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## TRANSCRIPT OF PROCEEDINGS

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O/N H-1063571

**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**

**MELBOURNE**

**9.15 AM, TUESDAY, 8 OCTOBER 2019**

**Continued from 7.10.19**

**DAY 52**

**MR P.R.D. GRAY QC, counsel assisting, appears with MS B. HUTCHINS and MS E. BERGIN**

**MR G. KENNETT SC appears with MR B. DIGHTON for the Commonwealth**  
**MS H. STANLEY appears for Helping Hand**

COMMISSIONER PAGONE: Ms Bergin.

MS BERGIN: May it please the Commission. We would like to welcome you, Commissioner Pagone, to your first sitting day on this Royal Commission.

5

COMMISSIONER PAGONE: Thank you.

MS BERGIN: And acknowledge Commissioner Briggs. This is the one year anniversary, a most auspicious day. It's the one year anniversary of the first Letters Patent of this Royal Commission. Before I call my first witness, there is an appearance to be announced.

10

MS H. STANLEY: May it please the Commission, my name is Stanley and I appear on behalf of Helping Hand.

15

COMMISSIONER PAGONE: Thank you.

MS BERGIN: I call Brian Joseph Lynch.

20

**<BRIAN JOSEPH LYNCH, SWORN**

**[9.16 am]**

**<EXAMINATION BY MS BERGIN**

25

MS BERGIN: Your full name is Brian Joseph Lynch.

MR B.J. LYNCH: Correct.

30

MS BERGIN: How old are you, Brian?

MR LYNCH: 73.

35

MS BERGIN: Where do you live?

MR LYNCH: I live at the War Veterans Home, RSL Care, Myrtle Bank in South Australia.

40

MS BERGIN: Thank you, Brian. Brian, you've prepared a statement for the Royal Commission; is there a copy of the statement in front of you there?

MR LYNCH: Yes, there is.

MS BERGIN: Operator, could you please bring up the statement, thank you. Brian, you have an amendment to paragraph 45 of your statement. Would you like to delete the final sentence of that paragraph, Brian?

5 MR LYNCH: Yes, I would.

MS BERGIN: Thank you. Subject to that amendment, is this statement true and correct to the best of your knowledge and belief?

10 MR LYNCH: What I would like to change is true and as a result my belief.

MS BERGIN: Thank you, Brian. I tender the statement of Brian Lynch dated 4 October 2019.

15 COMMISSIONER PAGONE: Yes, the statement of Mr Brian Lynch will be exhibit 10-8.

20 **EXHIBIT #10-8 STATEMENT OF MR BRIAN LYNCH DATED 04/10/2019  
(WIT.0513.0001.0001) AND ITS IDENTIFIED ANNEXURES**

MS BERGIN: May it please the Commission. Operator could you please bring up BJL.0001.0001.0005. Brian, would you like to read out your definition taken from  
25 the War Veterans Network of Australia. Can you see the definition of what is a  
veteran on the screen in front of you?

MR LYNCH: I have.

30 MS BERGIN: You have it.

MR LYNCH:

35 *A veteran whether active duty, discharged, retired or reserve is someone who,  
at one point in his or her life, wrote a blank cheque made payable to Australia  
for an amount of up to and including his or her life.*

MS BERGIN: Thank you, Brian. And thank you for sharing that definition of  
40 “veteran” with the Commissioners today. Brian, you were born in Sydney.

MR LYNCH: Correct.

MS BERGIN: And you lived in Sydney until you were 14 years old.

45 MR LYNCH: Correct.

MS BERGIN: Then you moved to the Central Coast of New South Wales.

MR LYNCH: Correct.

MS BERGIN: You were the second youngest of 10 children.

5 MR LYNCH: Correct.

MS BERGIN: You are an Irish Catholic.

MR LYNCH: Yes.

10 MS BERGIN: You attended school but you didn't like school that much so after intermediate you left school.

MR LYNCH: Yes.

15 MS BERGIN: You trained as an apprentice baker.

MR LYNCH: Yes.

20 MS BERGIN: Why did you become a baker?

MR LYNCH: In those days, an apprenticeship meant everything, for the working – it might be the wrong word to use nowadays, but the working class.

25 MS BERGIN: And did you like hospitality and looking after people?

MR LYNCH: Yes.

MS BERGIN: Brian, the early mornings as a baker became difficult; is that right?

30 MR LYNCH: Especially for your social life.

MS BERGIN: Especially for your social life. And you changed career to railways.

35 MR LYNCH: Yes.

MS BERGIN: You were, firstly, a senior station assistant; is that right.

MR LYNCH: That's correct.

40 MS BERGIN: And then you took some exams?

MR LYNCH: Yes, I studied for ASM.

45 MS BERGIN: And what does ASM stand for?

MR LYNCH: Assistant Station Master.

MS BERGIN: In this role you had mostly evening shifts.

MR LYNCH: Yes.

5 MS BERGIN: You met Sandra when you were 17.

MR LYNCH: Yes, before – before this new career, yes.

10 MS BERGIN: Before the new career and you met through mutual friends?

MR LYNCH: Yes.

MS BERGIN: And later on you married Sandra.

15 MR LYNCH: Yes.

MS BERGIN: At the age of 20 you were conscripted for national service.

20 MR LYNCH: Correct.

MS BERGIN: How did you feel about being conscripted to national service?

MR LYNCH: Honoured, actually.

25 MS BERGIN: You served in the army for 14 years in total.

MR LYNCH: Yes.

30 MS BERGIN: And are you wearing a few badges today, Brian, relevant to your service. Would you like to explain those to the Commissioners?

MR LYNCH: One is the RSL badge. The other one is the TPI badge, which means totally incapacitated. The other one is the federation that I'm in, the Vietnam Veterans Federation. The other one my friend, Jim, gave me about 12 months ago. The middle of it is the flag of the free Vietnam veterans, not the present Vietnam, not the – sorry, it's the flag of the free Vietnam, not today, the communist Vietnam. The two red stripes either side of the flag represents the Australian Army. At one end of the badge is the dark blue, which is the Australian Navy, and the other end is the Australian Air Force. That was our whole commitment to the Vietnam war.

40 MS BERGIN: Thank you, Brian. Brian, turning back to that time before your service in Vietnam, what was your first job in the army?

45 MR LYNCH: I was a private cook.

MS BERGIN: And you did your training at Singleton?

MR LYNCH: That's correct – sorry, I will go back on that. I went to – I was – did my basic training at Singleton, like all other recruits, they did either Singleton, Kapooka or Puckapunyal.

5 MS BERGIN: Thank you, Brian. Then you became a cook in Brisbane in the 52 Supply Platoon; is that right?

MR LYNCH: I did my core training first, and then I got posted to 52 Supply Platoon.

10

MS BERGIN: Did you want to go to Vietnam at this time?

MR LYNCH: Yes, I did.

15 MS BERGIN: And so what training did you volunteer for?

MR LYNCH: Well, I got posted to – firstly, to – and after 12 months I found out the unit wasn't going to Vietnam. So I rang up Corps and the RSM at Corp said if I extend my national service by 12 months he would send me. So I volunteered for Canungra which was the jungle training centre. All troops who went to Vietnam had to go through this course. I did the three weeks. I passed and I signed on for six months – sorry, an extra 12 months, and I was sent to Vietnam. I was posted and I got promoted to corporal cook in 1 Field Squadron RAE.

25 MS BERGIN: Brian, what was the jungle training course like?

MR LYNCH: Hard.

MS BERGIN: And you passed that course?

30

MR LYNCH: Yes.

MS BERGIN: What role did you have in Vietnam during your first tour?

35 MR LYNCH: Corporal cook.

MS BERGIN: Corporal cook. And were you posted to Vietnam on 18 December 1967?

40 MR LYNCH: Correct.

MS BERGIN: So you were in the First Field Squadron of the Royal Australian Engineers.

45 MR LYNCH: That is correct.

MS BERGIN: And you were promoted to corporal cook in 1 Field Squadron; is that right?

MR LYNCH: Yes, on arrival.

5

MS BERGIN: On arrival. How long did you serve on your first tour?

MR LYNCH: 12 months and one day.

10 MS BERGIN: And what was that like?

MR LYNCH: I describe 1 Field Squadron in this way: in my whole army career, I never served in another unit that had so much esprit de corps as what 1 Field Squadron had. They had a very special part of 1 Field Squadron; they had a very special section of men. They were called tunnel rats. They were exceptionally brave. I – I can't give them enough – and I don't think no infantrymen would speak – they would speak so highly of these special men.

MS BERGIN: Thank you, Brian. Brian, after your service in 1 Field Squadron what was it like returning home in December 1968?

MR LYNCH: It was a time of turmoil in Australia. We had the anti-war movement, Save the Sons. I – I felt absolutely disgusted the way the public – the government – the elected government sent our troops to Vietnam and the people in Australia voted for the government, and that should have been – they were the people's voice. But then you had these long-haired louts – and then what topped it off – I got married, as I said. And then what topped it off is the brigadier at taskforce – I was based at 23 Construction Squadron and the brigadier taskforce sent a memo suggesting that we didn't wear our uniform to and from work and that topped me right off.

30

MS BERGIN: Brian, you mentioned that experience in paragraph 17 of your statement. Would you like to read out paragraph 17?

MR LYNCH: Yes:

35

*Shortly after I had returned to Australia, I remember receiving a memo from the brigadier. We were –*

I would like to change that word, "instructed" with "suggested".

40

MS BERGIN: Suggested. Thank you Brian. I will make a note of that edit.

MR LYNCH:

45

*...not to wear our uniform when we travelled to and from work. For the returning troops from Vietnam, the reception from the public was very hostile, especially the anti-war movement.*

MS BERGIN: Thank you Brian. How was your health at this time?

MR LYNCH: I was having bouts of anxiety. Not pregnant, of course, but morning sickness.

5

MS BERGIN: That's how it felt? It felt like a bit of morning sickness as if you were pregnant.

MR LYNCH: .....

10

MS BERGIN: Brian, while you were in Vietnam, you and Sandra had been writing to each other?

MR LYNCH: Yes, we corresponded over the years.

15

MS BERGIN: And you wrote to her and asked her to marry you.

MR LYNCH: That's correct.

20

MS BERGIN: What did she say?

MR LYNCH: Yes.

MS BERGIN: She said yes and you got married and lived in Villawood in Sydney.

25

MR LYNCH: Yes, we got married. I arrived back home on 18 December '68. We got married on 18 January '69, and my posting was with another engineer unit, 23 Construction Squadron at Holsworthy. And we had a married quarter at Villawood. I had five months to do of my extension of national service and then the demonstrations and all that, I think the rest of it is written down or would you like me to repeat?

30

MS BERGIN: No, that's terrific, thank you, Brian. You were just talking about life in Sydney as newlyweds. How was life in Sydney after you married Sandra?

35

MR LYNCH: Like all newlyweds: very good.

MS BERGIN: Sandra passed away about a year ago.

40

MR LYNCH: Yes, she did.

MS BERGIN: Yes. And you must miss her terribly?

MR LYNCH: I do.

45

MS BERGIN: Brian, you were posted again to Vietnam in March 1970.

MR LYNCH: Yes, I was.

MS BERGIN: And your first son was born while you were away.

5 MR LYNCH: That's correct.

MS BERGIN: What was your role during your second tour of Vietnam?

10 MR LYNCH: I was sergeant, sergeant caterer. My first – my first actual posting was on the – what they call the pool. That was a reserve sort of a position where if other units in Vietnam needed a sergeant cook where a cook got wounded or had to be sent home or a unit needed a sergeant cook, I would be sent. If there was no need at the time, I had a New Zealand Kiwi 01. He would do the inspection of units in  
15 ALSG, Australian Logistic Support Group. That was the support – support area for the forward troops at Nui Dat. So I used to go around with him and inspect the units of AAD – sorry, of ALSG at Bung Tau. We used to finish the inspections by 11-12 o'clock.

20 MS BERGIN: What did you do after the inspections were finished, Brian?

MR LYNCH: Went back to the sergeant's mess and socialised.

MS BERGIN: And how did you socialise?

25 MR LYNCH: Drink.

MS BERGIN: Pardon?

30 MR LYNCH: Drink.

MS BERGIN: You drank alcohol?

35 MR LYNCH: Yes. Alcohol was – you know, Bacardi and Coke – you could buy a full bottle of Bacardi for a dollar. It cost you more for Coca-Cola than what it did for the 40 oz bottle of Bacardi. And then I was sent down to AOD, advance ordinance depot to prepare the unit for a sergeant cook, the strength of the unit went up to 250. And I got – I got up to a standard because they only had a corporal cook there and they were feeding 250. When I got there, I realised what was happening. The plans for cutting the strength down to Vietnam was in process and AOD was a supply unit,  
40 and also that was the unit that was going to cut down the material that was required for the final pull-out of Vietnam. So the teams were sent up there to get all this organised. So I got what I wanted so I asked the CEO could I be posted there, and he said yes. So I finished my last eight months in Vietnam posted to 2 AOD. Then I  
45 come home early 1971.

MS BERGIN: You came home in May 1971?

MR LYNCH: That's correct.

MS BERGIN: And you continued serving in the army?

5 MR LYNCH: Yes, I did.

MS BERGIN: You were posted to infantry battalion.

10 MR LYNCH: I was posted to 3CB as a sergeant.

MS BERGIN: You were promoted to sergeant?

15 MR LYNCH: I was promoted to sergeant in 23 Construction Squadron, the first unit when I come back from Vietnam the first time.

MS BERGIN: How did you feel about being promoted on your return from Vietnam?

20 MR LYNCH: Rather surprised because the promotion come so quick in my army career.

MS BERGIN: You then also served in New Guinea.

25 MR LYNCH: Yes, I was posted to New Guinea in '72. I was posted to 1PIR, Pacific Island Regiment training the Pacific island soldiers for two years. It was a family accompaniment and my wife, my son and my daughter was only six – sorry, six weeks old when we went. We had two years there. It was a very rewarding time and it was also a family time because there wasn't many Europeans at that stage because the downward handover to the people of Papua New Guinea was well in  
30 force, type of thing, the Australians were winding down on account of what the United Nations wanted.

35 MS BERGIN: Thank you, Brian. You continued to serve in the army after returning to Australia from New Guinea until 1980.

MR LYNCH: Yes, that's correct.

40 MS BERGIN: And looking back on this experience in the army and your service in Vietnam, in two tours, what impact did your service have on your health?

MR LYNCH: I – I think – I don't think I know, but physically I was fit. I was a big man, always have been. I used to always get in trouble with the doctors at annual reports. I got a bit heavy as sergeant. But mentally I was scarred and ups and downs still that way.

45 MS BERGIN: Did you have PTSD, Brian?

MR LYNCH: Yes, depression, anxiety and now last April, 12 months, bipolar grade 2.

MS BERGIN: Brian, were there some good things about your service?

5

MR LYNCH: Yes, and I – when you asked me the other day when we were doing our statement, you asked me what I got out of the army. And I – I was thinking on all these ways. When my friend Jimmy, Jimmy Richardson, a couple of days ago brought me this Legacy badge. It's funny how things happen. And on one side of it, it had Honour and on the other side it said – it didn't say the ..... it said about the wattle. And what it said on the side about honour, that was what I really thought of what the army was. And I wrote it down. What the military service is, is duty, mateship, courage, loyalty, and honour. That's what it's like.

10

15 MS BERGIN: That's what you got out of your time of service?

MR LYNCH: Yes.

MS BERGIN: Brian, I'm going to jump forward a bit now in time to September 20 1995. The DVA decided – that's the Department of Veterans Affairs decided that you had a total and permanent impairment; is that right?

MR LYNCH: Yes.

25 MS BERGIN: That is because you had multiple war-caused conditions and a service-caused condition; is that right?

MR LYNCH: Yes, one service cause, that was my legs.

30 MS BERGIN: At this time after you lived in New South Wales and in Queensland you then entered residential aged care in Albury-Wodonga.

MR LYNCH: Yes, I did.

35 MS BERGIN: What do you remember about your entry into residential aged care in Albury-Wodonga?

MR LYNCH: Nothing at all.

40 MS BERGIN: Brian, could you please read out paragraph 38 of your statement?

MR LYNCH: What number was that?

MS BERGIN: Paragraph 38. Thank you, Brian.

45

MR LYNCH:

*It is hard to describe a place that you have no memory of. It's an insidious thing to go through. To know that you were functioning at the time but have no recollection. I had wondered what had happened to me and what medication I had taken. I now know that I shouldn't have worried about it and look at that period of life as if I was in a big sleep. There is nothing else I can do about it now.*

MS BERGIN: Brian, your daughter has kindly written a letter for you which you've provided to us, explaining some of what occurred during this period on the basis of her recollections and we have included that letter with Brian's statement, Commissioners, or Brian has included it with his statement. Brian, your daughter also supplied a photo. Could you please bring up B JL.0001.0001.0001. Brian, could you describe this photo for us?

MR LYNCH: I'd describe it that I'm definitely not with it.

MS BERGIN: That's you there in the picture?

MR LYNCH: Yes. No, I've been involved in ..... in aged care of my own choice and I say I was over-medicated.

MS BERGIN: Brian, you then moved to Adelaide in November 2015 but you say in your statement you don't have any memory of this.

MR LYNCH: Not the early parts, no.

MS BERGIN: Not the early parts. You moved to an RSL facility.

MR LYNCH: Yes, I did.

MS BERGIN: And RSL helped you to get in touch with ward 17 at the repatriation general hospital which is also called the Jamie Larcombe Centre; is that right?

MR LYNCH: In sequence when I was in – that used to be called RSL Villas, I've got no memory of the first couple of months there. There was a lady there, I don't – I don't think I'm allowed to name names. But she went out – way out of her normal duty statement. She was more on the wellbeing side of care, and with a person on the psych side of ward 17, the psychologist, they put in place with the CEO, RSL Care at Myrtle Bank a system that I could – that they arranged so I could get treated by a psychiatrist in the old Repat. I don't remember. I'm only going on what I've been told after a couple of months, when I started the – started to be cognitively – impairment started to go back to normal.

MS BERGIN: And you started to get your memory back?

MR LYNCH: Yes.

MS BERGIN: And you moved from RSL villas in Angle Park, which is now known as Morlancourt, to - - -

MR LYNCH: Yes.

5

MS BERGIN: - - - the War Veterans' Home on 18 August 2016 - - -

MR LYNCH: That is correct.

10 MS BERGIN: - - - is that right? Operator, could you please bring up document BJL.0001.0001.0004. Now, you say in your statement, Brian, that you have a safety net.

MR LYNCH: Yes. I have.

15

MS BERGIN: Could you tell us about your safety net?

MR LYNCH: Yes. The safety net is this. I see a psychiatrist every five – every six weeks. I see a psychologist every three weeks, sometimes more. I am admitted to  
20 JLC, the Jamie Larcombe Centre, which was the old ward 17. And then they closed the Repat down in South Australia. Every three months, I go in there for three weeks. I will be going in there at the end of this week for my time. That's not a jail sentence, by the way. I had a long stay last April, 12 months, and I had 11  
25 treatments of ECT. That – the psychiatrist has assessed me with having bipolar disorder grade 2, which I discussed previously.

I have a copy of my neuropsych report, and it shows improvement in my mental impairment. I've got a copy of the assessment of my mental condition at present and my future diagnosis. The psychiatrist – the safety net in place for me, if I am unwell,  
30 I go and see the clinical governance team and they will liaise with JLC and information to the specialist, and together they look at – look to the plan and admission to JLC and, vice versa, I will be admitted.

MS BERGIN: Brian, what do you do at seniors' group?

35

MR LYNCH: There's – we're – every Friday, people – four of us from War Vets, we go over to JLC and we join another lot of veterans. About 20 of us, there is. And we socialise. We have quizzes and we're all in the same boat. But it forms a bit of corroboree; we're all together.

40

MS BERGIN: And - - -

MR LYNCH: We have morning tea. And it's a unique thing, you know.

45 MS BERGIN: And the other people that travel with you, or travel in taxis, are also residents of the War Veterans' Home?

MR LYNCH: They're – this is a – DVAs – yes, I will be honest. There's four of us. And, guess what, they put on four taxis. We're going to the same place. We're leaving from the same place. It's a waste of public moneys. We definitely need two taxis. I can't see the cost involved in four, why DVA does it. I can tell you other  
5 reasons what the DVA tightens their belt where they shouldn't, but – if we've got time, I'll go into that. But if we haven't, well, I'll leave that – things as it is.

MS BERGIN: Did you want to give some examples, Brian?

10 MR LYNCH: Of what, DVA? Now? Now, I'll go down this ..... you know, psychiatrist, dental, doctors, hospital, if you're over 80 – or, sorry, everything you can get, order a taxi, okay? For all medical. If you're under 80, you can only get a taxi ordered for doctors, dentist and hospital. You still get paid, but you have to make an application on paper. So that employs a clerk to do the work at the other  
15 end. And then they send it – then you get it sent back to your – a cheque – not a cheque, but it comes up on your bank account as a pension, you know.

But what gets in my craw is with psychiatrists and neuropsych people – they've got it on the screen what you're entitled to, your gold card, but guess what you have to do  
20 if you've got to see these two people? Because they're psych people, right? They send you out of the car – send you out with an application form, to be registered. It's like a council registering a dog. You know, a person with psychiatric problems, why should he have to be registered, when these illnesses are already on the screen? It's a way of knocking a man's pride down the drain.

25 MS BERGIN: Brian, you said that if we had time you wanted to give other examples of where DVA tighten their belt where they shouldn't. What did you have in mind there?

30 MR LYNCH: ..... see young – the younger veterans. At present, they top themselves off once a week – one a week. They come in; I see it. They come into JLC; the doctors and nurses and the associated people do a magnificent job, get them okay – not okay, but get them to a standard. And places like our place, emergency housing, and – does all that. And now they've got this – what they call –  
35 they can fix things up in 24 hours. It looks good on paper, but it's not done. It seems to me that if you've got something physically wrong with you, they get rid of you very nicely. But when it comes to psych, the way the delegates talk to the young fellows in reports, these young fellows, young mateys, are, you know – they've got impairment and DVA should be – look after and have a step-down and protect  
40 instead of wiping their hands and making it so hard to – for these young fellows that they're responsible. I put it on paper there, what our great Prime Minister said.

MS BERGIN: You have. And we'll come to that at the end of your examination, Brian. But I wanted to ask you, you talk with the younger veterans that you  
45 mentioned just now. Are there people that you talk with at the Jamie Larcombe Centre?

MR LYNCH: Yes. I get in trouble for it, because I need to look after – to get well myself.

MS BERGIN: Have they returned from other wars?

5

MR LYNCH: Yes. They have.

MS BERGIN: And which wars have they returned from?

10 MR LYNCH: Afghanistan, Kuwait, and even way back to Timor. They're still hanging on; they're still waiting for decisions.

MS BERGIN: And when you say they're still waiting for a decision, what are they waiting for, Brian?

15

MR LYNCH: A decision from – reference their pension. I can't get the right pronunciation, but if you look up the dictionary, the last words – word in the dictionary, Byzantium – Byzantium, I think it is, in the Bs. It describes the DVA clerk – DVA – what do they call them – delegates, properly. Them people, they – they're – it's based on Constantinople. They were renowned for three things.

20

MS BERGIN: Yes Is that - - -

MR LYNCH: Architect, war and language.

25

MS BERGIN: Okay.

MR LYNCH: Well, the language that they were renowned for, you have a look at a DVA delegate, they use it profusely.

30

MS BERGIN: So you're talking about the language in Byzantium, I think.

MR LYNCH: Yes.

35 MS BERGIN: Yes. It's quite a long time ago.

MR LYNCH: The DVA - - -

MS BERGIN: That's the language, is it?

40

MR LYNCH: Yes. That's the language. They – the delegates like to - - -

MS BERGIN: Right.

45 MR LYNCH: Confusing.

MS BERGIN: And, Brian, you gave us – was there an example where you’ve had to wait a long time for your supports to come through, such as your shoes?

MR LYNCH: Yes. Just recently, about six to eight months.

5

MS BERGIN: So you had to wait. DVA supply you with shoes, do they?

MR LYNCH: I’m entitled under VEA, Veterans’ Entitlement Act. On the – as I said, reference the – where I’m covered under VEA for SOS, Special Overseas Service, Vietnam. And then I’m entitled under Defence Services Australia; I’m covered under that Defence Services under Australia for my leg.

10

MS BERGIN: For your leg. And that entitles you to a pair of shoes - - -

MR LYNCH: Custom-made - - -

15

MS BERGIN: - - - how often?

MR LYNCH: - - - shoes.

20

MS BERGIN: Custom-made shoes.

MR LYNCH: Yes.

MS BERGIN: And do you apply for your shoes yourself?

25

MR LYNCH: I did, up to a few years ago. But this operator, he was in a backyard-type of thing in a farm in Wodonga. It nearly crippled me, so I gave it away and then I put it in here at – in Adelaide, and that’s when I had the trouble. But I got them.

30

MS BERGIN: You got your shoes eventually.

MR LYNCH: Yes. And then I spoke to them again. And I was lucky, the – our welfare – our veterans liaison officer was standing by. And I got on to a – to a lady who was from the – from Asia. And I was trying to get my point about, because I wanted a second pair, which I’m entitled to. And I was explaining – I think I expressed myself rather well, but I was trying to explain about requiring a second pair. And all she kept on saying, “You have to put in a – did you get your second – first pair?” And I got – not aggro, but I got very authoritarian in the way I spoke, I will agree.

40

MS BERGIN: Were you a bit frustrated?

MR LYNCH: Definitely so. And Kane was there as well, so I had the support. So he was going to fix it up. And guess what she done? She hang up on me.

45

MS BERGIN: She hung up on you, Brian?

MR LYNCH: Yes. I have dealt with war graves for a person. I've never had that; first time ever. I think some of the culture might come into it. So I think when I first dealt with DVA we virtually had a delegate who looked after us all the way through. But now – I will give you an example. Transport is not held by Adelaide; it's done  
5 by Brisbane. The Department of Defence centre is done by Cooma, a country town in New South Wales. You know, the individuality has been taken all out. I'll say no more.

MS BERGIN: Thank you, Brian. Brian, you've talked a bit this morning about how  
10 your health has improved since you moved to the War Veterans' Home in Adelaide. How do you feel about the quality of your care at Adelaide RSL Care?

MR LYNCH: Well, I'll say, in one word, home. It's like a family. If you've got – you get the basics of life: food, care, all the things to do with home, water – all that.  
15 The basics, I'm talking about. Then you get more than that. You're allowed to – not allowed, but – that's a bad word. But you're given the chance to put your expertise in the field that you were trained in, into – you can talk – but if you put it down in writing and it goes up the tree, you know – I'm just the army assistant. You go up the tree. You don't go to the boss first because that upsets the people in the lower  
20 ranks.

MS BERGIN: Brian, you served as a cook in the army. Are you on a catering committee at War Veterans' Home?

25 MR LYNCH: Yes. I am.

MS BERGIN: So are you involved in decision-making about the meals?

MR LYNCH: Not fully, no. I'm – I have to know my place, you know. There's  
30 paid professionals. But they take suggestions, you know. That's what I'm saying. I've read the eight standards of aged care which has come out. You know, I challenged one of them. The referee made a decision; I go along with the referee. That's what I like about RSL Care.

35 MS BERGIN: So you like being involved in - - -

MR LYNCH: Being chef.

MS BERGIN: In what your home looks like; is that right?  
40

MR LYNCH: That is correct. I've taken you people down and seen my room. It's home.

MS BERGIN: Thank you, Brian. Brian, could you read out the last two paragraphs  
45 of your statement, paragraphs 66 and paragraph 67, please?

MR LYNCH:

5 *I am proud of my service. Veterans are a group that do need special support  
and I recognise that we have complex needs, like the First Australians. I reflect  
on our Great War time leader in 1919, Prime Minister Billy Hughes, who made  
a pledge to the returning troops of the First World War, saying that the 60-odd  
thousand troops that were killed and of the 160,000 troops who were wounded,  
both physically and mentally, the Australian Government and people would  
look after them, both medically and financially, in order that they could  
reassimilate into society. We, the modern veterans, do not want anything other  
than the pledge of Billy Hughes to be honoured. I have been in a residential  
10 aged care facility for nearly 10 years. I am not quite sure that the regional  
facility knew what to do with me at the time. I was so much younger than the  
other residents. Signed, Brian Lynch.*

15 MS BERGIN: Thank you, Brian. Commissioners, that concludes my examination  
of Brian Lynch.

COMMISSIONER PAGONE: Mr Lynch, thank you very much for coming to give  
evidence to the Commission. It's been very helpful. Thank you.

20 MS BERGIN: If this witness could please be excused, Commissioner?

COMMISSIONER PAGONE: Yes. You may leave, Mr Lynch. You may go back  
to your home.

25 MR LYNCH: Thank you.

**<THE WITNESS WITHDREW** [10.04 am]

30 COMMISSIONER PAGONE: Ms Hutchins.

MS HUTCHINS: Yes. Commissioners, I call the next witness, Mr Ian Klinge.  
Sorry, Nathan Ian Klinge.

35

**<NATHAN IAN KLINGE, SWORN** [10.05 am]

40 **<EXAMINATION BY MS HUTCHINS**

COMMISSIONER PAGONE: Mr Klinge, do feel free to sit down and make  
yourself comfortable.

45

MR N.I. KLINGE: Yes, Commissioner.

MS HUTCHINS: Mr Klinge, your full name is Nathan Ian Klinge?

MR KLINGE: Yes. Pronounced Klinge.

5 MS HUTCHINS: Klinge. Sorry.

MR KLINGE: That's quite okay.

