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TRANSCRIPT OF PROCEEDINGS

O/N H-1053326

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

9.33 AM, THURSDAY, 8 AUGUST 2019

Continued from 7.8.19

DAY 45

MR P. GRAY QC, counsel assisting, appears with MR R. KNOWLES, MR P. BOLSTER and MS B. HUTCHINS
MR G. KENNETT SC appears with MR J. ARNOTT for the Commonwealth of Australia

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Commissioners, before we move to the next witness, there's a matter that requires a procedural direction from you. I'm instructed that tab 48 of exhibit 8.1 in the Earle Haven tender bundle was published on the Royal Commission's website with incomplete redactions that had the effect of identifying certain providers. That document has since been removed from the Commission's website this morning. A non-publication direction is sought over that version, that is, the version that was on the website until late yesterday evening.

Those following the proceedings, and who may have access to this document, are advised that it is not to be published pursuant to a direction under section 6D subsection (3) of the Royal Commission Act. We will prepare a formal order to that effect and provide it to the Commission, but we'd ask, Commissioners, for an order in those terms on an interim basis.

COMMISSIONER TRACEY: There will be an interim order in those terms which will stand until a written order is promulgated.

MR BOLSTER: Commissioners, I call Ann Wunsch, who is in the witness box.

<ANN DOMINICA WUNSCH , AFFIRMED [9.35 am]

<EXAMINATION BY MR BOLSTER

COMMISSIONER TRACEY: Ms Wunsch, I apologise on behalf of the Commission for any inconvenience that's been caused to you by your evidence not being taken yesterday as anticipated. As you no doubt gleaned, we got well behind with the schedule.

MS WUNSCH: Thank you, Commissioner.

MR BOLSTER: If the document WIT.0283.0001.0001 could be brought up on the screen, along with a more recent document, RCD.9999.0170.0001. Ms Wunsch, do you recognise your statement on the left and a document styled Corrections to Statement on the right?

MS WUNSCH: Yes, I do.

MR BOLSTER: And on the left is your statement.

MS WUNSCH: Yes.

MR BOLSTER: And I take it the only amendments you wish to make are those set out in the list of corrections on the right.

MS WUNSCH: That's correct.

MR BOLSTER: All right. And, with that in mind, are the contents of the statement true and correct to the best of your knowledge and belief?

MS WUNSCH: Yes, they are.

MR BOLSTER: I tender both the witness statement, which is dated 22 July 2019, and the corrections document, Commissioners.

COMMISSIONER TRACEY: Yes. I think I'll make them one exhibit. So the witness statement of Ann Dominica Wunsch, dated 22 July 2019, and the corrigenda thereto will be exhibit 8-30.

EXHIBIT #8-30 WITNESS STATEMENT OF ANN DOMINICA WUNSCH DATED 22/07/2019 (WIT.0283.0001.0001) AND THE CORRIGENDA THERETO (RCD.9999.0170.0001)

MR BOLSTER: I just want to make sure the correct pronunciation is Wunsch.

MS WUNSCH: That's correct.

MR BOLSTER: Thank you. You are currently the executive director of Quality Assessment and Monitoring Operations under the Commission.

MS WUNSCH: Yes.

MR BOLSTER: And I'll call it the Commission so we'll - - -

MS WUNSCH: Sure.

MR BOLSTER: For ease of reference. And, before that, you were the executive director of the Operations Division within the Quality Agency.

MS WUNSCH: Yes.

MR BOLSTER: Correct. And how long were you the executive director of the Operations Division in the Agency?

MS WUNSCH: Since 2015.

MR BOLSTER: All right. Could you describe the transfer of the division under the Agency to the Commission when the transfer of responsibilities occurred last year? How did that operate?

MS WUNSCH: Essentially, the responsibilities for each region under a regional director transferred from the Quality Agency to the Commission, so the structure within the operations area, essentially, operates in the same way, led by myself.

MR BOLSTER: So there were operational divisions in, for example, Brisbane?

MS WUNSCH: The operations in Brisbane, essentially, operate in the same way under the regional director under my leadership.

MR BOLSTER: Yes. And the staff are, essentially, the same?

MS WUNSCH: To the extent that they are the same staff. Of course, we have a recruitment program ongoing, but there are the same staff that were a part of the Quality Agency under my direction as part of the same teams operating under the Commission.

MR BOLSTER: What have been, if any, the significant changes in direction that have followed from the transfer from the Agency to the Commission?

MS WUNSCH: The direction has moved us to – far more into a risk-based responsive regulatory program, albeit that journey commenced before the inception of the Commission. We have, as part of our risk-based responsive program, a far more joined up working arrangements with our colleagues in the complaints resolution group. So the processes involve a combination of understanding of information that comes into the Commission via that complaints resolution group to inform the operations of the quality assessment and monitoring group in a far more comprehensive way.

MR BOLSTER: Let's take Brisbane, for example.

MS WUNSCH: Yes.

MR BOLSTER: Is there a complaints office - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - inside the Brisbane office? And the complaints officers who deal with complaints in Queensland and the Gold Coast would deal with those complaints?

MS WUNSCH: So the complaints office in Brisbane is in the CBD and the Quality Assessment and Monitoring Group are located at Spring Hill. The way these two groups work together is through joint meetings, discussions on a daily basis,

meetings on a weekly basis. And the Complaints Resolution Group personnel are also involved in the overall case management, the national case management, processes that are headed by my area.

MR BOLSTER: All right. The number of staff in each, has there been any significant fluctuation as we move from Agency to Commission?

MS WUNSCH: There has been some increases in the assessor work force in my area. I can't really talk to the changes or increases in staff in the complaints resolution group.

MR BOLSTER: And who do the complaints resolution staff report to?

MS WUNSCH: They report to the executive in that group.

MR BOLSTER: And who is that?

MS WUNSCH: Viv Daniels.

MR BOLSTER: And she is based where?

MS WUNSCH: She is based in Melbourne.

MR BOLSTER: And you're based?

MS WUNSCH: I am based in Parramatta in Sydney.

MR BOLSTER: All right. So we have – just for completeness, we have complaint staff and resolution staff in different offices in Brisbane and they report to different officers in different states, effectively, within the Agency – in the Commission as it now is.

MS WUNSCH: No, sorry. That was an incomplete answer on my part. There is a reporting structure in each regional office, both in the complaints resolution group and in the quality assessment and monitoring group. So the complaint staff report to a regional director based in Brisbane, and that regional director reports to an executive based in Melbourne.

MR BOLSTER: Right.

MS WUNSCH: In addition to the regional directors that are located around the country that report to me, I also have a director of operations and that director of operations happens to be located in our Brisbane office in Spring Hill.

MR BOLSTER: The two functions that we've been talking about eventually report to you on a national basis; is that correct?

MS WUNSCH: No, that's not correct.

MR BOLSTER: All right. Well, how do they – under Janet Anderson's office - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - who else, apart from yourself, deals with those processes?

MS WUNSCH: So Viv Daniels reports to Janet Anderson.

MR BOLSTER: Right.

MS WUNSCH: And so the Complaints Resolution Group has its reporting structure to the Commissioner and the Quality Assessment and Monitoring has its reporting structure to Janet Anderson. And I report directly to Ms Anderson.

MR BOLSTER: All right. Well, let's talk, can we, about the Homes of Interest list.

MS WUNSCH: Yes.

MR BOLSTER: What is it?

MS WUNSCH: The Homes of Interest list is a list that is generated by our business operating system to detail the services that the Commission is currently actively regulating through its regulatory programs. It includes services both in home care, national Aboriginal flexi care and residential aged care. The list is a tool, in effect, to support the national oversight of our regulatory program.

MR BOLSTER: Is it a list that is generated within the Commission and the Commission only?

MS WUNSCH: The list is generated in the Commission.

MR BOLSTER: Is it circulated to the Department?

MS WUNSCH: The list is not circulated to the Department. However, the list has significant overlap with the Service Providers of Concern list. There's about an 80 per cent overlap in terms of services that the Commission is actively monitoring and that the list that the Department maintains, which may include some other services that are not included on the Homes of Interest list.

MR BOLSTER: What's the best way to describe the difference between the Service Providers of Concern and the Homes of Interest list?

MS WUNSCH: The best way to describe it is the Homes of Interest list is a service-by-service list and it reflects the regulatory program for each service. The service providers of concern list is at a service provider level, not at a service level,

and the SPoC list essentially can contain information that the Department has, under its surveillance, broader than the Commission's remit, for instance, prudential concerns or other matters that it is seeking to bring to the attention of the Commission.

MR BOLSTER: All right. One of the differences that would seem to be apparent is that there is no fixed criteria for entry to the SPoC list. That is, there's a discretionary element to the inclusion of someone on the SPoC list. Do you agree with that?

MS WUNSCH: I cannot comment on that matter. It's not – it's the Department's remit.

MR BOLSTER: Well, you have sat, haven't you, on a liaison meeting for some years between the Department and the Agency - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - where, I take it, issues arising out of providers on the SPoC list have been discussed in the context of the Agency or the Commission's work in relation to the homes of interest list?

MS WUNSCH: Yes, that's the case.

MR BOLSTER: Is it a useful exercise in regulatory oversight to compare notes on what providers are doing according to the two lists?

MS WUNSCH: It's certainly valuable to have those discussions in relation to matters that the Department may have direct line of sight to that informs our regulatory actions, yes.

MR BOLSTER: All right. If we could bring up tab 53 in the Earle Haven tender bundle. You will see there that these are some minutes from 2017 of the SPoC committee meeting on 21 August. Are you familiar with those minutes; have you reviewed them in preparing for your evidence today?

MS WUNSCH: I have seen these minutes, yes.

MR BOLSTER: When we see compliance section as denoting the role of three officers from New South Wales who are attending that meeting. Are they – what compliance section are we talking about there? Compliance officers under your direction and control or a different form of compliance?

MS WUNSCH: Could you point to the line that you are referring to, please?

MR BOLSTER: Well, you see – the names of the attendees are obviously blanked out and the chair is identified as being the first person there. And then you can

assume from me that compliance section refers to three officers from New South Wales from the compliance section.

MS WUNSCH: Yes.

MR BOLSTER: Which compliance section? One under your control or one within the Department?

MS WUNSCH: That is not – they're not descriptors that we use to describe our officers.

MR BOLSTER: Right. Okay. Even in 2017?

MS WUNSCH: That's right.

MR BOLSTER: All right. Thank you. I don't need that any more. Ms Brammesan gave some evidence the other day to the effect that the SPoC list identifies a higher level of risk compared to the homes of interest list. Do you have any insight in relation to that comparison?

MS WUNSCH: I can understand that the – that statement would refer to that the – as the SPoC list is a list of providers that the Department may hold concerns in relation to approved providers that are beyond the regulatory activities in relation to a specific service of a provider. The Department's remit is far broader than the Commission's or the previous quality agency and so that inclusion on a SPoC list could indicate broader concerns about a provider.

MR BOLSTER: I just want to ascertain, though, the extent to which that sort of intelligence that the Department may have that it's obviously gathered together because there's an issue of concern about a provider, the extent to which, in the ordinary course, that comes within the purview of the Agency or the Commission.

MS WUNSCH: The communication between the Department and the Commission at a regional office level is frequent. It could be daily in relation to particular services or providers. And the information exchange is one to inform both parties on any concerns in relation to a service or a provider.

MR BOLSTER: All right. Well, let's talk then practically about the Brisbane office. Does that mean that, assuming someone was on the SPoC list in Queensland, that would be the result of work done by officers in the Department of Health in Brisbane?

MS WUNSCH: It could be.

MR BOLSTER: And the officers of the Department of Health in Brisbane, have they been co-located with the Agency and the Commission in the recent past?

MS WUNSCH: No, they have not.

MR BOLSTER: What is the relationship between Commission and Agency – I will put it another way. What is the relationship between Agency and Commission staff, on the one hand, and health staff in Brisbane? To what extent is there cooperation?

MS WUNSCH: I think there is – there are good working relationships between officers of the Department, the Commission, the previous Complaints Commission, and that we have been on a journey over some years, and more so since the inception of the Commission, to work in a far more joined-up way, in an effective way, to understand complex problems in relation to the regulation of aged care services.

MR BOLSTER: All right. Ms Brammesan gave some evidence the other day that the Commission has only had access to SPoC committee meetings since April of 2019. Is that correct?

MS WUNSCH: I'm sorry, can you just repeat, access to SPoC?

MR BOLSTER: Access to SPoC committee meetings since April 2019.

MS WUNSCH: Committee meetings?

MR BOLSTER: Yes.

MS WUNSCH: I've participated on SPoC – Service Provider of Concern meetings – since 2015.

MR BOLSTER: All right. Okay. When - - -

MS WUNSCH: And my – and my director of operations, in my absence, routinely participates in those meetings.

MR BOLSTER: We're talking about case liaison meetings, are we? That's the name that the minutes give to those meetings.

MS WUNSCH: They – those meetings are meetings to discuss the service providers of concern. There is a meeting scheduled for 22 August in relation to the service providers of concern. It's a routine meeting that is - - -

MR BOLSTER: In preparation for that meeting though, a document is prepared - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - which sets out the regulatory history, at least from Health's perspective, of each particular provider, correct?

MS WUNSCH: There is summary information around the relevant matters in relation to those providers for the purposes of consideration at the meeting.

MR BOLSTER: All right. If we could bring up tab 48, please. This is a document prepared for a SPoC meeting in May of 2017 which I assume replicates all of the providers on the SPoC list at that time. You're familiar with the format of that particular notice?

MS WUNSCH: Yes, I am.

MR BOLSTER: If we could go down through that document to the People Care entries, you will find those – it was number 9 on the list and there's a decreasing level of severity, isn't there? So the red coding that we saw on the first page shows an extreme or severe risk, and it's couched in terms of risk, isn't it?

MS WUNSCH: Yes.

MR BOLSTER: Do I take it that, when you went to the various meetings that you've just been talking about, these documents were circulated beforehand?

MS WUNSCH: I cannot recall that.

MR BOLSTER: Wouldn't you, when you went to a SPoC meeting, or a SPoC liaison meeting, whatever you want to call it, with department officials, wouldn't you want to go through in some detail the record of the various providers that you were discussing?

MS WUNSCH: Yes, but that – yes, I would, and I did, but that information is information that the Commission contributes to the SPoC meeting based on the activities the Commission has undertaken.

MR BOLSTER: To what extent, when you look at that, do you see information about People Care that comes from the Department and to what extent do you see information that comes from the Commission?

MS WUNSCH: There is a combination of both in this document. Information in relation to compliance history around home care services, notices of non-compliance. There is a combination of information generated from the department and from the Commission or the previous agency.

MR BOLSTER: The secretarial work for these meetings, is that done by the Department or by the Commission?

MS WUNSCH: The secretarial work in relation to the SPoC meeting is done by the Department.

MR BOLSTER: At the end of the meeting, are these documents available for circulation within the Commission?

MS WUNSCH: Yes. There are summary documents provided to the Commission from the outputs of the meeting, yes.

MR BOLSTER: And are they used then to inform the Commission staff about the particular views that the Department of Health may have about someone on the SPoC list?

MS WUNSCH: Yes, they are. And so are the routine meetings that occur between the Department and the Commission at a regional level in Queensland, on a weekly or fortnightly basis, to ensure that the Commission is updated in relation to all issues that are relevant to this particular provider or its services. So that discussion occurs far more frequently than the meetings that are held as SPoC or homes of interest, or national case management.

MR BOLSTER: Yes, if that could come down now, thank you. One of the things that's apparent from your statement is that, when a sanction process ends, assuming it was a sanction process that put someone on to the list, it automatically takes someone off your homes of interest list; is that correct?

MS WUNSCH: That is correct unless one of the other criteria for inclusion on the homes of interest list is still present, because there are four criteria that a service does not meet four of the requirements of the standards, that a service has a review audit in place or that a serious risk decision is made. So those matters are also relevant to whether a service remains on the homes of interest list.

MR BOLSTER: Let's talk about the serious risk decision. The listing ceases 30 days after the making of that decision; correct?

MS WUNSCH: Yes.

MR BOLSTER: If that's the only one why someone is on the homes of interest list - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - 30 days they're automatically off; correct?

MS WUNSCH: They are off that list, however, the active service management of those services continues in the regional offices where the officers are working, the assessment teams are being assigned to monitor, to continue the surveillance of those assessments to those services.

MR BOLSTER: Yes, but in paragraph 30, don't you say that listing has at least one significance for that provider, in that listing, or non-listing, informs the Commission's regulatory approach to a particular provider?

MS WUNSCH: Yes, that's correct.

MR BOLSTER: So when you go off the list, there's a different regulatory approach.

MS WUNSCH: No. The regulatory approach has already been considered through a national case management consideration, and the ongoing monitoring of that service is still conducted with oversight from myself or from the director of operations, because we are meeting regularly with our – my direct reports, regional directors, to continue to understand the performance of those services. And any regulatory intelligence that comes into the Commission from any source will also prompt further consideration of escalation to regulatory approach.

MR BOLSTER: All right. Is there a different regulatory approach depending upon whether the risk according to SPoC is high, medium, low, severe?

MS WUNSCH: The regulatory approach adopted by the Commission is informed by consideration of any matters that the Department brings to the Commission's attention, because it adds to the regulatory intelligence that we have in relation to the service.

MR BOLSTER: So let's take, for example, Earle Haven and People Care.

MS WUNSCH: Yes.

MR BOLSTER: It went off sanctions towards the end of 2017.

MS WUNSCH: Yes.

MR BOLSTER: It did not go back on sanctions before the events of 11 July. That's your understanding?

MS WUNSCH: That's correct. Yes.

MR BOLSTER: Is your evidence that even despite the relatively poor regulatory record of People Care up until December 2017, you kept what might be called a regulatory approach that was appropriate for a provider that had a serious or moderate risk, in SPoC terms?

MS WUNSCH: I believe we maintained a regulatory approach in relation to that service commensurate with our understanding of their current risk. We conducted an assessment contact at that service in June, and – towards the end of June 2019. The assessment of risk is one that is dynamic in each regional office in relation to all the

services that that office is responsible for engaging in. And an assessment was made in relation to the frequency and the form of those assessments by that regional office.

MR BOLSTER: Let's unpack that a bit with People Care. By December 2017, it had been through multiple sanctions; correct?

MS WUNSCH: Yes.

MR BOLSTER: It had come out of the sanctions process and you had seen it come up in SPoC, homes of interest, liaison minutes - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - on a number of occasions. Do you recall the number of occasions at which it came up in meetings that you attended?

MS WUNSCH: I certainly am very familiar with the organisation and its performance.

MR BOLSTER: All right. Well, describe the approach – or the regulatory approach that the agency at the time was intending to apply to People Care in December 2017.

MS WUNSCH: The approach is to – when a service returns to compliance, after a period of non-compliance, to determine risk based on information that is available to the Commission at a point in time and assessments are scheduled on that basis.

MR BOLSTER: Sorry. Had you finished?

MS WUNSCH: Yes.

MR BOLSTER: What risk did you apprehend in December 2017 when it came to People Care?

MS WUNSCH: Well, the circumstances in relation to the findings of the Agency advised us of the risks in relation to that service, but in our compliance monitoring work we came to a view that that service was then, at the end of that period, meeting standards.

MR BOLSTER: All right. Was the introduction of a third party service provider, in the form of HelpStreet, conveyed to the commission at any stage in 2018?

MS WUNSCH: The Commission – the Quality Agency was aware of HelpStreet as a subcontracted entity subcontracted by People Care.

MR BOLSTER: When did it become aware of that?

MS WUNSCH: I can't recall that at this time.

MR BOLSTER: What is the procedure for dealing with that sort of outsourcing when you become aware of it?

MS WUNSCH: The aged care service providers routinely contract parts of that service to subcontracted entities. It can be parts of their service such as kitchen or laundry or clinical care and, less commonly, although it is not rare, they subcontract their care delivery operations to a subcontractor.

MR BOLSTER: What do you do when you find out that that's happening?

MS WUNSCH: We understand that through the next assessment of performance against standards. We wouldn't necessarily take a view, though, that a subcontractor was – created risk for a service. In many instances, the engagement of a subcontractor has enhanced the quality of services for an aged care service provider and has been seen in a positive light, rather than a negative light. I'm not saying that, obviously, in the case of Earle Haven, but we have seen circumstances where an approved provider has sought to subcontract to another approved provider or another entity and that has benefitted the quality. And we see that through assessments of performance.

MR BOLSTER: Where do you see the role of ensuring that the person who's actually going to deliver the care – in this case it was a substantial assignment, effectively, of the obligation to provide vast bulk of personal care to the residents of this facility. Where does the responsibility lie, as you see it, for checking the bona fides, the experience, the qualifications of the entity that's going to do that?

MS WUNSCH: Under the new standards from 1 July, under the standard 8 governance, we see an opportunity for us to better understand the governance arrangements for aged care services, which would include the understanding of subcontracting arrangements, but we would do this through the process – sorry – through the lens of risk and also feedback from consumers. So it's the quality and the safety of the care that is delivered that is our primary focus. And feedback from consumers would inform us as to whether the arrangements that were in place, be they arrangements through a subcontractor, are delivering the quality of care that meets their needs.

MR BOLSTER: We'll come to the lessons learnt from Earle Haven a little bit later. Let's just focus now on the period in 2018 when it was apparent to the Department, and I'm assuming from your answers to the Agency, that this process had been implemented. It doesn't seem, from the record, that the Agency directed any queries to the provider or to HelpStreet about what was going on and what the terms were of their arrangement and what the contractual obligations were on the part of HelpStreet to deliver care.

MS WUNSCH: Assessment teams can seek to understand those issues, but they would normally do that through concerns or matters raised by an assessment – by information they receive at an assessment. And that would direct their inquiries.

MR BOLSTER: Wouldn't you agree with me that that task, that, effectively, second-guessing the accreditation of HelpStreet, is not really a task that your assessors are trained to deal with?

MS WUNSCH: I'm sorry. Can you - - -

MR BOLSTER: Well - - -

MS WUNSCH: I didn't understand your question.

MR BOLSTER: Your assessors - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - faced with a situation where they find out that People Care is no longer providing any care, all the care is being provided by a different organisation which has taken over a licence to operate the facility, there's no formal written agreement about the terms upon which they're going to do that, to what extent are your assessors in a position to make judgments, to request documentation, to seek information, about that sort of commercial dynamic?

MS WUNSCH: If I understand your earlier question in relation to that question, assessors could seek to understand the nature of the contract. They could. But that would be on the basis that they had a reason to understand those particular matters because of concerns.

MR BOLSTER: Well, surely they had a reason to understand what the arrangement was between the approved provider and some other company that had come in to actually provide the care.

MS WUNSCH: Only to the extent that that is – those inquiries are relevant to an assessment of performance against the standards. And the reason I took us to post 1 July is because the standards we currently operate under are fundamentally different and they provide a line of sight to governance in a way that the previous standards didn't. It's not – I'm not seeking to refer to lessons learnt. I'm seeking to establish that we have a stronger and sounder basis to understand those arrangements under current standards.

MR BOLSTER: All right. Well, let's look at the old accreditation standard 1.6, which required:

> *…appropriately-skilled staff and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care services philosophy and objectives.*

I'm sure you're very familiar with that - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - particular standard.

MS WUNSCH: Yes.

MR BOLSTER: Now, is that historically a standard that is enforced by the Agency – that was enforced by the Commission – by the Agency?

MS WUNSCH: The Agency assessed performance against standard 1 .6 at every re-accreditation audit, at every review audit and assessment contacts where that was the relevant scope of assessment. It's certainly the case that it was part of the assessment. However, it may not be the case that, through the assessment of that expected outcome, we would understand whether the staff in a service were contracted or were employees of a service. The nature of their engagement by the service may not be understood through that assessment, as it's a very common practice in aged care services across Australia to use contracting arrangements in a variety of ways, including in relation to key personnel of a service.

MR BOLSTER: All right. We're talking then about the actual terms of engagement for the staff with the provider.

MS WUNSCH: Yes.

MR BOLSTER: Which is different from the provider not having any staff and not having any relationships with individual staff, but having a commercial relationship with a third party who employs the staff. You'd agree with me that's a very different scenario.

MS WUNSCH: It's a scenario that, as I said earlier, is not rare. And there have been other instances that, where we have been aware of and confident with the arrangements where a provider has subcontracted its services to another entity, albeit most commonly it's another approved provider.

