approved provider status, what visibility does the department have of their proposed operating model and any intention to subcontract service delivery?*

MR SPEED: So in the approved provider application, the provider would be expected to detail how they intend to operate, is my understanding.

MR GRAY: All right. So that should be disclosed in the application form.

MR SPEED: That's correct. And, also, disclosed as a material change if they were changing their model after approval.

MR GRAY: Thank you. Two:

> *Is there any obligation on the applicant provider to disclose this in their application?*

You've just answered that. And so the second question is redundant. Three:

> *If an approved provider commences operations by employing staff who deliver care and services but subsequently decides to subcontract some or all of this work to another party, are they obliged to notify the department of this?*

MR SPEED: And it's my understanding that they should through the change of material process. Yes.

MR GRAY: It's a little – we went over that on Monday. It's a little unclear, though, isn't it? Would you accept that?

MR SPEED: I would accept that.

MR GRAY: It should be clearer. Do you agree with that?

MR SPEED: Yes.

MR GRAY: Four:

Is the department required to undertake any due diligence about whether the subcontractor is a fit and proper entity to fulfil these responsibilities?

That's an important question, Mr Speed. Do you have an opinion on that question?

MR SPEED: My opinion would be, if the department becomes aware of that arrangement, then it would – could request under a 9-2 notice, for example, further information about that arrangement to form that opinion.

MR GRAY: Yes. And what about the anterior point? Is the department required to issue that 9-2 and to undertake that inquiry process called by Ms Anderson a due diligence?

MR SPEED: A requirement – there is a requirement for the department to assure itself that key personnel at a provider are fit and proper. However, the Act requires the approved provider to provide that notice to the department.

MR GRAY: What powers does your compliance branch have over subcontractors?

MR SPEED: To my knowledge – well, the focus of the compliance programme is around whether a provider is meeting its obligations under the Act. If it's not meeting its obligations under the Act, then we have the authority and powers available to us in the Act to respond to that.

MR GRAY: Yes, but they're addressed to the approved provider, not to the subcontractor. That's right, isn't it?

MR SPEED: That's correct.

MR GRAY: So you can only apply indirect pressure on the subcontractor through the approved provider.

MR SPEED: The relationship is with the approved provider.

MR GRAY: So the powers of the branch and the department are sadly lacking in respect of the ability to direct subcontractors to do anything; is that right?

MR SPEED: We may direct the approved provider, but there's no immediate relationship with the subcontractor, that's correct.

MR GRAY: Yes. And, fifthly and finally:

If an approved provider's board forms the view that they're no longer willing or able to operate the service, what are the board's obligations under the Aged Care Act in terms of advising the department or commission and advising consumers, that is, care recipients and their family and advising staff?

Do you have any opinions on that matter?

MR SPEED: My opinion is that the department – the approved provider has obligations to advise the department, relatives and the commission.

MR GRAY: The only statutory notification obligation requires notification within 28 days after an event, doesn't it?

MR SPEED: I believe that to be the case, but there's also, I would think, a moral obligation to inform consumers and families of any changes.

MR GRAY: I agree with you, but a moral obligation is not enough if you're seeking, in your compliance branch, to enforce it, I suggest. Again, the powers of the department are sadly lacking in this respect, as well. Do you agree with that?

MR SPEED: That's a fair view.

MR GRAY: Is that a convenient time?

COMMISSIONER TRACEY: It is, Mr Gray. May I ask whether there has been a response to that request for information.

MR GRAY: It appears not, but over lunch we will see what can be done.

COMMISSIONER TRACEY: The request was made over a month ago or thereabouts. It would be very interesting to know what view – I assume it was directed to an officer of the department – to know what the views of the department are on each of those matters.

MR GRAY: Thank you. I don't know that it was directed to the department. It may have been directed to other staff within the commission.

COMMISSIONER TRACEY: I see.

MR GRAY: But I will follow up.

COMMISSIONER TRACEY: Thank you.

MR GRAY: Commissioner, we're running behind schedule. Of course, these are important topics we're traversing. Might I ask for a very brief luncheon adjournment.

COMMISSIONER TRACEY: Yes. Well, I was proposing to adjourn till 2 o'clock.

MR GRAY: Thank you, Commissioners.

COMMISSIONER TRACEY: Yes. There was one matter. And that is those instructing you will remind Mr Speed of that matter you were proposing to get him to inquire into over the lunch break.

MR GRAY: Yes.

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

ADJOURNED **[1.27 pm]**

RESUMED **[2.06 pm]**

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. Mr Speed, over lunch, have you had an opportunity to check the risk matrix in the terms of reference of the SPoC committee?

MR SPEED: Yes, I have and there is no reference to contractual matters in that matrix.

MR GRAY: Okay. And is there anything further you wish to add to your earlier evidence having had that chance to review the terms of reference?

MR SPEED: No, there is not.

MR GRAY: All right. Commissioners, may I now tender the general tender bundle for the hearing. The operator is now displaying it on the screen, and it consists of 154 tabs. I tender the documents referred to in the index currently displayed on the screen.

COMMISSIONER TRACEY: This is under the title Brisbane General Tender Bundle?

MR GRAY: Yes.

COMMISSIONER TRACEY: Yes. The Brisbane general tender bundle will be exhibit 8-27.

EXHIBIT #8-27 BRISBANE GENERAL TENDER BUNDLE

MR GRAY: Thank you, Commissioner. We will bring up tab 88 of that tender bundle, and I'm now turning to the topic of compulsory reports. Mr O'Brien was examined on compulsory reports earlier today. I'll be asking a few additional questions of Mr Speed. Mr Speed, are you the branch head responsible for the operations of Mr O'Brien's group?

MR SPEED: That's correct.

MR GRAY: Is it true that, at least as of June 2019, there are staffing issues in Mr O'Brien's group?

MR SPEED: There is – we have one vacancy in the allocation of resources that we have.

MR GRAY: Isn't it the case that a lower number of notification cases were closed in June 2019 by comparison with the preceding month by about a factor of a half?

MR SPEED: I'd need to check that.

MR GRAY: All right. Well, let's come to that in a minute. I'll start with tab 88, which is on the screen. This is a document which relates to an earlier period of compulsory reporting and contains statistics in relation to that period and, over the page, on page 7293, it captures reports – statistics – in relation to the period from 1 July 2017 through to the end of May 2018, so almost the entire financial year but not quite; is that right?

MR SPEED: That's correct.

MR GRAY: If we look at the table at the foot of page 7293 – if we can call that out, make it a bit bigger please, operator – reports processed 1 July 2017 to 30 May 2018. The total for what was almost the entire financial year, but not quite, was a little over 3000 reportable assaults. That's reportable alleged or suspected assaults, isn't it?

MR SPEED: That's correct.

MR GRAY: 3059 of those. Could I ask you just to make a mental note also please, Mr Speed, of the figure for out-of-scope reports, 345. Does that mean that a report was made by the approved provider, but it was found that they're not actually reportable according to the criteria in 61AA of the Act?

MR SPEED: That's correct.

MR GRAY: Thank you. Now, 61 – I beg your pardon, I should say 63-1AA, shouldn't I?

MR SPEED: That's correct.

MR GRAY: 63-1AA of the Act enables an exemption to apply under subordinate legislation, doesn't it, so that suspected or alleged assaults need not be reported if they fall within an exemption that's prescribed in the *Accountability Principles*?

MR SPEED: That's correct.

MR GRAY: For present purposes, I'll just ask you to bear in mind that the exemption that I'll be asking you about briefly is in relation to assaults that are alleged or suspected to have occurred where the alleged or suspected perpetrator has a diagnosis of a cognitive impairment and certain other things happen. And you know about that exemption, don't you?

MR SPEED: Yes, I do.

MR GRAY: All right. Now, just putting that to one side, and returning to the question of figures, if you just bear in mind that the figures for almost the entirety of financial year 2017-18 were a bit over 3000 and one would expect the ultimate figure to come in somewhere in the 3000s, it's the case, isn't it, according to Mr O'Brien's evidence, that there's currently about 7000 reportable suspected or alleged assaults occurring that his team is having to deal with. Did you hear that evidence this morning?

MR SPEED: No, I didn't hear that evidence, but figure would include the missing care resident reports as well.

MR GRAY: All right. And there aren't nearly as many of those as there are suspected or alleged assaults, are there?

MR SPEED: That's correct.

MR GRAY: If we look at the next document which is tab 150, we then have a monthly report in respect of June and a financial year to date for June 2019 to compare the previous document against. This is a similar report of the statistics in relation to reportable incidents to the one we just looked at but it's for this financial year up – I beg your pardon - - -

MR SPEED: The previous - - -

MR GRAY: The financial year that's just concluded.

MR SPEED: Yes, yes.

MR GRAY: Up to June 2019; is that right?

MR SPEED: Yes.

MR GRAY: Thank you. Now, we see on page 7952, the first page, that unexplained absences are roughly a fifth or sixth of overall figures; is that right? 22 per cent?

MR SPEED: For that month of June, yes.

MR GRAY: Yes. And is that – that's the general trend, unexplained absences tend to be only about 20 per cent or so of overall reports?

MR SPEED: Around that figure, yes.

MR GRAY: Now, if we just go down the page please, operator, there is a pie chart and some text alongside and this is a report in respect of June 2019. In the second paragraph on the text adjacent to the pie chart, it says a total 742 notification cases were closed during the June 2019 period. That means finalised; is that right?

MR SPEED: That's correct.

MR GRAY: In some cases, they've been – Mr O'Brien gave evidence about that; I won't ask you about that. Now, it then says that's down from a figure that's about double in May 2019. Do you see that?

MR SPEED: Yes, I do.

MR GRAY: Was this reported to you in the course of your duties as head of the branch?

MR SPEED: Yes, I received this report.

MR GRAY: Yes. And it then says this is due to decreased staffing capacity and leave?

MR SPEED: Yes.

MR GRAY: So have you put on more human resources on to Mr O'Brien's team as a result of this report?

MR SPEED: We have maintained the profile that we have funding for, apart from the vacancy that I mentioned earlier. We had additional resources available to us in the previous financial year to deal with a larger number of cases that we – we had.

MR GRAY: There's 7.4 full-time equivalents in the team that Mr O'Brien manages and works in; is that right?

MR SPEED: That's correct, around 7.2, I believe.

MR GRAY: That's roughly the same now as it was in the preceding year; is that right?

MR SPEED: Aside from the vacancy that I mentioned, yes.

MR GRAY: Yet, on the indications in this document and Mr O'Brien's evidence, that you'll just have to accept from me from the bar table, that they're now dealing with about 7000 reports, there seems to have been almost a doubling, or perhaps a doubling, in the volume of reports. Has that been reported to you?

MR SPEED: I'm aware that there has been a significant growth in the reports over the last two, for example, financial years.

MR GRAY: Yes.

MR SPEED: And the resource implications that that brings.

MR GRAY: So doesn't it follow that, even to maintain a level of qualitative assessment of the contents of the reports that are coming in, you would need to double the human resources available?

MR SPEED: Not necessarily. The team was dealing with a large lag of cases that arose when the team – when the function was consolidated in a single team back in the beginning of 2017/18. In addition to that, there was an additional piece of work that the team engaged in around the time that the Royal Commission was called, where the team reviewed the draft terms of reference that were provided to the department at that time and the department was initially managing the terms of reference procedure, to ensure that there were no issues within those comments received from the public which indicated that there are concerns around compulsory reports.

MR GRAY: Are you satisfied that the team is scrutinising, and is resourced to scrutinise, the reports that come in qualitatively to the level that you regard as appropriate for proper public administration?

MR SPEED: I'm satisfied that the team is resourced, if it was – all positions were filled to adequacy manage the processes described in the Act. Ideally, I would prefer additional resources to be able to undertake some more analysis and more detailed investigation. However, those functions are not required under this scheme as it's currently constituted.

MR GRAY: So is that a you're not satisfied? For proper public administration, you would require more?

MR SPEED: I would prefer more, yes.

MR GRAY: Yes. All right. Now, you didn't hear Mr O'Brien's evidence but, in certain circumstances, he said, "Well, if I was doing that, I would have looked further" or, "I can't see a report. I don't know enough about it". Are you familiar enough with the Japara case study to form a view whether an appropriate level of scrutiny was applied to the series of reports from the two or three facilities in question?

MR SPEED: I'm aware of some of the case studies and some of the compulsory reporting issues associated with those, yes.

MR GRAY: Just broadly, have you been able to form a view whether you're satisfied that the reports were followed up qualitatively to the extent that you would regard as appropriate for proper public administration?

MR SPEED: Where all the information that was provided by the provider was received on time and assessed, yes. However, I concede that there were opportunities for further follow-up which are not currently available in the compulsory reporting resources.

MR GRAY: All right. So if there had been more resources, there would, ideally, for proper public administration, had been more follow-up in the Japara case?

MR SPEED: For those cases that are managed in the team as it's currently constituted, I can't comment before 2017. I wasn't involved in the team then. I would see that the team now follows through with investigation as far as it possibly can with the resources available.

MR GRAY: So I think that's a yes to my question, is it?

MR SPEED: I'm satisfied that currently we are following up as much as we possibly can, yes.

MR GRAY: Yes, but if you had – ideally you would want more resources so you could – so in the – I withdraw the question and ask it again. In the Japara case, are you saying that you're not satisfied, due to resourcing issues, that sufficient follow-up on the qualitative content of all of the reports in that case was able to occur?

MR SPEED: Where it was within the scope of the scheme to do that. Some of the follow-up and assurance would have been the role of the quality agency at that time and now the Quality and Safety Commission. So there are some different functions associated with these cases that need to be considered.