10 MS HUTCHINS: And have you prepared a statement for the Royal Commission?

MR KLINGE: Yes. I have.

MS HUTCHINS: Operator, please bring up document WIT.0410.0001.0001. Is that  
15 a copy of your statement in front of you?

MR KLINGE: Yes. It is.

MS HUTCHINS: And do you have any amendments you'd like to make?

20 MR KLINGE: No. I don't.

MS HUTCHINS: Are the contents of your statement true and correct, to the best of  
your knowledge and belief?

25 MR KLINGE: Yes. They are.

MS HUTCHINS: Commissioners, I tender the statement of Mr Nathan Ian Klinge,  
dated 18 September 2019.

30 COMMISSIONER PAGONE: Yes. Thank you. That will be exhibit 10-9.

**EXHIBIT #10-9 WITNESS STATEMENT OF NATHAN IAN KLINGE  
DATED 18/09/2019 (WIT.0410.0001.0001)**

35

MS HUTCHINS: You're currently employed as the CEO of RSL Care South  
Australia?

40 MR KLINGE: Yes. I am.

MS HUTCHINS: Yes. And how long have you held that role for?

45 MR KLINGE: I was appointed the CEO in July of 2015.

MS HUTCHINS: And from November 2014 to that time, you were the director of  
develop with RSL Care?

MR KLINGE: That's correct. In that period of time. I was acting CEO from April 2015.

MS HUTCHINS: And what did that role involve?

5

MR KLINGE: The Director of Development role?

MS HUTCHINS: Yes.

10 MR KLINGE: Effectively, a second-in-command role. We were doing some minor redevelopments at the time as well, which I had carriage of, and looking into some of the veteran-specific aspects of our business operations as well.

MS HUTCHINS: And prior to that role, what is your professional experience?

15

MR KLINGE: Prior to RSL Care?

MS HUTCHINS: Yes.

20 MR KLINGE: I spent 23 years in the regular army, starting as an infantry soldier. And then most of my career in the army was health services, as a commissioned officer within medical corps.

25 MS HUTCHINS: And is RSL Care affiliated with the Returned and Services League of Australia?

30 MR KLINGE: RSL Care is its own charity. We're a not for profit; got our own board, own constitution. We have very close links with the RSL in terms of that community relationship piece, but we have our own constitution, our own association, so we are a standalone entity in that regard.

MS HUTCHINS: Yes. And as part of your not-for-profit operations, you have two residential aged care facilities?

35 MR KLINGE: That's correct. So we've got the War Veterans' Home with 95 beds, and Morlancourt with, now, 61 beds.

MS HUTCHINS: Yes. And in broad terms, what's the background and the nature of the facilities that you operate there?

40

MR KLINGE: Sure. It's – RSL Care – just those two residential - - -

MS HUTCHINS: Yes.

45 MR KLINGE: - - - care facilities? So the War Veterans' Home at Myrtle Bank, that's actually where we started our operations as an organisation back in 1917. We were looking after homeless then contemporary soldiers returning from World War I.

That facility, over the ensuing years, evolved through, effectively, a hostel for homeless male veterans. Through the fifties we became more focused towards the aged care side of the house, as that veteran aged.

5 And then, as a lot of community-based providers did through the fifties, through the eighties, we migrated across into what would be more the classic-age care model for what we have now. So it was a 95-residential care facility at the War Veterans' Home. We have a – certainly, a focus on veterans, but we're a community residential care provider in the not-for-profit space. Morlancourt, RSL Villas,  
10 opened in 1997 as a 55-bed facility. Again, it was focused very much as a men's hostel, looking after older male veterans. Now, it's a 61-bed facility. And, again, a classic residential aged care site.

15 MS HUTCHINS: Yes. And as part of your role as CEO, do you have much direct contact with your residents?

MR KLINGE: Not as much as I'd like, but as an organisation we have a fairly diverse portfolio. We're only a small provider. So we've got two residential care facilities, four retirement villages and we run a homeless program for contemporary  
20 veterans. As CEO, I'm across all of those, obviously. But, certainly, being co-located at the War Veterans' Home and spending quite a bit of time at Morlancourt as well, I do get to have daily interaction with our residents. And I look to get as involved as I can with veteran activities, veteran social activities and the commemorative events that we do at both sites, sort of, hitting the high points of our  
25 veteran calendars throughout the time as well. And the residents do have direct access to me. When they need to, they can bang on my door pretty much any time or write me letters.

30 MS HUTCHINS: Thank you. I would like to turn to the topic of veterans' needs.

MR KLINGE: Yes.

35 MS HUTCHINS: This is something that's discussed in some – set out in some detail in your witness statement. And you raise the point that there's a prevalence of veterans ageing and entering aged care at an age that's younger than the general population. You identify in your statement that across your facilities you've got 16 Vietnam veterans, with an average age of 74.3 - - -

40 MR KLINGE: Correct.

MS HUTCHINS: - - - as their admission age.

MR KLINGE: That's correct.

45 MS HUTCHINS: And this is considerably lower than the national average age of admission, which is 84.6. So I'd like to discuss with you what are some of the

factors that you're aware are leading to this earlier entry into aged care facilities by the veterans.

MR KLINGE: There's a number of factors across a resident's life history, a  
5 veteran's life history that will impact or can impact on their sense of wellbeing, their  
physical health and their mental health. One that – fairly common, that we'd  
understand – in terms of post-traumatic stress disorder and the impact that PTSD can  
have on a person's physical health and their mental being. And studies show that  
10 people with PTSD do age quicker. They age younger. The ailments of age tend to  
hit them a little bit earlier. It's a very similar thing with the homeless population.

So the homeless population – if you're a homeless person aged 60, then generally  
you'll represent comorbidities that represent someone around 20 years older. So it's  
– a veteran's life history, if they find themselves in a situation where they're  
15 struggling with issues, such as substance abuse, weight issues, mental health issues,  
post-traumatic stress disorder, social isolation, family breakdown or any combination  
thereof, what our experience is is that we can find ourselves with younger veterans  
who are physically unwell, that are facing a range of mental challenges and that don't  
have a network of family and social support around them to provide the supports  
20 they need to be to be able to stay at home comfortably.

And, as a result, there's a requirement – there's a need for them to have alternate  
sources of care. I do think that part of the aspects for things like the War Veterans'  
Home and Morlancourt is that that provides an agreeable alternative for them, given  
25 the peer support environment that they can experience in those areas as well, which  
then may encourage them to, sort of, look for those care opportunities, because of the  
badge, because of who we are and what we do for veterans.

MS HUTCHINS: And is there a greater prevalence of dementia among veterans?  
30

MR KLINGE: The studies reveal there – certainly, for post-traumatic stress  
disorder, there's a high prevalence for dementia for those who've been diagnosed  
with PTSD. I'm not a researcher. The jury's out as to whether that's a causative  
35 factor as a result of PTSD, therefore increases your risk factors for dementia or  
whether the risk factors for dementia increase your vulnerability for PTSD. But,  
either way, absolutely, for residents with PTSD, there is a statistically-significant  
higher prevalence of dementia for those residents as well.

MS HUTCHINS: And so you mentioned, as well as life experiences that can affect  
40 veterans more, is this – issues around social isolation and family breakdown.

MR KLINGE: Yes.

MS HUTCHINS: Is that something that's commonly seen in the veteran  
45 population?

MR KLINGE: Yes. It is. I mean, there's – certainly, there's veterans out who have great lives, great family networks. We have veterans who walk through our door at age 100, having lived fantastic lives, socially connected, grey nomadding with the grandkids, and they then enter residential aged care longer. In our experience across  
5 our years, we find that a veteran cohort seems to span around 30 to 40 years for us. They do move in younger. Those veterans then don't tend to be the ones that we see, you know, make it to those older age brackets.

10 So the veteran population that we see coming in are the younger bracket – earlier are the ones where we do tend to find that background of family breakdown and social isolation, caused by a range of factors. It could be substance abusive issue, violence in the home. High-risk behaviours are common within the veteran cohort; high risk either in terms of substance abuse or just in general activities of life. We do find that over time, a fatigue factor can get in, not only for the immediate partner of the  
15 veteran but studies reveal that it also impacts adversely on their children, so it impacts on the relationship that a veteran will experience with their children. And we certainly have seen that in our veteran population in residential care where the children have become fatigued with the pressure of being the child, in particular, of a Vietnam veteran which is particularly challenging with some studies that are out  
20 there. And as a result, those support networks can drop away and therefore we do find that we have got a cohort of veterans who are more socially isolated than what we might find otherwise within our resident population.

MS HUTCHINS: Yes. In your statement you provide an example of a resident who  
25 is Vietnam veteran who entered RSL Care SA when he was 68 years of age.

MR KLINGE: That's correct.

MS HUTCHINS: What were the circumstances of his life that led him to needing  
30 assistance at that time?

MR KLINGE: Mr ..... he was a Vietnam veteran. He served in the Special Air Service regiment in 3 Squadron in Vietnam so a really high calibre soldier, a really high calibre of training; someone who had to display a significant amount of  
35 tenacity and resilience through his career to be able to make it to that level and deploy successfully. Speaking with him he explained to me that he started drinking, as he said, at about 43 and sort of tracking back through his life – the SAS Association is quite a proud and well-formed social network for ex-SAS people and he, you know, around 50 started to drop away from the SAS Association and not  
40 connect up with his cohort as a result of his substance abuse, and alcohol was the substance he particularly abused.

He now has an acquired brain injury through his alcoholism and when we became aware of him, in fact, he had his medals in the pawn shop, he had hocked them to  
45 buy a bottle of rum, which was sort of how far his life had fallen away from him. So we moved him in – he moved in with us, I should say, at then RSL Villas, now called Morlancourt at age 68. He has been with us for a couple of years now. He's a really

– a great resident. He loves to paint. His room is absolutely chockful of artwork which we’re also putting up down on the wall now we finished a renovation in his particular area. The challenges that we faced – he, particularly early in his piece when he first moved in with us, still very much enjoyed going to his local for a drink.  
5 That did result in us having to work with him around his own safety. There were nights where he disappeared.

The local we worked in with pretty well; we knew the bar staff. They would ring us if they had concerns and we knew where he would be. I remember one night in  
10 particular, he had drunk quite a bit and he wasn’t there. So we had what was, effectively, we had lost him for a couple of hours, had to go for a drive in the streets to find him. When I found him, he wasn’t prepared to go back yet. So we sat down for a while for a – literally a couple of hours until he felt he wanted to go home again which was about 11 o’clock at night at that time. And talking with him, he explained  
15 to me that he lamented the lost sense of what he was. He could recall what he was as an SAS soldier. He saw in himself what he was now and that impacted around his depression and his sense of self.

You could really see that he had almost devalued himself in that regard. It’s one of  
20 the things with PTSD that we do find is the ailments of age start to impact on residents with PTSD, whether there’s substance abuse or not. The coping mechanisms that have helped them through life tend to not be available to them. So if, for example, you like to go for a run, that becomes more difficult as you get older. If your social network is your support that’s helped you cope; that becomes difficult.  
25 If you find it difficult to read because your eyesight is failing or your hearing is going; all these little tricks that have helped you survive through life can fall away from you and then therefore – and things like retiring, what’s kept you busy, and has kept the black dog at bay, as the veterans will explain, with that time and that time to think, that can then refreshen those wounds and then the coping mechanisms aren’t  
30 there.

So it’s not uncommon for us to see in that sort of older population, this really heightened experience around the PTSD that’s probably already been there in the previous witness. Brian spoke a little bit about that in terms of that impact as well,  
35 and why that’s such a challenge for veterans when they do hit those older brackets.

MS HUTCHINS: Yes, and in your statement, you detail that you’ve been involved in the development of a trauma-informed care workshop. What was it that was the  
40 impetus for starting this workshop?

MR KLINGE: We find as an industry – the aged care industry is fairly well structured around issues to do with mental health in the dementia space. What we find, with a much larger density of veteran residents, we manage more frequently  
45 issues of mental health to do around anxiety, the aggression, the post-traumatic stress disorder. We are fairly experienced at that, and we have got a lot of hands-on experience with that. We looked for the industry to find opportunities to help our staff and increase their tool bag of resources to deal with the sorts of things that

happen at 2 in the morning. We didn't find there was something off the shelf that would really hit that mark for us, so we went looking around to see where we could find something.

5 There's an organisation called Phoenix Australia which are the centre for post-traumatic mental health. Phoenix Australia do a lot of work with high risk organisations, they do a lot of work for DVA, AFP, those sorts of organisations. So we approached them about whether we could lift some of their PTSD experience and apply it to a trauma-informed care environment within residential care, because we  
10 are not researchers, we are not experts in that regard. So working with them, we developed the content for the trauma-informed care workshop with two goals. First, to help our own staff at RSL Care to look after the veteran cohorts that we're responsible – not just veterans, I mean, there's a – the reality is that 70 per cent of  
15 people who make it through to an aged bracket have an experience of trauma in their life.

So this is not a veteran issue; this is a residential aged care issue, but certainly our piece of the mission and object centred very much around the veteran piece, to give  
20 our staff the skill sets they needed. But we also felt a responsibility to help the industry a little bit more. We are only a small provider. We can't look after all the veterans. There are many more veterans in facilities and acute hospitals and things that we can't look after. So we then invited other providers to send their staff and, indeed, SA Health sent some staff members from the acute sector to attend our  
25 training with the hope that we can then seed plant some of that trauma-informed care experience into those who are touching residents, dealing with residents, assisting residents, whether it be the acute sector or in the residential aged care sector.

MS HUTCHINS: When we speak of trauma-informed care, what do you understand that term to mean?  
30

MR KLINGE: It's first and foremost evidence based, is really important. There's lots going on in this space. There's lots of views around what should be happening. There's lots of really encouraging work happening with peer support, art therapy programs. You can get a bit lost in the cloud of that sometimes. So we wanted to go  
35 back to, really, what was the evidence that demonstrated changes in our behaviour as a service provider that would enable us to be better, to do better, to help our residents better, which is why we went to an organisation like Phoenix Australia, because we're not researchers, we don't have that skill set. So the first bit about trauma-informed care is that it is evidence based and it's evidence that then informs our  
40 behaviour as a care provider as to how the care we can provide is trauma informed.

So when you are having an interaction with a resident, what you are seeing as in front of you, it's about actually understanding what's going on behind that scene, understanding the causes, understanding, and the second way is to help the residents  
45 either de-escalate from a fairly significant issue of anxiety and concern for them, but ideally understanding ahead of time so that we don't get there. We understand the triggers for residents, we know what the residents like. We know what they don't

like, we know what they'd like to do, we know what they don't like to do, and we work with them on that, and then we can actually avoid unnecessary hospitalisations where we have a resident who may have become aggressive. If we can cut that back here, then that's another hospital admission we don't have to deal with for that  
5 resident and a better outcome for the resident.

MS HUTCHINS: Sure. And in terms of knowing your residents and what they like and what they don't like, and what might be causing these behaviours, what are the types of systems or measures you put in place to gather that information when a new  
10 resident is joining or on an ongoing basis?

MR KLINGE: Sure. It starts preadmission with the first contacts that we have when someone either rings us or we become aware of someone who might need our support. So we have our conversations very early in the piece to understand who the  
15 resident is and who is approaching us and that they understand us to know what we are about and to see if that's a fit for them. At the point of admission, on day one, the registered nurses certainly take the lead in terms of us understanding the clinical needs, the mini maps, the falls risks and those sort of very immediate requirements. But then over the next five weeks our wellbeing staff work on pulling out a lot of  
20 detail around the resident's history. We write a narrative in the first person for the resident.

We find generally it's probably about three or four hours work but at multiple points across those residents' first few weeks where we have interviews, we have  
25 discussions and we pull out the aspects of their life. We call it their Really Special Life, RSL; we think that's pretty clever. And through our Really Special Life assessments, we gain a picture of who the resident was, who the resident is, who the resident wants to be in residential care. And then we actually take that information and put it in our model of care, which is called Janus. And our model of care is  
30 about – Janus was the god of looking forward and looking back, the god of transitions.

So very much through that understanding of the resident's life history but that doesn't always necessarily mean that is who they are now and what they want to be  
35 now either. They may have liked to play tennis all their life; that doesn't mean they want to go out for a game now. They just might enjoy watching it. So it's really through those assessments and then the key to that, though, is that that actually has to be reflected in our practice then. That has to be captured in the resident's care plan. We have to understand the so what of that and what that means for us and how that  
40 changes our behaviour so that we can then meet the resident's needs and expectations.

MS HUTCHINS: Yes. And are you able to provide the Commission with a practical example of how you may have tailored the care that's provided to a  
45 particular resident based on their needs in this space, particularly to do with trauma-informed care?

MR KLINGE: I would say there wouldn't be a resident where we don't do that, I guess would be the first and foremost. Particularly if we're using the veteran experience as an example. Through the Really Special Life assessments we don't ask just, "Are you a veteran?". We actually go into the veteran's military history.  
5 There's points and markers across a veteran's service history that will be critically important to them that might not necessarily pop up on a normal commemorative calendar. It might not be Anzac Day, it not be Remembrance Day. It will be their enlistment day, it will be the day a particular battle that their battalion or unit was related to. And it's about us understanding that and then respecting and reflecting  
10 that in terms of our behaviour and what we do within the home environment, how we memorialise that for them.

We have a veteran who doesn't want to go to Anzac Day, so he doesn't go to Anzac Day. You know, just because he's a veteran, that doesn't mean that's his thing. We  
15 need to understand that. It's not just about veterans. We had a resident whose family belief structure was such that the resident didn't want to be touched for 24 hours after she passed away. That was their religious belief instructor and through the Really Special Life assessment we knew that on admission. So the palliative care discussions right from admission involved how that 24 hour period would look like  
20 and we were already having meetings about staff – because our practices normally would not – normally we'd have staff going in, we would have doors being opened, we'd have doctors with hands on flesh, we would be doing a whole range of things around a resident passing away, that our normal procedure was not okay for that resident.

25 So when the resident did pass away, it was a really calm experience. We were able to meet all the family's needs. We were able to facilitate that 24-hour period. We had some discreet signage on the door. The staff knew what that was all about, and we were able to meet those needs really without a lot of effort, but it was something  
30 that was critically important to that resident and that family network.

MS HUTCHINS: Operator, please pull up paragraphs 10.3 and 10.4 of the statement. So in this part of the statement, you have detailed some resident profile, some of the resident profiles in relation to various diverse groups. And I wanted to  
35 ask you about a couple of these in terms. You have identified at H, operator, if you could please go to there, that you have 17 residents who identify as culturally and linguistically diverse.

40 MR KLINGE: Yes.

MS HUTCHINS: So the example that you've just given is a clear example of why it's important to understand the cultural differences. What other approaches have you implemented in order to facilitate effective communication with any of these residents or otherwise understand and meet their needs?  
45

MR KLINGE: Let me start by saying we would not profess to be CALD specialist provider. We are well-meaning amateurs, we do our best. For our CALD residents,

there's some really simple things, like just making sure that our documentation is available in their language of choice, if they so choose. Recognising that the language of choice for the parent is not the same necessarily for the kids who might have grown up in Australia and happily would be flicking through documents at a pace that the resident can't keep up with because they don't have the document in front of them in their language of choice.

And Morlancourt facility is nestled very much within a very strong Vietnamese community. It happens that with our veteran community, in particular Vietnam veterans, there is a really strong link and cultural link with the Vietnamese community. That's something that has persisted really strongly since the Vietnam War. It's a really positive relationship both ways for the Vietnamese community and for the Vietnam vets. And in fact we have a number of Vietnamese veteran residents in our Morlancourt facility. So it's about understanding there are slightly different needs. For example, one of our Vietnamese residents very much for his family network and his belief structure, they commemorated family deaths much more than birthdays, so there was no point bring the birthday cake out for him. That not was not an important factor for him, but commemorating the dates of deaths of family members was really important which, culturally, is something that we just normally would not make a big show of.

And then, of course, there's the opportunity for us to employ staff who have bilingual skills and, in particular, for example, once again understanding that we are in a Vietnamese community area, making sure that we have got Vietnamese staff on hand who can speak in the resident's language and choice.

MS HUTCHINS: Yes. And I note at the start of your response then you said something to the effect that you are not a CALD specialist provider but you make your best endeavours. Do you think across the board with providers, everyone should be endeavouring to have systems and procedures in place to meet the needs of people from different diverse groups or do you think that specialist providers really are better placed to be able to do that?

MR KLINGE: Both. There's absolutely a gap for niche providers providing a niche service for residents who make that choice, and we are no different in the veteran space. There will be plenty of veterans who choose not to come to us, because they might be Catholic, and they'd love to go to a Catholic home because that's their belief structure, which is great, and it's great that the industry can support that. And I imagine it would be similar for residents from the CALD community where, if you are from an Italian community, you may very well like to go to an Italian specialist provider. Notwithstanding that, I think there is a responsibility for the industry to be able to respond to our multicultural society by providing a service that is multiculturally respectful.

There are challenges with that. There are opportunities with that. The resident population changes, so what you are doing this year won't be okay next year because you will have a different resident cohort that you will need to respond to. But with a

little bit of effort and working in with the residents and their families there are a lot of opportunities to do things that the resident values. It's not always necessarily what we think is the best outcome or the thing that we need to do in a conversation with the residents and understanding their needs; often they're pretty simple, pretty basic and pretty easy to accommodate.

5  
10 MS HUTCHINS: I would like to return briefly to the topic of homelessness which we touched on earlier before. Are you aware whether there's any reliable data indicating the prevalence of homelessness amongst veterans in Australia?

10 MR KLINGE: It is a bit of a vexing question for a couple of reasons. Firstly, there's not an agreed dataset of what is the veteran population of Australia because there's a bit of grey area around what defines a veteran. The DVA definition of a veteran relates to someone who has served for a single day in continual full-time service, so in the permanent force, one day or more. For example, in our community we count those who might have served 20 years in the Army Reserve; they haven't served a continuous day of full-time service but they've done 20 years in the Army Reserve so we very much count them as part of our veteran community.

20 So the definition of veteran is a little bit grey. And no one has a button that you can push that says, right, there's this many veterans in Australia. So without that number, and then without a system of understanding the homeless community population with identifiers of who the veterans are in the homeless community you can't then come up with an accurate number. The best guess in terms of comparing datasets and things, so we've got some local acceptance in South Australia where we have managed to get veterans as an identifier on the Homeless Gateway, for example, and that helps. But a 2018 study by AIHW revealed that there's around 4.96 per cent of the homeless population are veterans, when veterans, at best guess, represent around 2.5 per cent of the population.

30 So there's a higher propensity for homelessness in veterans. I would suggest it's probably a little bit higher because I suspect that a large number of our veteran population residing in residential care actually come off the homeless spectrum but they're somewhat invisible to the data because they're in the residential care setting. So as a minimum – even with the minimum we do have a much higher propensity for veteran homelessness than the normal community.

40 MS HUTCHINS: Yes. And one of the services that you offer is the Andrew Russell Veteran Living - - -

MR KLINGE: Correct.

45 MS HUTCHINS: - - - which is intended to be for working age veterans that are homeless.

MR KLINGE: That's correct.

MS HUTCHINS: I note from your statement that of the 95 homeless veterans there's 11 over the age of 60.

MR KLINGE: That's correct.

5

MS HUTCHINS: Why is it those people aren't in an aged care facility?

MR KLINGE: There's an element of choice in that for some of them. Some of them are just skating over the 60-year mark, so 61, 62, 63, but again, as I mentioned earlier, the frailties of age impact homeless folks sooner. They age quicker. I do think there's barriers that prevent younger folk and younger veterans from entering residential aged care. A 67-year old veteran with post-traumatic stress disorder and substance abuse issues, when presenting as a resident for residential care even from a funding perspective there's limitations around the way we are currently funded. Activities of daily living enable a lot more flexibility for residential care providers in terms of what you can do because the funding is there. Complex health care needs; the funding is there to provide a lot of support.

When we are looking at, say, a veteran, a 68-year old Vietnam veteran who physically is otherwise reasonably capable, but requires a lot of support in what would be in the behaviour domain for ACFI but that's the domain that is really under-funded, so it creates a rather complicated resident as well. And I'm sure that that is a confronting thing for a residential care provider when they are trying to balance out their residential population. There's not a lot of choice for veterans. They can be a bit suspicious. They can have a, I guess, that sense of self-support where they will choose to reside by themselves. We had one resident who lived in a one-bedroom unit in a country town in South Australia. He was for a number of years, three weeks in ward 17 which is the mental health service at the time in Adelaide as an acute mental health patient.

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He would go back to his unit for a week. He would drink; he would have suicidal ideation. He would be back in the acute mental health sector again a week later for another couple of weeks stint, and that was his pattern of care for a number of years. We spoke with him about coming into residential care. He was quite expletive about his thoughts not to do that, so we said, "That's fine, don't move in. We have got a spare room; why don't you just stay with us to save driving home". So he opted to stay in our spare room for six months; he never left. He has never been a resident of ours now for three years and in that entire time he has never been back to the acute mental health sector.

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He didn't need acute mental care. He needed appropriate care for him. And with that he was then no longer in the acute sector. One of the challenges, of course, in the acute mental health sector where a residential care bed – were an occupied bed day is around \$1500 a day, you know, a resident like that that we can then support in the aged care sector, he might be getting \$156 a day.

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MS HUTCHINS: Sure. And so you've mentioned that you see some issues with the funding arrangements under the ACFI provisions. Do you think that the way that the funding is currently structured provides you with sufficient funds to adequately meet your residents' needs?

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MR KLINGE: I think, certainly our experience – you now, we run two good residential care facilities. We work hard. We have got a really supportive board that understands our mission and objects. They're really understanding about the need for us to invest more broadly than what the domains would suggest. They encouraged me and have allowed me to employ a veteran support officer. So this is a contemporary veteran with a lived experience of war. He is an Afghan veteran, and Brian mentioned him in his statement – Kane – about the support that he provided Brian when he was working his way through with DVA. That's something that as an organisation we've done.

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There's not really a system under ACFI to capture that kind of support. It sits a bit awkwardly in a wellbeing space but it's not really that. So as an example, around the flexibility and the agility to provide the services that we do, I'm reliant very much on a supportive board who understands our mission and objects for us to then be able to do those extra things that we need to that aren't clearly captured neatly under the ACFI model. So I think that there are some challenges there in terms of being able to better respond to resident expectations and needs, yes.

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MS HUTCHINS: There's also a supplement available known as the veteran supplement in residential care.

MR KLINGE: That's correct.

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MS HUTCHINS: You identify in your statement that you do have a number of residents currently receiving that supplement. However, there's further residents that you believe would be eligible but are not receiving that supplement.

MR KLINGE: That's correct.

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MS HUTCHINS: Why is that occurring?

MR KLINGE: There are some challenges to the way that the supplement is approved. It's a push supplement rather than a pull one. So DVA issue the supplement rather than a residential aged care facility being able to apply for it. There are some barriers to that process which I think mean that the industry isn't getting the support necessarily in the veteran cohort and residential care that it could. So the barriers, for example, a veteran needs to sign a particular form authorising the release of information so the supplement can be paid. The previous witness, Brian, explained some of the challenges and frustrations around that paperwork and having to make new statements and confirm again who you are. And particularly at the point of admission in residential care which is a confusing time as one of life's transitions anyway.

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So to be throwing some extra paperwork in there, in my view, somewhat unnecessarily when DVA have great understanding of who their veterans are. They have got the systems in place. I think there would be an opportunity, perhaps, for a residential care provider – it would be my recommendation that DVA have a look at that process and simplify it, come up with a way that isn't a requirement for a resident to sign a form. We had a resident who filled in the form but didn't sign it, so we didn't get the supplement. So we then chased it down and did it. It was through a residential care provider in regional Queensland. Your capacity to understand that for the small veteran population you might have and then to be able chase down the forms and the paperwork with DVA for what is a \$7.08 a day supplement is probably fairly limited.

MS HUTCHINS: Thank you. We are running out of time but I would like to touch on a couple of further topics with you, quickly, if I may.

MR KLINGE: Sure.

MS HUTCHINS: Firstly, we would like to understand better the impact of entering residential aged care on veterans' access to DVA entitlements. Operator, if you could please display tab 96 of the general tender bundle. This is a document entitled the Aged Care Eligibility Matrix.

MR KLINGE: Yes.

MS HUTCHINS: So just in broad terms, what is this document and what does it show?

MR KLINGE: Really what this reflects is the reality that veterans are funded – DVA is a private health care system, effectively, for veterans. So through life veterans are supported by DVA. When a veteran enters residential aged care they're supported financially for their care needs under the Act and under the funding instruments for residential aged care. So DVA go, "Well that has been paid for under the residential care service so we won't double dip." So there's certain logic to that that absolutely makes sense, and I think where you're heading with the questions relates to our concern where we feel that there's a difference.

We feel the support available through life for veterans through DVA does not necessarily follow across into residential care and we're also concerned that there's a visibility aspect where, who actually checks to see that the residents get what they're entitled to in the residential care service.

MS HUTCHINS: In your experience has there been those follow-up checks?

MR KLINGE: No, not in our experience. So we don't have DVA visits to the home. My understanding – for example, I'm involved with some different DVA forums and they are really good at tracking, for example, complaints in the acute sector that involve veterans. As I understand it, DVA don't track complaints through

the Aged Care Complaints Commission. Well, if we look at complaints in the acute sector for veterans, why aren't we understanding complaints made by veterans in the residential care sector. There's some really easy opportunities here. The infrastructure is there. The will and the desire of DVA to do good stuff is absolutely there. It's a case of perhaps using that existing infrastructure and just tweaking it a little bit so that we can develop those better outcomes for those in residential care setting.