MR BOLSTER: Was the contractual arrangement with People Care picked up in an audit of the old accreditation standard 1.6?

MS WUNSCH: I don't believe that it would have been understood under the scope of that expected outcome.

MR BOLSTER: Speaking more generally - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - and off People Care for a moment - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - under the old standards, to what extent was 1.6 enforced by the agency? Did it ever require, through the sanction process, the actual employment of extra staff in any particular case?

MS WUNSCH: The – when you say "enforced", I'm taking you to mean applied or used as an assessment against the standards?

MR BOLSTER: Let's assume there have been a number of accreditation visits, site visits, and the facility is just simply not employing enough staff. It might be the overnight situation where there's an enrolled nurse or a carer with a registered nurse on call that you find is in breach of 1.6. You get to the end of the road where the provider will do nothing about it. Do you issue a sanction to say, "We'll revoke unless you do this and you have a registered nurse on site overnight"?

MS WUNSCH: That is not the process that we engage in. When we make an assessment of the performance against 1.6, we make a finding of whether – we used to make a finding about whether there were sufficient and available staff to deliver care and services. That finding may contribute to an overall decision that the service doesn't meet other expected outcomes of the standards and the decision that flows from that may be to – to revoke or vary the period of accreditation. Sanctions imposed by the Department are specific to a particular outcome or issue and that sanction that the Department issues may result in the service increasing its staffing.

The service may come to that view without a sanction as well. They may come to a view that they need to increase or change the mix of staffing based on a decision of the Agency, then agency, in relation to that expected outcome.

MR BOLSTER: All right. If we could turn, please, to tab 95 and let's look at the last contact report for People Care before 11 July. You'll see that this contact occurred on 25 June.

MS WUNSCH: Yes.

MR BOLSTER: In briefing the Minister and looking into People Care and preparing for your evidence, are you familiar with this report?

MS WUNSCH: Yes, I am.

MR BOLSTER: When you read it, was there anything in it that concerned you?

MS WUNSCH: Yes.

MR BOLSTER: And what was that?

MS WUNSCH: I was concerned about the use of restraint in that service.

MR BOLSTER: I was going to ask you precisely about that. If we could go, please, to the page that has seven questions and seven dot points. I think it might be three or four pages in. The seven opening questions there, are they a mandated or a prescribed way in which an assessor opens up a meeting with a provider?

MS WUNSCH: An assessment contact with a provider in this case, yes, they are. They are the risk screening questions that we developed in 2017. They are available on our website and they are used routinely to understand or open up lines of inquiry to undertake an assessment.

MR BOLSTER: When you look at the second-last dot point - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - two quite striking figures come out, namely, 71 per cent of care recipients receiving psychotropic medication.

MS WUNSCH: Yes.

MR BOLSTER: When you read that, did that surprise you?

MS WUNSCH: That is at the very high end and I've seen examples where that percentage has been in reports for services that have predominantly consumers with mental health or other complex care needs but that's a very high number.

MR BOLSTER: Did that cause you to go back over the record to see whether there had been any previous reporting of that sort of prescribing regime?

MS WUNSCH: That is not my role but certainly the regional director and assistant director in this office were involved in reviewing this report and at the time of the incident of 11 and 12 July, we – this report has been since made available to the provider for the purposes of further information to inform these matters. So the assessment of this particular matter was not concluded at the point in time when the incident occurred on the 11th.

MR BOLSTER: The documentary record doesn't show – I mean, it was very limited time between the 25th and the 11th for anything to happen. What would be the ordinary regulatory response to this sort of voluntary reporting?

MS WUNSCH: To provide the report to the provider to seek their feedback in relation to these matters and, at the same time that this report was provided to the provider, the provider also received, along with all other residential aged care services in Australia, an assessment contact with a self-assessment tool to assist them to capture information in relation to each person in their service that was subject to psychotropic medication. That assessment to all residential aged care services in Australia was developed in response to information that was coming through, partly

from the responses to risk screening questions. So there was an escalation of – of activity that this service would have also received along with others.

MR BOLSTER: The second aspect – the psychotropic medication is one thing but the figure about physical restraint, may I suggest to you, that it's even more troubling?

MS WUNSCH: And I agree that is a very troubling number. We determined, in June, to undertake an assessment contact specifically in relation to psychotropic medications and we advised in a letter that I issued to the sector, to all services, that we would follow this up in August/September with a further same-type self-assessment tool process to understand physical restraint. We didn't collapse it together into one tool because we know that the sector is also on a journey of improving its performance and we want to support their own efforts to improve their performance in relation to the use of both physical and chemical restraint.

MR BOLSTER: Are you concerned that none of the earlier contact reports disclose these sorts of problems in relation to People Care and it's only in June 2019 that we see that sort of disclosure on the record?

MS WUNSCH: I believe that we have made significant progress in relation to this issue. When we first dropped this risk screening question in 2017, it was a broader question. Since the inception of the commission in February, we sharpened up this question so that we could see what a self-assessment percentage of restraint looked like and we've now moved to provide significant resources to the sector to assist their improvement in their performance and I think our line of sight to this issue is far sharper now and we expect that, with additional resources and attention, supported through also efforts of the industry associations, with policies, procedures and training, that we'll make a significant impression and impact in relation to this issue.

MR BOLSTER: If we assume that the incidence of those restraints didn't change over time – and we don't know the answer to that – is the effect of your evidence that, had the right questions been asked in 2018, we might have found out that information earlier?

MS WUNSCH: I don't know, but what I do know is that this reflects a point in time and what we don't know is whether the same cohort of care recipients were there at that time and there are many issues that impact on this information.

MR BOLSTER: But a 50 per cent figure for physical restraint is totally unacceptable. You'd agree with that?

MS WUNSCH: It's an unacceptable level and the sharper focus has brought this information to light and the value is in seeking to work to improve this picture across the sector and that is the reason for seeking to understand these matters in terms of percentages.

MR BOLSTER: All right. I want to move to a completely different topic; I want to talk about - - -

COMMISSIONER TRACEY: Before you leave this report, I just have one question that I want to ask and that is: after you read this contact report, were you concerned, not by what was there but by anything that wasn't there?

MS WUNSCH: I believe that the report gives us line of sight to issues that needed to be followed up with this service and following a response from the provider, the Queensland office would have made a determination in relation to next steps in terms of regulatory activities.

COMMISSIONER TRACEY: You haven't answered my question.

MS WUNSCH: I'm sorry.

COMMISSIONER TRACEY: The question was: once you read this report, were you concerned about the absence of any material issues that you thought should have been there but weren't?

MS WUNSCH: I'm concerned that there are statements in the report that point to significant problems and that concern requires further assessment and further regulatory action and - - -

COMMISSIONER TRACEY: You're referring there to things that are there and that have implications. I'm asking you about whether there were any matters that should have been there, in your view, but weren't.

MS WUNSCH: I'm sorry, I don't know how to answer that question.

COMMISSIONER TRACEY: Well, the answer may be that you didn't have any concern.

MS WUNSCH: That's not my answer. My answer is that the information in the report would suggest that there are further issues that need to be understood about the service. So there are – this is an assessment contact that took one day and, therefore, the scope of this activity was limited to particular matters. There is enough information in this report to raise concerns and our experience in many years of undertaking these activities is that a concern in one particular area may point to concerns in areas that have not been explored. And that's why the next step to this process is to seek further information from the provider and then come to a view about what the next steps would be.

Yes, Mr Bolster.

MR BOLSTER: Could I just take that a step further. A month earlier, another officer had gone to the facility and effectively been told by the facility manager that

the provider was not being provided with information about the complaints that were then before your organisation. That was obviously a matter of concern, wasn't it?

MS WUNSCH: Yes.

MR BOLSTER: That was a month beforehand.

MS WUNSCH: Yes.

MR BOLSTER: One of the things, perhaps, that the assessor could have asked the provider in June was had that issue been rectified.

MS WUNSCH: That could - - -

MR BOLSTER: Because it was the last pressing issue that had been on the Commission's file.

MS WUNSCH: And the – and I note that that information wasn't sought from the provider.

MR BOLSTER: No. Just on another point, the facility manager here who dealt with the officers and who answered the questions was not clinically trained. Is the that normal process when you're carrying out an assessment contact visit, to deal with someone who's, effectively, the business manager or the residential manager, but doesn't have a health qualification?

MS WUNSCH: The person in charge, who is nominated by the provider, could be a facility manager, it could be a registered nurse, it could be a clinical manager, it could be a non-clinical business manager. It's certainly not unusual for us to be liaising with an approved provider delegate who is not a clinical person.

MR BOLSTER: Is that a best practice procedure? Is that likely to get the best result when you're assessing whether this facility meets accreditation standards?

MS WUNSCH: I don't believe that that goes to those issues, because the assessment involves an assessment in relation to a broad range of matters and is informed by clinical personnel and non-clinical personnel across the standards. So the information the assessment team requires in relation to clinical matters is sought from clinical staff.

MR BOLSTER: All right. Now I will change to home care.
MS WUNSCH: Okay.

MR BOLSTER: Risk-based regulation of home care, how different is that from risk-based regulation of residential care?

MS WUNSCH: The key difference is that, as home care is delivered predominantly in individual's homes, that the assessment team has not had the same access to making observations about care and not the same access to interviewing consumers and their representatives. However, this has changed significantly under new standards and – from 1 July, where we have introduced consumer experience interviews into the assessment of home care services. We have always sought to engage with consumers through the provider, as required under legislation, but we now have additional avenues to seek that information to inform that assessment.

MR BOLSTER: I want to ask you about a specific aspect - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - of this. And that is that home care providers are allowed to commence operations before they are subject to a quality review; is that correct?

MS WUNSCH: Yes.

MR BOLSTER: And the average time taken to have a quality review is once every three years.

MS WUNSCH: Yes.

MR BOLSTER: How is that a risk-based approach to the regulation of home care?

MS WUNSCH: The quality agency sought to understand the introduction of new providers into the home care space, new as in commencing home care services, and did some risk analysis around those services to the extent that we had information available to us about those services and their configuration and to prioritise the assessments to those.

MR BOLSTER: All right. 2017, 2018, the median time for the first quality review in home care was 324 days.

MS WUNSCH: Yes.

MR BOLSTER: Last year, the year ending 30 June 2019, it was reduced to 201 days. What's an acceptable period of time to wait before a commencing home care provider has its first quality review?

MS WUNSCH: So in understanding an acceptable timeframe, we look to the information that we have in relation to the type of care that the provider is providing, whether we can understand that in terms of the acuity of the needs of the consumers of that service and the numbers of consumers receiving that service. And we prioritise those visits according to the best regulatory intelligence that we have available to us in the commission.

MR BOLSTER: The budget allocation for home care compliance and risk-based monitoring was $5.6 million, I think, in the last financial year, of which $2.4 million went to the commission. Did that involve the employment of extra staff to engage that process?

MS WUNSCH: There has been recruitment of 10 extra positions to enhance the staffing cohort to support the increased numbers of home care services that require quality review and monitoring.

MR BOLSTER: And have they been allocated geographically to meet the need for review that's outstanding?

MS WUNSCH: Certainly we allocate our staffing based on geographics and the numbers of home care services and the distribution of those services across the country.

MR BOLSTER: All right. The Carnell-Paterson report recommended that the commission develop a more robust risk profiling instrument.

MS WUNSCH: Yes.

MR BOLSTER: What steps have been undertaken to do that - - -

MS WUNSCH: So the - - -

MR BOLSTER: - - - in the context of home care, please?

MS WUNSCH: Sorry. The department is leading this work. We have contributed significantly to this work to seek to access datasets that have not been available to us to better understand risk in relation to home care. And we will be accessing a risk profiling system which will be underpinned by statistical models and analysis from 1 July 2020. And that will significantly benefit us in being able to understand the acuity of consumers.

MR BOLSTER: How are you going in terms of meeting that deadline?

MS WUNSCH: This project is progressing well and we are very confident that we'll have a sound basis to better understand risk from 1 July next year.

MR BOLSTER: Can I ask you to have a look at tab 140, which is going to come up, of the general tender bundle. Thank you. Are you familiar with this – it's called a dashboard, isn't it?

MS WUNSCH: Yes.

MR BOLSTER: And what's its purpose?

MS WUNSCH: This is a dashboard to inform the Department of Health of the progress in relation to its projects.

MR BOLSTER: If you look at the – let's focus on the red. The fifth column under, Risk-based Assessment – Extreme. It suggests there's a risk that the department may not have sufficient time to publicly consult on approach in order to meet the legislative timeframes. Is that the 30 June 2020 timeframe that you're talking about for the risk assessment instrument?

MS WUNSCH: I can't talk to this matter. This is a department's document, department's project. I'm confident, and I understand from the contributions the commission has made, that we will have a risk profiling system available to us. And there is significant work that the commission is doing in conjunction with the department to support this project.

MR BOLSTER: So are you unaware of the extent to which public consultation processes have been engaged and completed to enable - - -

MS WUNSCH: I'm not aware of this, as this is not my area, but I certainly have had meetings and discussions with the relevant personnel in the commission and the department in relation to this project.

MR BOLSTER: Is this a document that's not shared with the commission staff?

MS WUNSCH: I am not aware of the distribution of this document.

MR BOLSTER: Have you seen it before today or preparing for this hearing?

MS WUNSCH: It's possible I have seen this document. It doesn't spring to mind for me.

MR BOLSTER: So do I take it from your evidence that you say that the implementation on Carnell-Paterson in relation to risk profiling is on track?

MS WUNSCH: I believe so.

MR BOLSTER: You don't see any impediments in the way of a 30 June 2020 introduction of that process?

MS WUNSCH: I'm not aware of impediments.

MR BOLSTER: All right. Publication of risk profiling work, you've mentioned that the commission does not want to – or a decision has been made not to publish the outcomes of its risk profiling work. Could you explain briefly why.

MS WUNSCH: Risk profiling is an input. It's regulatory intelligence that supports regulatory activities and it should remain with the commission for the purposes of

internal decision-making around regulatory programs. Certainly we would want to publish research and outcomes from our work that is informed by risk profiling and the enhancements to the quality of our work that risk profiling has informed. But the risk profiling itself is material that should be maintained by the regulator, because it's of regulatory intelligence value.

MR BOLSTER: All right. So, in that respect, you accept that the commission takes a view that's different from what's in the recommendations of Carnell-Paterson?

MS WUNSCH: Yes.

MR BOLSTER: All right. And that decision about that was made by the commissioner or by the executive team at the commission or - - -

MS WUNSCH: I can't talk to how the decision was made, but the decision, I believe, is a sound decision and we will seek, though, to be open and transparent about – to the extent that we should, about information that comes from a risk profiling system that informs better regulation.

MR BOLSTER: All right. Finally, I want to briefly return to Earle Haven. If we could go to tab 101 of the Earle Haven bundle. Let me just summarise the context of this. You'd be familiar with this email from Janet Anderson to you and others?

MS WUNSCH: Yes.

MR BOLSTER: This was an email sent on the evening of the 11th following a briefing to the Minister - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - about the events of the day. And I understand you were present at that briefing?

MS WUNSCH: Yes.

MR BOLSTER: And in that email Janet Anderson indicates five areas or issues that she wanted addressed. In terms of some intermediate response, or an immediate response to what had happened, has the commission progressed a response to those five matters?

MS WUNSCH: I understand that discussions will be held with the department to seek to understand these matters. And the priority in relation to Earle Haven has been on the operational management of this particular matter which has involved significant numbers of officials in both the commission and the department. The matters in the email, though, are very relevant to informing how we will seek to assess performance under standard 8 governance to the extent that they are relevant to an assessment of performance against standards from a quality and safety lens.

But these matters are also ones that involve the department's oversight, as well. And we will progress further discussions with the department in relation to these matters.

MR BOLSTER: So I take it it's a work in progress - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - from a departmental and commission - - -

MS WUNSCH: Yes.

MR BOLSTER: - - - perspective to respond to Earle Haven.

MS WUNSCH: Yes.

MR BOLSTER: What is the status of those considerations and when are we likely to hear something, if at all, about what the response is going to be?

MS WUNSCH: In relation to the commission's work with Earle Haven?

MR BOLSTER: Yes.

MS WUNSCH: The – both the review audit and the quality review reports are with the provider, which is part of the procedural fairness process, to obtain their response – the provider's response, prior to making decisions in relation to the services delivered through People Care.

MR BOLSTER: What about the broader issues that are identified?

MS WUNSCH: And these matters are matters that we'll be seeking to progress with the department at the earliest available opportunity albeit numbers of officers of both the commission and the department are still significantly engaged in the operational management of the Earle Haven matter.

MR BOLSTER: I have no further questions, Commissioners.

COMMISSIONER BRIGGS: Ms Wunsch, thank you for your evidence. Not only are we interested in providers or services, we're interested in trying to gain an overall understanding of the industry as a whole. You, of course, are quite familiar with the three lines of defence in terms of audit risk arrangements, and I'm quite interested in your views, as a regulator, as to the sophistication of the sector in terms of understanding and operationalising those three lines of defence.

MS WUNSCH: I think we're at a watershed moment in time with the introduction of new standards and we will need about 12 months of assessment of performance against those standards to understand what the bell curve looks like across the sector. We have used various regulatory strategies and levers, including nudge regulation, to

try and influence provider behaviour and to understand provider behaviour better and that example of the self-assessment tool for understanding administration of psychotropic medication is a good example of getting a line of sight to a particular complex problem in the sector. I think there's variability across the sector in terms of its sophistication.

We have leaders and we have followers and I think, if I look at the way the Care Quality Commission describes the provider cohort that they regulate, I think we would have a similar distribution and that distribution will be better understood in 12 months' time when it can be informed by differentiated ratings of performance. So these are all ways of getting a more nuanced understanding of the sector that can then provide more detailed information to consumers, and to inform regulatory approaches that we take.

COMMISSIONER BRIGGS: Let's then go to, say, the top 100 providers of services. They're big organisations. How sophisticated do you think they are in terms of implementing the three lines of defence?

MS WUNSCH: I think we have seen examples of quite sophisticated performance in the sector. I think it's difficult to answer that question at this point and we are eagerly seeking to understand the outcomes of our assessments and we'll be reviewing those significantly over the next three months to see what results emanate from that. But we have providers that do inform us about the efforts that they take above and beyond meeting standards and demonstrate leadership in the sector.

COMMISSIONER BRIGGS: Would it be correct to say that, really, you don't know and you won't know for some time to come, until you've got your more sophisticated systems in place?

MS WUNSCH: Well, we won't know what performance looks like under new standards, and the bar has been raised by these new standards, until we have some data on that performance.

COMMISSIONER BRIGGS: Okay. What about performance under the old standards?

MS WUNSCH: Under the old standards, we certainly were able to identify examples of better practice but, under a binary system of met and not met, that nuanced view of providers could not be informed by regulatory activities. We're very interested in how that will change once we have a differentiated model that allows us to see the spectrum of provider performance.

COMMISSIONER BRIGGS: So fundamentally, we don't know much at all about the quality of the risk management approach of the services within the sector?

MS WUNSCH: We have limited information to differentiate beyond services that meet the standards and services that don't meet the standards. We have information

about providers that have performed consistently and met standards over many, many years. We have information that comes to us routinely by providers that are seeking to appraise us of their system development, their research, their efforts to move well beyond standards and we use that information to inform ourselves about what best practice looks like. Now, the new standards also require all providers to reference best practice in meeting these standards. So the lens has shifted and changed and it will provide us with a better understanding of that.

COMMISSIONER BRIGGS: But to date, you cannot tell us what proportion of providers, at least in a self-assessment model, believe they're meeting best practice?

MS WUNSCH: Only through an assessment of performance against standards and that is an ongoing - - -

COMMISSIONER BRIGGS: So your answer is yes; thank you.

COMMISSIONER TRACEY: Anything arising, Mr Bolster?

MR BOLSTER: Nothing. Thank you, Commissioners.

COMMISSIONER TRACEY: Yes, very well. Thank you very much for your evidence. You are excused from further attendance on your summons.

MS WUNSCH: Thank you.

<THE WITNESS WITHDREW [10.51 am]

COMMISSIONER TRACEY: The commission will adjourn until 10 past 11.

ADJOURNED [10.51 am]

RESUMED [11.13 am]

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. I call Ms Amy Elizabeth Laffan. Ms Laffan's in the witness box. If she could please be sworn or affirmed.

<AMY ELIZABETH LAFFAN , AFFIRMED [11.13 am]

<EXAMINATION BY MR GRAY

MR GRAY: Ms Laffan, what's your full name?

MS LAFFAN: Amy Elizabeth Laffan.

MR GRAY: You're the assistant secretary of the Aged Care Quality Regulatory Design and Implementation branch of the Department of Health of the Commonwealth; is that right?

MS LAFFAN: Correct.

MR GRAY: And you've previously given a witness statement to the Royal Commission dated 18 April 2019 in relation in particular to amendments to the quality of care principles around the topic of restrictive practices; is that right?

MS LAFFAN: Correct.

MR GRAY: And you gave evidence at the Sydney hearing.

MS LAFFAN: I did.

MR GRAY: You've made two further witness statements dated, respectively, 10 and 22 July 2019.

MS LAFFAN: Correct.

MR GRAY: I'll now ask they be displayed to you on the screen in order starting with the statement of 10 July, WIT.0279.0001.0001. Do you recognise that to be your statement of 10 July 2019?

MS LAFFAN: Yes, I do.

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

MS LAFFAN: No.

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

MS LAFFAN: Yes.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The witness statement of Amy Elizabeth Laffan, dated 10 July 2019, will be exhibit 8-31.

EXHIBIT #8-31 WITNESS STATEMENT OF AMY ELIZABETH LAFFAN DATED 10/07/2019 (WIT.0279.0001.0001)

MR GRAY: Thank you, Commissioner. Next, Ms Laffan, I will ask that your statement of 22 July be displayed, WIT.0282.0001.0001. Do you recognise that to be a copy of your statement of 22 July?

MS LAFFAN: I do.

MR GRAY: Do you wish to make any amendments?

MS LAFFAN: No.

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

MS LAFFAN: Yes.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The witness statement of Amy Elizabeth Laffan dated 22 July 2019 will be exhibit 8-32.

EXHIBIT #8-32 WITNESS STATEMENT OF AMY ELIZABETH LAFFAN DATED 22/07/2019 (WIT.0282.0001.0001)

MR GRAY: Thank you, Commissioner.

In your role as assistant secretary Aged Care Regulatory Design and Implementation – beg your pardon – Aged Care Quality Regulatory Design and Implementation branch, you're overseeing the process of a series of reforms to quality and safety regulation of aged care; is that right?

MS LAFFAN: Correct.

MR GRAY: And they're a work in progress at present. Is that right?

MS LAFFAN: That's right.

MR GRAY: Amongst other things, they involve implementation of aspects of the 10 recommendations of the Carnell and Paterson review; is that right?

MS LAFFAN: Correct.

MR GRAY: They don't involve implementation of all of the actions recommended within those 10 recommendations, do they?

MS LAFFAN: At this point in time, no.

MR GRAY: And is that going to change?

MS LAFFAN: It may depend on decisions of government.

MR GRAY: All right. So there are still pending decisions about whether certain of the actions that haven't yet been the subject of decisions might be implemented at some point in the future. Is that - - -

MS LAFFAN: Correct.

MR GRAY: All right. Now, there are other assistant secretaries at your level in the department who have titles such as strategic policy and regulatory policy. What's the difference between what they're doing and what you're overseeing?

MS LAFFAN: So my task is very – I would say is less strategic at the moment and details-focused. We have government approval to implement a number of recommendations, and I'm doing the policy and design work to implement those recommendations.

MR GRAY: Thank you. So you're not in the process of making recommendations to government to change decisions that have been made or to procure new decisions, but to execute the instructions of government on those decisions that have been made. Is that a fair summary?

MS LAFFAN: No. I would say things that relate to the decisions that have already been made. For example, in terms of Carnell-Paterson, that would be within my bailiwick, but things that are more strategic, more forward-looking, bigger sky kind of policy issues in terms of quality would be dealt with in another branch.