MR GRAY: Yes. I'm just asking whether – have you been able to form a view about whether there was an appropriate level of follow-up in relation to all that series of reports in the Japara case or not? Have you not been able to form that view?

MR SPEED: Not for every case but, broadly, yes, I can form a view and I consider there was, on the information available to the team, an appropriate level of follow-up.

MR GRAY: All right. So there are some reports in which you haven't formed that view. Is that what you're saying?

MR SPEED: That's correct, yes.

MR GRAY: All right. Now, there were various times when Mr O'Brien said, "Well, I can't tell from the face of the report, so I can't answer that question". I want to ask you about document 104, which is the compulsory reporting manual, which is ADS-15, one of your annexures. Now, if we, please, go to page 7290. It's the case, isn't it, that if there's a request for information that the officer assessing the report seeks to make to supplement the information in the report, the request must be recorded in the NCCIMS notification case. Do you agree with that?

MR SPEED: That's correct, yes.

MR GRAY: Yes. So if no document's been produced by way of a record from that NCCIMS notification case, then we can infer, can't we, that a request wasn't made?

MR SPEED: That's a fair assessment, yes.

MR GRAY: And when did this manual commence?

MR SPEED: This manual was completed in, I believe it was August 2017.

MR GRAY: And, prior to that, was there a quick reference guide?

MR SPEED: There was a quick reference guide plus an earlier version of this document.

MR GRAY: All right. Well, let's go to the quick reference guide. I just want to ask you about it, and then we will come back to the manual. If we go to tab 149, please, Operator. This was current in 2016/17. And then was it, what, replaced by the new manual?

MR SPEED: This quick reference guide is now included in the manual, yes.

MR GRAY: Yes. All right. Now, if we go to page 0021. Perhaps I should ask, Operator, if you show the bottom of 0020, the heading, leading into 0021. Do you see there the heading is Provision of a Safe Environment. And this quick reference

guide is instructing officers to consider, amongst other things, whether the information disclosed in the report from the approved provider raises issues about provision of a safe environment by that provider to recipients of care; correct?

MR SPEED: Yes.

MR GRAY: And I just want to ask you about what appears at the top of page 0021 in the second paragraph. For example:

> *Are there problems with maintaining a secure living space in units housing residents with dementia or other psychogeriatric conditions?*

Do you see that?

MR SPEED: I do.

MR GRAY: Now, I just want to suggest to you that the guidance in this document is, I would say, correctly posing the question is there a safe environment in relation to, amongst other things, the management of care for people who are living with dementia or other psychogeriatric conditions. Do you agree with that?

MR SPEED: That's the point of the question, I believe, yes.

MR GRAY: And do you agree that that's right, that that is a valid question to consider when one's considering whether a safe environment is being provided?

MR SPEED: On assessing the information that's been provided in the report, yes.

MR GRAY: And doesn't this suggest that the exemption that applies under the accountability principles – I withdraw that. I will just leave it and I'll ask another witness about that. In the compliance manual – beg your pardon – the reporting manual, which we were looking at a moment ago. Thank you. The compulsory reporting manual. If we go to page 7292 and 3, please, Operator, if we can display them both at the same time. 7292 and 3. This is the current guidance as of that date in 2018 you mentioned. Is that right?

MR SPEED: 2017. Yes.

MR GRAY: Beg your pardon. 2017. And it's still current now?

MR SPEED: That's correct.

MR GRAY: And if we look, for example, at the guidance around assessment of the reportable assault form here, which appears from a third of the way down page 7292, we see there's a reference in the second bullet point to review of the residents by their GP and/or specialist services, eg, occupational therapist, physiotherapist,

psychogeriatrician, DBMAS. That's Dementia Behavioural Management Advisory Service. Correct?

MR SPEED: That's correct.

MR GRAY: And if we go over the page, we see another reference to DBMAS or a mental health unit in the fourth bullet on the facing page, 7293. In other words, the guidance here, although it's not the same as the quick reference guide in terms of the words used, it's still directing the attention of the officers to matters concerning the management of the care of people who are living with cognitive impairment caused by dementia, or possibly other mental health issues; is that right?

MR SPEED: That's correct.

MR GRAY: Yes. And that's correct – and that's the right sort of guidance, because that is an important matter when considering whether there's been a safe environment provided by the approved provider; correct?

MR SPEED: That's fair, yes.

MR GRAY: Yes. All right. Now, I want to take you to the current figures in tab 150 again. Thank you. We've got Mr O'Brien's evidence that he is estimating about 7000 reports coming through, but you didn't hear that evidence. If we look at this document, as at the end of the financial year, on page 7954, do we see there that the total reportable assault figures alone, without the unexplained absences, are 5233. And then if you add the unexplained absences, you're getting up towards 7000; do you see that?

MR SPEED: Yes, I do.

MR GRAY: If you add the out-of-scope, then you are at the 7000.

MR SPEED: That's correct.

MR GRAY: Do you see the out-of-scope figures 500 – beg your pardon – 405 out of the 7000-odd, that actually is a lower proportional percentage than in the previous financial year for out-of-scopes. Do you agree with that?

MR SPEED: Without comparing it on the screen in front of me, I believe so.

MR GRAY: Yes. It was about 300-odd - - -

MR SPEED: Okay.

MR GRAY: - - - out of 3000-odd. All right. Now, does this suggest – in particular the gross figures, suggest to you that, previous to this financial year that's just concluded, there was actually underreporting of reportable incidents?

MR SPEED: I would agree that there would be a level of underreporting, yes - - -

MR GRAY: All right.

MR SPEED: - - - based on this data and other data.

MR GRAY: Yes. And if you look at the graph, please, on page 7955, you can see the trend lines in reporting longitudinally since 2016/17. And you see there – there's a bit of a spike, but there's a sustained increase from around January. And it looks like – it's dipping slightly from May to June, but it's more – it seems like a reasonably sustained increase compared to, say, 2016/17; do you agree with that?

MR SPEED: Yes.

MR GRAY: And has the department done any analysis as to what the causes of those trends might be and, in particular, whether there was underreporting previously?

MR SPEED: There's been some analysis that's been undertaken in the context of designing the serious incident response scheme. That's undertaken in another branch of the department. And I understand some of that analysis has included consideration of compulsory reporting data, as well as other data such as ACFI data.

MR GRAY: All right. I want to move to my final topic, which is the department's responses to coronial findings and in particular the findings made in the case of Mrs Quayle, which you've addressed in your statement of August, 2 August 2019, replacing your 10 July statement. If we please display tab 107, Operator. This was a case on the findings of the coroner in which a resident with a history of aggression inflicted physical harm on Mrs Quayle; correct?

MR SPEED: Yes.

MR GRAY: And Mrs Quayle died as a result of that?

MR SPEED: Yes.

MR GRAY: And the coroner found, at paragraph 81, that:

> *If Glenmead Village had adequately managed the risk of harm posed by Resident A, Mrs Quayle's death could have been prevented.*

Correct?

MR SPEED: I believe so, yes.

MR GRAY: The then agency – this was back in 2013 – conducted a visit shortly after the death of Mrs Quayle and in its report of that visit didn't refer to Mrs

Quayle's death and found there was no non-compliance in relation to behaviour management or safe environment; correct?

MR SPEED: That's my understanding.

MR GRAY: The coroner made some remarks about that in her findings; that's right, isn't it?

MR SPEED: Yes.

MR GRAY: Now, these findings were referred by the coroner to the department; is that right?

MR SPEED: Yes.

MR GRAY: And what action is the department taking in response to that referral?

MR SPEED: The information was referred to the department and to the Quality and Safety Commission. The department is not taking immediate action in response to those findings. Those findings particularly related to activities of the Quality and Safety Commission. But the circumstances of this unfortunate event would also be considered in how the department designs the serious incident response scheme.

MR GRAY: All right. Because the department is the steward of the overall regulatory framework, isn't it?

MR SPEED: In a policy sense, yes.

MR GRAY: All right. And it's completely unsatisfactory, isn't it, that, in the first place, an event like this occurred that could have been prevented, on the findings of the coroner, but also that in a visit shortly afterwards, the then agency decided that there was no non-compliance. That's completely unsatisfactory, isn't it?

MR SPEED: I believe so, yes.

MR GRAY: Doesn't that suggest, just by virtue of the fact that, in a setting where, on the coroner's findings, if the approved provider – in a setting where the coroner has found that the approved provider could have prevented the death, and at the same time the agency has decided that there was no non-compliance with the standards, doesn't that suggest that the standards that were in place at the time were wholly unsatisfactory?

MR SPEED: I think that would be a question that should be directed to the Commission in terms of how they applied those standards and measured those standards. I can only give a personal view on that.

MR GRAY: I have no further questions for Mr Speed.

COMMISSIONER BRIGGS: Yes. I just have one question. In your answers earlier on in the session, Mr Speed, you mentioned that the terms of reference around the matters that will be looked at around assaults had been updated around the time of the formation of the Royal Commission, and we heard something about that this morning, with a shift from a focus on were they meeting the reporting timeframe, to focus on safety and care. Was it usual practice at around September to November last year, for the department to revise many of its terms of reference, guidelines, policy arrangements, committee functions and so on, to focus more on quality and safety than might have been the case in the past?

MR SPEED: If I may just clarify that, Commissioner, I mentioned that there was a spike of activity which prevented the team from processing the complaints – the compulsory reports received, due to its activity in relation to looking at those draft comments. The change to the compliance manual predated the announcement of the Royal Commission. It was about when the team was established and ensuring that the procedural guidance was current at that time.

COMMISSIONER BRIGGS: I'd like you to answer the more general question: did the department go through a process of systematically reviewing its approach to ensure some kind of greater consistency to focus on safety and quality at around that time?

MR SPEED: At around that time, yes, there was the response to the Carnell/Paterson review and the department was considering the implementation of policy in response to that.

COMMISSIONER BRIGGS: The Carnell/Paterson review was sometime before that, I think over a year. Are you saying that it took the department that long to respond or what are you saying?

MR SPEED: No, I'm not. I'm saying that there's been ongoing quality reform measures that have occurred since the announcement of the response to that review.

COMMISSIONER BRIGGS: Thank you. I'm sure you will continue those ongoing quality reform issues.

COMMISSIONER TRACEY: Anything arising, Mr Gray?

MR GRAY: No, thank you, Commissioners.

COMMISSIONER TRACEY: Yes. Thank you, Mr Speed, for your evidence. You are excused from further attendance.

MR SPEED: Thank you.

<THE WITNESS WITHDREW [2.36 pm]

MR GRAY: Ms Hutchins will call our next witness.

MS HUTCHINS: Commissioners, I call the next witness, Ms Sarah Jane Holland-Batt.

<SARAH JANE HOLLAND-BATT, AFFIRMED [2.36 pm]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Ms Holland-Batt, you have prepared a statement for the Royal Commission; is that correct?

MS HOLLAND-BATT: That's correct, yes.

MS HUTCHINS: And for the benefit of the transcript, it's WIT.0330.0001.0001. It's a statement dated 24 July 2019. Have you had the opportunity to read over this statement before giving your evidence today?

MS HOLLAND-BATT: I have.

MS HUTCHINS: To the best of your knowledge and belief are the statements true and correct?

MS HOLLAND-BATT: They are.

MS HUTCHINS: Are there any amendments that you would like to make?

MS HOLLAND-BATT: Not at this stage, no.

MS HUTCHINS: Thank you. I tender that statement, Commissioners.

COMMISSIONER TRACEY: Yes. The witness statement of Sarah Jane Holland-Batt dated 24 July 2019 will be exhibit 8-28.

EXHIBIT #8-28 WITNESS STATEMENT OF SARAH JANE HOLLAND-BATT DATED 24/07/2019 (WIT.0330.0001.0001)

MS HUTCHINS: Thank you. Ms Holland-Batt, your statement relates to your father; is that correct?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: He is currently a resident in an aged care facility here in Queensland?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: Yes. And, for the purpose of today, we won't mention the name of the facility or your father's name but he has been living there since June 2015?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: Is that correct?

MS HOLLAND-BATT: Yes.

MS HUTCHINS: And what are the circumstances that led up to your father moving into that residential aged care facility?

MS HOLLAND-BATT: So Dad was diagnosed with Parkinson's in 2000 and he was able to stay at home for quite some time, for around 14 years because he was very, very mentally active and so he had a good home life for a duration. Around 2014, I became quite concerned about Mum's capacity to continue caring for him in the home. He was having a number of falls associated with movement disorder and so forth, and then he had quite a serious fall and Mum called the ambulance and he was taken to hospital. He had a quite steep decline in hospital and then, through discussions between my mother and myself and the hospital staff, they recommended that this might be a good transition point for Dad to move into care. So there was kind of quite a clear point at which Dad had a steep decline and, as a family, we decided that was time.

MS HUTCHINS: Yes. And how did your father find the transition into residential aged care?

MS HOLLAND-BATT: He was deeply kind of frustrated by it. So Dad was a really, really bright man. He was highly educated, very mentally active. He used to write compositions for fun, you know, had had a really kind of intellectually active life and so he found himself incredibly kind of bored and frustrated by his circumstances. He was quite devastated by his Parkinson's diagnosis, as someone who'd been really bright and active, and so he found himself quite bored and depressed when he moved in. At the time of moving him in, he was one of the – by far and away one of the most high-functioning residents in his kind of wing of the nursing home so he was a little bit depressed by the lack of conversation and the lack of things to do.

MS HUTCHINS: When you were looking to move your father into the residential aged care facility, were you involved in the process of choosing the facility?

