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TRANSCRIPT OF PROCEEDINGS

O/N H-1013576

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

SYDNEY

9.37 AM, WEDNESDAY, 8 MAY 2019

Continued from 7.5.19

DAY 17

MR P. GRAY QC, Counsel Assisting, appears with MR P. BOLSTER and MS B. HUTCHINS

MS M. ENGLAND appears for Mr Farmilo, Ms Lee and Ms Tinley

MR C. JACKSON appears for Dr Ginger

MR D. WILLIAMS SC appears for Ms Anderson

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

MR BOLSTER: Commissioners, I appear as counsel in the Brian King Gardens case study. I appear with Ms Hutchins. I understand there are some fresh appearances.

MS M. ENGLAND: May it please the Commission, my name is England. I appear for Anglican Community Services, also for Mr Richard Farmilo and Ms Cheryl Lee pursuant to leave granted on 30 April and I seek the Commission's leave to also appear for Ms Amy Tinley, T-i-n-l-e-y

COMMISSIONER TRACEY: Yes, you have that leave, Ms England.

MS ENGLAND: Thank you.

MR C. JACKSON: Commissioners, my name is Jackson. I appear for Dr Ginger. I understand leave has been granted for someone to appear for Dr Ginger.

COMMISSIONER TRACEY: Well, I'm not sure that's right but you seek leave to appear for her?

MR JACKSON: Yes.

COMMISSIONER TRACEY: Yes. Any objection, Mr Bolster?

MR BOLSTER: No, entirely appropriate, Commissioner.

COMMISSIONER TRACEY: Very well. Well, you have that leave.

MR JACKSON: Thank you, Commissioner.

MR BOLSTER: Commissioners, if the tender bundle index could be brought up on the screen, please. Commissioners, I tender the Brian King Gardens case study tender bundle.

COMMISSIONER TRACEY: Yes. That tender bundle will be exhibit 3-19.

EXHIBIT #3-19 BRIAN KING GARDENS CASE STUDY TENDER BUNDLE

MR BOLSTER: Commissioners, the second case study for the Sydney hearings concerns the Anglicare facility known as Brian King Gardens which is located at Castle Hill in north-west Sydney. The focus of the study will be on the quality and safety of the care provided to an 85-year-old woman who is to be referred to as Mrs CO. Mrs CO was born in July 1934 in England. She and her English husband

travelled to Australia in December 1959. They had four children, one boy and three girls. Their son died in infancy at 15 months and that will become relevant as the case study develops. He was, however, followed by three girls, two of whom will give evidence shortly. They are the representatives of Mrs CO for the purpose of care decisions.

She has six grandchildren and she is a person living with dementia. She is, and has been since 2013, a resident of Brian King Gardens. She originally came into that facility as a respite care resident but she was made a permanent resident on 22 February 2013. If tab 71 could be brought up, and the first substantive portion focused upon; this was the note of her needs on admission as a respite resident. Mrs CO - and I should say, Commissioners, when we deal with these patient notes they have all been redacted insofar as the names of relevant people are concerned but otherwise errors in spelling and grammar having been included so as to keep their authenticity:

> *Mrs CO is a pleasant 78-year-old lady with a history of anxiety, which will become relevant later, asthma, a number of other diseases. She will require supervision during all meals and reminders for meal times. She's on a full diet -*

But she had certain matters that she was allergic to. She was not incontinent. But relevantly:

> *She has an upper partial denture and her own teeth, will require supervision with oral hygiene. She suffers from arthritis in her back but does not take analgesia for management and states it is well-controlled. Pain rating –*

which will become relevant later –

> *one out of 10.*

There are a number of aspects of the care provided to Mrs CO that will be the subject of evidence in this case study. The first concerns the prescription and administration of the antidepressant psychotropic drug mirtazapine on 4 July last year, following a diagnosis of depression by Dr Ginger. Could we please bring up tab 71 and go to page 1530 of it. These are the same eye care notes – that's the way they will be referred to during the case study. They effectively are the clinical notes associated with Mrs CO for the duration of her residence. They comprise approximately 190 pages. I'm going to focus here on the narrative that led up to the prescription of the mirtazapine on 4 July. And can I begin with a note that's made on 18 June at the top of that page:

> *Resident was wandering to the ground floor and staying near the front door. Staff assist to bring resident back to level 1.*

Just skipping a bit:

LMO to consider PRN medications. Note in diary. Resident settled and asleep. Nil pain observed. Liaised with LMO and commence sleep chart as required.

So that was on 18 June. A week later on 24 June, and there is a box at the foot of the page, staff reported that they couldn't find CO at around 12.15. It then outlines in some detail quite considerable steps that were taken to find her and that, moving over to the next page, there's a note at 4.20 pm which records that at 1530 she was brought back to the facility by family in a wheelchair, conscious and responsive. Now, that incidence of wandering was not the first – wasn't the first time she left the facility. In fact, the records, and I don't need to go through this in any detail, it's fairly well established that Mrs CO was a wanderer; she moved around Brian King Gardens at all hours of the day and night. Now, if we go forward to page 1532, there is a note there of a consultation with Dr Ginger on 27 June, that's a few days afterwards:

Apparently wander from facility and was missing for three hours. Observation was to the effect that she was well and walking around and in no distress. Question mark, do we need to transfer her to DSU -

Which means a secured unit:

...for her own safety.

Later that day, one of the care staff made a fairly typical note of what Mrs CO's experience was at Brian King Gardens throughout her time at this time:

She was wandering around the cluster after dinner. She stated to staff that she wants to go home. Staff reassured her and directed to room but she kept coming out of room immediately and started to wander around again. Staff were monitoring her closely. She's sitting in the lounge area at the time of reporting.

The next line is an entry by Ms Tinley, the care manager:

Have booked a family conference with the daughter on Tuesday, 3 July, to discuss a move to Everglades.

Now, Everglades is the secure unit and that is where Mrs CO is today. The critical events that led up to the prescription occurred on 4 July at the foot of that same page, the last two lines, you will see there that a:

Pastoral carer -

The chaplain -

...passed on concerns regarding Mrs CO's emotional wellbeing to the care manager.

And she was then – a decision was made by Dr Ginger – you will see there right at the foot of the page – to transfer her to the DSU for her own safety, but going over the page is the critical thing. This is, again, Dr Ginger's note:

> *The pastoral care worker has discussed with the care manager that Mrs CO is emotional, upset, also upset about losing her baby son. Would suggest we commence Avanza 45 milligram nocte –*

Which means night –

> *...to assist with depression and anxiety. Medication chart reviewed.*

A nurse then makes a note, that's Ms Thomas, confirming that Dr Ginger had reviewed Mrs CO, that there had been medication changes, that the medication chart had been emailed to the pharmacy. Ms Tinley, at 3.10 pm, says that she made a note that she tried to call daughter DL to discuss medication changes made by Dr Ginger. Critically here, Dr Ginger did not speak to either of the daughters about the change in medication. It was left to the facility staff. She said she left a voice message and will try and call back tomorrow.

The next note is not until 9 July, but a lot happened in between. Commencing on 5 July there was a charting for the 45 milligram of mirtazapine which was – which the patient records show was missed. The first dose was delivered in the evening on 6 July. There followed doses on 7, 8, 9, 10 and, it would appear, 11. I will come back to the medication shortly. On the 9th, Ms Tinley made a further note that she again had tried to call the daughter, DL, left another message about a move to Everglades and new medications. The evidence is that DL called back at 4 o'clock. There was a six minute conversation according to the phone records and she was told certain things. We will hear from DL and her sister shortly and I will leave what they were told till then. But effectively they provided some form of consent to the prescription of that particular drug.

In case I did not say it Avanza is mirtazapine and I will be saying something in detail about the circumstances and the desirability of a dose of Avanza of 45 milligrams to an 80-odd year old woman suffering from dementia in those circumstances. That is a very live issue in the proceedings. Things did not get better with the prescription of the drug. The notes for 10 July, which the Commissioners will see as we move down the page, show that at 2 pm on the 10th:

> *She was feeling uncomfortable, trying to sleep. After breakfast staff escorted her back to her room and made her comfortable in bed. Later she came out and attended piano with other residents. Staff offered her tea and biscuits.*

On the 11th things got worse. She was visited by her daughter on her birthday. She could not be woken at 12.17 pm. Her daughter left flowers in the room and asked staff to let her know that she came to take her to the cafe for her birthday. At 2 pm some concern is being shown for Mrs CO. Staff reported that she was very drowsy

after breakfast but responded to verbal commands and instructions, had breakfast in the dining room, refused her lunch, not opening her eyes on verbal command. The nurse went to check. She was not responding to verbal command but responding to pain. Some observations were carried out. Dr Ginger was notified. The daughter was notified and wanted her mother to be transferred to the hospital if Dr Ginger thought it was needed.

At 2 o'clock, staff reported that she was awake and had a few bites of a muffin and then went back to bed. Dr Ginger reviewed her and the nurse notes that Dr Ginger had spoken to the other daughter and explained that she does not need to go to hospital at this stage and that Dr Ginger would review the medication. Dr Ginger's note is troubling; it follows at 2.22 pm, she notes that Mrs CO has had a period of being unresponsive, now is responsive, her pupils reacting and equally – and equal. Her toes were going down. She questioned a transient ischaemic attack, TIA, which means a mini stroke. Dr Ginger says she:

> *Discussed the matter with the daughter and explained that we will keep her in the facility.*

Effectively, Dr Ginger has told her she doesn't need to go to hospital. There will be some evidence about what was in that conversation from the daughters:

> *Would suggest we reduce the Avanza dose as she has apparently been increasingly drowsy over the week.*

Until very recently – I should add there that from the 12th Ms CO was charted 30 milligrams of mirtazapine on a daily basis and was given it until very recently, and I mean in the last fortnight when some of these issues became public. The issue in this aspect of the case study includes obviously the circumstances leading up to the diagnosis of depression. They are the only clinical notes that we have been able to obtain concerning such a significant diagnosis. We will consider the suitability of mirtazapine as an appropriate response to her condition at the time, given the content of the progress notes. We will obviously be dealing with the literature, the guidelines and the relevant publications about the way in which mirtazapine can affect older people and its merits as a drug to deal with people suffering from dementia, and the size of the dose in this case.

We will be considering whether and to what extent consent was given by the person responsible under the New South Wales Guardianship Act which applied to this treatment, which would appear to be major treatment for the purposes of that legislation. We don't understand that there will be any issue that Mrs CO was unable to give that consent herself, and I expect that the evidence will demonstrate that no consent or certainly no informed consent was given, and that there was no proper basis for the treatment without that consent.

The second issue of Mrs CO's care that is under investigation concerns further treatment provided to her commencing in late October 2017, that is, shortly before

this, in respect of pain that she was alleged to be suffering at that time. The evidence will show that in an ACFI form lodged with the Department of Health in November 2017 - if we could please bring up tab 43 at page 27, please - you will see there the assessment of Mrs CO's complex health care needs. If you could note, please, Commissioners, the box at the foot of the page that has a 6 on the left-hand side; that box has been ticked. It's called a 4B box and that will become apparent in the correspondence as we go through the case. A 4B claim for someone in respect of their complex health care asserts that complex pain management and practice is necessary to be undertaken by an allied health professional, that it will involve therapeutic massage and/or pain management involving technical equipment, specifically designed for pain management, and ongoing treatment as required by the resident of at least four days a week, and involving at least 80 minutes of staff time in total.

The evidence will, I anticipate, show that that claim for pain relief took Mrs CO from a medium level complex health care need to a high complex health care need, and that that meant that further funding would be obtained from the Department of Health under the ACFI funding instrument. The pain charts for Mrs CO's treatment, which I won't go to at this stage, they began in October 2017 and continued through until June 2018 when the treatment ceased. The treatment began about two weeks before an ACFI assessment was carried out and lodged by Brian King Gardens. When the pain treatment ended, the physio made a note, and we won't go to this at this stage, but it was to the effect that she was happy to cease the treatment. The note was to the effect that she would be monitored and treated as pain levels arise.

Prior to that, the treatment largely involved semiregular application of a heat pack for 20 minutes at a time and some massage. The eye care notes of Mrs CO prior to October do not record any relevant complaint of pain on her part in the lead-up to the commencement of that program. Her daughters will give evidence that at no stage in October or November 2017 or subsequently, and I understand this until around the time they were interviewed by Commission staff and their statements were undertaken, they weren't informed that their mother had a pain problem that required that sort of treatment, that major pain treatment.

The third issue concerns the oral and dental care provided to Mrs CO, and on the face of the clinical documents a fairly clear failure of Brian King Gardens to provide her with appropriate dental and oral care for a four month period in the second half of 2016. At that time, the quality of care principle made under the Aged Care Act provided that the care recipient's oral and dental health was to be maintained. The evidence will suggest that it was not. If the operator could bring up document 9 in the tender bundle, please, this was an assessment carried but Ms Gartier who was the clinical leader in 2015. Right in the middle of the page there is a reference to "natural teeth" and it says:

> *Resident has no tooth decay or broken teeth or roots.*

If we could then go to tab 13, this shows a plan the following June, effectively the management or the care plan for oral health and for most other health domains was reviewed on a yearly basis. So on 28 June this was a note from the dentist who was engaged to provide oral health to Mrs CO, and he made a note that staff were to assist Mrs CO to remove her upper partial denture every night. Instructions were given for the cleaning of that. If we could just go back to the previous page – thank you – yes – ensure that clean teeth each night, etcetera, and it's fairly clear that there was a dental plan in place.

Now, the evidence of the daughters will be that up until this time, up until the end of June 2016 their mother's teeth had been managed quite well and they had no complaints about the way in which this care was delivered. And that's evident in the assessment the previous year about decay. But something happened between this visit and a visit on 1 November. If we could go over to the next page, this is a note from the dentist on 1 November where he says this, following the routine examination:

> *Patient's dentures must be removed at night, teeth cleaned and denture upper should not be returned to the mouth. On presentation today I believe patient's dentures have been left in the mouth for weeks, if not more. The result is significant decay in four months. Needless to say, the family is very unhappy. All the protocols were given for staff guidance and this has not been followed again.*

The residential manager, Mr Farmilo, who will be giving evidence, did, to his credit, carry out an investigation and provided the family with an apology. If we could go, please, to tab 20. You will see when we go to tab 20, the terms of his apology indicated that staff were not aware of the directives, staff did not follow instructions, and then he made a claim that:

> *Mrs CO became agitated, resistive and prevented staff from removing her dentures when they attempted to do so. It appears that is this information was very rarely passed on to the RN so they could contact you when this occurred.*

There is not one single reference to Mrs CO being resistive of her dental care in the period in which the decline took place. The daughters will give evidence that their mother, throughout her life, had been a very strong advocate of looking after her own teeth and their own teeth, and it was important to her. They reject the assertion that seeks to shift the blame to Mrs CO. If you could go to tab 21, please, this is the next assessment after 1 November by the Brian King Gardens staff and for natural teeth, the observation was made that:

> *The resident has one to three decayed or broken teeth, roots or teeth are very worn down. There have been changes. At least three extractions were involved, new denture plates were prepared. It was a very difficult situation. It has led to other issues.*

In January of this year, the facility sought the consent of the daughters to place Mrs CO on a soft food diet. The reason given was that Mrs CO was not swallowing her food, and she was simply spitting it out. The daughters were concerned that this was a result of the situation with her teeth. They arranged for the dentist at a routine visit on 14 January to look at her teeth in this regard. If you go to tab – to index 113 and to page 4 of that, you will see that in – on 14 January this year the dentist made these notes:

> *Daughter said that Mrs CO had started spitting out her food. The nursing home has since put her on soft foods. This has stopped happening but she would like us to check there is no dental cause. Observed was mild to moderate inflammation of the upper palate under the denture. Advised this may be contributing to the spitting of food as this inflammation can make soft tissue quite sensitive.*

The dentist again had to stress the importance of removing the dentures at night and tooth brushing to remove soft plaque. A letter was written for the registered nurse as a reminder of the dental care instructions. The issues here concern whether the condition of Mrs CO was the result of ongoing poor quality care of her teeth. It certainly looks that way. The other issues are the risk of choking or dysphagia. Certainly, if someone is not swallowing their food easily, that risk can arise. We will hear from a speech pathologist who Brian King Gardens asked to assess Mrs CO and we will explore that issue with her. Mrs CO has always had a good appetite and the daughters say would want to be on a full diet. There is a dignity of risk issue here and the Commissioners will hear about what's at play on that issue.

The final issue that will be dealt with, and it's a very short issue but it's an important issue, it concerns the podiatry or the foot health of Mrs CO. If we could bring up item 6 in the tender bundle, please – I'm sorry, 26. If you go to the email complaint first, please, so this was a complaint on 6 March by Ms DM about Mrs CO's toenails not having been seen to for quite some time. She said that when her sister investigated, she saw that the toenails were overgrown and digging in. She attached a photo of the situation. If you could then scroll down to the photo in question, which indicates the position. Mr Farmilo said he would look into the matter, and to his credit he did, and he responded and you will see the response at tab 31.

In short, there was a breakdown in communication. Mrs CO was not taken to an appointment that had been made. The process would seem to be that when you attend an appointment, a further appointment is made for you for the next occasion. Because she missed that appointment, no further appointment was made, and she skipped through the system. And therefore, no appointments were made for her. It was the responsibility of Brian King Gardens, it would appear, to arrange for those appointments and to ensure that Mrs CO had adequate podiatry care. A theme is developing in these case studies, particularly with the last two issues about communication and how critical they are to ensuring that care is delivered safely and properly.

That's all I wish to say by way of opening and I wish to call Ms DL and Mrs DM. Thank you, Commissioners.

COMMISSIONER TRACEY: Yes.

<DL, SWORN [10.13 am]

<DM, SWORN [10.13 am]

MR BOLSTER: So Commissioners, on the left we have Ms DM, and on the right we have Ms DL. That's correct.

DL: Yes, that's correct.

MR BOLSTER: Could these documents be brought up, please. In the case of Ms DM, it's WIT.0099.0001.0001. Now, Ms DM, that's your statement; correct?

DM: Correct.

MR BOLSTER: You've got a copy of that in front of you?

DM: I do.

MR BOLSTER: Is there any amendment that you wish to make to it; is there anything that needs correction?

DM: No.

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

DM: Yes.

MR BOLSTER: Thank you. I tender Ms DMs statement; that is document number WIT.0099.0001.0001. Thank you, Commissioners.

COMMISSIONER TRACEY: The statement of DM dated 17 April 2019 will be exhibit 3-20.

EXHIBIT #3-20 STATEMENT OF DM DATED 17/04/2019 (WIT.0099.0001.0001)

MR BOLSTER: And in the case of you, Ms DL, you can see your statement, if that could be brought up, you can see that on the screen; and you have a copy?

DL: Yes, I do.

MR BOLSTER: Are there any changes that you wish to make? And are the contents of that statement true and correct to the best of your knowledge and belief?

DL: Yes, they are.

MR BOLSTER: Commissioners, I tender that statement as well.

COMMISSIONER TRACEY: Yes, the - - -

MR BOLSTER: That's - - -

COMMISSIONER TRACEY: Sorry.

MR BOLSTER: Document number 0136.0001.0001.

COMMISSIONER TRACEY: Yes, the statement of DL dated 18 April 2019 will be exhibit 3-21.

EXHIBIT #3-21 STATEMENT OF DL DATED 18/04/2019 ((WIT.0136.0001.0001)

MR BOLSTER: Could I begin with you, Ms DM. Your mother is 84 now.

DM: Correct.

MR BOLSTER: And she's still living at Brian King Gardens.

DM: Yes.

MR BOLSTER: And just wanted to get a bit more background. Your father died about 12 years ago, in 2007; correct?

DM: Yes.

MR BOLSTER: And she was on her own for a period of time before she needed the respite care; correct?

DM: Correct.

MR BOLSTER: Okay. And how would you describe the care that she received up until the middle of 2016?

DM: It was very good care. We had a lot of peace of mind that Mum was in good hands and her needs were being met.

MR BOLSTER: Right. Her teeth were being looked after?

DM: Yes.

MR BOLSTER: Had you had cause to see the dentist about her teeth and be told that there were problems with her dentures?

DM: No, just regular check-ups.

MR BOLSTER: Yes. And what was the history of dental care in your family?

DM: Mum was a stickler for good oral care.

MR BOLSTER: What did that mean for the two of you?

DM: Every six months we would get dragged to the dentist and have to get our teeth checked and cleaned.

MR BOLSTER: And what about her? Did she look after hers?

DM: She did.

MR BOLSTER: All right. Did you ever notice her to change in that regard, despite her dementia?

DM: No.

MR BOLSTER: And you read Mr Farmilo's letter, and you saw that he sought to suggest that she was resistive. You've read that at the time he sent that to you in 2016?

DM: Yes, I did.

MR BOLSTER: Did you respond to him?

DM: Well, after we got the letter I felt we had said everything we could.

MR BOLSTER: Yes.

DM: And we just thought from then on we would stay on top of her oral care.

MR BOLSTER: Did you agree with him, that her mother was resistive to oral care?

DM: Not to that part. Mum had occasionally been a bit resistive, but we always found there was strategies that we could put in place that helped her in her care.

MR BOLSTER: Was - - -

DM: But she - - -

MR BOLSTER: Sorry.

DM: She was never resistive in regards to her teeth.

MR BOLSTER: What was she resistive about?

DM: She didn't – she's a dignified lady and didn't want to wear incontinence pads. And occasionally, she might resist having a shower.

MR BOLSTER: In the case of the incontinence, the notes show there were many occasions where she would take them off and hide them in the room - - -

DM: Yes.

MR BOLSTER: - - - which is not at all unusual, but that's the sort of resistance you're talking about, is it?

DM: Yes.

MR BOLSTER: Right. And what about you, Ms DL? Is that consistent with your observation of your mother.

DL: Yes, that's correct. So there were really only those two times that we know of or we've been told where she was resisting some of the care there, so showers. She often felt that she had already had a shower and had to be reminded again that she may need – that she hadn't actually had that shower in the morning.

MR BOLSTER: All right. I want to turn now to what happened last year at around the time of your mum's birthday in June and July. There was the incident that you heard me talking about the end of June when she escaped, to put it in those terms, and you brought her back to the facility.

DM: Yes.

MR BOLSTER: Where did you find her?

DM: She actually had become trapped between a brick wall and some wrought iron fencing right at the perimeter of Brian King Gardens facility. It was hard to see her because you couldn't see through the brick wall - - -

MR BOLSTER: Yes.

DM: - - - and there was a lot of bush in that gated area.

MR BOLSTER: Yes.

DM: It was my daughter who spotted her.

MR BOLSTER: So she was inside the confines of Brian King Gardens?

DM: Yes.

MR BOLSTER: Yes. She wasn't out walking down the road to Castle Hill, was she?

DM: No.

MR BOLSTER: No. She wasn't trying to get on a bus and go somewhere, was she?

DM: No.

MR BOLSTER: No.

DM: No.

MR BOLSTER: Okay. All right. Were people surprised when you told them that's where you found her?

DM: She had been found close to there before - - -

MR BOLSTER: Yes.

DM: - - - but not stuck in that particular area. In fact, we had kept searching that very area because we thought that might be where she could be.

MR BOLSTER: Is that area a green, pleasant place?

DM: Yes.

MR BOLSTER: Did your mother have a nice garden at home?

DM: She did.

MR BOLSTER: Has your mother ever wandered outside of Brian King Gardens at all?

DM: I don't think so. She might have got as far as just the Castle Hill Road entrance.

MR BOLSTER: Yes. All right. But you've certainly not been told that she has ever been found on Castle Hill Road or attempting to leave the vicinity of Brian King Gardens; is that right?

DM: No.

MR BOLSTER: Okay. All right. Thank you. Now, I want to turn then to what happened. Ms Tinley, who was the care manager at the time, that's in June of last year, arranged a meeting. Who attended that meeting?