MR GRAY: All right. Well, we might have to come back to that topic. We'll see how we go. Ms Laffan, today you're being called to give evidence in relation to three broad topics dealt with in your statements. Firstly, government responses to those recommendations of Carnell and Paterson; in particular, progress towards a serious incident report scheme. And your statement of 22 July deals, at a holistic level, with recommendations of Carnell and Paterson and phases for implementations of reforms. And your statement of 10 July deals specifically with serious incident response scheme.

MS LAFFAN: Correct.

MR GRAY: In addition, you've being asked some questions about the regulation of home care - - -

MS LAFFAN: Correct.

MR GRAY: - - - and related matters. Now, I'll start with progress of implementation – or the extent of intention to implement the actions under the 10 recommendations of Carnell and Paterson. So, Commissioners, the statement of most relevance to this topic is Ms Laffan's statement of 22 July, Exhibit 8-32. Ms Laffan, I will ask the operator to display the second page of that statement, paragraph 11. You say there:

> *All 10 recommendations have been adopted in whole or in part, initially through a 2018/19 budget package.*

And then, at paragraph 12, you say some actions have not yet. And – some actions have not yet been the subject of proposals to implement that specific action. In the Sydney hearing, there was a ministerial submission in evidence in that hearing which I'll ask you to comment on. It's in tab 10 of the bundle of documents already tendered. It's Doc ID CTH.1000.0002.6501, thank you, Operator. You've had occasion to see this document and familiarise yourself with it before, I take it?

MS LAFFAN: I have.

MR GRAY: This was a departmental submission to two Ministers in relation to the recommendations in two reviews, wasn't it, the review of Mr David Tune and the Carnell-Paterson Review.

MS LAFFAN: Correct.

MR GRAY: And I'll ask you about the recommendations in it concerning the Carnell-Paterson recommendations. The memo on page three, if we could go for a moment to page three, said in the second bullet point that:

> *On releasing the report, Minister Wyatt announced that the government generally supports the broad direction of the report and committed to replacing announced re-accreditation audits with unannounced audits as soon as possible.*

That was part of recommendation 8. If we go back to the beginning of the memo, page 1 on paragraph 2, the memo conveyed – yes. Near the foot of the page, please, Operator. The memo, in effect, stated that current messaging – does that mean current information made public?

MS LAFFAN: Current information provided publicly, yes.

MR GRAY: Yes. Communicates the 2018/19 budget More Choices For a Longer Life package as the response to both reviews. And the recommendation being made in this document was that there should be a formal response document, because that would ensure that the government is seen to be transparent in its consideration of

every recommendation made within each review. That's a fair summary of the purpose of the recommendation in the submission, isn't it?

MS LAFFAN: Correct.

MR GRAY: And on page 2 at paragraph 7, there's a little more detail on this. It said that the package, that is, the budget package, isn't it, "provided a comprehensive public response to the 10 recommendations". Just pausing there, that word "comprehensive" is, really, on my reading of this document, tell me if you disagree, a reference to the fact that it covered all 10 recommendations, but not necessarily every action under the recommendation. Would you agree with that?

MS LAFFAN: That's correct, yes.

MR GRAY: Yes. And it was a comprehensive public response in that sense, but the package did not respond to all actions. And the gist of the submission to the Ministers is, in order to ensure clarity and transparency, there should now be an action-by-action response. Is that a fair summary of the recommendation to the Ministers?

MS LAFFAN: Yes.

MR GRAY: And the Ministers rejected that recommendation.

MS LAFFAN: Certainly Minister Wyatt did not agree to the recommendation.

MR GRAY: All right. And so I will take you through annexure B in some detail. Annexure B is a document contained within the submission which sets out the department's proposals as to an action-by-action response to the Carnell and Paterson recommendations, isn't it?

MS LAFFAN: Correct.

MR GRAY: But has a document in the nature of a formal response from government been published since the time of this recommendation in late 2018?

MS LAFFAN: Published by the government, no.

MR GRAY: There was a table attached to the Secretary Glenys Beauchamp's statement in February to the Royal Commission but there hasn't been an executive government response referring to each action in the recommendations to date?

MS LAFFAN: Correct.

MR GRAY: Okay. Now, I'll just ask you about some of the recommendations made in Carnell-Paterson. This is not going to be a comprehensive analysis of each and every one but I'll ask you about some aspects of those recommendations and the

department's suggested response to them. If we go please, operator, to 6513, that's the beginning of attachment B, and recommendation 1 of the Carnell-Paterson review was a recommendation for the establishment of an Aged Care Quality and Safety Commission constituting a number of independent commissioners, including a complaints commissioner and governed by a board. That's right, isn't it, Ms Laffan?

MS LAFFAN: Correct.

MR GRAY: And the response on 6513, amongst other things, is to the effect that that model, governed by a board and with multiple commissioners, was not cost effective. I just want to ask you about the proposal to have an independent complaints commissioner. Did the department do any modelling as to what would be the additional costs of having an independent complaints commissioner within the Aged Care Quality and Safety Commission?

MS LAFFAN: No, we didn't.

MR GRAY: So it can't be said with any certainty that it wouldn't be cost effective to have an independent complaints commissioner under the roof of the Aged Care Quality and Safety Commission, can it?

MS LAFFAN: I think we can expect that it would cost additional funding.

MR GRAY: You didn't do any modelling of it?

MS LAFFAN: No.

MR GRAY: So it's just an assertion?

MS LAFFAN: Yes.

MR GRAY: In fact, having an independent complaints commissioner would ensure that, in decisions around resourcing, the interests of the complaints function were robustly advocated within the commission, wouldn't you agree?

MS LAFFAN: Not necessarily.

MR GRAY: All right. Now, your department's response also refers to mitigation of the risk of creating silos. Recommendation 2 of the Carnell-Paterson report was for a robust data collection and sharing and risk profiling mechanism to be employed. If that was done right, then there wouldn't be an appreciable risk of silos occasioned by having an independent complaints commissioner, would there?

MS LAFFAN: I think there may still be that risk of silos.

MR GRAY: Well, I suppose there is always a risk whether you have an independent commissioner or not. We've seen evidence this week in the Royal Commission of complaints officers within the Aged Care Quality and Safety Commission not apparently communicating all of their concerns in a timely fashion across to the quality monitoring aspect of the commission. So there's always a risk, I accept that. But it's no higher a risk from having an independent commissioner under the model recommended by Carnell and Paterson, I suggest?

MS LAFFAN: I don't think it's information-sharing but it's about that decision-making and that decision-making being somewhat to the side and isolated to other decisions.

MR GRAY: Well, in terms of intelligence, the complaints function can simply transmit information gleaned during the complaints process and that won't impact on the issue that you're referring to, decision-making, will it?

MS LAFFAN: It shouldn't.

MR GRAY: When you speak of an impact on decision-making, the complaints function and the progression of a complaint is, in fact, a distinct form of decision-making from compliance-related decision-making, isn't it?

MS LAFFAN: That's correct.

MR GRAY: So there's no problem with a separation of those functions. In fact, in terms of decision making, they should be separated, wouldn't you agree with that?

MS LAFFAN: I do agree.

MR GRAY: All right. Now, what about the governing board? Were you present or were you able to review the evidence yesterday afternoon of Professor Paterson about the importance of a governing board in his view?

MS LAFFAN: Yes, I watched that.

MR GRAY: Was the importance of a governing board not appreciated by the department at the time of the preparation of this response document and, indeed, the legislation for the Aged Care Quality and Safety Commission?

MS LAFFAN: No. I would suggest we were aware of the matters that Professor Paterson raised yesterday.

MR GRAY: Because a board is a completely different proposition from a mere advisory council, isn't it?

MS LAFFAN: Correct.

MR GRAY: And according to Professor Paterson, it was very important that the commission be, in fact, governed by a board, not simply advised by a council and he hoped that there would be a consumer voice on the board. Don't you see the force of those reform recommendations?

MS LAFFAN: I do but I believe some of those things can be achieved, or that can be achieved through an advisory council in the model that's been adopted.

MR GRAY: Well, an advisory council is merely providing advice; it can't influence the actual governance of the organisation through direct decision-making, can it?

MS LAFFAN: No, it can't direct the commission.

MR GRAY: Well, then it can't take steps to bring the chief executive of the commission around to a particular manner of administering her functions; it can merely provide advice?

MS LAFFAN: That's correct, yes.

MR GRAY: Whereas a board would be able to exert far more direct governance capability; do you agree with that?

MS LAFFAN: Yes.

MR GRAY: I want to go to recommendation 2 now on page 6514. This recommendation is also critical to the future of the monitoring model under recommendation 8, isn't it?

MS LAFFAN: Correct.

MR GRAY: The monitoring recommendation, recommendation 8, is to move from cyclical accreditation to ongoing accreditation supported by risk profiling; that's right, isn't it?

MS LAFFAN: That's the recommendation, yes.

MR GRAY: What's the status of government's decision about whether that is the ultimate destination?

MS LAFFAN: Government has committed that it will progressively move to a more risk-based assessment system. That risk-based assessment system could be ongoing accreditation but it might be another option.

MR GRAY: So no final decision has yet been made whether to abandon cyclical accreditation?

MS LAFFAN: Correct.

MR GRAY: But there will be a risk-based approach to monitoring?

MS LAFFAN: Correct.

MR GRAY: Does that also apply in home care?

MS LAFFAN: Yes.

MR GRAY: Yes. So Carnell and Paterson weren't dealing with home care.

MS LAFFAN: No, they weren't. And also noting that home care doesn't have accreditation but the concept of a more risk-based approach, yes, would apply to home care.

MR GRAY: All right. That's, in effect the meaning of the words at – I believe they're at 6519 where we see a reference to "in principle support for recommendation 8". There's in-principle support but no firm decision yet, is that right?

MS LAFFAN: Correct.

MR GRAY: All right. Just back to recommendation 2 on 6514, the first action was the Australian Health Minister's advisory council is to consider options to improve sharing – that's a COAG council, isn't it?

MS LAFFAN: Correct.

MR GRAY: Is to consider options to improve sharing patient/resident information between, in effect, the state elements of health and mental health, on the one hand, and the, in effect, Commonwealth-supervised aged care sector on the other.

MS LAFFAN: Yes, that's my understanding.

MR GRAY: And what's the government's position on that particular proposal?

MS LAFFAN: Government is yet to make a decision on that.

MR GRAY: All right. It's a good idea, isn't it?

MS LAFFAN: It seems that if you can – to me, if you can get information from a variety of sources that would assist in risk profiling, then, yes.

MR GRAY: So it is a good idea?

MS LAFFAN: From my perspective, yes.

MR GRAY: Yes. Your personal opinion is that should happen.

MS LAFFAN: Yes.

MR GRAY: Yes. And what's the status of any departmental work on that proposal and has it been put to government?

MS LAFFAN: It's yet to be put to government and we're yet to do any thorough work on that. I think for us we'll develop the risk profiling system, have that bedded down and then we'll look at potentially ways to increase that information sharing and risk profiling systems that we have.

MR GRAY: Well, there's no need, is there, to wait before progressing those COAG-level efforts until you've got the risk profiling system up and running? In fact, it's illogical to wait until then. There's no causal connection between the two of them.

MS LAFFAN: I wouldn't say it's illogical. I agree that you would need to – that you could progress it at this point in time, but things about – I mean, I would suggest that any State and Territory Ministers would be interested to know what sort of information sharing, the sorts of protections we have around our system, the robustness of the information sharing system that we do have, so that would be an advantage to waiting until that system was in place.

MR GRAY: Well, why not start the discussion with them and see what they need by means of protections around their information?

MS LAFFAN: We could do that.

MR GRAY: Well, why haven't you done it already?

MS LAFFAN: It hasn't been one of our priorities.

MR GRAY: It's the case, isn't it, that the department is under-resourced to deal with a reform program of this kind and needs to outsource things to KPMG, as you've described in your statement regarding the Serious Incident Response Scheme.

MS LAFFAN: Correct.

MR GRAY: The department just doesn't seem to be able to move promptly on this large reform agenda; do you agree with that?

MS LAFFAN: No, I wouldn't.

MR GRAY: Okay. We'll come back to that in a minute. Now, in your statement you've referred to another aspect of recommendation 2, which is the action of obtaining the views of 20 per cent of consumers and their representatives. In the

response table at page 6514, there was – I should give you a more detailed reference. The reference to capturing the views of residents, families and staff all year round is at action 2 under recommendation 2. And there's then, at action 3 under recommendation 2, a recommendation that:

> *Assessment contact visits must seek the view of 20 per cent of consumers and their representatives.*

Now, in the response table it's said that consideration will be given – this is virtually adjacent to points 2 and 3:

> *Consideration will be given to the percentage of views to be sought during assessment contact visits.*

Etcetera. But in your statement you've said that you hold the view – this is at paragraphs 19 to 27 where you deal with this in your 22 July statement. At paragraph 22, in particular, you hold the view that the 20 per cent recommendation would be more prescriptive and less risk based and shouldn't be adopted. I raised this with Professor Paterson yesterday and he adheres to his recommendation about 20 per cent being an appropriate prescription for visits, because it's very important information from which one might glean intelligence. And it doesn't seem – well, I'll leave it at that. Did you hear the gist of what - - -

MS LAFFAN: I did.

MR GRAY: - - - was said about that?

MS LAFFAN: I did.

MR GRAY: Do you still adhere to your view that it's too prescriptive to require 20 per cent?

MS LAFFAN: With respect to the current assessment contacts, yes.

MR GRAY: And what about in site audits?

MS LAFFAN: Sorry?

MR GRAY: What about in site audits? Would it be too proscriptive, in your view, to have a 20 per cent approach to taking consumer experience report surveys from residents in the context of site audits?

MS LAFFAN: I certainly have less concerns for site audits.

MR GRAY: All right.

MS LAFFAN: Yes.

MR GRAY: It's because assessment contacts happen very frequently. Is that your concern?

MS LAFFAN: They happen frequently and they're also used for a variety of purposes. So they're not – so they're frequently used to assess against the standards, but not always. Sometimes you use limited – you assess limited standards and sometimes these assessments aren't carried out on site; they're via desktop or survey or something like that.

MR GRAY: Because there are three types of contact that the Aged Care Quality and Safety Commission has with facilities. There's review audits, when there's a particular concern known and the commission goes to investigate that concern. Agreed?

MS LAFFAN: Correct.

MR GRAY: Then there's accreditation site audits, which happen at about the time of cyclical re-accreditation. Correct?

MS LAFFAN: Correct.

MR GRAY: And then there's every other form of contact even by telephone, and they're assessment contacts.

MS LAFFAN: That's correct.

MR GRAY: And you're concerned that if there was a requirement to survey 20 per cent of the resident population on each and every occasion there was assessment contact, then that would divert resources.

MS LAFFAN: Yes. That level of prescription. Yes.

MR GRAY: But if that level of prescription was applied to the other two forms of visits, what would you say to that?

MS LAFFAN: I think the views of care recipients are extremely important. So I would support that, noting that might have resource implications for the commission.

MR GRAY: Well, presumably it would, but, on the other hand, giving people their say is not a terribly cost-intensive exercise, is it? You can provide them with a survey, and if they have high cognition, they can do it themselves.

MS LAFFAN: That's correct, yes.

MR GRAY: And there's ways to support them in indicating their views if they have lower cognition. That may be a little more resource-intensive. Do you agree?

MS LAFFAN: That's correct. Although, my understanding is that currently we conduct interviews face-to-face, so we can – so the commission can seek further answers or clarify things, yes.

MR GRAY: And that's entirely appropriate, even if it does have resource implications, because this is, as you've just acknowledged, a very important thing, to hear the voice of the people who are receiving the care and their families; correct?

MS LAFFAN: In my view, yes.

MR GRAY: Yes. So are you able to tell the commission whether there's actually a government position on that 20 per cent proposal?

MS LAFFAN: To my knowledge, there is no government position.

MR GRAY: All right. Has the department supported the 20 per cent recommended action to government?

MS LAFFAN: I don't believe we've provided advice on that.

MR GRAY: All right. Why not?

MS LAFFAN: And I refer to this in this – we talk about – sorry – in this exhibit, saying that it's something that we'll consider as part of recommendation 8. So the sorts of things that, in doing further steps on recommendation 8, we'd be looking at things like the – the three sorts of contacts that you talked about previously, do we have more sets of contact, do we change those, do we – what sorts of audits and visits would make up the system and what would be the requirements of those audits and visits and assessments? So considering consumer interviews and percentage for consumer interviews, I think, would logically come up under that consideration.

MR GRAY: And, in the meantime, there's into reason not to require it as an interim measure until you've sorted out exactly what monitoring regime you want to have.

MS LAFFAN: It could be, yes.

MR GRAY: It could be done easily, couldn't it?

MS LAFFAN: Yes.

MR GRAY: Now, Professor Paterson has also explained an additional recommendation, which is this idea of making the consumer experience reports accessible all year round and online. That could be done easily, couldn't it?

MS LAFFAN: From a technological perspective, I would say yes, although there may be issues with statistical analysis and making sure that – you know, I'd have to seek advice from experts on that.

MR GRAY: Has that action been the subject of a recommendation from the department to government?

MS LAFFAN: No, it hasn't.

MR GRAY: We're now getting on to two years since this recommendation was made. (ii):

> *The commission will develop options to capture the views of residents, family and staff all year round.*

That's directed to the new commission. Do you know whether they've been working on that?

MS LAFFAN: I know that's something that's been under consideration. I'm aware that they've set up a 1800 number to receive the views of consumers and their families.

MR GRAY: Okay. But with regard to the specific recommendation in the report about making the consumer experience reports available online all year round, you don't know whether that's been considered?

MS LAFFAN: So, to clarify, they're available all year round to view, just not to input into.

MR GRAY: Yes. I mean to input.

MS LAFFAN: Yes. Yes.

MR GRAY: I mean in an interactive - - -

MS LAFFAN: Yes.

MR GRAY: - - - interface where a resident or family member in any particular facility can fill out a consumer experience report and submit it to the commission.

MS LAFFAN: Correct.

MR GRAY: That's not yet happening?

MS LAFFAN: No, noting that any time people can raise concerns through complaints.

MR GRAY: Well, that's so. However, it's a lot less confronting to be prompted through the survey on consumer experience and to be able to rate the facility in that format, I suggest. Don't you think that's so?

MS LAFFAN: Yes. Yes, I do.

MR GRAY: And that would be a very useful tool to support the goal or the purpose that you acknowledged a short time ago in your evidence, that the voices of the care recipients are very, very important.

MS LAFFAN: Correct.

MR GRAY: Let's just think about that topic and unpack it a little further. The voices of the people receiving the care are really integral to a proper regulatory response on quality and safety, aren't they?

MS LAFFAN: Correct.

MR GRAY: What are your views generally about whether there are sufficient mechanisms under the present quality and safety regulatory design for those voices to be heard?

MS LAFFAN: I think that things have improved and grown, so with – especially with the new quality standards, which have the – by that consumer focus statement. That requires more of an assessment of consumers and what their perspectives of their care and services are. So I think it's something that we're building over time. There could probably be more things done.

MR GRAY: Professor Paterson referred to advocacy, strengthening the National Aged Care Advocacy Program. Would you agree that that would be a sensible suggestion?

MS LAFFAN: With respect to Professor Paterson's evidence, he was describing the advocacy program at a point in time, so I think around, say, October 2017. At that point, the – kind of the new provider was only established on 1 July that year. So I would suggest that improvements and things have been made since that time.

MR GRAY: When we consider the evidence, some of it quite confronting, about the experience of complainants under the complaints mechanism, do you accept that it sounds like there's room for vast improvement in engaging complainants in that process, including the outcomes?

MS LAFFAN: From a departmental perspective or advocacy perspective?

MR GRAY: From a program design – from a framework design perspective.

MS LAFFAN: Yes.

MR GRAY: Now, I want to ask about another topic that's covered by recommendation 2, which is data collection analysis and risk profiling. And you've already adverted to this a short time ago in the context of how important it will be for monitoring. In your statement of 23 July at paragraphs 45 to 51, you refer to a process where there's been, again, outsourcing to KPMG in relation to another project. And this project is the building of a risk model.

MS LAFFAN: Correct.

MR GRAY: And in your statement at paragraph 46, you refer to various input datasets, if I could use that expression, that have been provided to KPMG.

MS LAFFAN: Correct.

MR GRAY: Now, when we look at that paragraph, when the Commissioners come to consider what weight to put on that paragraph, the Royal Commission's also been provided with a confidential document which describes the risk model, which will not be published, and I'll be asking for a non-publication order in relation to it, but I'll ask that you be shown a hard copy of that document which is CTH.0001.1000.7539. Do you have that in the witness box?

MS LAFFAN: I don't have it.

MR GRAY: And copies for the Commissioners. Thank you. And in that document at pages 34 to 36, there's a passage on data sharing and capture inputs and gaps. I won't ask you to read those out, but have you had a chance to familiarise yourself with those pages?

MS LAFFAN: Yes.

MR GRAY: My question is when the Commissioners come to weigh your evidence about what KPMG was given, it's the case, isn't it, that what appears on those pages of that confidential document is more detailed and up-to-date than what appears in your paragraph 46?

MS LAFFAN: I would say that this is more detailed. So in my statement, I'm talking about broad categories of systems and I think in the KPMG report, we talk about slices of data within those systems.

MR GRAY: All right. And I think you're saying that the Commissioners would be correct to put more weight on what appears on those pages of this document than trying to draw inferences simply out of your paragraph 46; would you agree with that?

MS LAFFAN: Yes, the KPMG report provides further detail. Yes.

MR GRAY: Thank you. Commissioners, I tender that as a confidential exhibit and seek a non-publication direction in relation to it.

COMMISSIONER TRACEY: Yes. The KPMG document entitled Risk Profiling Model and Prototype dated 5 July 2019 will be confidential exhibit 8-33, and there will be a direction that none of the contents of that document be published.

EXHIBIT #8-33 KPMG DOCUMENT ENTITLED RISK PROFILING MODEL AND PROTOTYPE DATED 05/07/2019 (CTH.0001.1000.7539)

MR GRAY: Thank you, Commissioner.

Could I ask that you go back to the attachment B response to the Carnell and Paterson report in the ministerial submission at page 6514. There's a reference there to the consideration of inclusion of home care and flexible care in the model. What's the outcome of that consideration?

MS LAFFAN: So with respect to the model that we developed, that KPMG reported on as part of this report, home care wasn't included but since that time, government – there's been another government budget package and, as part of that package, a feasibility study for risk profiling of home care will be conducted as part of that.

MR GRAY: Now, the plan is that the risk model will be available by 1 July 2020; is that right?

MS LAFFAN: That's the go-live date, yes.

MR GRAY: However, this – in relation to home care, will that be later than that?

MS LAFFAN: It will.

MR GRAY: All right. In terms of the go-live date, you might have seen that Ms Wunsch was asked to comment on a dashboard of program status in relation to certain measures including this one at CTH.1016.1010.0427. In relation to risk-based assessment, it said on that dashboard document that there's an extreme risk that the department may not have sufficient time to publicly consult on approach. This is a document in respect of a period called a reporting period 21 March to 23 April. It says there's an extreme risk:

> *There's a risk that the department may not have sufficient time to publicly consult on approach in order to meet legislative timeframes and there's a high risk, there's a risk that delays to progress in policy discussion with the commission will impact the overall project.*

Is that a – just bringing that document up, CTH.1016.1010.0427. It's general tender bundle tab 140. Thank you. Do you see, going down the left-hand column, project risk-based assessment.

MS LAFFAN: Yes.

MR GRAY: Then moving across that row to risks and issues, there's an extreme risk that I read out earlier and then there's a high risk that I read out earlier.

MS LAFFAN: Yes.

MR GRAY: Is this still the case or has that risk been addressed?

MS LAFFAN: We've certainly had discussions with the commission since this document was created, yes.

MR GRAY: Are you confident that the 1 July 2020 go-live date can be met?

MS LAFFAN: Sorry, so this relates to risk-based assessment. So this is more about recommendation 8, whether we move towards ongoing accreditation or that sort of thing. In terms of the go-live date, so the system, I think that's captured in the item above, the risk profiling and second pass business case, and I am confident that that will go live on 1 July.

MR GRAY: Thank you. So the risks in relation to that element of the programs covered in this table identify high risks but not extreme risks?

MS LAFFAN: Correct.

MR GRAY: Yes. Now, the risk-based assessment; does that have a time target set for it, that is, recommendation 8?

MS LAFFAN: A legislative target, no.