MS HOLLAND-BATT: Yes. So Mum and I looked at a number of options and we were looking for not only a high degree of care but also for pleasant surroundings, because Dad at that stage could still play the piano to some extent, he still liked to read and so we were looking for something that would be pleasant, that had nice gardens, that had a good feel about it and we wanted him to have his own room as well. So we selected the facility on the basis that, not only did it purport to provide a high degree of individualised care but also that the surroundings looked really nice as well.

MS HUTCHINS: Yes. In your statement you detail that, from about 2016, you start noticing some issues with your father's care. Could you detail for the Commission what were the type of issues that you were seeing?

MS HOLLAND-BATT: That's correct. So it was – when Mum and I would go and visit, we would often find Dad dishevelled in unclean clothes. It was unclear whether he had not been showered and so was wearing clothes that were dirty from previous meals or the day prior or whether he had been showered but put back into dirty clothes. We'd obviously provided ample clean clothes for him and always ensured he had, you know, nice things to wear. So he was often unclean, dishevelled, lots of personal hygiene kind of issues. And more and more frequently, I began to notice issues, sort of small injuries, grazes, infections, cold sores, things that were unexplained and untreated.

And every time that would happen, of course, I would raise it with the resident nurse or Mum would raise it with the resident nurse or person on staff to say, "What's that going on with Dad's elbow? What's that going on with that sore? You know, what's happening here?" So it was a sort of pattern of what I began to perceive to be neglectful care.

MS HUTCHINS: What was the kind of response that you would get from staff when you would raise these issues?

MS HOLLAND-BATT: They would immediately move to treat it but my issue was – you know, and they'd say, "Sorry that we missed that. We must have missed that", that sort of thing. But my issue was that it, to me, suggested that overall the clinical observation was lacking, that these things were being left to families to observe.

MS HUTCHINS: Can you make any observations about what you think might have been the cause of those oversights?

MS HOLLAND-BATT: Absolutely. So it's staffing – staffing. I mean, half the time I would go and visit Dad and there's no one to be seen in his hallway. When people need to go to the bathroom, sometimes they have to wait for five or 10 minutes to get someone to attend. There are always sensors kind of pinging. You know, people have sensor mats on their beds, they can be just pinging away, and who knows when someone is actually going to come and attend to that. There's just not enough staff. And on top of that, I would observe that the number of medically-

trained staff is very low and there's been a high proportion of agency nurses and people who seem to come and go, that there's not much stability in the staffing or expertise along with a sheer lack of numbers.

MS HUTCHINS: And would you ever raise your concerns about the staffing that you've just detailed now – would you raise them with the facility management?

MS HOLLAND-BATT: Yes. Absolutely. All the time.

MS HUTCHINS: Yes, and what kind of response would you get?

MS HOLLAND-BATT: You'd get responses like, you know, it's really hard to find and retain good staff. You know, we've just had these problems. They were always sort of like little intermediate kind of explanations, "Oh well, that has just happened so we're suffering this issue this week" or something like that. But I came to see it as a sort of endemic issue.

MS HUTCHINS: Yes, yes. And so in your statement you detail at around May 2016, there was an issue that arose in relation to your father's medication?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: And so previously since the time your dad was diagnosed with Parkinson's disease, he has been taking a particular medication to treat that; is that correct?

MS HOLLAND-BATT: That's correct, yes.

MS HUTCHINS: Yes. And so could you explain what is that medication, you know, what's the types of symptoms that it helps to alleviate?

MS HOLLAND-BATT: Yes. So it's Madopar which is one of the most commonly prescribed Parkinson's medications. It allowed Dad to maintain some stability in his movements, allowed him to walk without suffering falls, helped with balance and coordination, helped with tremor. All those sorts of things. So it's – so it was his most essential medication related to maintaining his capacity to walk and move.

MS HUTCHINS: What was the issue that arose in relation to that medication?

MS HOLLAND-BATT: So in 2016, a GP who was recommended to us, who was at the facility, prescribed Dad with Phenergan, which is an anti-nausea medication because Dad was suffering from some nausea. That medication, as far as I understand, is contraindicated with Madopar which means it completely negates the effects of Madopar. The GP should have known that. The facility should have known that when they – when they observed his charts. But, due to no one noticing that these two medications, my dad was, essentially, without any support for his Parkinson's mobility issues. Dad was left without it for a period of several months.

MS HUTCHINS: Several months. Yes. And you note in your witness statement, as well, that even from the time when your father was first admitted into the facility, you had concerns about the regular administration of that medicine. Is that correct?

MS HOLLAND-BATT: That's true. So my mum and I had to raise – so Madopar works on the dot. It has to be given on the exact moment, at these hourly intervals, to ensure a steady supply of Madopar in the system. So we were aware dad was not being given the drug exactly on the dot, and so he was having sort of peaks and troughs in his capacity to move. And so that was something that we raised with them. And we would note that it seemed like that the drug was not being administered at the regular scheduled interval that it needed to be.

MS HUTCHINS: Yes.

MS HOLLAND-BATT: And then there would be, you know, steps to sort of remediate that, but then, again, the issue would recur. So it was a sort of recurring issue prior to him being prescribed with the Phenergan that cancelled it out entirely.

MS HUTCHINS: Yes. And then so in October 2016 when you had the appointment with the neurologist and it's identified the Phenergan is not compatible with that medication, what happened subsequent to that in relation to the medication?

MS HOLLAND-BATT: So the neurologist noted – this is dad's specialist neurologist – noted that he shouldn't be on it. And he gave an undertaking that he would write to the facility to ensure that dad was taken off the Phenergan, the anti-nausea medication immediately, and just didn't do that, did not send the letter.

MS HUTCHINS: Yes.

MS HOLLAND-BATT: Unbeknownst to Mum and I.

MS HUTCHINS: Yes. And so in your statement it comes to your attention that the letter was never sent when your father breaks his hip in December 2016; is that correct?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: Yes. And so what were the circumstances around that incident?

MS HOLLAND-BATT: So Dad broke his hip at some point during the evening and was taken to hospital, rushed to hospital. He had to have a hip replacement and, due to his advanced age, his mobility issues, his coordination issues, we were told pretty swiftly by the staff that he would not regain the capacity to walk again. Prior to that, he could walk short distances relatively unassisted.

MS HUTCHINS: And has that been the case?

MS HOLLAND-BATT: Yes, he doesn't walk at all. There was some rehabilitation, but he wasn't able to regain the capacity to walk. So when that happened, the staff at the hospital, the treating doctors, once again looked at his chart and said, "Why is he on Phenergan with Madopar? These things are incompatible." And that was the moment at which he was taken off that drug, but after he'd broken his hip, so it was too late.

MS HUTCHINS: Yes.

MS HOLLAND-BATT: Yes.

MS HUTCHINS: And, following that incident in March 2017, you detail in your statement that there's another instance where you notice an injury with your father's elbow. Is that correct?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: What arose in relation to that injury?

MS HOLLAND-BATT: So that was – so Dad went to breakfast, was taken to breakfast, by one of the morning carers. And someone at breakfast, one of the nursing staff, observed him with a tennis ball-sized kind of bright red infection on his elbow and said, "What's that? How long's that been there?" And Dad was then taken to hospital immediately that day and diagnosed with a really serious infection, bursitis, I think it was, in his elbow. And, again the hospital staff said, "How long has this been there? Why has this been untreated?"

And so then Mum and I made inquiries about how on earth this infection was allowed to get so bad. It was huge. It's not the sort of thing that comes up between having a morning shower and going to breakfast. And we were given the initial explanation by the facility that the person who had showered him just hadn't seen it - - -

MS HUTCHINS: Who – sorry – without saying the name - - -

MS HOLLAND-BATT: Yes.

MS HUTCHINS: - - - what position or role was that person in that gave you that explanation?

MS HOLLAND-BATT: That person was a carer. Yes. Entrusted with showering from – the transition from the night shift to the morning, when everyone's given their kind of morning showers. So initially the explanation we were given is she just hadn't seen it, which to me is ludicrous, just ridiculous. If you're showering – Dad needed a lot of assistance to shower, so how could you not have seen that? Yes.

MS HUTCHINS: And so what was the result of those inquiries?

MS HOLLAND-BATT: So then a whistleblower came forward to my mother, who was a nurse in the facility, who told mum that the carer who had showered dad and supposedly not seen this injury had been deliberately victimising and abusing Dad. So we were then made aware that not only was this infection allowed to get so bad, but, also, that there were really grave concerns about dad being victimised.

MS HUTCHINS: Did this whistleblower have a conversation with you and your mother about this?

MS HOLLAND-BATT: Yes, with my mother. Yes.

MS HUTCHINS: Yes. And so then your mother let you know - - -

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: - - - the contents of the discussion. Yes. And so when you found this out, what steps did you take?

MS HOLLAND-BATT: I was incensed, absolutely incensed. So, initially, we wrote a letter – Mum and I wrote a letter together to the facility detailing what had been told us by the whistleblower, which was to me really grave and deliberate kind of abuse, not mistaken neglect, but deliberately kind of victimising dad. So we set that out in a letter. We asked for an explanation. We asked for assurances that this would never happen again. And then the facility invited us to a meeting. Initially, they proposed that we would meet my mother, my father and I with the abusive carer and the facility manager, which I thought was incredibly inappropriate, a ridiculous suggestion to put dad in the room with someone who had deliberately belittled and abused him.

MS HUTCHINS: Yes.

MS HOLLAND-BATT: Yes.

MS HUTCHINS: Yes. And because it's of relevance, I would like to discuss the detail a bit further - - -

MS HOLLAND-BATT: Sure.

MS HUTCHINS: - - - of what the alleged abuse included. At paragraph 49 of your statement, you detail an instance where she observed the carer closing the door on your dad for hours while he was awake and desperate to be toileted.

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: Yes. And so what else occurred in relation to this situation here?

MS HOLLAND-BATT: So the whistleblower related to mum that dad had been deliberately left in distress in unclean incontinence pads for long periods, that she'd verbally abused him and told him that she was "sick of his shit", that she left his wheelchair away from the bed so that he was left completely immobile and just stuck in bed. She shut the door on him and told other staffers he was sleeping when he was awake and needed toileting and showering. And the whistleblower also mentioned to my mother that the reason that she told us and not the facility was that, if she told the facility, it would get swept under the carpet and absolutely nothing would be done.

MS HUTCHINS: Yes.

MS HOLLAND-BATT: Yes.

MS HUTCHINS: And so when you attended the meeting with the facility manager - - -

MS HOLLAND-BATT: Yes.

MS HUTCHINS: - - - describe for the Commission what happened during the course of that meeting.

MS HOLLAND-BATT: The one detail that stands out to me about that meeting, it was on St Patrick's Day, and the facility manager, in coming to the meeting – they'd had St Patrick's events for the residents prior to that. And he came to this meeting to discuss with me what is really grave and serious abuse of someone I really love in a St Patrick's outfit, wearing a St Patrick's Mardi Gras neckless. I found it so beyond insulting and absurd. It was a surreal kind of moment to sit there and discuss what had happened to Dad in that context.

At the beginning of the meeting he also tried to do some sort of bizarre sideshow by saying, "We fixed the Wi-Fi for your dad" to try and kind of throw out a bit of an olive branch with a completely unrelated issue, which I found really transparent and ridiculous. And then his main interest in the conversation was ascertaining who the whistleblower had been, not any kind of concern about what had happened to Dad. He said, "We can't do anything until we know who's told you this? Who told this?" And that was the kind of -the thrust of the conversation.

And I kept repeating that my main concern was that this person was still entrusted with the care of other vulnerable people in the facility and that that should be in his primary concern, as well. But the conversation just moved in that sort of intractable way where he insisted on identifying the whistleblower and we refused, because she'd come to us, in confidence, knowing that we could get something done where the management may not.

MS HUTCHINS: Yes. And were you told that anything would be done in relation to the alleged – the staff member that allegedly committed the abuse?

MS HOLLAND-BATT: Yes. The initial response was just, "Well, we'll move her to another wing, so she is away from your father", which I thought was manifestly inadequate. I mean, that's a ridiculous solution that maybe protects Dad, but then just puts a whole other group at risk.

MS HUTCHINS: And so what was the outcome of that meeting?

MS HOLLAND-BATT: The outcome of that meeting was my mother and I left feeling very upset and very concerned about the management's focus on the whistleblower, rather than our dad and what had happened to him and what should happen to the abusive carer. We – so they gave an undertaking that they would investigate. But I was left with really low confidence in what this investigation would entail. The overwhelming impression I was given was that the thrust of the investigation would be to identify the whistleblower, rather than to make any substantive changes to the care.

MS HUTCHINS: Yes. And you note in your witness statement, as well, that you notified, around March 2017, that the investigation was closed and that they would be willing to discuss details with you orally, rather than on the email; is that correct?

MS HOLLAND-BATT: That's right. So it was a very strange email. The initial email said there's been an investigation, but the findings are confidential, which I thought was quite bizarre, given the findings directly related to my dad, so I wasn't sure why they were confidential to me. And then when I wrote another email requesting further information – and I wanted a written explanation, because I got the sense they would give verbal undertakings that weren't then followed through.

I was told by email that the facility manager – from a regional manager, I was told that the facility manager had been given approval to discuss limited details with me verbally, which concerned me further. And then when I pushed back and said, "Well, is there a difference between what you can release verbally or in writing?" I was then told, "No. You we can release exactly the same details", but we still never received a full and frank account in writing.

MS HUTCHINS: Yes. And so, following that exchange, in your statement, you identify that, on 3 April 2017, you lodged a formal complaint with Aged Care Complaints Commissioner.