DL: I was there.

MR BOLSTER: So that's you, Ms DL.

DL: Yes.

MR BOLSTER: Yes. You weren't there, Ms DM?

DM: I was on phone.

MR BOLSTER: On the phone. Okay. Well, how about you, Ms DL? You tell us what was discussed at that meeting.

DL: So I was told that Mum was having some issues with being agitated, so she was often found wandering the different levels, which she had always been free to do because she had actually made friends on the other different levels, so she was quite good at moving between them, but she was getting more agitated and she was often found crying and quite distressed. She wasn't sure where she was going, but she – she was always very involved in all the activities so she would always, you know, try to go along to those. But Ms Tinley was saying that, yes, Mum was getting to the point where she was crying a lot and she was just upset all the time.

MR BOLSTER: And did Ms Tinley indicate that something needed to be done?

DL: I'm just trying to recollect which conversation that was. I'm so sorry. Yes, she did. That was the time she suggested that, yes, if Mum continued in this way that she would probably have to go into the secure facility.

MR BOLSTER: Right. Okay. Your mother has had dementia for a very long time.

DL: Yes, that's correct.

MR BOLSTER: Has she been consulting a geriatrician at all?

DL: Prior to going into care - - -

MR BOLSTER: Yes.

DL: - - - she did, but not since she's been in care.

MR BOLSTER: Not since. Okay. All right. And has Brian King Gardens ever indicated to you that that might be a good idea?

DL: No.

MR BOLSTER: Or that she might have behaviours that need some form of management?

DL: No. Just the two episodes of resisting the incontinence pads and showering.

MR BOLSTER: All right. Now, on 9 June you received a – and I'm talking to you now, Ms DL – you received a phone message from Ms Tinley and you called her.

DL: Yes.

MR BOLSTER: Your phone records, which will – are in evidence show that you called and spoke to her for about six minutes. Do you remember what the conversation was about?

DL: I don't think it was actually Ms Tinley who called me. I think it was actually one of the carers who spoke to me.

MR BOLSTER: Yes.

DL: But they said that Mum was reliving childhood memories of abuse that she had had and that she was continuing to be very agitated, crying, and she was wandering a lot more and the nurses were finding this difficult for them. And they suggested that she goes on medication.

MR BOLSTER: Did they say what the medication was?

DL: Axit, which I had never heard of before.

MR BOLSTER: Did you agree with that?

DL: I – yes, I – I did give my consent for that to be used, but I had no idea actually what it was.

MR BOLSTER: Did they tell you that it was about – it was an antidepressant?

DL: No, they just said that it would help with Mum's crying and agitation and - - -

MR BOLSTER: Did they tell you what the dose would be they were going to give?

DL: No.

MR BOLSTER: Did they tell you anything about what the side effects might be?

DL: No, they didn't.

MR BOLSTER: At that time, was your mum having a problem with her weight?

DL: Yes.

MR BOLSTER: Was it that she was too heavy or that she was too light?

DL: Yes, so Mum probably entered Brian King I think about 54 kilos.

MR BOLSTER: Yes.

DL: And at this stage she would probably be about 80-something kilos, so she was eating very well when she went into Brian King Gardens.

MR BOLSTER: All right. Did anyone ever indicate to you that one of the side effects of Axit or mirtazapine is weight gain?

DL: No.

MR BOLSTER: Did anyone tell you any other side effects about mirtazapine?

DL: No, none at all.

MR BOLSTER: When did you first find out about them?

DL: About what Axit is?

MR BOLSTER: Yes.

DL: So I was actually on holidays when I took the phone call from the – the carer, and my other sister, my – the middle sister between the two of us was there with me, and we sort of said, "What is this thing? Never heard of it before." So we did the old "google it" thing and it came up, and I realised it was a fairly heavy-duty drug, but I felt that, you know, "I'm not a doctor." I didn't know what it was exactly, so I put my faith in what was happening on their end, that this is what Mum needed.

MR BOLSTER: Yes. All right.

DL: And I feel so bad about it.

MR BOLSTER: I want to move ahead to 11 July, and that's your mum's birthday. And, Ms DM, you went and saw her and took a cake.

DM: I did.

MR BOLSTER: And can you tell the Commission, what did you see? How was your mum on her birthday?

DM: Well, we got there in the morning because that's when Mum is usually pretty sprightly.

MR BOLSTER: Yes.

DM: She was fast asleep, fully dressed on her bed. I was with my two daughters and we tried to make some happy birthday noise around her to arouse, you know, wake her up so we could celebrate her birthday. After 10 minutes, we couldn't get any response from her.

MR BOLSTER: Yes. Did you sing happy birthday to her?

DM: We did try. The kids were really - - -

MR BOLSTER: What did you do to try and wake her.

DM: The kids were really embarrassed about it, but it was you know, "Nanna, time to wake up. It's your birthday. You're 84 today."

MR BOLSTER: Yes.

DM: That kind of thing. So we were quite rowdy and – but we were also very careful with – with touching her because we thought we didn't want to shake her in case she woke up with a start. So we made a lot of sound.

MR BOLSTER: Yes.

DM: But then we called the nurse because we couldn't wake her up and said, "Oh, she's very sleepy." And I said, "So how about I take the girls downstairs to the café, and maybe in half an hour she will have finished her –" what we thought was a nanna nap, and come back, and maybe take her to lunch. So we waited, must have been over 45 minutes, came back up and she was still out to it.

MR BOLSTER: Yes. Did you know at the time she was on a new medication?

DM: No.

MR BOLSTER: What did you do?

DM: I was – after, I was worried and I rang DL, and that was when she told me she had had other conversations about Mum being sleepy.

MR BOLSTER: Yes.

DM: And I can't recall if it was that day, but I did speak – there was a phone call with Dr Ginger.

MR BOLSTER: You did?

DM: I spoke with her.

MR BOLSTER: Tell us what you and Dr Ginger talked about.

DM: That she wasn't waking up, that she wasn't responding, and at that time there was a question, the – the Brian King Gardens wanted to know if we wanted her to go to hospital if they couldn't - - -

MR BOLSTER: Who asked you that?

DL: I was the one who wanted Mum to go to hospital.

MR BOLSTER: Yes.

DM: And - - -

MR BOLSTER: But did anyone at Brian King Gardens suggest that she needed to go to hospital on the 11th?

DM: No. It was a case of, "If you are concerned - - -"

MR BOLSTER: Yes.

DM: "- - - it is an option." After speaking to Dr Ginger - - -

MR BOLSTER: Yes.

DM: - - - she talked through pros and cons and the distress of going to hospital versus staying where she is.

MR BOLSTER: Yes.

DM: She reassured me there was no medical reason for her to need to go to hospital, and this just sometimes happens.

MR BOLSTER: Did Dr Ginger tell you about the medication?

DM: No.

MR BOLSTER: And did you speak to Dr Ginger, Ms DL?

DL: No. Not about that, no.

MR BOLSTER: Has she ever spoken to you about the medication? And I'm not talking about in the last two or three weeks.

DL: No.

MR BOLSTER: So you've obviously spoken about it in the last two or three weeks.

DL: Yes, I have.

MR BOLSTER: The position is now, isn't it, that she's coming off the mirtazapine?

DL: Yes.

MR BOLSTER: She's having a 30-milligram tablet every second day.

DL: Yes, that's correct.

MR BOLSTER: And when was that instituted?

DL: About two weeks ago when I found out, like, speaking to people here, that it was such a heavy duty drug and - - -

MR BOLSTER: Yes.

DL: - - - I questioned Dr Ginger as to why she still needed to be on it when she was, you know, now in a confined space, she wasn't wandering any more, we want get her to wake up when we go and visit her any more, and was there a need for her still to be on this particular drug.

MR BOLSTER: And what did Dr Ginger tell you?

DL: Well, she said that she would review the medication, and – and that's when the decision was made to wean her off it. They couldn't take her off it straightaway because - - -

MR BOLSTER: Side effects.

DL: Yes, side effects and things wouldn't be so good for Mum.

MR BOLSTER: Did Dr Ginger tell you what those side effects would be?

DL: No, actually, she didn't. No. But, yes, just it would be too hard for Mum's body to cope with it. So we're still in that two-week process of being weaned off it now.

MR BOLSTER: Did Dr Ginger tell you why she put your mother on the mirtazapine in the first place?

DL: No, she didn't.

MR BOLSTER: Have you asked her?

DL: No, I didn't.

MR BOLSTER: All right. I wanted then to talk about your mother's neck and shoulders - - -

DL: Yes.

MR BOLSTER: - - - the year before, in October. Was your mother someone who, if she was in pain, would let people know it?

DL: Yes, yes, she would.

MR BOLSTER: Did she complain to you about being in pain in around October/November 2017?

DL: No, she didn't.

MR BOLSTER: You - - -

DL: And I visit Mum every week.

MR BOLSTER: Yes.

DL: So I'm there regularly.

MR BOLSTER: Did you know she had been started on a new physiotherapy routine for pain management?

DL: No, I did not.

MR BOLSTER: Did the care staff there, did Ms Tinley or anyone else tell you about that?

DL: No, they did not.

MR BOLSTER: I then wanted to turn to your mum's – go back to your mum's teeth and the situation as it stands now. Is your Mum eating properly?

DL: Yes, she is. Yes.

MR BOLSTER: Do you sit with her when she eats?

DL: My other sister has, my middle sister. So she was there last week with her.

MR BOLSTER: Your mum saw a speech pathologist recently. You know about that?

DL: Yes, that's correct.

MR BOLSTER: And the speech pathologist, in a nutshell, says that your mum eats too quickly.

DL: Yes, that's right.

MR BOLSTER: She doesn't control the food that goes on, and it all goes in and fills up her cheeks, and then she doesn't know what to do with it.

DL: That's right.

MR BOLSTER: She tries to swallow but can't.

DL: Yes.

MR BOLSTER: And that's where the difficulties lie.

DL: Yes.

MR BOLSTER: And it would seem to be an issue with her dementia. Does anyone ever just sit down with her and help her eat, that is, feed her so that she doesn't go too quickly?

DL: They do now.

MR BOLSTER: They do now. When did they start doing that?

DL: I can't recollect, I'm sorry.

MR BOLSTER: Are we talking about this year?

DL: Yes, just this year, so just in the last – whenever the speech – whenever I spoke to the – you've got the dates there.

MR BOLSTER: Yes.

DL: So whenever I spoke to the speech pathologist last time she assured me from then on somebody would sitting with Mum to help her with her feeding.

MR BOLSTER: To help her.

DL: Yes.

MR BOLSTER: All right. I don't need to ask you any questions about the podiatry; I think that's covered in your statement and in the correspondence, but is there anything that you wanted to add that you wanted to add to your evidence?

DL: There was also a situation where before Mum's dementia progressed I took her away on holidays.

MR BOLSTER: Yes.

DL: I think it was in 2016 or 2017, the dates will be in there somewhere, and she was actually given somebody else's medication.

MR BOLSTER: Yes.

DL: When we went away.

MR BOLSTER: That's set out in your statement and in the documentation and in the evidence and that doesn't seem to be in any significant dispute. So we had that. We also have the issue about her stockings, her TED stockings. Can you tell the Commission why your Mum needs those stockings.

DL: For - she gets swelling in the legs so she needs to be wearing those pretty much all the time.

MR BOLSTER: Does Brian King Gardens ever run out of those stockings for her?

DL: All the time. It's really frustrating. I just - you know, my father left Mum in a very good financial situation, so if Mum needs anything, I've always told them, buy it, get it for her, you know, we want her to be happy, we want her to be comfortable there. And there doesn't seem to be this process where if something runs out or something doesn't happen that it then gets followed up, and I just feel like I'm constantly having to check on her – you know, her meds, her stockings, whether she's gone to the hairdressers. It's just hard.

MR BOLSTER: Was it like that before June 2016?

DL: No, it wasn't.

MR BOLSTER: Commissioners, just excuse me for a minute. That's the examination. Thank you.

COMMISSIONER TRACEY: Thank you both very much for coming and giving your evidence. We appreciate it very much.

<THE WITNESSES WITHDREW [10.37 am]

MR BOLSTER: Commissioners, the next witness is Mr Richard Farmilo. I call Richard Farmilo.

<RICHARD FARMILO, SWORN [10.37 am]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: If two documents could be brought up, please. The two statements of Mr Farmilo, the first is WIT.0130.0001.0001, and the second one is WIT.0154.0001.0001. Are they your two statements in this matter, Mr Farmilo?

MR FARMILO: Yes, they are.

MR BOLSTER: I understand you wish to make an amendment to your second statement. Could you please tell the Commission the substance of that amendment?

MR FARMILO: That's correct. Paragraph 20.

MR BOLSTER: Yes.

MR FARMILO: The second sentence was misread in proofreading and that should be deleted.

MR BOLSTER: The second sentence of 20?

MR FARMILO: Correct, starting with:

Ms Tinley also called DL.

MR BOLSTER: Let me just – yes. Thank you. Other than that, is your statement true and correct to the best of your knowledge and belief?

MR FARMILO: Yes, it is.

MR BOLSTER: I tender both of the witness statements, Commissioner.

COMMISSIONER TRACEY: Yes, the statement of Richard Farmilo dated 26 April 2019 will be exhibit 3-22.

EXHIBIT #3-22 STATEMENT OF RICHARD FARMILO DATED 26/04/2019 (WIT.0130.0001.0001)

COMMISSIONER TRACEY: The statement of Mr Farmilo dated 2 May 2019, subject to the correction which he has just made, will be exhibit 3-23.

EXHIBIT #3-23 STATEMENT OF MR FARMILO DATED 02/05/2019 (WIT.0154.0001.0001)

MR BOLSTER: Mr Farmilo, you are the residential care manager of Brian King Gardens.

MR FARMILO: Correct.

MR BOLSTER: And Brian King Gardens is one of a number of residential aged care facilities operated by Anglicare.

MR FARMILO: Correct.

MR BOLSTER: Anglicare is the approved provider.

MR FARMILO: Yes.

MR BOLSTER: And Brian King Gardens is part of a very large facility at Castle Hill.

MR FARMILO: Correct.

MR BOLSTER: Where there are other nursing homes and - - -

MR FARMILO: There's five in total.

MR BOLSTER: - - - and retirement villages.

MR FARMILO: Correct.

MR BOLSTER: And correct me if I'm wrong but I understand that the total number of residents in the area is about 3000.

MR FARMILO: I would say closer to 2000 but it's a significant number, yes.

MR BOLSTER: And it's a precinct at Castle Hill where these facilities are all together and they're substantially in a garden setting, aren't they?

MR FARMILO: Correct, there's a lot of bushland and garden surrounding all the homes, yes.

MR BOLSTER: Linked together by pathways and roads, and things like that.

MR FARMILO: Yes.

MR BOLSTER: You've held that position since around June 2016; correct?

MR FARMILO: July 1, 2016, I commenced there.

MR BOLSTER: To whom do you report?

MR FARMILO: To the regional manager for the north-west region for Anglicare.

MR BOLSTER: Are you the chief executive officer of a corporation or are you - - -

MR FARMILO: No.

MR BOLSTER: Right. So the parent body is Anglicare itself.

MR FARMILO: Anglican Community Services is the business name, trading as Anglicare.

MR BOLSTER: All right. And you don't hold board level at that organisation?

MR FARMILO: No, I don't.

MR BOLSTER: And under you, who reports to you?

MR FARMILO: My direct reports would be to the care manager, admin and services coordinator, lifestyle leader, workplace trainer, hospitality manager. They're my direct reports.

MR BOLSTER: All right. And the care manager is ordinarily a very experienced clinical nurse?

MR FARMILO: Yes, a registered nurse.

MR BOLSTER: Registered nurse; the current care manager - how many years experience does he or she have in aged care?

MR FARMILO: I don't know how many years experience. I know that he has been a registered nurse at Brian King Gardens for approximately five years before stepping into that role late last year.

MR BOLSTER: Does he have any involvement in relation to Mrs CO's treatment as it has developed in this case?

MR FARMILO: He's been in that role since approximately October last year.

MR BOLSTER: Yes.

MR FARMILO: I'm not sure of his direct involvement, sorry.

MR BOLSTER: Does his name appear in the care notes that are relevant in relation to the wandering and treatment for depression? I don't want to name him unless I have to.

MR FARMILO: Yes, no, I'm just trying to remember if they're in there at all. Possibly not.

MR BOLSTER: Okay. We will leave it for now. What is the role of the care manager?

MR FARMILO: The care manager is essentially responsible for the clinical care, oversight of all the residents within Brian King Gardens.

MR BOLSTER: Do you make clinical care decisions at Brian King Gardens or is that left to the care manager?

MR FARMILO: I don't, no.

MR BOLSTER: Are you consulted about critical care events as they arise?

MR FARMILO: On occasions, yes.

MR BOLSTER: Were you consulted about any of the interventions that I discussed in my opening to this case study when they arose.

MR FARMILO: The prescription of Avanza, no, I wasn't consulted at that point. I was obviously aware of the oral hygiene issues and the podiatry issues.

MR BOLSTER: After complaints were made.

MR FARMILO: Correct. Yes.

MR BOLSTER: I understand. Your training is an occupational therapist.

MR FARMILO: Correct.

MR BOLSTER: And you have an MBA as well.

MR FARMILO: Correct.

MR BOLSTER: Now, in your first statement you addressed the guidelines, procedures and policies that Brian King Gardens has in place, concerning the capacity of residents to consent to treatment and how you obtain that consent from either the resident or the person with authority for that resident.

MR FARMILO: Yes.

MR BOLSTER: And the short answer to that issue is that there are no formal policies in place; is that correct?

MR FARMILO: That's correct. Anglicare currently doesn't have a policy regarding resident capacity or consent.

MR BOLSTER: So on a day-to-day basis that's dealt with based on the experience and knowledge of the care manager?

MR FARMILO: The care manager in consultation with other people, yes.

MR BOLSTER: Who?

MR FARMILO: Doctors, registered nurses - - -

MR BOLSTER: Right.

MR FARMILO: - - - families, residents. Yes.

MR BOLSTER: But as far as decisions that Brian King Gardens has to make about treatment, it rests with the care manager?

MR FARMILO: Yes.

MR BOLSTER: Okay. Now, the policy under development, is that an Anglicare-wide policy?

MR FARMILO: Yes, Anglicare are currently developing a number of new policies.

MR BOLSTER: And - - -

MR FARMILO: One of those is around supportive decision-making and also one regarding capacity and consent, and they will be Anglicare-wide policies.

MR BOLSTER: All right. Is it informed by the circumstances of Mrs CO's medication in July 2018?

MR FARMILO: No. It's not directly relevant. It's in response to the aged care standards taking effect 1 July.

MR BOLSTER: Is the experience, though, of Mrs CO's situation going to affect the next draft of that policy?

MR FARMILO: I think certainly in light of the circumstances we have here, I think it's – it's a worthwhile case, yes.

MR BOLSTER: Have you provided a report to the committee that's drafting that policy about the experience on 4 and 5 and 6 and 7 July last year?

MR FARMILO: The relevant people drafting that policy have been working with me in developing this statement and they are aware of the circumstances surrounding that.

MR BOLSTER: All right.

MR FARMILO: Yes.

MR BOLSTER: Okay. Now, you observe in your statement at paragraph 142 that residents with a cognitive impairment require consent from the person responsible, and that's a term under the Guardianship Act; correct?

MR FARMILO: Correct.

MR BOLSTER: And do you keep up to date with these issues in your role as the residential manager?

MR FARMILO: Which issue, sorry?

MR BOLSTER: Well, the issue of consent. It would appear that you are the link between Anglicare and the clinical people when it comes to these issues.

MR FARMILO: Yes.

MR BOLSTER: Is – do you make it your job to make sure that your organisation is complying with the Guardianship Act?

MR FARMILO: That's part of my role, yes.

MR BOLSTER: So you're familiar with the categories of treatment?

MR FARMILO: Yes.

MR BOLSTER: And do you take issue that the treatment involved for Mrs CO involving the prescription of mirtazapine was a major treatment for the purpose of the Guardianship Act?

MS ENGLAND: I object to that. He doesn't have any legal qualifications, with respect. So perhaps the precise part of the Act - - -

COMMISSIONER TRACEY: Well, I don't think he's being asked for a legal opinion.

MR BOLSTER: No, he's not.

COMMISSIONER TRACEY: He's just asked about his knowledge.

MS ENGLAND: Yes.

COMMISSIONER TRACEY: If he doesn't have the knowledge, he can say so.

MS ENGLAND: Thank you.

MR FARMILO: So I don't have the – I'm not fully aware of the – the extreme – sorry, can you just rephrase what that was, I'm sorry?

MR BOLSTER: Is it fair to say this, to bring it to an end quickly.

MR FARMILO: Yes.

MR BOLSTER: You rely on your clinical staff to comply with the Guardianship Act?

MR FARMILO: Correct.

MR BOLSTER: And it's not something that you direct your mind to. You rely upon what they do; correct?

MR FARMILO: Correct.

MR BOLSTER: Yes. Okay. Thank you. Now, you're familiar with the term "psychotropic"?

MR FARMILO: I am.

MR BOLSTER: And it refers to a drug that affects the mind or mental state of the user. You understand that, don't you?

MR FARMILO: Correct.

MR BOLSTER: And you've always understood that, I take it.

MR FARMILO: Yes.

MR BOLSTER: And you indicate in your second statement that as of 1 July 2018, Brian King Gardens had 197 permanent residents.

MR FARMILO: Yes, that's correct.

MR BOLSTER: And that was down from 221 the previous year?

MR FARMILO: Yes.

MR BOLSTER: 231 the year before that.

MR FARMILO: Yes.

MR BOLSTER: And 227 for the year before that.

MR FARMILO: Yes.

MR BOLSTER: For the year – and on top of permanent residents there would be respite residents, wouldn't there?

MR FARMILO: Correct.

MR BOLSTER: Roughly how many respite residents do you have from time to time? That probably varies week to week.

MR FARMILO: So we have – correct. We have four permanent respite beds available for respite, but we can have more than that if - - -

MR BOLSTER: Yes.

MR FARMILO: - - - room is available and the need is there.

MR BOLSTER: You probably have more availability now because you're only at 197 capacity – at 197 occupancy.

MR FARMILO: As at – as at 1 July 2018.

MR BOLSTER: Yes.

MR FARMILO: Correct.

MR BOLSTER: Then you say that 112 residents were prescribed psychotropic drugs at that time.

MR FARMILO: Correct.

MR BOLSTER: That's nearly 59 per cent of the resident population; 109 were on a regular prescription, that is, 55 per cent; and 21 were on what's called PRN.

MR FARMILO: Yes.

MR BOLSTER: Which, for the record, is Latin for pro re nata which, means administer as needed. You understand that.

MR FARMILO: I do.

MR BOLSTER: PRN medication at Brian King Gardens, who makes the decision? Who is the one that determines if it is needed?

MR FARMILO: They are prescribed by the – by general practitioners.

MR BOLSTER: But generally, a GP wouldn't determine whether a PRN drug is needed at a particular time. Who is the person on the floor that determines whether it is needed?

MR FARMILO: So when a GP prescribes medication they will document in the medication chart the reasons why it has been charted, and then it is up to the – the registered nurse to make the determination if it's required at that point, in line with the – the doctor's prescription.

MR BOLSTER: Right. Now, are you concerned by the psychotropic figures for Brian King Gardens?

MR FARMILO: No.

MR BOLSTER: You don't think that's too high?

MR FARMILO: No, I don't.

MR BOLSTER: Has your attention been drawn by anyone to that figure in your role as the residential care manager?

MR FARMILO: No.

MR BOLSTER: Do you report on your psychotropic drug usage to Anglicare?

MR FARMILO: So we receive regular reports from our pharmacists around psychotropic medications which are also provided to our quality and support team.

MR BOLSTER: So where's your quality and support team located?