MR GRAY: If we look at this row again, under risks and issues, where it says extreme, it says:

> *There's a risk the department may not have sufficient time to publicly consult on approach in order to meet legislative timeframes.*

So my question is if this row relates to recommendation 8, it seems to be referring to a legislative timeframe. Do you know what it is?

MS LAFFAN: Yes, I think what we're trying to get at there is we think that any changes will have any – any kind of reforms in that space will have legislative implications and that those will take time.

MR GRAY: Okay. Are you on the aged care quality and safety standing committee?

MS LAFFAN: I am.

MR GRAY: Has there been a more up-to-date program status dashboard produced by that committee?

MS LAFFAN: Yes, there has.

MR GRAY: I will be calling for that – I call for that, if necessary, now, Commissioners, and we'll be seeking a direction from the Commissioners for the production of that document.

COMMISSIONER TRACEY: Yes. I'm sure Mr Kennett's instructors have heard what's been said.

MR GRAY: Thank you. I just want to ask you, Ms Laffan, just without reference to that confidential document – I'm not seeking to make any use of it – I just want to ask you whether certain inputs are going to be included in the risk model that's currently envisaged by the department? Firstly, consumer experience reports, CERs?

MS LAFFAN: The information used from consumer experience reports, which inform then accreditation decisions, yes, but the CERs themselves, I'm not sure.

MR GRAY: So a statistical analysis of the CERs will be included, is that what you're saying?

MS LAFFAN: I couldn't answer that.

MR GRAY: All right.

MS LAFFAN: Sorry.

MR GRAY: It's just that going back to that point about the importance of the consumer voice in trying to achieve a responsive regulatory design, that would suggest that the CERs would be very important data to try to capture in a risk model, wouldn't you agree?

MS LAFFAN: I agree. So the – that the consumer voice is the assessment against the standards, so whether a service is accredited, whether it meets or doesn't meet the standards, is influenced by those consumer discussions. That's the purpose for which those discussions are held.

MR GRAY: It's somewhat indirect though, isn't it?

MS LAFFAN: I would say that the consumer experience directly results in those met or not met findings.

MR GRAY: All right. Well, that's really a matter for the methodology of the particular assessor who's come to the facility or gone to the home care service from the Aged Care Quality and Safety Commission, I suggest. There's no straight line, there's no direct connection between the contents of the consumer experience reports and the decision that assessor makes about whether the quality standards are met. What do you say to that?

MS LAFFAN: I think that's a question best asked for the commission but certainly things I've seen, accreditation reports, things like that, talk really specifically about what the consumers have found, what their experiences have been. It actually contains statistics from those consumer experience reports so I think that they are a large input into those met or not met decisions. And I think, if you look at the commission's guidance material, that talks about how the commission is going to inform itself, whether certain standards are met and how they'll do that and talking to consumers is part of that.

MR GRAY: All right. And this is post 1 July, is it?

MS LAFFAN: Correct.

MR GRAY: What about prudential and financial risk analysis; is that going to be included in the risk model envisaged by the department?

MS LAFFAN: That category of risk, yes.

MR GRAY: No, I mean data resulting from analysis of the annual financial and prudential reports filed by approved providers, that is, provided by approved providers to the secretary?

MS LAFFAN: I'm concerned about providing details as to specific reports.

MR GRAY: All right. What about complaints and that is trends in complaints about particular approved providers and the content of particular complaints made about approved providers, is that going to be included?

MS LAFFAN: Broadly complaints, yes.

MR GRAY: Broadly?

MS LAFFAN: Sorry, I don't want to go to specifics of what particular risk features we use as part of complaints but, yes, there's complaints features.

MR GRAY: All right. What about outsourcing arrangements to management companies?

MS LAFFAN: Again, I think that goes to – that's providing detail that I probably wouldn't like to provide publicly.

MR GRAY: All right. Past concerns about – past concerns that officers of the department or the commission have formed about the level of engagement and cooperation with inquiries shown by particular approved providers?

MS LAFFAN: Not to my knowledge.

MR GRAY: Past concerns expressed and found by officers of the department or the commission about the corporate governance capabilities of approved providers?

MS LAFFAN: Governance matters, yes. Concerns or opinions on those matters, I don't think so.

MR GRAY: Okay. Serious incident reports? So I'm now making a link to the serious incident reporting scheme that's under consideration.

MS LAFFAN: Yes, so I would suggest that, once a serious incident response scheme is under way, that that information would be a data source for risk profiling.

MR GRAY: What about before then with the compulsory reports about suspected and alleged assaults and unexplained absences, albeit there's an element of an exception that applies to the assaults; is that information that's going to be taken into account?

MS LAFFAN: Compulsory reporting, yes.

MR GRAY: What about national quality indicator program data?

MS LAFFAN: Again, I think you are asking me some very specific questions which go to what we do and don't count as – as – in that risk profiling system and I'd prefer that they remain confidential.

MR GRAY: All right. I won't press you. Tip-offs?

MS LAFFAN: Tip-offs that come through complaints and various other mechanisms, I would expect that would be included, yes.

MR GRAY: All right. Can I just ask you more broadly, not necessarily in connection with the risk model, but just more broadly, does the department have any proposal to expand the concept of key personnel to key personnel of contracted management companies?

MS LAFFAN: Not to my knowledge.

MR GRAY: There's an obligation in the Act to report – this is an obligation imposed on approved providers – to report material changes in circumstances relevant to the suitability of the approved provider. Are you familiar with that provision?

MS LAFFAN: That's my understanding, yes.

MR GRAY: But it's only a requirement to report within 28 days of the change. Is there any proposal within the department to tighten that requirement?

MS LAFFAN: Not to my knowledge, noting that that probably wouldn't fit within my responsibilities.

MR GRAY: All right. What about monitoring of ASIC disqualifications for people who are identified as key personnel? Is that within the reform agenda of the department?

MS LAFFAN: That's not one of the data categories that we've proposed.

MR GRAY: All right.

MS LAFFAN: It's not to my knowledge, sorry.

MR GRAY: Yes. Okay. I just want to ask you now about an aspect of recommendation 7. So if you've still got the document available to you through the operator. If we go to the response to recommendation 7, which is around the use of restrictive practices. It's on page 6518. And there's a recommendation within recommendation 7 to take action (ii):

> *Approved providers must report and record the use of restrictive practices in residential aged care to the Aged Care Commission.*

Now, of course, you've answered a lot of questions about these reforms in the Sydney hearing. And I will just ask you about this aspect of it in light of something Professor Paterson said yesterday on this. The regime that's been in place since 1 July has tightened in some respects, the practices of approved providers around restrictive practices. For example, in combination with the now compulsory national quality indicator program, the use of physical restraints must be reported, although perhaps there are some issues around the definitions of physical constraints as between the quality of care principles and the reporting obligations in the accountability principles. You're familiar with this topic, aren't you, Ms Laffan?

MS LAFFAN: Sorry, the - - -

MR GRAY: The reporting of physical restraints.

MS LAFFAN: Yes. As part of quality indicators, yes.

MR GRAY: Yes. Now, and the national quality indicator program has also been made mandatory since 1 July. And that means that the reporting of physical restraints – reporting of the use of physical restraints is a mandatory matter for all approved providers - - -

MS LAFFAN: Correct.

MR GRAY: - - - in a residential setting.

MS LAFFAN: Correct.

MR GRAY: Now, there's no equivalent requirement in relation to chemical restraints, is there? They don't have to – the use of chemical restraint doesn't have to be reported by the relevant approved provider.

MS LAFFAN: Correct, noting the government is committed to extending the mandatory quality indicator program to include medication management, so it may be captured under that.

MR GRAY: Okay. Now, when I asked you in Sydney, there was still uncertainty around what the content of the medication indicator would be. It might, for example, be polypharmacy or it might relate to the use of chemical restraint. We didn't know at that point in time. Has there now been a decision that it's going to be one topic or another?

MS LAFFAN: There's no decision at this stage.

MR GRAY: All right. So it's at present unknown whether there'll be any mandatory requirement to report the use of chemical restraint to the Aged Care Quality and Safety Commission as and when that restraint is used?

MS LAFFAN: Correct.

MR GRAY: All right. Now, Professor Paterson said that was a very important matter, it was important to shine a light on to that practice, if only to make approved providers think carefully about what they're doing. Did you hear that evidence?

MS LAFFAN: Yes.

MR GRAY: Do you agree with that?

MS LAFFAN: I do.

MR GRAY: Has the department advocated the extension of mandatory reporting to the use of chemical restraint?

MS LAFFAN: Not mandatory reporting, no.

MR GRAY: And when I say advocated, I mean advocated to executive government.

MS LAFFAN: No.

MR GRAY: No. All right. The Australian Law Reform Commission recommended a national approach to regulating restrictive practices covering all sectors, most relevantly disability, as well as aged care, didn't it?

MS LAFFAN: Correct.

MR GRAY: And, in the disability context, there's a national framework which is more prescriptive – I'll withdraw that. Can I just ask you about another aspect related to medication management. And that is residential medication management reviews. Did you hear Professor Paterson's evidence on that too?

MS LAFFAN: I did.

MR GRAY: And there seems to be a disagreement between the two of you about whether that should be mandated on, for example, admissions and re-add missions to residential aged care facilities.

MS LAFFAN: Yes. And I think the key word there is mandated.

MR GRAY: Yes. And why do you say they shouldn't be mandated?

MS LAFFAN: I think it's a matter for the care recipient, for their care team, as to whether something is required at that point in time. Certainly if people think that it should be done, then it can be done. And there's also other things we're doing in medication management and looking at, you know, the use of chemical restraint.

MR GRAY: There's been evidence on a number of occasions before the Royal Commission that the care recipient is not well equipped and is subject to asymmetries of information, if I can put it that way, that would be necessary to make an informed decision about their own medication regimes. And there's also been some evidence from time to time in hearings of the Royal Commission to the effect that the care team responsible for the medication management of a particular resident doesn't always turn its mind to obtaining informed consent and thinking through all the implications of a particular medication regime.

So I suggest that your argument, or your evidence, your opinion, relating to placing the onus on the care recipient and the care team is an insufficient answer to Professor Paterson's opinion that it would be useful to mandate RMMRs on admission to facilities. Do you have any comment on that?

MS LAFFAN: I accept that, but I think that the RMMRs are not the be-all and end-all of what we're doing in this area, so – and things that rely on a care recipient kind

of advocating for themselves. So, for example, one of the things that's being implemented as part of the chief medical officer's group that he held on chemical restraint is looking at streamlined authority for Risperidone. So that's something that would be built into the system and doesn't rely on a consumer advocating for themselves.

MR GRAY: That would just cover that one anti-psychotic, though.

MS LAFFAN: At this point in time, yes.

MR GRAY: I want to ask you about the online register of complaints that Professor Paterson spoke of in his evidence. Is there a misunderstanding here? Professor Paterson clarified that he was talking about aggregated and de-identified information. This is recommendation 10(iv) on page 6521. Is there a misunderstanding? If the information is deidentified and aggregated, would you, as a matter of your personal opinion, support the implementation of an online register of complaints?

MS LAFFAN: I think somewhat Professor Paterson and I are talking about different things. I do personally support information being out there about complaints. And I note that the commission has recently released a sector performance report which talks about categories of complaints, percentages, those sorts of things. I think where my comments go to is the detail of the report, which talks about a specific register, that register being available monthly, and a level of detail that would go into that register, which I think is potentially too much detail or too specific.

MR GRAY: Well, so the devil's in the detail, but - - -

MS LAFFAN: Yes.

MR GRAY: - - - if trends in types of complaints were identified, that'd be useful, wouldn't it?

MS LAFFAN: Absolutely, yes.

MR GRAY: Could I ask the operator to put up a document now relating to the progress of the transfer of functions. It's general tender bundle tab 143, CTH1016.1023.1926. I just want to ask you about one aspect of this document, Ms Laffan. Are you familiar with this form of document?

MS LAFFAN: Yes.

MR GRAY: Yes. There have been a series of drafts in relation to proposals for transfer of functions in the lead-up to 1 January 2020.

MS LAFFAN: There have. So this isn't the final.

MR GRAY: This isn't final?

MS LAFFAN: No.

MR GRAY: No. The key point I want to ask you about is 1.3 and 2.1. 1.3 suggests that, amongst other regulatory functions, prudential compliance, ie, operational compliance will be going to the commission as of 1 January 2020. But prudential and financial analysis will be staying with the department. Is that a topic you know anything about?

MS LAFFAN: I do know some about that, yes.

MR GRAY: And is that what's going to happen? Is that a firm decision?

MS LAFFAN: Subject to the passage of legislation through Parliament, yes.

MR GRAY: Now, there's a risk, isn't that, that keeping prudential and financial analysis within the department could lead to the very siloing of risk-related intelligence that you referred to in your evidence a little earlier as a risk to proper regulation.

MS LAFFAN: There is a risk and we'll have to work quite closely with the commission on cooperation and information sharing to mitigate that risk.

MR GRAY: All right. Do you know what the steps are that are going to be put in place to mitigate that risk?

MS LAFFAN: I don't think we've done any specific planning at this stage, but certainly I've seen discussions about MOUs, also the information risk profiling system that I was talking about earlier, which is mainly for use by the commission, would also be used by the team working on prudential and financial analysis.

MR GRAY: Thank you. I will leave Carnell and Paterson and now go to what's really a subset of the recommendations in Carnell and Paterson, but it's really a topic of its own, the Serious Incident Report Scheme, and the progress towards implementing a serious incident report scheme. This is the subject of your 10 July statement. It also is the subject of recommendation 6 of Carnell and Paterson, but you can put your other statement away for the time being.

In your 10 July statement, which is exhibit 8-31, at paragraph 56 you refer to KPMG having estimated that there are 10,500 resident-on-resident incidents each year where the aggressor has a mental or cognitive impairment that would be exempt from reporting. I want to ask you about progress towards implementation of a scheme and, in particular, whether the current exemption in relation to cognitive impairment is going to feature in the scheme or not feature in the scheme. Is there any decision on that question?

MS LAFFAN: A decision's still to be made by government on that feature.

MR GRAY: Okay. Has the department advocated a particular position to government?

MS LAFFAN: I'm not sure that I'm – I think if I were to answer that, that might expose Cabinet.

MR GRAY: All right, I won't press you. Now, there's some evidence from Mr O'Brien yesterday I just want to ask you about. He refers, of course, to the reports that actually are made, not the reports that aren't made, because of the exemption. And he refers to a rough estimate of annually about three reports coming in per 100 places. Now, he might have been including in that notional estimate – this is at transcript 4503. He might have been including in that notional estimate unexplained absences, as well as suspected or alleged assaults. But, given the magnitude of that figure, that's an annual figure, this suggests that some very urgent action is needed on tightening up this area of incident reporting, wouldn't you agree?

MS LAFFAN: Sorry, I don't understand the question.

MR GRAY: Well, it seems to be a very high figure that the department is getting what it estimates to be three out of – that three out of 100 residents are being subjected to a suspected or alleged assault, or possibly in smaller numbers and unexplained - - -

MS LAFFAN: That's very concerning, yes.

MR GRAY: - - - absence. It's extremely concerning.

MS LAFFAN: Yes.

MR GRAY: It requires very urgent action, doesn't it?

MS LAFFAN: It requires action, absolutely.

MR GRAY: And if you take the KPMG estimate, about three quarters of incidents aren't actually being reported, so the figure's actually much higher than estimated by Mr O'Brien. Would you agree with that?

MS LAFFAN: I'm not familiar with Mr O'Brien's estimate but, yes, there seems to be – there's a number of, you know, a large number of resident-on-resident incidents that aren't currently captured.

MR GRAY: I'll just display from an old exhibit from the first Adelaide hearing, exhibit 1-23, CTH.0001.1000.4651, the exemption in question, and it's to this exemption I wish to direct my questions. At page 4667, we have section 53 of the

Accountability Principles 2014. Section 53(1) in effect displaces the mandatory reporting obligation that's in the Act if – the relevant element here is (b):

> *before the receipt of the allegation or the start of the suspicion, the care recipient had been assessed by an appropriate health professional as suffering from a cognitive or mental impairment;*

and then (c) the exception applies if:

> *within 24 hours after receipt of the allegation or the start of the suspicion, the approved provider puts in place arrangements for the management of the care recipient's behaviour.*

Professor Paterson also gave evidence about this exemption yesterday and it's his evidence that there is an overwhelming case – that's my summary of his evidence – for removal of the exemption because of the obvious safety imperatives that are raised and also because there doesn't appear to be an obligation on the approved provider imposed by this provision to actually report what the arrangements are. They're required to make arrangements and that triggers the exemption but, in terms of providing a mechanism for the scrutiny that those arrangements have been put in place and are efficacious, there's no statutory obligation imposed on the approved provider?

MS LAFFAN: Correct.

MR GRAY: What's your personal opinion about those two elements of Professor Paterson's evidence? Do you think he's right on those two things: the exemption should be removed and there should be an obligation to report what the arrangements are?

MS LAFFAN: My personal view is yes.

MR GRAY: Yes. And KPMG has been retained in the manner you've described in your statement. Beginning with a process in – was it about September 2018 they were retained to advise on options for a serious incident report scheme?

MS LAFFAN: Yes.

MR GRAY: And there was a consultative process and, in effect, an options paper and you've produced the options paper.

MS LAFFAN: Yes.

MR GRAY: That was then given to the department in February 2019 and published in March 2019?

MS LAFFAN: Correct.

MR GRAY: Now we're in a series of further consultations about the options KPMG has identified; is that right?

MS LAFFAN: There's further preparatory work, not just on, you know, developing options or responding to options.

MR GRAY: Further preparatory work involving consultation with industry peaks?

MS LAFFAN: Some of it involves consultation, yes.

MR GRAY: I'll just ask you to comment also on this: Do you know whether that KPMG estimate of 10,500, is that the best information the department has as to the scope of the incidents that are not being reported by reason of the exemption; 10,500 a year?

MS LAFFAN: At this point in time, that is the best we have and that's why, in fact, we've recently gone through a procurement process to have someone look at in further detail the prevalence and the kind of categories of incidents involved in resident-on-resident. I think we could probably get a better estimate.

MR GRAY: All right. There's an exhibit from the Sydney hearing that I should show you. It's, operator, available in the list of previously tendered documents. It's the Oberon Village tender bundle reportable assaults register. It was previously exhibit 3-29, tab 82. I don't know if you have had a chance to look at this, Ms Laffan, but if we just go to the first page, there were redactions so we don't see the identities of any of the suspected or alleged people involved. I won't go through the whole document but I've done an arithmetic exercise. You see down the right-hand side there's "Status not reported – resident has cognitive impairment" in a number of cases.

MS LAFFAN: Yes.

MR GRAY: In fact, there aren't that many in the entire document that don't have that status. If we just keep going please, operator, you see at the top of that next page, there's one that's finalised. It can be inferred that that was a case that didn't involve the exemption. So it was reported and finalised. That's my suggestion about a reasonable construction of this document. Now, if that's the case, there are 82 incidents in this register and only 10 of them were reported and the exemption applied to the rest. Anecdotally, it suggests that KPMGs estimate is actually a very low estimate and, in fact, the extent of the effect of the exemption is much greater than merely a proportion of three-quarters; it's something more like over 10 per cent, between 10 and 20 per cent.

This evidence suggests, at least anecdotally, that the problem is even bigger than KPMG suggested. Do you have any comments on the points I've just made?

MS LAFFAN: I would say that's precisely why we've gone to this further costing and kind of counting exercise. In fact, this is extremely useful because part of that procurement process, part of what we'll be engaging the consultant to do, is to actually go to aged care providers and see if they have these sorts of documents available so that we can use those to make better estimates.

MR GRAY: Yes. This approved provider has absolutely done the right thing in maintaining a register of this kind, hasn't it, but I guess there's no guarantee that they all have; is that right?

MS LAFFAN: That's correct.

MR GRAY: Thank you, operator, we can put that document away. I asked Mr Speed yesterday about some policy documents relating to the assessment of compulsory reports that come into the department. There's a compulsory reporting manual. Previously there was a quick reference guide in relation to assessment of compulsory reports. And they both indicate that consideration should be given to accessing Dementia Behaviour Management Advisory Service and considering whether the care given to people living with dementia is satisfactory in light of the reports that are made. In other words, the policy documentation that the department provides to its own officers suggests that cognitive impairment is a very important issue in this space. You'd agree that it is, isn't it?

MS LAFFAN: Yes.

MR GRAY: Yet the fulfilment of that policy objective is completely undermined by the fact that the exemption applies to suspected or alleged assaults where there's been a diagnosis of cognitive impairment, isn't it?

MS LAFFAN: I understand there were some policy reasons why that exemption was made in the first place, in 2007 when the scheme was introduced.

MR GRAY: Can I ask about another aspect – so you're not disagreeing with me. The exemption is contrary to guidance to officers to consider cognitive impairment because the exemption means that the very incidents that involve cognitive impairment aren't going to be reported?

MS LAFFAN: I don't disagree but I'm not familiar with the document so - - -

MR GRAY: Now, there's another element to Mr O'Brien's evidence I just want to raise with you. At transcript 4492, with reference to those reports that are received by the department, he said that there isn't a register or database maintained of the alleged or suspected perpetrators of assaults. Is that something that you have knowledge about?

MS LAFFAN: No, it's not something I have knowledge about.

MR GRAY: There should be a register of such people, shouldn't there? That would be an obvious risk mitigation measure to take so that the department could track whether the same suspected or alleged perpetrators are coming up repeatedly?

MS LAFFAN: I think there's a few issues raised by that. So largely it's the approved provider's responsibility to deal with staffing, if we're talking about staff, or are we talking about the care recipients themselves if there's a - - -

MR GRAY: Well, if we're talking about staff, let's just focus on staff for the time being. Staff can leave one approved provider and go to another, can't they?

MS LAFFAN: That's correct.

MR GRAY: So as steward of quality and safety regulation, certainly steward of the design of quality and safety regulation in the aged care space, shouldn't the department be tracking the movement of alleged or suspected perpetrators of assaults in the workforce?

MS LAFFAN: I think there's an open question as to what we should do in that space.

MR GRAY: What's your personal view?

MS LAFFAN: Personally, I think that ultimately the approved provider should retain responsibility and that they should be making assessments and judgments and calling referees and talking to people before they hire someone.

MR GRAY: But they might not know that the person has been previously subject to possibly a pattern of suspected or alleged assaults?

MS LAFFAN: That's possible if past referees or other places they've worked haven't been honest or filled in all the detail.

MR GRAY: That just sounds like raising an obstacle to an obvious risk mitigation measure, doesn't it? Wouldn't it be much more sensible for the department to just collate the reports it receives, maintain a database or a register and then, on application by a particular approved provider seeking to recruit a new employee, provide an indication whether that person is the subject of previous suspicions or allegations or not?

MS LAFFAN: I think in the way that you've described, that seems, you know, quite suitable but I think if you kind of work into implementing that, there's issues about due process, whether people whose names appear on that register have had a chance to, you know, talk about allegations that are made against them. So I think in a broad sense, it does make sense, it would be something that would be useful, but I can see a number of implementation issues that would need to be considered and resolved before such a system would be able to be in place.

MR GRAY: Subject to that detail around due process, it could be done, couldn't it?

MS LAFFAN: Sorry, I should add here that the government, as part of the '19/20 budget measure, is looking at a feasibility study for a staff register.

MR GRAY: Would that pick up matters of this kind reported under the SIRS?

MS LAFFAN: I believe some of the things we talked about would be part of that consideration.

MR GRAY: Now, just returning to the current status of the consultation on the SIRS. KPMG has come back with an options paper with five options ranging from no change through to removing the exemption for resident-on-resident aggression where cognitive impairment is involved; correct?

MS LAFFAN: Correct.

MR GRAY: Isn't it just obvious that we should proceed to the SIRS that is available, which is the one recommended by Carnell and Paterson and Australian Law Reform Commission beforehand, which is one that doesn't have such an exemption?

MS LAFFAN: I think that's just one aspect of a SIRS and there's other aspects that require consideration and deliberation.

MR GRAY: So the industry consultation that has occurred so far included some quite stringent resistance, is that right?

MS LAFFAN: That's my understanding from the KPMG report, is that there was some stakeholder resistance to that option, yes.

MR GRAY: Is that because there'll be a reporting burden on them or is it a more substantive concern that there's a big issue here that they want to conceal?