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: Yes. And so how was that process initiated?

MS HOLLAND-BATT: Well, I sort of then – after I lost confidence in the facility taking this seriously, I started to look around to see what was available. I came across elder abuse and rang them. They notified me that they'd primarily focus on sexual abuse cases, not on cases of neglect or negligence. I asked some friends who were journalists what I should do and they eventually pointed me towards the ACCC.

But it was not immediately clear to me, even after, you know, sort of, internet searches and so forth, which agency would be appropriate for this. I'd also looked at AHPRA, but then realised that AHPRA would not be appropriate in this instance either. So I ended up with the ACCC after a little bit of looking around.

MS HUTCHINS: Yes. And you identified in your statement that you understood they wouldn't be appropriate because this is a personal care worker that wouldn't be covered by the type of people they cover.

MS HOLLAND-BATT: That's correct, yes, by AHPRA.

MS HUTCHINS: Yes.

MS HOLLAND-BATT: Yes.

MS HUTCHINS: And so how was it you went about lodging your complaint with the commissioner?

MS HOLLAND-BATT: I rang. I rang the commissioner and I spoke to a complaints officer, I believe was the title. And that initial conversation was quite long and I detailed the allegations. I repeated that my primary concern was the wellbeing of other people in Dad's nursing home; that, you know, the threat against Dad had been neutralised, but I was worried that this person, who had sort of quite sadistically and deliberately abused Dad, was, you know, still in the same position.

And the complaints officer relayed to me that the ACCC was unable to pursue individuals and was really only able to work with the facility around what the facility could do, rather than this person, which was slightly alarming to me, because my concerns were about this person in particular, along with general concerns about the facility. But together through this conversation, we identified three major areas that the facility would be asked to address.

MS HUTCHINS: And what were those areas, just in broad terms?

MS HOLLAND-BATT: So do you mind if I just refer to - - -

MS HUTCHINS: Not at all.

MS HOLLAND-BATT: - - - some things here, just so I make sure I get that correct.

MS HUTCHINS: And I can assist you. They are set out at 71.

MS HOLLAND-BATT: Okay. Thank you. So – that's right. So the complaints officer sort of summarised my concerns in three ways. She said there was the issue that the carer had failed to escalate the infection in dad's elbow to a clinical care; that there was an overarching issue that the facility failed to provide a safe environment, in that it failed to identify and action abuse. And the third issue was

that part of the reason that this infection had gone unobserved was that there was only one person showering Dad with very limited time to do so, whereas Dad, in his care plan, it had specified that there should be two people assisting him with showering, which would have, obviously, also, helped with the degree of clinical observation.

MS HUTCHINS: Yes.

MS HOLLAND-BATT: Yes.

MS HUTCHINS: And so what did the complaints officer tell you would be the next steps?

MS HOLLAND-BATT: So she basically said – she said very little in general about what the process would be but she said these three issues would be put to the facility and that the facility would have a week or some time to respond to those issues to the ACCC and that the ACCC would then call me and discuss the response.

MS HUTCHINS: Yes. Thank you. Just as a sidenote, just because it can be a source of confusion sometimes for people, when we're referring today to the ACCC, we're referring to the Aged Care Complaints Commissioner and not the other - - -

MS HOLLAND-BATT: Yes, not the competition watchdog.

MS HUTCHINS: Yes. Sorry to interrupt you, but just to continue with the narrative, what was the next thing that you heard from the complaints commissioner about the process of what was happening with the treatment of your complaint?

MS HOLLAND-BATT: So then the facility was given that time to respond. In the intervening period, through a conversation between my mother and I and the whistleblower, we convinced the whistleblower to come forward and substantiate the allegations of abuse. And I was notified in writing from Dad's facility that that person no longer worked there because the whistleblower had come forward.

So then I had the next call with the ACCC in which I was told that the facility was unable to substantiate the allegations of care – of abuse and that they were going to do – it was just a bunch of jargon. It was things like, "We are going to do toolbox sessions, we'll add it to the staff meeting".

To me, nothing substantive but there was sort of a laundry list of relatively low-level things they were going to do to address it. They said they would add a second person to assist Dad with showering. Really kind of low-level assurances and nothing that got to the meat of how this happened and preventing it happening again.

MS HUTCHINS: Yes. And what were you told could be done in relation to that particular staff member?

MS HOLLAND-BATT: I was told that the ACCC couldn't do anything in relation to that particular staff member, which to me was really quite alarming.

MS HUTCHINS: Yes. And so were you provided with a copy of the response that had been given - - -

MS HOLLAND-BATT: No.

MS HUTCHINS: - - - by the provider?

MS HOLLAND-BATT: No, no. I just had the – a verbal interpretation from the complaints officer at the ACCC.

MS HUTCHINS: Yes. And so what happened then during the course of the conversation in terms of you were advised of what the provider response had been; what was your reaction to the operator?

MS HOLLAND-BATT: So she took it issue by issue and we agreed to resolve the first issue around, I think, escalating the infection because they'd said they would add – I don't know, they made a couple of sort of suggestions around increased training about skin care observation and so forth that to me seemed to satisfy that. And then we talked about the other two and I was dissatisfied with what they'd provided in relation to providing a safe environment and identifying and actioning abuse. And I was also dissatisfied around what they'd said with the two people assisting Dad with showering. So the complaints officer then said that she would go back to the facility to get further detail on that.

But it felt very woolly for me on the phone, I felt very much as I was relying on her interpretation of whatever the facility had said and that I was expected to take these assurances at face value, that all this would be followed through and it would effect change.

MS HUTCHINS: Yes. And in paragraph 75 of your statement as well, you also detail that you were asked by the complaints officer what measures you thought the facility should have to do to improve?

MS HOLLAND-BATT: Yes.

MS HUTCHINS: What did you think about that line of questioning?

MS HOLLAND-BATT: Well, it's not my field and it's not my area of expertise so I was quite astonished that that would be relegated to me as a complainant, to come up with suggestions. I did propose that I would like to see some reassurance around the facility's whistleblower program or policies because I was concerned at the behaviour that I'd witnessed from the facility manager, but I was kind of dumbfounded, to be honest, to be asked what I thought the facility – what measures

they should take. I thought there should be some – well, frankly, I thought that should be the function of the ACCC to impose a standard.

MS HUTCHINS: Yes. And so at the end of this telephone conversation, you've referred the – resolved the first issue but there's still two outstanding and you're told that the officer will go and make some further inquiries with the provider?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: Is that correct? And so what were you thinking after this call, in terms of whether you were on the path to the matter being resolved?

MS HOLLAND-BATT: I – I was really disappointed, to be honest, by the sense that I felt that they were just pushing to resolve the issue and I was also concerned that there didn't seem to be any robust investigation or any kind of oversight. I just felt that it seemed as though the facility would say – I could predict what would happen which was that the facility would come back with a few more of these sort of suggestions of what it would do, pay lip service to whatever, you know, the complaint was but I didn't get the sense that there was any sort of push from that regulator for meaningful oversight of the case.

MS HUTCHINS: And so by this time – around this time the whistleblower had come forward?

MS HOLLAND-BATT: Yes, yes.

MS HUTCHINS: Yes. And so what were the consequences of that happening in terms of whether this carer remained in employment or not?

MS HOLLAND-BATT: Well, I was notified that the carer – I was notified in a phone call from the facility manager that the carer – that the abuse allegations had been substantiated and that the whistleblower had come forward and that they no longer worked at the facility effective immediately. I was also told that in email but I noted that in the email it doesn't say that the allegations had been substantiated; it just says that the whistleblower had come forward and that the person no longer worked at the facility so that was an interesting omission. But so as far as I was aware, the person no longer worked at the facility prior to the ACCC complaint being resolved.

MS HUTCHINS: Okay.

MS HOLLAND-BATT: Yes.

MS HUTCHINS: And then – so in your witness statement, you detail that about a week later you receive a call back from the commissioner?

MS HOLLAND-BATT: That's correct.

MS HUTCHINS: Yes. And what happened during the course of that telephone conversation?

MS HOLLAND-BATT: So the complaints officer relayed to me further measures that the facility was going to take and essentially said to me, "This is about as far as we can get with this. This is about as much as we are empowered to ask them to do." So I was very dissatisfied with the process but I was left with the overwhelming impression that this was as far as we were going to get and, on that basis, I agreed to resolve it because I felt there was no further recourse left to me.

MS HUTCHINS: So at that point, you agreed to close the complaint; is that correct?

MS HOLLAND-BATT: Yes.

MS HUTCHINS: Yes. And so what was the impression that you were left with after going through that complaints process?

MS HOLLAND-BATT: Well, that it did absolutely nothing to resolve the issue and that I was better off trying to pursue it myself, you know, by encouraging, with Mum, the whistleblower to come forward and substantiating it myself. I did not feel as though the regulator, (a) was on my side and, (b) had any powers, was my impression.

MS HUTCHINS: And did you feel that you understood what was happening during that complaints process and understand, I guess, the different options that were available to you in terms of the level of the process that might be adopted by the commissioner in performing their investigations?

MS HOLLAND-BATT: No. So I was only really made aware of that recently when I saw the annexure that has been put forward, that there were different levels that things could be escalated to, that there were more robust forms of scrutiny and I was really quite shocked, belatedly, to learn that, while this complaint had been assigned a major complaint, it was also marked for early resolution which to me seems quite kind of incompatible but at the time I was given the impression that everything was conducted over the phone, and that this was the standard process. So nothing was explained to me about the options. Obviously, given the gravity of what had happened to Dad and my concerns, if I had been given the option to opt for a more robust process, for evidence in writing, for access to any of the documents, I would have.

MS HUTCHINS: Is there anything about the process that you went through, besides the actual outcome but with the process itself, that you would like to have seen done differently, that you think would have resulted in a better experience for you?

MS HOLLAND-BATT: I think some transparency to the complainants about how it works would have been really, really helpful. To know that there were options

available to me to escalate this or to pursue a more robust process. That would have been really helpful. I also got the impression that the complaints officer was keen to resolve the case, that that was the desired outcome. So it would have been really helpful, as someone who was new to this process, to perhaps have someone – a disinterested party helping me navigate it or giving me advice or information because my feeling was that the complaints officer was kind of taking the facility at their word and so I didn't really have anyone to help me push back against that. So, yes, someone perhaps – some function where people could be given some disinterested advice and support would have been helpful as well.

MS HUTCHINS: Yes, thank you. I have no further questions, Commissioners.

COMMISSIONER TRACEY: Ms Holland-Batt, thank you very much for sharing that experience with us. You can be assured that the shortcomings in the process that you have described will be taken into account by us when we come to make recommendations for improving the system and we can only do that if we know exactly what's going on on the ground. Your evidence this afternoon has been extremely helpful in that regard. Thank you for coming.

MS HOLLAND-BATT: Thank you, Commissioner.

COMMISSIONER TRACEY: You are excused from further attendance.

MS HOLLAND-BATT: Thank you very much. Thank you.

<THE WITNESS WITHDREW [3.11 pm]

MS HUTCHINS: Thank you, Commissioners. Mr Gray will call the next witness.

MR GRAY: I call Professor Ron Paterson ONZM.

<RONALD JAMES PATERSON, SWORN [3.12 pm]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Professor Paterson, what's your full name?

PROF PATERSON: Ronald James Paterson.

MR GRAY: Thank you. You are a professor of law at the University of Auckland?

PROF PATERSON: That's right.

MR GRAY: You're a distinguished visiting fellow at the University of Melbourne?

PROF PATERSON: I am.

MR GRAY: You have previously, for some 10 years, been the New Zealand Health and Disability Commissioner?

PROF PATERSON: Yes.

MR GRAY: You've had ombudsman roles in New Zealand?

PROF PATERSON: Yes.

MR GRAY: You are one of the authors of the Carnell/Paterson report into review of regulatory processes in the aged care setting?

PROF PATERSON: Indeed, I am.

MR GRAY: Now, Professor, you've prepared a precis of your evidence. I will ask that be displayed. It is RCD.9999.0143.0001. I won't ask you to verify the contents because it's in precis form, not statement form, but that's the precis of your evidence that you've prepared?

PROF PATERSON: Yes, it is.

MR GRAY: I tender the precis.

COMMISSIONER TRACEY: Yes. The precis of the evidence of Professor Ron Paterson – does it bear a date?

MR GRAY: No, it doesn't, Commissioner.

COMMISSIONER TRACEY: Will be exhibit 8-29.

EXHIBIT #8-29 PRECIS OF THE EVIDENCE OF PROFESSOR RON PATERSON (RCD.9999.0143.0001)

MR GRAY: Operator, please bring up exhibit 1-25 RCD.9999.0011.1833. This is a previous exhibit, it's the Carnell/Paterson report. This is the report of the review to which I referred a moment ago and to which you are a joint author; is that correct?

PROF PATERSON: It is indeed.

MR GRAY: Thank you. And if we go, please, Operator, to page 1843, commencing at that page, Professor, you and your joint author, Ms Carnell, set out 10 recommendations broken into various subcomponents as a result of your review.

PROF PATERSON: Yes.

MR GRAY: Commissioners, there's an additional document to which we will occasionally be making reference. That is an attachment to Ms Beauchamp's statement in February 2019, exhibit 1-23, at CTH.0001.1000.4510. Professor, you've been provided with a copy of this document, haven't you?

PROF PATERSON: I have.