MR FARMILO: They're in our head office.

MR BOLSTER: At the head office.

MR FARMILO: Correct.

MR BOLSTER: So your head office knows the extent to which psychotropic drugs are prescribed to each resident; correct?

MR FARMILO: They have that information.

MR BOLSTER: Are they collected on a group basis inside Anglicare?

MR FARMILO: I'm not sure, sorry.

MR BOLSTER: Right. And is this a topic that ever comes across your desk as the residential manager?

MR FARMILO: So I receive the reports from our pharmacy, yes.

MR BOLSTER: Right. And when you get them, what do you do with them?

MR FARMILO: I generally have a look at them so I'm aware of what's happening and I will pass them onto our clinical teams, so our care manager.

MR BOLSTER: Does your clinical care manager ever express any concern about the issue of how much prescribing of psychotropic drugs is going on?

MR FARMILO: He hasn't explicitly expressed that, no.

MR BOLSTER: Is there a target that you're working towards to reduce psychotropic drug use?

MR FARMILO: There is no set target.

MR BOLSTER: Yes. There is no set target.

MR FARMILO: Correct.

MR BOLSTER: You provided overnight – if we could have called up, please, WIT.0165.0001.0001. If you just have a look at this document. If you go to the second page, please, this was an answer to a notice to give evidence to you, and it is a breakdown of the categories of psychotropic drugs that were prescribed - - -

MR FARMILO: Yes.

MR BOLSTER: - - - at Brian King Gardens as of 1 July 2018.

MR FARMILO: Yes.

MR BOLSTER: And do I take it from your earlier answers that the clinical aspects of these is beyond your expertise?

MR FARMILO: That's correct.

MR BOLSTER: And there's not much point in me asking you many questions about them.

MR FARMILO: I wouldn't be able to give you any real - - -

MR BOLSTER: Right.

MR FARMILO: - - - information. Sorry.

MR BOLSTER: So if I were to ask you the difference between mirtazapine and Citalopram, you would - - -

MR FARMILO: I wouldn't know, sorry.

MR BOLSTER: Okay. Good. All right. I tender that document, Commissioners.

COMMISSIONER TRACEY: Yes, the document entitled Response to Royal Commission Into Aged Care and Safety NTG-0165 dated 7 May 2019 will be exhibit 3-24.

EXHIBIT #3-24 DOCUMENT ENTITLED RESPONSE TO ROYAL COMMISSION INTO AGED CARE AND SAFETY NTG-0165 DATED 07/05/2019

MR BOLSTER: And I notice that at the end of that document, that you were asked some questions about are the Dementia Behaviour Management Advisory Service. We will come back to that later. Just continuing on, the iCare system at Brian King Gardens, which we've seen up on the screen today - - -

MR FARMILO: Yes.

MR BOLSTER: - - - when I opened and went through the notes, that is effectively the client or the patient or the resident, however you want to describe them, medical record whilst they're in your care, custody and control, isn't it?

MR FARMILO: Correct.

MR BOLSTER: The idea of that record-keeping system is to record everything that's relevant to the clinical care of the resident; correct?

MR FARMILO: We have a rule in Anglicare to document by exception. So we don't document every – every occasion of care. We don't document every event.

MR BOLSTER: Well, what does "document by exception" mean?

MR FARMILO: Something that's out of the ordinary for the resident.

MR BOLSTER: Hang on. So let's just pause there. You only record things that are out of the ordinary, do you?

MR FARMILO: No.

MR BOLSTER: Well, what do you record? What does your guideline say about what should go onto the iCare system?

MR FARMILO: The information about – information about the care of the residents.

MR BOLSTER: Yes.

MR FARMILO: Yes, correct.

MR BOLSTER: And there are other records that are generated for residents. There are extended care plans. Are you familiar with those?

MR FARMILO: Correct, yes.

MR BOLSTER: Have you looked at the extended care plan for Mrs CO in preparing to give evidence in this matter?

MR FARMILO: I have.

MR BOLSTER: Do you ordinarily look at clinical extended care plans for residents as part of your daily responsibilities.

MR FARMILO: Not typically, no.

MR BOLSTER: Right. So the way in which a clinical care plan is prepared for a resident, whether clinical care plan or extended care plan - - -

MR FARMILO: Yes.

MR BOLSTER: - - - that's in the responsibility of the care manager. Correct?

MR FARMILO: Correct.

MR BOLSTER: And it doesn't come across your desk?

MR FARMILO: No.

MR BOLSTER: Okay. All right. Well, I just want to go back to that issue of what needs to be in the iCare records. Is there a guideline or procedure for your staff that they can go and look at and say, "Ah, yes, I need to note that this happened to Mrs CO on this occasion"?

MR FARMILO: To my knowledge, there's not one that's – provides that, that clear information.

MR BOLSTER: All right. Well, when you induct staff, when they come in, a new personal care attendant or a new nurse is inducted, what do you tell them about their responsibilities for entering material in iCare?

MR FARMILO: I don't have intimate knowledge of the induction plan at this point, sorry.

MR BOLSTER: Do you know what the rules are?

MR FARMILO: As I say, I don't think we have a clear-cut policy around what the rules are for documenting.

MR BOLSTER: All right. Would Ms Tinley know if I asked her?

MR FARMILO: I'm not sure.

MR BOLSTER: Okay. And you weren't involved at this stage between 24 June and 11 July last year in the incidents that occurred with Mrs CO; correct?

MR FARMILO: With the Avanza prescription?

MR BOLSTER: Yes.

MR FARMILO: I wasn't involved in those discussions, no.

MR BOLSTER: Okay. You made a statement, though, about what happened based on your review of the records - - -

MR FARMILO: Yes.

MR BOLSTER: - - - and conversations that you have recently had with Ms Tinley and Dr Ginger. Correct?

MR FARMILO: And other staff - - -

MR BOLSTER: And other staff.

MR FARMILO: - - - at Brian King Gardens, yes.

MR BOLSTER: All right. And when did you speak to Ms Tinley?

MR FARMILO: It would have been approximately a week to 10 days ago, from memory.

MR BOLSTER: And Dr Ginger?

MR FARMILO: Around the same time I would say.

MR BOLSTER: Okay. You say in paragraph 19 of your second statement, and it's your second statement that deals with this issue.

MR FARMILO: Yes.

MR BOLSTER: That both the care manager and Dr Ginger tried to contact DL on 4 July but were unable to do so. Is that something that Dr Ginger told you, or Ms Tinley told you?

MR FARMILO: I got that information from Ms Tinley.

MR BOLSTER: Right. Did you raise it with Dr Ginger?

MR FARMILO: I believe I did, yes.

MR BOLSTER: Did Dr Ginger recall trying to contact the daughter when she spoke to you?

MR FARMILO: She did at the time, yes.

MR BOLSTER: She did. Did she tell you what she told the daughter?

MR FARMILO: As I've stated there in my statement they were unable to contact the daughter on that day.

MR BOLSTER: Right.

MR FARMILO: So I don't think there was a discussion.

MR BOLSTER: Did she say what was the content of the message she left for the daughter?

MR FARMILO: No.

MR BOLSTER: All right. Dr Ginger's statement makes no reference to trying to contact the daughters. Have you read her statement?

MR FARMILO: I've seen it, yes.

MR BOLSTER: Now, and you know that the records show – I'm sorry, I withdraw that. Ms Tinley told you, even though the records don't show, that she spoke to one of the daughters on 9 July; correct?

MR FARMILO: Correct.

MR BOLSTER: And the evidence will show that it was at 4.01 pm and lasted six minutes 35 seconds. There is no record of that conversation on iCare. Do you accept that?

MR FARMILO: Yes, I do.

MR BOLSTER: Ms Tinley told you that she started to compose an email to one of the daughters but deleted it after she spoke to her on the 9th. Do you recall that?

MR FARMILO: Yes.

MR BOLSTER: Have steps been taken to try and recover that deleted draft email?

MR FARMILO: I believe steps have been tried, yes.

MR BOLSTER: And were they successful or unsuccessful?

MR FARMILO: Not successful.

MR BOLSTER: Not successful. And you say that the consent of the family was obtained on the 9th, three days after the drug was first administered; correct?

MR FARMILO: Correct.

MR BOLSTER: When you say "consent" you are talking about consent as you understand it; correct? You're not making a statement that it was consent for the purposes of the Guardianship Act, are you?

MR FARMILO: No.

MR BOLSTER: That's consent as far as you're concerned.

MR FARMILO: Correct.

MR BOLSTER: Given what your knowledge of the word consent means.

MR FARMILO: That the medication can be - - -

MR BOLSTER: Yes. All right. You say whether consent is sought depends on the circumstances. Are you sure about that?

MR FARMILO: Yes.

MR BOLSTER: Doesn't consent - whether the issue of whether consent is sought, depend on the treatment and depend upon what the Guardianship Act says about that particular treatment?

MR FARMILO: It does, and I think this is the – the core issue obviously to be looked at here.

MR BOLSTER: Yes. The care manager here sought consent twice before it was given.

MR FARMILO: The care manager attempted to contact the family. It's typically not the care manager's responsibility to obtain consent.

MR BOLSTER: Is there a policy or procedure about the doctor's role in all of this? I mean, I would have thought – correct me if I'm wrong – that the doctor is required to consult with the person responsible before a treatment is agreed upon; correct?

MR FARMILO: Yes.

MR BOLSTER: In your experience, is that what happens normally at Brian King Gardens?

MR FARMILO: That is typical practice, yes.

MR BOLSTER: Yes. Is there a procedure that assists your staff in that regard?

MR FARMILO: As I mentioned earlier, we don't have a policy around consent.

MR BOLSTER: Right. You try to – I withdraw that. In your statement you seem to suggest that the drug administration in this case was necessary. You seem to argue that it was a case of necessity, that is, it needed to be administered before the daughters consented. Am I right in thinking that's your position?

MR FARMILO: I believe it was in Mrs CO's best interests, yes.

MR BOLSTER: Well, that's what you've been told by Ms Tinley, isn't it?

MR FARMILO: And the information I got from other staff at the time.

MR BOLSTER: You say that that was because her – she was very distressed and her distress was escalating, and that was on 4 July.

MR FARMILO: Correct.

MR BOLSTER: Because that's when the script issued; correct?

MR FARMILO: Correct.

MR BOLSTER: I want to suggest to you that if that were the case, you would expect the care notes to make some record of the fact that the distress was escalating and they don't, do they?

MR FARMILO: The progress notes don't show that.

MR BOLSTER: And if it was necessary because she was distressed and her distress was escalating, why would you wait till the 6th to administer it when she was distressed on the 4th?

MR FARMILO: The two days delay was there waiting for the medication to arrive from the pharmacy.

MR BOLSTER: Is that right? If it was necessary for her to be administered mirtazapine at 45 milligrams because she was distressed on 4 July, no one could have obtained that drug sooner than two days; is that right?

MS ENGLAND: I object. It's not a correct statement of the evidence, with respect. The evidence was not that it was necessary, but that it was in her best interest. It's an important distinction, in my submission.

COMMISSIONER TRACEY: Yes, I think the question could be reframed.

MR BOLSTER: I will put it another way. Thank you, Commissioner.

You say it was necessary – you say it was a necessity for Mrs CO to be prescribed mirtazapine on that occasion; correct?

MR FARMILO: It was in her best interests, I believe, to have that.

MR BOLSTER: And if a drug was necessary, surely it could be obtained faster than the two days that it took this drug to be obtained; correct?

MR FARMILO: Possibly, yes.

MR BOLSTER: I mean, there's a chemist at Castle Hill; correct?

MR FARMILO: Yes.

MR BOLSTER: Someone could have driven down to Castle Hill on the 4th and obtained the drug if it was necessary.

MR FARMILO: Potentially correct, yes

MR BOLSTER: Potentially correct?

MR FARMILO: Yes, it is correct, someone could have gone and purchased it from the chemist.

MR BOLSTER: There's not one observation of Mrs CO's condition between the 4th – I withdraw that. There is no updating of the observation of her on either 5 or 6 July to suggest that her condition was escalating; correct?

MR FARMILO: Correct.

MR BOLSTER: There's no note on eye care at all between 4 and 9 July. Commissioner, I note the time. Would that be a convenient time to take the morning tea adjournment?

COMMISSIONER TRACEY: Yes. How long have you got to go with this witness?

MR BOLSTER: I'm sorry, Commissioner, I had misread the clock. I thought it was – I need my glasses, I thought we were closer to 11.45.

COMMISSIONER TRACEY: We're not at a point at our – Mr Bolster, I thought you - - -

MR BOLSTER: I do apologise.

COMMISSIONER TRACEY: I thought you might have needed to check something.

MR BOLSTER: No, I can keep going. I thought we had reached a certain time but we hadn't.

Are you concerned about the evidence that the daughters were not told of the side effects of this drug, by your staff when they obtained their consent?

MR FARMILO: As I said in my statement, it's typically not the responsibility of Brian King Gardens staff to make sure the families are aware of side effects. That lies with the doctor.

MR BOLSTER: But they took up that responsibility in this case, didn't they?

MR FARMILO: Due to Ms Tinley's involvement with the family in the months prior, she was proactive in trying to contact them.

MR BOLSTER: And are you concerned that none of this was documented properly?

MR FARMILO: Yes. Yes.

MR BOLSTER: When you came to read the eye care notes about the state that Mrs CO was in on 11 July, and you saw me open to that effect - - -

MR FARMILO: Yes.

MR BOLSTER: - - - were you concerned about that?

MR FARMILO: I was aware of those notes at the time and other events that had happened around that time.

MR BOLSTER: When were you made aware of them?

MR FARMILO: During my reading of the progress notes in preparation for this statement.

MR BOLSTER: So events like that aren't events that you are routinely consulted about?

MR FARMILO: No.

MR BOLSTER: Right. Have there been other occasions where, to your knowledge, a psychotropic drug has had a similar effect on a resident?

MS ENGLAND: I object. The relevant progress note, with respect, says query TIA. If the question is going to be put to the witness as a statement of fact that the drug had this effect, he ought to be shown the progress note in fairness.

MR BOLSTER: All right. I will rephrase the question and I will put it another way.

MR JACKSON: Could I say I would be prepared to go further with that objection and say that this witness is in no position to say in any way whether the cause of the patient's or the resident's condition was the medication.

MR BOLSTER: I will reframe the question.

COMMISSIONER TRACEY: I thought the question was, was he aware of other instances of these drugs being administered to patients. He wasn't asked about the effects on anybody.

MR JACKSON: Well, the question was, in my submission, unclear really precisely what was being asked.

COMMISSIONER TRACEY: Well - - -

MR JACKSON: But the transcript - - -

COMMISSIONER TRACEY: - - - I thought I understood it but Mr Bolster can rephrase it and if you wish to renew your objection, I will hear it.

MR BOLSTER: I will rephrase the question. I will deal with it another way, Commissioner, to make it very clear.

Residents at Brian King Gardens who go into a state where they are unable to be woken in the middle of the day and there is a concern for their health such that there's a decision to be made as to whether they're taken to hospital, and that they have recently been put on a psychotropic drug, right, how often are you aware of such incidents occurring, in your experience as the residential care manager?

MR FARMILO: I'm not aware of any other incidents.

MR BOLSTER: Right. All right. You said you were aware of the extended care plan for Mrs CO, generally.

MR FARMILO: Yes.

MR BOLSTER: Did you look at her extended care plan after this event? That is, the extended care plan that was prepared in – I think on 11 July 2018?

MR FARMILO: I don't believe I have.

MR BOLSTER: Right. Okay. I want to change topics, Mr Farmilo, to Mrs CO's pain treatment - - -

MR FARMILO: Yes.

MR BOLSTER: - - - the year before. You're familiar with that?

MR FARMILO: Yes, I am.

MR BOLSTER: That's a situation where, unlike your evidence so far, you seem to have had a role in Mrs CO's actual clinical care; correct?

MR FARMILO: No, I wouldn't say that's the case.

MR BOLSTER: All right. Paragraph 46 of your affidavit, you talk about the series of extended care plans for Mrs CO over time.

COMMISSIONER TRACEY: Are you referring to the first or the second statement, because otherwise it won't be brought up.

MR BOLSTER: This is his first statement, Commissioner. Thank you.

Your first statement. You talk about the series of extended care plans and you list them. You go to great length in listing all the various assessments and care plans that were undertaken. I take it that these were all care plans and assessments that occurred by your staff that you had no involvement in; correct?

MR FARMILO: Correct.

MR BOLSTER: And you say that on 30 June 2017:

> *Her existing care plan was reviewed for currency, but no new care plan was generated.*

Correct?

MR FARMILO: Correct.

MR BOLSTER: And in the case of pain you say at paragraph 45(g)(vi) and (vii) on page 19 - - -

MR FARMILO: Yes.

MR BOLSTER: - - - that there was a periodic assessment on 11 June and a further assessment on 24 October - - -

MR FARMILO: Yes.

MR BOLSTER: - - - and that the October review was in response to:

> *Changing care needs, including reports by Mrs CO of increasing pain.*

Are you sure about that?

MR FARMILO: That's right.

MR BOLSTER: It's fair to say, though, that in June there was no pain that required ongoing treatment; correct?

MR FARMILO: Yes.

MR BOLSTER: You had a look at that assessment, didn't you - - -

MR FARMILO: Yes.

MR BOLSTER: - - - when you were preparing your statement?

MR FARMILO: Yes.

MR BOLSTER: And it's implicit that if there was a change in October that she didn't need it in June; correct?

MR FARMILO: Yes.

MR BOLSTER: All right. You see, I want to suggest to you that if you look at the notes for 2017 prior to 23 October, there's no complaint about neck or shoulder pain by Mrs CO.

MR FARMILO: Yes.

MR BOLSTER: There were falls, there were instances where she was checked for pain, and there were many occasions when she was asked if she was in pain and she said she wasn't in pain. Do you accept that?

MR FARMILO: Yes, I do.

MR BOLSTER: The notes ultimately do speak for themselves.

MR FARMILO: Mmm.

MR BOLSTER: But as recently as 29 August, 5 November, 29 November, there was no suggestion that she had pain in her neck or shoulders. Now, I want to take you to the bundle at tab number 35, please, and page 1905. And that was a functional ability assessment of Mrs CO on 28 July 2017. You see there's a treatment intervention on page 1906. You see that? If that can be brought up. Treatment intervention number 3:

> *CO was on a massage program which has been ceased as she no longer has pain. Staff to closely monitor pain levels and refer to GP. PT, means physiotherapist, if any changes.*

MR FARMILO: Yes.

MR BOLSTER: You're not aware of any reference to the GP or the physio, are you?

MR FARMILO: I know the GP and the physios have both seen Mrs CO regularly. I'm not sure around that particular time.

MR BOLSTER: All right. Well, let's go to page – to – withdraw that – to tab 36, please. If we can go to the email on the next page at the foot of the page, this is an

email – actually, go back and highlight the bottom email. You see that? This was an email from a physio - - -

MR FARMILO: Mmm.

MR BOLSTER: - - - who we won't name, if you could - - -

MR FARMILO: That's fine.

MR BOLSTER:

> *Just confirming, was it CO that you asked about pain treatments for this morning? If so, she is currently receiving no physio intervention. Does she need to be reviewed for pain treatment?*

And then you replied – and if we could go then to the email at the top of the page, you reply – can you read that to yourself.

MR FARMILO: Yes, I'm aware of that email.

MR BOLSTER: You're familiar with that email?

MR FARMILO: Yes.

MR BOLSTER: "HP" means heat pack; correct?

MR FARMILO: Yes.

MR BOLSTER: "TEDs" refer to the long stockings that stop blood clots in the legs. You heard the daughters talk about that before.

MR FARMILO: Correct. Yes.

MR BOLSTER: What was going on with this letter, Mr Farmilo? What were you seeking to do with that letter?

MR FARMILO: From my understanding at the time, Mrs CO's care needs were changing, I think the number of assessments completed around that time. Typically when a resident's care needs changing that – that triggers a comprehensive review, including a review of the ACFI submission at the time. So as a result of changing care needs, this email was simply asking that the physios conduct a comprehensive review to see if perhaps pain was involved and if any interventions would be appropriate for Mrs CO.

MR BOLSTER: The ACFI is the assessment instrument that determined how much the Commonwealth will pay Brian King Gardens to provide care for the resident.

MR FARMILO: Correct.

MR BOLSTER: And that's on top of the care or the fees that you charge the resident for care as well.

MR FARMILO: Correct.

MR BOLSTER: In this case, Mrs CO was funding herself for care; correct? Or the daughters were – the family was funding her care on top of the ACFI or the Commonwealth funding that you would receive.

MR FARMILO: So every resident is asked to pay a basic daily care fee. Correct.

MR BOLSTER: And they had paid an accommodation bond?

MR FARMILO: I understand so, yes.

MR BOLSTER: And how much was the accommodation bond that they had paid?

MR FARMILO: I'm not sure, sorry.

MR BOLSTER: Now, there's an ACFI for each resident; correct?

MR FARMILO: Correct.

MR BOLSTER: And they have two lodged with the Department of Health every year/two years.

MR FARMILO: No. No.

MR BOLSTER: How often?

MR FARMILO: One needs to be submitted on admission within two months of someone becoming a permanent resident.

MR BOLSTER: Yes.

MR FARMILO: There is then a requirement that they are – the – the initial one is reviewed six months later.

MR BOLSTER: Yes.

MR FARMILO: If someone returns from hospital, you need to submit one. If someone is in hospital for 28 days or longer, you need to submit an ACFI submission that time as well, and then voluntarily in relation to changing needs.

MR BOLSTER: Yes. So you were proposing a voluntary lodgement of an ACFI for Mrs CO at that time.

MR FARMILO: Correct.

MR BOLSTER: And an ACFI was lodged on 15 November; correct?

MR FARMILO: Yes.

MR BOLSTER: All right. Just in terms of the acronyms that are in that document, to assist the Commission - - -

MR FARMILO: Yes.

MR BOLSTER: - - - LL – "LLH" means low high high for the three ACFI domains - - -

MR FARMILO: Correct.

MR BOLSTER: - - - of activities of daily living or ADLs.

MR FARMILO: First one.

MR BOLSTER: Behaviours, "BEHAVIOUR", and the third one is complex health care.

MR FARMILO: Yes.

MR BOLSTER: Correct? So she was assessed as low for ADLs, high for behaviours, principally because of her wandering.

MR FARMILO: I don't recall the behaviours. They're the - - -

MR BOLSTER: You don't recall that.

MR FARMILO: They're the – I don't know the behaviour that fed specifically into that domain at the time.

MR BOLSTER: Okay. And high for complex health care. And the treatment of pain is relevant to determining the level of CHC, or complex health care; correct?

MR FARMILO: Correct.

MR BOLSTER: If a person needs a significant pain treatment like a 4b pain treatment, a facility is paid more than if they do not; correct?

MR FARMILO: It can have an impact on the claim, yes.

MR BOLSTER: Yes. And how much more is it to be a high CHC compared to a medium CHC?

MR FARMILO: I don't know those specific details.

MR BOLSTER: Are you sure?

MR FARMILO: Yes.

MR BOLSTER: You don't know that?

MR FARMILO: Correct.

MR BOLSTER: It's about $7000 a year, isn't it?

MR FARMILO: Could be.

MR BOLSTER: Right. At the time you sent that email, you hadn't been round to see Mrs CO and ask her how she was, had you?

MR FARMILO: I don't believe I had.

MR BOLSTER: No, and no one had told you that Mrs CO has got a problem and needs a pain treatment, did they?

MR FARMILO: That's why I was asking the physiotherapist to go and review her for that.

MR BOLSTER: You see, she's currently LHH in ACFI. Wouldn't she stay at LHH if you did nothing?

MR FARMILO: Correct, yes.

MR BOLSTER: So why were you putting in the application in the first place?