MS HUTCHINS: And one outcome that you draw as an example in your statement is where a resident is deemed to have a chronic condition, they lose their entitlements. Why do you suggest that that's not an appropriate course?

MR KLINGE: One of the examples that we're dealing with at the moment has been a recent change – and I'm not an advocate or an expert in terms of entitlements with DVA, but around – once someone has a condition that isn't getting better; if you, for example, use physiotherapy or hydrotherapy and I'm a contemporary veteran, once I've had X number of the trips to the physio, I've got to go back to my GP to confirm that I still need to do this because the logic being that you're not getting better so let's do something else and make you better is the rough logic around the change in response and that, which is great.

If you're in the home care environment and are you're palliating, the goal is not necessarily to get better. The goal is to live well. So the hydrotherapy-type activities create – have a different desire, a different impact. I am aware, for example, of residents in the residential aged care setting who were accessing hydrotherapy entitlements outside of residential care but those entitlements don't exist for them inside residential care, and they would still love to go and do hydrotherapy. So we look at ways to support that. And even in the home care setting I'm aware of a veteran who – at a local swimming centre; they just don't charge him because they don't want to tell him no, even though the entitlement stopped that they used to send off to DVA. So they're actually just allowing him to keep coming because they don't want to have the conversation with a World War II RAAF veteran that he can't come and do his Thursday swim session any more. And they've rung me saying, "What can we do?", and I said, "Well, you might want to ring DVA".

MS HUTCHINS: Thank you. In relation to the aged care assessment rounds, are you able to explain to the Commission what your experience has been in relation to that process for applying for bed licences.

MR KLINGE: Sure. Probably two experiences. I will bookend it now by saying we had a very rapid and quick approval, which is great. So we have managed to get what we asked for but to rewind a little it; we've been approved 72 bed licences to construct a regional facility in Murray Bridge which the board is planning to have operational by 2023. I have six newly constructed beds at Morlancourt that are ready to be operationalised, and in a very high density area for veterans and a very high area of need for us, 100 per cent occupancy, average occupancy at 98 per cent.

We did approach the Department of Health for a meeting to discuss about relocating six bed licences that were sitting there till 2023 unused in the Morlancourt so we could operationalise those immediately and get veterans in them. It was an hour and a half meeting. We were actively discouraged from doing that. We were advised we were very unlikely that we would have been successful because it was a regional area transferring into a low priority, a category 6 area in a metro area. We did explain that there was an absolute special needs group requirement that was not reflected in the big data of residential care bed licence allocation and that we could demonstrate that through the DVA population data.

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MS HUTCHINS: What was that special need?

MR KLINGE: So the special need around veterans. So of the top six LGAs in South Australia for veteran populations, five of them are immediately around Morlancourt so it's a very high density area. But the western area of Adelaide is an over-serviced area from a bed licence perspective. So the two didn't necessarily align up. And it was – certainly – so that meeting process, to the point that we – I walked out and thought, well, it's almost not worth us applying. We persisted, we applied, and we had approval. I learnt a couple of weeks ago that you guys sent across my submission, which might have helped but, regardless, the outcome has been given which is great.

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MS HUTCHINS: I guess, as a result of that experience, have you formed an impression about whether the ACAR system generally is sufficiently agile to recognise and meet individual areas of needs as they emerge?

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MR KLINGE: So I think ,accepting we've managed to get the outcome, but at point of contact, no, it was not. We were actively discouraged in terms of there just not being an option that this would get up. Effectively, the computer says no; that was basically what we were presented with. If you're a small provider like us and you're coming up against that, you've only got so much time to put into those things and what we encountered was a fairly firm wall, that we decided that we'd have a go anyway. So, yes, we got what we asked for but we could have easily turned away at that first meeting and not persisted.

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MS HUTCHINS: Given the time, there's no further questions, Commissioners.

COMMISSIONER PAGONE: Thank you.

COMMISSIONER BRIGGS: I would like to ask you, Mr Klinge, and I know this is a very open-ended question but what we're trying – one of the things we're trying to understand is the cost additionality of giving someone a life that they're happy with. And you've given interesting examples of taking away entitlements to a swim when people aren't getting any better or what have you and, sadly, this is a function of aged care. Have you got any sense of what might be necessary to support an individual, on average, to live a fulfilling life in residential care?

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MR KLINGE: That's a really interesting question Commissioner, because it's such an individual thing for each resident. You know, some aspects of it are really – from a financial perspective are really very affordable. You know, certainly organisational focus and time which can be difficult to cost capture. I would suggest that as an  
5 organisational provider we would probably have about \$60,000 in salaries per year that we would commit towards extra veteran things and activities as a service provider above and beyond what would be a routine residential care year, so for the two residential care homes to put a number on something like that for us which I would not think would be dissimilar for a CALD or an LGBTI or an Indigenous  
10 special care provider.

What I would say, though, for things like the DVA entitlement, these are not massive amounts of money, the restriction is probably more around what the legislation says. There is absolutely a passion that I've seen in the DVA people I've dealt with to  
15 want to provide support but everything is tied back to legislation, which does not change quickly and it is not just responsive and agile enough to deal with those individual cases and when we do get them and persist, and we have the conversations like Mr Lynch's testimony around his shoes; that was a five or six month discussion. Well, that proved successful in the end. That's a pretty long five and six months for  
20 what was really quite a small amount of money in the long run, and that also then generates quite negative outcomes, as Mr Lynch explained, for him where he felt devalued through that process for the cost of a second pair of shoes.

That's where I think we might be able to come together and use – there's a lot of  
25 infrastructure out there in the veteran community that would be available to the residential care sector. Phoenix Australia, the organisation that I mentioned, they operate a practitioner support service where they provide free advice to ex-service organisations dealing with veterans with special needs in the community that are challenging. It's a great clinical group of GPs and psychiatrists and social workers  
30 who sit around a table and will provide free support. It would not be a huge issue for that group to then become specialist advisers in the aged care sector on veteran issues like we do with Dementia Services Australia.

The infrastructure is there. The people are already sitting around a table. It's funded  
35 by DVA. We just need to use it a little bit differently to make it more accessible in the aged care sector and the system is there to be used and could be operational in a month.

COMMISSIONER BRIGGS: Thank you.  
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COMMISSIONER PAGONE: Yes, thank you, Mr Klinge. Anything else?

MS HUTCHINS: Nothing arising.

45 COMMISSIONER PAGONE: Thank you very much, indeed, for giving that evidence. It has been very helpful. Thank you.

MR KLINGE: Thank you, Commissioner.

5 <THE WITNESS WITHDREW [10.52 am]

COMMISSIONER PAGONE: We will now adjourn for about 10 minutes.

10 ADJOURNED [10.52 am]

RESUMED [11.04 am]

15 COMMISSIONER PAGONE: Yes.

MS HUTCHINS: I call the next witness, Ms Helen Radoslovich.

20 <HELEN MARGARET RADOSLOVICH, AFFIRMED [11.05 am]

25 <EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Your full name is Helen Margaret Radoslovich.

30 MS H.M. RADOSLOVICH: Yes.

MS HUTCHINS: And you have prepared a statement for the Royal Commission.

MS RADOSLOVICH: Yes.

35 MS HUTCHINS: Operator, please bring up WIT.0445.0001.0001. Is this a copy of the statement in front of you?

MS RADOSLOVICH: Yes.

40 MS HUTCHINS: And do you have any amendments to the statement?

MS RADOSLOVICH: No.

45 MS HUTCHINS: Are the contents of the statement true and correct to the best of your knowledge and belief.

MS RADOSLOVICH: Yes.

MS HUTCHINS: Thank you. I tender the statement of Ms Helen Radoslovich dated 18 September 2019.

5 COMMISSIONER PAGONE: Yes. Thank you. That statement will be exhibit 10-10.

**EXHIBIT #10-10 STATEMENT OF MS HELEN RADOSLOVICH DATED  
18/09/2019 (WIT.0445.0001.0001)**

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MS HUTCHINS: Now, you're are you currently employed as the manager, growth and development in the research and development unit of Helping Hand Aged Care?

15 MS RADOSLOVICH: Yes.

MS HUTCHINS: Yes. And how long have you held that role for?

20 MS RADOSLOVICH: I've held a role or a similar role for 18 years.

MS HUTCHINS: And what does the role involve?

25 MS RADOSLOVICH: I have responsibilities related to strategic planning or supporting strategic planning, policy development, development of new services and new service approaches and sometimes portfolio interests such as consumer care and engagement and diversity inclusion where I help the organisation to think about those issues and decide what to do about them.

30 MS HUTCHINS: And so, as part of Helping Hand's operations – has this research development unit.

35 MS RADOSLOVICH: It's been around since about 2005 in its current form. It's resourced by the – by Helping Hand itself. It includes several – three – three areas of activity; one is the development space which is the sort of work I do. We coordinate all the research activity that happens within the organisation, including maintaining the relationships with a range of research institutions. And we also oversee and manage the student participation program. The organisation places around 800 students per year in various opportunities within the organisation ranging from vocational education students through to post-glads but primarily being in the allied health and vet space.

45 MS HUTCHINS: And in your statement, you identify that Helping Hand intends to act as an incubator to develop tools through its projects so that they can be shared with colleagues. Why is it that Helping Hand has adopted has adopted this approach as part of its operations to, I guess, do research and share those learnings more generally with the industry?

MS RADOSLOVICH: We believe that the activities that we become involved in, which can improve the sector for everybody to benefit from, not just ourselves. We're not setting out to be the preeminent provider of this or that but what we can learn if it can do better for the industry, that's what we would aim to do and we've demonstrated that over time. An example would be our approach to using exercise physiology within an aged care organisation. We've presented that in numerous conferences and advocated for that approach in many different ways. But that's just a general approach to the way we do business.

10 MS HUTCHINS: And more generally, what are the types of aged care services that Helping Hand provides?

MS RADOSLOVICH: We provide residential aged care, a suite of home care services including home care packages and Commonwealth Home Support Program services but also we are a provider of veterans home care services, mental health services funded by the State Government. We also do retirement living.

MS HUTCHINS: And what is the service approach that's adopted by Helping Hand?

20 MS RADOSLOVICH: We've got a broad approach, our person centred care approach which means placing the person at the centre of what we do and with a focus on choice and empowerment, controlled by the consumer.

25 MS HUTCHINS: And within the focus of this hearing being on diversity, we would like to understand how the concept of culturally safe care feeds into those practices that you adopt.

MS RADOSLOVICH: Yes. The concept of culturally safe care means understanding who people are, and where they come from, and I'm going to refer to my notes because I'm not very good at quoting definitions off the top of my head and I think you need accuracy as well. Sorry. Let's start again. Culturally safe care is providing an environment which is safe psychologically, emotionally, physically for everybody to be able to be who they are, express themselves and have a sense of identity. Identity is core to who we are as humans. It is also a place that people can feel that they can have some control over about what is happening in it. So that they can enter that, continue to be who they are and make changes when the environment around them doesn't support them. When I say environment, I don't just mean physical, I mean the whole sense of service and place and feeling.

40 MS HUTCHINS: I note that your current strategic plan includes a key performance indicator that:

45 *Our service delivery has been adapted and continues to adapt to meet the needs of specific diverse groups.*

We're interested to know how is it that you intend to measure this as an indicator.

MS RADOSLOVICH: Yes. We take a different approach to measuring impact than what some people might think of, there's a number or a percentage. We are looking at a systems approach so that we can see from our board engagement with this – with our approaches through to what happens with services on the ground, that we can see  
5 change or things that have made a difference or an impact because of the activities we make. The board will help change our settings by approving policy, by listening on a regular basis, getting feedback, often through case studies, through our committee structures to hear and see what we're doing and learning from those about other settings we might need to change within the business.

10 We have an approach we call Turn Up Your Voice to listening to consumers and their family members and other supporters, to find out whether we're actually hitting the mark or not. We also use co-designers in approach to service delivery and out of that, that will make sure that the people who are going to be affected by services are  
15 engaged in designing those services. If we see those practices in place then that's one way of indicating that we are moving towards having an impact for those groups. From the specific projects we are running, particularly the one we will talk about, I'm sure, later, real care the second time around, we have a dedicated evaluation project – sorry, evaluation in place for that project that was part of the funding. That  
20 will measure those. So we layer those levels of understanding but we aimed it so we have a line of sight from what's happening, service delivery through to board reports about what we're achieving.

MS HUTCHINS: Yes. And in terms of your service delivery to your clients, how  
25 important is it to understand what their there are background or circumstances might be that might impact upon their care?

MS RADOSLOVICH: It's critically important. We can't work with a person, effectively, and understand their needs or give them space to communicate those  
30 needs to us if we don't have some understanding of who they are and what that background is. We need to provide opportunities at every part of every interaction we have with people for them to feel that they can trust us, to open up and declare to us who they are and what they want. Sometimes we will find that we will work with someone for a long time before they will declare certain information and that's part  
35 of their learning – their learning to trust us. And we need to be open and listen all the time and be quick to respond.

MS HUTCHINS: And when you have people first entering your services, are there  
40 some questions that you think are appropriate to ask around understanding what people's needs might be, in terms of their backgrounds, whether it be in relation to, say culturally or linguistic diversity, so care leaders or identifying as members of the LGBTI community. What's the approach that you take in relation to try and understand what that person's background might be and, really, where is the line  
45 between what's appropriate to ask and what is not appropriate to ask?

MS RADOSLOVICH: Our general forms and the forms we also get through the assessment agency, always remembering that by the time people come to an aged

care organisation they have had to answer lots of questions and often declare their identity to others first, so we will have access to that information. We are, all the time, refining the questions that we ask. So we currently ask questions about country of birth and language and people become comfortable, I think, over time with  
5 answering those, although still people don't always want to. We've refined the questions we ask about gender to make sure that they're inclusive of intersex, trans and queer communities.

We are, through the work we're doing now, thinking about how to ask questions  
10 about the question of are you a Forgotten Australian or not. Forgotten Australian is not necessarily a term that all of that community relate to. Some people don't even know they're in that community, as we found through our work. We also have a second level of questioning once – because they're kind of the top order demographic questions that I guess we're all used to because we get asked all the  
15 time in any service we relate to, for that sort of information. We then also have other questions where we're starting to get through – talk to people more about who they are as an individual. And in our community questions, questioning in our residential questioning, there are questions which will say, “Is there anything you want to talk to us about, about you that you think it's important for us to know about your diverse  
20 background?”.

There's always room to improve those questions and that's some of the work we want to do with the communities that we are working with, so how can we ask these questions better and at the right time. We are also cautious that we should only be  
25 asking people about things we need to know to provide them with a service. If we are providing a six-weekly gardening service, how much do we really need to know about that person. Sometimes we don't need to know a lot, sometimes we might need to know more because they might say we don't want a male doing our lawn mowing, for whatever the reason is behind that. We make sure – we currently  
30 employ a female home handy person so we can meet that need but they're some of the challenges that we have to face.

MS HUTCHINS: Thank you. And in terms of the diverse backgrounds of your residents, sorry, and home care recipients, what do you know about the cultural and  
35 linguistic background of those clients?

MS RADOSLOVICH: That's one question that we have started improving our data around. In my statement on page 4, we've identified that - - -

40 MS HUTCHINS: Operator, please call out paragraph 4, the first dot point which includes some statistics around the demographics of your residential care clients.

MS RADOSLOVICH: Yes. For our residential care clients 18 per cent come from or identify as being born overseas and in our community it's 11 per cent. And the –  
45 73 different countries of birth were identified which shows quite a diverse community. The main communities represented are Italy, Greece, Germany, Netherlands and the UK.

MS HUTCHINS: Thank you. And, operator, if you could please pull out paragraph 15 on the same page. In this paragraph, you set out the statistics in relation to the culturally, linguistically and diverse backgrounds of your workers.

5 MS RADOSLOVICH: Yes.

MS HUTCHINS: It says here that 40.3 per cent have identified from being overseas and of these 120 or 29 per cent were born in India.

10 MS RADOSLOVICH: Yes.

MS HUTCHINS: All 60 countries of birth were identified with the largest groups after India being the UK, Philippines, Kenya and Nepal. So this tells us that there's a, I guess, difference in the backgrounds of the residents compared to the workers in a number of instances. What's the kind of challenges or opportunities that that has presented for your organisation?

MS RADOSLOVICH: The challenges are coming to grips with our whole community if we include everybody we provide services to and the people who work for us as being our community. Our population is very diverse culturally and linguistically but we might not necessarily have a match between the communities. Sometimes that can result in tension between residents who come from a different understanding, a different time and era, I guess, of cultural understanding and may not appreciate the fact that they're being delivered a service by someone who is from an African country, for example. It's outside their knowledge. Similarly, our staff experience that negative feedback as well.

We have taken through some of the work, the need for us to understand that everybody has their own cultural and linguistic background. We need to work with everybody, our residents, our home care service clients and our staff to be appreciative of, and think positively around what other cultures can offer us. We can learn a lot from some cultures about respect of older people which is not necessarily a feature of the Australian society, which is, yes, can be quite ageist in some ways. That is just one example of some of the learning that we've got by starting to work with our staff, to talk more at induction or particularly through our student program about what it means to – what does culture mean. Culture is not – or people with a cultural or linguistic difference are not that group over there. It's actually all of us.

And we need to learn how we communicate with each other and how we seek to understand that difference. It's an ongoing process, and some of it is dealt with at individual levels, some of it would be more through our training.

MS HUTCHINS: And Helping Hand has developed three position statements which address diversity and inclusion matters. One of those does relate to the cultural and linguistic diversity position statement. Operator, if you could please go to paragraph 21 and pull out the three bullet points there. Thank you. So here is the names of the three policies that you've identified as being – sorry, position statements that you've

identified as being relevant to this topic of diversity. You've identified in your witness statement as well that you've developed these position statements and that you want to make them broadly available to the sector or anyone that might want to access and use them. Why is that the approach that has been adopted?

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MS RADOSLOVICH: Partly it's that previous statement I made about sharing and sharing our learning. We also have – are communicating to people who are our clients by having that available. We're also communicating that internally by doing that approach. The approach we've taken to each of the statements, or particularly the last, to the LGBTI communities and the Forgotten Australian ones, approach which is simple and which articulates our understanding of the issues, as has been told to us by the communities that are affected. And what impact that has on them, and how that might impact on their needs in aged care. And then what we understand from what they've told us they would like us to do in response. So it's a way of communicating to our clients, our prospective clients, our workforce, where we stand and what we think we should be doing.

We make them available publicly so that other people who may not have had the opportunities we've had can have access to that information as well. So that they're not starting from ground zero, if you like, in learning. We've found particularly with the last one, which is the Real Care, the Second Time Around, we printed that. Then we had to reprint it and now it's available on our website. We've had a remarkable demand for that. We also were able to use the launch of that to gain a lot of media attention around the issues for Forgotten Australians as they come to face aged care because it's not necessarily a well-known topic.

MS HUTCHINS: Yes, and we will turn to that shortly. First, I would like to take you through each of these in turn, starting with the cultural and linguistic diversity statement. Commissioners, I will not call up the specific document but for your records, it's in the general tender bundle at tab 91. This position statement highlights a matter that you raised earlier, in that the importance of the collaboration and partnership with specific communities is your preferred way of developing services for them. What are the types of specific services that Helping Hand is referring to and what are the ways that you are able to collaborate with various communities in practice?

MS RADOSLOVICH: You're speaking generally about all the communities or just the CALD ones?

MS HUTCHINS: Yes, in the CALD communities.

MS RADOSLOVICH: Okay. In that one we were working – the main collaboration was with the University of South Australia who was – we jointly applied to SafeWork SA to do some work around communication of safe work messages. We found that our workforce didn't understand our procedures because they didn't understand the language. That's not to say that they can't speak English, it's that they don't understand jargon. And surprise, surprise, we found out that even

some of – even people who don't come from different language backgrounds couldn't understand some of it as well. That's part of that let's understand each other's culture and where people are coming from.

5 So we worked really closely with our workforce to – through using a narrative approach, the researchers were able to hear from the workers what it was like to come from a different culture and work within aged care within its rules and its structures and those sorts of things. And from that, to come to this point of  
10 understanding that we all have our own culture that impacts on how we view the world around us, how we understand concepts such as care and safety and that we need to create learning places and spaces and procedures that allow people to understand what is actually required in that space. We also learnt through that, that the way we converse, the conversations we have, and the way we speak with each other, needs to take account of those different cultural backgrounds.

15 MS HUTCHINS: You note in your witness statement that the collaboration you've just mentioned with the University of South Australia had a number of outcomes that came from that project. In relation to the training modules that fell from that project and that work, what do these modules cover and how are they delivered?

20 MS RADOSLOVICH: They cover the questions of culture and how you understand other people's culture and they also cover the issues of communication. The packages were – are – sorry, were and still are available on Uni SAs website but they also on-sold those products or commercialised them, I'm not quite sure what the  
25 correct language is, through Kineo which is an e-learning platform. We learnt through that project that e-learning does work quite well for our client – our work group; it is an accessible way for people to access training. Kineo has further developed those packages and I understand they're now one of their biggest selling products, yes.

30 MS HUTCHINS: And in terms of the Everyone is Welcome And Included: Helping Hand and the LGBTI Community, you've already mentioned the driver behind the development of this policy. For the Commissioners' reference, the document is at tab 92 of the tender bundle. I'd ask the operator to please bring up tab  
35 93 which is the third position statement I've identified which is called Real Care, the Second Time Around. So what prompted the development of this document in particular?

40 MS RADOSLOVICH: This was in line with our approach of stating publicly our understanding of the needs of a particular group and how we would respond to it. The style of the document was to have – it's really in three parts. One is what is our understanding of the issue and how that has impacted on people's lives so that those narratives are there, and then the commitment out of it, coming out of it as to what we would do. At this point I would like to acknowledge Forgotten Australians who  
45 are in the room or who are listening, and particularly the Forgotten Australians who have worked with us in developing this and all the Forgotten Australians who have contributed their stories through other research projects and the other work that had

led to the development of this. Their stories are very powerful and they're their stories.

5 We did not want to become someone who is saying hey, we are telling all their stories for them. They've done that very powerfully and the stories belong to them. What we needed to own was how we will respond to those stories. But in producing it in this way, we wanted to make it clear and simple to anyone picking it up, that they could understand quickly what the issues are for this group. They could see the individual impacts through the stories and then see our response. We've chosen to  
10 use this art form, if you like, the animations, if you – because using real faces is not appropriate, I don't think, in this space. The daisies that you see on the front cover are an artistic representation of the Forgotten Australians Memorial in South Australia.

15 MS HUTCHINS: Thank you. Operator, could I you ask you to please move across a number of the pages to the show the form of the booklet as has just been described. Please move to the next page. So you will see the use of illustrations and the stories throughout which has extracts from these personal accounts which you have just detailed. Thank you, Operator. This work, I understand, has fallen out of two  
20 projects that you've been involved in focusing on Forgotten Australians; is that correct?

MS RADOSLOVICH: Yes, that's correct.

25 MS HUTCHINS: And so the first project is the Listening and Responding to Forgotten Australians project.

MS RADOSLOVICH: Yes.

30 MS HUTCHINS: And what was the objective of that project?

MS RADOSLOVICH: It was to listen and work out how we respond. We always believed at the end of it we would create a position statement. But when we first  
35 decided to work with the Forgotten Australian Group, we needed – and I guess it's a fundamental for how we approach service delivery – we need to start by talking to the people who are most involved. And we didn't know much about who they were. I mean, we could read the resources and things, but we wanted to really connect strongly with people.

40 We started by working in partnership with Relationships Australia South Australia – I will call them RASA for simplicity from now on – because they run, as do most – they run the Find & Connect Services for Forgotten Australians in Adelaide. They were already interested in looking at aged care implications for this group and had a small group working on them. We connected with those. We then sought within our  
45 own services to find people who were Forgotten Australians who might wish to identify, and they did. And so we got a small group together to talk to us about – initially, we needed to hear their stories, but what we were really interested in –

because the focus of the project was what does aged care need to do about it in response? And we came up with this statement which gives us a bit of a road map for where we should go into the future.

5 MS HUTCHINS: And in brief terms, what are some of the main lessons that you have learnt from that project in terms of what are the needs of Forgotten Australians and how can service providers better meet them?

10 MS RADOSLOVICH: The most important thing I think we learnt was trust. This is a group of people who have been abused and mistreated by organisations and institutions. There is absolutely no reason why they should trust that the care they get this time around will be real care compared to the care they got first time round, and that's why the project is called Real Time – Real Care the Second Time Around. That's their words, and that's our guiding light. So the activity, anything we do  
15 needs to build that trust with them, to prove that we can be trusted with their stories, with their lives.

The second thing we learnt was the importance of a trauma-informed approach in working with this group, and we're just starting to learn about that. And the third  
20 thing we learnt was there are a number of small things that we might be able to do immediately – or seem like small things. There are some approaches we might be able to develop immediately to respond – to change what we do, change the settings in our services so that they are responsive to their needs.

25 MS HUTCHINS: And for the first project, the Listening and Responding to Forgotten Australians, how was that project funded?

30 MS RADOSLOVICH: We received a small grant from the John T Reid Foundation, who have been incredibly generous and quite humble in themselves. They don't like necessarily the name being publicised, but they do now. They don't mind us mentioning it now. And we match that funding with our own resources.

35 MS HUTCHINS: And in terms of the second project that you've just mentioned as well, called Real Care the Second Time Around, how was it that that project has been funded?

MS RADOSLOVICH: That was funded by out-of-round grant by the Department of Health through their Dementia and Aged Cares Services Fund.

40 MS HUTCHINS: Yes. And this project is still currently underway.

MS RADOSLOVICH: It has just started. We're about a couple of months into it, yes.

45 MS HUTCHINS: Yes. And I understand this work is informed by research being conducted in parallel by Flinders University?

MS RADOSLOVICH: Yes.

MS HUTCHINS: What's the work that they're conducting?

5 MS RADOSLOVICH: They are doing research with Forgotten Australians into what a trauma-informed approach in aged care might look like. We began working with the main researcher, Monica Cations, during the last project and it seemed natural for us to combine – to work together, so their research is working in tandem with us. And Flinders Uni, who – where Monica is based with this research, is a  
10 partner in the project. So that as they're working – they're learning and the research findings are coming through, they can inform the work that we do.

MS HUTCHINS: And the research thus far, is it showing or indicating how important trauma-informed care is to care for Forgotten Australians?

15 MS RADOSLOVICH: I think it's fair to say that the need for trauma-informed care is well established through the preceding research. I refer in my statement to the – and I always get this – it's loan as the LOFA report, so I never remember its correct name – Long-Term Outcomes for Forgotten Australians Forgotten Australians study.  
20 It was done in 2016. That – the work that the Find & Connect Services across Australia have been doing with Forgotten Australians for a long time, it's well established that a trauma-informed approach is what is needed. It's just it's not an approach that is being used in aged care, and we don't really know what that might look like. Her – the research will be to say, "Well these are the sorts of things that  
25 you might need", and then our project will take that learning and trial it.

MS HUTCHINS: Thank you. And your statement identifies that at this stage you've already identified two solutions that might enhance Forgotten Australians' knowledge and capacity to access aged care services, being individually targeted supports and researches such as what questions to ask. What's envisaged as part of these individually targeted supports?

MS RADOSLOVICH: We came up with a list of ideas. They were – the ones that are in the paper are some of them. We will be putting them back to Forgotten  
35 Australians to say – just to check that they're still the sort of things they want, and then we will be using co-design processes to work through them. In our early preliminary conversations, something like a "What You Need to Know About Me" document, which is one of the ideas that has come up, was in recognition that for Forgotten Australians, or any person who has experienced trauma, every time we  
40 have to go back and say, "This is my story", it can be re-traumatising, and they shouldn't have to go through that. So one of the questions that was asked in the first project was, "How can I get across to people that this is what I need without having to go through this whole explanation?"

45 People would say things to us like, "I know I'm strange. I know there are some things about me which are odd. How do I tell people this?" And they feel like they have to go through and tell their whole story again to get to the point where they will

say, “That’s why I don’t want the door shut at night”, when, in actual fact, if we could develop – we’re hoping we might be able to develop where they can say, “There are five things or seven things or whatever it is that it’s important for you to know when you work with me. Don’t tell me things immediately or boss me around.  
5 Don’t touch my stuff when you come into my room. If you’re going to do the dusting, I will tell you where you can dust, but don’t move other things. When I have my food, this is what I want to eat. Please don’t give me this or that.” Or whatever the other things that might come up that are difficult for people, which are triggers for a trauma response. Maybe that will be a tool that will help.

10 We’re interested in exploring with them whether peer support approaches might be helpful as well. So our first conversations around this as part of the project are happening in the next week or so. And we can’t do everything. I mean that’s the other thing. We can’t figure out everything, but we will aim to come up with some  
15 resources which will be useful, and we will be able to share them with the industry as we go through.

MS HUTCHINS: I now turn to ask you some questions about the definition of “special needs” in the Aged Care Act. Your statement identifies that it would be  
20 useful to have a broader discussion about the future-term “special needs” in the Act. Why do you think this is?

MS RADOSLOVICH: There has always been debate about whether “special needs” is the right language to use. How many special needs groups do you end up having?  
25 How do you identify who the special needs groups are, and how do you get into the Act? Is it just luck? Is it advocacy? Are there groups out there we don’t know about yet? There’s all that sort of thinking. However, I think it’s really important to follow – so I think that’s a conversation to be had. It’s also important that we talk with the groups who are already in there about how did they want their needs  
30 reflected, and what is the best and most effective response for them.