MR GRAY: And this document, Commissioners, you may recall, it's a table of responses by Ms Beauchamp as at February 2019 to the recommendations in the Carnell-Paterson review. Professor, I want to return to that part of your career which I mentioned when introducing you, that is, to your term for about 10 years as New Zealand's Health and Disability Commissioner. Did your role cover aged care?

PROF PATERSON: Yes, it did.

MR GRAY: and what reflections do you have regarding the protection of people receiving aged care from your term as New Zealand's Health and Disability Commissioner for those 10 years, 2000 to 2010?

PROF PATERSON: So I suppose it's helpful just to clarify that the commissioner's role includes both the individual practitioners, whether they are registered or care assistants, and also the organisations, the approved providers, as they would be called here. The impression that I had in that sector was that it was very difficult for people to make a complaint. It was a brave thing to do, because they feared retribution. The people who were receiving care were often vulnerable, frail, elderly people. And it was an area of the work that we did that worried me greatly, to be honest.

MR GRAY: In respect of that vulnerability, was an element of it relating to the information that they were expected to process, as well?

PROF PATERSON: Absolutely. I can recall on the day that I started office – in the office, being taken aside by the chief lawyer and saying, "You're about to be served with an injunction." A rest home provider was resisting a decision that had been taken by my predecessor. And it all related to the fact that an elderly man, whose wife had just died, had been bundled up by stepchildren and moved into a facility without getting any proper information. And so often we see at the time that an individual is moving into residential care, it's a time of crisis, they may have been very unwell, something's happened and decisions are being made in short order and both the individual, if they are able to make decisions, and their family lack information.

MR GRAY: Thank you. Professor, I want to ask you about the concepts that underpin your approach, and that of your co-author, to the 2017 review. But, speaking for yourself, because we don't have Ms Carnell here, I'm not asking for her impression of those concepts that underpin the review. And I just want to ask you about, firstly, the concept of using a market mechanism to deliver an essential service such as aged care. Can quality and safety be left to market forces, in your view?

PROF PATERSON: No, clearly not. We're not talking about going on a cruise here. We've seen even in the banking sector that that's unsatisfactory, but it's all the more so here. People are vulnerable. People need protections for their safely, for the quality of the care they received, for the quality of the life we hope they will enjoy in the new facility.

MR GRAY: To some extent, can market forces, perhaps in other settings, have an influence on quality improvement if the market's working perfectly?

PROF PATERSON: Yes, in theory. And we see that model especially in the United States. And yet, even in the United States, after many scandals, they moved 40 years ago to a nursing home compare system. They recognise that you cannot simply leave it to the market, that the notion of individual consumer choice is quite artificial in this context.

MR GRAY: This is a matter that you pick up in your precis at paragraph 8. Perhaps the operator will display that. So is there a place for harnessing market forces to encourage improvement?

PROF PATERSON: Obviously, encouraging improvement is important. And one of the ways you do that, of course, is shine a light on what works well, so that other providers are encouraged to say, "We need to lift our game. We need to do what they are doing at this facility down the road."

MR GRAY: What are the key elements you need in order for that to occur around information for the people who are using the services?

PROF PATERSON: So – I mean, there's a lot of sophisticated work, obviously, that's being done in this area. I must say, I'm very attracted to the way in which the Care Quality Commission boils it down to some pretty simple questions that people making choices can understand but the providers themselves would recognise are meaningful. Is this well led, this organisation? And it needs to be presented in a format that people can understand. I was intrigued during the time of our review to look quite closely at some of the reports, the State of Care reports coming out of the Care Quality Commission. And provider organisations themselves were saying – I recall one figure of over 80 per cent, I think it was, in the 2017 annual report. They found it helpful for their improvement, for their own improvement, to be getting this information.

MR GRAY: And is that the Care Quality Commission in England?

PROF PATERSON: In England, yes.

MR GRAY: Yes. And you've addressed some of these points in your precis at paragraphs 10 and 11. I notice a little later in your precis you also refer to the voice of people receiving care and families, sometimes called the consumer voice. What's your view about the importance of the voice of the people receiving the care and their families in this context?

PROF PATERSON: I think there's nothing more important. And I think it's so difficult for that voice to be heard. I think in all sorts of ways the system here in Australia, and in other countries, we hear far too much, I believe, from the providers working in the system, not nearly enough from the people who are receiving our services, and, if they are not able to speak for themselves, from their families or advocates.

MR GRAY: And this is picked up in paragraphs 15 and 16, if the operator would kindly display that. Might come back with reference to some of the contents in the Carnell-Paterson report to that topic later on, Professor. Your report appears to have adopted a lensing form by best practice principles in a Productivity Commission report in 2011, as informed and updated by OECD principles on good governance.

PROF PATERSON: Yes, indeed.

MR GRAY: We see in the report that there are, essentially, three principles that you glean from those sources, starting with, around the concept of good governance, clarity of roles and responsibilities. A second principle is appropriate choice of standards. And the third choice is responsive regulation to encourage and enforce. Is that a fair summary of the lens you were bringing to the review?

PROF PATERSON: Yes, it is.

MR GRAY: Where did the pursuit of the first principle take you when it came to assessing the health of the aged care sector in Australia and its quality and safety?

PROF PATERSON: So, obviously, we thought that there wasn't the clarity of roles that was needed, but, also, there was the lack of integration. It was very clear that, having, you know, the roles split between the compliance role of the department, the audit role of the quality agency and the complaints role of the Aged Care Complaints Commissioner, that, it seemed to us, was not consistent, either with the recommendations, I think it was of the 2014 Productivity Commission, that the people in their submissions in the review were saying to us, "We need to move back to that." So we had submitters saying that. You know, or, "Rather, we need to achieve that vision," which wasn't introduced. But, also, we could see that it was consistent with the OECD principles and with the earlier Productivity Commission principles. So that was the thinking behind both the creation of the new Aged Care Quality and Safety Commission, but also in our thinking about the governance of that commission.

MR GRAY: And I'll come to that in a little more detail, but when you refer to the governance of the commission, are you referring to the recommendation that it be governed by - - -

PROF PATERSON: By a board.

MR GRAY: - - - a board?

PROF PATERSON: Yes.

MR GRAY: Now, I won't ask you too much about appropriate choice of standards, because, as you may be aware, there have been some new standards only very recently introduced, and it's early days in assessing how they're going. But when it comes to responsive regulation to encourage and enforce, that overarching principle, I do wish to ask you quite a few questions about your views on that. But, just as a precursor, are you referring there to concepts that have been developed in the literature by the Braithwaites?

PROF PATERSON: Indeed.

MR GRAY: Yes. Now, I want to ask you, with reference to your precis at paragraphs 9 and 10, about the purposes of regulation you identify for the purposes of your evidence today and I assume more generally. What's the primary purpose you identify for those purposes?

PROF PATERSON: Consumer protection, if you want to word it that way, you know, to keep people safe. I think, in our life, we see it really clearly. If you imagine taking a small child to hospital. In that situation, you just absolutely assume they're going to be safe. And when you or your parent is moving into a residential aged care facility, you want to know that they are going to be safe and you want to know they're going to get good care, good clinical care, but, also, that they'll have a good – you know, good quality of life where they are moving to. So you want them to be protected in that situation.

MR GRAY: All right. And moving into other aspects of the purposes of regulation, you refer to protection from information asymmetry. You also refer to regulation being purposed to improve performance. Can you please explain those concepts in a little more detail.

PROF PATERSON: So it's easy to think about regulation as just being, you know, "We've got to protect people and keep them safe". But it's interesting to think about this idea of responsive regulation or sometimes called right-touch regulation. What ways can we use regulation to lift the quality of care, the quality of life, the quality of services? And it seemed to us, looking at the literature and talking to people who made submissions, that there was a place, a secondary role, here in quality improvement.

It was very clear that that role was being used in the United Kingdom, but it was also clear from the writing, both of the Braithwaites, but from others, you know, Vincent Moore, who writes from Brown University in the United States; Kieran Walshe, who had done a – who's one of the leading writers in regulation in the United Kingdom. So others who were thinking about the ways in which responsive regulation can also help improve. Kieran Walshe called his book on the topic, "Regulating healthcare: a prescription for improvement". And I think that secondary role is very important.

MR GRAY: With respect to information asymmetry?

PROF PATERSON: Absolutely.

MR GRAY: Protection from information asymmetry. Do you have any comments to offer at this point?

PROF PATERSON: When you say "protection", I mean, it's trying to lift people up so that you've got some of the information that – you know, you're completely in the dark, you're completely in the void. And so you're struggling to find good information. And, of course, many people are very confined in their choices and they are just looking within, you know, a limited geographical area at the facilities that are available. But at that point, at that time, often of crisis, they are trying to get good information, you know, verified information. And I think, ideally, you'd want to know it's come from multiple sources, not just advertising from the approved provider.

MR GRAY: Yes. Now, when we look inside the report in the executive summary at (vi), which is page 1838, we see there a little bit more on the consumer protection role and you've, in effect, made a number of points there. You've referred to the need, on the behalf of the Commonwealth, to know that providers are adhering to at least minimum standards, including safety and quality and quality of life.

You've referred to rigorous accreditation, reporting of serious incidents. You've referred to mandating compliance with guidelines against the use of restrictive practices and you've referred to ensuring access to an independent complaints commissioner to raise red flag information from complainants. All of these matters I'll be asking you some questions about.

With respect to this secondary role of reducing information asymmetry and disseminating information to improve performance, again, on that same page, from about the middle of the page, you've referred to a secondary role for regulation in the aged care sector being to encourage quality improvement. Is an accreditation regime that simply provides for a met or a not met binary outcome, in which 98 per cent of the relevant services meet the standard of "met" rather than "not met" sufficiently informative to achieve this purpose?

PROF PATERSON: Clearly not. No. This doesn't even meet the minimum standards, really, of information.

MR GRAY: Yes. You've referred, in your evidence a minute ago, to the CQC – the Care Quality Commissioner in England, and you've referred to the approach they take. In your precis at 28 and 32, you refer to Australia falling behind. Are you able to expand on what you mean by that?

PROF PATERSON: So what I mean by that is if you put yourself in the situation – the situation of you know, you're looking, you're trying to compare residential aged care facilities in this country and – with what you'd be looking at in the United Kingdom, you simply – I mean, you know, you are looking at – at this time we were doing the review, you were looking at "mets" and "not mets". I know since then the consumer experience reports have been developed and that's a good move but there simply wasn't the same quality of information available. If you looked at nursing home compare – I think in the body of the report, we give an example of looking at Cleveland Heights and looking at facilities. - - -

MR GRAY: That's the American nursing home compare?

PROF PATERSON: Yes. So more granulated information. Information that's going to help people. Sure, not everybody will go and look at it but if they have the time and the ability to go and look it up, it's there, and they can learn far more than we saw was available in Australia. And we found that surprising because Australia had been talking about doing this for a very long time.

MR GRAY: If we look inside the Carnell-Paterson report and we go to page 1917 at the foot of the page with more of the text over the page at 1918, is this the international benchmarking that you and your co-author were considering back in 2017 on this topic?

PROF PATERSON: Yes, it is.

MR GRAY: We are now almost two years down the track and we don't see anything yet available in this space for the public to consider apart from the results of consumer experience reports that are administered to about 10 per cent of the resident population of a given facility at a generally three-yearly accreditation audit. Is that sufficient progress in your view?

PROF PATERSON: No. I think that's disappointing. It's disappointing, not only because it's nearly two years since this review but because we noted in our review that – I think it was the aged care road map, had already said, you know, a year and a half earlier I think it was, they'd said we should do this but, as I understand it, quite a lot early, going back quite some years ago, this had been talked about. And so both in terms of what had been on the agenda here in Australia, it seems like the progress has been slow and then all the more so when you look at the way in which similar initiatives have been progressed internationally. So, yes, it is disappointing.

MR GRAY: There's a lot of industry consultation around these matters. Is there a place for industry consultation and is there a point at which there's too much industry consultation?

PROF PATERSON: Well, of course there's a place for it because, you know, you also need to – they need to believe they can work with these – you know, whatever the agreed published information in, it needs to be workable and you also need to do it in a way that doesn't stifle their innovation and their creativity. I know that's been something that Dr Trigg talked about in her evidence but there also has to be an end to consultation. At some point, you have to get on and do it and it does seem like there has been an awful lot of consultation and it does seem as if the consultation is dominated by the provider groups.

MR GRAY: All right. I will move now back to this topic of responsive regulation and you've mentioned the influence of the Braithwaites. I should also say Professor Makkai was a co-author of - - -

PROF PATERSON: Yes.

MR GRAY: - - - the seminal 2007 test on responsive regulation in aged care. And could I ask, as a general – at a very general level, what's the degree of influence of those ideas on the report as a whole?

PROF PATERSON: I think those ideas were – they were influential. I mean, they were already – they'd already influenced my own thinking so after I stepped down as Health and Disability Commissioner in my academic work, I've done a lot of work including writing in relation to the regulation of doctors but also work for AHPRA looking in particular the area of the regulation of doctors but, more generally, how do you get the balance between regulation and professionalism. So that – you know, the idea of responsive regulation, or the notion of right-touch regulation, as it's referred to by Harry Cayton and the Professional Standards Authority in the United Kingdom, which has also been very influential and this idea of having a pyramid, that influenced us and it's been very influential, I think, internationally.

MR GRAY: Let's go to the pyramid; it's on page 1912. Can I just confirm for the transcript that when you are referring to right-touch, that's right with an R for Romeo - - -

PROF PATERSON: Yes.

MR GRAY: Yes. Not L for Lima.

PROF PATERSON: Correct.

MR GRAY: There is an expression, light-touch regulation, isn't there?