MR FARMILO: So as mentioned earlier, it was in response to changing care needs for Mrs CO. I believe the care needs were changing and, as mentioned, that triggers a review of all of her care needs.

MR BOLSTER: Okay. Let's just go back a step. You ran into the physio, you asked the physio – if we could go back to the foot of the page, the email at the foot of the page. You asked about pain treatments for this morning for Mrs CO. You say there were changing care needs.

MR FARMILO: Yes.

MR BOLSTER: What were they? When you had that conversation at 1.30 pm on the 20th or before 1.30 pm on the 20th, on the morning of the 20th – I withdraw that. What was the extended care need that you had in mind?

MR FARMILO: I don't specifically remember. That would have been prompted from our daily handover meetings where we discuss residents in the mornings.

MR BOLSTER: Right. So every morning at Brian King Gardens you sit with the care manager, do you, and they tell you how each resident is going?

MR FARMILO: Each morning there is a daily handover. It involves the care manager, the resident nurses, the care supervisors, physios, lifestyle staff, and I will often attend that meeting as well.

MR BOLSTER: Yes. This – so is that the meeting that you were talking about? I withdraw that. Was it at that meeting that you asked about pain treatment for Mrs CO?

MR FARMILO: It would have been, yes.

MR BOLSTER: Okay. And why did you ask?

MR FARMILO: In response to changing care needs for her. I wanted to - - -

MR BOLSTER: What were they?

MR FARMILO: I don't remember exactly what those changing care needs were at the time.

MR BOLSTER: Who told you?

MR FARMILO: They would have been discussed in that handover meeting.

MR BOLSTER: Was that – is that the sort of thing that the care manager would do? The care manager would talk to you about the changing care needs of a resident at a handover meeting every morning?

MR FARMILO: So the discussion would have been coming from the care supervisor and the registered nurse, who would know the residents' care needs more intimately than myself.

MR BOLSTER: All right. Well, how long did these meetings go – these handover meetings go every morning?

MR FARMILO: Typically 30 to 45 minutes.

MR BOLSTER: All right. And what was the thing that concerned you about Mrs CO when her name was brought up at this meeting that led you to ask this question?

MR FARMILO: Sorry, I can't remember the specifics of that discussion.

MR BOLSTER: I want to suggest this to you. When you sent that email, you weren't aware of any changed clinical needs for Mrs CO in relation to the question of pain. What do you say about that?

MR FARMILO: No, I don't accept that.

MR BOLSTER: Right. If you were, you would be able to tell us precisely what that was, may I suggest.

MS ENGLAND: I object to that. It's a very unfair question in relation to the meeting on 20 October 2017, with over 200 residents, a meeting of that nature every morning, 18 months ago. It's very unfair, with respect.

MR BOLSTER: I withdraw the question, and I will ask another question.

COMMISSIONER TRACEY: I think it's a comment rather than a question.

MR BOLSTER: Yes. Do you have any observations about sending that letter to the physio?

MR FARMILO: No.

MR BOLSTER: You see, that letter suggests that it was sent because of an impending ACFI assessment, as opposed to changing care needs of Mrs CO. What do you say about that?

MR FARMILO: I say that's in reverse. The ACFI submission would have been made in response to changing care needs.

MR BOLSTER: All right. Were you concerned that you may have been linking the ACFI assessment to a care issue when you sent that email?

MR FARMILO: Sorry, could you just repeat that question?

MR BOLSTER: Were you concerned that you were linking the ACFI assessment that you had in mind to a care issue when you sent that email?

MR FARMILO: ACFI assessments are always linked to care.

MR BOLSTER: What do you mean by that?

MR FARMILO: So an ACFI submission needs to be the reflection of the care that a resident is receiving.

MR BOLSTER: Shouldn't the care drive the ACFI?

MR FARMILO: Correct.

MR BOLSTER: Rather than the other way round?

MR FARMILO: Correct. And that's what's happened in this instance.

MR BOLSTER: If we go, please, to tab number 38 of the tender bundle. You will see there that the physio reported back to you that Mrs CO reported pain and stiffness in her neck and shoulders. And the physio said that she was happy to commence a new 4B and HP. Now, the email dealt with a number of other residents as well, didn't it?

MR FARMILO: This email here?

MR BOLSTER: Yes. Go down to the second page, see it says:

> *Physio will continue to monitor the above residents. Have spoken to care staff and asked them to let us know if there are any changes, too. If you like, I can get another physio, may I suggest –*

who I don't wish to name.

MR FARMILO: Yes.

MR BOLSTER:

> *...to review the residents who deny pain in a few days as they may respond differently to a different physiotherapist.*

So Mrs CO was one of a number of residents who were asked if they had pain for the purpose of going on pain treatment; correct?

MR FARMILO: If they have pain we would want to treat their pain, yes.

MR BOLSTER: And when the physio got back to you, may I suggest she was offering an alternative in the case of residents who had denied pain, that is, you get another physio to ask the same question, and see if you get a more favourable answer; correct?

MR FARMILO: We find that different residents respond to different people in different ways. So we want to make sure that we're providing a comprehensive assessment of their pain to ensure that any pain they have is captured and treated.

MR BOLSTER: Mrs CO suffers from dementia, doesn't she?

MR FARMILO: Yes.

MR BOLSTER: Were her daughters consulted about the need for a pain management regime of the kind that was ultimately implemented?

MR FARMILO: I don't know.

MR BOLSTER: You don't know? Should they have been, given the policies and procedures in place at Brian King Gardens at that time?

MR FARMILO: Not necessarily so. I think – I don't think that's always going to be the case.

MR BOLSTER: For residents who denied pain, were ACFI assessments in your mind about them at that time?

MR FARMILO: I'm not sure, sorry.

MR BOLSTER: Right. And you saw, when I displayed in my opening the 4B and HP pain regimes, didn't you? Let's bring them up again. Tab number 43, please. And if we could go, please, to the previous page we were on for pain, if we just stay with that page for now. No, if we can go down, please, I think it's to page 9 or page 10. Page 2022 - 2027, that's it. Thank you. If we can just have HP, do you see there the third box with 1, the score of 1 on the left-hand side?

MR FARMILO: Yes.

MR BOLSTER:

> *Pain management involving therapeutic massage and/or application of heat packs, frequency at least weekly and involving at least 20 minutes of staff time in total.*

MR FARMILO: Yes.

MR BOLSTER: You didn't claim that, did you? Sorry, you did claim that, didn't you?

MR FARMILO: We did.

MR BOLSTER: And that is a category 3; correct?

MR FARMILO: Correct.

MR BOLSTER: And then you have the 4B, complex pain management.

MR FARMILO: Correct.

MR BOLSTER: What was complex about it? I mean, the complaint that she gave to the physio was that she had sore neck and shoulders.

MR FARMILO: Mmm.

MR BOLSTER: Where was the complexity?

MR FARMILO: I wasn't involved in that assessment so I'm not sure of those details.

MR BOLSTER: You made the ACFI application?

MR FARMILO: Yes. It would have my signature on it.

MR BOLSTER: Yes. Well, you surely had some idea in mind when you signed off on the ACFI application what complex pain management you were certifying was necessary for her care.

MR FARMILO: Mmm.

MR BOLSTER: What was it?

MR FARMILO: So I was trusting that my physiotherapist had performed the appropriate assessments and had prescribed appropriate clinical treatment for that.

MR BOLSTER: Can we just go back, please, while we're here, to 2023 in that document. And you will see there – if that could be brought up, the mental and behavioural disorders box which is the – there was no diagnosis of depression. If you see box 555A at that time.

MR FARMILO: Correct.

MR BOLSTER: And that was November 2017.

MR FARMILO: Correct.

MR BOLSTER: But the ACFI did include the fact that she was a fairly high level wanderer; correct?

MR FARMILO: It would have, yes.

MR BOLSTER: Yes. All right. Do you maintain, Mr Farmilo, that the decision to characterise Mrs CO as requiring 4B pain treatment and thus remain at the high level for CHC was clinically justified, or is that something you think should be checked up?

MR FARMILO: I believe it was.

MR BOLSTER: And why do you believe it was?

MR FARMILO: Because I trust in my physio staff that they provide proper assessments and then treat as required.

MR BOLSTER: Does Anglicare and Brian King Gardens utilise ACFI coordinators to maximise the needs of residents for care in order to obtain the best ACFI outcome?

MR FARMILO: We utilise ACFI coordinators to ensure that we are claiming for all the care that we're providing, yes.

MR BOLSTER: Are you familiar with the term "ACFI gaming"?

MR FARMILO: No.

MR BOLSTER: You've never heard that term?

MR FARMILO: I haven't.

MR BOLSTER: If we could go, please, to tab number 40, if we could go to the second page, to the first email in the chain. I think you will need to go further down. Thank you, operator. So this is an email from Ms Bartrop to you, and if we go back down to the last page:

ACFI will need quite a few things fixing before we can progress with her –

Sorry, I withdraw that:

Mrs CO's ACFI will need quite a few things fixing before we can progress with her ACFI. Would you like to do this today or wait until Mary returns on Wednesday? I can leave Mary a list of things to review and she can prepare it for me to submit on Thursday next week. One thing we need is her diagnosis form signed. Does Dr Ginger work at BKG today?

If we go up the page:

Dr Ginger won't be back till next week.

Do you see that?

MR FARMILO: Yes.

MR BOLSTER:

If you could please print a form we will get Dr Ginger to sign early next week.

Then you ask this:

What needs to change to make CO a H in ADLs or is this not possible? As for all other changes required happy to wait for Mary to return to fix all of this up.

Then Ms Bartrop, who is your ACFI coordinator – and I presume she's the person who provides advice about how ACFI forms and applications should be made.

MR FARMILO: Yes.

MR BOLSTER: And you rely on her, do you?

MR FARMILO: We did at the time, yes.

MR BOLSTER: She says:

I don't think a high in ADLs would be possible. She's basically just scraped in as medium, based on the assessments last week. To become a high in ADLs you need a combination of –

Etcetera, etcetera. I want to suggest this is – the ACFI driving the issue, not Mrs CO's care?

MR FARMILO: No, that's not the case.

MR BOLSTER: Not the case.

MR FARMILO: Correct.

MR BOLSTER: All right. Did you get her up to a high in ADLs or did the application go in at medium?

MR FARMILO: I believe it went in at a medium.

MR BOLSTER: Yes. At the time this process was going on, how familiar were you with the way in which ACFI applications were lodged with the Department of Health?

MR FARMILO: I was familiar with the process.

MR BOLSTER: Yes. Were you involved at all in the follow-up to the pain treatment for Mrs CO in May of 2018 or June of 2018 when it ceased?

MR FARMILO: I'm not sure to be honest.

MR BOLSTER: Did you take any interest in how her pain treatment that you had initiated was going?

MR FARMILO: Can I just confirm the pain treatment was initiated by the physiotherapists who assessed her. It wasn't initiated by myself.

MR BOLSTER: Okay, that's your position.

MR FARMILO: Yes, correct.

MR BOLSTER: The physio. However you say it was initiated, were you involved in the process of observing how it went?

MR FARMILO: I'm not sure.

MR BOLSTER: Right. Okay. And when she went off it, in June of 2018, I take it she remained a high for complex health care?

MR FARMILO: That rating would have remained.

MR BOLSTER: Is she still a high for complex health care?

MR FARMILO: Most likely, yes.

MR BOLSTER: Even though she's not receiving that pain treatment. Is there an obligation on you when a critical element of her care needs changes for ACFI purposes to let the department know?

MR FARMILO: I don't think so.

MR BOLSTER: It's not something you've raised with the ACFI coordinator who you obtain advice from?

MR FARMILO: I'm not sure. I don't think so.

MR BOLSTER: Might that be a convenient time, Commissioners?

COMMISSIONER TRACEY: Yes. Very well. The Commission will adjourn until noon.

ADJOURNED **[11.44 am]**

RESUMED **[12.04 pm]**

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Mr Farmilo, I wanted to talk now about the oral issue.

MR FARMILO: Yes.

MR BOLSTER: You carried out an investigation promptly when the matter was raised with you.

MR FARMILO: Yes, I did.

MR BOLSTER: And you observed there were several breakdowns for the Brian King Gardens protocol to ensuring directives received from external health professionals were carried out.

MR FARMILO: Correct.

MR BOLSTER: And you assured the daughters that see that steps would be put in place to see that oral health would be attended to in future.

MR FARMILO: Yes.

MR BOLSTER: You also, can I say, sought to assert that resistance on the part of Mrs CO was responsible for the inability to provide oral care. You recall doing that?

MR FARMILO: Yes, I do.

MR BOLSTER: Was that the on the basis, I assume, of what you were told by staff in the course of your investigation?

MR FARMILO: Yes.

MR BOLSTER: You've heard the evidence of the daughters given today?

MR FARMILO: Yes.

MR BOLSTER: Did you seek their perspective on the resistance issue before you made that conclusion?

MR FARMILO: In November 2016?

MR BOLSTER: Yes.

MR FARMILO: I don't believe I would have, no.

MR BOLSTER: No. You see, the iCare notes don't record resistance to oral health in the period in question, that's the four months that led up to 1 November. Do you accept that?

MR FARMILO: I accept that the – the notes demonstrate resistance to care generally. However, there's no specific mention of oral care.

MR BOLSTER: So when the carers and the nurses found resistance, so, as you heard, resistance to showering, resistance to toileting, resistance to other things, they made notes of it; correct?

MR FARMILO: I believe they have, yes.

MR BOLSTER: They didn't make any notes in relation to her cleaning her dentures, cleaning her teeth.

MR FARMILO: Not specifically.

MR BOLSTER: No. All right. And what's your reaction to the evidence of the daughters to the effect that, well, they never observed their mother being resistive in this way, and that oral health was important to her?

MR FARMILO: Yes, so I accept that oral health certainly was important to her and to her daughters on an ongoing basis. Yes.

MR BOLSTER: Who made the decision to place Mrs CO on the soft food diet at the beginning of this year?

MR FARMILO: That was a recommendation made by the speech pathologist.

MR BOLSTER: Right. Okay. And we will be hearing from the speech pathologist shortly.

MR FARMILO: Yes.

MR BOLSTER: Now, it wasn't a decision that you made?

MR FARMILO: No.

MR BOLSTER: No. Okay. All right. Finally, I want to deal with some questions about the Brian King Gardens response to the Commission's initial request for information. You recall that?

MR FARMILO: Yes.

MR BOLSTER: Were you involved in preparing that document?

MR FARMILO: I was.

MR BOLSTER: Would you agree with me that it does not isolate or indicate or inform about any of the matters that we have been discussing today?

MR FARMILO: I would agree with that.

MR BOLSTER: Do you have a view about the response, whether it was adequate in the circumstances?

MR FARMILO: I believe it was.

MR BOLSTER: Does that mean that you don't regard the matters that we've been discussing as occasions of substandard care?

MR FARMILO: No, they certainly are.

MR BOLSTER: Well, you were asked to indicate occasions when substandard care had been delivered.

MR FARMILO: Correct.

MR BOLSTER: And you didn't - - -

MR FARMILO: Correct.

MR BOLSTER: - - - in this case. You accept that?

MR FARMILO: That's correct.

MR BOLSTER: All right. And do you have an explanation for that?

MR FARMILO: The explanation for that is there was a – a failure in – on my behalf and some of the other staff to properly document feedback and complaints that had been received. Verbal feedback had not been – or email had not been documented in a proper format and hadn't been captured.

MR BOLSTER: All right. I just wanted to ask you one last series of questions. The DB mass, the intervention for people who have difficult dementia behaviours.

MR FARMILO: Yes.

MR BOLSTER: You're familiar with that service that's run by HammondCare, funded by the Commonwealth Government?

MR FARMILO: I am.

MR BOLSTER: You're familiar that it's a free service - - -

MR FARMILO: Yes.

MR BOLSTER: - - - that provide specialist advice, assistance and care to people very much in the category of person that Mrs CO is in, that is, people with dementia who have troubling difficult behaviours that need to be managed in the residential aged care context. Correct?

MR FARMILO: Yes.

MR BOLSTER: And in your response today, exhibit 3-20, you indicated that Brian King Gardens did not use the DB mass for Mrs CO, or indeed for any other residents in the last 12 months; is that correct?

MR FARMILO: That's correct.

MR BOLSTER: And you say that was – I will come back to that – and you say that was because Anglicare has its own specialist professionals to consult with in that field. Correct?

MR FARMILO: Yes.

MR BOLSTER: Do you have any explanation as to why they weren't consulted when Mrs CO displayed these particular difficult behaviours?

MR FARMILO: I can't respond to that specifically, no.

MR BOLSTER: Is that a question you asked Ms Tinley when you discussed the matter with her?

MR FARMILO: No, not directly.

MR BOLSTER: Is it something that Brian King Gardens is prepared to contemplate in the future as something that needs to be looked at when people display these sorts of behaviours?

MR FARMILO: Yes. So we acknowledge we need to use the full range of resources available to us. So our internal dementia care specialists as well as external sources, yes.

MR BOLSTER: There's nothing further. Thank you, Commissioners.

COMMISSIONER TRACEY: Mr Farmilo, you would have seen the photograph that was shown to the Commission in opening this morning of the condition of Mrs CO's feet - - -

MR FARMILO: Yes.

COMMISSIONER TRACEY: - - - with the nails just allowed to grow for months and nothing was done about it.

MR FARMILO: Yes, I have.

COMMISSIONER TRACEY: The explanation that was given in the correspondence once a complaint was made had to do with missing appointments and things of that kind. What troubles me is that on a daily basis one would have assumed that there were nurses and carers who would have observed that situation. There is no mention made in the explanation that is tendered to the family as a result of the investigation that took place as to why those observations were not made or reported for a period of at least six months.

MR FARMILO: Yes.

COMMISSIONER TRACEY: Have you any explanation as to how that could possibly have come about?

MR FARMILO: So, Commissioner, I acknowledge in my statement that was certainly something I was very disappointed about. I agree it would have been evident that Mrs CO's toenails were growing and had not been attended to for some time. It would have been several months before the toenails would have got to a length that the staff would have noticed, but they still should have seen it, absolutely they should have, and it should have been reported at the time. At this point in time I cannot give you a clear explanation as to why the staff did not come forward and let somebody know that her toenails had grown to that length.

COMMISSIONER TRACEY: Very well. Thank you for your evidence. You're excused.

MR FARMILO: Thank you, Commissioners.

MS ENGLAND: Commissioners, I have a few questions, if I may.

COMMISSIONER TRACEY: Well, you may if you've taken the matter up with counsel according to the protocols.

MS ENGLAND: Yes. Might I have a moment to do that now, please? Some of these matters have just arisen.

COMMISSIONER TRACEY: Yes.

MS ENGLAND: Thank you.

COMMISSIONER TRACEY: Well, I don't want to delay things. Mr Farmilo, can you remain within the precincts of the Commission and, if need be, return to give some evidence at 1.30?

MR FARMILO: Yes, Commissioner.

COMMISSIONER TRACEY: Yes. Very well.

MR BOLSTER: Commissioners, I formally tender the document that was produced and shown to Mr Farmilo. That's SUV.0001.0012.3856. That's the response breaking down the psychotropic drugs prescribed as of 1 July 2018.

COMMISSIONER TRACEY: The Anglican Community Services' response to the Royal Commission's request for information dated 7 January 2019 will be exhibit 3-25.

EXHIBIT #3-25 ANGLICAN COMMUNITY SERVICES' RESPONSE TO THE ROYAL COMMISSION'S REQUEST FOR INFORMATION DATED 07/01/2019 (SUV.0001.0012.3856)

MR BOLSTER: Commissioners, I call Cheryl Lee.

<CHERYL LEE, SWORN [12.15 pm]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Yes. Could document WIT.0131.0001.0001 be brought up. Thank you. Ms Lee, is this your statement?

MS LEE: Yes, it is.

MR BOLSTER: On the screen in front of you. Yes. Thank you. And do you wish to make an amendments to it?

MS LEE: No.

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

MS LEE: Yes.

MR BOLSTER: Ms Lee, you are a speech pathologist employed by Anglicare Health.

MS LEE: That is correct.

MR BOLSTER: You saw Mrs CO – and we are referring to her as Mrs CO, please don't use her name - in January this year.

MS LEE: That is right.

MR BOLSTER: The issue was there was a concern about her swallowing her food. She was retaining it in her mouth in both cheeks and spitting it out.

MS LEE: That is correct.

MR BOLSTER: When you saw her, did you look at whether there could have been a dental issue associated with that behaviour?

MS LEE: I'm not a dentist but I did check that her teeth were in place and they were not really loose, and that her mouth was free of any signs of any food left over or any – yes, I did check that.

MR BOLSTER: The food that she was retaining, what sort of food was it?

MS LEE: It tended to be foods that were of harder textures, so foods that are more crunchy, more dry, requiring more chewing.

MR BOLSTER: The behaviour though, correct me if I'm wrong, the behaviour that you noticed was that she would eat very quickly and she would eat far too fast for her ability to swallow the food.

MS LEE: That is right.

MR BOLSTER: So she would get to a point where she had too much food in her mouth and she couldn't swallow it.

MS LEE: That is correct.

MR BOLSTER: Is that a typical behaviour for someone with dementia?

MS LEE: That can be; they can have that reduced ability to inhibit the rate.

MR BOLSTER: Correct me if I'm wrong, but wouldn't the standard response from the carer for that sort of behaviour be to just feed her carefully one on one?

MS LEE: That is one strategy. That is right.

MR BOLSTER: Has that strategy been employed for Mrs CO?

MS LEE: Yes, it has been.

MR BOLSTER: And has it been working?

MS LEE: So I saw Mrs CO twice and I would say that that level of supervision and that assistance is working.

MR BOLSTER: Yes.

MS LEE: But she still requires foods to be manually adjusted for her.

MR BOLSTER: Yes. If a nurse or trained carer were to deal with her and give her food, and cut it up for her and sit with her when she ate it, particularly if it was a harder food, there should be no risk, should there?

MS LEE: There would still be some level of risk because it's not just the rate that was causing the issue. That was one of the issues. Also because of dementia she was not always aware of food left over in her mouth.

MR BOLSTER: Yes.

MS LEE: And she was also not always completely chewing her food up properly before she tried to swallow.

MR BOLSTER: Yes. All right. But there's no barrier to her having any type of food, is there, so long as someone attends to her when she's eating it?

MS LEE: What do you mean by barrier?

MR BOLSTER: If someone sits with her and assists her, and doesn't give her the next mouthful until she's in a position to accept it, there shouldn't be any risk, should there?

MS LEE: But if you give her anything that's still too hard there would still be food left over because that ability to chew in itself and ability to be aware of food is still
- - -

MR BOLSTER: All right. Nothing further. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you for your evidence, Ms Lee; you're excused.

<THE WITNESS WITHDREW [12.20 pm]

MR BOLSTER: Commissioners, I call Dr Ginger.

<MARGARET ANNE GINGER, AFFIRMED [12.20 pm]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Could Dr Ginger's statement be brought up, please. The number is – I don't have a number on my copy, Commissioners, I apologise. We will get that. We do have it. We do have it. That's for the record, WIT.0155.0001.0001. Now, Dr Ginger, is that your statement?

DR GINGER: Yes, it is.

MR BOLSTER: And do you wish to make any amendments to it?

DR GINGER: No.

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

DR GINGER: Yes.

MR BOLSTER: - - - and belief?

DR GINGER: Yes.

MR BOLSTER: Just bear with me.

COMMISSIONER TRACEY: Before you move on, Mr Bolster, I'm not sure that you tendered either this statement or Ms Lee's.

MR BOLSTER: Can I rectify that, Commissioner. Can I tender this one first.

COMMISSIONER TRACEY: Well, why don't we do it in sequential order. The statement of Ms Cheryl Lee dated 26 April will be exhibit 3-26.