It’s also – I think you will hear this from other witnesses – it’s also important to understand that people are not in one box. These are not homogenous groups of  
35 people and we can’t label people and say, “Well, you’re a forgotten Australian and, therefore, you look like that, and look alone.” People are complex and diversity is much broader than that. So special needs groups I think came about initially to try and highlight some groups that we’re very aware of – veterans, very specific need – some of the first, the Aboriginal and Torres Strait Islander groups. Then it’s being used as a tool to add a lot of others, and I think we maybe need to have that  
40 conversation around what’s a more sophisticated, better, more effective way. It might turn out that we get back to identifying specific - - -

MS HUTCHINS: Yes.

45 MS RADOSLOVICH: - - - groups, but I think it’s a conversation we can have. It’s like lots of things in aged care; they’ve evolved over time.

MS HUTCHINS: Yes. And what are, I guess, a different way that this problem could be approached?

5 MS RADOSLOVICH: I don't know. I think that's why we need the conversation. There might be other people who have already thought that through, but it's not a solution I've come to, no.

10 MS HUTCHINS: And if we were sticking with the system of maintaining the groups that are identified in the definition of "special needs", do you think that the existing categories adequately capture the types of people who require additional assistance by virtue of their diverse characteristics and needs, or do you think it may need to be expanded or reduced?

15 MS RADOSLOVICH: I guess one way of answering that is to look at the experience of the Forgotten Australians. Until they appeared in the Aged Care Act – and that was in 2009, and it has still taken us, what, 10 years to have the – sort of like one of the first aged care projects around it – I don't think people knew who they were, and there are probably lots of people still out there who wouldn't know who Forgotten Australians were if they weren't a special needs group in the Act. What  
20 other special needs groups might there be or groups of people out there might there be that haven't yet been named? So, yes, does that answer your question?

MS HUTCHINS: Yes, thank you. Do you think that aged care sector would seek to meet the needs of the types of people that are falling within these defined categories  
25 if their special needs status didn't exist under the Act and accord the benefits that may flow from that for the providers?

MS RADOSLOVICH: If we take by that meaning would there be a special focus? Would people consciously work for those groups, I think the evidence from the  
30 reviews of the LGBTIQI and CALD action plans is a probably no, the industry wouldn't necessarily take those leads. There will always be individual organisations who, for social justice reasons or for the communities they live in or for the personal drive of key individuals or CEOs, will take up the needs of certain groups. But to get a whole-of-sector approach, I'm not certain that we would necessarily be focusing on  
35 some groups without a carrot or a stick.

MS HUTCHINS: And do you think that there's currently challenges faced by providers in meeting the needs of people that might fall within these special needs groups or, indeed, other people that aren't identified as falling in these categories  
40 which makes it difficult for them from a, you know, business profitability perspective to meet their needs within the current funding environment?

MS RADOSLOVICH: I'm not sure about the business profitability part of that, but I would say that the challenges in terms of taking – specifically addressing the needs  
45 of these groups relate to understanding but can also relate to resources. For a standalone residential care facility in a small rural environment, they might be very, very close to their – and understanding their rural environment but not at all prepared

to deal with or understand how they might approach mental health issues or Forgotten Australians in a different way, or even small, city-based ones. They don't have the resources to run projects or to have a research development unit like we have. Conversely, for big organisations there are big challenges in saying, "Okay. We've got a number of residential services, a whole pile of home care services. How do we push these messages through all of those?" It takes time and it takes resources.

So understanding opportunities, resources are all the challenges that are there. If an organisation aspires to respond to the needs of its community, though – I can guarantee you every aged care organisation in this country has Forgotten Australians living in it, or in their services somewhere. That's our experience. You just start asking and people – every conversation we've had, someone has appeared. We are working with these people. We need to know how to respond, but the challenges will be knowing who's there and accessing the resources to respond appropriately.

MS HUTCHINS: Yes. And do you think the current funding arrangements are adequate to meet the needs of people with diverse characteristics and experiences?

MS RADOSLOVICH: That's a difficult question to answer. I think the broader question of are the current resourcing for aged care, per se, sufficient might – is one conversation which, I think, the Royal Commission is set up to address. The – for some groups, we're not – we wouldn't necessarily know what the responses are, whether it's something additional you have to do or whether it's a change in your own practice. Change in practice can be – for example, the trauma-informed care approach. Once we know a bit more about what that looks like, we will then, through that, learn how much is this going to – what we're going to have to change, how much would that cost to change. Some of it can be done internally, but some might need external resources.

We also need to look at the partnerships we can form with others. So aged care cannot be all things to all people. Sometimes, and I think the veterans example was a good example, Forgotten Australians also are that. There are other people who are experts, for example, in trauma-informed practice, which is a therapeutic approach. We should partner with them to create the resources around the individual. Aged care clients are still – are citizens and they have the right to access the health care systems, the mental health system, all those other systems that are there to meet their needs. And we should be looking for how we can pull all that together, so that aged care does their bit and other sectors do their bit as well.

MS HUTCHINS: And, finally, your statement identifies that funding through the Aged Care Approvals Rounds or Commonwealth Home Support Program is paying for care rather than service improvement or development. What do you see as the consequences of this approach?

MS RADOSLOVICH: For us, the consequences have been we've had to look outside ourselves to get resources, to support, to make the change. And if we're like

that, then I would assume everybody else is as well. Where things need additional effort and additional activity to create change, I think the previous speaker or witness also spoke about that. You need commitment from board level down to divert resources into that special activity. Or you need the ability to get other resources from outside to make the change.

That's partly why we also share our resources, so we can say, "Look, we were the ones who were lucky enough or active enough to get a grant to do this work, but you can share from it as well, so that it's not just stuck within one organisation." But, yes, I think, as aged care clients become more complex, they're not necessarily the people who are envisaged would be clients when the current Act was created. We're quite a different cohort. Whether it's still sufficient to meet all that diversity of need and complexity of need, I think, is a question that needs to be answered.

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

COMMISSIONER PAGONE: Thank you, Ms Hutchins.

COMMISSIONER BRIGGS: Ms Radoslovich, in the community forums we've had, we've often had Forgotten Australians speak to us. And a number of them has said, "The last thing I want to do is to go near another institution in my old age. I'll kill myself." It that kind of stark response. So the strong suggestion from these people is that, at least to us to date, has been that they wanted to have an effective home and community care regime. And the work that Helping Hand is doing, I'm wondering if you see any nuancing around this work that might make home and community care different or better than the issues around residential care.

MS RADOSLOVICH: I think raising awareness for the group, because I think there is a big – big – people often don't think about – or aren't aware that you can get home care support or what's possible through that. Then – so that – firstly, raising that awareness you can stay in your own home. The issues will be same but different, if you like. So still things like how do you respectfully enter someone's space and work in a space where people may not be used to having their own home things or will want their world worked in a particular way? So you don't go in and disrespect that space and what they want. But the first conversation I think we need to have is to, really, help people to understand what is possible, so that – it's not all about the building of the residential care facility, but we still have to build trust, as well, with them, that an institution is going to live up to their promises.

COMMISSIONER BRIGGS: What we've heard from some Aboriginal and Torres Strait Islander communities is a similar issue around trust, for these reasons and many many more. And we've learnt that provision of basic services – so wash – cleaning the house and doing some gardening or some maintenance works in that time of building up trust. And we've heard sometimes it takes six to 12 months to build that kind of trust. Have you got any sense of that for the Forgotten Australians more generally?

MS RADOSLOVICH: Yes. Yes. I think there's a little bit of a belief that a system works by – people come in and they tell you all about themselves and then you build things up. We often don't find out things about people for a long time until after we meet them, until they feel like it's relevant as well. They don't necessarily want to tell everything about – I mean, when I first meet someone, I don't want to tell everything about my life when I first meet you until I get to know you had better. And it's exactly the same. So if we think about these service responses as relationships and relationship-based, then I think we have a better chance of understanding who the person is. And the person coming out and saying, "Actually, I really do need this or that", or, "This is something you need to know about me and I haven't been able to tell you before because I didn't know if I could trust you with that information."

COMMISSIONER BRIGGS: And the final question – I'm very conscious that I'm taking a little time, so I'm sorry – is you referred to something we've also heard a lot about, which is that people don't want to repeat their information a lot; we typically hear that is repeating their information for government. But in this area of trauma, it's a particularly important area. So how do you avoid that? You know, we've got a privacy arrangement that sits - - -

MS RADOSLOVICH: Yes.

COMMISSIONER BRIGGS: - - - across the top in an umbrella way, for very good reasons, but, within the service sector, what's an effective way to do that? Any suggestions?

MS RADOSLOVICH: I can talk about what we do internally, which is to try and connect up our records, so that – if people are moving between our services, that we make that as seamless as possible through – and electronic data systems are easier for doing that. Some of it is asking – only seeking information which is relevant to what you need to know. So do we really need detailed case studies or detailed assessments of someone's life history if we're coming in to clean their house? Having said that, I can hear people saying, "Well, yes, we do, because we often get to a house" – finding out information in a way that's timely and maybe allowing people to choose the right time to tell us some of the information.

I can once again hear practitioners – it's a big debate. Some of the stuff, I think, that people get asked over and over again is more that general up-front information. And our electronic systems were meant to be designed to stop all of that. And so only having the more complex conversations about who I am when I get to know the right person – when I am with a person who can actually make a difference, I think, is – yes, timeliness of questioning and asking information, I think, is important.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Yes. Thank you.

MS HUTCHINS: Nothing arising.

COMMISSIONER PAGONE: Thank you, Ms Radoslovich. You're free to go.

5 MS RADOSLOVICH: Thank you.

**<THE WITNESS WITHDREW**

**[11.55 am]**

10

MS STANLEY: Commissioners, as that concludes my client's evidence, I seek leave to be excused.

COMMISSIONER PAGONE: Yes. Yes. Thank you.

15

MS STANLEY: Thank you.

COMMISSIONER PAGONE: Yes. Ms Hutchins.

20

MS HUTCHINS: Thank you, Commissioners. I call the next witness, Ms Anne Therese Tudor. Before Ms Tudor is sworn in, I have a matter of housekeeping to attend to. Ms Tudor has signed a supplementary statement dated today, 10 October. The version that's currently available on the leave to appear space is an unsigned version. So we'll hand the original to the Commission today, to regularise the paperwork.

25

COMMISSIONER PAGONE: Yes. Thank you, Ms Hutchins. I assume it's otherwise the same, apart from the signature?

30

MS HUTCHINS: Correct.

COMMISSIONER PAGONE: Yes. Thank you.

35

**<ANNE THERESE TUDOR, SWORN**

**[11.56 am]**

**<EXAMINATION BY MS HUTCHINS**

40

MS HUTCHINS: Your full name is Anne Therese Tudor?

MS A.T. TUDOR: Yes. It is - - -

45

MS HUTCHINS: Thank you.

MS TUDOR: - - - counsellor.

MS HUTCHINS: And for the purposes of this commission, have you have prepared two statements?

MS TUDOR: I have.

5

MS HUTCHINS: Yes. And so the original statement, for the transcript, is WIT.0514.0001.0001. There's also a – that's dated 2 October 2019. There's also a supplementary statement of today's date, which is, for the transcript, WIT.0514.0002.0001. Have you had the opportunity to read over these statements before your evidence today?

10

MS TUDOR: I have.

MS HUTCHINS: And are there any amendments you would like to make?

15

MS TUDOR: No. That's - - -

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

20

MS TUDOR: Yes. It is.

MS HUTCHINS: Thank you. I tender the statement of Anne Therese Tudor, dated 2 October 2019.

25

COMMISSIONER PAGONE: Yes. Well, that statement will be exhibit 10-11.

**EXHIBIT #10-11 WITNESS STATEMENT OF ANNE THERESE TUDOR  
DATED 02/10/2019 (WIT.0514.0001.0001)**

30

MS HUTCHINS: Thank you. And the supplement statement of 10 October 2019.

35

COMMISSIONER PAGONE: And the supplementary statement of Anne Tudor will be – dated 10 October will be exhibit 10-12.

MS HUTCHINS: Apologies, Commissioner. I've just realised today's date is actually 8 October.

40

COMMISSIONER PAGONE: You are quite right and I - - -

MS HUTCHINS: Thank you.

45

COMMISSIONER PAGONE: - - - should have picked it up myself. With that correction, it will be exhibit 10-12.

**EXHIBIT #10-12 WITNESS STATEMENT OF ANNE THERESE TUDOR  
DATED 08/10/2019 (WIT.0514.0002.0001)**

5 MS HUTCHINS: Thank you. Operator, please bring up tab 81 of the general tender bundle. So, Ms Tudor, what is this a picture of, displayed on the screen?

MS TUDOR: It's a picture of Edie, my partner, Edie, and myself and our beautiful dementia assist dog called Melvin.

10

MS HUTCHINS: Yes. And how long have you and Edie been together for?

MS TUDOR: We've been a couple for 35 years.

15 MS HUTCHINS: And what's Edie's current health position like?

MS TUDOR: So Edie has younger onset dementia advancing. And she is now in residential care.

20 MS HUTCHINS: Yes. And how did you and Edie first meet?

MS TUDOR: We were introduced by a friend, someone I grew up with from the same small town. And he taught with Edie; they were both teachers of the deaf. Yes. So we actually knew each other for 10 years before we became a couple and had a – I guess, a relationship based very much on trust and friendship.

25

MS HUTCHINS: Yes. And what's your experience been like over the years, you know, coming through, I guess, the change in the times with being in a same-sex relationship?

30

MS TUDOR: Well, I don't often reflect on this, but I have, in terms of the statement to the Royal Commission. I think it's much healthier to stay in the present. But I'm talking about 50 years ago. We were considered mentally ill, and lots of people could – were charged with a crime. It was shameful, really, to be a member of the LGBTQI community. So you put on a face, a public face, and sought out a community, a supportive community.

35

MS HUTCHINS: Do you – has there been times where you felt discriminated against over the years?

40

MS TUDOR: I think that in those early years, because it was considered unacceptable, it was considered deviant, then, by its very nature, your true identity was kept hidden, really. So there was – if you kept it hidden, you didn't experience discrimination. If you were very public, and especially employers found out about it, you were very much at risk of losing your job.

45

MS HUTCHINS: Right.

MS TUDOR: So I've found a pretty easy knack of just staying under the radar, so didn't tend to experience a lot of overt discrimination.

5 MS HUTCHINS: Yes. Do did you find yourself not disclosing to colleagues that you were in a same-sex relationship?

MS TUDOR: Very selective.

10 MS HUTCHINS: Yes.

MS TUDOR: Only trusted friends. And that was the safest way to live.

MS HUTCHINS: What is your professional background?

15 MS TUDOR: So I was a secondary school teacher for 20 years and studied psychology part-time. I did my Master's in Clinical Psychology full-time when I retired from working in a secondary school and then studied psychoanalytic psychotherapy. So that – as a clinical psychologist working as a psychoanalytic psychotherapist for the last 20 years.

20

MS HUTCHINS: And for a time you were living in Sydney?

MS TUDOR: That's where I did my original - - -

25 MS HUTCHINS: Yes.

MS TUDOR: - - - teacher training, and that was to prepare me to work in Papua New Guinea as a lay missionary.

30 MS HUTCHINS: Yes. And then later on you've returned back to the smaller country town. How did you find that experience of returning back to an environment, particularly - - -

MS TUDOR: Yes.

35

MS HUTCHINS: - - - with Edie and your same-sex relationship?

MS TUDOR: I think it was a revelation because you needed to be much more discreet in Melbourne at the time. When we moved to Ballarat, we were of a more mature age, we had been together for a long time and things had changed. Both Edie and I were automatically invited to each other's work functions, something that had never happened before. We returned to Ballarat because my mother had dementia, she had vascular and Alzheimer's dementia, and we moved to support my father and my mother. And I think all the older people, all their friends were happy enough that we were prepared to do that. So it seemed like your sexuality was becoming a non-issue, and that was certainly our experience when we moved.

40

45

MS HUTCHINS: And did you make friends with many other couples that identified as being part of the LGBTQI community?

5 MS TUDOR: Yes, and there was a couple there that we knew quite well beforehand, and an older lesbian couple. But over time, we got to know, yes, a number of people and, yes, it was very much – it felt very much like home.

10 MS HUTCHINS: And when did you first notice that Edie was developing signs of dementia?

MS TUDOR: The same year that my mother died, in 2005. Edie had a remarkable memory, much better than mine would ever be and she started to forget things. People would make phone calls, invite us to functions. I never got the message. And just little things, really. She started to withdraw more. She wasn't communicating as well. In the evening she would go into the study and, yes, it was difficult. It became more and more difficult because I didn't know what the problem was.

MS HUTCHINS: And when was it that she was diagnosed?

20 MS TUDOR: She was diagnosed in October 2010. For the two years prior to that, I was thinking it was dementia. I had done a master's thesis on dementia and a lot of reading, and I suspected it was. We had neuropsychological reports, and it was really through a neuropsychiatrist in Melbourne that the diagnosis was confirmed in 2010.

25 MS HUTCHINS: And what was it like for you both emotionally receiving that diagnosis?

30 MS TUDOR: Well, the first reaction, I suppose, as I said, was suspecting it was something along those lines. We were both devastated. We were more towards the end of our working lives and we had lots of plans to travel, and it meant that was a changed future. But on the other hand, it gave us a reason for the changes in Edie, and we knew that once we got our head around it, we would make a plan and we would make the most of whatever we had.

35 MS HUTCHINS: And you've mentioned that Edie is now living in a residential aged care facility, where she moved in September 2018; is that correct?

40 MS TUDOR: Yes.

MS HUTCHINS: Yes. And so prior to that time, you were able to live together in your home?

45 MS TUDOR: Yes.

MS HUTCHINS: Yes. And from about 2011, you received some home support, firstly, through a charitable organisation, then, from 2014, through a Commonwealth home care support package provider.

5 MS TUDOR: Yes.

MS HUTCHINS: What was the type of assistance you were receiving in the home?

10 MS TUDOR: So the reason that we first had the charitable organisation involved was – Carers Victoria assisted us in that respect, and Edie had had major surgery. She had had hip replacements and revisions of hips and knee replacements, and I needed to make sure that we had extra support when she was discharged from hospital. And so that organisation primarily provided opportunities for Edie that – workers would take Edie out for the day and – or not the day but three hours – three  
15 or four hours, I think, and do interesting things. I mean, she loved going to the coffee shop. She was no longer driving. She couldn't work because she had to give up her job.

20 So it provided me with an opportunity to have some time to do other things. But it was an opportunity for Edie to enjoy the company of others. And that particular organisation, over the seven years Edie had four case workers, and one person who was her case manager, so there was a lot of consistency and predictability. And those four workers still visit Edie today.

25 MS HUTCHINS: Yes. And so when you first became involved with their services, were there any ever any specific discussions about your care needs with the home providers in terms of your status as, you know, a same-sex couple or whether that might impact what it was that you were after from them?

30 MS TUDOR: With the first provider, there was a lot of publicity around the fact that Edie and I were striving towards making our city more dementia-friendly city. So people were aware of our status, and they were remarkably supportive and sensitive. The one – the organised provider through home care packages, it was just a really different set-up. And I think probably one of the things that, you know, I  
35 would like to say is that the status for most LGBTQI people needs to be acknowledged. At least if they're asked, "Is this something that we need to take into account?", you know, "Do you have particular needs or special needs?" For some, they may not want it to be an issue. I would have really valued that. You know, "Have you two – are you a couple? Have you been together long?", so that we were  
40 known more, you know, as people, given the stigma in the past that was associated with being part of that community.

MS HUTCHINS: Yes, the Commission has heard some evidence that some LGBTQI community members might not feel comfortable being asked questions.

45

MS TUDOR: Yes.

MS HUTCHINS: Do you think it would be appropriate to include some kind of questions on, you know, a questionnaire or a form or – you know, what do you think would be a sensitive way of going about asking people some questions?

5 MS TUDOR: An opportunity for people to respond in a way that either maintains their privacy if that's what they want, or an opportunity to actually express that. For Edie and I, we have always been really open, and we would have liked that and we would have liked then the opportunity to know that people who were coming into our homes had a sensitivity towards members of the LGBTI community and maybe had  
10 done some training, have some awareness, at least not have negative views towards us.

MS HUTCHINS: Certainly. And did you ever have the sense, you know, with the care workers that did attend your home, you know, did they – did you feel like they  
15 were accepting of your relationship or not understanding of it or uncomfortable about it, or, you know, what were the kind of observations you could make about that?

MS TUDOR: We never experienced any overt negativity. And it's difficult to know whether some of the workers didn't have a comfortable attitude, whether that  
20 was related to sexuality or whether it was related to themselves and their own personality or – it's difficult to know. But there – I guess what I would like to say, there are some people that are really well suited to the role of a respite worker, and there are others who are probably more suited to other things.

25 MS HUTCHINS: And would you have preferred to have had, you know, a lesbian come as a care worker to look after you and Edie, you know, assuming that that particular care worker has got the other requisite needs of carer trades?

MS TUDOR: All things being equal, yes, and yet, you know, the first provider I  
30 was talking about, three out of those four workers did not have an LGBTI background. One did. And yet, you know, they were all highly valued. So I don't think it's – it's not essential. It might be for some people. For us, it was more, you know, respectful, accepting attitude where they're comfortable with themselves. Edie was the sort of person who – very good judge of character, and some people  
35 came in and they were very anxious. Why they were anxious, I don't know, but they were anxious and, therefore, that would make her anxious. So I think it's really important to have a sense that a relationship gets built up over a period of time, especially with someone with dementia. It's just so necessary.

40 MS HUTCHINS: And in terms of the approach that carers could adopt to make you feel comfortable in terms of, you know, your same-sex relationship within your home, what are the types of things that you would think would make you feel more comfortable?

45 MS TUDOR: I think the – a person who is themselves, a person who enjoys the work that they're doing, a person who enjoys interacting with others, somebody who knows something about dementia – preferably a lot more than a little. Particularly

with a younger person, where they're ambulant, they're active, they want to go out, they want to do things, they want to have an interesting life, a life that has quality of life. And I think the type of person that comes into your home needs to have an understanding that we were two very, very independent people, very self-sufficient,  
5 and we were then relying on others, and your life becomes centred around who is coming and what time they're coming, and it's extremely difficult.

So that you want those people to have an understanding, a sensitivity around, you know – and acknowledging that it is extremely difficult for the person with dementia  
10 as well as the care partner. Those issues are large ones that need to be considered.

MS HUTCHINS: As it came towards the later years of Edie's time with you in your home together, what were her care needs, and how many of those were being met by the provider, you know, compared to how many you were looking after yourself?  
15

MS TUDOR: So, you know, it starts off with Edie used to look after all the finances. So it starts off with you taking over the finances. It moves to doing all of the cooking. It moves to running the whole household. It then moves to taking  
20 personal care of your partner, to showering, to choosing clothes, to doing the thinking for them, to making decisions that need to be made. So it becomes a total responsibility for the carer to look after their loved one which is – over time it becomes more and more difficult. So you're relying on people who come into your home to provide some sort of respite for both; some stimulation for Edie and, for me, a break, some time out where I could go and do something else.  
25

In terms of – we never used respite carers for showering or any intimate personal care, more to spend time with Edie and to do things with her that she would enjoy and also gardening. We have a large double block and I love gardening but it was impossible for me to keep up with everything. So we also – a cleaner would come  
30 on a regular weekly basis. So they were the ways that we needed support. But over time we needed more and more of the personal respite. So if you had, say, six hours in a week, six hours in a week when it's 24 hours a day doesn't amount to very much. So, from time to time, Edie would have respite care in a residential care home and without that, I think it's very difficult to continue.  
35

MS HUTCHINS: And so when Edie made the move to residential aged care in 2018, did you feel a reluctance to make that move?

MS TUDOR: The hardest thing I've ever done. Because it doesn't matter how tired you are, and it doesn't matter that you know that you're not enough, that you can't  
40 continue on, you still feel a sense of guilt. You don't believe that anyone can look after your loved one as well as you will. You worry about the little things, whether they will put coordinated clothes on, whether she gets to have the things that she enjoys, whether they will look after her in a way that gives her a sense that she is  
45 regarded well and respected. You worry about those things and the caring doesn't stop when your loved one goes into residential care because you're there nearly every day and you continue to do those things.

But yes, moving into residential care is the toughest decision around somebody who is – not just people with dementia but someone who is frail and needy, and we all know that in the past, you know, those places have been God’s waiting room. And we utterly reject that idea that it should be like that now. We want – we want –  
5 where residential care is offered to be a home for people, where they feel safe and secure.

10 MS HUTCHINS: And so, yes, so when you were looking for a residential care facility for Edie, what were the types of things that you were looking for?

MS TUDOR: I know the aged care system very well because of my mother and because of 10 years that I worked in the hospital, and I’ve been to virtually every one of them, and over time and how they’ve changed. The decision about where Edie was to go was based on a new model of care, based more on a small home with eight  
15 residents, with the kitchen where the food is cooked in that home and the clothes are washed in that home. And I say that we’re blessed to have that in, you know, in our town because it’s – Edie settled in really well. It’s only a few minutes from where I now live. And I’m full of praise for the way – the culture, the values. It’s about relationships, based on relationships. And I think that’s what’s needed in care.

20 MS HUTCHINS: And how did you find your interactions with this residential aged care provider in terms of discussing your same sex relationship or, you know, whether that – was that something that was up for discussion?

25 MS TUDOR: So I saw the first turn of the soil two years before it was built and I was hanging in there for as long as I could so that Edie could go to this place. And a couple of weeks before it opened, the CEO of – it’s a national group, a health group – and he was taking a tour of people and Edie and I were a part of that, with a group of others. And someone must have spoken to him because he came across to Edie  
30 and I and he said “You two have been together a long time. I want you to treat this as your home as well.” And he followed that up with “And if you needed to come into care, we would find a double room for you.” That’s respect. It’s acceptance. It’s love. And from that moment on, I knew that this was the right place for Edie.

35 MS HUTCHINS: And in terms of fostering a culture of inclusiveness for LGBTI community members, I mean, how important do you think leadership like that is?

MS TUDOR: It can’t happen without leadership from the – you know, the CEO of the organisation to the managers, to the senior people who are working in the  
40 organisation; the message has to filter to everybody that every single person there needs to be accepted for who they are and what they are and whatever their background is, whatever their culture is, whatever their belief systems are, that they will be given an opportunity to live in an environment that provides them with what they need right through to the end of their life. And the organisation has that in  
45 spades. And because it has human beings in it, there will always be things that don’t go the way it should.

But I'm there speaking to the manager or whoever is in charge of nursing or whatever, and making my point, and change happens. Yes. So nothing is perfect but there's an opportunity to give feedback and to know that you will be heard.

5 MS HUTCHINS: What are some of the practical measures that they take at the facility to make you feel like it is an LGBTI inclusive environment?

MS TUDOR: Well, I do know that management of this organisation in the area has completed LGBTI training. I know that nationally they're wanting to roll out pilot  
10 studies with LGBTI training next year. And I also know they've made contact with Trans Victoria. And you know, on behalf of people who are transgendered, they're honestly considered at the bottom of the totem pole, and I think we all have to be very mindful that when somebody who has a very different background comes into residential care that extra effort is made to assist that person to settle in and to have a  
15 life there that is, you know, worthy of them as human beings and provides them with what they need. So someone who looks different or someone who is different, we need to be celebrating this. We need to be celebrating diversity and not be frightened of it.

20 MS HUTCHINS: Thank you. Your statement identifies a range of community service that you have been involved in, and unfortunately we don't have time to go through it all today in the hearing time, but I draw it to the attention of the Commissioners that Ms Tudor has been actively engaged with work around supports for the LGBTI community particularly for those living through dementia, and I note  
25 that in 2016 Edie and you were made honorary members of Dementia Australia and were awarded the Minister of Health Outstanding Achievement as a Volunteer Supporting Diversity, and in 2017 you received the Ballarat Mayor's Senior Citizen of the Year Award. And in 2018 Dementia Australia nominated both you and Edie for Victorian Senior of the Year Awards. I mean, how important has it been to your  
30 life experience being involved in these types of community work – this type of community work, particularly around, I guess, fostering a feeling of acceptance as a LGBTI community member?

MS TUDOR: Both Edie and I in all our working lives have worked in the service of  
35 others. So when Edie was diagnosed and we were asked to speak at an international conference, and some time later, you know, I said to Edie, "We have had these amazing experiences, we have met mazing people from all over the world due to dementia" and I prattled on as I do sometimes, and Edie said to me, "Our hearts are bigger". And we call it Bigger Hearts, the work that we do in Ballarat for Ballarat to  
40 be a more dementia-friendly city. I think how important it is, it's continuing to live a life that supports other people. It's different to the life that we would have chosen. But at least it has been in full to support others who may not have had the advantages that we have had. And to speak up for people who can't speak up for themselves and to change attitudes towards dementia is really important.

45 People are frightened ever dementia, and it's a horrible disease towards the end. But, you know, we have had five overseas trips since Edie was diagnosed. There's a life

that can be lived, and both of us feel that living a life that is very positive within whatever it is that you have to deal with is incredibly important. And if anything that is said today can assist the Royal Commission in making things a little bit easier for carers, certainly easier for people with dementia and for those who look after them and to value those people more that spend their working lives supporting people who need that help, who don't have – where their families can no longer look after them, you know, we need – we need society to have people in residential care who want to be there, who value what they do and they are valued for doing what they're doing.

10 MS HUTCHINS: I have no further questions, Commissioners.

COMMISSIONER PAGONE: Yes, thank you very much.

15 COMMISSIONER BRIGGS: Thank you for your evidence. This has been incredibly valuable.

MS TUDOR: Do you mind, Commissioner, speaking up a little.

20 COMMISSIONER BRIGGS: Yes. I'm always getting into trouble for not speaking into the microphone. What is it, Ms Tudor, that could help make life a happier life for somebody with dementia living in residential aged care?