PROF PATERSON: Indeed. It's not light touch, it's not light-handed touch; it's right-touch regulation.

MR GRAY: Thank you. Now, if we look at this pyramid, Professor, could you please explain to the Commissioners what's meant by responsive regulation by reference to this pyramid?

PROF PATERSON: So the idea of a pyramid is that – we shouldn't automatically be going to the very top of the most severe sanction or revocation or court process; that, in the first instance, we are trying to work at the lower levels, the green level where we encourage and support compliance and we use education and support mechanisms to do that. So the notion that you might work your way up the pyramid depending on what information you have and the level of concern that you might hold in a particular situation. And some of that, of course, very much depends on the nature of the risk you're thinking about.

So if I can just draw on some other work, the work I did for AHPRA on the use of mandated chaperones when an allegation of sexual misconduct has been made, there are some risks for which we have zero tolerability. In situations like that, you might want to go right to the apex because you have to be absolutely certain that you are keeping people safe. You have to look very carefully at what is the nature of the risk that we're talking about and, in this context, we're talking about risks of harm to very vulnerable people. So what's the nature of that risk and then what information do we have about the way in which that risk is being addressed in this particular facility.

MR GRAY: If we get to a situation where the regulator, which has this armoury of different interventions available to it, becomes habituated to a mindset of managing each and every provider back to compliance, does that hold dangers for the regulatory system in that setting as a whole?

PROF PATERSON: It does hold dangers. I think it holds grave dangers. I think that's something we were very much aware of in the context of Oakden in 2017, during the time of our review, and I have to say, having sat through the evidence on Monday, having looked at the transcript for yesterday and then having sat through the evidence this morning, it does feel as if there's still this whole idea that we have a compliance model where we're trying to manage providers back to compliance and we're very reluctant to go to the apex of the triangle.

MR GRAY: What are the dangers if that becomes the mindset to which the regulators habituate and, perhaps even more so, if it becomes known that that's the default position of the regulator?

PROF PATERSON: I think one of the dangers is that people can't see red flags that are right there before their eyes. You know, that they become desensitised to information and that they become less agile and skilled at putting together the pieces of the puzzle and seeing, "Hello, we've got a problem here. We've had this information from accreditation. We've had this information from complaints.

We've had some information in terms of prudential information perhaps". When you look at that together, "Hello, we've got a problem here and we need to do something about it".

MR GRAY: What's your experience to the extent to which these sorts of mindsets can be become acculturated within a regulator?

PROF PATERSON: I know that it can happen. I mean, I know from having been a complaints commissioner, even in that context, there's so much information coming in, you are under so much pressure to be dealing with files and so you need to build into your own system checks to make sure you are not simply being acculturated to it. What I've heard this week and what I learnt during the review, is I think the system had become rather – in Australia, had become desensitised to that and certainly I hoped that Oakden and our report would be a wake-up call.

MR GRAY: Going on the evidence you've heard this week, what's your impression about any progress that's been made since your report post-Oakden, on that question of the agility of the regulator to go to the top of the pyramid if necessary, be innovative at the bottom of the pyramid, if necessary?

PROF PATERSON: It feels like there's a disconnect between the evidence that I've read, the document that was tabled, the February 2019 progress update which follows Minister Wyatt's statements and so that seemed very hopeful. But listening to the examples of how cases like Earle Haven are actually being handled this year suggests to me that the lessons have not yet been learnt and I can see why there's been a need for this Royal Commission, to be honest.

MR GRAY: All right. I just want to ask you about this concept of the conditional revocation in particular. Was this prevalent on the material that you considered in 2017? What I mean by "conditional revocation", it was, in form, a sanction that imposed revocation but said the revocation won't take effect if the provider agrees to appoint an adviser or, in some cases, an administrator. Is that an effective form of sanction to be the default form of revocation? And should there be very careful review of what happens as a result of any such sanction and no second chances afforded?

PROF PATERSON: So there's quite a lot tied up there. I mean, I don't specifically recall hearing about that during the review, but, in answer to your question, absolutely. If you thought that we can safely use some sort of conditional revocation, you know, that's an appropriate safeguard for a limited period, you would have to be very – you'd have to monitor very, very closely whether you think that's sufficient. And so if there is then a further lapse, then it should be game over. At that point, you should say, "Well, no, we absolutely have to revoke your licence".

MR GRAY: What's the role of intelligence or sources of information about potential risks – red flags, I think you mentioned a minute ago – in responsive regulation? What's their role? What's their importance?

PROF PATERSON: A responsive regulator needs to be an intelligent regulator. And to be an intelligent regulator, you need intelligence. So you need to be drawing information – you know, this is not kind of cook book stuff. You actually need to be looking at all the source of information. That was why, I think it was our second recommendation, where, you know, we talked about the need – so have an integrated commission, bring those functions together, but also bring the intelligence together.

MR GRAY: So, Operator, if we could bring up 1843, please. You made a specific recommendation about developing and managing a centralised database for real-time information sharing. What was the purpose behind that? What you've just referred to, I assume.

PROF PATERSON: Absolutely. So you want the best available real-time information for this powerful new agency. The Aged Care Quality and Safety Commission is going to have all the source of information, so that it can – it can look and see yes – you know, it's not just we've had this one bit of information about what's been happening at Earle Haven; we can look back and actually – we can look at the whole history, we can look at the history in dealing with complaints, you know, look at it all and say, "Hello, we think there's an issue here. We need to act".

MR GRAY: Is that going to be optimal if it's limited to formal non-compliance issues or should it be broader?

PROF PATERSON: Clearly not. It's got to be more than met/not met. It must go further than that.

MR GRAY: Yes. And would it include complaints information, including complaints that haven't yet been followed through to a conclusion?

PROF PATERSON: Absolutely. Even if it the complaint is at that point simply, you know, notice of a complaint, it's an allegation that's been made, but it's still a piece of relevant information that should feed into, you know, to the total picture.

MR GRAY: I think this is probably a good segue into a discussion of the recommendations in the report. And I'll advance some questions now about those recommendations. Before I go to the detail of the recommendations, by way of a brief overview, I will give a bit of an introduction to those listening of the themes of the recommendations. And, Professor, if you disagree with any part of my introduction, please say so.

But there was a theme relating to, as you've mentioned, establishing a single place where people could go for all quality and safety-related purposes. And that was the Aged Care Quality and Safety Commission. And clarity of roles and responsibilities and integration would be promoted in that manner. Another theme was improvement of the quality of information available to the people who'd be receiving care and their families. And you've spoken about that. Another theme was promoting the

voice of the people receiving care and their families and their engagement in relevant aspects of the regulatory framework.

Now, an important part of that would be better and more consumer-centred complaints processes. You also had specific recommendations around the protection of rights, around compulsory reporting of serious incidents, and limits on the use of restrictive practices. And, last but not least, a key theme was the improvement of monitoring of residential aged care facilities and a recommendation to move away from a cyclical, predictable, accreditation cycle, to unannounced, unpredictable visits based on risk profiling. Is that a fair overview for those listening?

PROF PATERSON: It is.

MR GRAY: Thank you. Can we start with recommendations 1 and aspects of 2 together. This is the topic of bringing the functions within the fold of one organisation, the commission. Now, in recommendation 1 you refer to the Aged Care Commissioner being overseen by an Aged Care Commission board. Just taking that aspect of it first, what was the purpose you had in mind in recommending – I think you elsewhere use the word governance by a board.

PROF PATERSON: So the recognition of the importance of governance and safety and quality goes back a long time. It was something that in 2004/2005 I chaired the review in this country of governance arrangements for safety and quality in healthcare. And the recommendations of that report led to the setting up of the Australian Commission on Safety and Quality in Health care.

And, in reading at that time and again during this review when we referred to the Productivity Commission and the OECD principles, you want good governance to – in other words, you want to ensure that the organisation – we're setting up this critical new entity. We need to know that it's being – that it's well governed, that it's on track, that it's achieving the things that it set out to do. So we had a different model in mind than, you know, an advisory council. That's not what we were thinking about. We were very much pegging it to what we say in the report about good governance, having a board, as you would have for any other major entity.

MR GRAY: Under the Act that establishes the commission, the 2018 Aged Care Quality and Safety Commission Act, there is only provision for an advisory council. And is it the gist of your evidence that that's unsatisfactory, that's not an implementation of your recommendation?

PROF PATERSON: Well, it's not what we had in mind. So, yes, there's always a valuable place for advisory councils, but a governance board is something different. And you'd look for people with a range of backgrounds, including, most importantly, with some, you know, consumer experience or linked to those groups, but with experience in governing it to be a body with oversight of the commission. This commission has a really critical role to play in Australia now, so we all have an

interest in ensuring that it is well governed. So that's, certainly, what we had in mind. And in the statute, that's not what we've got.

MR GRAY: Thank you. I might come back to the topics you've just opened there, including the inclusion of a consumer representative. In recommendation 1, you also refer to various commissioners within the commission. I want to ask you about the complaints commissioner. You are recommending, and it's clear from the body of the report, as well, that there be an independent Complaints Commission, albeit under the roof of the commission. Is that the right?

PROF PATERSON: Yes, that is right.

MR GRAY: Is that the recommendation?

PROF PATERSON: It is.

MR GRAY: Yes.

PROF PATERSON: And I think we refer specifically to this at page x of the executive summary.

MR GRAY: Yes. You say at page 1842, just above the heading Conclusion:

> *We believe that the Complaints Commissioner needs increased statutory powers to enable the Commissioner to share information and to publicly name non-compliant providers (subject to due process protections).*

PROF PATERSON: It's the sentence above that.

MR GRAY: Thank you:

> *It is essential that the autonomy of the Complaints Commissioner, as an independent ombudsman-like office, be maintained in the new Aged Care Commission.*

Why?

PROF PATERSON: Because complaints matter and because – I mean, I believe Australia had taken a very good move in the setting up of the Aged Care Complaints Commissioner role. So I think that, compared with having the department – the prior history was the department dealt with the complaints and there was simply an ombudsman function. So I think that had been a good move. We as reviewers could see the sense of bringing the three functions together, but we regarded it as, you know, essential that you didn't, within this new large organisation, lose – I mean, complaints, in my view, can be red flags, they are the noise from the system, they are the canaries in the coal mine, and we were concerned that that role didn't simply get

consumed within a big new commission. It's an absolutely critical piece of the architecture.

MR GRAY: There seemed to be, on the face of it, potentially, some tension between the recommendation that there be one commission and the recommendation made in tandem for preservation of an independent office of the commissioner. Can you explain why it's, on the one hand, important they be, in effect, in one commission, at the same time as those other matters you've just averted to being promoted?

PROF PATERSON: So, in terms of the integration of information and the – you know, we've had a complaint, it's a second or a third complaint, we've got some protocol and we're sharing that information. We're not just sending it off to some separate quality agency or off to the department. It's within this one – within the one commission. So we saw that as an important improvement.

But in the handling of those complaints and in the educational role relating to the complaints, you know, in fact, all those functions related to the way in which you seek to resolve the complaints, to learn the lessons, to get information for people who are making the complaint, but also to provide an alert. We needed to know that the commissioner is free to get on and do that independently and not constrained by sort of other organisational objectives. You know, their job would then be to handle the complaints, you know, to assess the complaints appropriately, to seek to resolve them, to investigate, if necessary, and so forth.

MR GRAY: And if we bring in aspects of recommendation 2 now, I see in recommendation 2, 4 and 6, there's the beginning of a theme of creating or improving a risk profiling tool, incorporating additional intelligence to better support risk management. Earlier on in your evidence when I asked you about complaints, you said, "That would be an important source of intelligence". Is this part of the vision of bringing complaints within the fold of the unitary commission, but at the same time preserving an independent statutory office for the complaints commissioner?

PROF PATERSON: Yes. That's – yes, it is.

MR GRAY: Yes. and you refer at one point in your precis to the need to sometimes act very promptly. Can you explain why it might be very important to have institutional connections under the same roof, as it were, between the complaints function and the safety monitoring function.

PROF PATERSON: Because – and we've seen this week and all my – you know, everything I've learnt about complaints in the last 16 years, because I also went on to be a parliamentary ombudsman dealing with complaints and to be the chair of the banking ombudsman scheme in New Zealand. So I've seen complaints in a range of context. And I think there's a tendency to think, "Well, we need to wait until this,

you know, has been substantiated and we have proven it". Then you look at most complaint-handling bodies and commissions.

In fact, they're only investigating a very, very small proportion of the complaints and there's so much push to sort out early and low-level resolution. If you're going to have that sort of system, at the same time when the complaints body itself, the commissioner won't be sitting on all the information about that provider, but the agency as a whole might have that information, might be getting – financial risk information that's come in or non-compliance or some problems that's come up at an audit, you want to know that all that intelligence, including the early noise in a complaint that you haven't yet completed the handling of, that it's all being considered in real time.

MR GRAY: At the time – I'm sorry.

COMMISSIONER TRACEY: You were here, I think, today when evidence was given about the prudential problems of one of the companies involved in the recent problems down on the Gold Coast, and you would have heard that there was a regulator in one part of the Health Department. There was also a prudential reviewer in a separate part of the department and no indication that the material known to one had come to the other and then, sitting alongside all this was the complaints commission about the care, or lack of it, that was being provided at these facilities. How do you envisage that sort of problem being resolved in this structure?

PROF PATERSON: I found it alarming to listen to that evidence. One of the points that it highlighted for me was that, even when you bring functions now within a single regulator, you could say, "Well, we already had that for the compliance part within the department" and yet the left hand didn't talk to the right hand. We're now talking about bringing that function with the complaints function and the audit function, putting them all together.