EXHIBIT #3-26 STATEMENT OF MS CHERYL LEE DATED 26/04/2019 (WIT.0131.0001.0001)

COMMISSIONER TRACEY: And the statement of Dr Margaret Anne Ginger dated 2 May 2019 will be exhibit 3-27.

EXHIBIT #3-27 STATEMENT OF DR MARGARET ANNE GINGER DATED 02/05/2019 (WIT.0155.0001.0001)

MR BOLSTER: Thank you, Commissioners. Dr Ginger, in paragraph 2 of your statement you observed that you are a general practitioner who provides medical services to Brian King Gardens nursing home.

DR GINGER: Yes.

MR BOLSTER: Is that correct?

DR GINGER: That is correct.

MR BOLSTER: You also provide medical services to the residents of Brian King Gardens nursing home, don't you?

DR GINGER: Yes.

MR BOLSTER: They are your clients.

DR GINGER: Yes.

MR BOLSTER: And your patients; correct?

DR GINGER: Yes.

MR BOLSTER: Do you have a commercial relationship with Brian King Gardens whereby you provide them with extra services?

DR GINGER: No.

MR BOLSTER: All right. Now, I want to ask you some questions about the events of 4 July last year. How did you come to be called to the nursing home that day?

DR GINGER: I believe that was my usual Wednesday that I work on that day. And the care coordinator actually came to see me to discuss what the pastoral care worker had discussed with her concerning - - -

MR BOLSTER: What did – that was Ms Tinley, the care manager.

DR GINGER: Yes.

MR BOLSTER: And you had a working relationship with her.

DR GINGER: Yes. Yes.

MR BOLSTER: You had obviously spoken about Mrs CO - - -

DR GINGER: Yes.

MR BOLSTER: - - - on a number of occasions previously.

DR GINGER: Yes.

MR BOLSTER: And at that time you knew that she was a wanderer.

DR GINGER: Yes.

MR BOLSTER: That she had anxiety.

DR GINGER: Yes.

MR BOLSTER: She was often disorientated as to where she was?

DR GINGER: Yes.

MR BOLSTER: And she often was tearful?

DR GINGER: Crying quite a lot.

MR BOLSTER: Yes. But till that point in time, there had been no diagnosis of depression; correct?

DR GINGER: No.

MR BOLSTER: And on that occasion, the clinical notes of the facility, which you obviously had access to and enter from time to time when you see a patient, they make no reference to any of the standard tests for depression having been carried out in relation to Mrs CO; is that correct?

DR GINGER: Yes, that's correct.

MR BOLSTER: Were those tests carried out?

DR GINGER: No.

MR BOLSTER: Can I ask why not?

DR GINGER: Dealing with a patient with depression, it's difficult to get answers that would verify the situation.

MR BOLSTER: So you don't accept, do you, that the – that there are any tests for people living with dementia that can be used to assess whether they are suffering from depression or not.

DR GINGER: There can be, but Mrs OC was advanced in her dementia which makes it more difficult to make the test reliable.

MR BOLSTER: All right. Aren't tests important to mark out improvement in the future when you embark on a treatment plan for the depression that you've diagnosed?

DR GINGER: Yes.

MR BOLSTER: So in the notes that have been provided to me, and the Commission, it doesn't appear that there's any information that would enable you in the future to assess whether or not the medication was working; correct?

DR GINGER: Correct.

MR BOLSTER: And typically, an antidepressant prescription would have little effect on the depressive symptoms for a period of days, sometimes a week or two.

DR GINGER: Mmm.

MR BOLSTER: It's a – you agree with that?

DR GINGER: I agree.

MR BOLSTER: Here, it's been suggested by Mr Farmilo that there was a necessity, a pressing necessity for her to be given the drug that you prescribed immediately.

MS ENGLAND: I object to that. It's an inaccurate statement of his evidence, with respect. What he said was that it was in her best interests. Counsel assisting repeatedly used the word "necessity" in a tone that conveyed urgency. The actual evidence was "it's in her best interests".

MR BOLSTER: All right. Well, let's put it in those terms. Let's ask you: why did you prescribe mirtazapine for Mrs CO on 4 July?

DR GINGER: From the reports of the pastoral carer she was again crying and – and very upset. She was having memories back of her baby son and – and the – the dying of that baby son and that's very distressing for a patient with dementia because they can't really – they think it's very real at the time. And she had also had previous episodes where she was crying constantly, when they asked – the staff were asking her why are you crying, she couldn't remember why she was crying but she was upset. She was agitated.

MR BOLSTER: Yes.

DR GINGER: So at that stage I – I did – I didn't want to leave my patient distressed and in a distressed condition.

MR BOLSTER: All right. Do you know when the first dose was, in fact, administered to her?

DR GINGER: I had assumed it was going to be administered that night and it was – I just found out during this session that it was several days later.

MR BOLSTER: When the decision was made to prescribe the drug, did you try and contact the daughters?

DR GINGER: Yes. The case manager and I actually tried several times to – to contact the daughters.

MR BOLSTER: And you prescribed the drug, even though you could not contact the daughters.

DR GINGER: Yes, I did.

MR BOLSTER: And why was that?

DR GINGER: I just thought it was necessary to commence the medication for her.

MR BOLSTER: So you thought it was necessary?

DR GINGER: Yes.

MR BOLSTER: All right. Did you convey to Ms Tinley that it was necessary that the prescription be administered that day?

DR GINGER: I – yes. I can't recall telling her specifically but when I wrote it in the note – in the medication chart, it's assumed that it will be provided that day.

MR BOLSTER: Right. How many patients do you have at Brian King Gardens?

DR GINGER: I have 25 now.

MR BOLSTER: Right. At that time, how many did you have?

DR GINGER: I can't recall. It would be 35.

MR BOLSTER: 35. Okay. And how many of those were people living with dementia?

DR GINGER: Vast majority.

MR BOLSTER: And of those, how many had depression?

DR GINGER: I'm just trying to think. A minority. There would be very few.

MR BOLSTER: And did you prescribe mirtazapine for those residents of yours that had depression?

DR GINGER: I can't recall.

MR BOLSTER: Right. Is mirtazapine your preferred response to a person with dementia who - - -

DR GINGER: I - - -

MR BOLSTER: - - - has depression?

DR GINGER: I have used mirtazapine because of, one, it is an antidepressant and an antianxiety medication, and it tends to help them settle.

MR BOLSTER: If we could please go to tab 129 – sorry, we will go somewhere else first. If we could go to the tab 117, please. You're familiar with the medicines handbook?

DR GINGER: Yes.

MR BOLSTER: I assume you take a copy with you to work, or you have one at work.

DR GINGER: I actually take a MIMS on my phone.

MR BOLSTER: Right. Okay. All right. Are you aware of the cautions that are in place in relation to mirtazapine and antidepressants in that publication in the case of people living with dementia?

DR GINGER: No.

MR JACKSON: Could we clarify – sorry, could we clarify which publication, whether it's this one or MIMS?

MR BOLSTER: I'm talking about the Australian Medicines Handbook.

DR GINGER: No.

COMMISSIONER TRACEY: It's the one on the screen.

MR BOLSTER: Yes, there's only one document.

DR GINGER: Yes. No.

MR BOLSTER: You're not?

DR GINGER: No.

MR BOLSTER: Are you aware of studies – widely published studies, may I suggest –concerning the effect of mirtazapine as an antidepressant for people with dementia?

DR GINGER: No.

MR BOLSTER: Right. If you could go, please, to the handbook at page 749 in the actual handbook. It should be the third page in the bundle. You see the box "Elderly" on the right-hand side? No, go back a page. Yes. See the box "Elderly", the right-hand column on the page? Could we bring that up. No. No. Right in the middle of the page. That one. Thank you. So this is for – this is in the case of antidepressants generally:

> *The elderly may respond more slowly, have adverse effects, including falls.*

This is in the case of all antidepressants. It says:

> *Consider a low starting dose with a more gradual increase to minimise these.*

Then go down a couple of lines:

> *Mirtazapine and Sertraline seem ineffective in people with dementia and depression, and convincing evidence of benefit of other antidepressants is lacking.*

Is that something that you were aware of?

DR GINGER: Not particularly. Yes.

MR BOLSTER: All right. If you could go over, please, the page with "mirtazapine", and you will see there the dosage, if you go to the right-hand column, please, about point three of the page, dosage, up from there. Thank you:

> *Adult, 15 milligram at night, increasing gradually as indicated to 30 to 45 milligrams at night with a maximum 60 milligrams.*

Are you familiar with that guidance?

DR GINGER: Yes, I am.

MR BOLSTER: I want to suggest to you that an appropriate starting dose for someone of that age with dementia of mirtazapine, assuming it's warranted, would be less than the 15 milligrams, probably half of that.

DR GINGER: Mmm.

MR BOLSTER: What do you say about that?

DR GINGER: Yes, I – I would agree.

MR BOLSTER: Can I ask, then, why you prescribed 45 milligrams to start in this case?

DR GINGER: Yes, I – I had previously had discussions on a – on a medication review when they were looking at mirtazapine 15 milligrams and the pharmacist had said there have been several studies that, actually, the 15-milligram mirtazapine could increase – actually cause more sedation than the higher dose.

MR BOLSTER: I think the pharmacist was talking about – I withdraw that. I will leave that to the experts. I won't go that way. Could I bring up another document, though. Go to tab 129.

COMMISSIONER TRACEY: Before you do, do you want to tender that?

MR BOLSTER: It's in evidence, Commissioners.

COMMISSIONER TRACEY: It's already there?

MR BOLSTER: It's there. Yes. Tab 129. You see this? This is a paper by a Dr Banerjee in England in The Lancet, it was published in The Lancet, which is a large clinical study of mirtazapine in the elderly. Are you familiar with Dr Banerjee's work at all?

DR GINGER: No.

MR BOLSTER: Right. If we could go then to tab 128, this is an article by Professor Brodaty. Are you familiar with Professor Brodaty's work?

DR GINGER: Yes.

MR BOLSTER: And you would understand that he would be one of the leading psychogeriatricians in the country.

DR GINGER: Yes.

MR BOLSTER: And if you go to the left-hand column at the foot of the page, he is talking about this study of Professor Banerjee, and this is a publication that's online,

freely available. And it's – you will see there that participants were aged 80 years, had moderately severe Alzheimer's disease with average mini mental state examination scores of around 18. We're in Mrs CO's category, aren't we? If we could go then to the next page. I'm sorry, I think we have gone – if we go back again. Go back another page. Yes. You see there on the right-hand column at about, towards the end, just above the photograph:

> *Banerjee and colleagues emphasised a stepped care approach of watchful waiting followed by low intensity psychosocial interventions, and, if unsuccessful, by more complex and intense interventions.*

Now, the study showed – and I won't take you to it because it really speaks for itself –that the – as against a placebo, the mirtazapine was found to have substantially little effect on people in that cohort with dementia. You were unaware of that?

DR GINGER: Yes.

MR BOLSTER: Right. Thank you. Are you aware of the – if we could go, please, to the general tender bundle, tab 3. Are you familiar with the managing behaviours of psychosocial symptoms of dementia by the DB mass?

DR GINGER: Yes.

MR BOLSTER: You would agree with me that that refers to Citalopram as being the preferred medication in the case of people with dementia or depression?

DR GINGER: I'm not – no. I'm not - - -

MR BOLSTER: You're not aware of that?

DR GINGER: No.

MR BOLSTER: All right. If we could go to page 143 of that – 143. Thank you. One of the things that that paper emphasises is the need for attendance to behaviours through a physical intervention, that is, psychosocial engagement with the patient; correct?

DR GINGER: Mmm.

MR BOLSTER: And that's before medicating for depression; correct? And you would be aware, wouldn't you, of the DB mass intervention that's provided by HammondCare?

DR GINGER: Yes. Yes.

MR BOLSTER: And you – have you used that in the case of patients with dementia?

DR GINGER: In other – in another facility.

MR BOLSTER: Yes. And have you sought to use it in the case of HammondCare – sorry, I withdraw that – in the case of Brian King Gardens?

DR GINGER: No.

MR BOLSTER: Can I ask why not?

DR GINGER: They did have their own people at one stage.

MR BOLSTER: Well, leaving aside whether they had their own people, Mrs CO would seem to be the perfect candidate for their services. Would you agree with that?

DR GINGER: Yes.

MR BOLSTER: Did you raise with Ms Tinley the prospect of Mrs CO being referred to DB mass?

DR GINGER: No.

MR BOLSTER: And was that because you understood that they had their own experts to deal with these sorts of behaviours?

DR GINGER: Mmm.

MR BOLSTER: Did you raise with Ms Tinley the desirability of those experts coming in and providing that assistance?

DR GINGER: No, I didn't.

MR BOLSTER: All right. Can I ask why, then, the jump on the day of diagnosis, without a test, to a prescription of mirtazapine at 45 milligrams, without any other intervention that may have assisted her behaviourally? Do you have a - - -

DR GINGER: I really have no explanation why I did that.

MR BOLSTER: Are you – sitting there today, are you happy with your prescription on that occasion?

DR GINGER: No, I'm not.

MR BOLSTER: Sitting there today, what is your view on what you should have done for Mrs CO? What was the best care outcome for her?

DR GINGER: We – we had tried to put her in a safe environment. I was still concerned about her crying with the death of her son. We did have the pastoral care people coming to see her. Maybe we should have continued with pastoral care visitations.

MR BOLSTER: I mean, this wasn't the first time she had been seriously upset, was it?

DR GINGER: No.

MR BOLSTER: No. And when you go through the notes, it seems that as though when someone sat down with her, when someone took the extra five minutes, 10 minutes to assure her, reassure her, give her a cup of tea, whatever, it seems as though the behaviours de-escalated.

DR GINGER: Mmm.

MR BOLSTER: Is that a fair summary from your experience of her?

DR GINGER: Yes.

MR BOLSTER: Right. And you were concerned for her when you saw her on 11 July, weren't you?

DR GINGER: I was concerned and she was more alert when I saw her and was actually talking, and that's when I spoke with the daughter.

MR BOLSTER: Yes.

DR GINGER: Because we were talking about whether to send her to hospital.

MR BOLSTER: Yes.

DR GINGER: My concern about that was mainly sending patients with dementia to hospital can increase their anxiety and make problems a little worse and she had actually settled.

MR BOLSTER: She is still a wanderer, isn't she?

DR GINGER: She wanders, she's more settled than she has been. She's not as agitated. When I go into the secure unit, she's colouring in, and now they've got a big fish tank as well, and she loves watching the fish.

MR BOLSTER: Yes.

DR GINGER: She doesn't seem as agitated or anxious as she used to be.

MR BOLSTER: Right. And she's now – the prescription is now changed?

DR GINGER: Yes. It was the 26th, I had been reviewing her and she had been remaining stable for a while. I did notice sometimes I would go in of a morning and she would be a little sleepy, and I'm thinking it's about time we started stopping this. I had a phone call from the facility to say the daughters would like to speak to me. I came in on the Saturday, talked to the daughters, and suggested that we stop the medication, but I couldn't stop it quickly.

MR BOLSTER: Yes.

DR GINGER: I had to do it slowly because I didn't want her rebounding.

MR BOLSTER: All right. Looking back on it, did anything – the reason – I withdraw that. Your decision to prescribe, was that solely your decision or were you responding to any request from any of the care staff at Brian King Gardens?

DR GINGER: It was my sole decision.

MR BOLSTER: All right. Thank you. That's the examination. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you very much for your evidence, Doctor. You're excused from further attendance.

DR GINGER: Thank you.

<THE WITNESS WITHDREW [12.48 pm]

MR BOLSTER: Commissioners, the – other than for the prospect of re-examination of Mr Farmilo there is one further witness in this case study who will not be available today. That's Ms Tinley. We will have to do our best to get a statement from her and interpose her some stage next week. But other than that, that is the evidence for the case study. I will discuss with Ms England the other issue. Other than that, there is a further direct experience witness who is here who we could deal with before lunch, Ms Nobes. Her evidence is largely a statement that she would like to read onto the record but I'm in the Commission's hands.

COMMISSIONER TRACEY: Yes. We will hear her before lunch and if that takes us past 1 o'clock, so be it.

MR BOLSTER: Thank you, Commissioner. I call Ms Nobes.

<KATHRYN JILL NOBES, SWORN [12.49 pm]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: If the document WIT.0143.0001.0001 could be brought up. Ms Nobes, can you see on the screen the statement?

MS NOBES: Yes, I can.

MR BOLSTER: And you've got a copy of that as well.

MS NOBES: Yes, I have.

MR BOLSTER: All right. Now, I understand there's a couple of things you want to add to your statement. We will deal with that at the end if you don't mind.

MS NOBES: Yes.

MR BOLSTER: But you would like to read your statement onto the record; is that correct?

MS NOBES: Yes, that's right.

MR BOLSTER: Why don't you start, assume that paragraphs 1, 2, 3 and 4 have been read, and you start at paragraph 5.

MS NOBES: Start at paragraph 5. Certainly.

My full name is Kathryn Jill Nobes. I am 62 years old. I live in New South Wales. I am an aged care worker known as an ACE at the facility which is located in New South Wales. Prior to working at the facility, I worked for a service provider in the community. That job involved going into people's houses and cleaning, personal care and social support. I left that job as the hours were unpredictable. I also felt that there was no support to workers and community care. I wanted to work in a facility where there would be more support and training available. I commenced part time work as an ACE level 1 at the facility on 13 November 2015. I am currently employed as an ACE level 2 and have been in this role since 20 July 2016.

I was working at the facility when a resident was killed by another resident. Following this incident, I was diagnosed with post-traumatic stress disorder, PTSD. I feel that my condition was aggravated by the manner in which the management of the facility made it difficult for me to talk to the police. I am speaking to the Royal Commission as I believe the working conditions for care workers in aged care has a serious impact on the quality of care that the workers are able to provide to the residents. I am also concerned about the safety and wellbeing of the care workers.

The facility. The facility has about 200 residents. There are two buildings. The facility also has self-contained apartments surrounding these buildings. One building, named Building 1, has three floors and each floor has 34 rooms. The other building, named Building 2, has two floors. On the ground floor of Building 1 there are two separate secure units for 34 high dependency dementia residents. The two units are separated by a locked kitchen/foyer area. One unit, named Unit 1, has 18 bedrooms. The other unit, named Unit 2, has 16 bedrooms. The male residents are usually located in Unit ,1 and the female residents are usually located in Unit 2.

In an afternoon shift there are two ACEs who worked on the ground floor of building 1. There was also a senior ACE who usually has a Certificate IV in Ageing, who does the wound management and gives out medication. We call this person the in-charge. The in-charge is also around to help the two ACEs feed residents and put residents to bed. There was also an ACE who worked a four hour shift, 1630 to 2030.

Training provided by the facility. Prior to working at the facility, I completed a Certificate III in Aged Care and Disability. I also completed a first aid certificate. The Aged Care Certificate covered a range of different subjects with an emphasis on treating the aged with respect and not to discriminate because of their race, gender or colour. This included the unit, Provide support to people living with dementia. This course focused on the theory of the subject, and my job is mainly helping residents with hands-on practical basic personal care and helping feed them their meals. I feel my most valuable training was through raising my children. You might feed your toddler with food on a spoon in a similar way as how you would feed a resident who was unable to hold a spoon for themselves.

When I first started work at the facility, I had two shifts working with a buddy. I was teamed up with another ACE who was more experienced. I followed them around and helped them. The buddy helped me shower somebody and get the beds made. I was shown how to use a slide sheet and I was also shown how to use the equipment, including the sling lifter and stand-up lifter. It can be confusing to use the lifting equipment as different ACEs use different techniques. I ended up watching videos on YouTube to teach myself. There are some really good videos on YouTube.

Since I started working at the facility in late 2015, the facility has provided me with at least three days of training. In 2016, we received two days of training. Each day was six hours long. There was also another separate hour of training. On the full day of training, a registered nurse came in and spoke to us and finished with us filling in a questionnaire with the correct answers. The registered nurse talked about four or five different topics. The topics included managing difficult behaviours of residents with dementia, basic clinical skills, recognising the deteriorating resident and elder abuse. In every subject we

were told of the importance of recording and reporting everything. We also received fire safety training once a year.

I have asked management at the facility for training on how to perform my job and to remain safe. During the full day training session, I asked the facilitator about the safety of the carers. The facilitator responded with the words to the effect, "You have to walk away when it is not safe and then come back 10 minutes later to try again." This is useful advice that I now use. I am concerned on what happens when there are 16 to 18 residents in a room and two residents start fighting. You can't just let a fight continue to happen, as there are other residents in the room and you need to keep everyone safe. I think there was a discussion amongst the workers in the room on how to divert the aggressive residents.

Caring for people with high dependency dementia. From March 2016 to November 2018, I worked most of my shifts on the ground floor of Building 1 and helped care for about 34 residents with high dependency dementia. I worked the afternoon shift. At the beginning, I did an eight hour shift from 2.15 to 10.45 pm. My eight hour shift would typically start with the handover. I changed to a four hour shift on January 2018. My four hour shift would start at 4.30 and finish at 8.30 pm. When I changed to a four hour shift, I felt like the handover was to be told of any resident who had passed away since I last worked, and to identify anyone who required special care. A handover consists of each member of the afternoon shift receiving a sheet of paper listing the room number and name of each resident, their medical condition and care needs.

The day shift in-charge advises any change in their conditions or care needs. This information is exchanged at 2.15 at the start of an afternoon eight-hour shift. I would miss out on a lot of information when I changed to a four-hour shift and started at 4.30.

Dinnertime was around 5 pm. I made sure that all residents were at the dining table and helped feed those that needed help. I handed the food out to the residents at dinnertime. I also took any food trays to the residents who preferred to eat in their room. After dinner, I escorted the residents to either the lounge or their room. If a resident wanted to go to bed, I would assist them onto the toilet, help them into their night attire and attended to their personal care, such as brushing their teeth. If required, I would help them into bed and make sure they had everything they needed. Most dementia parents have the bed lowered to the floor, which I would do. If they had a sensor mat, I would turn this on if it was not automatic.

From about 5.45 pm, my duties also include relieving the other two ACEs who were working the eight-hour shift would they could have their 30-minute dinner break. At around 7 pm, I gave out supper to the residents. After dinner or

whenever a resident requested, I would help the two ACEs change the residents into their night attire and put them into bed.

Throughout the shift, I had to deal with a range of behaviours associated with dementia. This included, (a) care workers cleaning a resident who is soiled because of incontinence of faeces while the residents is lashing out because they are confused or angry or failing to understand due to their dementia.

One of my most disturbing assaults happened while toileting a male resident. Another ACE had taken him to the bathroom, got him to hold on to the rail adjacent to the toilet, and pulled down his trousers and incontinence pad. This is in preparation to cleaning and changing him as per the usual procedure. His pants were full of faeces. In an instant, he let go of the rail, made fists of his hands and plunged them into the faeces. He quickly turned towards me and punched me in the breasts. I spun around and he continued to punch me in the arm and in the back. I ended up with his faeces all over my shirt.

The other ACE, a strong, young man, grabbed his wrists and told me to get out. Another ACE heard the noise and came to help me with the resident. I told the in-charge what happened, that I would go home as it was time for my dinner break and I needed to have a shower, also that I would take a towel to protect the car. I can't remember if I documented it. I – I really don't want to think about it, as I was so shaken.

Can I have a glass of water, please? Thank you:

(B) Care workers being subjected to racial verbal attacks from residents; (c) residents repeatedly trying to get out of their chair or bed, even when it is not safe for them to do so; (d) residents repeatedly calling out to relatives or seeking a loved one, this is often complicated when the relative is deceased; (e) residents walking into another resident's room; (f) residents trying to get out of the building grounds; (g) residents taking objects that don't belong to them; (h) a resident urinating or defecating in public spaces; (i) inappropriate sexual behaviour.

Some days were just chaotic. I had to constantly think of how to approach tasks. When there was three or four incidents happening at the same time, I had to ask myself, "Which one do I do first? And which one is going to cause me the most damage?" Simple tasks take much longer with residents with dementia, and to rush them can trigger aggressive behaviours.