MS TUDOR: It's probably a really simple answer, it's familiarity, the same people. So in this care home 85 per cent of the time, the same care workers work with them. And so Edie is happy enough for a person to shower her and provide intimate personal care if she knows that person. But if a complete stranger comes in and wants to take her to the shower, she is not comfortable with that. And even in advanced dementia they recognise faces. They know the same person. And so I think that part is incredibly important. To also accept that they still have a mind. It doesn't work in the same way. But I always – I wouldn't sit on Edie's bed without saying, "Do you mind if I sit on your bed?". I wouldn't walk into her room when I visit her without saying, "Can I come in?" I think it's those basic courtesies and respect. People just assume there's nothing going on there. But there's a great deal that goes on there and I wish people would understand that more and just give them a little bit more acknowledgement.

COMMISSIONER BRIGGS: Thank you.

40 MS TUDOR: Thank you, Commissioner.

MS HUTCHINS: Nothing arising, Commissioners.

COMMISSIONER PAGONE: Thank you very much for your evidence.

45 MS TUDOR: Thank you very much.

**<THE WITNESS WITHDREW**

**[12.29 pm]**

5 MS HUTCHINS: Peter Gray QC will call the next witness.

COMMISSIONER PAGONE: Yes. Thank you. I think I have seen him somewhere in the back there, Mr Gray.

10 MR GRAY: Thank you, Commissioner. I call Elizabeth Cosson, AM CSC.

COMMISSIONER PAGONE: Yes.

**<ELIZABETH COSSON, SWORN**

**[12.30 pm]**

15

**<EXAMINATION BY MR GRAY**

20 COMMISSIONER PAGONE: Thank you, Ms Cosson. Do feel free to sit down and make yourself comfortable?

MS E. COSSON: ---Thank you, Commissioner.

25 COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Ms Cosson you've prepared a statement for the Royal Commission dated 19 July 2019, WIT.0219.0001.0001. It should be now displayed for you.

30 MS E. COSSON: That's correct, counsel.

MR GRAY: And what you see on the screen bearing that code number is a copy of your statement, the first page thereof.

35 MS COSSON: That's correct, counsel.

MR GRAY: Thank you, Ms Cosson. To the best of your knowledge and belief, subject to one amendment I'm going to ask you about in a minute, are its contents true and correct?

40

MS COSSON: Yes, they are.

MR GRAY: Thank you. The amendment is on page 0025, paragraph 109, I believe.

45 MS COSSON: That's correct.

MR GRAY: And in the second line at paragraph 109, you wish to delete the third, fourth and fifth words, “the CHSP and”, from that line; is that right?

MS COSSON: That’s correct, counsel, yes.

5

MR GRAY: Thank you. So having made that amendment, and you having verified that, to the best of your knowledge and belief, the rest of the contents of the statement are true and correct, are there any other amendments you wish to make?

10 MS COSSON: No, no other amendments, thank you.

MR GRAY: Commissioners, I tender the statement.

15 COMMISSIONER PAGONE: Yes, the statement of Ms Cosson dated 19 July 2019 will be exhibit 10-13.

**EXHIBIT #10-13 WITNESS STATEMENT OF ELIZABETH COSSON  
DATED 19/07/2019 (WIT.0219.0001.0001)**

20

MR GRAY: Thank you, Commissioner. Operator, please display pages 6 and 7 so Ms Cosson can see paragraphs 38 to 40. Ms Cosson, I just want to ask you some questions about the veteran population - - -

25

MS COSSON: Certainly.

30 MR GRAY: - - - and the veterans who are eligible to receive entitlements under programs administered by your department, Department of Veterans’ Affairs. The veteran population and those veterans who are eligible for entitlements under the programs administered by DVA, they’re two different concepts, aren’t they?

35 MS COSSON: So, counsel, if I explain it this way. We only know those veterans who have actually submitted a claim with the Department, and those veterans may have different levels of eligibility for treatment or compensation. So we are conscious that there are many veterans in Australia that we do not know. And so what my statement is reflect is that we have done some research to try and identify who has actually served in our Australian Defence Force, and in the statement the Australian Institute of Health and Welfare did do that analysis for us. And they  
40 estimate approximately, as you see, about 631,000 men or women have served and are still alive.

MR GRAY: And - - -

45 MS COSSON: So what we know are those veterans who have submitted a claim to us and then we’ve determined their level of eligibility for the services that we can provide to them.

MR GRAY: And so my question is, the concepts of the veteran population on the one hand and those veterans who are eligible for entitlements under the legislation your department administers, they are two different concepts, aren't they?

5 MS COSSON: They're two different cohorts of veterans, that's correct, yes.

MR GRAY: Two different cohorts.

MS COSSON: Yes.

10

MR GRAY: Thank you. And the estimate you've just referred to appears in the table in paragraph 38, broken down by aged cohorts?

MS COSSON: That's correct.

15

MR GRAY: And the number of veterans who are eligible for entitlements under legislation administered by DVA appear in paragraph 39; is that right? As at - - -

MS COSSON: That's correct.

20

MR GRAY: - - - 31 March 2019?

MS COSSON: That's correct.

25 MR GRAY: And there are roughly a little less than half of the total estimated veteran population of Australia who are included in the cohort of clients who are entitled to benefits under DVA administered legislation; is that right?

30 MS COSSON: So can I just understand your question? So 39 bravo, which says that we have approximately 184,000 veterans that are aged 65 and older, they are the veterans that we know. So they're the veterans that have approached the Department and are in receipt of veteran services from DVA.

35 MR GRAY: Yes, and my question relates to the total figure, 287,069 clients as at 31 March 2019, that's a figure that is a little less than half of the total estimate of the veteran population of Australia; is that right?

40 MS COSSON: No. Actually, the 287,000 clients of DVA include veterans and they include dependants, which could be widows of veterans. So – and then the breakdown that sits beneath that are the veterans of that – the cohort that we're responsible for.

45 MR GRAY: Thank you. And the figure in paragraph 38 is just the veterans; it doesn't include the dependants, spouses and so on.

MS COSSON: That's correct, counsel.

MR GRAY: Thank you very much. Now, in your statement at pages 32 and 33, there's another table, paragraph 138. The operator will bring that up for you. Taking that figure of DVA clients of roughly 287,000 people, some of those are referred to in this table, that is, the cohort over 65 years.

5

MS COSSON: They are included in that table, that's correct.

MR GRAY: Right. And those people are categorised into the people receiving entitlements under the different programs that appear in that table; is that right?

10

MS COSSON: That's correct.

MR GRAY: And when we get over the page, to page 33, there's a reference to veterans supplement in home care, 190 total recipients. There isn't a reference to veterans who are receiving home care packages, and is that because DVA doesn't administer the home care packages?

15

MS COSSON: So – if I can, yes.

20

MR GRAY: Yes.

MS COSSON: So we don't administer the supplement. What we provide to Department of Health is appropriation for a supplement for those that are in residential aged care. For veterans who are receiving home care packages through the Department of Health, we don't administer the supplement, nor do we fund the supplement for those veterans receiving home care packages.

25

MR GRAY: Are they administered by the Department of Human Services?

30

MS COSSON: Department of - - -

MR GRAY: The supplement.

MS COSSON: The – so Department of Human Services pay it through their systems, but the actual program is administered by the Department of Health.

35

MR GRAY: And when it comes to the supplement, are you saying DVA doesn't fund the supplement either?

40

MS COSSON: For home care, no, the DVA does not fund the home care package supplement, no.

MR GRAY: Thank you.

45

MS COSSON: But we do provide appropriation for the supplement for residential aged care.

MR GRAY: All right. Do you know how many veterans are in receipt of home care packages?

5 MS COSSON: Off the top of my head, counsel, no, I'm sorry, I don't have that number, but I could certainly find that number out for you.

MR GRAY: Does DVA keep a record, a running record of how many veterans are in receipt of home care packages?

10 MS COSSON: We certainly do know how many veterans are receiving home care packages and we do know how many of our veterans are in residential aged care because they remain clients of the Department of Veterans' Affairs. They would be receiving some other benefit so that we would be aware of who is there. I just don't have the numbers, sorry.

15

MR GRAY: Now, putting aside home care for the moment and turning to residential care, the next entry in the table for veterans in residential aged care facilities, DVA eligible and total veterans, the entry is 35,792 DVA clients, includes full-time and respite care admissions. Then it says:

20

*DVA does not have data available on the total number of veterans.*

What's the explanation for that last reference:

25

*DVA does not have data available on the total number of veterans.*

MS COSSON: Yes, so this goes back to – we think there are around 631,000 veterans in Australia. So we only know those that we support as our clients. So what that's referring to, we're aware of the 35,792 veterans that are clients of the  
30 Department of Veterans' Affairs that are in residential aged care. We do not know the total number of other men and women who have served that have not lodged a claim with the Department of Veterans' Affairs.

MR GRAY: Thank you for clarifying that. On the left-hand side of that same row,  
35 where it says:

*Veterans in residential aged care facilities –*

and then it says –

40

*(DVA eligible and total veterans) –*

is that correct, or should it just say DVA eligible?

45 MS COSSON: That's a good question, counsel. Veterans in residential aged care facilities, so DVA eligible will be those that are eligible for services and the total

veterans, I'm assuming there may be some veterans who are eligible for respite but they're not eligible for full services of residential care, but I can clarify that.

5 MR GRAY: So are you saying you're not sure whether the 35,792 clients includes some people who maybe are not DVA eligible? Or you just are you speculating that that's the answer?

10 MS COSSON: No, I do know. I am confident that 35,792 are veterans – DVA clients that we know and that we don't know those that are non-clients but are veterans in residential care. So I do know that. I'm very confident of that. In relation to what's in the words on the other side of the table, it may be referring, and I am speculating and I will confirm for you, that there are veterans that would be getting respite care that may not be eligible for full residential care but they will be known to DVA; they will not be sitting in that 631,000.

15 MR GRAY: Let's just get back to what you said about the basis on which DVA would know about veterans who are in either form of aged care administered by the Department of Health, that is, home care or residential care. You said in respect of home care that DVA would have some basis for knowing when a veteran who is registered with DVA is also receiving a home care package administered by the Department of Health.

MS COSSON: That's correct.

25 MR GRAY: And could you just explain how DVA knows that.

30 MS COSSON: So we have what we refer to as a data train. So we share information between the Department of Veterans' Affairs with Department of Human Services and Department of Health, and we do data-matching. So we would have visibility of our veterans who are moving potentially from our system into mainstream through – to receive packages through the Department of Health or actually moving into residential care. So we do that data-matching regularly just to determine who is receiving aged care services.

35 MR GRAY: How regularly?

40 MS COSSON: I will need to just check how regularly. I could speculate but I'd prefer to actually give you an answer, so the Department will be able to give that to me today.

MR GRAY: Thank you. I will call for that answer in due course, if it's after your evidence, if that could be provided by correspondence.

45 MS COSSON: Absolute, we can do that. Yes.

MR GRAY: Thank you. What's the purpose of the data matching?

MS COSSON: So the data matching is looking at what are the level of services that we can provide to veterans, particularly with those veterans who are going into residential aged care, we look at what benefits they're receiving from the Department to inform means testing, for example. And we look at what services that we provide to veterans through veterans home care, or community nursing, because what we are very conscious of is that we don't want to duplicate the services that would be provided through the mainstream.

MR GRAY: So is it really about making sure that DVA, the Department of which you are the Secretary, isn't paying for something that should be paid for by either the Department of Health or the resident or the home care package recipient under the aged care system administered by the Department of Health?

MS COSSON: I think it would be a mix of that, counsel, but also having a look at the care needs of our veterans as well. But we are – through our entry level services, we look at the individual needs of our veterans to determine what level of service they can provide – what level of service we can provide to them. And as their care needs grow, then we are conscious of the fact that they would potentially move into the mainstream or residential care. So yes, we do data matching to determine whether the provided facility is actually receiving Commonwealth funds for that or if we can actually supplement the services that are provided by the provider.

MR GRAY: Thank you. What's the section in the department that's responsible for the function of monitoring the care needs by the data matching that you've just mentioned and how many personnel are in that section?

MS COSSON: So if I can break that down a little bit as well. Where the veteran is actually in receipt of DVA aged care services, we would be looking at making sure that their needs assessment and their care plans are being monitored and we have a team that would be monitoring that in the Department. When we're looking at veterans who are in the mainstream system receiving health care packages or in residential care aged care, we don't monitor the level of care that's being provided by the providers. But what we do have is a relationship with the Department of Health and we have great connections with veterans' advocates to make sure that we're hearing of any issues in relation to their care plans.

So we have a division within the Department that looks after the delivery of services to the veterans community and it's a mix of aged care, veterans home care, community nursing and I wouldn't have the exact number of staff because it would cross over a few of the service delivery elements but I can certainly find out how many staff are doing that work.

MR GRAY: Ms Cosson, we are about to break for lunch but I will just ask you to think about this question over lunch. The questions I was asking you were about clients who are in receipt of home care packages or who are in residential care; they're both mainstream services - - -

MS COSSON: Yes, that's correct.

MR GRAY: - - - to use the terminology you've adopted and you've just said, after giving the Royal Commission some information about data matching and claiming  
5 that it had a function of assessing care needs, you've just clarified that the data  
matching doesn't inform the monitoring of care needs for people who are in the  
mainstream services. It's only for the people who are receiving DVA services that  
the data matching has the function of informing the assessment of care needs. That  
10 was in summary what you just said by way of clarification of your evidence, wasn't  
it.

MS COSSON: Yes, that's correct. We don't monitor the care needs that are being delivered through the Department of Health.

15 MR GRAY: All right. Commissioners, I see the time.

COMMISSIONER PAGONE: Yes. Thank you. Mr Gray, would it would be desirable to have Ms Cosson make some inquiries over lunch about the matters that you have asked about or do you want to deal with it after the evidence given.  
20

MR GRAY: If Ms Cosson could make those enquires over lunch, that would be most convenient.

COMMISSIONER PAGONE: Ms Cosson, it may not be possible for you to make those inquiries or at least it may be impossible to make the inquiries but not get an answer but if you can, it will save everybody, I think, time in the long run.  
25

MS COSSON: I will do that.

30 COMMISSIONER PAGONE: Thank you. We will now adjourn until 2 o'clock.

**ADJOURNED** [12.49 pm]

35 **RESUMED** [2.04 pm]

40 COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Ms Cosson, veterans have poorer physical and mental health outcomes than the general population, according to some evidence; is that correct?

45 MS COSSON: Certainly, counsel, that observation has been made particularly in the middle age group.

MR GRAY: And it's government policy that they deserve to have their sacrifices recognised?

MS COSSON: Absolutely, counsel.

5

MR GRAY: And in your statement on pages 4 and 5, you've outlined the history of government policy in that regard?

MS COSSON: Yes, I have.

10

MR GRAY: And it's policy, is it, that there should be a comprehensive system of support for veterans for the whole of their lives?

MS COSSON: That's correct.

15

MR GRAY: In your statement you refer to the strong need to ensure services within the aged care sector provide appropriate support. That's at paragraph 61.

MS COSSON: That's right.

20

MR GRAY: That's an opinion you hold, isn't it?

MS COSSON: Yes, it is, counsel.

25

MR GRAY: In your statement at paragraph 45 you outline the programs that DVA funds and administers and I should have asked you a question at the outset about this, but you're the secretary of DVA. There are two other agencies or departments which are relevant to your evidence, aren't they, the Department of Health and Department of Human Services.

30

MS COSSON: And – yes, and Department of Social Services for a lot of the other veteran services that we provide, that's correct.

35

MR GRAY: Thank you. The operator is going to put up tab 62 which is one of the documents referred to in your statement, Navigating Aged Care. You're obviously familiar with this document, I take it?

MS COSSON: Yes, I am.

40

MR GRAY: And by way of the infographic that appears in the middle of a page, it indicates that for entry level care for people who are over 65 years old there are various programs that are – in dark blue that are funded and administered by DVA; is that right?

45

MS COSSON: If I can just add, counsel, that those programs that are outlined at entry level care aren't just limited to veterans over the age of 65. You can access

those services at any age, if you've got eligibility under the DVA system. But that's correct, we do administer those programs.

5 MR GRAY: Thank you. And they are available to veterans who are registered clients of DVA who are over the age of 65.

MS COSSON: As well, that's right.

10 MR GRAY: Thank you. And there's also a reference to the CHSP program administered by the Department of Health. There may be some veterans who are eligible clients of DVA who also access CHSP services; is that right?

15 MS COSSON: So there are veterans that are accessing our services and there will be veterans that are accessing the CHSP, that's correct. But, importantly, what we assess is if they are receiving services under our programs, they shouldn't be receiving the same services under the CHSP program.

MR GRAY: And that's one of the purposes of the data matching you mentioned?

20 MS COSSON: I would love to think that all the data matching is doing that for me but it's not that sophisticated, to be honest, but that's where we do need to be heading, yes.

25 MR GRAY: And then when we look at the right-hand side of the infographic, in the top corner there's a reference to high level care. I will come to exactly what high level care means in a minute and I will ask you about that, but just accepting that description, high level care for the moment, when a veteran who is an eligible client of DVA needs higher level care, they enter programs administered and funded by the Department of Health; namely, the home care packages program or the residential aged care program; is that right?

30 MS COSSON: That's correct, yes.

35 MR GRAY: Now, when that happens, and we will come to this in a minute, it's possible there could be duplication of certain services and DVA can conduct the data matching you referred to to try to ensure that duplication of funding for the same sorts of services doesn't occur. Is that right?

40 MS COSSON: The data matching probably isn't that sophisticated, as I mentioned. But what we do rely on is during the assessment for the veteran from moving from our low level entry care into that high level care that they go through the assessment process which would then identify if they're in receipt of veterans services because the aim is absolutely to avoid any duplication but importantly we can also supplement what may be available through the health programs. There's a matrix that identifies what services that we provide for low-level assessments and high level  
45 but we also, where we have an individual veteran who has some need, we can cross

over those – that boundary to go into higher care. But the aim is to avoid any duplication of services.

5 MR GRAY: Just before lunch you clarified the evidence that you had given up to that point by saying that the data matching in question was not for the purposes of assessing the care needs of veterans who are in mainstream services. Do you stand by that clarification?

10 MS COSSON: Yes, I do, counsel, yes.

MR GRAY: And the mainstream services are the ones in green on this infographic; is that correct?

15 MS COSSON: That's correct.

MR GRAY: Now, could I just ask you to look again at the programs – I beg your pardon. I will ask the operator to zoom out. At the foot of page 7, there's a reference at the bottom of that page to the government's aged care reforms, and I will ask the operator to call all of the text under that heading out. You see there there's a reference to reforms being led by the Department of Health, and there's a reference to the benefits including more tailored and holistic approaches to community in aged care assessments and identification of needs. And then more choice in community and aged care programs and more control over services being delivered through consumer-directed care. Ms Cosson, before taking up your role last year as Secretary of DVA, you did have some history in the Department of Health but not in aged care, is that correct?

25 MS COSSON: That's correct, counsel

30 MR GRAY: However, you have a familiarity with the aged care system; is that right?

MS COSSON: I have learnt a lot recently but when I was in the Department of Health my role was the Chief Operating Officer and that's predominantly the enabling services to the Department of Health. I was familiar with aged care.

MR GRAY: It's all right. It's just a simple question.

40 MS COSSON: Sorry. Okay.

MR GRAY: Yes. Did you have a familiarity with the aged care - - -

MS COSSON: Not, really. No.

45 MR GRAY: No. Do you know what consumer-directed care is in the context of the aged care system?

MS COSSON: I am aware of consumer-directed care. Yes.

MR GRAY: And you know that it's directed to the home care package program so far.

5

MS COSSON: Yes, that's correct.

MR GRAY: And do you know that there are proposals that have been made in reports that it might be extended to other programs, but that hasn't happened yet.

10

MS COSSON: I'm aware but not across all of the detail, counsel, that's right.

MR GRAY: All right. Then it says:

15

*DVA is working closely with the Department of Health to ensure that reform measures are complementary to DVA programs and will result in improved outcomes for veterans and DVA aged care providers.*

20

What's the scope of the work that DVA is doing, working closely with the Department of Health to ensure those outcomes, in respect of the consume-directed care measure?

25

MS COSSON: So we have a good relationship with the Department of Health and that could be through interdepartmental committees or through working level groups where - - -

30

MR GRAY: I'm not asking about the modalities, but just about the scope of any work that has been done to ensure the reform measures are complementary to DVAs programs in the consumer-directed care area. I'm not asking about how often there might be general consultations, just what work is being done in that regard.

MS COSSON: I'm not aware of the actual level of work that is underway but I am aware that there are discussions and collaboration regarding the work.

35

MR GRAY: Okay. You're the Secretary of DVA and you don't know what work is being done to ensure the consumer-directed care reform measures are complementary to DVAs programs.

40  
45

MS COSSON: I'm aware there's a lot of work underway, counsel, in relation to reform for veterans and that is one component of it, and our whole transformation program has been about putting the person at the centre, putting the veteran at the centre and that is a message that is across the department. So any work that is underway with the staff in DVA would have that front of mind when they're working with Department of Health.

MR GRAY: The model under which veterans are cared for throughout their lifetime involves a switch at the high level of care domain into mainstream services; do you agree with that?

5 MS COSSON: A switch – I’ve never looked at it as a switch but there is a point where a veteran would move from our system into Department of Health into care that is above what we actually provide because our services are low-level entry care and so there is a time when they will transition out of that; that’s correct.

10 MR GRAY: And as secretary of DVA, do you see it as part of DVAs role to continue to promote and safeguard the interests of veterans once that move has occurred?

15 MS COSSON: If I can, counsel, absolutely. I agree that we have been quite passive in our role in relation to our veterans moving into mainstream aged care. Given our focus for the last three years on transformation, we do know we are changing the way we frame our engagement with veterans, that we can’t just, as you put it, turn a switch and then not have any visibility of what is the care that they’re receiving and to ensure that we do take that responsibility through life for our veterans and that we  
20 do have active programs and active management arrangements. That’s correct.

MR GRAY: And in your role since May last year, as Secretary, you’re supervising an organisational transformation of DVA, aren’t you?

25 MS COSSON: That’s correct.

MR GRAY: And is that called the Veteran Centric Reforms?

30 MS COSSON: That’s correct.

MR GRAY: Yes. And you referred to the Veteran Centric Reform program in your statement, at pages 30 and 31, paragraphs 135 to 137. You don’t refer to any consultations with Department of Health about monitoring the progress of veterans through the aged care system, safeguarding their interests or anything of that kind  
35 once that move into mainstream services has occurred, do you?

MS COSSON: I don’t specifically reference that in my statement. You’re correct.

40 MR GRAY: All right. So when is that work going to happen?

MS COSSON: So Veteran Centric Reform is a multi-year program that – we are now just in year 3 of the program. And there’s two key streams in year 3, which is health pathways and also provider engagement.

45 MR GRAY: It’s all right. When - - -

MS COSSON: Sorry.

MR GRAY: - - - is it going to happen? When's the work concerning following the progress of veterans through the mainstream aged care services going to happen? And promoting their interests when that occurs.

5 MS COSSON: Well, work has commenced. Work is underway, but when will the end result will be known, that will be a few years away, Counsel.

MR GRAY: Well, why wasn't the work that's underway mentioned in this passage?

10 MS COSSON: Probably because it's just – we're in year 3. It's – I did the – signed the statement in July. And over the recent months, what we have been doing – having a Productivity Commission report, which actually identified how we need to completely transform DVA, and we were waiting for the outcomes from that. So it's an omission, but it's certainly something – we've been talking to veterans of all ages,  
15 to understand how we need to transform.

MR GRAY: Okay.

MS COSSON: We've had workshops with our older veterans and through our  
20 National Aged Care consultative forum. Understanding what we need to do differently with our ageing veterans is really important to us.

MR GRAY: So it's started, as of July this year?

25 MS COSSON: No. No. The – sorry.

MR GRAY: That aspect of the - - -

MS COSSON: The whole transformation. Yes.  
30

MR GRAY: No, but that aspect of the work?

MS COSSON: That's right.

35 MR GRAY: And started with some consultations - - -

MS COSSON: With our veterans? Absolutely.

MR GRAY: - - - with veterans - - -  
40

MS COSSON: Absolutely.

MR GRAY: - - - as from July this year, a few months ago.

45 MS COSSON: No. It's been ongoing, to be honest. We've had consultation now with workshops for the last three years. And, importantly, what we have heard more recently – so I don't want to say there was a start date, because what we've been

learning through all of those consultations is that we have not been, really, focused on the whole ageing process for our veterans. We've concentrated a lot on the transition from military service, and that has been a considerable focus of effort for the first couple of years. But, through the workshops, we've now heard that  
5 potentially we need to be stepping forward more into the aged care, to understand what is happening with our ageing veterans. And one of the key initiatives that we've put in place, which will help our ageing veterans, is early engagement; knowing them from their point of departure from military and then understanding what life experiences they may have through their life journey, so that we connect to  
10 them throughout.

MR GRAY: Thank you. Look, I - - -

MS COSSON: So - - -  
15

MR GRAY: I only really - - -

MS COSSON: Yes.

20 MR GRAY: - - - asked when had it occurred and what did it - - -

MS COSSON: It's ongoing.

MR GRAY: - - - consist of. Consultations - - -  
25

MS COSSON: It's ongoing, Counsel.

MR GRAY: If you continue volunteering a lot of information like that - - -

30 MS COSSON: I'm trying to be helpful.

MR GRAY: - - - that doesn't respond to the question - - -

MS COSSON: Okay.  
35

MR GRAY: - - - we're just going to take a very long time.

MS COSSON: Okay. Sorry. I'm trying to be helpful.

40 MR GRAY: No, that's fine, Ms Cosson, of course. You understand that there are risks in moving a population of veterans who are eligible for DVA services into mainstream services, and you refer in your statement to those risks.

MS COSSON: Absolutely.  
45

MR GRAY: You're conscious of that.

MS COSSON: Yes. I am conscious of that.

MR GRAY: A great deal of attention needs to be given, I suggest, to that interface, to make sure that confusion doesn't result, because confusion can lead to people not  
5 receiving the services they need. Do you agree with that?

MS COSSON: That's – I do agree with that.

MR GRAY: It sounds like you're not satisfied at present with the state of that  
10 interface. Is that a fair summary?

MS COSSON: That'd be a fair statement. Yes.

MR GRAY: Yes. So you've outlined that consultations have occurred with regard  
15 to the way forward. But no concrete measures have been implemented to improve that interface yet; is that right?

MS COSSON: I'd – well, we have been working with the Department of Health in  
20 relation to their systems navigator, so that that could help with our veterans through that transition. Also, what we have been building – sorry, I'm adding more information. We've been building a capability on how we can understand at-risk veterans, to give them case coordination or case management. So we have built that capability. And what we need to do is now expand that, to help pick up our ageing  
25 veterans.

MR GRAY: All right. That hasn't occurred yet?

MS COSSON: No. It hasn't.

MR GRAY: But you have a plan to do that, do you?  
30

MS COSSON: Yes. That's correct.

MR GRAY: And I'll just ask you about navigation - - -  
35

MS COSSON: Yes.

MR GRAY: - - - because that sounds like it's the very topic you just referred to  
40 then. You're trying to build a capability that will help identify the services that people need. Is that, essentially - - -

MS COSSON: So the capability's actually being built by the Department of Health, and we're engaged with them in the building of that navigation system.

MR GRAY: That's the navigation?  
45

MS COSSON: Yes. That's right.

MR GRAY: It's the same point as the navigation trial you mentioned?

MS COSSON: That's correct.

5 MR GRAY: And that's the pilot program that's due to report in about mid-2020? Is that that program?

10 MS COSSON: I'm not too sure when it's due to report, but I assume it is that same program. It's the only program I've heard of. Yes.

15 MR GRAY: All right. Let's just consider the issue of navigation, by which I mean the process by which a person who may need aged care services is provided with information or assisted to process information so that they can access the relevant services to which they might be entitled. Now, would you agree that the first step is the provision of accurate and accessible information to the person who might need the service or their power of attorney or spouse, next of kin? Would you agree that that's the first step that needs to occur, in order for - - -

20 MS COSSON: So the first step - - -

MR GRAY: In order for a person to gain access to the services they might need.

25 MS COSSON: The first step for me would be to actually have a plan before you need it. And that's something we've been very conscious of in our transformation. I won't go into all the detail, but it is have that plan before you are – then trying to find out what is available to you. And that is part of our transformation with early engagement. So that members that transition, they start to have their plan through life and know when they need to touch us or when we will reach out to them.

30 MR GRAY: All right. Then, would you agree that there needs to be accurate and accessible information available to them?

MS COSSON: Absolutely. Absolutely.

35 MR GRAY: And then would you agree that there needs to be an assessment of what their needs are?

MS COSSON: Yes. Absolutely.

40 MR GRAY: Now, I'll come to this a minute, but there seemed to be multiple avenues of assessment that apply for veterans in this area of aged care related services. Would you agree that, ideally, there should be, simply, one assessment?

45 MS COSSON: I agree they need assessment. And assessments will change over time. Your needs will change. So there's probably a requirement for multiple assessments. I wouldn't like to think you'd have one assessment and then you have a

set and forget arrangement, particularly in the aged care situation. I can go on if you'd - - -

MR GRAY: Yes.

5

MS COSSON: - - - like, Counsel.