MS LAFFAN: I can't speak to providers but I expect it's a regulatory burden issue.

MR GRAY: Why is it taking so long to complete this consultative process?

MS LAFFAN: I would say that a serious incident response scheme is a large and complex scheme and I think some of the things that you read in ALRC and KPMG report demonstrate that we need to do work around definitions, that the devil is in the detail on these things, that we require really active consideration of a number of issues.

MR GRAY: All right. I want to ask you now about the third topic, which is home care quality and safety regulation. You address this also in your 22 July statement. You've accepted, paragraph 64 on page 11, various gaps and weaknesses in home

care regulation that currently exist in your opinion – or in the department's opinion. You know, of course, that there's no accreditation requirement for home care services.

MS LAFFAN: Correct.

MR GRAY: And, in effect, a home care provider can begin operations without there ever having been a prior review by the Aged Care Quality and Safety Commission as to the safety or quality of its services.

MS LAFFAN: That's my understanding, yes.

MR GRAY: Is that going to change?

MS LAFFAN: I'm not sure that I can answer that question. I think that would be a matter for government, whether accreditation would expand to home care.

MR GRAY: Is it your personal opinion that it should change?

MS LAFFAN: For some types of home care, yes, I think it – potentially it's a scalable thing depending on the risk and the services provided. But I think some sort of assessment prior to delivering care would be a sensible one for home care.

MR GRAY: All right. Well, let's now look at point (b), the conduct of reviews. You sought – or the department sought clarification as to aspects of the commission's rules on the processes that the commission applies to conduct monitoring and auditing within care recipients' private homes. What was the nature of the clarification you were seeking?

MS LAFFAN: Sorry. I would say that we've made that clarification. So in the development of the rules, which was done at the end of last year, following passage of the primary legislation, we've made it a lot clearer in those rules that the commission can go into a care recipient's house to ask them about their care experiences of home care.

MR GRAY: I see.

MS LAFFAN: Yes.

MR GRAY: And has that measure actually now been implemented, to the best of your knowledge? Is that happening?

MS LAFFAN: I would have to ask the commission that.

MR GRAY: Quality assessment information is not published. That's in contradistinction to the publication of accreditation outcomes following re-accreditation audits in the residential care setting, isn't it?

MS LAFFAN: Correct.

MR GRAY: So why the difference? Why don't we publish quality review outcomes in the home care setting?

MS LAFFAN: So I'm not sure that quality reviews have the same outcome in a sense that accreditation does. So accreditation you are accredited or not, but there's no decision in that sense in the home care settings. So that's my understanding as to why that distinction exists.

MR GRAY: Home care is an area where the approach known as consumer directed care is applied.

MS LAFFAN: Correct.

MR GRAY: It's an approach that's intended to optimise the use of a market mechanism to allocate services to particular consumers at their choice; correct?

MS LAFFAN: Correct.

MR GRAY: And so isn't there an even stronger argument to allow the demand side of the market to be informed about the relevant performance of providers under consumer-directed care?

MS LAFFAN: I think that information would be really important, particularly to people seeking that information prior to receiving care, rather than already being in care. Yes.

MR GRAY: So it's your personal, is it, that those quality reviews should be published? Is that what you're saying?

MS LAFFAN: Yes.

MR GRAY: In paragraph 66, you refer to some factors that have influenced the department's approach to home care regulation, including that it's less complex care and you've said lower risk. You also mention privacy issues in assessors going into homes, but that's been addressed by the amendments to the rules you just mentioned. Is that right?

MS LAFFAN: I think that some of those issues still exist. So I can recall in our discussions when we were developing the rules that some consumer groups were concerned that consumers didn't feel that they had to or were required to let assessors into their house, that there was consent available. So I think it's still – that they were able the consent or not consent. So I think it's still a live issue, in that it is more difficult, you need to seek that consent.

MR GRAY: Okay. But moving past the privacy issue and looking at the concept of there being lower risk in a home care setting, isn't it the case that, in a sense, there's a higher risk, because what's happening is happening on closed doors on private property, not in an institutional setting. So there are less eyes on what's happening.

MS LAFFAN: So I believe what I was referring to was historical – my view of the historical findings, that it was seen to be less risky.

MR GRAY: It was a view that was held within the department. You don't necessarily agree with it. Is that what you're saying?

MS LAFFAN: I think – I understand it was a view held within the department, but I think the department acknowledges that times have changed and that with the complexity of care that's now, you know – and people's acuity, you know, growing before they, for example, go into residential care, that more complex care is provided in the home care setting.

MR GRAY: I just want to ask you about one further matter, that is, enhancing the sanctions regime with measures that are specifically directed to directors of approved providers. Ms Brammesan suggested in her evidence that it would be amazing, and I take that to mean good, if measures of that kind were incorporated in the regulatory design. Do you agree?

MS LAFFAN: I think that we should look at all potential regulatory tools. And that would absolutely be one of them.

MR GRAY: And would financial penalties against directors be one of them?

MS LAFFAN: That could be, yes.

MR GRAY: No further questions from me.

COMMISSIONER TRACEY: Are you likely to need Ms Laffan further in relation to that document you've called for?

MR GRAY: No. I will be able to make submissions in due course on the basis of the document alone.

COMMISSIONER TRACEY: Yes. Thank you.

COMMISSIONER BRIGGS: Ms Laffan, thank you for your evidence. It's been quite helpful. One of the things that we hear is that there's a lot of emphasis around reduction in red tape. And, as a result of that, the department sometimes is incapable of moving on regulation that might be deemed to be necessary and appropriate, because the providers create such a strong force not to move. I don't want to ask you

that in the general. I want to ask you specifically have you experienced examples of that?

MS LAFFAN: I have experienced examples where providers have said there is undue regulatory burden, yes.

COMMISSIONER BRIGGS: Does the government – or has the government in the last couple of years introduced new regulatory arrangements without consulting with industry, in your knowledge?

MS LAFFAN: I don't believe so, noting that we would also consult with consumer and consumer peaks, as well.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Ms Laffan, thank you very much for your evidence. You are excused from further attendance.

MS LAFFAN: Thank you.

<THE WITNESS WITHDREW [12.43 pm]

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Yes, Commissioners. The next witness for today – and for the sake of all those present, I hope to finish this evidence by 1.30 – is Mr Graeme Head.

<GRAEME HEAD , AFFIRMED [12.44 pm]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: If document WIT.0291.0001.0001 could be brought up, please. Mr Head, you will see a screen in front of you. Is that a copy of your statement?

MR HEAD: Yes.

MR BOLSTER: Do you wish to make any amendments to the statement?

MR HEAD: No.

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

MR HEAD: Yes, to the best of my knowledge.

MR BOLSTER: There is one other matter of tender that I wish to deal with, Commissioners. If the following document could be brought up, RCD.9999.0166.0001 through to 0208. That's an information paper that's referred to in your statement.

MR HEAD: Yes.

MR BOLSTER: And there are five – six attachment thereto. For the record, Commissioner, they run through from page 1 through to page 208 which I tender.

COMMISSIONER TRACEY: If you look at the cover page, it appears to conclude at 0204.

MR BOLSTER: Yes, but that goes right through to 0208. It's a four-page document. So it starts at 204. Yes.

COMMISSIONER TRACEY: I see. It starts at 0204, but continues?

MR HEAD: Yes.

COMMISSIONER TRACEY: Yes, I see. Yes. Thank you. Well, firstly, there's a witness statement. Is that right?

MR BOLSTER: Yes. I tender that.

COMMISSIONER TRACEY: All right. Well, the witness statement of Mr Graeme Head dated 25 July 2019 will be exhibit 8-34.

EXHIBIT #8-34 WITNESS STATEMENT OF MR GRAEME HEAD DATED 25/07/2019 (WIT.0291.0001.0001)

COMMISSIONER TRACEY: The information study with attachments A to F inclusive will be exhibit 8-35.

EXHIBIT #8-35 INFORMATION STUDY WITH ATTACHMENTS A TO F INCLUSIVE (RCD.9999.0166.0001)

MR BOLSTER: Thank you. Mr Head, you are the commissioner of the NDIS Quality and Safeguards Commission.

MR HEAD: Yes, that's correct.

MR BOLSTER: Can I raise with you that word safeguards.

MR HEAD: Yes.

MR BOLSTER: Because it's a word that's different from safety, which we see in both health and aged care. What's the significance of using the word safeguards, as opposed to safety?

MR HEAD: Well, the arrangements that have been established for the commission, really, focus on how supports are provided to people in such a way as to support what they're seeking to achieve through their participant plan with the NDIS, while making sure that those supports are delivered in a way which reflects both quality and ensures the safety of people. But I think I can't answer the exact basis why that word was chosen – why that term was chosen.

MR BOLSTER: Could I perhaps venture this explanation. You can tell me if I'm on the right track. Is that the concept of safeguarding, really, goes to lifestyle and includes and embraces safety, as well. In other words, when a disability service provider is attending to one of their customers, they have to pay heed to both the lifestyle and the safety of the services that they're providing.

MR HEAD: It's certainly the case that central to design of everything to do with the National Disability Insurance Scheme is the idea of choice and control by participants and that the person with disability is at the centre of what is happening in an NDIS arrangement. And that includes the quality and safeguarding arrangements.

MR BOLSTER: Is the source of that perhaps the human rights focus that we see in the NDIS legislation?

MR HEAD: Yes, I would say so. The convention referred to in my witness statement is a key underpinning of everything to do with the quality and safeguarding arrangements.

MR BOLSTER: And, for the benefit of those listening, if you could elaborate, please, on the essential aspects of that source for the entitlements of your participants.

MR HEAD: Well, The Convention on the Rights of Persons With Disability and the objects of the legislation and functions and powers of the commission link up in such a way that consideration of the ordinary human rights of people with disability to be upheld and promoted through the way that quality and safeguarding is undertaken as part of the NDIS. And that includes things like the exercise of choice and control. It includes things like being free from violence, abuse and exploitation. It includes key elements related to the involvement of people in decisions that affect those people.

MR BOLSTER: You've been a senior official in the Department of Health, and I take it you have experience in relation to aged care regulation?

MR HEAD: As my witness statement indicates, while I've had experience as deputy secretary in the Department of Health and Ageing, I haven't had direct involvement in aged care regulation. My role in the Department of Health was running national health reform with a focus on hospital reform but I have had experience in other regulatory settings.

MR BOLSTER: All right. Paragraph 28(d), subsection (4) of the Act states:

> *People with disability should be supported to exercise choice, including in relation to taking reasonable risks in the pursuit of their goals and the planning and delivery of their supports.*

What's the challenge for a regulator in accepting a choice-based risk when it comes to delivering care?

MR HEAD: Well, I guess I would preface my remarks by saying that any regulatory design will have challenges related to the context in which it's being deployed. In respect of quality and safeguarding as it relates to the NDIS, it's helpful to understand, I guess, some of the key design features that relate to people with disability exercising choice. So all providers who provide supports and services under the NDIS are regulated but not all are required to be registered. So self-managing participants can use unregistered providers. Unregistered providers are regulated because they're subject to the code of conduct which is expressed in one of the rules made under the Act but, of course, the challenge from a regulator's point of view is that, for us to take action against an unregistered provider, we need to be notified, a complaint made to us about that activity, whereas with a registered provider we have a range of other tools.

So the challenge for us is really to make sure that people with disability understand that, whomever they are using for NDIS supports is regulated, that they have the right to complain and that we can take action in respect of complaints against either registered providers or unregistered providers if those complaints relate to code of conduct issues.

MR BOLSTER: When registration is necessary, is there a situation where there has to be an assessment of the provider before registration or, like as we see in home care, services can be delivered before a person receives accreditation?

MR HEAD: So when – NDIS providers are required, under the registration and practice standard rules, to be audited as part of the process. There are two audit pathways to registration. One is a full third party certification process against the practice standards, and the other is a verification process which is also described in the practice standards. The second of those is a more light-touch process and it relates to providers who are providing lower-risk supports. So risk is central to

determining which pathway a provider is on. And then the process in the rules describes what happens in what order for a prospective provider to be allowed to operate.

MR BOLSTER: And, briefly, is registration required before services can be provided?

MR HEAD: Registration is required for certain mandatory registration groups. So if a provider is providing specialised behaviour support or specialist disability accommodation, they must be registered. Also, if providers – if a participant is not self-managing, the provider must be registered, if it's a plan-managed participant. There are elements of the guidelines for auditors which relate to new providers, so people coming into the market who will undergo a suitability assessment from us and an initial audit and the auditor guidelines set out the arrangements that apply to new providers that do not yet have participants.

MR BOLSTER: In terms of compliance, is there a compliance emphasis that's directed by risk as well?

MR HEAD: Yes. I would preface my remarks by saying that the commission is a new organisation that's taking over the registration of providers from the NDIA – the National Disability Insurance Agency – and at the same time taking over the regulation of quality and safeguarding from the states or territories in which providers operated and moving those providers under the new national framework. The characteristics of the regulatory framework that the commission operates under are quite different than the frameworks that operated in states and territories so there has been, in the first year, a heavy emphasis on successful transition management but the commission has started to use the range of compliance tools that it has and we have a compliance and enforcement policy that relates to our work as well as an internal high-level committee that oversees the rollout of our approach to compliance.

MR BOLSTER: Is risk responsiveness embedded in that procedure in that framework?

MR HEAD: Everything about quality and safeguarding in the NDIS is designed to focus on risk. So the combination of the requirements under specific rules as well as the integrated approach that the commission has by virtue of having all of the key functions in one organisation allows us to connect the dots, as it were, in relation to risk and determine what the right course of action is.

MR BOLSTER: I wanted to talk about the organisational structure. You talk about both operational streams and enabling structures in the commission. What's the difference between the two? I get a sense, from reading your statement, that the structure is really one that embraces all of the streams?

MR HEAD: That's right. I mean, we're a national organisation. We're – we're working across a range of key regulatory functional areas and it's the case that we have, I guess, nationally-focused parts of the organisation that support work across one or more of those streams. So, for instance, an operational stream related to complaints or reportable incidents is also enabled by work that's happening in the education and engagement area, the work that's happening in IT around system development, the work that's happening in other central areas. So really that description alludes to the fact that there's somewhat of a matrix in respect of those things.

MR BOLSTER: Am I right in thinking – let's speak practically here that, say, for example, the Brisbane office of the commission, the staff there would operate seamlessly across the operational streams of the commission?

MR HEAD: That's correct. The focus of state and territory officers is principally around complaints management and resolution and also around some work in behaviour support and responding to reportable incidents as well as some work in investigations.

MR BOLSTER: For example, in paragraph 22 of your statement where you list the six streamed functions, staff would be across all aspects of those particular operational streams; am I right in thinking that?

MR HEAD: So registration is a stream that's performed centrally. So there's not – so the process of registering people happens through a central unit nationally but processes that relate to compliance with the conditions of registration may involve both staff from the relevant state or territory office in addition to some specialist resources from one of the enabling groups in the national office.

MR BOLSTER: What's the driving force between having that streaming structure? Is that taken from best case practice in other areas, in your experience in New South Wales where you were the Public Service Commissioner? Where does the design for that scheme come from?

MR HEAD: I don't think I can refer to my Public Service Commissioner experience in respect of the design of this particular organisation. Essentially, in the work that the Department of Social Services did in developing the initial operating model for the commission, the focus was on reflecting what ministers had agreed and COAG agreed in the quality and safeguarding framework in the general kind of functional remit of the organisation and its approach. The reality is that certain types of work that people do really requires that people are locally present in order to talk to participants, talk to providers, maybe conduct site visits, that they have an understanding of local issues and the way service provision has historically operated, and some functions make sense to perform centrally from the point of view of both consistency and efficiency but the key thing is to make sure you have governance arrangements that mean that those things that are done centrally talk properly to those things that are done in state and territory offices and that's been our focus.

MR BOLSTER: Third party audits would seem to be a process that is different from the aged care sector. Why the need for third party audits in your system?

MR HEAD: The NDIS market is intended to evolve. So if you look at the market today, we have providers transitioned into the NDIS who historically have had quality and safeguarding managed often through funding agreements with state and territory governments that were block-funding services. The NDIS is a very different model and, over time, the market that provides supports and services will diversify. That's the intent. I think that, certainly from my point of view, and the decision about the audit model was taken before the commission was created, but I think it makes good sense in terms of availability of expertise, particularly given that the commission has a lot of authority in the way the audit process is conducted.

So the registration and practice standard rules determine what kind of audit is required for what class of supports and then for full third party certifications, there is both a core module and specific modules related to different classes of supports and we, through the joint accreditation scheme Australia-New Zealand, have a process for approving new accreditation bodies to come in where part of that process is that we train the auditors. So already we have over 19,000 providers that are registered. The transition process involves registered providers re-registering and going through that audit process. So this model, I think, is very appropriate in terms of meeting the supply requirements of auditors. And the way it's been designed ensures that the things that the commission is concerned about, in terms of the quality of audits, are addressed through our arrangements with JAS-ANZ and our direct involvement in the training of auditors.

MR BOLSTER: Paragraph 86 of your statement, you refer to the requirement for auditors to notify uncontrolled risks that might impact on participant safety. Is there a body of such reporting that's developing or is it still too early to talk about that?

MR HEAD: It's too early to talk about that. And I'm not aware of the specifics of instances where that's occurred, but I do know that these arrangements were certainly included in some of the earlier discussions with JAS-ANZ, as well.

MR BOLSTER: All right. If we could turn then to the question of the home – or in-the-home delivery of NDIS services. What proportion of NDIS participants would receive services in the home?

MR HEAD: I don't have that information off the top of my head.

MR BOLSTER: Well, is there a different regulatory approach or strategy to focus on the way in which NDIS services are delivered in the home?

MR HEAD: So the practice standards and the code of conduct, which are both relevant in this space, are, really, focussed on how services are provided by providers, not the specific environment in which they're provided. So if one were to go through the various schedules to the practice standards that relate to registered

providers, the outcomes that are described in those standards and the quality indicators that attach to those outcomes are not specific to the environment in which the supports are provided. They're specific to the types of supports and what a participant should experience in the receipt of those supports irrespective of where they're received.

MR BOLSTER: And how will you engage with the care recipients to assess performance against those standards or those criteria?

MR HEAD: In a number of ways. So the auditor guidelines that are a notifiable instrument made by me in connection with the provider registration and practice standard rules talk about the specific requirements as part of audits to involve participants and including guidance on sampling and those sorts of things. So the voice of participants is built into the audit process. It's also the case that information that we get through complaints and reportable incidents is relevant in respect of that, as well.

MR BOLSTER: I was going to turn then to the issue of complaints. And I saw a video on the website where you emphasised the need for participants to have the confidence to complain. I was wondering if you could talk about what that means and how important it is to maintaining or safeguarding the process.

MR HEAD: So both in the quality and safeguarding framework that governments agreed to and in subsequent work that the commission's been involved in, the centrality of the need for people to be able to complain and to make that as simple as possible and to encourage people to feel confident has been emphasised. There is an often-stated view, which is a view that I share, that there's probably been a tendency on the part of people with disability to not complain about things that they should feel free to complain about because of concerns about what might happen as a result of making a complaint or a belief that the complaint wouldn't be taken seriously.

So a part of the commission's work directly with people with disability, but also a part of our work in dealing with advocacy organisations, is to encourage people to speak up, to attempt to de-mystify the process of what happens when a person makes a complaint and to ensure that we handle the complaints in the way that the rules require, which include an emphasis on involving people with disability in the process and also providing feedback to the person with disability or another complainant about the process.

MR BOLSTER: The other aspect of the complaint process is what it tells you as a commission. You may have heard the evidence of Professor Paterson yesterday when he described the complaint system in relation to aged care as like the canary in the mine, because it enables you to see precisely what's going on. Do you share that metaphor?

MR HEAD: It's not one I ever use, but, yes, I mean complaints can be an extremely important early warning system.

MR BOLSTER: What do you expect complaints to tell you going forward with the commission?

MR HEAD: So some complaints will tell us about a unique experience that a participant is having that needs to be dealt with specifically. Some complaints will tell us both about that unique experience, but will also provide a window on to, I think, other more systemic issues. So information about complaints will often raise, potentially, or present insights, about things like the culture of an organisation, workforce training issues, whether or not good systems are in place. So complaints data is important in its own right. It's important to ensure that the individual complaints are resolved, but also to provide those insights into wider problems.

And, in an organisation like the commission where we also have the information we collect through registration processes through our monitoring of behaviour support and through reportable incidents, we have the capacity to join dots in a way that historically hasn't been available in this sector and to, I think, determine where there might be systemic issues much earlier than would have been in the case previously.

MR BOLSTER: Is it too early to talk to whether you are getting data in your complaints process that's of assistance in that way?

MR HEAD: It's not too early to make the general observation that some of the information we've received in complaints, alongside information we've collected in reportable incidents, has assisted us to take proactive action. But it is important to point out that we're still building our analytics capability. There's work that the commission is about to undertake which will much more explicitly consider what our information holdings are, how we make the best of those in order to predict issues, as well as how we work with other key players both in terms of them sharing information with us and the other way around.

MR BOLSTER: There's the related issue of audits. So separate from a separate complaint where you – from an individual complaint where you get an individual instance of conduct that may be troubling, the audit process is designed to pick up other issues through interviews with family and the participants themselves.

MR HEAD: Yes. The audit process, once again, focuses on a provider's conformity with the particular standards – the core module and the particular standards that relate – this is in a certification audit – that relate to their particular registration groups. And part of the process of that audit is around involving people with disability, families and others, in, I guess, commenting on the extent to which the experience is a reality for the people who are receiving supports.

MR BOLSTER: The choice, though, of family, friends and carers, what was the specific reason for that in including that in the audit provisions?

MR HEAD: So the auditor guidelines, really, acknowledge, I think, that participant voice is critical and that the support for that voice being included depending on the

circumstances of a person with disability may involve family, other carers or, indeed, other people who are appropriate to represent a perspective on the part of a participant.

MR BOLSTER: What do you see as being the role for state and territory community visitor schemes that have jurisdiction in this area? How important are they?

MR HEAD: I should start by saying they're all constituted somewhat differently. So it's – and are staffed differently and do similar things, but often in slightly different ways. So the commission recognises the importance of community visitor schemes. They're schemes that are controlled by state and territory governments. We treat community visitors' schemes in a similar way to how we treat state and territory statutory officers that have a relevant role.

So the commission has information-sharing principles that we've developed at a high level, which talk generally about what we're able to share information about and the checks and controls on that. And, for each state and territory, we then have a sort of series of entity-by-entity schedules that are under development at the moment to describe how information sharing will occur with those entities and where, at least in a number of jurisdictions, community visitor schemes will have their own schedules as part of those arrangements. And a community visitor could make a complaint about something they observed that could be managed under the complaints process.

So there's a recognition of the importance of community visitor schemes and arrangements being looked at through the information-sharing arrangements about how we work with them.

MR BOLSTER: Can I turn to the issue of restrictive practices, which has parallels in aged care. What's the principal attention that the commission is directing to providers when it comes to this issue? What's the focus of your work?

MR HEAD: So at the highest level of focus, of our work is to work to reduce and ultimately eliminate the use of restrictive practices. And that's in broad keeping with the principles in the convention.

The way we do that is through a set of arrangements that relate to both the registration rules and the behaviour support rules, which are really about ensuring that people who require behaviour support as part of their NDIS supports have a proper plan for the way those supports are provided: that that plan is put together by somebody who's appropriately skilled to put it together; that the use of restrictive practices in respect of such a plan are properly identified; that they're properly approved by the relevant state or territory, and that plans are reviewed to make sure that they remain appropriate and relevant for people and that unauthorised uses of restrictive practices are notified to us.

Those behaviour support plans are plans that are required to be lodged with the commission if they contain a restrictive practice. So there's a – really, the commission has an oversight role to try and ensure that the way behaviour support is used is evidence-based, it's centred on the person's needs, there's a principle of seeking to reduce and eliminate the use of restrictive practices and where they're required to use the least restrictive practice available and to work with states and territories to achieve consistency, national consistency, in the way authorisation processes work.

COMMISSIONER BRIGGS: Does that mean that the organisation accepts that there might be some shorter-term need for restrictive practices on an individual basis rather than you're talking more generally about you want to phase out use of restrictive practices; what are you saying, Mr Head?