There was a male resident who walked up and down the corridor and turned all the taps on. He would urinate in inappropriate places. He did this all day and night for four days straight. When his dementia became more advanced, he could no longer walk and became bedbound. It was my job, with the help of another ACE, to transfer this resident from a water chair to his bed. The other

resident called the other male ACE "black bastard". I would tell him to stop being rude, that the ACE was a good nurse and he should show some respect.

It was difficult to move this resident. When he sat in a chair, he either punched or kicked out at you or he became very stiff. We had to put the resident in a sling lifter. After transferring him to his bed, he often had a bowel motion. It was very difficult to take his trousers down as he would become very stiff, would swear at you and lash or kick out. So we would follow standard procedure, which is we would roll him on his side and pull down as much of his pants as possible, then roll him on the other side and pull his pants down completely.

It is more difficult when his continence aids was full of faeces. We would clean him up and would place this continence aid and clothing. Sometimes he would have another bowel motion. This meant we had to clean him again. It took 20 – between 20 and 30 minutes to get this resident from his chair to clean and dressed in bed. This becomes more difficult when all the residents want to go to bed at the same time. You often have them knocking at the door or trying to enter the room.

Many residents were confused or frightened when we try and clean them after they have a bowel motion. This is exacerbated when we don't have enough cleaning products. Sometimes there was no night pads or no wipes to clean the residents. At one stage, we had to use towels to clean the residents but then were told we can't do this. Instead, we used paper towels. Because the paper towel can rip the skin of the resident, we had to wet the – we had to wet the towels.

It is also upsetting when a resident doesn't have any suitable clothing to be changed into. At the facility, the residents are supposed to provide their own clothing. I have noticed that when residents have been there for a long time, that their clothing is too tight for them, because the clothing has either shrunk or the resident has put on weight. Sometimes the resident simply doesn't have clothes. This can be really horrible for the person.

There are also issues with the male residents who urinated everywhere. I remember there was one male resident who thought everything was a urinal. One worker told me that he had urinated over the nurses' counter and into the keyboard she was using. This was an issue when a resident urinated on another resident's walker in the dining room at dinnertime. The other resident got up and yelled at the man. I had to calm the furious resident down, make sure no one would trip on the urine on the floor, clean up the urine, get the other resident out of the dining room. This was all while I was trying to ensure everyone was fed.

I was repeatedly assaulted by residents. I have received blows, kicks, headbutts, twisting of the skin on my arms, grabbing and squeezing of my

hands and arms, attacks with faeces, verbal abuse and threats. I documented these assaults on the work computer. I have not noticed any real changes in the workplace. You were just sort of expected to deal with it. When I informed my in-charge that I had been assaulted by a resident, the in-charge shrugged their shoulders and said "That's dementia." This has happened on different occasions. I think there was an overriding culture in aged care of simply shrugging it off. I changed my shift from an eight hour shift to a four hour shift as I hoped that there would always be another carer around to help me when I was attacked.

When I was on an eight hour shift in an afternoon, I didn't have additional support for the last few hours. Sometimes this meant I had to look after 18 men by myself. I didn't feel safe. On a particular day at work, I started my shift at 4.30 as usual. At around 5.45 that afternoon, I entered a resident's room in unit 1 to relieve another ACE, ACE1 so she could go on her dinner break. I then walked to the lounge room. I saw the in-charge seated at the computer. I saw a resident standing at the nurses' station. I asked the resident if he wanted to come with me and get changed.

I walked the resident to his room, which was room 103. This particular resident had a strong accent and was quite deaf. I spoke loudly to him so he could hear me and he spoke loudly to me in return. I assisted the resident onto the toilet and changed him into his night attire, then helped him to his chair. While I was in the room 103 with the resident, I heard someone call my name. I walked out of the room and saw ACE1. She was standing in the corridor outside the dirty linen room. I walked over to speak to her. We had a discussion about the residents I had attended to. While ACE1 and I were talking, I looked down the corridor and saw the resident walking towards us.

The resident was holding a walking stick in his right hand, like it was a club. I saw the resident wearing a dark pair of shorts and that he had blood on his knees. I think I remember seeing blood on his hand. ACE1 and I discussed that the resident must have had a fall. I saw ACE1 take the walking stick from the resident. I looked at the resident. He was staring intensely into space and his body looked very rigid. I remember thinking that this was typical of his behaviour. I heard ACE1 ask the resident to come with her to the chair opposite the nurses' station. I saw the resident follow ACE1 to the nurses' station. He didn't resist. I saw the resident sit down in the chair. I noticed that the resident had blood on his knees and some blood on his hands.

He had some indent on his knees too. I think I also saw blood on his face around his mouth. ACE1 said words to the effect, "The blood must be because of a nose bleed." I saw ACE1 clean the resident with wet paper towels. I remember feeling concerned for ACE1s safety. This particular resident had a history of violence towards staff. ACE1 assured me that she was okay and asked me to go relieve ACE2 who was working on the afternoon shift in unit 2. I then walked to unit 2 and found ACE2. We had a discussion about how I

would attend to the residents while she was on her break. After a short period of time, ACE1 came running up to us and said words to the effect, "While I was at break, there has been a murder. The resident has murdered another resident." When we arrived at unit 1, I saw two registered nurses had arrived.

When we arrived at unit 1, I saw two registered nurses had arrived. ACE1 directed ACE2 that she was to go on break. ACE1 directed me to go to unit 2 and look after the residents. The registered nurse directed me to not leave unit 2. I noted that the residents of the men involved in the incident were in the office outside the lift and assumed that was why we had to stay in unit 2. There was a lot of people in the foyer, and I thought some of them were the police.

It was my role to prepare the supper trolley. To do this, I had to enter the kitchen that separated unit 1 and unit 2. When I was in the kitchen, I looked through the servery hatch into unit 1's dining room. The dining room was full of police officers. I left the kitchen, returned to unit 2 and gave out the supper to the residents. Unit 2 quickly became very crowded as the residents from unit 1 were transferred into it.

After I had given the supper to the residents in unit 2, the registered nurse directed ACE1, ACE2 and I to go on break. When walking to the tea room, I walked past a woman who was crying uncontrollably. I now know this was the wife of the resident. After my break, I gave out cups of hot chocolate to the residents and continued with my job of helping the residents get into bed. I escorted two residents back to their rooms in unit 1 and helped them get into bed. The following morning, I attended a police station and made a statement to the police.

Prior behaviours of the resident. I have reflected on what happened. I remember that a – that the resident had a particular history of violence towards both staff and residents. A few weeks prior to the incident, I was working on a shift with another male ACE, who, in conversation with me, said "The resident attacked me, and I was unable to stop him." He explained that the female in-charge that night came to his aid, but she was assaulted and unable to stop the resident either. It wasn't until another resident yelled, "You don't hit woman," that they managed to stop the resident. On another shift, around mid-November, another ACE informed me the resident had been found in the room of a bedbound resident. The resident was found with his hands around the bedbound resident's neck.

On 26 November 2018, I saw a note written in the handover sheet. The note recorded that a particular female resident needed to be kept away from the resident at all times. I was aware that it was because the resident had attacked that particular female resident. When the resident first came to the facility, he insisted that he could take care of his own personal care; therefore, I provided

very little personal care for him. I did give him a cup of hot chocolate at supper time.

Final comments and recommendations to the Royal Commission. I still work at the facility, but I do not work on the ground floor of building 1. I am making this statement to the Royal Commission as I feel that the work conditions at the facility are having a serious impact on quality of care and the safety of not only the residents but also the staff. I don't know what the answer is. I don't believe anyone does. And usually the problem is solved when the resident dies or they become bedbound. My hope is that this Commission will provide some answers and guidelines.

When you work with people with dementia, you often find there is at least one person, usually male, in the same violent state as the resident on the night of the incident. It is not uncommon to have more than one person with dementia that shows a level of violence, so you must be very careful. This is why I changed from an eight-hour shift to a four-hour shift, as I didn't want to deal with a violent person by myself. Sadly, this proved not to be the case. I fear that this type of incident will be repeated.

In my opinion, staff working with dementia residents need more training. It is very helpful to understand that this is the disease of the brain, that there can be over 100 diseases that may cause neurological dysfunction. This will lead to a more tolerant attitude to know that this is not a choice but a behaviour caused by this disease. I think we also need more training on how to de-escalate a potentially dangerous situation. Sometimes it can be as simple as diverting someone with a cup of tea. This may also include training on how to stay safe and not be physically hurt. For example, how to get out of holds without hurting the resident.

In my opinion, there is insufficient staffing at the facility. We are told that everyone is an individual and has to be treated with respect. As care workers, we completely agree with this statement; however, we repeatedly find ourselves with such a heavy workload that we just have to manage the situation, that we can't give the residents the time that we would like.

People with dementia lack empathy and can be very demanding. They shouldn't be rushed, as this can aggravate aggressive behaviour. So while you attend to one resident, there are up to 17 other residents unattended. The nature of their disease, dementia causes unpredictable and irrational behaviours, so more staff would also improve the security and safety of the other residents. There can – they can be there to stop a situation becoming more dangerous for the residents.

For security reasons, I think – I believe you need to be able to lock the doors of each bedroom, as many residents with dementia roam the corridors and intrude on other residents' room. This is the case in unit 1 and unit 2, although I was

not given a key. Sliding doors would also allow much better access to the rooms and avoid the situation when you can't enter a room when a resident has fallen against the door. Each afternoon shift around 2230, I had to check the room to confirm the resident was asleep safely in bed. A glass panel would allow this without disturbing the resident.

In the interests of being fair, I would like to say the following. I returned to work on 20 March 2019 but only on light duties on the floor in building 2 that only had residents with minor cognitive impairment. I have spoken to residents who do not have dementia and asked them if they were satisfied with the quality of care at this facility. They all replied that they are happy to live there, that their rooms are to their wishes and the place is clean and tidy and staffed with caring and hardworking workers. I also asked about the food, which they said was good and ample, and that the gardens were attractive and well-maintained.

MR BOLSTER: Ms Nobes, you wanted to add one further paragraph which you have written out. Could you please do that now.

MS NOBES: Yes, certainly:

My employer also provides a program where you can receive counselling from a qualified counsellor. I have found this very helpful in dealing with the stress and psychological trauma of my job. My daughter works in community care with aged and disabled clients, and her employer does not provide this service. I believe professional counselling would be of great benefit to all people working in the aged or disability care.

MR BOLSTER: That's the evidence, your Honours – Commissioners.

COMMISSIONER TRACEY: Do you wish to tender the statement?

MR BOLSTER: I do wish to tender the statement.

COMMISSIONER TRACEY: Yes, the statement of Kathryn Nobes dated 29 April 2019 will be exhibit 3-28.

EXHIBIT #3-28 STATEMENT OF KATHRYN NOBES DATED 29/04/2019

COMMISSIONER TRACEY: Now, Ms Nobes, we're very grateful to you for sharing your very difficult experiences with us. It is very important that we have a proper understanding of what it is like in the real world of caring for dementia patients, and your insights have been enormously helpful in that regard. Thank you.

MS NOBES: I'm pleased. Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until 2 pm.

ADJOURNED **[1.25 pm]**

RESUMED **[2.09 pm]**

COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Commissioners, for the record, it's important to emphasise that Ms Nobes' evidence was entirely unrelated to anything to do with the Brian King Gardens case study. We wanted to make that very clear on the record. There's no link whatsoever in time or space or anywhere. My learned friend and I have reached an agreement about dealing with the matters in reply in the case of Mr Farmilo. And I think my learned friend wishes to outline that to the court and make one or two very brief observations.

COMMISSIONER TRACEY: Yes. Certainly. Yes, Ms England.

MS ENGLAND: Commissioners, on the basis of two emails it was put to Mr Farmilo as a positive proposition that the funding, the ACFI funding drove assessments. A brief supplementary statement will be put on addressing that. And the evidence that will be covered just for the Commission's benefit in that statement will be that ACFI assessors regularly audit claims, including at BKG, that the New South Wales average across all service providers for the downgrading of claims after audit is 55.4 per cent. And at Brian King Gardens, during the entire time that Mr Farmilo has been there, zero per cent of claims have claims have been downgraded. So that will be the subject of some brief supplementary evidence with related issues.

COMMISSIONER TRACEY: How quickly do you think you will be in a position to file those statements?

MS ENGLAND: I anticipate by Friday afternoon, Commissioner.

COMMISSIONER TRACEY: Yes. It's just that if anything arises, I think it would be tidier if we could deal with it next week.

MS ENGLAND: Yes.

COMMISSIONER TRACEY: It may be that it doesn't require any further attention but lest it does, if you could have it in by Friday and counsel assisting will advise you if there is a necessity for you to come back and deal with it next week.

MS ENGLAND: Certainly, Commissioner. And might I now be excused for the day.

COMMISSIONER TRACEY: Certainly.

MS ENGLAND: Thank you.

MR BOLSTER: That's the conclusion for the time being of the case study. We will indicate to the Commission a likely resumption sometime next week. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you, Mr Bolster. Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. The counsel assisting team now propose to move to the third case study. It's a case study relating to Columbia Nursing Homes Proprietary Limited, Oberon Village, and I will take the Commissioners through the case study tender bundle tendering process and make some opening remarks before we proceed to our two witnesses in this case study.

MR D. WILLIAMS SC: If the Commission pleases, my name is Williams. I appear for Columbia Nursing Homes Proprietary Limited, and the witness Ms Anderson, instructed by Thomson Geer Solicitors, pursuant to leave already granted.

COMMISSIONER TRACEY: Yes. Leave has been granted. Thank you.

MR GRAY: Commissioners, I will ask the operator to display the Oberon Village case study tender bundle index. In the manner that's now familiar to you, I seek to tender the documents in the case study index as a compendious exhibit, and I will be referring to these documents by tab number through the case study.

COMMISSIONER TRACEY: Yes. The Oberon Village tender bundle will be exhibit 3-29.

EXHIBIT #3-29 OBERON VILLAGE TENDER BUNDLE

MR GRAY: Thank you, Commissioner. I ask the operator to display the witness statement WIT.0134.0001.0001. Commissioners, before I tender this statement, which is a statement of Cheryl Anne O'Connell, made on 24 April 2019, I need to make a few remarks by way of explanation of counsel assisting team's position on the statement. Ms O'Connell is not available to be asked any questions about the statement. The information in the statement is probative and important to the case study. There are certain remarks in the statement which are not necessarily consistent with the submissions that the counsel assisting team currently intend putting at the end of the day in this case study. If I could just identify those. They are at page 0003 in paragraph 19 where Ms O'Connell says:

> *The strategies in place at Oberon Village for managing resident aggression and resident-to-resident physical assault were able to be adequately*

implemented on a day-to-day basis during my time as an RN in June 2018 including on 27 June 2018.

Next, page 0007, firstly, at paragraph 43:

In June 2018 and including 27 June 2018 the number of direct care staff in Oberon Village's dementia unit was adequate to provide a safe quality environment for residents, including Ms CA.

Next, paragraph 48:

In my experience, these numbers of staffing are adequate and provide a safe environment for residents with a high quality of life.

And finally on page 0008 at paragraph 58, simply the word in the first line "appropriate":

The incident that took place on 27 June 2018 occurred within the appropriate supervision parameters I have set out above.

Now, can I make it clear, Commissioners, that in no way am I suggesting that these assertions by Ms O'Connell can't be put before you. It's simply that they don't necessarily represent the position of counsel assisting.

COMMISSIONER TRACEY: They're expressions of opinion.

MR GRAY: With that proviso, although Ms O'Connell isn't available to answer questions, and I will tender a document or a series of emails in a compendious document which outlines that position, I do tender the statement.

COMMISSIONER TRACEY: Yes. Very well. If you could just scroll back to the first page, please.

MR GRAY: I will read out the code if that would assist.

COMMISSIONER TRACEY: Yes.

MR GRAY: It's the witness statement of Ms O'Connell, WIT.0134.0001.0001.

COMMISSIONER TRACEY: Thank you. The statement of Cheryl Anne O'Connell dated 24 April 2019 will be exhibit 3-30.

EXHIBIT #3-30 CHERYL ANNE O'CONNELL DATED 24/04/2019 (WIT.0134.0001.0001)

MR GRAY: Thank you, Commissioner. I will now ask the operator to display the emails in a compendious chain at document RCD.999.0044.0001. Commissioners, these emails demonstrate the attempts to obtain some sort of access to Ms O'Connell for the purposes of the hearing. We were unable to facilitate any sort of access to Ms O'Connell for the purposes of the hearing. I tender that email chain.

COMMISSIONER TRACEY: Yes. Very well. The email chain between Commission staff and various other people relating to the availability of Ms O'Connell, that chain occurring on 30 April 2019, will be exhibit 3-31.

EXHIBIT #3-31 EMAIL CHAIN DATED 30/04/2019 BETWEEN COMMISSION STAFF AND VARIOUS OTHER PEOPLE RELATING TO THE AVAILABILITY OF MS O'CONNELL (RCD.999.0044.0001)

MR GRAY: Thank you, Commissioner. Now, I ask the operator to display a chronology of key events prepared within the Office of the Royal Commission. Thank you. I will just read the code for the transcript. It's RCD.9999.0045.0001. And Mr Williams can indicate for himself whether and to what extent he agrees with it but my understanding is that with a correction that I'm about to make, this will be an uncontroversial document. If the operator would kindly go to the entry for 22 June 2018, I can give you the page number. That is on page 3. There is a sentence that has been put, in effect, in two places, or a passage of three lines or so of text that has been put in two places and where it appears the first time, that's the incorrect position for it. So we can simply delete it. It's at the – in the box relating to 22 June at the foot of the first paragraph of text in that box, the sentence:

CA attempted to -

Etcetera.

COMMISSIONER TRACEY: That last sentence comes out?

MR GRAY: Yes.

COMMISSIONER TRACEY: Very well.

MR GRAY: It appears in the correct position in the next paragraph. We will make that amendment and make this document available on the Commission's public documents in due course. It will – it's not necessary for me to tender it, but it will remain as an aide-mémoire in respect of this case study.

COMMISSIONER TRACEY: Yes.

MR GRAY: There are pseudonyms in this case study. The resident in question has the pseudonym CA. That resident is currently 82. She has advancing Alzheimer's

disease. Her daughter is a witness in the case study and she has the pseudonym DF. Ms CA, the resident, went into Columbia Oberon Village for respite care on 16 May 2018 and she left on 27 June 2018 in a state where she was badly injured and was admitted to hospital. Then, as her daughter DF will recount in her evidence, there are certain experiences that are of relevance to the Commission's work to recount in that hospital. The hospital is not identified but the account is important to the work of the Commission.

And the resident, CA, is now residing at another facility and that facility isn't identified either, and only comes into the case study incidentally but on an interesting issue concerning the perceptions of the resident's family about what is a good and conducive environment for care of the family's mother, the resident CA. Can I say some things about how the counsel assisting team characterised this case study. This case study stands apart from the ones that you've heard so far, Commissioners. It's a case study we're placing before you to illustrate the complexities of the issues relating to the management of the behaviours of certain residents in residential aged care who have what are sometimes called challenging behaviours.

In particular, it raises a host of difficult issues concerning how a facility is to deal in a way that balances freedom of movement of people who may have challenging behaviours and may even have risky behaviours. On the one hand, compared with the undesirability of allowing them to be in peril and sustain injury, these are crucial issues and it may be that there are no easy answers on any of these issues, the balance of the dignity of risk with safety from potential interactions that may be aggressive interactions with other residents is a real dilemma and a conundrum in the management of aged care residential services.

This is not a case study where it could clearly be said that there was substandard care. It may be open to you at the end of the day to find that in some respect there was substandard care, but it is in no way an easy matter to jump to that conclusion. On the face of the evidence, the facility's clinical and care management was adequately directed at the time, and certainly in its planning aspects it was scrupulous and detailed. The issues in the case relate to the carrying out of those strategies. As I've said, when CA, when Mrs CA left Oberon Village she had suffered serious injuries, and she had suffered those injuries in an incident on 27 June which took place in the room of another resident, a male, who had a reported history of alleged aggression.

Now, the fact that Mrs CA was in that room at all might well have been the result of a fleeting absence of direct supervision of Mrs CA. Mrs Marian Anderson who's part of the management of the approved provider of this facility, that is, she's part of the management of the organisation which conducts the operations of this facility, she will be giving evidence, and no doubt Ms Anderson will make the point that staff of a facility of this kind cannot have eyes on everyone at all times.

The circumstances of exactly what happened within the male resident's room are not clear. There are competing versions, and it's difficult to draw any clear inference

about what actually happened within the room. Commissioners, we present this case study to you as a counterpoint to the case study which you heard yesterday about restrictive practices. And we submit that this case study, especially in contrast to the other case study, raises the following issues.

Depending on the make-up of the population of a particular facility or an area within a particular facility such as a wing, there's a tension between the imperative of dignity of risk and freedom of movement on the one hand, and direct impacts on the physical safety of residents on the other. The case study is not only intended to illustrate that point, but it's also to shed light on the valid perspectives of various actors who are affected by incidents of this kind, including, very importantly, family. Family of residents who come to sustain injuries in incidents of this kind have a perspective that must be heard. But it's also important to consider the perspective of management and the difficulties management faces and how they grapple with the difficult issues that are raised.

Now, I've mentioned that chronology. If I could ask the operator to bring it back up, I will just outline some of the key events within that chronology by way of concluding these opening remarks, and then we will proceed to hear the evidence. Before I say anything about the particular events, it would be convenient to show you, Commissioners, a diagram of the area within the facility that is, in effect, the Secure Dementia Unit at Oberon Village, as we understand things. It's at tab 84, if the operator could please bring that diagram up. It's also annexure A to Ms O'Connell's statement. We will come back to that diagram in a moment, Commissioners.

I will ask that instead the operator puts up tab 82. Tab 82 is the register of Oberon Village titled Reportable Assaults, Sexual and Physical Register. It's an important document in the case. If we scroll through from the first page to the third page, please, you will see that there are dates at which reports are recorded in the second column, going back to around the beginning of 2016. There are spaces left for the name of the person making the allegation. Of course, those have been redacted or pseudonyms have been applied. There has been then, in the next column, reference to the class of reporter, whether that's staff or resident. There's then a column for the name of the person against whom the allegation is made and another reference to the class of the person against whom the report is made. There's a reference to the type of the interaction, if I could use a neutral word, and it's most often described as physical assault. There's one sexual assault referred to later on. There's a column for whether there has been a report to police.

Over at the right-hand side of the table there's a status and sometimes there's a reference to a finalisation, but most often there's a reference to the report not being reported. That means not being reported to the department, in my submission. And it's said:

> *Resident has cognitive impairment.*

That needs to be explained. The Act provides for mandatory reporting of matters defined as reportable assaults, and that is in section 63.1AA of the Aged Care Act 1997. However, there is an exception in subsection (3) of that section in relation to matters which the accountability principles are exempt from the operation of that reporting obligation.

And I will now ask the operator to display the accountability principle, section 53. At section 53(1) of the accountability principles, if we could just call out subsection (1), the exemption applies if within 24 hours after receipt of the allegation or the start of the suspicion, the approved provider forms an opinion that the assault was committed by a care recipient to whom the approved provider provides residential care; and (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 (c), within 24 hours after the 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; and (d), the approved provider has a copy of the assessment or other document showing the care recipient's cognitive and mental impairment and a record of the arrangements put in place under the preceding paragraph.

Now, in – if we return to tab 82, the register, and if we go to page 3, please, we see at page 3 the commencement of – so page 004 in terms of document coding. Thank you. We see at the foot of this page in the third-last and last rows, allegations against somebody who has been given the pseudonym CB. CB, Commissioners, is the male resident in whose room the incident occurred involving Mrs CA on 27 June 2018.