MR GRAY: I'll just bring up tab 129, which is the RSLs submission to the Royal Commission, 20 September 2019, at pages – beginning at page 3, please, Operator. Now, in this submission, under the heading Navigation of the Aged Care System, the RSL has made a number of points. And they touch upon assessments under a heading on the next page, Complexity Traversing Two Systems. And if, Operator, you could pull out the bullet points at the bottom of that page and the sole bullet point on the next page, there's then a list in the submission of:

15

*The unique assessment and application and request processes that apply or can apply during the veteran's journey between the two systems.*

So this is a point distinct from the valid point you made, Ms Cosson, about the need for assessment when there's a change in clinical conditions or circumstances of the veteran. This is an administrative list of multiple - - -

20

MS COSSON: Yes.

MR GRAY: - - - assessments, simply constituting different administrative steps, irrespective of whether there's been a material change in clinical condition or circumstances. I don't know if you've had a chance to reflect on this submission, since it was alerted to you - - -

25

MS COSSON: Yes.

30

MR GRAY: - - - in recent times.

MS COSSON: I have. Thank you, Counsel.

35

MR GRAY: Are you satisfied that this list is an accurate depiction of all the multiple administrative steps and assessments that apply or can apply to a veteran during the journey from DVA-specific services to mainstream services?

MS COSSON: So if – I can, Counsel. A few of them are actually specific to veterans' services, where you will enter through our assessment process, which, hopefully – and what I hear – it's not very onerous, and I've lived through it with my own father – and some of the other assessments will be when you're going in and out; particularly, respite would be a different assessment. So some are necessary for that particular change in your circumstance. Others are actually entering into different phases of the aged care system. But, yes, it does look an extensive list.

45

MR GRAY: Would you agree that there should be consolidation of these assessments, so that, absent a change in circumstances, the veteran isn't put through multiple assessments?

5 MS COSSON: What I'd like, to be honest, Counsel, is that when you enter into whichever system, mainstream or the veterans' system, that you only have to tell once what your circumstance is, and that you can then have auto-population of data.

MR GRAY: Yes.

10

MS COSSON: That would be ideal for me, rather than having to continually repeat your story. And I - - -

MR GRAY: Have you directed officers of your department to advocate that to the  
15 Department of Health?

MS COSSON: Well, part of our transformation is that what we are establishing is a single view of client. Previously, we had multiple systems that – our staff could not do that. They would have to ask the questions over and again. Our aim is to have a  
20 single view of clients for our veterans by the end of this year and – but with the Department of Health, their systems are a little bit separate to ours. So I have been focusing, really, on the veterans that are in DVA system.

MR GRAY: We'll go to page .0005. The first full paragraph. The point made in  
25 the RSL submission, in the first full paragraph, is that there's no interface between the DVA services and the Commonwealth aged care programs; the systems do not talk to each other. Do you agree with that?

MS COSSON: I do agree with that. Yes.

30

MR GRAY: Have you taken that up or directed your officers to take that up with the DoH, to rectify that system? That failure of interoperability?

MS COSSON: So if I can, Counsel, that's – I'll skim back to the transformation  
35 where it was identified that the multiple systems that the Department of Veterans' Affairs had didn't even talk to each other. So we've had significant investment to try and address that. And what we are doing is leveraging off the Department of Human Services' technology, so that we have greater connectivity. And I know that the Department of Human Services and Department of Health are looking at their  
40 systems. From a whole of government perspective, the aim is to have that interoperability across our systems and have better data sharing. That is a few years down the track, but it is certainly on the agenda for transformation through our departments.

MR GRAY: Why is it a few years down the track before Department of Health and  
45 DVA systems will talk to each other?

MS COSSON: Our IT systems are quite old, Counsel, and it just takes a long time to make sure that we are doing it together and not in isolation. Previously, we used – DVA used to have its own IT system branch and we used to just build our own. So our whole focus now is working together, and – but it does take time for our  
5 technology.

MR GRAY: The submission goes on, two paragraphs down, on the same page, to make the point that there are three different numbers, by way of client or identification numbers, that will be issued during the journey a veteran might well  
10 have, in using DVA-eligible services and then using mainstream services, or moving between the two from time to time. That is, the DVA number, a Medicare number and an aged care number. And you agree with that, I take it?

MS COSSON: Yes. I do.  
15

MR GRAY: Yes. And when you were able to have regard to this submission in preparation for giving your evidence in recent times, were you able to digest the case study that appears in the box from about halfway down page 5 all the way through to  
20 the top of page 7?

MS COSSON: I read that case study and it was – yes.

MR GRAY: And - - -

MS COSSON: I don't know the actual case itself, but - - -  
25

MR GRAY: No.

MS COSSON: - - - I certainly read the case study. Yes.  
30

MR GRAY: The case study, in summary, is an account of a phone call to the My Aged Care call centre. It was a phone call made by the spouse of a veteran.

MS COSSON: Yes.  
35

MR GRAY: The veteran himself was a person with dementia and was not able – certainly not able unassisted - - -

MS COSSON: No.  
40

MR GRAY: - - - to be able to make that call. The spouse made the call herself, being assisted by a person who was essentially providing navigation services. And the gist of the case study is that the call centre operator, on a number of occasions, cited the Privacy Act and admonished the navigator, so that navigator's role became  
45 very, very difficult to fulfil. And indeed, it was quite difficult even for the spouse of the veteran to be able to make her requests known. And in the end, all that was achieved by the call was possibly a reinstatement of the veteran to a waiting list from

which he had dropped out some months before, apparently. Is that account consistent with any anecdotal complaints that you've heard about My Aged Care and the experience of veterans with My Aged Care?

5 MS COSSON: In that level of complexity and the challenge that was faced by the spouse, I had not received that level of complaint. But I certainly am aware that it can be challenging when you're trying to navigate any system regardless of its DVA or aged care when you're going through challenges, as she is with her veteran husband. In this case, I would love to be able to help them and we are very fortunate  
10 to have advocates who are doing exactly as the RSL advocate did. But, yes, I did – I was concerned for this veteran and the spouse when I read that story.

MR GRAY: One of the concerning aspects is that when the navigator or the advocate suggested to the veteran spouse that My Aged Care should recall the  
15 veteran's DVA number, this was refused. Is that a topic you've heard anything about - - -

MS COSSON: I haven't personally.

20 MR GRAY: - - - in your role as secretary?

MS COSSON: No, I haven't counsel, I haven't heard that before. But I have heard about the fact that we do have multiple numbers when we serve in the defence force. We have regimental numbers and we have administrative numbers and then a DVA  
25 number and a Medicare number. So I have heard of that, which is complex just in the nature of our military service.

MR GRAY: It suggests that My Aged – if it's correct, it suggests that My Aged Care isn't operated in a way that prompts the operators to record information about  
30 DVA numbers or even the status of a client as a DVA-eligible client. Would you agree with that?

MS COSSON: I wouldn't. I'm sorry, I'm not aware of the actual system where they record that information. I don't run the system. But I would – I am aware that  
35 when Department of Health sits with a veteran, they do ask if they are a veteran. I've had that experience with my dad, where he was going through an assessment and they asked him if he was a DVA client. So I know that that was asked, but that was a face-to-face assessment, not a call centre.

40 MR GRAY: It was a face-to-face assessment by a regional assessment service or - - -

MS COSSON: Yes, that's correct.

45 MR GRAY: - - - an aged care assessment service?

MS COSSON: Aged – I think it's Aged Care Assessment Service.

MR GRAY: An ACAS?

MS COSSON: Yes.

5 MR GRAY: On page 8 of the RSL submission, there's a point made about a topic I think you adverted to very briefly a minute ago: respite. Now, respite is a service that is available to some extent from DVA; is that right?

10 MS COSSON: Yes, we do provide respite care in a home and in residential, that's correct.

MR GRAY: A hundred and - - -

15 MS COSSON: In home and in residential, yes.

MR GRAY: 196 hours.

MS COSSON: That's right, or 28 days, or a combination of the both. That's right.

20 MR GRAY: And the respite in question takes place where? Within a residential aged care facility?

MS COSSON: It can be in home or it can be in a residential aged care facility.

25 MR GRAY: I see.

MS COSSON: That's right.

30 MR GRAY: If it's in a residential aged care facility, it's necessary for the veteran or her or his representative to go through My Aged Care and go through this exercise - - -

MS COSSON: That's correct.

35 MR GRAY: - - - of trying to explain their needs afresh. Is that right?

40 MS COSSON: That's - they have to go through that assessment. I'm not too sure whether they have to present all their needs again. But given what I've been reading, I would suggest that the systems aren't speaking with each other and they're not populating, so they might have to go through all their needs again, yes.

MR GRAY: And is that the case even though DVA is actually funding 196 hours worth of respite?

45 MS COSSON: If it's through us, then they are unlikely to have to go through it again. But there may be occasions when, if our systems are not communicating or they've been done, then we have had to go through all those questions again.

MR GRAY: All right. That's a topic - - -

MS COSSON: Yes.

5 MR GRAY: - - - like the other topic that I raised about interfaces more generally that really needs improvement. Would you agree?

MS COSSON: I agree, yes.

10 MR GRAY: And that's a – or, rather, that's an area that needs a great deal of attention given to it, to achieve a smooth interface and to streamline the assessment process. Would you agree with that?

MS COSSON: I would agree with that, yes.

15

MR GRAY: And the submission also refers to care post-hospitalisation at the foot of page 8. There's a DVA program for restorative care, isn't there?

MS COSSON: That's correct, counsel.

20

MR GRAY: But is there a need to resort to a residential aged care for some people who need restorative care?

MS COSSON: Potentially. Potentially, yes.

25

MR GRAY: When those circumstances arise, what happens? Does the veteran or her or his representative have to approach a residential aged care facility through My Aged Care afresh?

30 MS COSSON: Yes, they do.

MR GRAY: And go through the same process?

35 MS COSSON: Yes, that's right. If a veteran is entering into residential care, residential respite, any mainstream services, they do have to go through another assessment, that's right.

MR GRAY: All right. And would – same question. Would you agree that that is an area that needs attention and improvement as well?

40

MS COSSON: Would be great for information sharing to be strengthened, so that subject to privacy limitations, if they exist, that we would be sharing information.

MR GRAY: Well, I will just ask you now about the privacy - - -

45

MS COSSON: Yes.

MR GRAY: - - - point. It comes up in a minute in relation to the veteran supplement - - -

MS COSSON: Supplement, yes.

5

MR GRAY: - - - for home care packages and residential care. But what's your personal view about the effect – about whether the effect of the Privacy Act in apparently requiring fresh assessments and preventing the free communication of care needs between the three agencies we've mentioned? Do you believe as a personal opinion that that should be reformed and the Privacy Act requirements should be relaxed?

10

MS COSSON: I like to respect privacy and I am aware that some of our veterans would not want me sharing details in relation to any of their conditions. So if there was to be a reform of the privacy provision, then that respect is also important to me. There are occasions where – and we have implemented some change with the Australian Defence Force, for example, that we now anybody that enlists indicate they're happy for Defence to share information for us, for example. So it's informed consent, rather than trying to get consent at the last minute.

15  
20

MR GRAY: Well - - -

MS COSSON: There are different ways to do it and respect that privacy.

MR GRAY: Well, what about this? Without any reform to the Privacy Act, as you know, because you just mentioned it, if there's informed consent at the outset for a particular use of - - -

25

MS COSSON: Yes.

30

MR GRAY: - - - personal information, then that facilitates the - - -

MS COSSON: Yes.

MR GRAY: - - - provision of that information for that purpose.

35

MS COSSON: Yes, and I would support that.

MR GRAY: When DVA first assesses the needs of the particular eligible veteran and identifies, say, a mental health issue that might be relevant down the track to whether that veteran could access a veteran supplement when they move into mainstream aged care services, shouldn't DVA be making a change to the way it collects that information from the veteran in the first place so as to facilitate the free provision of that very important care-related information into the aged care system down the track?

40  
45

MS COSSON: I would certainly like to find a way to be able to do that. Where – if we can have first engagement with a veteran when they’re planning their life journey, which could go into ageing for them to be able to indicate that yes, if they have an accepted mental health condition, that they would be happy for us to share that information because, as I’ve read some statements, it can be confusing when we’re asking them to do that. At the point of navigating and during a period where they are experiencing some vulnerability and stress, it would be good to be able to take that factor away.

10 MR GRAY: Thank you. Now, over lunch, have you had an opportunity to make those inquiries about how often the data train is run to do the data matching for the purposes of trying to identify duplicated provision of payments for similar services?

15 MS COSSON: The data train is run monthly and its primary purpose is to look at veterans who are moving in and out of our system and to inform where there would be eligibility for a supplement. So that is a monthly data sharing.

20 MR GRAY: And when you say – so you’ve made a point – I suggested that the summary of your evidence basically was that the data matching was done to identify duplicated payments for similar services to try to iron out any such duplications, but you’ve added another point which is to identify eligibility for supplements.

MS COSSON: Supplement. That’s right, yes.

25 MR GRAY: So if the data train process identifies that a veteran is eligible for a supplement, what’s the process that then occurs?

30 MS COSSON: So we then write to the veteran to let them know and to seek their consent to share the information. My personal view is that’s too late to be doing that, that we should be able to, as we’ve just talked about, connect with them earlier in their planning to get their consent to share that data.

MR GRAY: Thank you.

35 COMMISSIONER BRIGGS: Could I just ask, so you write to them. Do you then present them with a form and say, “Fill in this form”? Or do you say, “You’re eligible. Let someone know”? Or how does it work?

40 MS COSSON: So, Commissioner, we do send them a form and there’s a copy in my statement. It’s a very simple form, fill out their details and they sign for the consent. What I would like to do is – I don’t think we are advertising that or communicating that very well with our veteran community. And given the numbers that I’ve seen that are eligible – in receipt of the supplement, I would like to be more active in communicating what is available and, once again, doing it early before you’re actually at that point when you might be eligible for a supplement.

COMMISSIONER BRIGGS: Could I also ask you just a little bit more about the data matching, dare I use that word, with social services. Do you get permission from veterans to give their data to social services?

5 MS COSSON: So that's the purpose of the consent form. They're actually agreeing that the secretary of DVA and the secretary of Human Services, who run the systems - - -

COMMISSIONER BRIGGS: Can share data.

10

MS COSSON: - - - can share it with the Department of Health. That's right. But we don't share what conditions, we just identify that they're eligible for the supplement.

15 COMMISSIONER BRIGGS: Thank you.

MR GRAY: Thank you, Commissioner. If we get time, I will ask Ms Cosson to explain that consent form in a little more detail. But I want to just start that topic of access to DVA entitlements for those who are in mainstream aged care services by asking you about gold card entitlements. Now, Operator, I believe the gold card entitlements are at tab 58. Could you please bring up tab 58. No, I'm sorry, 62 – 61. Thank you. Ms Cosson, there's a list in this exhibit of a number of forms of care under Other Types of Care to which a veteran holding a gold card is entitled in the community – and I could describe them as essentially allied health services, including dental.

25

MS COSSON: That's right.

MR GRAY: And there's an issue, isn't there, about the extent to which the mainstream aged care services into which the veteran moves or switches are supposed to provide those services at certain assessed levels of care for home care package and for residential care. And at a certain point, the veteran is not entitled any more to claim these services under her or his gold card entitlements and they have to obtain those services from the aged care service provider. Is that essentially a correct summary?

35

MS COSSON: That's, yes, a correct summary but there are also opportunities for individual needs that we will look at on a case-by-case basis. But that's generally the arrangement, yes.

40

MR GRAY: And they can be quite time-consuming if you need a special pair of shoes, for example, as we heard earlier today, to pursue special – special provision can be quite time consuming; is that right?

45 MS COSSON: Some can, counsel. I won't go into that detail about the – Mr Lynch's shoes, but it will depend on the engagement we have with the allied health provider to get information from them for any special circumstance and then we

would give prior approval. We're certainly, I feel, getting a lot better at responding quicker to those requests from our veterans.

5 MR GRAY: And there's a certain point you describe it in your statement and it's referred to in explanatory material as a higher level of need under both home care package and residential care, where it's expected that these sorts of services will be provided by the mainstream aged care service, and the question of exactly what is that higher level of need is spelt out in the Quality of Care Principles; is that right.

10 MS COSSON: That's correct, and they're the Department of Health's principles, yes.

MR GRAY: Yes, your agency, DVA, doesn't administer those principles but you have to know about them, do you?

15 MS COSSON: We are aware of them, yes.

MR GRAY: And if we take residential care, and we – I beg your pardon. I think the best way to do this is to ask the operator to put up tab 129, which is a fact sheet, and in fact sheet H5VO5, which is a DVA fact sheet – I beg your pardon, 130 please, operator – with respect to residential care, this is a fact sheet about moving from DVA eligible services to residential care.

MS COSSON: That's correct.

25 MR GRAY: If we go to page 3 of 6, please, operator, the bottom heading, What assistance does DVA provide to gold or white card holders – that's a different format, operator, I'm sorry. If we keep going down to the heading What Assistance Does DVA Provide to Gold or White Card Holders in a Residential Aged Care Home. That's the heading at the foot of that page. If we go to the text on the next page, thank you, in the middle of page 0009, there's text:

*With this type of –*

35 I beg your pardon –

*there are limits to services that can be provided to you in an aged care home if you are classified as requiring a greater level of care.*

40 And the details of that are spelt out in the Quality of Care Principles. And:

45 *... with this type of classification allied health services and aids and appliance should be provided to you by the residential aged care home therefore they should not be assessed under DVA health card arrangements except in exceptional circumstances where DVA has provided approval.*

And that's the mechanism you just referred to a minute ago.

MS COSSON: That's correct, yes.

MR GRAY: Now, the data matching that occurs, is that to make sure that there isn't duplicated payment been going on in this - - -

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MS COSSON: Counsel, I'm pretty sure our data doesn't go that far in that matching. So we would be relying on the veteran in seeking it or a provider seeking additional services and then also discussing with the aged care facility what they are providing.

10

MR GRAY: But there can be confusion, I suggest, as to what the aged care provider should be providing to a particular veteran. For example, they might be potentially in dispute or at least not communicating very well about the extent to which the aged care provider should be paying for allied services for a particular resident. Do you agree with that?

15

MS COSSON: Yes, and I'm certainly conscious that we can do more in that regard. We have been very passive, we wait for a complaint or we wait for someone to raise a concern with us that a provider may not be meeting the needs that we can actually supplement. So I've been very aware of that and what we need to do is formalise a practice in the department on how we can better communicate with the veterans about how we can top up or supplement what might be available.

20

MR GRAY: Because, generalising but thinking about this realistically, this is a very vulnerable cohort of people.

25

MS COSSON: Yes.

MR GRAY: They're not young any more. They might have various disabilities. They might even have cognitive impairments, for example. They're not well-placed to identify what they should and shouldn't be paying for by way of allied health care needs in a residential care context, I suggest. Do you agree with that?

30

MS COSSON: So the veterans – I would trust the system to be able to provide them the level of services to which they are eligible in the aged care facility and that goes to allied health, but if they are not at the high end level of care, then we still can provide access to allied health services but also we have had occasions where a provider has said the clinical need for that veteran, they might benefit from more allied health such as psychology services and we can offer prior approval for that.

35

40

MR GRAY: There's also another topic which is appliances.

MS COSSON: Yes.

45

MR GRAY: And there's a matrix to which you referred a short time ago. I believe the matrix in question is the one we have at tab 96.

MS COSSON: Yes.

MR GRAY: Is that the matrix to which you referred? And this indicates that by a tick and a cross at either lower or higher level of what's called ACFI classification which is the level of assessed need in residential care, that a particular appliance is either available or not available to the veteran once they're in the mainstream residential care system; is that right?

MS COSSON: That's correct, yes.

MR GRAY: And it's really quite detailed but, again, you wouldn't expect the veteran necessarily to be able to promote and defend their own interests to make sure they're obtaining from DVA the appliances to which they're entitled. Would you agree with that?

MS COSSON: So some veterans would find that challenging, navigating that particular matrix but that's why I mentioned earlier I'm very grateful for the advocates that are out there and also family members that can help a veteran. Importantly, it's the planning, as I mentioned earlier. Start to plan before you enter so that you know what support and services are available and that's why I like our system, that you can come in through DVA and what we should now be doing is helping you understand as you move through the system what would be available when you enter into the mainstream.

MR GRAY: So we get back to navigation.

MS COSSON: Yes.

MR GRAY: But now we are looking past navigation to advocacy functions, really, aren't we?

MS COSSON: It's a combination. It's a combination of navigating but in our veteran community we've been very fortunate to have volunteer advocates for years, mates looking after mates - - -

MR GRAY: As you say, volunteer advocates.

MS COSSON: Yes, that's correct.

MR GRAY: And family members you referred to.

MS COSSON: That's correct.

MR GRAY: But there isn't a systemic approach taken by DVA to providing navigation and advocacy services; is that right?

MS COSSON: Not at the moment, counsel, but that would be something I believe is where, can I just offer one little – when members transition out of the Australian defence Force, we’ve invested and built a capability to help them navigate their way out because going into – to become a civilian after your military service, some  
5 veterans do find that challenging. I believe we now need to do something similar in the aged care space and potentially put forward an outline of building a capability for a coordinator, a veteran coordinator to help our veterans transition into mainstream. We don’t have that at the moment.

10 MR GRAY: Is there a pilot program?

MS COSSON: Not at the moment, no.

MR GRAY: So is this just an idea that you formed since May 2018 when you took  
15 over the role?

MS COSSON: This is an idea I formed since preparing for my appearance at the Royal Commission, to be honest, counsel.

20 MR GRAY: All right. Have you heard anecdotally about – I’m talking about have you heard in your role as secretary of DVA since last year, have you heard anecdotally of cases of confusion within these mainstream aged care systems about whether a particular veteran was or wasn’t entitled to a DVA-funded appliance or service, or whether the aged care provider had to provide it, or whether the aged care  
25 recipient him or herself had to pay for the relevant appliance or service. Have you heard anecdotal complaints about those matters?

MS COSSON: I have. I have, counsel. I have heard those complaints, yes.

30 MR GRAY: Yes. They’re fairly frequent, aren’t they?

MS COSSON: I – if I can, I look at our complaints system. It hasn’t been the best it can be to actually do that sort of systemic analysis to say, well, what are the emerging issues. So in the last couple of years we have been investing in a new  
35 system to really capture what are the complaints. We are also quite passive again. Where we received a complaint on residential aged care we referred the complainant to the commission. I feel that we now have an opportunity to actually help them capture that complaint with our new system but importantly we actively manage that complaint through the commission to then provide that feedback to the veteran.  
40 That’s what I would like to do with complaints.

MR GRAY: All right. Just on that, the Aged Care Quality and Safety Commission has the role of receiving complaints in relation to mainstream aged care services; correct?

45 MS COSSON: That’s correct.

MR GRAY: What's the extent to which the Aged Care Quality and Safety Commission is earmarking particular complaints as complaints by veterans, do you know?

5 MS COSSON: And my understanding at the moment, counsel, is it's not being captured nor do we have visibility of complaints that are being lodged to the commission. And that's my point before that I would like to actively manage that with the commission so that when we receive our complaint rather than just refer it to the commission, that we are actively managing it with the commission. I think  
10 there's some great opportunity there.

MR GRAY: Have you asked the Quality Commission to start capturing whether a particular complaint is a complaint by a veteran?

15 MS COSSON: No, I haven't.

MR GRAY: Will you do so?

MS COSSON: I will do so. But they are veterans that we know. Those that we  
20 don't know, that's something else that we're trying to introduce through a veteran identifier through the ABS so you actually know who all your veterans are and that would then potentially help the commission capture that information.

MR GRAY: Do you see DVAs role as extending to the promotion of the interests of  
25 veterans in the broader sense, not just those who have registered with DVA?

MS COSSON: Absolutely, and that is a huge effort of outreach. As I mentioned, I wrote to the chief statistician to have a question on the ABS – the 2021 census, "Have you served?", so that we can start to capture who is really out there in our  
30 veteran community but also active social media and promoting that it is easier to enter the DVA systems and to give them greater awareness of we have a department that is actually there to support veterans and families.

MR GRAY: Perhaps this follows from an earlier answer that you gave about your  
35 concept of a veterans' coordinator for the transition into mainstream aged care services, and that's just a recent idea of yours.

MS COSSON: Yes, it is.

40 MR GRAY: Is there anybody doing a gap analysis when a registered eligible DVA client moves into the mainstream services to make sure they're no worse off?

MS COSSON: No, counsel, that's not happening at the moment.

45 MR GRAY: Should it be happening?

MS COSSON: I think it should be. I think we should be doing more and understanding what our veteran experience is in the aged care environment particularly when they have left DVA. The Productivity Commission – that recent report has actually identified that we should be looking at through life, as you pointed out at the beginning of your questions.

MR GRAY: I want to ask you, briefly, some questions about veterans supplement and if you could please bring up tab 64 in relation to veterans supplement in home care. That is another fact sheet of DVA; correct?

MS COSSON: That's correct.

MR GRAY: And veteran supplement, as you outlined in your evidence before lunch, is – in the case of veterans supplement in home care, it's not funded by DVA and it's not administered by DVA. Is that right?

MS COSSON: That's correct.

MR GRAY: It's actually funded by DoH and administered by DoH.

MS COSSON: That's correct.

MR GRAY: In the case of residential care veterans supplement, that's at tab 63 please, operator; that supplement is actual funded by DVA.

MS COSSON: That's correct. The appropriation is from DVA to the Department of Health, that's correct.

MR GRAY: But it's not administered in terms of being paid by DVA. You have an arrangement with DHS by which DHS pays that supplement; is that right?

MS COSSON: That's correct.

MR GRAY: Just looking at this document, with respect to residential care, the figure in question for the last financial year was \$7.08 per day. What's the evidence on which that figure was arrived at, do you know?

MS COSSON: I don't know the history of that to be honest, counsel, on how they arrived at that figure.

MR GRAY: It says in this document that – this is under the heading What is the Veterans Supplement in Residential Care, it says that:

*The supplement is designed to ensure a veteran's mental health condition does not act a barrier to accessing appropriate care and is paid directly to a residential aged care facility on behalf of an eligible veteran.*

Just pausing there for a moment, one of the criteria on which an assessment is made as to whether the supplement is payable is that the veteran must have one of a number of recognised mental health conditions; correct.

5 MS COSSON: Must have a mental health condition that has been accepted as a result of their military service, that's right.

MR GRAY: Thank you. And have you made inquiries to understand whether that \$7.08 last financial year and this year, if it's similar, whether that is adequate to ensure, in the average case, in all cases, or at least in some cases that the veteran's mental condition doesn't act as the relevant barrier?

MS COSSON: I have not made any inquiries about the effectiveness of that supplement, no.

15 MR GRAY: All right. That supplement is paid into the general revenue of the approved provider for the approved provider to use as it wishes; correct?

MS COSSON: I'm not too sure how the Department of Health administers it, but I am aware that the supplement isn't paid to the veteran; it's actually paid to the provider who is providing the care to the veteran.

MR GRAY: All right. And do you know of any sort of safeguards or any sort of onus on the approved provider to actually spend that on - - -

25 MS COSSON: No I'm not aware, counsel.

MR GRAY: - - - removing barriers to care for the particular veteran?

30 MS COSSON: No, I'm not aware.

MR GRAY: Commissioners, those are my questions for Ms Cosson.

COMMISSIONER PAGONE: Yes, thank you, Ms Cosson. You may go.

35 MS COSSON: Thank you.

40 <THE WITNESS WITHDREW [3.04 pm]

COMMISSIONER PAGONE: Mr Gray, who is next? We have got a five minute adjournment for the video conference; is that right?

45 MR GRAY: To set up the video link I believe, Commissioner, yes.

COMMISSIONER PAGONE: All right.

MR GRAY: Thank you.

COMMISSIONER PAGONE: We'll adjourn for five minutes.

5

**ADJOURNED**

**[3.05 pm]**

10

**RESUMED**

**[3.16 pm]**

MS HUTCHINS: Commissioners, I call the next witness, Janette McGuire.

COMMISSIONER PAGONE: Yes, thank you.

15

MS HUTCHINS: Ms McGuire is attending via video link and I understand that she's being sworn in by someone who is present with her there; is that correct? Yes.

20

**<JANETTE McGUIRE, SWORN**

**[3.16 pm]**

**<EXAMINATION BY MS HUTCHINS**

25

COMMISSIONER PAGONE: Yes, thank you.

MS HUTCHINS: Ms McGuire, you have prepared a witness statement for the Royal Commission

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MS McGUIRE: Yes, I have.

MS HUTCHINS: And do you have a copy of that there before you?

35

MS McGUIRE: Yes, I do.

MS HUTCHINS: Thank you. For the transcript, it's document WIT.0445.0001.0001. Have you had the opportunity to read through your statement ahead of today?

40

MS McGUIRE: Yes, I have.

MS HUTCHINS: Are the contents of the statement true and correct to the best of your knowledge and belief?

45

MS McGUIRE: Yes, it is.

MS HUTCHINS: I tender the statement of Ms Janette Maguire dated 29 September 2019.

COMMISSIONER PAGONE: Yes, that will be exhibit 10-14.

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**EXHIBIT #10-14 STATEMENT OF MS JANETTE MAGUIRE DATED  
29/09/2019 (WIT.0527.0001.0001)**

10

MS HUTCHINS: Thank you. Ms McGuire, in your own time, please read from the statement you've prepared.