What it highlights is that that's a great vision, but you still need people to do their job properly. And unless people are absolutely on the ball and looking at the information – so many of the inquiries that I've seen over the years in healthcare – I think in particular of the Bristol Royal Infirmary Inquiry in the United Kingdom in 2001, Bristol was awash with data.

So, often, the information is sitting there if people will just look at it. So then you have to ask, "Why aren't they looking at it? What's the way in which it's actually – how is it being presented? And what sort of dashboards do we have so that it becomes readily visible that we have a problem?"

MR GRAY: If I could just take that topic one step further and ask the professor: Professor Paterson, is it also a question of engendering a culture of curiosity and agility, and not simply what are all the dashboards and the databases that are available. Is that also an issue in your experience?

PROF PATERSON: Yes. I don't think we use the word "curiosity" but we do use the word "agility". But I agree; you want both. I mean, you shouldn't be in these sorts of roles unless you actually – you know, unless you care about your work. And part of caring about your work – I mean, if you are in a complaints agency, certainly, or if you're in any form of regulator, absolutely you need to be curious. You are a watchdog, you need to prick your ears up and think, "Hello, what's going on here?". And that, it seems to me, is something that's not always been evident in our system.

MR GRAY: In light of the evidence you have heard so far this week, in your assessment are you satisfied with the level of curiosity that you have seen from the officials who have given evidence so far?

PROF PATERSON: I think there has been a total lack of curiosity. I think there has been a mechanistic approach to the role. It feels as if people have been going through the motions and not looking at what's right there in front of their noses.

MR GRAY: I just - - -

PROF PATERSON: If I can just - - -

MR GRAY: I'm sorry, Professor. Yes.

PROF PATERSON: I know that's a strong statement, but it's made on the back of a situation that we've heard evidence about, in relation to Earle Haven, where, you know, these weren't simply minor issues that were being raised. When I hear evidence of somebody who's completely unwilling to engage in a complaints process, that by itself is a red flag that there's a problem, and all the other bits of information we've heard about.

MR GRAY: Can I ask you, with reference to a handy schematic in the report at page 1929, about the sorts of information that might have been useful to have brought to the attention of decision-makers in the Earle Haven case. You refer to data inputs in the left-hand column and outputs on the right. Can I suggest that there's consumer/staff experiences there, that's really encompassing complaints; is that right?

PROF PATERSON: Sometimes the staff experience won't come through as an actual complaint, but it will be raised as a concern in some other way. And I think very often the workers in the facility, that's really important noise.

MR GRAY: And you've got complaints and tip-offs as a separate category?

PROF PATERSON: Yes.

MR GRAY: There is also accreditation audits and monitoring inspections more generally; is that right?

PROF PATERSON: Yes.

MR GRAY: That's one of the inputs that has to be taken into account. You refer to incident data. Is that report of serious incidents that you have in mind there?

PROF PATERSON: Yes.

MR GRAY: In respect of - - -

PROF PATERSON: And we also – I mean, we talk about, you know, what's sitting – this was very much a feature at Oakden – what did the State know and how long did it take before that was brought to the attention of the Commonwealth? So those issues as well.

MR GRAY: Yes. What about prudential and financial analysis? Is that something you would regard as a sensible input?

PROF PATERSON: Very – it's not there but I think it's a very sensible input, yes.

MR GRAY: Yes. And that information you just referred to as a serious red flag about disengagement from inquiry processes or non-cooperation with inquiry processes. An issue arose in the Earle Haven matter about ASIC disqualification. Is that too difficult to expect the Department of Health to be monitoring, that sort of thing? If they were to have a particular name as key personnel notified to them, should they have some mechanism to keep an eye out for - - -

PROF PATERSON: I mean, I'm assuming that ASIC disqualification is not something that happens every day and it would seem to me that's certainly a piece of information – if you're saying that somebody is now disqualified from running a company and they therefore couldn't be providing these services, of course that's information that the department that's sitting there looking at the compliance and whether they should continue to be an approved provider, of course that information should be considered.

MR GRAY: Now, Commissioners, I should clarify, in having asked that question, I'm not suggesting that Mr Bunker had been notified as key personnel but there are submissions we want to make about the framework and whether he should have been.

On the question of prudential analysis, the state of the evidence before the Royal Commission is somewhat unclear, Professor Paterson, on this topic but it seems there might be some uncertainty about whether the substantive analysis of financial and prudential information and its scrutiny for potential red flags and risks, whether that function will be conferred to the Aged Care Quality and Safety Commission in January 2020 along with all the other regulatory functions. If it were not to be transferred, would that be of concern to you?

PROF PATERSON: If it were not to be transferred, I would want to know that there is a very clear protocol and that it's, you know, absolutely put into practice to ensure – it's not impossible for information to pass from the Department of Health and Aging to the commission but one would want to know that there's a clear protocol and that it is followed.

MR GRAY: Now, part of the function of your recommendation 2 was to inform a recommendation I'm not going to ask you too much about because it's been well traversed. It's recommendation 8 and it's the point about cyclical accreditation being replaced over time with ongoing accreditation informed by a risk profile approach to visiting facilities. Part of the reason for recommendation 2 was to inform that risk approach in recommendation 8; is that right?

PROF PATERSON: Yes. We were influenced by the astonishing story at Oakden and the history of problems back in 2007 and the sense that there seemed to be no institutional memory about why this might be a facility that you'd need to keep a closer eye on. A combination of that plus the sort of residents, you know, the difficulties of, you know, people with dementia, with mental health problems, who were highly vulnerable and who were in that facility. So, yes, they absolutely go together.

MR GRAY: Could I ask you now about the voice of the people receiving care and their families. Sometimes we call this the consumer voice. There are various elements of recommendation 2 that reflect this theme. There is also recommendation 5. For example, in recommendation 2(ii) on page 1843 please, operator. We have:

> *The commission will develop options to capture the views of residents, families and staff all year round.*

Later in the report you include the suggestion of having a consumer experience report available online to be used all year round. We don't see that yet implemented. I don't know whether it will be implemented. Do you still regard that as a proper and satisfactory recommendation?

PROF PATERSON: So recommendation 2(iii)?

MR GRAY: (ii):

> *The commission will develop options to capture the views of residents, families and staff all year round.*

PROF PATERSON: Sorry.

MR GRAY: And in relation to the detail of that, later in your report, there's a suggestion about having consumer experience reports available online to be filled in.

PROF PATERSON: Sure. So, yes, absolutely, I would stand by that. I think it's a very important recommendation and on my own thinking, I was again influenced by Kieran Walshe; he talked about regulatory tripartisan, but so often it is just between the facility and the regulator, the agency. And that, actually, we need to do much more, to be hearing from the people who are living there, from their family and also from the workers in that facility. And so we need to be really creative about how we get their voices and here we were saying capturing that all year round as well as the 20 per cent when you come to have a contact visit.

MR GRAY: Thank you. And (iii) is broadening the approach to the consumer experience report so that it's not limited to 10 per cent of care recipients during accreditation site audits but it's actually extended to 20 per cent.

PROF PATERSON: It was already 10 per cent, I believe, at the time we were doing the review.

MR GRAY: In respect of site audits, that's my understanding. But you've made a recommendation that it should be 20 per cent during assessment contact visits which are more frequent than site audits. Do you stand by that recommendation?

PROF PATERSON: Absolutely.

MR GRAY: Yes. If I tell you that that hasn't been implemented and Ms Laffan is going to give evidence that she is of the opinion that it's an inflexible measure and shouldn't be adopted, what do you say to that?

PROF PATERSON: I don't accept that. I accept that it might be more difficult. I've seen it described as prescriptive. Well, you know, actually, that's part of regulation sometimes and we quite deliberately said, "No, we've got to be more ambitious here". Providers and agencies will come up with all sorts of reasons why it's too difficult to get 20 per cent. Ultimately that, it seems to me, is a way in which we end up diminishing the voices of the people who we need to hear from. So I think that was an important recommendation and I'd be disappointed if it's put in the too-hard basket.

MR GRAY: Is part of the reason for that this idea that capturing the broader spectrum of the experiences of the people receiving the care, is actually more likely to be a useful risk profiling tool?

PROF PATERSON: Yes, because these are people's homes and family are coming in and out all the time and they get to talk to staff and they find out what's happening – you know, what's actually happening there in that home. And you want to make sure that that intelligence is being fed and feeding into assessment contacts, into your audit processes, but also more generally into all the processes in which we are ensuring that this is a good place for people to live.

MR GRAY: And, in addition, there's that theme that you've already spoken to about lifting the performance of others if that information is made available to other providers and to the market; is that right?

PROF PATERSON: Yes, because nobody wants to see that the home down the road is getting much better feedback from people who live there and from the families.

MR GRAY: I will ask the operator to put up 1934 under the heading Intelligence Gathering from Consumers, Families and Aged Care Staff. And this is some detail in your report on the intelligence-gathering purpose of broadening the base for those consumer experience report questionnaires. Now, I want to ask you about, again, something that's arisen from your experience of a decade in the seat as Health and Disability Commissioner in New Zealand and the views you have about extending systematic and robust support for advocacy networks. What are your views on that?

PROF PATERSON: Within New Zealand, the advocacy service was always regarded by – I think by the public, but certainly by the advocates themselves and the people they dealt with – as the sort of jewel in the crown of the system, my colleague Judy Stred would refer to it. And the reason for that is that, whereas people handling complaints in a commission are there on the phone or they're looking at the papers, advocates are out there in the community. They stand alongside – you know, they meet with the family member, they meet with the resident, they can help them, they can help mediate the concerns, but they are ears and eyes on the ground.

And I think the New Zealand system of publicly-funded advocates is one way of doing that. There are other ways. And I know in Dr Trigg's evidence she talked about the critical role that Health Watch plays in the United Kingdom. In our report we refer to the resident councils in Ontario. I think there are different mechanisms. At some point the community visitor scheme and also the OPAN network that, I believe, have been intended to fulfil this role.

MR GRAY: Precis 15 to 18, please, Operator.

PROF PATERSON: But it seemed to me that it's currently a weakness in the Australian system. And I think the availability of publicly-funded advocates in this sector, in the aged care sector, is a strength in the New Zealand system.

MR GRAY: Thank you. When it comes to complaints processes, what's the role you see of that systematic support for advocacy networks?

PROF PATERSON: So as a family member, I may not want simply to be talking to somebody at the end of a line, you know, back at head office in the complaints agency. I might actually want somebody to come and sit with me and sit with Mum or Dad and talk about the issue and give us some practical help, come to a meeting with us or help us write a letter that we might take – you know, we may choose to go back to the facility directly, but we might feel we need some help in doing that, particularly when we know that people are so fearful of retribution.

You know, you've struggled to find a suitable facility and now you're about to make a complaint and you're really scared that it's going have an impact on Mum or Dad. And they're saying, "We don't even want to make a complaint in the first place." They're saying, "Look, don't even bother about it". So an advocate can be very helpful, just give you some help in how you go about doing that. Because not everything needs to be dealt with by, you know, the complaints agency. On the other hand, I believe an advocate should have a duty, if a matter is not resolved and they think there are concerns, that must be fed into the, you know, overall commission or, within the complaints part of it, to the complaints commissioner.

COMMISSIONER TRACEY: I'm just trying to picture where an advocacy operation would fit with the commission structure which you proposed. I assume that advocates would have to be independent of any part of the commission. So they'd have to be, in some organisation, organised and set apart from the commission structure. Is that right?

PROF PATERSON: Yes. In the New Zealand statute, in the Health and Disability Commissioner Act, there is provision for a statutory independence of the advocacy service. Obviously, as you point out, that's essential, because you can't be both advocate and judge. So that's one model, that you provide it within the statutory umbrella, but you say it must be independent. Otherwise, you need to ensure that it's through some other, you know, funding arrangements that you are funding those sort of community visitors or advocates or whatever we call them, and they are able to funnel information to the commission.

MR GRAY: In your precis, Professor, you've mentioned, apropos the second model, that the Australian Government is funding, through the National Aged Care Advocacy Programme, the organisation OPAN, Older Persons Advocacy Network. And there are some advocacy services available along those lines, but I take it that the gist of your evidence is that this should be strengthened and systemised; is that right?

PROF PATERSON: Yes. It was our clear sense that it was pretty loose at the time of our review and certainly in talking to the few residents we talked to, but the many families that we heard from, it seemed as if a lot more could be done to strengthen that.

MR GRAY: Thank you. Can I just – is that all right, Commissioner?

COMMISSIONER TRACEY: Yes. Thank you. Please continue.

MR GRAY: Can I just about some related issues concerning complaints. And the Commission, just today, heard what can really only be described as confronting and disturbing evidence from Ms Holland-Batt about the experience she had of the complaints system. What's the importance, at a general and regulatory policy level, of ensuring that complainants, families, people receiving care themselves are kept engaged in the complaints process?

PROF PATERSON: It's very important. My colleague at Melbourne University, Dr Maree Bismarck, has done a lot of research in this field. And what we so often see is a clear gap between complainant expectations and the reality of what happens when people make a complaint to an agency. And, sadly, the story we heard is all too often the experience of some complainants.

On one particular point that came up in the evidence, I had some sympathy, I must say, for a complaint agency staff saying, "Well, what do you think would be a good outcome?" Because, actually, within all the literature in this field, it's increasingly recognised that it's really important to try and get some clarity about that, but, obviously, you don't want to do it in a way that makes the family member complainant feel like that this is just an additional burden. So this is really hard stuff. Doing this well is very difficult.