Now, the relevance of my taking you to these entries in the register is that on 4 April 2017 and 9 May 2017, we see in this register allegations against the male resident CB being made and reported in the register a year or so prior to the events that are going to be examined in this case study. Then over the page, on page 4, we see in the fifth line another set of allegations, this time on 8 November 2017, against the male resident CB.

While we're on this page, can I note in passing that in the line above the one I just referred to, so in the row dealing with allegations on 28 July 2017, there's allegations against a resident CC. This is also a relevant matter, and that's because prior to a serious injury being incurred by Mrs CA on 27 June 2018, there was an incident involving an altercation between Mrs CA and a female resident, to whom we've given the pseudonym CC, and this occurred on 22 June 2018. That female resident, CC, also appears in this register a number of times. She appears in that row of 28 July 2017. If we go over the page, please, Operator, to page 0006, she appears four times on that page on various dates leading up to June 2018.

Now, please note in the penultimate row of this page, on 3 June 2018, there are allegations against Mrs CA herself. This is part of the complex matrix of fact relating to behaviour management in this facility, and one could infer that this is something that arises frequently. Mrs CA, we will see from the evidence in a

minute, was recorded and assessed as herself having certain challenging behaviours, including intrusiveness, and she was capable, it appears, due to her cognitive difficulties because of her condition, of lashing out. So this is something that's reflected in the register as well, and goes into the matrix of facts.

And if we – just before concluding with this document I should, for completeness, take you to the next page, 0007, on the – on page 0007. If we go to the third row, we see a record here of the incident I just mentioned on 22 June which involved the interaction between the female resident, CC, and Mrs CA, in which Mrs CA came away with an injury to her face inflicted by female resident CC. And in the row just below that for 27 June 2018, we see the incident in which Mrs CA sustained serious injuries. It's recorded in the register as involving allegations against the male resident CB, but, as I've said, the exact circumstances of how the injury came to be sustained are unclear. Operator, we can put that document away for the moment, please.

Operator, please bring up tab 84. Tab 84, Commissioners, is a diagram of the layout of what we, the counsel assisting team, understand to be the Secure Dementia Unit within Oberon Village. It consists of 14 beds in 12 rooms. Two of the beds were not occupied during the period in question, the period in question being the period in question being – thank you – being June 2018, more precisely, 16 May 2018 to 27 June 2018.

As we understand the evidence, Mrs CA was at all times residing in room 12, and that is – thank you – being indicated by the laser pointer, but we will obtain clarification. I will withdraw that. We will just wait until we obtain clarification. It appears that Mrs CA was in either room 12 or the room across the corridor from room 12, and that the rooms of the male resident, CB, and the female resident, CC, who I mentioned a short time ago, were respectively in the room across the way and in the next-door room. But we will obtain clarification during the course of evidence.

So the co-location or the close location of those rooms is another fact in the matter that needs to be taken into account. We will also seek some clarification about the nurses' station. It appears on this diagram to be the place marked in the middle – thank you – middle of the top section of the diagram. Thank you. The communal space just to the right of the nurses' station, we understand to be the meals area. I think I will – I think I've made – I need to make a clarification or a correction, in fact, Commissioners. I've been looking at a different map and I've transposed them – I've transposed the rooms. The rooms in question are, in fact, over towards the right-hand section of the diagram. I do apologise.

COMMISSIONER TRACEY: I thought I read somewhere that CA was in room 3 but I - - -

MR GRAY: Thank you, Commissioner. I do apologise. So we're talking about the right-hand edge of this diagram. Thank you.

COMMISSIONER TRACEY: Anyway, it can be clarified with - - -

MR GRAY: Yes.

COMMISSIONER TRACEY: - - - one of the witnesses you're going to call.

MR GRAY: Other relevant documents in the chronology which we need to traverse during evidence include tab 54 in relation to the 22 June incident. If – thank you – thank you operator – tab 54 relates to the 22 June incident which is recorded as having taken place at 1505, 3.05 pm on that date. And it involved Mrs CA and the female resident CC. It's said in that report that:

> *When staff completed handover, CA and CC were standing at the table, CA holding mouth, CC looking defensive and agitated. Staff noted CA to be bleeding from right side of mouth. Contacted registered nurse as soon as possible.*

The next relevant fact is that soon after this incident at tab 64, a behaviour observation chart was commenced and there's close observation of Mrs CA's behaviour on 23 June and following. The behaviours observed include "get to inappropriate places", that's for 23 June and if we go down that column, Commissioners, I understand this is a document that's read in columns, we see the detail of that is:

> *Additional information. Resident walking in hallway.*

We've got to go over the page:

> *Attempting to enter other residents' rooms. Actions. Assisted residents to lounge chair. Gave her a doll and put blanket on resident.*

25 June:

> *Behaviours observed: socially inappropriate behaviour. Additional information: resident entering other residents' rooms.*

I won't go on, but there's close observation occurring. One of the points that is arising out of this is the propensity of Mrs CA to enter other people's rooms and be intrusive. Next, on 27 June there are a number of sources for what actually was observed on that day. If we first go to tab 61, please, operator, an incident report, a critical incident report, the time at which the allegation is received is 2053. It said:

> *CB was observed pulling CA out of his room by the arms. CA was bleeding from wounds on head. CB was seen pulling resident out of room into corridor.*

This is the incident which resulted in the hospitalisation of Mrs CA. The next document of relevance in relation to records of this incident is at tab 63. This is an account by an AIN. Relevantly, at – it looks like 1959, I suggest:

Walking down corridor with CA.

And then:

Went into dining area and then went to assist somebody, buzzer. After leaving room I was walking towards the dining room when I noticed CB exiting his room bending over. Then saw CB holding her arms and pulling CA by her arms out the door. Went to get phone to ring RN. Rang all floors trying to reach RN. Waited with CA while my offsider went and got the observation box. CA kept stating that she needed help.

Next, tab 65, this is an internal email the next day within the approved provider organisation. It's captioned a critical incident form:

CB can recall incident and states CA fell in his room and he pulled her out into the corridor to get help. Both the GP and police believe this probably is what happened. CCTV footage does not assist us with anything else.

Next, Ms O'Connell's statement, Ms O'Connell was the RN on duty at the time of this incident on 27 June 2018. That's to be – thank you – if we go to page 0014 at paragraph 96(b), page 0014 at paragraph 96(b) at the time Ms O'Connell performed a post-incident assessment on Mrs CA. Amongst other things, Ms O'Connell observed:

CA responded to my question regarding what had occurred with the response "That man pushed me".

I will now proceed to call in evidence from our available witnesses. I will first call Mrs CA's daughter, Ms DF.

<DF, SWORN [2.53 pm]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Ms DF, I will ask that a witness statement be shown on the screen in front of you.

DF: Mmm.

MR GRAY: For the record I will just read out the code number. It's WIT.0102.0001.0001. Is that a copy of the witness statement that you've made for the Royal Commission dated 17 April 2019, although it's in redacted form?

DF: Yes, it is.

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

DF: Yes. Though there's just something I do want to change, and I have talked to you about that, and that is about - - -

MR GRAY: Yes, it's – thank you – it's on paragraph 15, isn't it?

DF: Yes.

MR GRAY: Do you wish to make a correction to the references to AIN in paragraph 15?

DF: Yes. I believe after looking at my notes that my sister actually talked to the RN, which I thought was the AIN but it was an RN.

MR GRAY: So there are two references to AIN in paragraph 15 and do you wish to change them so that they refer to RN instead?

DF: The RN, yes.

MR GRAY: Subject to that correction, to the best of your knowledge and belief, are the contents of your statement true and correct?

DF: That's – yes, it is.

MR GRAY: Thank you, Ms DF. I tender the statement of Ms DF.

COMMISSIONER TRACEY: The statement of DF, subject to the correction to which she has just referred in paragraph 15, will be exhibit 3-32.

EXHIBIT #3-32 STATEMENT OF DF DATED 17/04/2019 (WIT.0102.0001.0001)

MR GRAY: Thank you, Commissioner.

Ms DF, how old is your mother?

DF: My Mum is actually 82. She will be 83 next month on 5 June.

MR GRAY: And what's her health status?

DF: Today she is chairbound or bedbound, and she doesn't talk at all. She does not - hardly recognises anyone, unfortunately, which is a little bit different than she was 12 months ago.

MR GRAY: And has she got Alzheimer's disease.

DF: She has got Alzheimer's. She was diagnosed in 2010, and her health has been declining since then. And in 2017 it sort of accelerated so that she needed further care where she needed to be fed, she couldn't talk very well, and she needed some help as far as showering, feeding, meals, etcetera, by the family.

MR GRAY: And by about October 2017, how had her condition deteriorated at that point?

DF: Okay. Mum was able – not able to look after herself. She could walk. She needed to be fed on occasions. She needed to be showered, dressed and she needed to wear incontinence pads. She would often refuse Dad to toilet her because she didn't recognise him actually most times, and most times she would not change her clothes and pads and she often went to bed in her clothes, too. She sometimes would lash out to Dad, and Dad would be cranky back and he wouldn't – Mum wouldn't let Dad go into the bathroom with him – with her, I should say. So they would get cranky at each other.

MR GRAY: When it came to assistance with personal hygiene tasks in the bathroom was your mother more comfortable with her daughters, including yourself, helping her?

DF: Yes.

MR GRAY: And less comfortable with men helping her; is that right?

DF: Yes, she just – she was - it was like she was about a five year old or a 12 year old; she just didn't know what a man was, really. That's what we thought anyway.

MR GRAY: And I want to now ask you about the extent to which your father was otherwise able to care for your mother up to May 2018. Was he otherwise able to provide for her daily care?

DF: Well, Dad, he – we provided meals. My sister [REDACTED] – my sister DG would come out and help a lot. She had stopped working. The rest of us were working so we actually helped her when we could. They – we would provide meals as best we can, put a couple of meals in the freezer, in the fridge. We would shower Mum when we could, but Mum – Dad had his health that wasn't very good and he needed a knee replacement.

MR GRAY: And did this lead to a decision for your mother to enter into respite care?

DF: Yes, it was planned respite care. So once we found out that when Dad could have a knee replacement, then we sort of sought places for respite, and that's when we came across Columbia.

MR GRAY: Yes. And - - -

DF: And - - -

MR GRAY: - - - so what then followed after that decision was made? Did you help admit your mother into respite care at Oberon Village? Is that right?

DF: My sisters went out there and my sister, who – DG went out there, and she was the one that helped – and my dad, and discussed what her condition was and stated just some of the – the problems that we had with her.

MR GRAY: Now, did you frequently visit your mother in Oberon Village?

DF: I saw her about three or four times. I visited her with a couple of family members and sometimes by myself I – once or twice by myself.

MR GRAY: All right. So - - -

DF: Usually on the weekend.

MR GRAY: In your statement at paragraph 18, you refer to finding out about an incident on – an incident that had occurred on 22 June 2018, and you found that out from one of your sisters.

DF: Yes.

MR GRAY: Is that right?

DF: Yes.

MR GRAY: And so your knowledge about that incident is all second-hand; is that right?

DF: Yes.

MR GRAY: Yes.

DF: I went out and visited my mum on 24 June and I had taken a cake out to her, and I was feeding – giving it to her, and I noticed a bruise on the left side of her face, just above her lip. And I thought it was some dirt or some – lipstick or something.

She did like lipstick. And I was trying to remove it, and then I realised that it was a bruise or – and it was sort of a bit scabby, so I didn't know what had happened. And she also had a – someone else's dressing gown on, which I thought was odd. And I did discuss it with the RN on, and she said, "Oh, that happens here." But I took it off because I wouldn't have liked my mother to have someone else's dressing gown on, and I wouldn't have liked someone else to have my mother's clothes on. But the RN on didn't sort of say anything else about it, "It just happens like that." So I took it off and I folded it and I put it in the lounge room.

It wasn't until I got home and I was talking to my sister, DG, that she said that on the Friday she had received a phone call to say that there was an altercation with another patient. She had apparently touched her clothes and she was punched in the mouth and – or hit in the mouth, and Mum hit her back. So – and that was after – there was some kind of party or something upstairs. They were fairly ambulant, these two people, which is Mum and this other lady. They were brought down and left unsupervised for a short period of time while they got a few more people, and that's when it happened. That's all I know.

MR GRAY: Now, in your statement in that paragraph, paragraph 11, you – I meant to refer to paragraph 11. I might have referred to paragraph 18, I understand. But in paragraph 11, you refer to your understanding of where this incident took place, but I take it that your knowledge of that is indirect?

DF: Yes.

MR GRAY: You don't have direct knowledge of where it took place?

DF: No. No. I thought it was in this lady's room, so that's all I was – I was told it was in lady's room because it was her clothes that were - - -

MR GRAY: And you say in the next paragraph, paragraph 12, that you:

…don't think we –

That must be the family, I assume - - -

DF: Yes.

MR GRAY:

- - - *made any complaints about that incident.*

DF: No, we didn't.

MR GRAY: I want to ask you now about the next incident, the more serious incident on 27 June. Again, are the Commissioners to understand that your knowledge about that incident is indirect knowledge?

DF: Yes.

MR GRAY: Yes. And you set out in paragraph 13 your understanding of what occurred which you've heard from other people; is that right?

DF: Yes, from my sisters, yes, that's right. From DH and DG, I found out on the Thursday morning that Mum was – had been assaulted by another patient and then she had been hit and was hit – had fallen over onto her side and she was admitted to hospital.

MR GRAY: Now, I want to ask you about the experiences of your mother in hospital.

DF: Yes.

MR GRAY: Do you have direct knowledge of those matters, or are they again matters that have been reported to you?

DF: No, my sister who was – no, they are from my sisters.

MR GRAY: So based on that information from your sister - - -

DF: Yes.

MR GRAY: - - - what's your understanding of what went on in the hospital? I won't flame the hospital, but I will just ask you - - -

DF: As in - - -

MR GRAY: - - - about your understanding of what went on in the hospital with - - -

DF: The first one?

MR GRAY: - - - respect to your mother's care. Yes.

DF: The first hospital?

MR GRAY: Yes.

DF: The first hospital was where my sister went and she checked her out. She's an RN too, and she saw her there and seemed – Mum seemed to be – quite a lot of blood onto her right side of her head. She didn't seem to be too bad. They were going to send her back and my sister said no, and they said that we were going to wait until – until there was going to be some X-rays taken, especially of her – she didn't seem to be exhibiting any pain at that stage, but they were worried about her head because of the large haematoma.

MR GRAY: And what then happened? In paragraph 22, you refer to what was discovered when - - -

DF: Okay. So - - -

MR GRAY: - - - a proper examination was made of your mother.

DF: We had to wait till the Friday before – because we had to go another 40 kilometres into town, so they waited till Friday, but the radiographer was off sick. So this is the day that Mum looked close to death. She looked very pale and wasn't talking or responsive or anything like that when she was taken into [REDACTED]. And she had a few X-rays, and it wasn't until the lady at the X-ray – radiographer saw her with the haematoma on her head that she decided to have a CT, which found out that she also had a bleed on the brain.

MR GRAY: And were there other injuries that she had also sustained?

DF: Yes, she had a fractured clavicle on the left-hand side, and she also had a fractured pubic rami.

MR GRAY: Now, Commissioners, there was a mention of a location. It didn't – it wasn't streamed on the webcast of the hearing. I would ask that the Commissioners indicate to any reporters present that they please forebear from reporting the name of that location.

COMMISSIONER TRACEY: Yes, there will be a direction to that effect.

MR GRAY: Thank you. At the hospital in that location, Ms DF, you recount in your statement what you understand to have been the treatment of your mother and you make certain points about that.

DF: Yes.

MR GRAY: Is this direct knowledge or - - -

DF: Yes, this is direct knowledge.

MR GRAY: This is direct knowledge. So please explain to the Commissioners what you observed in relation to the care of your mother at that location.

DF: It makes me sad to think – I'm a registered nurse – to look after my mother in these – in the hospital. I and my sisters, we all took turns in looking after my mother in the hospital. And because she was demented and she couldn't talk, we had to feed her. She was – they – all they wanted to do was send her back to the nursing home, and because she was on respite she actually didn't have a nursing home to go back to, and we refused her to go back to her previous respite area.

The senior staff and the doctors did not talk to us. We had requested in many occasions that we were talking for her and for our father, who was completely distraught after my Mum came back and fell and had all the fractures and problems that she did have. We wanted her to walk. Mum could not walk after her incident at the nursing home that she was in. And we wanted her to get up and start walking because that's what she does. However, they – if we weren't there and because she couldn't talk, she couldn't give permission, she couldn't say she wanted medication, she couldn't say she was thirsty, she couldn't say anything like that, and so probably – I don't know what happened after we left, but we would insist on her having medication. We would feed her. We would insist that her pad be changed.

We sort of helped with the staff to give her a walk. And then we talked to the doctors about getting her to go to rehab, but no one wanted to talk to us. We wanted – as we said, we wanted her to go to rehab. We had two other senior doctors who were in charge of rehab come in, just barge in, "I'm – I'm a doctor. Who is this, and who is this? This is –" he was asking two of the – like, my two sisters, who – who – asking my mother who these two people were, and I – my mum was quite upset, and so was I because I said, "My mother cannot talk."

MR GRAY: So just stopping you there, when the doctors came in to assess your mother for entry into rehabilitation, did they not know that your mother had a diagnosis of Alzheimer's disease?

DF: She would – yes, they did know.

MR GRAY: They did know.

DF: They did know.

MR GRAY: All right.

DF: Yes.

MR GRAY: But notwithstanding that - - -

DF: That was spelt out to them.

MR GRAY: You mean they knew it once you spelt is it out to them, or did they - - -

DF: They knew because the doctor – it was referred because he – they needed another doctor from Medical Ward needed to – needed to refer Mum to rehab and they needed to assess her to be accepted into rehab. So they knew what her diagnosis was before they came in to speak to her.

MR GRAY: All right. So notwithstanding that those doctors had been informed - - -

DF: Fully.

MR GRAY: - - - that your mother has Alzheimer's disease, they were directing their questions to her, rather than to her daughters present in the room.

DF: Yes. I can understand if they wanted to ask her, you know, "Do you know your name?", or, "What is your name?", or something like that, but the way they came in, it was – it was just distressing and Mum was distressed, and you could see her just stepping back – sitting back, and it was just – it was just so irritating and disgusting, really.

MR GRAY: What was the outcome with respect to rehabilitation? Did you manage to - - -

DF: We - - -

MR GRAY: - - - achieve entry into rehabilitation with your mother?

DF: We did. She went in for five days. The nurses were good. They did take her to – they do take her to the bath – the – the dining room, but there was no rehabilitation as in the – there was no staff to actually take her for a walk, whereas in Medical Ward there was staff even on weekends, as in I'm taking the – the physiotherapist on the medical ward was fantastic because she took her for a walk. She knew when Mum would go for a walk and when Mum resisted. But in rehab, I think there was none.

MR GRAY: In the end, how many days of rehabilitation was provided to your mother?

DF: Five.

MR GRAY: And what then happened?

DF: They basically said she failed because she couldn't communicate. And because she couldn't communicate, therefore, she didn't understand.

MR GRAY: So communication issues because of cognitive impairment were taken to be a disqualifying factor from getting rehabilitation for a broken pelvic bone; is that right?

DF: Yes.

MR GRAY: Now, after that happened, what arrangements did your family make for the accommodation of your mother?

DF: The two days - on the day that Mum was taken into hospital on the Friday, the 29th, I had rung around to try and find some emergency care for Mum and we were –

we found some, and all the paperwork was done. So the hospital knew that we had a bed there, and they said she needs to go into a nursing home. We were just so upset with the hospital, with medical ward, the doctors and the senior staff, that we said we just – it's just best for Mum to go to care.

MR GRAY: Now, I want to ask you a bit about the aged care facility where your mother then went and remains, as I understand; is that right?

DF: Yes.

MR GRAY: And I don't want you to name that facility but I want to ask you about your impressions of it. I understand you're a registered nurse yourself.

DF: Mmm.

MR GRAY: What are your comments about the environment in that nursing home and what do you consider to be good or bad aspects of that environment, including the built environment?

DF: Okay. The – well, Mum doesn't walk anymore. She's bedbound or chairbound I should say, so they put her in a chair, and gets fed. So they're in a common room where they get fed much like that other place in – where she was before for respite. They have sort of a round area in a corridor which – which they can see. There's a glassed nursing station where they write up notes, where they can see everyone in the common room. They can see - it's glassed all around, it's glassed, and they can see actually the staff – the clients when they go into the garden. There's always staff around. They've got – I think there's about 20 patients and all the rooms are locked, so patients cannot get into the rooms unless a staff member opens it, or there's family there and they want to go into the – into the rooms and spend time with the family members.

MR GRAY: Do you mean all the rooms are locked, to your understanding, when they're not occupied by the resident in question?

DF: Yes. Yes.

MR GRAY: I want to ask the operator to show you a diagram of what we understand to be the dementia unit at Oberon Village where your mother was residing from 16 May to 27 June 2018. Now, this diagram is not arranged the same way as the diagram that you've previously seen.

DF: Mmm.

MR GRAY: It's a diagram where the entry is in the centre bottom of the page.

DF: Yes.

MR GRAY: Do you see that?

DF: Yes.

MR GRAY: Right. Whereabouts was your mother's room?

DF: Do you want me - - -

MR GRAY: Was it the top right-hand corner?

DF: Room 2.

MR GRAY: Room 2. Thank you.

DF: Yes.

MR GRAY: And I take it that you know the identity of the female resident with whom your mother had an altercation on 22 June. I don't want you to say her name.

DF: Yes, I do.

MR GRAY: Do you know which room she was in?

DF: Yes, she was in room 4.

MR GRAY: Thank you. And I take it you know the identity of the male resident that's CB - - -

DF: Yes.

MR GRAY: - - - with whom – well, in whose room there was an incident in which your mother sustained injuries on 27 June.

DF: Yes.

MR GRAY: Which room was that?

DF: Room 1.

MR GRAY: Room 1. The bottom right-hand corner. Thank you. Now, there's a handwritten annotation for nurses' station.

DF: Yes.

MR GRAY: Yes, in the middle top of the page.

DF: Yes.

MR GRAY: Does that accord with your observations on the four or five times - - -

DF: Yes.

MR GRAY: - - - you visited?

DF: Yes.

MR GRAY: Yes. Now, was it the case that the nurses weren't necessarily in the station but were moving around; is that what you observed or did you observe them in the station?

DF: I have seen them both there, too, the two that I've seen; I've seen them there, two at a time.

MR GRAY: And the communal space to the right of the nurses', is that where there were meals and also - - -

DF: Watching TV.

MR GRAY: Watching TV, chairs and so forth.

DF: Yes.

MR GRAY: What are your observations as a registered nurse about the advantages of the glassed nurses' station you've just referred to, compared with the layout of this area of Oberon Village which is lower ground, north wing?

DF: Even – if the – if the nurses' station did have some glassed area to the – going into the quiet room or the nurses' station, it would have at least seen a little bit more of the communal space, but it certainly wouldn't have shown you, going down the corridors by any chance at all. It's a little bit hard.

MR GRAY: Do you mean that, because of the location of the nurses' station?

DF: Of the nurses' station.

MR GRAY: Or the quiet room?

DF: Or the quiet room - the nurses' station.

MR GRAY: Even if there had been glass it just wouldn't have been possible to see down - - -

DF: No.

MR GRAY: - - - either end of the corridors where the rooms are.

DF: No. It would have been a little bit difficult to even seen sort of over to the bottom of it, to like room 5 or 6 to the entrance.

MR GRAY: And we don't have a diagram of the other aged care facility which you've referred to in your evidence.

DF: No.

MR GRAY: But can you just describe it again. What's the difference? Is the nurses' station in that aged care facility positioned in a way that you can see all of the doorways into the residents' rooms?