MR HEAD: So if an organisation is providing behaviour support, they must be registered. The registration rules require them to do certain things, to have proper behaviour support plans in place. There is an allowance for interim behaviour support plans where something is required in the short term but where something is required in an ongoing sense, there are requirements about a behaviour support plan and the timeframe within which it must be developed, the sorts of things it must include, what must be provided to the commission, what authority for the use of restrictive practices is required from the relevant state or territory government.

There are also provisions that recognise that sometime there will need to be an emergency use of a practice and the rules also speak to the obligations on providers around what is an emergency use and what they do in relation to that.

MR BOLSTER: Can I turn then, finally, to the issue of reportable incidents. What's the criteria for reporting?

MR HEAD: So both the Act and the related rules define what incidents are reported to us and it includes – so reportable incidents are reportable when the incident occurs in connection with the provision of supports and NDIS services and includes the death of a participant, serious injury of a participant, unlawful physical or sexual contact or assault, other forms of sexual misconduct. So the rules specify what people must notify us about and – and a process where we oversee what happens in relation to those incidents.

MR BOLSTER: Is there any carve-out for situations where the person who inflicts the assault has a cognitive impairment or it may be associated with their particular disability?

MR HEAD: The rules don't – they don't carve out classes of people who are not subject to the requirements. What they do recognise is that there might be situations where something is technically captured by one of those definitions but there's negligible impact on the person. So that is the only carve-out, except for those that relate to the use of restrictive practices.

MR BOLSTER: With the reporting information that you receive, in what way is that going to inform your regulatory approach at a broader level and at the level of the provider themselves?

MR HEAD: Well, providers themselves are required to have incident management systems in place. And that's a critical feature of providing safeguarding in certain environments. So information from reportable incidents will sometimes tell us whether or not there's, I guess, a poor set of arrangements in place generally about incident management. They may point to major issues in terms of the appropriateness or the capability of staff to work in particular situations. Patterns of reportable incidents may speak to more systemic issues with a provider or with an area of activity that a provider appears to be less expert in.

Of course, reportable incidents also, depending on their severity, may trigger us to take formal investigative action and to use one of the many regulatory tools we have to prevent harm, further harm, coming to either the individual involved or to other participants. So our first response to receiving a reportable incident is around ensuring that the provider has taken all necessary steps to avoid any additional harm occurring and to consider, when appropriate, if there are other regulatory steps we should take.

MR BOLSTER: Is there any evidence coming through that this is of assistance to you or is it still too early?

MR HEAD: Look, it is very early and I would be loath to talk about trends or anything in information we're seeing but it is an important source of intelligence to us about what's happening in the sector and in line with the comment I made to you earlier about complaints, some of the reports we've received have assisted us to take early action in the form of talking to providers about things that appear to be happening in a less-than-ideal way. Taking account of the fact that we're dealing with a transitioned provider cohort, many of whom are only – well, they're going through their re-registration against the new practice standards in a phased approach, so reportable incident reports are very important insights into what's happening.

MR BOLSTER: Finally, to finish, what's the most important message for the Commission in the operation of a complaints mechanism and a regulatory mechanism such as that which you oversee?

MR HEAD: So from my perspective as NDIS Quality and Safeguards Commissioner, the thing that I think is central to our ability to succeed in this space is the fact that we have the key functions in one organisation and we'll be able to connect the dots in a way that has, I guess, historically been atypical. I think that will allow for much more focus on preventing problems before they become systemic but will also allow for, really, more precise judgments about the right regulatory response to particular issues. So I think it's an extremely – in the disability space, it's an extremely important development.

MR BOLSTER: Thank you. I have no further questions, Commissioners.

COMMISSIONER TRACEY: Thank you, Mr Head, very much for your evidence. As you have no doubt heard, we're grappling with a number of issues, not least the one that's just been mentioned and that's regulatory issues. Your guidance has been of great assistance. Thank you very much.

MR HEAD: Thank you.

COMMISSIONER TRACEY: You're excused from further attendance. The Commission will adjourn until 2 o'clock.

<THE WITNESS WITHDREW [1.29 pm]

ADJOURNED [1.29 pm]

RESUMED [2.08 pm]

COMMISSIONER TRACEY: Yes, Mr Knowles.

MR KNOWLES: Thank you, Commissioners. I now seek to call Ms Beverley Johnson, who is appearing via video link.

COMMISSIONER TRACEY: Yes.

MR KNOWLES: I understand that there is a solicitor in the room with Ms Johnson who is able to assist with the administration of the affirmation in this case.

<BEVERLEY JEAN JOHNSON, AFFIRMED [2.09 pm]

<EXAMINATION BY MR KNOWLES

MR KNOWLES: Thank you, Ms Johnson. Can you state your full name to the Royal Commission for the transcript?

MS JOHNSON: My name is Beverley Jean Johnson.

MR KNOWLES: Do you have before you a copy of a statement that you have prepared for the Royal Commission dated 2 August 2019?

MS JOHNSON: That's correct.

MR KNOWLES: That document is WIT.0332.0001.0001.

MS JOHNSON: Yes.

MR KNOWLES: Ms Johnson, have you read your statement recently?

MS JOHNSON: Yes, I read it yesterday.

MR KNOWLES: Yes. Are there any changes that you wish to make to your statement?

MS JOHNSON: No.

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

MS JOHNSON: Indeed they are.

MR KNOWLES: Thank you. I seek to tender to tender the witness statement of Ms Johnson dated 2 August 2019.

COMMISSIONER TRACEY: Yes. The witness statement of Beverley Jean Johnson dated 2 August 2019 will be exhibit 8-36.

EXHIBIT #8-36 WITNESS STATEMENT OF BEVERLEY JEAN JOHNSON DATED 02/08/2019 (WIT.0332.0001.0001)

MR KNOWLES: Ms Johnson, you are 83 years old; is that correct?

MS JOHNSON: That's right.

MR KNOWLES: You've been resident in an aged care facility in regional Victoria for the last 10 years or so.

MS JOHNSON: Yes, that's right.

MR KNOWLES: Now, before I come to talking with you about your time in that facility, could I ask you some questions about other aspects of your life both prior to and after your entry into the aged care facility?

MS JOHNSON: Yes.

MR KNOWLES: Now, you were born with cerebral palsy?

MS JOHNSON: That's correct.

MR KNOWLES: At paragraph 5 of your statement, you describe some of the challenges that you've faced in your life living with cerebral palsy. You say you've faced being continually told that you can't live life as other people do. In broad terms, what are some of the can'ts that, despite what you were told by others, you've still achieved?

MS JOHNSON: I was initially at school age told I can't go to normal school unless my four and a half year old brother went with me and then in secondary education I was expected to leave school at 14. Being disabled, I would never have a career or higher education. But I went on to get a Bachelor of Arts degree with distinction and I'm now studying a second one, and I went on to have a career in accountancy and then I've been to – worked both in London and in Melbourne and yes – I might be told I can't, but I will.

MR KNOWLES: When you say that you engaged in further studies, you first sought to do so, I think, in the 1950s at what is now RMIT in Melbourne; is that correct, Ms Johnson?

MS JOHNSON: Yes, that's correct.

MR KNOWLES: Yes. But that was interrupted by marriage; is that right?

MS JOHNSON: That's right.

MR KNOWLES: And you then went overseas in 1956 and that was before you could graduate from what is now RMIT?

MS JOHNSON: Yes, that's right.

MR KNOWLES: You said before you worked in London and Melbourne; was it at that time you were overseas that you were working in London?

MS JOHNSON: Yes, I spent four and a half years in London.

MR KNOWLES: What did you do during those four and a half years, for work?

MS JOHNSON: For work, I worked in London in three different firms in accounting positions. In this role I was with an accounting firm and a garage as their assistant accountant.

MR KNOWLES: Yes. And you stopped work to give birth to your son; is that right?

MS JOHNSON: That's right, yes.

MR KNOWLES: When was that?

MS JOHNSON: 1963 he was born. I gave up working towards the end of 1962.

MR KNOWLES: And can you describe the circumstances in which you then returned to work subsequently?

MS JOHNSON: I was in London and had my child there. I didn't want to go back into accounting because that was not my choice so I wanted to be a maths teacher so I did my HSC before going on to uni. I realised that information was more important than teaching it so I did a librarianship course and graduated with distinction as a librarian.

MR KNOWLES: Yes. And it's true, also, isn't it, that you were awarded the College Medal from what now is Charles Sturt University for excellence in academic application and achievement in connection with that course.

MS JOHNSON: That's right, yes.

MR KNOWLES: Yes. And then what work did you return to after completing that qualification, Ms Johnson?

MS JOHNSON: I specialised in information for people with disabilities and went on to work first of all in the Braille and Talking Book Library, as the Braille librarian. Then I went on to the Spastic Society, then on to the Multiple Sclerosis Society, then the Spastic Society and then the Yooralla society as the librarian in those institutions.

MR KNOWLES: Yes. And when did you retire from that work?

MS JOHNSON: In 1982.

MR KNOWLES: And after - - -

MS JOHNSON: I don't think I've got the year right.

MR KNOWLES: What's the year, Ms Johnson?

MS JOHNSON: It was – wait a moment – I forget what year. 1998.

MR KNOWLES: Right. And after you retired in 1998, what did you do then in terms of your extra - - -

MS JOHNSON: Then moved in 2002 to the north-east and moved up to – am I allowed to say Wodonga?

MR KNOWLES: Yes.

MS JOHNSON: And moved up to Wodonga.

MR KNOWLES: Yes

MS JOHNSON: And I had already started taking classes in Melbourne, so I continued with my current classes with the adult continuing education centre under the University of the Third Age and it had given me – I had success. And then I got passes at La Trobe University, as do all students at the University of the Third Age. And I enjoyed it so much that I enrolled at La Trobe University to do my second Bachelor of Arts degree.

MR KNOWLES: And that was in 2014, was it, Ms Johnson?

MS JOHNSON: That's right. Yes. That's correct.

MR KNOWLES: And can you tell the Royal Commission what you found rewarding about going back to study since 2014 in the Bachelor of Arts at La Trobe?

MS JOHNSON: Well, besides the intellectual stimulation, it was getting out among a younger, more diverse community and escaping from the restrictions of being in aged care.

MR KNOWLES: Yes. Well, can I come to your move into aged care. You've already acknowledged that that occurred some 10 years ago. It was in July of 2009; is that right?

MS JOHNSON: That's right, July the 7th 2009.

MR KNOWLES: And, prior to that date and that time, can you say how independent your living was in your own home.

MS JOHNSON: Yes, I owned my own home and bought my home in Wodonga and I lived on my own, coming and going, driving a car, going out enjoying whatever a normal life is, I led a normal life. It is no more a normal life in today's society. Then the University of the Third Age, I went to theatre, art galleries, museums, dining, anything that most people do that lead a full life.

MR KNOWLES: Yes. And what led to you then entering the aged care facility where you still are today?

MS JOHNSON: Well, unfortunately, I trod on something that rolled under my foot and ended up breaking my right ankle. And, unfortunately, the break was such that the bones would not repair and I could no longer weight-bear, so I had to use an electric wheelchair. Bit hard on your own in a wheelchair. So - - -

MR KNOWLES: Yes.

MS JOHNSON: - - - aged care, I mean, home care wasn't available as it is now. So it was aged care.

MR KNOWLES: So I take it from that, Ms Johnson, you say that the lack of availability of home care played some part in your decision to move into the aged care facility?

MS JOHNSON: That literally was the only reason I made that decision, because it's very difficult on your own. And - - -

MR KNOWLES: Yes.

MS JOHNSON: - - - by that stage my companion had died, so I had no one else to fall back on to.

MR KNOWLES: Yes. And, without naming the facility, can you describe what it was like in July 2009 when you moved there.

MS JOHNSON: The facility was owned by a small company, with home life. And it was definitely person-centred, with a team – the same team of care workers looking after you each day. And they were well aware of your routine and likes and dislikes and attended to you accordingly. Yes.

MR KNOWLES: So - - -

MS JOHNSON: And you got to know people and they got to know you, the residents, personally, and treated them accordingly.

MR KNOWLES: Yes. So you formed relationships with care staff. Is that what you're saying, Ms Johnson?

MS JOHNSON: Yes, that's right. Yes.

MR KNOWLES: Yes.

MS JOHNSON: You knew them personally and even knew a bit about their family life. And they were like other people you met in the community. You got to know them. Yes.

MR KNOWLES: Yes. And were you mostly able to maintain your active way of life that you'd had before?

EQUIPMENT MALFUNCTION

MR KNOWLES: Staff were rotated through the four wings of the facility?

MS JOHNSON: That's correct, yes.

MR KNOWLES: And what did you observe of staff morale and absenteeism as a result of those changes – or around the time of those changes, at least?

MS JOHNSON: It definitely – staff turnover went up – staff were constantly absent. It was a different staff all the time and when they were attending there, they would talk among themselves and there was no doubt about their discontent. They'd even discuss other employment opportunities and I would hear complaints about management and what was expected of them. It was very obvious to anyone with two ears that they were very unhappy with the job situation.

MR KNOWLES: And there were further changes that occurred, you say in your statement, in 2014 when the facility was taken over by a new owner. What happened at that time?

MS JOHNSON: Following further staff cuts and more rotation. Previously, when staff were expected to answer your call bell within three minutes – that was abandoned – and you could wait anything up to 24 minutes or longer for staff to attend to you. And not only were the care staff cut, but even the cleaning and laundry staff were cut, as well. And basic cleaning things didn't get done.

MR KNOWLES: And in your statement you've said that people were encouraged, in those circumstances, to go to bed by 9 pm each night.

MS JOHNSON: Yes. Because after 9 o'clock, there was only one staff per 40 residents. So while there were two staff on duty, they would go from room to room saying, "It's bedtime." And you had to be very strong willed to refuse to go to bed by 9 o'clock. But the majority of the residents would be in bed by 9 o'clock.

MR KNOWLES: And, by this time, what sort of opportunities were there for residents, including yourself, to form ongoing relationships with staff members?

MS JOHNSON: Well, it was very difficult when you see a different person every day and if you see up to 110 people over a 12-month period. Very hard to get to know them. You might see them today. It might be a month or longer before you see them again. And so new staff, particularly if they didn't wear their name, it took a long time to know what stranger was coming into your room instead.

MR KNOWLES: Did - - -

MS JOHNSON: It was - - -

MR KNOWLES: Sorry, Ms Johnson.

MS JOHNSON: It was very difficult to get to know anyone. Also, very difficult for them to get to know your routine and how it should be done for you and your care.

MR KNOWLES: Did you and other residents subsequently complain to management about staffing levels?

MS JOHNSON: There were complaints about staff, but we were told that the policy of the provider was to rotate their staff so that staff got to know everyone. And it's a bit hard to get to know 80 people when you only see them once a month.

MR KNOWLES: And were there complaints ever made about the numbers of staff by residents?

MS JOHNSON: Yes. Indeed.

MR KNOWLES: What resulted from those complaints?

MS JOHNSON: Well, there were complaints from some of the residents who were aware that the staff were harassed. And nearly two years ago, because of complaints, they did add one carer to the morning shift on a four-hour shift as a floater to help out.

MR KNOWLES: How were those - - -

MS JOHNSON: [Inaudible]

MR KNOWLES: Sorry, Ms Johnson.

MS JOHNSON: Pardon?

MR KNOWLES: They added one staff member. Was that adequate, in your mind?

MS JOHNSON: No, not at all. Because they still had absenteeism, so instead of the extra staff they often had one or two less staff, because staff were not turning up, and not always replaced.

MR KNOWLES: And how were those - - -

MS JOHNSON: Or if they were replaced, it would be an agency staff who had never been inside the facility before. They didn't know anything.

MR KNOWLES: Yes. And how were those complaints able to be registered by residents with management? What was the mechanism for making those complaints?

MS JOHNSON: Well, they've had several forms under different titles, but they had complaint and competence forms that residents and families could fill in with their complaints. And they had a separate form that staff could fill in. Complaints that were lodged were looked into by management or allegedly looked into.

MR KNOWLES: You said earlier that you don't think that was an adequate increase in the number of staff. In your statement, you've referred to how mornings can now still be – and these are your words – "harrowing for both staff and residents". And that's at paragraph 23 of your statement.

MS JOHNSON: Yes.

MR KNOWLES: Can you tell the Royal Commission why you say that that is the case, that the mornings can be harrowing for both staff and resident.

MS JOHNSON: Well, in the limited time that staff have, because they had to handover at 7 o'clock and handover can go 15 to 20 minutes. And then staff have got until 8.30 in the morning to get residents up ready for breakfast. And when you've got two staff trying to get 20 people up in that short time, when they have be got up, toileted, washed or showered and dressed and enter the dining room within that time period, and seeing they're not on the same wing each day, they haven't got a set routine, because the same staff don't work together on consecutive days. So there is no routine or coordinated working together.

And they're dashing from room to room with call bells going and loudspeakers announcing that they should be in the dining room and they complain – say that they've still got residents on the toilet or in the shower and they can't leave a resident under the shower, but they're still being harassed to finish attending to the residents. And, at the end of the day, the nurses are your servers and are serving trays.

MR KNOWLES: You have said in your statement that the staff are, from your observations, rushed and stressed in this environment. How has that affected the way in which staff care for residents at the facility in the mornings, from your observations and experience?

MS JOHNSON: Well, because they're rushed, they try to do things as quickly as possible, although not all residents can move quickly or respond quickly. They do things instead of allowing you to move at your own rate, they will grab or push you into a position and, in my case, keeping me in my wheelchair. They will push the lifter so that my ankle hits the steel foot plate of the wheelchair, which I can tell you is very painful. And, because of this rush, and doing things and the fact that they aren't watching what they're doing, there is a bit of manhandling. And this is a danger, it could lead to abuse of residents, physical abuse. And it may be not always intentional, but it does lead strongly to that possibility of residents being badly treated.

MR KNOWLES: And in this environment, do you consider that staff understand your individual abilities and needs, Ms Johnson?

MS JOHNSON: Those that get to know me understand that I'm capable, but, because they're changing all the time, it takes them a long time. And day after day I get staff that haven't learnt or don't understand that I'm perfectly capable. And often new staff are amazed when they're told to leave me to shower myself,

because they've been trained to believe that everyone needs everything done for them. It's very frustrating to have your independence taken from you.

MR KNOWLES: On that topic of your independence, you mentioned earlier that you go out of the facility and go to restaurants, go to university, have various other places that you need to go to. You say in your statement you visit libraries and museums and theatre, attend to banking and medical and other appointments. How often per week would you go out unaccompanied from the facility by yourself?

MS JOHNSON: Well, as often as possible, but usually three to four days a week.

MR KNOWLES: Yes. Now - - -

MS JOHNSON: As long as buses are running or taxis are running. Yes.

MR KNOWLES: Yes. And when you initially moved into the facility, you were classified as low care - - -

MS JOHNSON: Yes.

MR KNOWLES: for funding purposes; is that right?

MS JOHNSON: That's right.

MR KNOWLES: And that classification, you say in your statement, was changed in 2014 to high care, soon after the change of ownership of the facility.

MS JOHNSON: That's correct, yes.

MR KNOWLES: And were you told about the change in your care classification at the time of the change?

MS JOHNSON: No, I wasn't told by management. It was a comment by one of the carers that things had changed that led me to question whether it had been changed. And I was told, "Yes, it was". I was told, because they had to use a lifting machine to place me on the toilet to use my bowels, now it made me high care. The fact that they used a lifter to put me in the wheelchair, to put me on the bed at night, tended to be irrelevant.

MR KNOWLES: Right.

MS JOHNSON: The fact that I had to use my bowels was the point.

MR KNOWLES: So simply by reason of being lifted for a particular purpose, that was the reason that was given as to why, now, you were classified as high care.

MS JOHNSON: Yes.

MR KNOWLES: Okay.

MS JOHNSON: And so I questioned that and said that was ridiculous, that was the reason I was given.

MR KNOWLES: Yes. And did you find yourself being treated differently by care staff as a result of the change in your care classification?

MS JOHNSON: Well, initially they tried to have attendants shower me, which I had to resist very strongly before they believed I could continue showering myself. And the staff that had been there previously didn't treat me differently. It was the newer staff that had to be told - - -

MR KNOWLES: So, Ms Johnson, am I to understand you to say that, initially, in line with the higher care classification, there was an endeavour to try to have people attend on you while you were showering, despite your desire for that not to occur?

MS JOHNSON: Yes. They said that I should have staff shower me, instead of me doing it by myself. The practice then and now because I insist on it - - -

MR KNOWLES: Yes.

MS JOHNSON: - - - they place me on the chair under the shower, they leave me and I ring the call bell after I have showered and dressed myself.

MR KNOWLES: Yes.

MS JOHNSON: They then transfer me from the shower chair to the wheelchair. But I really had to make a song and dance to get that to continue.

MR KNOWLES: You've also referred in your statement to your attempts to get access to personal information in the form of your care plan from staff at the facility and that being unsuccessful, at least initially. Can you tell the Royal Commission about your requests for your care plan and what the response was that was given to you?

MS JOHNSON: Yes. I said to one of the carers or care worker, could I see my care plan, and they said the registered nurse is the only person who gets access to it. And when I asked one of the RNs 'could I see my plan', she told me that she would be in trouble if she showed it to me. She gave me no other explanation. Also, which I didn't put in my statement, a survey was sent out to residents asking them at different times about how happy they were with the service and one of the questions was 'were we happy with our care plan?' and several times in writing I said, "I have never seen my care plan and would like to see it". That written request was never, ever answered and so I never, ever saw my care plan.

MR KNOWLES: It's probably a question that has an obvious answer, Ms Johnson, but why did you want to see your care plan?

MS JOHNSON: Well, I'd like to know what was on it, everyone has the right to know what their treatment is and how it has been recorded so that you know what to expect and also to know whether you are getting the care that your care plan says you're getting and if the care plan is incorrect, then surely the provider is claiming funds from the government under false pretences.

MR KNOWLES: You've described in your statement about the circumstances in which you happened to see the care plan, where it was inadvertently left with you by your GP whom it had been given to for signing. When you read the care plan, what did you read about in terms of your medical conditions, in the care plan as set out?

MS JOHNSON: Well, the care plan said that I had cerebral palsy and depression, but I've never had depression. I've had seasonal affective disorder once only - - -

MR KNOWLES: When was that, Ms Johnson, that you had seasonal affective disorder?

MS JOHNSON: That was in 2015.

MR KNOWLES: That was some considerable time before you saw your care plan which, from your statement, you say was in November 2018?

MS JOHNSON: That's right, yes.

MR KNOWLES: You never had any psychological diagnosis at any other time?

MS JOHNSON: No, no, never had any problems at all.

MR KNOWLES: Did you raise this with your doctor at some later stage?

MS JOHNSON: Yes, the next day I asked about the depression and she said there's definitely no sign of depression at any time, and she has been seeing me for 12 years.

MR KNOWLES: Why do you think the depression diagnosis was somehow inserted into your care plan?

MS JOHNSON: I can only think that the seasonal affective disorder, which is one kind of temporary depression, whether they interpreted that for their own purposes as depression.

MR KNOWLES: You've said some other things in your statement about the information as to your cerebral palsy which you regarded as grossly inaccurate. I'm not going to go into that now with you, Ms Johnson, but the fact of you finding those matters in your care plan and regarding them as inaccurate, is that part of the reason

why you think it's also important for residents to have access to information about their care and how they're perceived by their carers?

MS JOHNSON: Yes, well, one reason, they need to know whether the plan is accurate to start with because depending on what's in the plan is the way they treat you and to be mistreated because of misinformation in the care plan or in any of their documents held by the facility. As residents, we haven't got the opportunity to correct that information and if we don't know the information, we don't know whether we are getting the care that we are entitled to.

MR KNOWLES: Yes. Now, you've also given evidence in your statement about a continuous improvement committee at the facility. You came to be a member of that, I think, in early 2011 after making what were regarded as some positive suggestions by management, you were invited by management to be a member on that committee; is that right?

MS JOHNSON: Yes, that was for the first provider, yes.

MR KNOWLES: Yes. To your knowledge, had there ever been a resident on the continuous improvement committee before you?

MS JOHNSON: Not before and not since.

MR KNOWLES: And who were the members on the committee at that time? What were they – without naming people, broadly speaking, were they management or staff?

MS JOHNSON: They were all management, the directors of the facility, as the title was then, the director, the management officer and the care manager, they were all management staff.