But one of the things that also came through less clearly in the evidence that we heard earlier this afternoon, but I think we do touch on in our report and in our recommendations, is that so often people make a complaint and then they never know what the outcome is. So, you know, it's their complaint, as far as they are concerned; it's about their mum and dad and their experience and they get this very vanilla, "Yes. The issue has been followed up. We've made a report to, you know, the quality agency as it then was, but we can't tell you any more". And I think that's deeply unsatisfactory.

MR GRAY: And as to unpacking why it's unsatisfactory, I suggest – tell me if I'm wrong – it's just the sheer humanity of the – or the inhumanity of the outcome, of not being engaged in what the process is and where it leads. But, over and above that, is there actually also a systemic problem, which is that you might risk affecting your sources of intel? If you alienate your complainants, you might end up discouraging people from using the complaints process.

PROF PATERSON: Absolutely. People lose confidence. So the loss of public confidence. Whenever one reads in the media reports – you know, when an unhappy family member who's made a complaint goes public with their story and they say, "It's just a waste of time making a complaint", you know, that's a real loss for our regulatory system. So yes, it's the humanity point, "This is my compliant about my mum, my dad." But, in addition to that, we all have an interest in a well-functioning complaints system, you know, and having the confidence that the watchdog will do its job properly.

MR GRAY: Can I turn to another topic which we're sort of moving out of recommendation 2 and 5 and now moving into the territory of recommendation 6, which is around incident reporting. You made a recommendation, if we go back, please, Operator, to – it's now page 1844 of the Carnell-Paterson report. Recommendation 6 is:

Enact a serious incident response scheme, a SIRS, for aged care.

And there's quite a lot of detail in the body of the report on how that would look. I want to ask about a particular aspect that is receiving attention from government at present, but it seems to be in the process of consultation. It's an exemption that applies under subordinate legislation in relation to suspected or alleged assaults where there's a diagnosis of cognitive impairment and the approved provider, provided it does certain things within 24 hours, knows those things don't have to be reported, then it doesn't have to report the suspected or alleged assault where there has been a diagnosis of cognitive impairment. Now, it's the case, isn't it, in the Carnell-Paterson review, the report, in the body of the report, makes it clear your views were that that exemption should be removed; is that right?

PROF PATERSON: Yes. We thought the Australian Law Reform Commission report on elder abuse was absolutely compelling. We met with the then Chair Professor Croucher. And, you know, this was not difficult for us. We thought, "This needs to happen". And there were two aspects to it, the aspect that you're emphasising, but also the fact it shouldn't be ritualistic, but you should be reporting what you've done about it. You know, we've had this serious incident. Widen those to cover, so you don't have the exemption you've described, but also require the provider to report what has been done to fix the problem.

MR GRAY: Now, just taking the exemptions first, why is it important that that exemption be removed?

PROF PATERSON: Because people are at risk of – you know, if you look at it from the perspective of the individual, you know, the resident who's been assaulted by somebody who's suffering from cognitive, you know, dementia, from the perspective of keeping them safe and from that primary purpose of the regulatory system to ensure people are safe, carving off those cases which – they might be very difficult for all sorts of reasons but pretending that they don't have to be reported is – you know, it's a hole in the safety net. And so we thought that hole needs to be fixed.

MR GRAY: And what about the other aspect of this that you've just mentioned, which is imposing an obligation to report the concrete steps taken in response?

PROF PATERSON: We heard, and we thought, that it became too simple to say, "Well, we've reported the matter. That's the end of it". You know, that's not the end of it. You actually want to know what's been done to fix the problem. So to us that seemed – you know, it seemed a no brainer.

MR GRAY: In respect of those incidents that are reported, so presumably not those falling within the exemption, but other suspected and alleged assaults, there's been evidence from Mr O'Brien that there can be assessment of the information that is reported and there sometimes can be follow-up to the approved provider. Is that satisfactory or would you adhere to a recommendation about imposing an obligation to report what's done?

PROF PATERSON: I see no reason to depart from the – you know, I think the recommendation that we made, that was based on the work of the Australian Law Reform Commission, is still a sensible and appropriate response when we're talking about these serious incidents.

MR GRAY: Thank you. I want to ask you just about an aspect of recommendation 7, which is one of the specific protective recommendations, this one on mandating adherence to guidelines to minimise the use of restrictive practices, sometimes called restraints, physical or chemical. There's an aspect of this. I understand you've done some reading on what's been done recently in respect of the quality of care principles and the insertion of part 4A in relation to both physical restraint and chemical restraint. I want to ask you about an aspect of the chemical restraint provisions.

Your recommendation, if we have that available on page 1844, included inter alia "any restrictive practice should be the least restrictive and used only" – that was (i) of recommendation 17. (d) was, "As prescribed by the person's behaviour support plan". And (ii) was:

> *Approved providers must record and report the use of restrictive practices in residential aged care to the Aged Care Commission.*

Now, I don't say anything about physical restraint, because under some amendments to subordinate legislation we understand that there will be reporting of the use of physical restraints. But, with respect to chemical restraints, we don't understand the subordinate legislation, as amended with effect from 1 July, to include an obligation to report the use of chemical restraints. Was that an important element of the recommendations you were making? And what are your views about the absence of any subordinate legislation requiring that?

PROF PATERSON: So the context of this recommendation was the evidence that we heard – and I've had the chance to now read the evidence from Professor Brodaty – you know, is the extent to which chemical restraint, or polypharmacy, you know, is going on within residential aged care settings with so many people with dementia and, you know, behavioural issues. And we thought – well, firstly, we noted the prevalence of that, the harms associated with that, sometimes, frankly, the lack of evidence of efficacy. So there was that context.

There was also the context of not really having a human rights approach to the use of these. And I think that's something that's also been remarked on in Dr Trigg's evidence. So that was the sort of broader context. Having said that, in the body of our report we recognise that it's very difficult to change practice in this area and so there is a need for education and support, there's a role for the clinical adviser in the commission. And we say all of that. But we thought that the reporting of it was a very – recording and reporting of it was a really important incentive to change. So you have to actually put a spotlight on this practice, so that you can start to say, "Right. It's happening more here than here in this – and some facilities are using it much more than others. What's going on there and how can we change that?"

MR GRAY: And did you have in mind specific reporting of each instance in which there was a prescription of a chemical restraint for an individual on an individual by individual basis?

PROF PATERSON: Yes. I mean, it's probably going to be – I assume it would be deidentified in some way, but, yes, absolutely. We wanted to – you know, X number of residents on Y number of occasions, then that information would be reported, at least at that level.

MR GRAY: Yes. There was another recommendation in the body of the report at page 1986, native page 141. If we go to 1986, please, Operator, there was a recommendation related to this issue of medication management and, in particular, perhaps poly-pharmacy, where you and Ms Carnell recommended that:

> *A residential medication management review must be conducted on admission for residents to an aged care service after any hospitalisation upon deterioration of behaviour or any change in medication regime.*

Why is that important?

PROF PATERSON: Just a little bit of history here. Some will be aware that the chair of the review and the co-reviewer in an earlier life was a pharmacist. I recall during the review, we were sort of surprised to learn, and Ms Carnell reminded us, "Well, actually, there's provision for this, it's publicly funded" so why isn't this happening. Anybody who's had a family member knows that these are really important turning points, you know, and they are admitted to hospital, they come back to the facility, a change in the medication. It's an important opportunity and surprise, surprise it's already funded. There is such a review, so why isn't that happening. So we thought it was important and I'd be very disappointed if it were the case that that's not being followed through.

MR GRAY: Well, it led to recommendation 9(v) which we see in a box on page 1992 at the end of that passage in the report. And Ms Laffan's evidence is going to be that the specified action that RMMRs be conducted after hospitalisations, deterioration, or change of regime is not supported by the department. She will go on to say that the circumstances under which clinical services are received is a decision for each resident in consultation with their representatives and health team, etcetera. Is that an adequate justification for not implementing this recommendation?

PROF PATERSON: I don't find that convincing in any way, shape or form.

MR GRAY: Professor, I want to ask you about an aspect of recommendation 10 now. Recommendation 10 – operator, if you would please, 1845. Recommendation 10 makes a number of recommendations about enhancing the complaints process and its impact. Some of those have been accepted by government. But the idea of a complaints register has not been accepted by government. Firstly, Ms Laffan's evidence is going to be that government doesn't support the development of an

online register of all complaints and their handling as the information related to a complaint is protected information. It's a reference to statutory secrecy under the Aged Care Act and also the Commission Act. And also the personal information provided during a complaints process is also subject to the Privacy Act.

But, Professor, this online register that you were making recommendations about, was that intended to be information at an aggregated level or at an individual level?

PROF PATERSON: Of course it was intended to be at an aggregate level. So – I mean, the thinking behind – it seems to me that too often we strike the balance in favour of privacy at the expense of transparency and openness of information. I say that partly having, as parliamentary ombudsman, also been our Freedom of Information Commissioner, and it seemed to me important that a complaints body makes it visible to people who are looking; what are the nature of the complaints they are receiving, how many have they got, how have they been resolved, which ones are being escalated and so forth.

Of course we're not talking about – that you should identify the name of the resident or the family member complainant, nor even the name of the provider. So we're not talking about that. We're talking about aggregated information but something that would give you a much better picture than the sort of vanilla information that one tends to find in the annual reports of complaints bodies.

MR GRAY: You do have a recommendation about naming providers subject to due process in cases of non-cooperation with inquiries, don't you?

PROF PATERSON: Yes.

MR GRAY: Yes. Now, can I just ask you at a general level about statutory secrecy in the Act. Operator, please put up the Aged Care Act, RCD.9999.0002.0014. Thank you. And if we go to page 0362. This is the commencement of division 86. The default position, in a nutshell, is that information in relation to the affairs of approved providers is subject to statutory secrecy binding on officials who have acquired that information in the exercise of their functions under the Act, subject to specific authorisation provisions. Is this, in your view, a healthy approach to information management under the Act or should there be a more open framework?

PROF PATERSON: No, I don't think it is the right balance. These are publicly-funded providers and they are providers who are caring for the most vulnerable members of our community. Why would the default position be secrecy of information about the providers? That strikes me as odd. I fully accept that we must always protect the confidentiality of individual residents and their families but I think there needs to be a much more nuanced approach than we see in this statute. I think it needs a re-examination.

MR GRAY: Professor, just finally, allowing you to, in effect, sum up, are you satisfied with the progress in implementation of the recommendations of the Carnell-Paterson review?

PROF PATERSON: I was gratified to read the responses from Minister Wyatt soon after the review was made public, in October 2017 and encouraged by the statement that was made shortly before the introduction of the legislation. I'm disappointed, however, to learn of the slowness in implementation of the recommendations and I am left with a sense that the 10 recommendations have all been accepted in principle but the devil is in the detail and I can't help suspecting that some of them are not actually being progressed and, given what we're talking about here, given what this whole Royal Commission is about and given what we were reviewing, I think one needs to go back to the rationale for the recommendations. I believe there is still force to them but, of course, that is a matter that will now be revisited by this Royal Commission.

MR GRAY: Thank you, Professor. Commissioners, I have no further questions for Professor Paterson.

COMMISSIONER BRIGGS: I am not sure I can formulate this question appropriately, Professor Paterson, but I'll have a stab. In my experience, transparency and openness is something that organisations of all shapes and sizes struggle with. Similarly, they struggle with consumer complaints information. You could say that frustration around complaints with the banks led to our Royal Commission there and similarly frustration of the community with their complaints going nowhere in this sector contributed significantly to this Royal Commission. That said, transparency is a big issue, and I think it is fundamental to reform in the sector. This is perhaps an unfair question: how do you achieve transparency and what do you see, in this sector, as the fundamentals of that transparency? I don't mind if you use the health system as an example because you've done a lot of work in that sector as well.

PROF PATERSON: So I do think there is a role for the law and for statute law here. Internationally, in other areas, including the work that's been done in comparative healthcare, quality information and surgery, it was Official Information Act or FOI laws in New York State and in the United Kingdom that have actually – that have ultimately led to changes. Though interestingly in both cases, that needs to be partnered by what I like to call professionalism.

So the people working in the sector, they're the provider groups, they need to take that message on board. I think in this sector – and particularly I've been struck by what I've heard, this evidence – there is a very strong need for the people and key roles in the agency, whether it's the department or the commission, to model that themselves. And so the law sets the framework for that. The agencies also model it.

I think the providers – I mean, one of the things that I observed in my time in New Zealand was that providers – everybody will be too ashamed to admit they'd ever

had a complaint. And yet you look in other sectors – when I was working in the banking sector, we were publishing comparative table, naming the banks, and you could see Westpac, ANZ, you could see the complaints and the rates were adjusted and so forth.

So I think we need – and I know the Aged Care Complaints Commissioner was encouraging providers, "Be prepared to show your dirty laundry." Don't think of it as dirty laundry, think about it as the way in which you are learning from complaints, learning to do your job better. So I think transparency is an over-used word but I agree that it is actually key to the shift that we need to see in the aged care sector. It needs to become real rather than lip service.

COMMISSIONER TRACEY: Anything arising, Mr Gray?

MR GRAY: No, thank you Commissioner.

COMMISSIONER TRACEY: Professor, thank you very much for returning to this country, not for the first time, to deal with intractable problems that it falls to us on this occasion to wrestle with. Your evidence has been extremely helpful, and I suspect you haven't heard the last from us. The Commission will adjourn until 9.30 tomorrow morning.

<THE WITNESS WITHDREW [4.47 pm]

MATTER ADJOURNED at 4.47 pm UNTIL THURSDAY, 8 AUGUST 2019

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