DF: You can see most of them, and there is another room with a nurses' station in it also, but that's on the other side. I do not know if they've got CCTV or anything. I wouldn't have a clue.

MR GRAY: Right. No further questions.

COMMISSIONER TRACEY: Thank you. Yes, thank you very much for your evidence, Mrs DF. We're very grateful to you for having explained what must have been a very difficult period when you were looking after your mother, but it helps us to understand how these facilities work and we're very grateful to you for having done that.

DF: Thank you.

COMMISSIONER TRACEY: Thank you.

<THE WITNESS WITHDREW [3.23 pm]

MR GRAY: I call Marian Anderson.

<MARIAN ANDERSON, SWORN [3.24 pm]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: What is your full name?

MS ANDERSON: My full name is Marian Anderson.

MR GRAY: Have you made a statement for the Royal Commission dated 24 April 2019?

MS ANDERSON: Yes, I have.

MR GRAY: You should see before you on the screen document WIT.0135.0001.0001. That is the first page of a statement that bears your name. I will ask the operator to go to the last page, page 0013, so you can see the signatures. Do you recognise this document to be the statement you made for the Royal Commission?

MS ANDERSON: I do.

MR GRAY: Do you wish to make any amendments?

MS ANDERSON: No.

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

MS ANDERSON: They are.

MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The statement of Marian Anderson dated 24 April 2019 will be exhibit 3-33.

EXHIBIT #3-33 STATEMENT OF MARIAN ANDERSON DATED 24/04/2019 (WIT.0135.0001.0001)

MR GRAY: Thank you, Commissioner. Ms Anderson, you're the general manager, operations, of Columbia Aged Care.

MS ANDERSON: I am.

MR GRAY: You don't have any direct knowledge of the care provided to Mrs CA. You make that clear in your statement.

MS ANDERSON: Yes.

MR GRAY: That's correct, isn't it?

MS ANDERSON: That is correct.

MR GRAY: What you've done is you've reviewed the documentation held by Columbia - - -

MS ANDERSON: That is correct.

MR GRAY: Yes. In relation to that care and in relation to certain regulatory visits and actions.

MS ANDERSON: That is correct.

MR GRAY: And it's the case, isn't it, as you mention in your statement that there was some regulatory action in relation to Oberon Village in the period March to July 2018.

MS ANDERSON: That is correct.

MR GRAY: In brief, was some noncompliance including around behaviour management identified by visitors from the Aged Care Quality Agency in about March 2018 and then the facility took steps in relation to that; is that right?

MS ANDERSON: That is correct, yes.

MR GRAY: And by July, what was the position?

MS ANDERSON: By July we were deemed met.

MR GRAY: Right. I just want to ask you about an aspect of that regulatory issue. And I appreciate that you're working off the documents. But did you also have direct communications around these issues in that period between March - - -

MS ANDERSON: Yes, I did.

MR GRAY: - - - and July 2018?

MS ANDERSON: Yes, I did.

MR GRAY: Direct communications with staff of the facility?

MS ANDERSON: I did. Yes.

MR GRAY: Thank you. So the relevant paragraph of your statement is paragraph 22. And perhaps if the operator could call that out. In that statement, you say:

> *For the period March 2018 to July 2018, being the timetable for improvement granted by the Australian Aged Care Quality Agency –*

yourself and the chief executive officer were based at Oberon for 34 days equivalent to an additional 510 hours of roster during the period:

> *At Oberon we worked on comply with the undertakings given by Columbia and to rectify Columbia's noncompliance with the Aged Care Act and accompanying principles and regulations.*

Now, in respect of those regulatory matters, I just want to go to tab 21, please, operator, which is the notice of noncompliance which was served on Columbia in respect of Oberon Village. Do you recognise that document, Ms Anderson?

MS ANDERSON: Yes, I do.

MR GRAY: And if we go, please, to the remarks made in respect of – I beg your pardon. Just pardon me for one moment. If you could please search 2.13, operator, and go to the remarks made in relation to behaviour management. Thank you. On page 7 I'm told; 2.13 on page 7. Thank you. Now, in respect of expected outcome 2.13, which is , "The needs of care recipients with challenging behaviours are managed effectively," there's a reference to the author being satisfied of noncompliance because of information concerned in two earlier assessment contact reports. And then the author says:

> *In particular, they're concerned about the following matters.*

I will skip past the first one and the second one, and I will go to the third one:

> *Staff practices are not monitored to ensure behaviour management strategies are delivered consistent with care recipients' needs, preferences and identified strategies.*

So just on that one, in brief compass, what did you do over the period from March to July to remedy that matter?

MS ANDERSON: We did quite a lot. We – it was a lot of re-education, re-training, there was some work performance. We engaged a dementia – an in-house dementia adviser. We consulted with DBMAS, Dementia Australia, external agencies like that. We certainly were on the floor, myself and the CEO as well as the care manager. We did a lot of education that was one on one, a lot of group education. We were able, with our rostering system, to send out emails to individual staff and to, for SMSs as well. We did a lot of mandatory education, after-hours as well as in-hours, to ensure that the staff did receive that retraining re-education.

MR GRAY: And was that directed to ensuring that direct care staff – not only nurses, but direct care staff read and fully understand the behaviour management - - -

MS ANDERSON: Absolutely yes.

MR GRAY: - - - plans that - - -

MS ANDERSON: Yes.

MR GRAY: - - - are documented by - - -

MS ANDERSON: Yes.

MR GRAY: - - - Oberon Village?

MS ANDERSON: Yes.

MR GRAY: So prior to that there had been a problem, had there, in the staff actually reading, comprehending and following those plans?

MS ANDERSON: I believe that, yes. Look, I believe it was to do with inconsistent documentation and staff perhaps not really fully understanding the policies and processes as well. But once we did start the education, it was – was very good, very effective. They were very engaging, and the in-house dementia adviser was, in fact, three days, and she worked on the floor. She didn't have an office. And she was there able to do case studies one on one, things like that that were – we felt were very effective.

MR GRAY: Were you personally present on either 22 or 27 June?

MS ANDERSON: No, I was not.

MR GRAY: No.

MS ANDERSON: No.

MR GRAY: I think your statement says that.

MS ANDERSON: Yes.

MR GRAY: But you were present for a number of the days in that period - - -

MS ANDERSON: That is correct, yes.

MR GRAY: - - - of three months or so between March and July.

MS ANDERSON: Yes, the CEO and myself, the most senior managers of Columbia, lived in Oberon - - -

MR GRAY: All right.

MS ANDERSON: - - - for that period of time.

MR GRAY: The relevant timeframe of concern here is around the – well, middle or the second half of that three month period. What's your evaluation of how far things had improved during your program of improvements by that time, in particular around 22 and 27 June?

MS ANDERSON: Look, I felt – I felt they – it had improved, and feedback from the agency – they were there every month giving us feedback, and feedback from them was very positive.

MR GRAY: I want to ask you about the documents in the matter that relate specifically to Mrs CA. But before I do that, I will just return to that register of reportable assaults. That's tab 82. Now, if we go to page 0004, as you might have heard me saying during my opening remarks about this document, we see here in the third-last line and the last line the beginnings of a series of repeated references to a particular resident, a male resident, CB. And his name comes up a number of times in this register in the lead-up to an incident on 27 June 2018. Have you reflected on this register in preparation - - -

MS ANDERSON: Yes, I have.

MR GRAY: - - - for giving your evidence?

MS ANDERSON: I believe he - - -

MR GRAY: My question is - - -

MS ANDERSON: Yes.

MR GRAY: My question is part of what is supposed to occur is that, albeit that an incident of this kind doesn't have to be reported under the accountability principles, there does need to be effective follow-up. Would you agree with that?

MS ANDERSON: Absolutely, yes.

MR GRAY: And "effective follow-up" means follow-up that ensures, to a reasonable degree of certainty, that an incident of the kind won't happen again. Would you agree with that?

MS ANDERSON: It's very difficult to say that. There's a lot of – with residents living with dementia, there's a lot of unpredictability there.

MR GRAY: Yes, but if you have somebody about whom there are repeated allegations, time and time again, over a relevantly contained period, doesn't something need to be done to ensure that that person isn't involved in another incident?

MS ANDERSON: Yes, that's true, and we did have this resident assessed. There was, in fact, only one in 12 months after this that he appeared in this register.

MR GRAY: You mean after - - -

MS ANDERSON: After - - -

MR GRAY: After June 2018?

MS ANDERSON: No. We're looking at 2017 here. In 2018, I believe he only appears once in the register.

MR GRAY: In relation to the incident on 27 June?

MS ANDERSON: Yes.

MR GRAY: Well, just pardon me for a moment. What about on the 11th – on 8 November on page 5 he seems to appear – seems to appear just – beg your pardon. On 11 November 2017 in about the middle of that page, do you see that, Ms Anderson? There's another reference to Mr CB.

MS ANDERSON: Yes.

MR GRAY: And then - - -

COMMISSIONER TRACEY: I think we're on page 4 of the screen. It should be 5, I think.

MR GRAY: Well, it's – no, Commissioner, I think there's just a disconformity between the native page number and the coded page number. My - - -

COMMISSIONER TRACEY: I see. I beg your pardon.

MR GRAY: If we go to coded page 0005.

COMMISSIONER TRACEY: Yes.

MR GRAY: Do you see, Ms Anderson, I think it's the sixth - - -

MS ANDERSON: Yes, perhaps then too there was - - -

MR GRAY: The fifth. I'm sorry, it's the fifth row.

MS ANDERSON: Yes.

MR GRAY: 8 November 2017, there's an additional reference to him there.

MS ANDERSON: Yes.

MR GRAY: And then there's the reference on 27 June 2018 on the next page, 000 – beg your pardon – 0007, if we go to that page. That's then the reference to the incident concerning Mrs CA in the fourth line. So is your point that there was follow-up after those incidents I was asking you about?

MS ANDERSON: Yes.

MR GRAY: But they didn't prevent an incident in November of that year?

MS ANDERSON: No.

MR GRAY: Right. And do you – did you inquire into what had happened and why there was a repeat incident in November 2017

MS ANDERSON: Yes, the - - -

MR GRAY: And what was the reason?

MS ANDERSON: The critical incident does – this is a form that says – you have the reportable register, then you have a critical incident that does come to me. I believed that it – and I think that residents living with dementia it is very unpredictable, and there was – it was a – an incident that did occur that, even though all the strategies had been put in place, they did not prevent it.

MR GRAY: The next point is to ask you about resident CC as well. There was an incident between Mrs CA and resident CC, the female resident - - -

MS ANDERSON: That is correct.

MR GRAY: - - - on 22 June which involved violence. Correct?

MS ANDERSON: There was an incident, yes.

MR GRAY: It didn't involve a very serious injury to Mrs CA, but it did involve some sort of contact by Mrs CC to Mrs CA. That's right, isn't it?

MS ANDERSON: That's right.

MR GRAY: And bleeding from the face of Mrs CA; correct?

MS ANDERSON: Yes.

MR GRAY: So I suppose the obvious point to make is that it could have been more serious. It might have resulted in a fall or something of that kind. Would you accept that?

MS ANDERSON: It could have, yes.

MR GRAY: And Mrs CC or Ms CC, the female resident with whom this occurred, she features in this register quite a number of times in the lead-up to 27 June. Would you agree with that?

MS ANDERSON: Yes.

MR GRAY: Same question, really. If follow-up requires taking steps to get to a level of reasonable certainty that there won't be a repeat incident, why are these incidents occurring repeatedly with respect to resident CC? Has the follow-up been ineffective?

MS ANDERSON: The follow-up for CC, we do – had our in-house dementia adviser wrote her care plan and the behaviour plans there. We had those reviewed by DBMAS, who felt that they were adequate and - - -

MR GRAY: And do you recall the detail of what the interventions were for Ms CC?

MS ANDERSON: There were a lot of interventions there for her: music therapy, doll therapy, not just care but non-care as well, re-directing her, engaging her in music that she liked. She did have a very difficult upbringing and she does have comorbidities with her diagnosis, and these strategies involved staff talking to her, calming her down, always assessing for triggers for her behaviour.

MR GRAY: In respect of each of these two residents, Mr CB and Ms CC, starting with Mr CB, did he present a risk to other residents at the – as at May and June 2018?

MS ANDERSON: Well, this resident had a diagnosis of dementia and he – with the unpredictability of that as well, I mean, you don't know when these triggers occur to cause the behaviours as well. So he was quite calm but, once again, the triggers are unexpected and spontaneous.

MR GRAY: And are you saying he did present a risk because of those factors?

MS ANDERSON: Well, I believe everyone in that unit could, with a diagnosis of dementia as part of their living with dementia, would – could propose a risk, yes.

MR GRAY: In terms of a comparison amongst the residents in the unit, was he at the upper end of presentation of risk to other residents, compared with the average level of risk?

MS ANDERSON: I don't know if I can answer that. I'm not across all the other residents in the dementia unit. They are there for a number of reasons where their GP and their family elect for them to stay in – in that unit for lots of different reasons.

MR GRAY: So you don't have enough knowledge about the particular circumstances of the other nine residents who are present?

MS ANDERSON: That is correct.

MR GRAY: And with respect to Mrs CC or Ms CC, the female resident with whom there was that incident on 22 June, in effect the same questions, did she present a risk to the other residents of that unit in Oberon Village?

MS ANDERSON: She was living with a diagnosis of dementia. She had triggers as well that often could cause her to become physical.

MR GRAY: And that's really manifested in the frequency of entries in the register, isn't it?

MS ANDERSON: At that point of time, yes.

MR GRAY: Yes.

MS ANDERSON: Yes.

MR GRAY: If we look at the diagram that I've taken the Commissioners to, tab 84, and we've established that the rooms in question are rooms 2, that's where Mrs CA was; room 1, that's where Mr CB was; and room 4, that's where Mrs CC was. We see that Mrs CA has been located…

... and we've established that the rooms in question are rooms 2, that's where Mrs CA was, room 1, that's where Mr CB was, and room 4, that's where Mrs CC was. We see that Mrs CA has been located – do you agree with – do you agree with that, do you know whether that's correct?

MS ANDERSON: That they were located there?

MR GRAY: Located as I've just recounted.

MS ANDERSON: I believe so, yes.

MR GRAY: On that basis it seems that Mrs CA was put into a room adjacent, in effect, on both sides to residents who had featured in the register of reportable assaults; correct?

MS ANDERSON: Yes.

MR GRAY: Do you know why that was done and whether there was any consideration of whether it was appropriate to locate her near residents who had featured in the register of reportable assaults with that frequency?

MS ANDERSON: There were a lot of residents in that unit that feature in the register as well. I don't – I'm not aware of why the placement occurred there. The resident CB did not spend very much time in his room at all. I'm not aware of how

the manager elected to put those residents in, but all the residents in that unit, as I said, do appear in that register.

MR GRAY: All of them do?

MS ANDERSON: I believe a majority do, because we report not just reportable and non-reportable, we also report allegations of resident assault to staff as well. So our register is quite concise. There's no need to - - -

MR GRAY: I will bring up the admission documentation at tab 32, please, operator. In – if we go to the sixth page of this document, this records that admission occurred – I beg your pardon – yes. Admission occurred on 16 May 2018.

MS ANDERSON: Yes.

MR GRAY: And if we go to tab 38, please, there's an extended care plan at tab 38. Was this completed on 31 May 2018; is that right, 31 May 2018, or was it completed at admission; do you know?

MS ANDERSON: At admission we do commence assessments for the care plan.

MR GRAY: So the fact that it bears a date at about a third of the way down the page, care plan created 31 May 2018, that may be a point at which it had reached.

MS ANDERSON: It had gone into the iCare system, yes. We had a paper-based admission process before that.

MR GRAY: It would be iteratively developed in the period between 16 May and 31 May; is that right?

MS ANDERSON: That is correct, yes.

MR GRAY: Thank you. Now, at some point in that time, if we go to page 0014, it's clear that the nurse making the relevant assessment 0014, under behaviour assessment attended at time of admission, it states in the right-hand corner under intervention:

> *When CA displays intrusive wandering. Staff are to redirect CA to familiar surroundings and reorientate her to her bedroom/dining room where necessary.*

And then under the next line there's a line across the middle of the page and then in the text in the right-hand column intervention below that it says:

> *CA is easily distracted and can be distracting to others at times therefore staff are to assist CA with undertaking activities of interest to facilitate engagement and minimise disruption/disturbance to others.*

I suggest on the basis of these entries that it was clear to Oberon Village that there was a risk that Mrs CA would be intrusive and would wander into other residents' rooms. Do you agree with that?

MS ANDERSON: Wandering is a part of living with dementia, yes.

MR GRAY: Well, in particular, Mrs CA showed a tendency to be intrusive in other people's rooms; is that right?

MS ANDERSON: She did wander and, yes, she had gone into other people's rooms.

MR GRAY: And doesn't that make it risky for her to have been located next to Ms CC, with her history in the register of a number of incidents in the lead-up to June 2018, and also opposite Mr CB, who had featured in the register as well, albeit not as frequently?

MS ANDERSON: CB did have his room – asked that his room be locked. The residents are free to wander around there. CC liked to spend her days in the sitting area. I notice that was on her care plan as well, that her activities involved integrating and talking in the dining area.

MR GRAY: So are you disagreeing with me? It wasn't risky to locate Mrs CA in a room near those two other residents given - - -

MS ANDERSON: I think we endeavour to minimise the risk but I don't think we can totally prevent the risk.

MR GRAY: It heightens the need for very alert supervision of Mrs CA, I suggest? Would you agree with that?

MS ANDERSON: I believe there was supervision in that unit.

MR GRAY: You've - - -

MS ANDERSON: Are you suggesting one on one?

MR GRAY: The evidence that the approved provider, the organisation has put forward in this matter includes the evidence of Ms O'Connell and she refers to a regimen by which there's a check every 30 minutes or so on residents. Is that your understanding of the supervision regimen?

MS ANDERSON: The nurses - there are two nurses there at all times and they are continually walking around and observing because they're looking for triggers, for exacerbations in behaviour and, yes, they would be monitoring those residents frequently.

MR GRAY: Given the frailty of some of the residents in question - the physical frailty of some of those residents, and given the dire consequences that could result from any aggressive interaction, physical interaction, it suggests that more frequent supervision than 30 minute checks would be appropriate. What do you say to that?

MS ANDERSON: Well I – there probably is more frequent observation of the residents. There are two nurses but there are other staff in there at times as well. The dementia adviser was there three days a week in that unit. There are other people there observing: the care manager, facility manager. There are cleaners, maintenance people there as well.

MR GRAY: I want to ask you about the interventions that were carried out to the best of your knowledge after the 22 June incident. If we go to your statement, do we have that available, please, operator, at page 6, paragraph 40. Thank you. You refer here to responses to the incident which involved the altercation between Mrs CA and Ms CC on 22 June.

MS ANDERSON: Yes.

MR GRAY: And you say, contrary to a statement in some other material:

> *There were a number of different strategies used by everyone to manage CA wandering behaviour. Both residents suffered from a cognitive impairment and accordingly Columbia exercised its discretion under the Act to not report the incident, however, it was entered on Columbia's assault register.*

We've already seen that. I want to ask you about the number of different strategies used by Oberon to manage CA's wandering behaviour. Are you able to recount those off the top of your head or do you wish to go to any care documentation?

MS ANDERSON: I could go to the care documentation - - -

MR GRAY: I understand you have the tender bundle - - -

MS ANDERSON: Yes, I do.

MR GRAY: - - - before you. One thing I wanted to ask you about was a series of behaviour assessments. I don't wish to stop you answering the question in any other way but were behaviour assessments one of the ways in which there were responses to incidents of this kind generally.

MS ANDERSON: Yes. Yes.

MR GRAY: I notice that there were three behaviour assessments that were made in respect of Mrs CA, and one of them was very shortly after the incident on 22 June. It was about half an hour afterwards, was that a behaviour assessment that was done because of the incident on 22 June, do you know?

MS ANDERSON: No, I don't know - - -

MR GRAY: All right.

MS ANDERSON: - - - what time that was done.

MR GRAY: I will just take to you that.

MS ANDERSON: Yes.

MR GRAY: If we go to document tab 56, the incident on 22 June was reported, as I mentioned in the opening, to have taken place shortly after 3 pm, 1505 on 22 June, and this document at tab 56, if we call out the text under Behaviour Assessment, we see time of assessment seems to be 22 June 2018 at 1534, although it does then say in text underneath that:

Time of assessment, behaviour assessment attended at time of admission.

It also seems that there is no difference in this document in the text of this document between the earlier behaviour assessment. Do you have any knowledge about why that may be so? Do you want me to take you to the earlier behavioural assessment to demonstrate that?

MS ANDERSON: This behaviour assessment was assessed by our in-house dementia adviser as we did also contact the DBMAS and they were aware of these strategies, and they agreed that they were sufficient.

MR GRAY: There was another behaviour assessment on 25 June. Was that a response to a DBMAS suggestion, do you know? I will ask you to look at that document. That's at tab 60.

MS ANDERSON: The tab 60 - that behaviour assessment was attended by our in-house dementia adviser.

MR GRAY: And there are some differences in text.

MS ANDERSON: Yes.

MR GRAY: The text is a little expanded, although it seems to be text that doesn't add a great deal in substance to what has been stated before. Do you have any comment on that? Have you reflected on this document and whether it in substance amounts to a different set of strategies for managing Ms CA's behaviours?

MS ANDERSON: Some of the strategies were the same but if you have expert advice from DBMAS and they state that these strategies are right, then I believe then we would go with that. They're – yes.

MR GRAY: Yes. So my learned friend wants me to break it down for you, and to take you through the extra text. If we look at page 0593 under Behaviour Management Interventions, when we compare behaviour management interventions, if we could call that out, please, operator. When we compare that more expansive text to the text which previously existed in the behaviour management assessment in tab 56, there's a lot more text there, but it seems to have been drawn from the extended care plan which is a document at tab 38 on page 0014. Do you wish to – you've got the bundle in front of you.

MS ANDERSON: I do.

MR GRAY: Do you wish to comment on that characterisation, or are there additional matters of substance?

MS ANDERSON: I'm not quite sure what you're asking me.

MR GRAY: What I'm suggesting is that there has simply been a picking up of content from the behaviour management section of the extended care plan, to which I took you earlier which bore the date 31 May 2018, but had been intuitively prepared prior to that. Suggestions from that document were put into the – this expanded version of the behaviour management – behaviour assessment document on the suggestions in relation to behaviour management interventions.

MS ANDERSON: With the iCare, the assessments populate the care plan.

MR GRAY: On 27 June, do you accept that there must have been a point in time at which Mrs CA wasn't under supervision and intruded into Mr CB's room while not being under supervision?

MS ANDERSON: No immediate supervision, yes.

MR GRAY: But it – but I take it that you disagree with the proposition that that amounted to substandard care?

MS ANDERSON: Yes, I do disagree.

MR GRAY: Given the risks that were already known by Oberon Village management, that Mrs CA showed signs of intrusive behaviour, including wandering into people's rooms, and given that will Mr CB had featured in the register of reportable assaults, wasn't there a need to provide a greater degree of supervision to Mrs CA to prevent an incident of this kind occurring?

MS ANDERSON: It is regrettable that this has occurred. We – I believe the supervision was adequate with two nurses in the unit at all times. I think it's the unpredictability of people living with dementia where their triggers for their behaviours occur spontaneously, as I had said, and without notice.

MR GRAY: No further questions.

COMMISSIONER TRACEY: Thank you very much for your evidence, Ms Anderson. You're excused from further attendance.

<THE WITNESS WITHDREW [4.03 pm]

COMMISSIONER TRACEY: Are there any housekeeping matters that need attention?

MR GRAY: No, Commissioner.

COMMISSIONER TRACEY: Very well. The Commission will adjourn until 10 am next Monday, 13 May.

MATTER ADJOURNED at 4.04 pm UNTIL MONDAY, 13 MAY 2019

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