MS McGUIRE:

15

*My name is Janette McGuire. I am 74 years old. I live in a suburb of Sydney's inner west. I am a Forgotten Australian. Before I retired I worked in various domestic roles, cleaning houses and at one point I also worked as a cleaner at a nursing home.*

20

*For a few years I delivered Meals on Wheels. I didn't receive a proper education. My Mum went missing when I was 14. It was a cold case. She never returned. In 1960 I was taken from my home in Lismore and moved into a State-controlled child welfare institution in New South Wales. I lived at the home until I was 18. While I was there I was subjected to physical labour. I was made to scrub the floors with a toothbrush at all hours of the night. I was put into isolation cells. I was belted, kicked and punched. If I talked when I was not supposed to, I was made to stand for long periods of time at the end of my bed at night.*

25

30

*I went to school inside the home. It wasn't a normal school. It was a terrible, pretty rough school, actually. Girls would throw things at teachers. I feel like I did not learn much. At the end of 1961 they put me into another institution. It was a place where they sent girls to break their spirit. We would be disciplined and punished. After I had run out of the home, I had a nervous breakdown. I was admitted to a psychiatric centre. I remembered thinking at the time, "Here I am back in another institution". It was not a nice place. I suffer from post-traumatic stress disorder. I also have a terrible reflex reaction to situations that I find stressful. For example, if someone comes too close to me in a shopping centre, I jump through the roof. It's horrible and embarrassing.*

35

40

*I have arthritis all through my body; it causes me a lot of pain. My arthritis requires me to have operations all the time. I also have plates in my shoulders, to my knees and feet. Medical professionals have told me that my health issues were related to the trauma and physical labour I experienced in the home.*

45

5 I am making this statement to the Royal Commission as a member of the  
community of Forgotten Australians. I feel that the issues faced by Forgotten  
Australians need to be better understood by the public and the government.  
About 10 years ago, I started going to Wattle Place. Wattle Place provides  
support services specifically for Forgotten Australians. It also supports people  
who have experienced institutions or out of home care as children. People  
from the Stolen Generations, former child migrants who were placed in  
institutional or out of home care and people seeking support with  
understanding the National Redress Scheme.

10 At Wattle Place, I run a women's peer support group that meets monthly. I am  
in a consultative group that talks about how to improve Wattle Place and I also  
attend activities like art classes and gardening. I like to be involved in helping  
others. A booklet has been prepared about Forgotten Australians and Wattle  
Place which I was involved in co-authoring.

15 As mentioned above, I am part of and facilitate a women's group at Wattle  
Place. We meet on the last Thursday of every month. The group includes over  
a dozen women from different backgrounds and with varied experiences in  
institutions. Our shared experience of being in institutional care helps us to  
understand and support one another.

20 In the group we discuss all sorts of things. One of the topics we discuss is our  
fear of going into an aged care facility. It terrifies us. We are all elderly now  
and some of us are starting to stockpile pills. We are really scared of being re-  
traumatised. We are scared of going back into an institution and having  
experiences similar to when we were younger. In my experience with an aged  
care facility you are not in control. You are told what to do all the time. It is  
just like when Forgotten Australians were being told what to do in institutions  
as children.

25 We are scared of being treated and having all the painful memories from our  
childhood come back to us. We are trying to move on with our lives, but we  
can go backwards so quickly when we are triggered. Being triggered takes us  
back to feeling powerless like we did when we were young. The strict routine,  
being told what to do all the time, being talked down to; it all just takes you  
back to having no control over your life. We panic and feel helpless.

30 If I had to go into residential aged care, I would prefer to be surrounded by  
other Forgotten Australians. I would need that peer support and shared  
experience to feel comfortable.

35 We don't have counsellors in the women's group. Some of the women in the  
group have told me that they would prefer to talk amongst ourselves rather  
than a counsellor. I can relate to them. It is helpful talking with someone who  
has gone through the same thing.

5        *In 2017 I had an operation on my foot at Concord hospital. My leg was in plaster and I couldn't walk. My house has 15 steps so I couldn't go home after the surgery. The social worker from the hospital tried to keep me at the hospital for as long as she could. The other option was an aged care ward where patients were transferred after their stay at the hospital. My counsellor from Wattle Place had explained to the hospital that I didn't want to go into aged care.*

10       *After two weeks, I was sent to the short-term aged care facility. It was dreadful. I was only in the facility for about two weeks and I couldn't believe the things I saw. I outline my reflections about the experience below.*

15       *I was taken to the facility in the late afternoon. It felt like I was back at the home and I'd lost all control. I was panic stricken. I was hostile before I went in the door. I knew where I was going and I went in there swinging. I was angry. They put me in the back of an ambulance, and I am claustrophobic. I am claustrophobic because at the home we were put in cells I also experience flashbacks. Being put in the ambulance gave me flash backs of being back at the home. It was terrible. I knew they were taking me to a facility and I didn't want to go there. I was scared that if I went into the facility that I was never going to come out.*

25       *When I arrived, I observed that at 73 I was one of the youngest people in there. I often heard people crying in the facility.*

30       *On certain shifts at the facility, all the staff were male. This meant that sometimes there was no choice but to be showered or toileted by male staff. I didn't like being taken to the shower or toilet by male staff. Being left alone with male staff made me feel uncomfortable and unsafe. It was important to me that there was female staff but it didn't always happen that way. I think this would be even worse for people who, as children, were subjected to abuse by male staff in out-of-home care.*

35       *A lot of Forgotten Australians were sexually abused in homes. To me, there is nothing worse than been showered by a male. The male Forgotten Australians I speak to, they feel the same way. They don't want to be showered by male staff either. They were often abused by male paedophiles at institutions. Staff at aged care facilities should be better educated to be aware that this is an issue. Facilities should put systems in place to make sure we can be made to feel as comfortable as possible when staff are assisting with such intimate tasks.*

45       *At the facility, staff were constantly telling me what to do. There was a daily routine that felt regimented. This triggered my feelings of being back in an institution again. It reminded me of when I was 14. Even now, years later, I am still triggered by things like being told when the lights need to go out.*

Staff also told me I was not allowed to lay on my bed in the afternoon. I was left just sitting in a chair. I said to the other patients, "Of course we can lay down for an hour or two; who can stop us." No one ever did stop us.

5 I also felt like the staff at the facility treated me like a child. Staff would pat me on the head and say things to me like "poor dear". I thought I was being treated like a five-year-old. The facility would have silly games like bingo and things. Some people might have liked it, but it wasn't right for me. It was patronising. We are people with minds and brains. I tried to get used to the way I was treated at the facility. I don't think I could ever get used to it.

10 While I was at the facility, I experienced and witnessed a lack of dignity, privacy and respect. For example, on several occasions, the social worker based at the facility came up to my bed and talked loudly about my personal business in front of other patients and their visitors. People could hear what the social worker was saying. I felt this was a breach of my privacy and my dignity.

15 On another occasion in the middle of the night, I witnessed a lady in the bed beside me repeatedly ask staff to go to the toilet. At one point I heard a staff member say to her, "Why do you need to go to the toilet all the time?" The staff member spoke to her abruptly. She started crying. It was sad to see.

20 On another occasion, the same lady soiled herself while sitting in a chair. After about half an hour a staff member came out and put her in clean clothing. I then saw the staff member throw the lady's soiled clothes into her wardrobe and leave them there. They were not even in a plastic bag. The smell was terrible. The clothes were left in the wardrobe for two days. Family members of the lady beside me in the room eventually took the clothes home and washed them.

25 Sometimes I would wake up during the night and find a lady from the ward standing over my bed. I think she was an alcoholic. The lady would really frighten me and the other residents. I would tell her to go away and leave me alone. It reminded me of being back in the home. At the home, I was occasionally woken up at night to find someone standing over our bed. It was traumatic. I don't think they should have those sorts of people in the same ward as frail older people.

30 I had difficulty communicating with staff at the facility. For example, one night I needed to go to the toilet. I was not able to walk. I asked the nurse for a bed pan. The nurse responded to me, "You can't have a Panadol". After the fourth time that I repeated that I needed a bed pan, she finally understood what I needed and brought me a bed pan. Another example that illustrates the language barrier relates to my ability to get out of my bed. I had a sign above my bed saying that I needed assistance for daily tasks including getting out of bed. I was under strict instructions from the surgeon not to put any weight on

*my foot. Despite this, nursing staff would come to my bed and order me to get up. I tried to communicate to the staff that my leg was in plaster and I could not weight bear but they didn't understand me.*

5 *I had another problem where staff didn't communicate with each other. I have taken the same medication for many years and know what I need. At one point, I told one of the nurses that I needed my medication. She argued with me and refused to give me the medication I was supposed to take. Another nurse had to intervene and tell her I was right and could have the medication I needed.*

10 *The food served at the facility was almost inedible. It was disgraceful. Another patient helped me to somehow access a better standard of meals. I am not sure how this came about but it was not available to everyone. I think it might have been someone's food who was on a special diet with a heart condition. The*  
15 *food I was able to get through the resident had more variety. The normal hospital food was the same every day. The food reminded me of being back in the home.*

20 *It took me a long time to recover from my experience in that facility. I felt that it triggered memories from when I was in the home. I didn't want to stay in there any longer. After two weeks, I was taken by ambulance to get the plaster off my leg. And I rang up the people I knew, had someone come and get me the next morning. I wasn't staying in the facility one minute longer than I had to. When I left the facility, I felt like I was free. I have recently been told that I*  
25 *need further surgery but I don't want to go back. My experience has terrified me*

30 *I don't think there is enough understanding in the community about Forgotten Australians. People don't know anything about who we are and what we have gone through. People need to know about the violence we suffered. The lack of education. The lack of community and government support throughout our lives that have followed our horrific experiences in institutions. It needs to be brought to people's attention.*

35 *The government and aged care sector needs to be educated about the needs of Forgotten Australians. We need them to understand who we are, what we have been through and how they can help us. Forgotten Australians don't want much. We just want the government and the community to understand the trauma we suffered as children. This will inform people's ability to care for us*  
40 *when we again enter into a vulnerable time of our lives in old age. We continue to try to move on with our lives. But being a Forgotten Australian means the trauma is always with you. As we get older, our fears become worse. We are becoming more and more terrified of entering aged care.*

45 *The community needs to understand that Forgotten Australians have triggers that make us different to the normal person. Educating people that we were abused as children helps them understand this. We may act differently to*

5 people without a similar history of trauma. For example, many Forgotten Australians have issues towards people in authority. Understanding the cause of this attitude is important. My first preference is to never go into a residential aged care facility. Providing more aged care support for Forgotten Australians in their homes would avoid the distress and re-traumatisation of being re-institutionalised.

10 If any Forgotten Australians have to go into a residential aged care facility, it is hugely important that we have access to appropriate counsellors or support groups. When I was at the aged care facility, I had a counsellor from Wattle Place call me every two days. It made such a difference. It would have been a big help if the counsellors at the aged care facility were aware of Forgotten Australians. The social worker at the aged care facility had no understanding of what I needed or how to help me. Having someone to talk to that  
15 understands you can make such a difference.

20 Access to counselling and support is also important for Forgotten Australians outside of facilities. I have always said to people that we, as Forgotten Australians, need to move on with our lives. But when I went into the facility, I realised that I had not got over what I thought I had. I am lucky I have a good counsellor at Wattle Place. I have known her for 15 years and she rings me every few days. This support is helping me manage the impact the stay at the facility has had on me.

25 Forgotten Australians should be identified on paperwork. Being identified allows people to understand someone is a Forgotten Australian and has unique needs. It would help the government departments understand why we react to things in a certain way. The government ran the institutions we were put in. As young kids, we were belted, thrown into cells and traumatised. So the  
30 trauma we have suffered as children is always there. If they hadn't treated us so poorly, we would not be here now, dealing with our trauma. Now that we are older, the government has an obligation to help Forgotten Australians with the support and recognition we need.

35 When Forgotten Australians first started coming out in the press, we were promised action. The government said there would be nursing homes for Forgotten Australians. We were promised that staff in aged care would be trained and educated to understand our unique needs. In 2009, the Australian Government made a national apology to Forgotten Australians. The apology  
40 acknowledged that the way we were treated was unacceptable and wrong and has been the cause of a range of complex issues affecting us for the rest of our lives. We were promised recognition and support. But nothing has happened in that ten years. Nothing. Instead of talking, holding meetings or ministers making more promises, we want to see real action.

45

Thank you.

COMMISSIONER PAGONE: Ms Hutchins.

MS HUTCHINS: Thank you, Ms McGuire. There's no questions from counsel for this witness.

5

COMMISSIONER BRIGGS: No. I just have – I wish to say thank you for that, Ms McGuire. I read your witness statement, which you have now relayed, and I couldn't imagine what you've been through. And the fact that you rewrote it. You came in here and you told us about it, and what you think the people who work in residential aged care need to be aware of to deal with people who have been through the traumas that you have. It's very helpful to us and to hear your views more generally. So thank you very much. We really appreciate your contribution today.

10

MS MCGUIRE: Thank you, Commissioner.

15

COMMISSIONER PAGONE: Yes. Ms McGuire, I want to echo those thoughts as well. It was a very useful and important witness statement and you read it out with much courage. I thank you for doing that.

20

MS MCGUIRE: Thank you, Commissioner.

COMMISSIONER PAGONE: Well, at this stage, Ms McGuire, I would ordinarily say that you are excused and can go, but I think what we do is just turn off the television. Thank you.

25

**<THE WITNESS WITHDREW**

**[3.37 pm]**

30

MS HUTCHINS: Thank you. Mr Gray will announce the next witness.

COMMISSIONER PAGONE: Back to you, Mr Gray.

35

MR GRAY: Thank you. I call Dr Duncan McKellar. Just while Dr McKellar's coming into the witness box, can I mention that five documents have been added to the tender bundle, tabs 128 through to 132. And could I apply for an amendment to the tender bundle, by way of tendering those five documents? The Quality of Care Principles, the RSL submission, factsheet H5VO5; those three documents were mentioned in the previous examination. And, in addition, a regularly impact statement that will be referred to tomorrow. And, finally, at tab 132, a document prepared by DVA, relevant to Ms Cosson's evidence.

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COMMISSIONER PAGONE: Mr Gray, I'm sure that can be done. For my benefit, it would be desirable to see a version of the tender bundle in a form that I could actually look at. But subject to that, of course, you can amend the tender bundle accordingly.

45

MR GRAY: Thank you. If they could be taken as tendered now, we will arrange - - -

COMMISSIONER PAGONE: Subject to your promise.

5

MR GRAY: - - - for the relevant hard copy to be provided.

COMMISSIONER PAGONE: Yes. Thank you.

10 MR GRAY: Thank you, Commissioner.

**<DUNCAN STUART McKELLAR, AFFIRMED**

**[3.38 pm]**

15

**<EXAMINATION BY MR GRAY**

COMMISSIONER PAGONE: Dr McKellar, do feel free to sit down and make yourself comfortable.

20

DR D.S. McKELLAR: Thank you.

COMMISSIONER PAGONE: Mr Gray.

25

MR GRAY: Thank you, Commissioner. Dr McKellar, thank you very much for preparing a statement for the Royal Commission. That statement is dated 3 October 2019. I'll ask that it be displayed on the screen before you. It has the code WIT.0530.001.0001. Do you see a copy of the front page of your statement there?

30

DR McKELLAR: Yes. I do.

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

35 DR McKELLAR: No. I don't.

MR GRAY: To the best of your knowledge and belief, are the contents of the statement true and correct? And the opinions in it are opinion which you truly hold?

40 DR McKELLAR: Yes. They are.

MR GRAY: Thank you. I tender the statement.

COMMISSIONER PAGONE: Yes. The statement of Dr McKellar, dated 3 October 2019, will be exhibit 10-15.

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**EXHIBIT #10-15 WITNESS STATEMENT OF DUNCAN STUART  
MCKELLAR DATED 03/10/2019 (WIT.0530.001.0001)**

5 MR GRAY: Thank you, Commissioner. In addition to preparing the statement, Dr  
McKellar, you've arranged for the collation of a bundle of documents, some of  
which are referred to in the statement, some of which are new, but they relate to your  
evidence more generally. There are 14 such documents and they appear in an index  
10 that bundle of 14 documents compendiously as a single exhibit?

COMMISSIONER PAGONE: So you want the bundle – you want this piece of  
paper, in effect, as a separate exhibit?

15 MR GRAY: As the cover sheet of the exhibits that are on the system and to which  
I'll take Dr McKellar through the course of the examination.

COMMISSIONER PAGONE: Yes. But you want the list of these documents  
separately identified as an exhibit?

20

MR GRAY: As part of – if this sheet could become exhibit 10-16, representing,  
also, all of the documents which are held on the database, which are listed therein.

COMMISSIONER PAGONE: And does that mean that some of those documents  
25 exist as part of other exhibits?

MR GRAY: No. They don't.

COMMISSIONER PAGONE: All right.

30

MR GRAY: Not to the best of my knowledge, Commissioner.

COMMISSIONER PAGONE: All right. So the list of the bundle of documents –  
or, rather, the document headed Bundle of Documents – Dr Duncan McKellar,  
35 together with each of the documents referred to in the list, you want as exhibit 10-  
16?

MR GRAY: Yes, please, Commissioner.

40 COMMISSIONER PAGONE: All right. Well, that'll happen.

**EXHIBIT #10-16 BUNDLE OF DOCUMENTS – DR DUNCAN MCKELLAR  
AND 14 DOCUMENTS REFERRED TO IN LIST**

45

MR GRAY: Thank you, Commissioner. Dr McKellar, you're the head of unit of the Older Persons Mental Health Service, the OPMHS, in the Northern Adelaide Local Health Network in South Australia?

5 DR McKELLAR: That's correct. Yes.

MR GRAY: You've held that position for about two and a half years?

DR McKELLAR: Yes. Correct.

10

MR GRAY: You're a psychogeriatrician and a psychiatrist of older age?

DR McKELLAR: Yes. Correct.

15 MR GRAY: You've got extensive experience in psychiatry and you have a particular interest in the psychiatry of older-aged people?

DR McKELLAR: That's correct.

20 MR GRAY: You also have interest and expertise in trauma-related care; is that so?

DR McKELLAR: Inasmuch as I'm a psychiatrist and I deal with people who have high prevalence of trauma in their previous experience.

25 MR GRAY: In 2017, you were a member of the Oakden review panel, led by the South Australian chief psychiatrist, Dr Aaron Groves; correct?

DR McKELLAR: That's correct.

30 MR GRAY: You helped author the report with the chief psychiatrist, I understand; is that right?

DR McKELLAR: Yes. That's correct.

35 MR GRAY: What went wrong at Oakden? I won't ask for a compendious description, but in terms of the key organisational failings that drove the terrible outcomes at Oakden, what do you identify as the principal causes of what occurred?

40 DR McKELLAR: So I think, if we were to sum it up to just a couple of issues, I would have to say that governance was one of the key failings. And I would suggest that it was a failure of corporate governance and clinical governance. And, you know, that's been unpacked in other forums. But the other aspect that I think that's really critical to understand – that it was also a cultural failing; that there was – as a complex consequence of the failings in other sectors, there was, over time, a  
45 deterioration in the care which – and the culture of the organisation and, therefore, of the people that worked within it. And we certainly identified that in the Oakden report and spoke about that. And in reflecting – now that I've worked through that,

the – sort of, the reform process for the last two and a half years, for me, that’s, really, at the core of what went wrong. And it was contributed to by all of those things, like governance and resourcing and training and investment. But when it came down to it, it was a – it’s a work of culture.

5

MR GRAY: I’m going to be asking you, in some detail, how you’ve approached the task of transformation over that two and a half years since you’ve been appointed as head of unit. In a nutshell, as you advert to in your statement, you’ve approached the organisational transfer through a co-design model; is that right?

10

DR McKELLAR: Correct yes.

MR GRAY: What’s co-design?

15 DR McKELLAR: So – well, co-design in simple terms is actually collaborating and partnering with the people that service design actually impacts. At the heart, it’s actually bringing the people who will use that service in as equal partners into the process of actually dreaming and designing a service, and it’s applicable across any kind of domain.

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MR GRAY: Thank you. You’ve also – and this is at page 4 of your statement, paragraph 14 – you’ve adverted to an article authored by yourself together with a co-author in relation to trauma-informed care forming part of a broader culture change within aged care. At the foot of that paragraph, you refer to the article

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parenthetically as McKellar and Hanson 2019.

DR McKELLAR: Yes.

30 MR GRAY: I will come to the detail of this later in your examination, but, in broad compass, how has the team you’ve built approached transformation of the workforce and the organisation at the former Oakden campus, now Northgate House, into the kind of organisation you describe here, compassionate, person-centred, supported by priorities of developing a values-based workforce?

35 DR McKELLAR: Well it’s a big piece of work, and, look, I would acknowledge that it’s an ongoing piece of work. So this is something that we are engaged in and that we have made tremendous progress in, but we are far from the end of this particular journey. The key thing at the beginning of this was, in actual fact having – it was the design of the framework, that was really critical to our moving forward,

40

and that’s where the co-design process was so relevant. And the idea of being trauma-informed is embedded all the way through this.

45 So the central guiding philosophy and goal of the culture – the co-design culture framework is compassionate, relationship-centred care which is all about acknowledging putting the person at the centre of care and the matrix of relationship that they bring with them. And you can’t – so, in essence, being trauma-informed is all about understanding who that person is, what their experience and story is. And

that's the guiding sort of light of what we're seeking to do. The culture framework which – and the co-design process that helped us develop that has been the blueprint for everything that we've done since. And so, you know, I suppose as we unpack the nitty-gritty of what does that really look like, it starts to make more sense, but the  
5 framework is the foundation.

And so in terms of my leadership of this process, I'm continuously asking myself how does what we do today in terms of delivering care, in terms of working as an organisation, working with our staff, how does this relate to this framework? Where  
10 are we sitting within this framework, and how are we moving to be a better version of ourselves as we fulfil this?

MR GRAY: Thank you. I will ask the operator to put up tab 6 from the new exhibit, exhibit 10-16. Is that – are you able to - - -  
15

DR McKELLAR: Yes.

MR GRAY: - - - view that? Yes.

20 DR McKELLAR: Yes.

MR GRAY: Is that a pictorial representation of the cultural framework that you just mentioned?

25 DR McKELLAR: Yes, correct. Yes, it is.

MR GRAY: And how was this developed?

DR McKELLAR: So after the Oakden report, the South Australian Department of  
30 Health and Wellbeing established an oversight committee which had an independent chair and included broad stakeholder and – representation. So there was all of the SA Health – local health networks had representation, but, more importantly, there was broad representation from community and advocacy groups, so representation, for instance, from the Aged Rights Advocacy Service, from COTA, from a number  
35 of peak body organisations, representatives from the Health Consumers Alliance, from the Community Visitors Scheme, all formed an oversight committee for the work that needed to be done within South Australia after the publication of the Oakden report.

40 And then sitting under that, under that committee were six stakeholder working groups, one for each of the six recommendations that were made in the Oakden report. I was privileged to be able to chair three of those, and to also then sit on the other three as a member as well. So I was very involved in the whole piece of work.

45 I was a member of the Culture Reform Stakeholder Working Group, and that was chaired by Jackie Hanson, who was then CEO of the Northern Adelaide Local Health Network, and that group had representation again from a broad range of

clinicians and representatives from local health networks, from different disciplines, from advocacy organisations and, very importantly, from people with genuine lived experience, so people who had lived through the Oakden campus, who had lived through other experiences of aged care and mental health service delivery.

5 Importantly, Barbara Spriggs who was, you know, really, the leading whistleblower around the Oakden situation, was a key member of that group.

MR GRAY: Thank you. So are the Commissioners to understand that the key elements of this framework were a product of the collaboration - - -

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DR McKELLAR: Absolutely.

MR GRAY: - - - of all the people you've mentioned, including, very importantly, the people who had been involved - - -

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DR McKELLAR: Yes.

MR GRAY: - - - and exposed to the - - -

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DR McKELLAR: Yes.

MR GRAY: - - - prior practices at Oakden?

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DR McKELLAR: Yes. So to explain the process that we went through, the group met very regularly, quite intensively over a period of six months. We started with literature review. There were regular meetings where the group came together and worked very collaboratively. We did have an organisational culture change consultant that came and worked with the group, so to bring some independence and to make sure there was sort of a sense of evenness and not hierarchy within the

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And we then went to the community with a number of stakeholder engagement programs, a gallery walk, focus groups, collected themes, brought those back together, then worked together around unpacking those things, working out what are the most commonly occurring ideas that emerge out of this data from the community stakeholder engagement. And then there was, you know, sort of a whole conversation that occurred around that, and that's how that then eventually coalesced into these priority areas. And so the heart of – the thing that kept coming up was – so similar to the kinds of stories that I think are emerging through the Royal Commission, is that people want to be treated with dignity, with respect. They want to encounter care services that are compassionate, that are truly kind, that have a sense of shared humanity and decency. And that was – so that was the central thought.

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As well the thing that came out of that engagement was this idea that the person has to be at the centre of care. So you can see on that diagram there's this idea that emerged – one, from the literature but also from the conversation around that process

of co-design, of the triangle of care, where the older person in our case is at the front and centre and top of that triangle, but you cannot separate that person from their family, from their carers, from the important people in their community. But nor either can you actually then separate them out from the staff, which is both clinical  
5 and non-clinical staff who are going to be engaging with the delivery of their care.

And so what we – what emerged out of that conversation is that people want compassionate relationship or person and family-centred care that puts that person first. And then the ideas that emerged then that will support that are these four  
10 priority areas. If we actually give proper attention and due diligence to these four priorities, then we might be more confident that we will actually deliver the kind of compassionate relationship-centred care that we aspire to. And, of course, you know, you can see them there on that diagram, the idea of priority 1 of developing a values-based workforce, where it's not just skills and expertise but it's actually the  
15 heart of the person that is essential in actually developing the kind of fit-for-purpose workforce that will deliver the kinds of services that we expect older Australians to be able to receive. Of course, we can't do that, however, without cultivating safety, which is priority number 2, and that really works – speaks to a rethinking of how we actually deliver our workforce and our workplaces.

20 By definition, psychological safety is a shared belief that the workplace is safe for interpersonal risk-taking, and that means that we need workplaces where it's actually safe and easy to speak up if you see something that's not acceptable. One of the big lessons that happened at Oakden was that there were many people who knew there  
25 were many things wrong, but there was no psychological safety where people could make those things known, they could speak up. People could struggle to speak up about their own care, or families struggle to be heard. So psychological safety is about everybody, every stakeholder being able to actually know that it's safe to make a mistake and learner from it, that it's safe to be clear or speak up about something  
30 that's going wrong in the environment. And then the third priority, facilitating excellence in care - - -

COMMISSIONER BRIGGS: Dr McKellar, could you pause you there - - -

35 DR McKELLAR: Certainly.

COMMISSIONER BRIGGS: - - - because it's very hard to keep up.

40 DR McKELLAR: Sorry, I get excited about this stuff.

COMMISSIONER BRIGGS: I can tell that, and I'm very happy to hear it. For the benefit of the Royal Commission, understanding a little more about what a values-based workforce means is pretty important. You take culture to the heart. What does that mean in practice? How does a values-based workforce differ from any other  
45 workforce?

DR McKELLAR: So there's so much I could say here, Commissioner, and I'm mindful that I need to try and get to the heart of this issue.

COMMISSIONER BRIGGS: Yes.

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DR McKELLAR: Look, in very simple terms, when I think about the kind of service that I want to work in and the kind of team that I want to be part of – so I'm a psychogeriatrician. My purpose is to work with older people, and that's very important to me as a human being. So then when I think about who are the people that I want to work alongside, they're people who share that same passion, who are absolutely committed to principles of respect and dignity, to deliberately and intentionally being committed to deinstitutionalising things wherever we can, to removing barriers to care, to – instead of saying, "No, we can't do that", to thinking about, "Well, what can we do?", to removing power imbalances.

15

So as soon as you go into any healthcare setting, we're fraught with sort of built in, institutionalised power imbalances, and I think that building a values-based workforce is going to bring passion and care and commitment and humanity back in as a core recruitment element. And a principal thing that we're seeking to build within a workforce, people who are committed to removing those sorts of power imbalances that happen between doctors or nurses or clinicians and people who receive care. And that needs to be organisationally embraced then as well. It needs to go across whole organisations and it needs to go from the CEO through to the people that are managing hotel services or cleaning or delivering food or whatever. It should be part of the whole package.

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COMMISSIONER BRIGGS: Okay. Thank you.

MR GRAY: Could I just take that further, and then we will address the other quadrants of the framework.

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COMMISSIONER PAGONE: Well, just before you do - - -

MR GRAY: I'm sorry, Commissioner.

35

COMMISSIONER PAGONE: - - - can I just ask whether it's a term of art that has an established meaning somewhere that you're picking up, or is it a generalised description that you're using that we seem to need to try and unpick?

DR McKELLAR: Commissioner, do you mean in terms of values-based workforce?

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COMMISSIONER PAGONE: Yes.

DR McKELLAR: So, look, I would make reference to the very important report of QC Robert Francis relating to the Mid Staffordshire NHS Trust in the UK, so published in, I think, 2013. So one of the – I mean, a very substantial piece of work from a UK health service that had gone very, very wrong. Remarkably, when we

45

were doing the Oakden report, we came across a lot of similarities with that, and, really, emerging out of his work there's a whole body of literature emerging around values-based workforce, values-based recruitment, a lot of – some research emerging from the UK. So, look, I think it is an art and it's something of the art, but it is all  
5 something that there's a body of evidence around.

COMMISSIONER PAGONE: I was using the expression “a term of art” as a term of art in the sense that lawyers use the word “term of art”. In other words, is it an expression which has come to have a particular meaning within the industry?  
10 Because the question that Commissioner Briggs asked was, “Well, in a sense, every workforce should be described as having that kind of approach. How do we distinguish what every workforce should have from what the workforce you envisage should have?” If there is a particular meaning that is now sort of, as it were, gaining traction within the industry, it's useful to know what it is. But if not, then I  
15 understand that, and that's a sensible answer too. That's all I meant.

DR McKELLAR: Sure. So, Commissioner, I think, really, there is a body of literature that can unpack the meaning of that terminology further.