MR KNOWLES: Yes. And what was your response to the invitation to join the committee?

MS JOHNSON: Well, I said that if I was to represent residents, they needed to have a say in whether they wanted me to represent them so they did put a motion in at one of the residents' meetings and they called nominations; I was the only nomination and they were asked to vote yes or no, and the majority voted yes so I became their representative member in May 2011.

MR KNOWLES: After that first occasion when you were on the committee in May of 2011, how often did the meetings of the committee take place?

MS JOHNSON: They met every month, once a month - - -

MR KNOWLES: Were you involved – sorry, pardon me, Ms Johnson.

MS JOHNSON: Then it was changed to bi-monthly.

MR KNOWLES: Bi-monthly after. Yes. And what was your involvement in those meetings?

MS JOHNSON: At those meetings, they discussed all the complaints and competence forms they'd received and I could bring to their attention complaints from the other residents and also help the committee to decide what action should be taken from a resident's point of view to all those complaints. Those complaints then went to the appropriate section, then when they came back, the committee, including myself, decided on any further action that had to be taken.

MR KNOWLES: Yes. And how were you received, yourself, on the committee by the other members of the committee?

MS JOHNSON: Well, initially, until the changing of staff, I was received very well, my contribution was accepted and my suggestions and even they were very tolerant of me suggesting that maybe they were on the wrong track and from a resident's point of view, what was wrong with any decision they might have made and they would reconsider based on what I had said, yes.

MR KNOWLES: I take it that you saw this as an important function that you were fulfilling. Can you just explain, if that is so, why you felt that way to the Royal Commission?

MS JOHNSON: It meant that the residents had at least one voice in how the facility was run and how residents were treated. It at least gave the residents some voice in their lives about how their lives were treated.

MR KNOWLES: Did you see any changes that were made to the operations at the facility as a result of action on residents' complaints or suggestions? Are there some examples that you can give of that, Ms Johnson?

MS JOHNSON: Well, one example was we were having problems with a new chef and the food was inedible and the residents were very unhappy about the food supply and had made individual complaints. There were so many complaints that I organised to send out a form asking for residents to make their comments about the food and about 20 or so residents who were able, completed this form with their personal complaints and I presented this to the committee, they accepted them as a valid complaint and that particular chef was fired and another one hired and the food improved greatly after that.

MR KNOWLES: You were removed from, you say in your statement, the committee by the facility's care manager after serving two years on it. What reason was given to you by the care manager for your removal from the committee?

MS JOHNSON: First of all, he said that two years was long enough for anyone to serve on the committee. Also they had opened offices in town and he said the wheelchair will not be able to get into the office. There was no testing on whether I could or couldn't but on the ground that two years was long enough and the offices were not accessible, I should leave the committee.

MR KNOWLES: Was it proposed they might have had the meeting somewhere else, Ms Johnson? Sorry, I understand there are some building works at your end.

MS JOHNSON: I did suggest that the meetings could continue where we were having them because it was only once every two months and the manager could easily come to the facility surely once a month but, no, that was turned down.

MR KNOWLES: In terms of you being given the reason that two years was long enough for you, was somebody else from the resident cohort appointed to the committee to replace you?

MS JOHNSON: No, and there was no suggestion that they should, and I think the reason that they had – one possible reason is when the office moved to the city and the meetings held there, I was the only resident independent enough to travel to the office on my own so if they had been agreeable to have another resident, they would have had to arrange transport to and from the meetings. That was possible but I don't think they were interested in having a resident having their say.

MR KNOWLES: Yes. And on that, what does that lack of resident representation on the so-called continuous improvement committee say to you about the provider's commitment to continuous improvement, Ms Johnson?

MS JOHNSON: It means that they're not really interested in hearing what the residents have to say. That the provider thinks or believes that they're doing their best and that they know what residents do and don't need. And that all they have to do ask residents, "Are you happy?" And what are residents going to say? Definitely not, of course, "no". Residents will say, "Yes, we're happy". There's not really any definite say that residents have.

MR KNOWLES: On that, you've mentioned in your statement that there is monthly resident forum meetings that are conducted at the facility, do you think those meetings adequately provide for the making and consideration of residents' complaints and suggestions?

MS JOHNSON: No, not really. They're always much the same. One meeting is virtually identical to another. The residents really don't get much of a say, the executive director has most of the say and when the residents are asked to have their say, if you do something like, "Are you happy with the service?" "Yes, we are" or maybe "I don't like thick soup" says one resident but of the questions put to them, if they only need a yes or no answer, they don't really encourage residents to speak up and say what they really would like to. They're more or less just going around - - -

MR KNOWLES: Do you yourself continue to attend those resident forum meetings at present?

MS JOHNSON: Not regularly. I attend them roughly four times a year now, because they're so repetitious and, also, the times of days they're held on has been changed. And then the changed date is when I go to university or some other commitment, so, no, I'm not a regular attendee. I have gone as the only one that occasionally speaks up.

MR KNOWLES: Yes.

MS JOHNSON: I must admit, I'm not a very popular member.

MR KNOWLES: And what kind of representation for residents and their families would you like to see in aged care facilities generally yourself?

MS JOHNSON: It's a bit difficult with the residents ageing and more dependent now, to find residents capable or willing to stand up as a representative. But there should be something where even – well, both residents and their families representing them could have some means of either being on a management committee representing the residents or maybe some small committee of residents and families meeting regularly and nominating one person to represent them on management. There needs to be some form, no matter how difficult, for residents to have a say in their treatment and care.

MR KNOWLES: Yes. And you are obviously - - -

MS JOHNSON: But I - - -

MR KNOWLES: Sorry. Pardon me, Ms Johnson.

MS JOHNSON: Yes. Those that are now receiving home care have a say in how they're treated, so why shouldn't residents have the same say in how they're treated and who does their care? Not someone different every day.

MR KNOWLES: Now, can I just lastly ask you about your experience in around 2015 of trying to make a complaint to what was then the Aged Care Complaints Commission. Can you tell the Royal Commission what happened at that time when you spoke to a representative of the Aged Care Complaints Commission?

MS JOHNSON: Yes. The representative had come to the facility to speak to residents about what the Commission did, their role, and I made the – sought out this representative and spoke to them about a complaint I had made to management about – it was about staff. And this representative told me that I should bring it up with management, that it wasn't anything to do with the Commission, even though I told them I'd already been down that route and tried to solve it.

MR KNOWLES: How did you feel about that response, Ms Johnson?

MS JOHNSON: Well, I wondered why they had the Commission if they weren't prepared to listen to complaints, to dismiss them as, you know, "Sort it out with management". If you can't sort it out with management, who do you turn to? Why have a Commission?

MS JOHNSON: Can I just finally ask you if there's anything further that you wish to say to the Royal Commission about the adequacy of resident representation in aged care, Ms Johnson.

MS JOHNSON: Well, I would say, "What representation?" There seems to be very little of it. And, like anyone in the community should have a right as to how you're treated. And residents, it would appear, once they pass through the front door of the facility, give up that right. And that's not correct. We still have that right to have our say and to live life according to the way we would like, within the confines of a facility. We can't have everything exactly the way we want it, but we want to be treated with respect and dignity and have the right to have our say in how we live and how we're treated. We are still human beings. We're not a species from outer space or something. We're still human beings. We have rights to live a decent, respectful life.

MR KNOWLES: Thank you, Ms Johnson. I have no further questions for Ms Johnson, Commissioners.

COMMISSIONER TRACEY: Ms Johnson, thank you very much for your evidence this afternoon over such a lengthy period. We're very grateful to you for sharing your experiences with us. And they will be taken into account when we come to write up our report. Thank you very much indeed.

MS JOHNSON: Thank you for listening.

<THE WITNESS WITHDREW [3.07 pm]

MR KNOWLES: Commissioners, might I suggest that there be a brief five minute adjournment after this witness to make some arrangements in terms of the next witnesses.

COMMISSIONER TRACEY: Yes. Certainly. The Commission will adjourn for five minutes.

MR KNOWLES: Thank you, Commissioners.

ADJOURNED [3.07 pm]

RESUMED **[3.14 pm]**

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Commissioners, I call the next witnesses, Natalie Siegel-Brown of the Queensland Public Guardian, and Geoffrey Rowe of Aged and Disability Advocacy Australia.

<GEOFFREY FRANCIS ROWE , AFFIRMED **[3.16 pm]**

<NATALIE SIEGEL-BROWN , AFFIRMED **[3.16 pm]**

<EXAMINATION BY MR HUTCHINS

MS HUTCHINS: Mr Rowe, you've prepared a statement for the Commission.

MR ROWE: I have.

MS HUTCHINS: And, for the record, it's WIT.0319.0001.0001, dated 29 July 2019. Have you had the opportunity to read over your statement before today?

MR ROWE: I have.

MS HUTCHINS: And are there any amendments you'd like to make?

MR ROWE: No amendments.

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

MR ROWE: They are.

MS HUTCHINS: Thank you. I tender that statement, Commissioner.

COMMISSIONER TRACEY: Yes. The witness statement of Geoffrey Francis Rowe, dated 29 July 2019 will be exhibit 8-37.

EXHIBIT #8-37 WITNESS STATEMENT OF GEOFFREY FRANCIS ROWE DATED 29/07/2019 (WIT.0319.0001.0001)

MS HUTCHINS: Thank you. And, Ms Siegel-Brown, you have also prepared a statement for the Commission today?

MS SIEGEL-BROWN: Yes, I have.

MS HUTCHINS: And, for the record, that's WIT.0318.0001.0001, dated 1 July 2019. Have you had the opportunity to read over that statement before today?

MS SIEGEL-BROWN: Yes, I have.

MS HUTCHINS: And are there any amendments you would like to make?

MS SIEGEL-BROWN: No amendments, thank you.

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

MS SIEGEL-BROWN: They are.

MS HUTCHINS: I tender that statement, also.

COMMISSIONER TRACEY: Just bear with me. This appears to be a public document, rather than a statement.

MS HUTCHINS: Yes. Well, that's correct, insofar that it's not in the usual form that the statements have been prepared in. You can see, Commissioner, if you turn to page 4 of the statement, that it's been signed there by Ms Siegel-Brown.

COMMISSIONER TRACEY: I see.

MS HUTCHINS: But you're quite right. It's not in the usual templates in which these statements are provided.

COMMISSIONER TRACEY: Very well. Well, what date does it bear?

MS HUTCHINS: It bears the date July 2019. And I understand it was received by the Commission on the 1st.

COMMISSIONER TRACEY: On the?

MS HUTCHINS: 1 July 2019.

COMMISSIONER TRACEY: 1 July. Very well. The witness statement of Natalie Siegel-Brown, dated 1 July 2019, will be exhibit 8-38.

EXHIBIT #8-38 WITNESS STATEMENT OF NATALIE SIEGEL-BROWN DATED 01/07/2019 (WIT.0318.0001.0001)

MS HUTCHINS: Thank you, Commissioners. Now, Ms Siegel-Brown, you are the Queensland Public Guardian?

MS SIEGEL-BROWN: That is correct.

MS HUTCHINS: Yes. And the Public Guardian is the Chief Executive Officer of the Office of Public Guardian, which is an independent statutory office. Is that correct?

MS SIEGEL-BROWN: That is correct.

MS HUTCHINS: Yes. And how long have you been in that role?

MS SIEGEL-BROWN: Just over three years.

MS HUTCHINS: And what is the purpose of the Office of the Public Guardian?

MS SIEGEL-BROWN: The purpose of the Office of the Public Guardian from a generic perspective is to advocate for the human rights of its clients. It's a very expansive role which covers overseeing the rights and interests of kids in child protection, youth detention, disability and mental health services, as well as providing guardianship of last resort for adults with impaired decision-making capacity, adult community visiting services to people in disability services, mental health services and supported accommodation. And we also investigate matters of abuse, neglect and exploitation for people with impaired decision making capacity, approximately 80 per cent of which is for older people.

MS HUTCHINS: And, as part of your role, that you have a community visitor program.

MS SIEGEL-BROWN: That is correct.

MS HUTCHINS: What does that program involve?

MS SIEGEL-BROWN: So I'll speak about the scope of that program with respect to adults, because I think it's most relevant here, although it is quite expansive with respect to children, as well. For adults, it's a paid, professional, legislatively-entrenched community visitor scheme where staff who are paid, not as public servants, but as employees of the Public Guardian, under the Public Guardian Act, operate as the independent eyes and ears to monitor and advocate for the rights and interests of the people in facilities that they visit. So that would be people in mental health services, private hostels and services where disability accommodation is being received

MS HUTCHINS: And what are the objectives of the scheme?

MS SIEGEL-BROWN: The objectives of the scheme are to monitor the rights and interests of people in those facilities, but also advocate for the resolution of issues to do with their accommodation and their human right. But it really works by providing a bridge to the major complaints disciplinary and other bodies. So, for example, in the disability space, my community visitors will go in and monitor whether restrictive practices are being used in an authorised manner. And, if they're not, a complaint will be made to the quality and safeguarding Commission. And, depending on what the Quality and Safeguarding Commission of the NDIS do with it, the provider may, in fact, lose their registration.

We will attempt to resolve issues through pathways of escalation. So there'll be instances where, for example, if it's a government-run facility and we're not seeing resolution of a resident's human rights, I will go in to bat directly with the Director-General or Secretary of Department or a Minister of a Department. It tends to be quite successful. So, to give you an example, and I believe this is contained in my statement, for the adults that we visit, in about 80 per cent of cases where we've identified human rights abuses, we've been able to resolve those matters and seek resolution.

A critical factor in our success has been the linkage between the community visitor program sitting in my office and the guardianship function, because if a guardian is communicated with by a community visitor, then they can take steps to change the accommodation and otherwise – and there'll be instances where we make referrals to the police, as well. The other key linkage we have is with bodies like Geoff's body, ADA Australia, where we think that our advocacy may not go far enough for a particular individual, and we will link that person with their own individual advocate through ADA.

MS HUTCHINS: Yes. And, in terms of the statutory powers and functions that you have to make your role more effective, what are some of the things you've got in your tool kit?

MS SIEGEL-BROWN: So a fundamental aspect of the legislation that surrounds the power of community visitors is that they have a right of entry to premises. They don't have a power of entry, so we can't force entry, although we do have the ability to go and seek a warrant for police. And, under my investigations powers, which is slightly separate again, I actually have the ability to go and execute a warrant myself, which I have done on one occasion. And my staff regularly go and execute warrants, as well.

So there's the right of entry, but there is also very strong powers around requiring information. So we have the ability to obtain incident reports about any incident that might have occurred on site. We have the right to obtain any and all information to do with people and the rights of those people living at the site we're visiting. And

there are, in fact, penalties associated with failure to provide my community visitors with the information we seek.

There are a number of other powers that extend to their ability to make announced and unannounced visits. And I have to say that, at the moment, we're sitting probably around 80 per cent unannounced visits in the adult community visitor space. There are probably different times where you'd invoke an announced or an unannounced visit, but we end up becoming the eyes and ears of the system that create that critical bridge to the disciplinary bodies or the bodies that can actually invoke a proper sanction. More often than not, we try the – you win more flies with honey than vinegar approach - - -

MS HUTCHINS: Yes.

MS SIEGEL-BROWN: - - - which is where we try to resolve the issues with the service provider itself. In some instances, that will result in, for example, a staff member being dismissed from the facility but it still indicates a more systemic issue, which we seek to resolve as well.

MS HUTCHINS: Yes. In terms of the fact that you're independent as an entity from – sorry, the independence from government, how do you think that that impacts on your ability to effectively perform your duties?

MS SIEGEL-BROWN: I think it's a really critical measure. What's fascinating is if you go back to the creation of the function, and look at the fact that community visitors, although paid effectively by government, are not regarded as public servants. They're considered to be employees of the Public Guardian on the basis that they visit many government facilities and can't advocate with real teeth against government-run facilities unless they have that really critical independence.

MS HUTCHINS: Thank you.

MS SIEGEL-BROWN: Can I just add to that for the purposes of today, and I understand some might find this controversial, but in the aged care sector, that's even more important because various sectors of the aged care providers have quite strong lobbying powers with government and it means that my community visitors are completely unencumbered by any lobbyists or otherwise. We are solely there to perform those legislative duties and we are not beholdened as servants of any minister.

MS HUTCHINS: Yes, thank you. Mr Rowe, turning to ADA Australia, what is your organisation and what does it do?

MR ROWE: ADA Australia is an independent advocacy service. It's a community-based, not-for-profit company that operates here in Queensland. We've been operating about 25 years. We employ about 35 staff across the state. We provide individual advocacy support, information and education to users of aged care

services, potential users of aged care services and their families. We also have a human rights service which is a group of lawyers that don't work as lawyers, they work as advocates and they specifically work with people with impaired decision-making, and representing them in matters associated with enduring powers of attorney, advance health directives and guardianship arrangements in their interactions with QCAT. We also operate a range of disability advocacy services as well.

MS HUTCHINS: Yes. And it's a member of OPAN; is that correct?

MR ROWE: Yes. We are the Queensland service delivery organisation of OPAN, the Older Persons Advocacy Network.

MS HUTCHINS: You are a participant in the national systems navigator trial?

MR ROWE: We have been funded as a site around Bundaberg and we are also part of a consortium in Brisbane south with the primary health network.

MS HUTCHINS: Yes. And how is it that ADA Australia is funded?

MR ROWE: Look, ADA Australia receives funding from a range of sources, primarily government – Commonwealth government for our aged care services, although, if we look at it, I suppose properly, up until two years ago, ADA Australia received funding directly from the Department of Health to provide National Aged Care Advocacy Program services. Two years ago, the department moved to a situation where they funded one organisation nationally to deliver those services so that they would end up with a nationally-consistent service. So OPAN now is the contractor with the Department of Health and effectively we subcontract to OPAN to deliver those services in Queensland. We receive our disability advocacy funding through the Commonwealth government and also through the State Government and we also receive funding through Legal Aid Queensland and we also generate some income ourselves through training project work, etcetera.

MS HUTCHINS: Yes. Do you perceive the level of funding that you currently receive is adequate to be able to service as many people as you would like to?

MR ROWE: Look, absolutely not. I think – when I talk to my colleagues, the other OPAN service delivery organisations, they look at ADA Australia and see that we probably receive the most funding of any of the state and territory SDOs and that's part of the history, but one of my real frustrations, and you'll see that in the witness statement, is despite best efforts, we are only supporting less than one per cent of aged care users. To me that's extraordinarily frustrating and what we're seeing is a real growth in demand for advocacy services. I think if I go back to 2012, we were dealing with about 220 advocacy cases a year. In 2018/19, that's increased to 660 and at the moment we're receiving about 100 new referrals a month for advocacy for services.

As I said before, part of our role is that absolutely the one-on-one work that we do with individuals and I'm talking about users but also potential users of aged care but another really important role is providing education services to users of aged care and that education is about their rights as aged care users. It's also about their responsibilities. And we also do some training of aged care staff around rights and responsibilities and, to some extent, the work that we do in education, where we can get into services, provides us with probably some of our strongest referrals. People don't know about us until we get out there and I've sat in this room the last couple of days and have heard some of the direct evidence where people weren't aware of advocacy services and that really troubles me.

MS HUTCHINS: Yes, and in terms of the increased amount of referrals being around 100 a month, are you able to keep up with the demand or is there now a wait list?

MR ROWE: We've had to instigate a wait list. We like to work with people face-to-face wherever we can. One of the things about ADA – I think one of our strengths is that we have staff based from right across Queensland, from Cairns in the north to Toowoomba in the west, and south to the Gold Coast. I think we've got eight regional offices and that allows, very much in line with the cohort that we are supporting, that opportunity to meet face-to-face and also to assist people when they go and raise a concern locally, you're able to physically go there with them. We're having to look more now at doing work on the telephone.

We're trialling Skype but, again, you'll find in my submission that I've raised concerns about the growth in the aged care population and particularly in the home care package area, which has been an area of significant demand in recent times and while we're seen a 30 per cent increase in numbers, there's been a zero increase in funding for advocacy services. So it's making it more and more difficult.

MS HUTCHINS: Do you have a sense in terms of that wait list, for people that do want to get the face-to-face service rather than needing to speak on the phone, how long the wait time might be for them at the moment?

MR ROWE: For us it's going up to six weeks, which is, you know, I mean, we do have a triage arrangement we prioritise but, yes, it's just growing.

MS HUTCHINS: Yes. And in terms of the overall mission, if you could call it that, of ADA Australia, how would you best describe that?

MR ROWE: Look, we've used the tag line in the past of, "Giving you a voice". Effectively that's what we do. We try and give a voice to the older person. The person who is fearful of speaking up. We try not to replace their voice. We are very much about assisting a person to understand their rights, understand that they are able to raise complaints, that there won't be retribution, or there shouldn't be retribution, and giving them the confidence and the skills to raise that and, ideally,

after that experience, feeling comfortable, that next time they're faced with a situation where they need to raise a complaint, that they're comfortable to do that.

MS HUTCHINS: What do you think are some of other features of an advocacy service?

MR ROWE: One of the things I didn't talk about in the very short introduction, one of the really important things for an advocacy service is to raise systems issues. Systems issues with providers, system issues with government. So if the system is broken, we need to be able to say, "We're seeing a whole lot of people for whom this is a problem, this is the issue, do you know that? Do you need to fix that?" Again, I'll talk a little bit about my frustrations but, up until two years ago, when, I suppose, OPAN was funded as a single entity, for me as a state-based jurisdiction service, it was virtually impossible – well, it was impossible – for me to get a meeting with the Commonwealth minister to raise concerns. It was very difficult to get a meeting with central office bureaucrats to raise concerns.

So since the inception of OPAN, I think it has been easier for us to raise some of those systems issues at the higher level, although we've continually done it through the various inquiries and investigations that have occurred, so that's part of it. Part of the important role of an effective advocacy service. It's also about having the tools to do the job and the tools are about having, you know, an adequate number of staff and we've touched on that and my frustration there. It's also about us having the tools so that when we go and try and support someone to raise their concern with a provider, that there is something that we can make reference to. So while the new charter of rights has been useful, we've lost some tools that we've had in the past, like the aged care manual, the consumer-directed care guidelines, they're no longer out there in the domain.

So when we go – unlike Natalie where she says, "I've got a legislative reason for being here", we've got to use our powers of persuasion to get in the door and that's becoming even more difficult. I think we're finding now that calls are being screened and I think – I fear that, with the Royal Commission being on, that where media or someone that's trying to talk to people and do an exposé. So it's – yes, look, it's very much about having the tools to do the job, being in those local areas where we can meet people but ideally, yes, I'd like some stronger tools for us to be able to – that there be an obligation that we are, or an expectation, that we will deliver education to consumers, that there be an expectation that education/advocacy contact is something that's considered as part of the quality accreditation process.

MS HUTCHINS: Yes, and you note in your statement also that you would advocate for the scope to be in a position to be making recommendations about what appropriate action might be in the circumstance and that there be some kind of obligation for a provider to respond to that particular recommendation?

MR ROWE: Absolutely. I mean, one of our frustrations is we can go through the process with the older person, we get what we think is resolution. We leave and then

we get contacted again by the older person to say, "Well, it actually hasn't translated into practice". Something that allows us to, yes, to see those commitments that are made translate into practice and into change.

MS HUTCHINS: Yes. Thank you. Ms Siegel-Brown, I'd like to explore with you what the difference is between the Public Guardian's role with respect to clients receiving disability services compared to those that are receiving aged care services. Are you able to provide an explanation of that to the Commission?

MS SIEGEL-BROWN: Absolutely. So the community visitor program has almost no scope when it comes to visiting aged care. I believe that that was established because it was considered to be a federal regime. And what becomes very interesting right now, in today's environment, is that we are now operating in a federal scheme when it comes to the NDIS. So I think we're at a beautiful point in our history where we could make some comparisons and say, well, if we've got state-based community visitors visiting effectively what is a federally-funded scheme, or federally-regulated scheme, there are some really strong analogies there. One of my greatest observations that I just want to proffer at this point is that it would appear to me that the aged care sector is where we were 20, 30 years ago with disability when we had, for example in Queensland, the Carter inquiry that gave rise to this need for regular eyes and ears monitoring the rights of people who very often may not have the cognitive capacity or the self-efficacy to advocate on their own behalf and when we talk about aged care, we can be talking about large cohorts of people who are non-verbal.