20 MR GRAY: Thank you.

COMMISSIONER PAGONE: Sorry, Mr Gray.

MR GRAY: Not at all, Commissioner. Thank you.  
25

In that regard, could I ask the operator to bring up tab 108, which is your article with Ms Hanson, Co-design Framework for Organisational Culture Reform. And on the third page, in the middle of the left column, there's – after an introduction referring to the Mid Staffordshire NHS Foundation Trust Public Inquiry, you identify some of  
30 the sources. Perhaps if you could please call out the middle paragraph on the left column, operator. You've given references to some of the sources on values-based recruitment and you also supplied the Royal Commission in your bundle of documents with some of the recruiting materials. For example, at tab 13, you've given the Royal Commission the interview template for recruitment, thank you, Dr  
35 McKellar.

DR McKELLAR: Yes.

MR GRAY: If we go in that document to the second page, there's an introduction describing what the organisational transformation underway looks like. And there's  
40 references to the importance of a developing or growth approach. In the context of the documents you provided to the Royal Commission when you refer to the organisational transformation as involving growth, or a growth approach, what does that mean?  
45

DR McKELLAR: Okay. So what we're undertaking is a project, is a piece of work around cultural transformation and change. So it's very holistic. It's very complete.

So in terms of our culture framework, I said before that every day we are sort of thinking about how are we actually going to operationalise this, how do we implement all of these things. So one of the things that we have done – and it is referred to in the article published in Australian Health Review is adopted some of the principles and practices that were initially described by Kegan and Lahey in the Deliberately Developmental Organisation book: An Everyone Culture.

We undertook a very focused project around what would it look like if we started doing things within our service that are a bit countercultural in a typical public health setting context. And so in terms of talking about a growth culture, that really refers to that work. What's very important for us is that when we bring someone new into our team, we want to make sure that we are bringing somebody in who is comfortable with the way that we're working. So there is – within this way of working, there are some things that can be quite demanding and potentially even confronting for staff members in that there is a degree of accountability that sits within this way of working. There's a degree of vulnerability, an ability to actually, you know, be honest about the whole self, bringing the whole self to work. So in fact this interview starts with that process.

We have a practice called the check-in which we started using in clinical handover times between shifts and so on, where our staff, the first thing they do when they come to work is acknowledge who they are. And they acknowledge what's on top of their mind. So as they come into their clinical handover, before that clinical data around what's happening in the shift is handed over, there's a moment to talk about themselves and to talk about what's happening in their lives. And what we have found is that that's very humanising of the workforce. It starts to level people out because we realise it actually doesn't matter what your position is; actually, everybody is the same.

I guess the science or the art or the theory behind this is that if we actually start working like that as a team what that will do in the end in terms of a cultural transformation, it will actually translate over into people recognising that just as everyone around this group here has a story, the people that we are also providing care for actually they also have a story and, in fact, they could be us and we could be them. So that's the idea of what we're trying to achieve. And then in terms of the recruitment – so that's what I'm referring to there is a kind of deliberately intentionally developed culture that acknowledges those kinds of things at the essence of how we work together and what we do. We're looking in this values-based recruitment approach for people who seem to be able to go there and fit there comfortably with that kind of approach.

MR GRAY: Thank you. You've referred in this recruitment, in these recruitment templates on, for example, the third page, to a number of attributes that the recruiters are considering when the applicant for a job identifies their strengths and skills. Sorry, page 0007. And they include client-focused respectful behaviour, honesty and integrity, passion, empathy; are these are amongst the values that the organisation is looking for?

DR McKELLAR: Absolutely.

MR GRAY: And you've referred to the vision statement of the organisation because the organisation, I suppose, must have its own values; is that right? The  
5 mission statement is referred to on page 8, the next page.

DR McKELLAR: Yes.

MR GRAY: And there's a snapshot of what that vision statement is:  
10

*In our service we deliver exceptional, innovative and compassionate person and family-centred care through teamwork where everyone matters, everyone contributes and everyone grows.*

15 Is that expression "everyone grows", is that intended to correspond to the developmental approach that you mentioned earlier in your evidence?

DR McKELLAR: Yes. Correct, yes.

20 MR GRAY: How does trauma fit into this framework?

DR McKELLAR: So the importance – it's really important when thinking about a trauma-informed approach to care, to recognise that actually trauma fits everywhere. And that's the importance of trauma-informed care. Trauma-informed care is not  
25 something that we apply to some groups within the population. It's not something we do to people but it's actually, it's an approach to care and it's also part of a framework to service design and delivery that actually informs everything that we do and sits embedded within everything else. So it's one of those core threads that – it's like person-centredness. If we want to use that more commonly used language that  
30 sort of encompasses the whole approach to care.

But trauma-informed care should actually be a thread and a theme that runs all the way through that. What we are trying to achieve in our service is a truly person-centred approach to care that will include, intrinsically within it, an understanding  
35 that everyone has a story and that at least 50 per cent, you know, depending on the measures you use, up to 75 per cent, in some references up to 90 per cent of people will, in actual fact have some kind of trauma theme that they will have encountered within their life story. So what we are trying to achieve is a service where we have that universal precaution of trauma-informed approach that means we won't re-traumatise anyone, that we will be ready to provide dignified respectful care to all.  
40

In 2017 the Mental Health Coordinating Council from New South Wales published a document and made the really important statement that trauma is expected. It's not the exception. And that's really important because we need to understand the high  
45 prevalence of trauma experiences within our community and realise that, therefore, it is impossible for any health service provider, for any aged care service provider to actually avoid encountering people for whom even without us knowing anything

about it, will actually have had trauma as part of the tapestry of their life. And therefore we need to be mindful that that might, that can re-emerge in their interrelationship and interactions within the systems that we create to deliver services. That can emerge at any time.

5

And the possibility of re-traumatising people through things like the power imbalances that we keep sort of creating within these systems can happen so easily. And so in order to be able to have a trauma-informed workforce, we actually need to be trauma-informed organisations and we need to recognise that it's not just the people we provide services to who carry these trauma histories. In actual fact it's our staff as well because this is all of us regardless of whether we are employed or we're receiving services; we are actually all just people, we are all the same. And these statistics about the prevalence of trauma and the things that happen in people's lives, they relate to all of us.

10  
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So what we're trying to do is create a culture where the difference between the people giving or receiving care is actually much reduced where we're levelling the playing field and we're compassionate and kind to everyone. And inherent in that is going to be a much more informed approach to trauma.

20

MR GRAY: There are various descriptions of so-called groups of people who come into the aged care system and it's suggested that they have, to use the statutory language, special needs. For example, veterans, and we have heard some evidence this morning about - - -

25

DR McKELLAR: Absolutely.

MR GRAY: - - - Mr Lynch's experience and his trauma. We've heard about the experience of Forgotten Australians. We've heard just before you gave evidence - - -

30

DR McKELLAR: Yes.

MR GRAY: - - - Ms McGuire's account, a very moving and compelling account of how her trauma can be retriggered. In your statement, you refer to various groups who are likely to have trauma.

35

DR McKELLAR: Yes.

MR GRAY: But it sounds to me as if you're essentially wanting to move beyond groups to a focus on the individual. What's the relationship between person-centred care and trauma-informed care, in your view?

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DR McKELLAR: So person-centred care is part of a language that has been around for quite a while now within the aged care context, and in actual fact within health contexts more broadly. Often when you go into the acute sector, the sort of patient-centred care sort of tends to emerge but I much prefer the idea of person-centred care because it speaks to that sort of commonality that we're actually all the same. And

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so I think that the person-centredness is an appropriate philosophy of care approach and my view is that a trauma-informed approach to care actually sits – if we're really doing this person-centredness properly, then trauma-informed care sits within that and adds value and richness and depth to that.

5

And that's where my expectation would be that all health services and all aged care services should be trauma-informed and that would fit with our understanding of the prevalence of trauma across the population. And that would prevent the kinds of things that the previous witness to myself described – tragically described from her experience in, you know, engaging with the aged care sector. If the whole of aged care were trauma-informed and truly person-centred, then we wouldn't have that kind of account being so confrontingly – so confronting to us with our own sort of sense of failure.

15 So my view is that trauma-informed care does have some parameters around it, it does have a set of principles and those for me within the aged care context sits within person-centred care and adds depth and value. And that should be for everyone because this is a universal precaution, as it were, just the same as we teach all health practitioners to wash their hands; we should also be ensuring that all care providers are trauma-informed. And that way we will actually make sure that we look after everybody.

Now, then there are the groups of special needs populations, as described by the legislation. And I think that we also need to recognise that the prevalence of trauma in those communities is exceptionally high for a whole range of diverse reasons. And also, the imbalances that those communities experience in terms of access and equity and the power differentials that they've had to live with are such that we may actually need – in order to help level the playing field, there may actually need to be some specific work and specific programs that also address the particular needs of those populations. And I think that there has been evidence around that, around that from today's sessions.

So it's like there's two layers here. There is the baseline where everyone should be trauma-informed, and that is part of person-centredness. You can't separate the two. And then there's that extra layer where we need to think about specific populations and needs because what has happened to those communities is such that they have experienced more significant levels of trauma.

MR GRAY: Mr Klinge recounted earlier today his experience of veterans entering the aged care system at a younger age than the general population, and he spoke of the prevalence of trauma and, indeed, post-traumatic stress disorder in the population of veterans. And he also mentioned that being prevalent in the homeless population. Does that accord with your own views?

45 DR McKELLAR: Absolutely, yes, it does.

MR GRAY: He said:

5 *A veteran's life history, if they find themselves in a situation where they're struggling with issues such as substance abuse, weight issues mental health issues, post-traumatic stress disorder, socialisation, family breakdown or any combination thereof, what our experience is that we can find ourselves with younger veterans who are physically unwell, that are facing a range of mental challenges and that don't have a network of family and social support about them to provide the supports they need to be able to stay at home comfortably. And as a result, there's a need for them to have alternative sources of care.*

10 Does that accord with your own experience and opinion?

DR McKELLAR: Certainly, I think that's a very appropriate statement.

15 MR GRAY: The concept of trauma-informed care, you mentioned there are a set of principles and you've referred in your statement to the SAHMCA, the SAMSHA model out of America. Operator, please display tab 107 of the general tender bundle. This is the document you supplied to the Royal Commission - - -

20 DR McKELLAR: That's correct.

25 MR GRAY: - - - setting out the principles. The origins of the approach are also outlined in the document, the origins that have led to the methodology. There's a background on native page 5, please, Operator. And this refers to the development over the last 20 years of an approach recognising the need to address trauma as a fundamental obligation for public mental health and related service delivery. Then there's a concept of trauma which you adopt in your own statement that's two pages on, at native page 7, please, Operator. What are the hallmarks of trauma when it comes to the provision of a human service such as aged care? What has it actual done to the person who needs the care that the service provider needs to pay attention to?

30 DR McKELLAR: Sorry, I just wonder, counsel, if you - - -

35 MR GRAY: Sorry, what's the effect of the trauma on the - - -

DR McKELLAR: Yes.

40 MR GRAY: - - - person who needs to receive care that the provider has to be conscious of?

45 DR McKELLAR: Yes. So I think that it's really important in answering that question to think – to think – to be aware that not only is trauma prevalent but it's also very diverse, and it's also highly individualised. So it is very – I don't think it's possible – in fact, it's not trauma-informed to make too many assumptions about what is this person's experience and where is the trigger point going to be for that person around re-traumatisation. However, there are certainly a number of common themes that emerge from people who have experienced trauma, and certainly at the

more acute or more severe end there are quite clear clinical syndromes described in post-traumatic stress disorder, which is highly prevalent in some populations. So veterans particularly have a very high prevalence rate of very specific post-traumatic stress disorder symptoms. The previous witness to myself actually made reference to  
5 her post-traumatic stress disorder and was able to articulate very specific symptoms that she experiences.

So hypervigilance or an increased sort of arousal level or startle response is sort of a hallmark symptom of post-traumatic stress disorder. So – and there’s a whole range  
10 of symptoms like that, from – through to things like sleep disturbance, which we know from studies that have been done in aged care populations that it – in fact, that historic traumatic memories can be associated with disruption of sleep for aged care populations. But then it can also go through to the impact of less tangible things than  
15 sort of clinical symptoms like an anxiety response. That is to things like a sense of disempowerment that will come as a result of having experienced trauma at some other earlier point in life. And then that – so that can be much more difficult to actually understand what does that look like in an aged care context.

I provided a case study around a woman that I worked with who was at the Oakden  
20 campus who had dementia and had significant dysphasia, so difficulty expressing herself in verbal communication as a result of that illness, and had very what were perceived as highly problematic responsive behaviours in the context of her dementia. And she was accommodated at the Oakden campus after this prolonged sort of very, actually, re-traumatising experience of being bounced around between  
25 different care providers, lots of quite pejorative things said about her where she was perceived as the problem.

And it was really only when we started to unpack and understand her trauma history, the fact that she had actually been through three domestically violent relationships,  
30 that she had been in a significant motor vehicle accident, she had had – as a consequence of all of those experiences, she had had significant difficulties with episodes of severe depression, some substance misuse that again had come as a result of the trauma experience.

And then in the context of dementia, this started to manifest in what was actually lots  
35 of – it wasn’t – not aggressive behaviours but, in actual fact, highly defensive behaviours, particularly around things like intimate personal care where she would become extremely distressed. And so, really, in the aged care context, trauma can emerge in so many things, and even in the sense of somebody feeling disempowered  
40 from actually being able to express what their needs are, to be able to articulate what they would like in terms of the care that’s provided to them, because if they come from a trauma background where they weren’t – you know, where they’ve been institutionalised, for instance, then it makes it all the more difficult for them to actually express themselves.

45 So in answer to your question, counsellor, it is diverse and complex and, on one level, can be possibly relatively obvious, although, even so, can still be missed. Then

it can be much more subtle and easily misinterpreted, and that's why having a proper trauma-informed care approach that is built on the right knowledge and on the right attitudes is so important because it really shifts the perspective from seeing the person as the problem to sort of then being able to be much more curious in inquiring about, "Well, what is the story here? What has contributed to this person's experience such that they might present in a particular way with a particular set of behaviours?"

MR GRAY: Thank you. In the SAMSHA document you adopt – I beg your pardon, in your statement you adopt an approach identified in the SAMSHA referred to as the three Rs. You say that's a useful organisational approach to trauma-informed care. In summary, there's realisation which is a general realisation about the issue throughout every aspect of the organisation; is that correct?

DR McKELLAR: Yes, that's correct. So it means that the whole organisation has taken on board this understanding. "This is the prevalence of trauma. This is the experience of people. These are the effects on them. We are actually going to build our policies our procedures, our guidelines – we're actually going to build this idea into everything that we do."

MR GRAY: The second R is recognition, which is at an individual level, trying to understand the history of the person concerned. How does the provider, the service provider go about trying to understand that his so that it can recognise what may be the triggers for trauma?

DR McKELLAR: So many providers will state that they deliver person-centred care. So if we're delivering person-centred care, then we need to know the person. So in terms of how that's done, there is a myriad number of ways that we can actually engage with a person, and I know I've provided you with a number of sort of checklists that can contribute. But at the end of the day, it's not about having just – well, there are – you know, services certainly need procedures.

They need to have a clear sense of what's the baseline assessment that needs to be done. But then that also needs to be applied with human sensitivity, and that's where that ties back into actually having a values-based workforce where we actually then employ people who have empathy and have emotional intelligence because there are some of those – so we then might have a number of tools that we use to actually understand who the person is, to – but if they're not actually delivered by somebody who can actually do so in such a way that it facilitates a safe interaction where that person actually feels safe to tell their story, to share what their experience has been, and when they start to talk about experiences that may have been traumatic, and the person will only do so if they're in a safe place, if they're in a safe relationship.

So this is where it all starts to come together, where we might have a set of processes that we might use. But if they're not applied by people who can use them well in that interpersonal human interaction, then it won't be as successful. But when it does come together, we can deliver person-centred care because we actually get to know

the person. And sometimes that will take some time. You're not going to necessarily unpack the whole of the person's trauma history in your – in fact, it's unlikely that you will do that in your first interaction. So it's actually then about taking a truly compassionate relationship-centred approach to care where – which is  
5 really what person-centredness is about.

All of these – we use all these terms, but, in actual fact, we're really talking about one thing here. Then over time you get to know the person. That story emerges. And that has to then – led by that person and their key people, their family, their  
10 loved ones, whoever they bring with them, that has to then be – they have to be empowered to then lead the development of that care plan. It must be informed by their whole story, which includes trauma.

MR GRAY: Thank you. Just for completeness, the tools you mentioned or the  
15 checklists at tabs 1, 2 and 3, the Geriatric Depression Scale, Life Events Checklist and screening for PTSD, the gist of your evidence is you can have the best checklists in the world, it's actually the empathy and the quality of the person - - -

DR McKELLAR: Absolutely.  
20

MR GRAY: - - - interacting with the person receiving the care that matters.

DR McKELLAR: Yes, absolutely. And, in fact, I would go further to say that you can actually have checklists and tools, and you could tick a box that says, "Yes,  
25 we're compliant", but, in actual fact, you could be doing harm. So more important than the tools is the quality of the workforce and the ability to engage in that human interaction because that's what actually then intrinsically will protect people from those possible retraumatisations.

MR GRAY: Just to complete the rest of the SAMSHA model, the third R is to be  
30 responsive, and that's – you began to describe that, I think, Dr McKellar, in the way that the organisation responds once it understands the needs of the person, collates a proper care plan. Are there other aspects of responsiveness that are important here?

DR McKELLAR: I think it's that organisational commitment that's required, and it  
35 needs to go from the CEO level right through to the – you know, the grass roots delivery of care. Well, that's where it's most important, but it needs to be supported organisationally.

MR GRAY: And, finally, just for the sake of having an R, they call it resist, or - - -

DR McKELLAR: It's a curious one, isn't it?

MR GRAY: It's avoiding retriggering harm - - -  
45

DR McKELLAR: Correct.

MR GRAY: - - - is that right?

DR McKELLAR: That's right.

5 MR GRAY: And, presumably, that's, in effect, the other side of the coin. There are positive responses, but there's also the very important imperative not to - - -

DR McKELLAR: Yes. Well - - -

10 MR GRAY: - - - retraumatise; is that right?

DR McKELLAR: Absolutely. And, in fact, the previous witness gave us a beautiful illustration – well, you know, a dreadful illustration, actually, you know, for – of, actually, how retraumatisation can happen so easily. And without – you know,  
15 it's not that clinicians or care providers do this deliberately. Perhaps sometimes they do. At the Oakden campus, perhaps some of them might have. But it can happen, sort of, ineptly, without – you know, without being trauma-informed. And that's why this is actually a really important piece of work.

20 MR GRAY: You've also provided the Royal Commission with managerial and governments level organisational transformation toolkits - - -

DR McKELLAR: Yes.

25 MR GRAY: - - - which we don't have time to ask you about. But they're at – we'll start with tab 7. That's actually on the starting point of co-design; is that right? Tab 7. Just quickly putting that up on the screen. It's entitled Principles of Co-design.

DR McKELLAR: Yes. Yes.

30

MR GRAY: And then, when we're focusing on the trauma-informed care aspect of the organisation, we've got tab 8, putting co-design – I beg your pardon. Tab 9, Trauma-Informed Care and Practice Organisational Toolkit, TICPOT.

35 DR McKELLAR: Yes.

MR GRAY: And another element of that toolkit at tab 10.

DR McKELLAR: So there's – that's right. There's two parts to that piece of work.  
40 And that's a very – it's an Australian piece of work and it's a really solid document that would support – you know, it's really intended, you know, for mental health services, but this is translatable across – as an organisational approach into aged care contexts.

45 MR GRAY: Thank you. Then there are, from a different source, trauma-informed care resources for leaders and managers, at that sort of governance level, at tab 11. Just briefly, if we can put that up - - -

DR McKELLAR: So I believe - - -

MR GRAY: - - - on the screen.

5 DR McKELLAR: I believe – yes. That’s – so that’s from the Te Pou service in  
New Zealand. And it’s a link to a whole range – so there’s work happening around  
the world around this. So this is a good document, built on the work that’s  
happening in New Zealand currently, and is a good illustration of service change.  
Shows some really good commitment within this particular service in New Zealand.

10 MR GRAY: Thank you. And with a focus on homelessness – if we go to tab 12,  
please, Operator – is this an equivalent resource at an organisational level, but with  
specialisation - - -

15 DR McKELLAR: Yes. Yes.

MR GRAY: - - - on the issues raised by homelessness?

20 DR McKELLAR: But the organisational approach, what – there are nuanced  
differences between each of these documents and each of these models, but the  
essence is very similar. And depending on the service context, an aged care  
provider, any health service provider, could actually adopt some of these principles  
and then start to develop a strategic plan to actually engage in a culture shift. Well,  
engage in a – becoming more trauma-informed as a whole piece of a – of a larger  
25 piece of culture change within an organisation.

MR GRAY: Finally, in tab 14 of the bundle that you’ve provided to the Royal  
Commission, it begins with the framework. Again, you’ve already explained the top  
two quadrants. Perhaps the third quadrant, bottom left, is – in a way, you’ve covered  
30 it.

DR McKELLAR: Indeed.

35 MR GRAY: You haven’t perhaps – I haven’t given you enough time to cover  
providing transparent accountability, but you did advert to it earlier when you were  
speaking of checking in and the importance of a developmental or growth approach  
rather than a fixed approach. Is there something you can briefly tell the  
Commissioners, by way of explanation of that fourth quadrant?

40 DR McKELLAR: Sure. So one of the things that was missing at Oakden was this  
transparency, this – you know, things were not known. And we determined within  
our service that we wanted to be transparent about everything. So when we make a  
mistake, we own up to it. If there are consequences, we accept them. That’s a much  
healthier way to move forward as an organisation than cultures of cover-up. So what  
45 we found within our service was that, actually, we started reporting more on the  
safety learning system. We have more incidents. We report more incidents than  
were being reported before. To my mind, that’s actually a really positive thing. It’s

a sign of a much more psychologically safe culture because it's one that's actually using the safety learning system to actually learn about safety.

5 But this priority touches everything around our culture as well. So one of the illustrations that I use when I'm talking about this idea with our team is an illustration that comes out of Kegan and Lahey's book and everyone culture where they describe one of the deliberately developmental corporate organisations that has taken this kind of way of working, and they have a strategy where all of the business meetings are actually recorded. And if somebody's name comes up – if a staff's  
10 member's name comes up in that meeting, they will receive a message and they will get advised that they may actually want to log on to the system and actually listen to what was said about that person in that meeting.

15 That really struck me, because I work in a health organisation where people – you know, there's things that get talked about in formal settings and then there's all of that other conversation that happens outside. And one of the things that would – that's a vision for our service is that we start to align those conversations so that there's not the water cooler conversation versus the conversation that happens in a meeting, or the conversation we have with somebody and then something we say  
20 about that person with somebody else. This is about actually having integrity.

Transparent accountability is actually, you know, really walking the talk, and working in a whole environment where we own up to mistakes, where we don't  
25 sound off about people just because we're venting and then actually – in fact, we're actually causing trauma through those kinds of relationships. So this is – that's what this refers to, and it should be run as a commitment and a thread through the whole organisation.

30 MR GRAY: Thank you. Behind that document at tab 14 you've provided again, in an easier-to-read format, the vision. That's on the next page. You've then set out, under Principles and Practices, a number of bullet points which you've explained in the course of your evidence. I don't think I need to take you to any of it now. I was interested in "watch our language". Is that a reference to not only the obvious, be  
35 careful about not causing hurt and harm in our language, but also a reference to this idea of the open disclosure of what's occurring in managerial meetings?

DR McKELLAR: So – well, it's a reference - - -

40 MR GRAY: If we go to the next page, 0004, please.

DR McKELLAR: - - - to all of that. So – and that has actually emerged as we've worked with our team. This has become a priority. It has emerged as an area where our team have said, "Well, this is something that we're not doing so well." So this is  
45 about actually – but making sure our language is truly person-centred.

Often when you're working in context where – particularly, we work with a lot of people who have quite severe responsive behaviours as a result of a diagnosis of

dementia. And when you work in contexts like that, you will often hear nursing staff in particular using terms like, “They’re being resistive”, or, “That person is intrusive.” And as we’ve been doing this piece of work with our team, there has been a voice that has emerged from within the ranks of the staff that have said,  
5 “Actually, that language is not respectful and we need to collectively start to change it.” So when we – when I refer there to “watch our language”, it really refers to, “All of what we’re saying, is it person-centred? Is it respectful? What’s the attitude that’s implied behind these words that I’m using?” Because – and, look, it’s an important principle within trauma-informed care.

10

MR GRAY: Last point – thank you. The last point, Growth Culture Hub Space, I believe you explained that in the co-design article. Is that a reference – no, perhaps it isn’t explained in the article.

15 DR McKELLAR: So - - -

MR GRAY: Could you please briefly explain it.

DR McKELLAR: Look, it’s just a – it’s a practice. So the idea here is that there –  
20 so we have our culture framework that sort of is the guide for everything we do. Then emerging out of that there are those principles, you know, that everyone has a story, that rank doesn’t have its usual privileges, that everyone grows the culture and that everyone can grow. And then what we have done is we have quite intentionally built practices that we hope are and we believe are repeatable, and that are  
25 sustainable and that in themselves the practices carry some meaning like the check-in, for instance. And that there are ways that – and the importance – they carry some symbolism as well because what we need to do is communicate on a continuous and daily basis that, actually, this is a piece of culture work we’re doing here. So the growth culture hub space is a practice. So we actually have created some visual  
30 space within our – the environments of where our bedded inpatient-type services are where we have places of care.

So we don’t call them beds like lots of bedded services do. We call them places of care and that’s watching our language and that’s actually come from engaging with  
35 the people that we provide care for. We have a visual space where we actually transparently put up the sort of documentation from the conversations we are having around how we work, our culture work that we are doing together. We put up conversations, for instance, about what we are not doing well because we actually want to put up that where – and it’s in an area where the people who use our service and their families and carers can actually come and interact act with it as well and  
40 they can talk to us about that and so, you know, we put up information about medication errors and everything that’s happening because we actually want – we value transparency.

45 We recognise that that’s a principle that we actually need – it’s a priority area that we need to apply. That’s what that’s referring to there.

MR GRAY: I've gone over time but just very briefly - - -

DR McKELLAR: My apologies.

5 MR GRAY: - - - the people using the service and their family representatives, they're actually involved at each level of the service from recruitment up.

10 DR McKELLAR: Yes, I didn't want you to forget that, so I actually wrote it in red on my paper just a moment ago. Yes, so look, I think if there's anything that I would want to finish my evidence to the Royal Commission around, it's actually the importance of the lived experience voice. Now, that's a terminology that's used a lot in - certainly in mental health services, and in health services in general. But I actually - I like it because, it's - in fact somebody recently corrected me and said it's the living experience because it's not just about having had it in the past it's about  
15 that this is an ongoing journey.

So we have - you know, what comes of Oakden for me is that we absolutely have to champion and empower people like Barbara Spriggs. We need them to tell their story and we need to hear that story with an open heart that says we are not going to  
20 be defensive when you tell us that we are failing in some way. We are going to take that on board and we're going to respond to it coherently and sensibly and with action. So we have some commitments within our service. We don't interview now. We have a lived experience representative. That is - wherever possible, that is somebody who actually uses our services, not just somebody who comes from  
25 somewhere else; it's somebody who knows the work we need to do and they - - -

MR GRAY: You don't interview without such a person being there, you mean?

30 DR McKELLAR: We don't interview without them being there. Yes.

MR GRAY: This is in the recruitment process?

35 DR McKELLAR: Yes, so when we're recruiting, there must be a lived experience representative on every panel. We have - so lived experience representative employed in our service. So we have employed a carer's consultant who went through an incredibly long and difficult journey with her husband who had a younger onset dementia and then was accommodated in the aged care sector at the age of 43. She is one of our true change champions and it's such a privilege to have her work with us because what she brings is - and we've deliberately made it this way, is that  
40 she is empowered to hold us to account with anything that she sees in our service that's not meeting the mark in terms of what does this mean for the people who receive the services from us.

45 And then there's the ongoing engagement around care planning together. We have wellbeing reviews at Northgate House. That's a sort of a core part of our planning process where the whole of our clinical team sits down with the representatives of the people that we provide care for and in that context we are looking after people

who have got quite significant disabilities. So the conversations are with their loved ones and families and we seek to respond – to elicit and to respond as much written feedback as we can as well.

5 MR GRAY: Thank you. No further questions, Commissioners.

COMMISSIONER PAGONE: Thank you.

10 COMMISSIONER BRIGGS: Dr McKellar, that was a very interesting presentation. The sector, it wouldn't surprise you to hear, is a long way from where you aspire that it might be. If there's one lesson or one approach or one thing we can think about in terms of workforce improvements, what should we focus on? Or what should organisation or providers focus on is probably the point?

15 DR McKELLAR: I think it has to start with values-based recruitment. If there was one thing that organisations were going to do - - -

COMMISSIONER BRIGGS: Thank you.

20 DR McKELLAR: - - - and I'd hope that they might get beyond that, but if they were going to start with something it would be recruit the right people.

COMMISSIONER BRIGGS: Yes. I think that's right. Recruitment is the source of all workforce issues, in my experience, so thank you.

25 COMMISSIONER PAGONE: Dr McKellar, thank you very much. You are free to go back home.

30 DR McKELLAR: Thank you.

<THE WITNESS WITHDREW

[4.45 pm]

35 COMMISSIONER PAGONE: Adjourn the Commission for the day.

**MATTER ADJOURNED at 4.46 pm UNTIL  
WEDNESDAY, 9 OCTOBER 2019**

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