And the difference between what is happening in aged care and what is happening in the NDIS and disability world is that my community visitors become the bridge between what is happening on the ground and what is seen by the enforcement agency. And without those eyes and ears on the ground, there would not be the numbers of complaints investigated, there would be no attention on some of these people. People in aged care very often are even more isolated than people with disability, which perhaps beggars the need for community visitors at an even greater rate. But one of the most important aspects about the community visiting in the disability space is that they are there also monitoring the use of restrictive practices and whether they are going on in an authorised manner. We are one of the greatest reporters of the use of unauthorised restrictive practices both to the tribunal and, as I understand it, to the Quality and Safeguarding Commission and previously to the State when disability services were delivered by the State.

In the absence of a community visitor scheme, regulating restrictive practices, in my eyes, becomes almost meaningless, because you don't have anybody monitoring what's really happening. When you think about the fact that the average Joe on the street doesn't often make a complaint where it's warranted, and then you think about people in aged care being required to take that initiative themselves in an environment where they could risk retribution for making that complaint – and we heard just before a very powerful direct testimony about that – there is a higher need

for those eyes and ears on the ground to be elevating that and creating the bridge between the investigative and the disciplinary system.

So the difference between the aged care sector and the disability sector is that there are eyes, ears and, effectively, legislative teeth in a system. My role when it comes to aged care, I just should add, is really only in a guardianship space. So about a-third of people under my guardianship are over the age of 65. Many of them are either in aged care or eligible for aged care. And the purview I, therefore, have into aged care is really for the most vulnerable in the community. So my guardians get to see, perhaps, some of the highest risk and most poorly equipped aged care services by virtue of the fact that many of my clients are impecunious and that they have almost nobody left in their lives, or their own guardians have disagreed to the point that the tribunal has thought it appropriate to appoint me.

MS HUTCHINS: Thank you. And there is currently a Commonwealth aged care community visitors scheme. Is this a similar scheme to your Queensland community visitor program?

MS SIEGEL-BROWN: My understanding is it's a very different scheme and, interestingly, we've had very limited view into what it's doing and how efficient it is. I found it very interesting to read that the scheme had the second-highest number of community visitors here in Queensland, yet my guardians who are in the facilities had not heard from any of them.

Now, when you think about the fact that my community visitors in disability are regularly liaising with guardians about the problems that they're seeing in a facility for a particular client, so that decisions can be made that change outcomes for those people. It's quite confounding that we've had such limited view. My understanding – and I must say it's quite limited – is that it's much more of a companionship-type arrangement. It's not about being that bridge of complaints to a body that has real teeth to mete out an outcome.

I think the other thing to remember is – and this is the same for what we see in disability – many people whose rights are being breached are not even aware that their rights are being breached in these facilities. And people who are under significant chemical restraint don't even have the wherewithal to communicate. So my speculation would be that if this is a companion-based scheme and you have people in facilities who are non-verbal, I don't know what degree of training these volunteers have to actually communicate with people who are non-verbal, to understand what's going on in their world, because people who are non-verbal, in institutions – and this is, effectively, in an institutionalised environment – have even greater vulnerability by virtue of the situation they're in, whereas our community visitors, we place a high priority on being able to observe the environment and attempt to communicate with people who are non-verbal. So I'm intrigued to understand how that goes on.

Of course, the other major, major difference is that they are volunteers under the Commonwealth scheme, ours are paid professional employees who work under contracts which regulate how they operate, how they interact with clients. And I think that that is critical. If you're going to empower really strong legislative teeth, you must have it under some form of contract which regulates whether somebody can be held accountable for, effectively, abusing the powers they have.

MS HUTCHINS: Yes. Thank you. Mr Rowe, is the introduction of something similar to the Queensland community visitor programme something that ADA would support?

MR ROWE: Look - - -

MS HUTCHINS: Across Australia that would be.

MR ROWE: Yes. Yes. No. Look, absolutely. I think Natalie sort of spelt it nicely when she said it's more a companionship service. As an advocacy organisation, we have very little contact with the community visitor scheme in Queensland – sorry – the aged care community visitor scheme. We do hear statistics like 40 per cent of aged care users, particularly residential care users, have no contact with family. We've heard Minister Wyatt talk about going to facilities where everyone in the – no one in the facility has had a visitor in the last 12 months. So clearly there are a lot of very vulnerable people within our aged care system.

And I suppose, touching on some of my background, being disability, one of the things that shocked me when I moved into the aged care sector was the lack of a human rights basis. So I frequently talk about older people are being asked to check in their rights when they check into aged care. There's nothing in the legislation that talks about human rights. It's not part of the language, it's not part of the culture. You know, even moving to a customer basis, we don't have empowered customers. We have disempowered customers. And we have customers who are subject to chemical restraint, without even sort of agreement to such. So, look, I think the more safeguards that we can put in place, you know, I think that's really important.

MS HUTCHINS: Yes. Thank you. And, in terms of the types of complaints that you would receive through the advocates for your body, what are the types of common complaints that you receive from people in relation to aged care services in the home?

MR ROWE: Look, I might start with the ones that are across both, because we constantly get complaints about the My Aged Care system, about people's ability to access, about how it's unfriendly, if you're from a special needs group, there's no real understanding, how you can talk to two different people on two different days and get two different answers. We hear, also, about the complexity of the aged care system and that's given rise to the navigator service which is, I suppose, trying to address that.

Fees and charges and the complexity of fees and charges is something that we see in both areas, although when we bring that into the home care space, people are – or do expect to see financial statements. For those who do see them, they're complex, they can't understand them, they're not encouraged to understand them, they're not provided in a format that is user friendly. The concept of choice within the home, it's, "Do you want a green one or a red one?", not, "What is it you actually want?". When people try and broker services or have a say in how the services are delivered, that is not offered.

Certainly when the home care packages came in, we saw these enormously complex care agreements or, you know, I suppose, service agreements. and that's across both sectors when it comes to it. And I guess I've raised a number of times the need for – you know, we can go and rent a house or a unit and we have a very standard residential tenancies agreement, and we can compare different facilities with different facilities. When we go to aged care, we get very different looking documents where some of the details – and the things that we should know as informed customers we can't find. So, you know, I guess I'd be encouraging the commission to look at that as a way of making the aged care system more accessible, more user-friendly.

Other issues that we hear frequently are around care staff, about the use of agency staff, about the – we heard from that last witness about that constant turnover of staff, so that, you know, you're constantly retraining the staff about, "This is who I am and this is what I need". Look, the list really goes on, but - - -

MS HUTCHINS: Yes.

MR ROWE: - - - there's more detail in the statement.

MS HUTCHINS: Yes. Thank you. And you have both touched on this briefly already, the idea of the power imbalance that residents are faced – or elderly Australians in the community. Do you think that the voice of aged care recipients is represented in the aged care system well compared to the interests of other participants?

MR ROWE: Short answer no. I think the rhetoric is there, but the translation into practice hasn't really happened effectively. And that's at both the service level and at the system level.

MS HUTCHINS: And why do you think that is?

MR ROWE: Well, I suppose I don't see it translating into action. And if, I suppose, to veer off a little bit, when we looked at the development of the aged care standards, when I went to consultations and I looked at who was around the table, the minority group were the consumers. The majority group were the service providers and other interest groups. And, you know, putting it bluntly, I saw people who were wanting to use that instrument not as a tool for the aged care consumer, but as a tool

that the service provider could use to hold the aged care consumer for paying their fees. And that was completely the wrong intent of the document. And I think that's indicative of some of the issues that we're seeing in the aged care system.

And, look, to an extent, that's supported by the consumer group themselves. We often hear them called the grateful generation. They're a generation that's grown up through the war, through the Depression, they don't complain, they don't bite the hand that feeds them and they will accept. And they're reluctant to complain. Some of that's the culture, some of that's also fear of retribution, as we've heard. I'm optimistic that the generation is changing and the baby boomers are coming. No one has ever described them as grateful, and I think they will try and change the system. So, you know, there's an opportunity for service providers to be focused and think, "Well, if not for the people who are here today, I know the group tomorrow aren't going to tolerate that, so it's time that we moved and it's time that we included."

And, look, while I'm saying that, I also have to say there are some fabulous aged care providers out there. And, as an aged care advocacy organisation, we hear from people who aren't happy with their services. We know there are a lot of people who are. There are a lot of service providers that are very inclusive, that talk to the consumers, that listen to the consumer voice, but there is a significant number out there who aren't.

MS HUTCHINS: Yes. And what do you think are some barriers to care recipients having a meaningful voice within the system?

MR ROWE: Look, I think it's fear. It's also capacity. And that capacity – some of it – you know, we hear people talk about they've been worn down. They've tried to complain, they've tried to raise issues in the past and it's fallen on deaf ears. And we hear that from families, as well, that the families are seen as being difficult or they're excluded. So, you know, they're some of the really simple barriers, but I think, you know, the lack of the human rights framework, you know, within the aged care system, I think that's the door that's absolutely closed. And it doesn't open up for participation of the – or doesn't encourage the participation of older people.

MS HUTCHINS: Yes. And, Ms Siegel-Brown, do you think that the model is sufficiently focused on human rights of care recipients?

MS SIEGEL-BROWN: From my perspective, the aged care model is anything but focused on the human rights of the client. And, in fact, I would say the legislation to some degree entrenches that. If you had asked me a month ago, I would not have been even as strong as I am today, but the recent amendment to the Aged Care Act that resulted in the new principles, to some degree actually reflects an attitude of how absent the voice of the consumer is.

So, for example, under the new amendment, the use of physical restraint has to be consented to by either the consumer or the consumer's representative, who could be an enduring power of attorney that a solicitor who the person's only met once can

consent to the restraint. And there's nothing in that amendment that says whether the aged care provider has to go to the consumer first and then only if they don't have capacity, to go to somewhere else, to a representative, and a representative who has some form of close nexus with the consumer. So, yet again, taking that voice away. It's, effectively, the aged care provider's choice as to whom they go to to seek consent for restraint.

And then when it comes to chemical restraint, there's actually no requirement for consent at all, other than to advise a consumer representative that it's being used. And so what I fear will occur is that there will be a rise in the use of chemical restraint, which many people believe in the restrictive practices sector is one of the most restrictive of restrictive practices, because you're, effectively, imprisoned within your own body. And that can actually dampen somebody's ability to vocalise, as well.

The model itself, when we talk about the model of care – and just park the legislation for a minute but I do want to come back to that because the legislation obviously governs it – the model of care is ultimately a medicalised, institutionalised form of care that we saw in the disability sector 30 years ago, that both the discourse and the human rights sector and ultimately where we've moved to federally has said, actually, a health model and a medicalised model might have a place in a hospital but, at the end of the day, we're talking about a cohort of people in the community who have a right to inclusion, not just to being cordoned off in an institution. Effectively what we've got is a model of institutionalisation that says for an age bracket in life, you should be cordoned off in an institution, as opposed to having choice and control, views and wishes recognised, all these things that we now see enshrined in guardianship legislation, in disability legislation, in the NDIS rules.

So we've moved leaps and bounds ahead when it comes to not just disability and guardianship legislation but even child protection legislation because, let's be real, this is actually where we were with child protection decades ago but the aged care sector hasn't moved at the same rate. Now, you could postulate that that's because the other sectors came from a not-for-profit, somewhat paternalistic base and, at the end of the day, what drove those sectors was meant to be the welfare of the client. We're in a different environment with aged care where it's dominated by the private sector and one could argue potentially, therefore, profit as the motivator as opposed to client outcomes. As a result, legislation will be key.

Depending on what school of jurisprudence you come from, it's that old chain of events where the community conversation drives legislative change drives cultural change on the ground and hopefully you would see a different outcome through that. This Royal Commission has come about as a result of the community moving its conversation to a place where human rights must be front and centre. I would hope that, out of this community conversation at the highest levels of government, what we will see is a change in legislation that enshrines human rights and actually puts choice and control front and centre and who knows, maybe we'll end up with a model that's like NDIS for aged care.

MS HUTCHINS: Just returning to the observations you were making in relation to the deficiencies with the current position in relation to chemical and physical restraints. What are the types of measures that you would like to see implemented to overcome those issues?

MS SIEGEL-BROWN: If I may say, and I realise this is a bit bolshie, the legislation regulating restraint is – it's a wonderful move that government has made to attempt to regulate it but it looks like it's being done in a huge hurry. Out of the huge disability inquiries that we had here in Queensland, and that have occurred in other states, we formulated our own regulation of restrictive practices in the disability sector that is a very thorough, comprehensive system that has several layers of oversight, that does not allow the facility or the service provider itself to make the decision about the administration of restraint. So, for example, in the disability area, I'm actually – I undertake a senior practitioner role.

So if somebody wants to use particular restrictive practices for up to six months, they have to come to me for authority to do so in the disability sector and I have a huge number of legislative matters that I must take into account and my own decision-making framework. Once I give authorisation, and I do so using a very strong human rights framework, I then have community visitors who can monitor that. So – and sorry to preach Queensland, just so you know, I'm not actually a Queenslander, so when I say Queensland seems to be the best in this, I'm not actually biased. I come from Victoria, but Queensland's regulation of restrictive practices in the disability sector is thought of as world-leading. There's a beautiful framework around regulation of restraint that was done and completed using a huge number of experts that's ready to be transported but if it is going to be transported into legislation, it needs to be accompanied by the suite of mechanisms that oversee its enforcement, its monitoring and ultimately a penalty for misuse.

So, again, reflecting on the disability space, the fact we're now in a federally-regulated regime, if my community visitors detect that restrictive practices are being used outside of our very comprehensive legislation in a disability facility, that's then reported to the national quality and safeguarding commission who will then determine whether registration of that provider should be maintained. And I do think that regulation of restraint must be tied to permission for that provider to continue operating.

MS HUTCHINS: Thank you. Mr Rowe, in your statement, you express a view that oversight of chemical restraints should occur by a tribunal or an ombudsman; is that correct?

MR ROWE: Absolutely. It needs to be independent of the service provider and I guess if I can re-enforce Natalie's comments, I found myself working in the disability sector at the time when that restrictive practices legislation came in and so it really moved from being a first resort to a last resort option and then that last resort option, you had to have gone through so many hoops and get an approved plan by someone external before you could use it. What it meant for the organisation that I

was working for at the time was we identified initially about 750 clients who were subject to restrictive practices. When I left five years later, we had it down to 104 clients so it was about reviewing people's medication, it was about training staff, it was about changing practices, it was about better outcome for the consumers and a better quality of life and, you know, a better job for the workers because they were dealing with people who were able to interact with them again.

So, you know, I see the aged care sector as going the opposite direction to where disability has gone in recent years and that deeply troubles me. Independent of services, absolutely. I think – actually, I didn't outline it in here, we've made a submission to the Joint Parliamentary Inquiry on Human Rights which is looking at the principles and I guess what we've seen within aged care, one of the rights that people tend to give up in residential aged care is the right to have their own GP and you suddenly become, you know, one of the patients of the GP of the facility. I guess I've heard some horrendous stories about how many people are processed in a short period of time by the resident GP. It seems to be that it's no longer the person who's informing the GP about what their needs are, it's someone external to them who is informing the GP of what their needs are and the result is chemical restraint.

MS HUTCHINS: In your statement as well, you raise a concern with the use of enduring powers of attorneys and that, in some circumstances, you are hearing they are being used to erode people's rights, is that so?

MR ROWE: A very frequent story we hear is that a person will arrive at aged care, they're being asked to enact their enduring power of attorney, whether or not it needs to be but more frequently the story we hear is someone turns up and says, "I'm Mum's attorney, she's not to have any spending money, not to have any phone calls, not to go out and certainly not to have any visitors". The aged care provider says, "Yes, right, you're the attorney". That's not what an enduring power of attorney is. So there is a lack of understanding within the aged care system. It should be that, you know, someone is able to challenge and say, "That's not the role of the attorney to make those sort of decisions for the older person". And I think, you know, whether – I don't know that it's intentional but it is that lack of rights focus that we continually see where people's rights to have a normal life are eroded.

MS HUTCHINS: I'd like to ask you further questions, Mr Rowe, about the effectiveness of providers in dealing with complaints that they receive. What are some observations you can make about difficulties or frustrations that people are experiencing when they're dealing with providers?

MR ROWE: Look, I have to qualify it by saying we get a perverted view of the world because we hear from people whose complaints haven't been resolved. So we know there are a lot of providers that have a robust complaints system, that the complaints are listened to, they're processed. But we also know that there are a lot of providers out there whose complaints process is lacking. So people raise a complaint, it's dismissed. Complaints are raised sometimes with the direct care staff that someone has a relationship with, that doesn't seem to translate up through the

system. We hear more and more that with the constant turnover of staff, people are unsure about who to – or don't have a relationship where they feel comfortable about raising concerns or they see others who have raised concerns that have gone nowhere and so are reluctant to raise concerns. So it's not a welcoming culture.

Again, one of the things that struck me when I started working in the aged care sector was the focus of quality was on compliance, it wasn't about quality improvement. We heard lots of stories from people about – and I know things are changing with the unannounced visits but when the audits were on, it's on a certain date, there were different meals, there was different cutlery, there was tablecloths, there was – the difficult people went out for a bus trip for the day. That's now harder to do. But I think the focus is still on compliance. It's not on about what's the best service that we can deliver, what is it that our clients really want. It's that paternalistic approach is still very much alive and well in some aspects of the aged care sector.

MS HUTCHINS: When your clients are not receiving the outcomes they're looking for from the provider, do you then work with them in making a complaint to the Aged Care Quality and Safety Commission?

MR ROWE: I suppose there are a number of steps with the complaints process. One is to raise it directly with the agency themselves and, as I said, some people get an outcome and are happy and we never see them. Some try and raise it and get knocked back and then will engage with us. If it's a serious matter, or a police matter, we will refer it to the police or directly to quality and complaints system. But generally, the advocates will go out and meet with the person and try and raise it through the service provider themselves. And as I said earlier, we can only encourage; we don't have any tools to make people do things. To the credit of some of the providers, yes, they do and things change for people. Where it doesn't change, we will then support people to go to the Aged Care Quality and Safety Commission to raise the concern there but, again, our experience and, again, qualified that it's slightly perverted, we see more often than not, is that the person's complaint hasn't adequately been dealt with, the voice of the service provider has been listened to, the case has been closed and it's all over and the person says, "I'm not going back there again".

MS HUTCHINS: What are the reasons why people are left feeling that way?

MR ROWE: Look, I think often it's about – well, the Aged Care Complaints Commission, for a range of reasons, doesn't meet with people face-to-face. Most of their work is done by telephone. So already older people are feeling disconnected and disempowered. They will take a statement from the older person, then go and get a statement from the service provider. If the service provider says, "No, that's not true" – I'm being a little bit flippant in the way I'm putting that – more often than not we see the older person gets a letter that says, "We've been in contact with the service provider, it's not true. Thank you very much, come back to us if you're not happy", which of course they don't do.

Or alternatively, I guess you get, "Yes, the service provider said they're not doing that, they will change their ways". Again, case closed because the service provider has given a commitment but there is no follow-up in the process by the Complaints Commission to go back and say, "Have they actually implemented that commitment that they said that they would do". Again, more often than not, the feedback that we get is that it's been little more than lip service. There is a huge frustration with the cohort that we support around the complaints system. They don't feel it works for them.

MS HUTCHINS: You note in your statement that you would like to see a more collaborative approach adopted between the Commission and your advocates?

MR ROWE: That's certainly true. I'm aware that I'm doing what I hate people do and that's painting the aged care system as mad and bad because there are some really good people in that system and there is at the local level, some collaboration, but at the systemic level, they don't connect as well as they should. I think we're talking about a multi-layer system to support people to have their complaints resolved and I don't think that that really is working as well as it should. I mean, ADA Australia, and certainly the OPAN services have people on the ground who can do that face-to-face. The Complaints Commission by and large doesn't have people on the ground. So, you know, we can work more together on that stuff but also in terms of the validating people's concerns and even the follow-up. I think there's a conversation to be had.

MS HUTCHINS: Because as a matter of practicality, what type of engagement or involvement would your advocates have with staff or officers that have been responsible for looking after one of your client's complaints at the Aged Care Quality and Safety Commission?

MR ROWE: Look, sometimes we will be consulted but, again, if you stick to the role of an advocate, it is to give the older person a voice. So it's not to – it's not to be a member of the complaints system. It's to make sure that the voice of the older person is taken into consideration within that process. We certainly from time to time get requests, particularly where someone has a communication issue or a mental health issue, to go and meet one-on-one with the person to support them through that process. But, again, it's not optimal.

MS HUTCHINS: Thank you. Ms Siegel-Brown, we've touched on a number of issues with the system as you see it and a number of areas for reform. Of the matters we've discussed already, or any further matters, what would you like to tell the commission are matters of real concern for you that you would really like to see change effected in?

MS SIEGEL-BROWN: So I'll probably travel in terms of most immediate to perhaps the longer burn. I think, right now, guardians across the country would agree – and I know because they've signed a letter that's gone to the Federal Parliamentary Inquiry on the aged care amendment, the new principles, they are

actually creating a huge amount of trouble. I'd like to see those principles repealed and, instead, a proper, thorough, comprehensive suite of regulation around restrictive practices. And you heard from Geoff, who worked directly in the disability sector, what a difference that's made in disability.

That must be annexed with strong, robust, legislated oversight, such as community visitors. So Geoff just spoke about the Complaints Commission and the fact that, even once a complaint's been raised, there's no way of really knowing whether what the Complaints Commission has asked the facility to rectify has ever actually been rectified. Community visitors can give you that. You need eyes and ears for a system where people are already isolated and very often have nobody else to whom to raise a complaint or even to know their rights have been jeopardised in the first place.

Proper restrictive practices regulation allow the Disability Services Act and Guardianship Administration Act in Queensland. Immediately required. Community visitor program, that is, paid professionals with legislative teeth, desperately required. A body, whether it be the Aged Care Complaints Commission or another body which has the ability to resolve issues in a way that creates some deterrent for the aged care provider, is desperately required.

Going forward, I really think the bigger picture reform here is about how we put the person at the centre of service delivery here. I know it's a well-worn old phrase about person-centred care. It's something that I hear people trot off their tongues very haphazardly, but, as Geoff rightly pointed out, people park their human rights at the door when you have the model that we currently have. I would love to see the sector changed. At the moment it's not enough of a penalty for a guardian to say or a person to say, "I'm leaving this facility", because we don't have enough market bandwidth in some places to even choose a different provider and you could be stuck with no one.

And certainly for my guardianship clients, some of whom have had criminal backgrounds, there are very few aged care facilities that will take somebody who's been convicted of sex offences in prison. And so I'm stuck with one or two providers in Queensland who I would say to you that I would not place my dog there. And, thankfully, they are really bringing up that level of service delivery. But, ultimately, we need to move to a model that is not a medicalised, institutionalised section, this generation of the community away from the rest of the community type model. It must be more of that social model that we see in all those other sectors that are now 10, 20, 30 years ahead of where we are with aged care.

MS HUTCHINS: Thank you. Mr Rowe, do you agree with those observations? Would you like something further or different?

MR ROWE: No. Look, it's a hard act to follow, really. But, look, absolutely concur. I guess, putting an advocacy hat on, again, my frustration is that – and I've seen it, you know, with a number of the direct witnesses – that people aren't aware of

advocacy services, the fact that they're there, they're available and they're able to help. So I'd like to see the profile of advocacy and the funding for advocacy services improve, so that we can more adequately support people through that process. And, again, in the longer term, moving away from this, you know, health, paternalistic model of service delivery to a human rights-based service would make me a very happy man.

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

COMMISSIONER TRACEY: Thank you both very much for telling us what it is really like on the ground in Queensland. We've been wrestling with the idea that advocacy services are desperately needed around the country. And it's nice to know that, in some small pockets, it is being provided, but it's nowhere near good enough. And one of the things that we're going to have to deal with when we come to make our final recommendations is the establishment or the utilisation of existing systems, or both, of arrangements under which those who need them have access to advocates who can act on their behalf. And we're very grateful to you both for telling us what's happening and what's needed. Thank you.

MS SIEGEL-BROWN: Thank you.

<THE WITNESSES WITHDREW [4.16 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 9.30 tomorrow morning.

MATTER ADJOURNED at 4.16 pm UNTIL FRIDAY, 9 AUGUST 2019

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