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

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

SYDNEY

10.02 AM, MONDAY, 6 MAY 2019

Continued from 22.3.19

DAY 15

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

MR A. CROSSLAND appears for Ms McCulla

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

MR GRAY: Commissioners, this is the third substantive public hearing of the Royal Commission. The first in February was an overview of the issues raised by the terms of reference. The second in March addressed home care. This hearing will address residential care, and there will be a focus on dementia care. By way of context, I want to explain how this hearing fits into what has gone before. At the February overview hearing, the Commission heard from a range of advocacy groups and health practitioner bodies and from industry peaks and unions. Among the topics covered in that review the Commission heard evidence relating to dementia and relating to residential aged care, including statistical evidence about Australia's changing demographics.

The Commission also heard direct account evidence which raised aspects of dementia care in both the home care and residential aged care settings and evidence from government witnesses. At both the February overview hearing and the March home care hearing, the Commissioners heard that the preferred setting in which Australians wished to receive aged care is in their own homes. The demand for higher level home care is growing and far outstrips current supply. But not all older Australians are able to receive the amount and level of the care they need in their own homes for a variety of reasons. The Commission has heard that the viability of aged care in the home often depends on the efforts of unpaid carers, usually partners and other family or friends.

These carers are among the unsung heroes of aged care. At times, those carers themselves must attend their own needs and may temporarily be unavailable to care for their loved ones. This raises the need for respite care, including in residential aged care. The availability of respite care is critical to sustaining the efforts of those carers. People enter permanent residential care for a range of reasons such as after a fall, when incontinence takes hold, or when people experience advanced dementia. They may simply choose to enter residential care or they may need to transition into permanent residential aged care because of the complexity of their care needs.

The Commissioners heard of the prevalence of dementia in Australia's ageing population and the living and care arrangements for those with dementia. Most people with dementia live in the community. About 46 per cent of people living with dementia in the community receive only informal assistance. Twenty-nine per cent receive both informal and formal care. Sixteen per cent receive formal assistance only. And nine per cent have no assistance at all. This hearing will involve an inquiry into, first, the perspective and experience of people in residential aged care, and people living with dementia, and their families and carers. Secondly, quality and safety in residential aged care, particularly for people living with dementia.

Thirdly, the use of restrictive practices in residential aged care. Fourthly, the extent to which the current aged care system meets the needs of people in residential aged care. And fifthly, good practice care for people living with dementia, particularly in

the context of residential aged care. The office of the Royal Commission has prepared two background papers in advance of this hearing. The first titled Dementia in Australia: Nature, Prevalence and Care, and the second, Restrictive Practices in Residential Aged Care in Australia. In addition, the office of the Royal Commission recently released a background paper prepared by Dr David Cullen on The Changing Demographics and Dynamics of Aged Care in Australia, which provides context on the demand for residential care.

These background papers are all available on the Commission's website. As with all background papers, they do not represent a position of the Royal Commission on the issues they cover. Rather, they have been prepared for the benefit of the Commissioners and public. I will be referring to the background papers on dementia and restrictive practices throughout these opening remarks and at times during the hearing. As the Commission heard in February, providers of residential aged care receive a daily subsidy from the Australian Government under the Aged Care Act for each resident they are caring for as long as certain conditions are met. The level of subsidy depends on an assessment of care needs against three domains: activities of daily living, complex health care, and behaviour, and behaviour is the third of those domains, and that assessment is conducted by the provider using the Aged Care Funding Instrument known as ACFI.

There are also various supplements available but none of the supplements presently relates specifically to dementia care. A range of other interventions related to dementia are in place, and will be referred to in evidence during this hearing. The provider may also charge the resident various amounts for accommodation costs, basic daily costs, care fees and costs for other services. The payment for accommodation costs is means tested and may be met by paying a refundable accommodation deposit where the provider retains the interest and agreed costs are subtracted from the deposit. The basic daily fee represents 85 per cent of the aged pension. The care fees are means tested and are subject to annual and lifetime caps.

The level of care subsidy payable by the government is reduced by the amount of the means tested care fee paid by the resident. The model is essentially one of service provision by for-profit or not-for-profit entities with those providers subject to government subsidy, quality and safety regulation and constraints on the supply of subsidies. In 2017/18 there were 886 operational residential aged care providers operating 2695 services. There were about 207,000 operational places with an occupancy rate of about 90 per cent, and the occupancy rate was about 90 per cent. The profile of the providers is that 63 per cent of them operate only one facility each. However, recently there has been consolidation such that two per cent of providers now operate more than 20 facilities each, together accounting for 31 per cent of the operational places.

The average age at which a person enters residential aged care is 83.4 years. In 2017/18, 241,723 people received residential aged care, and 61,993 people received residential respite care. In this hearing, the Commission will hear evidence from two people, Ms Merle Mitchell AM and Ms Darryl Melchhart, about their experience in

residential aged care facilities. There are about 6000 younger people living in residential aged care, about 1000 of whom are below the age of 55. Younger people in the residential aged care system will receive specific attention at a public hearing later in the year.

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I will now turn to people living with dementia and their care needs. The Australian Institute of Health and Welfare reports that over half of all people in residential aged care have a diagnosis of dementia. This is based on reports from approved providers using the ACFI. Dementia is an umbrella term for over 100 conditions affecting the brain. It has been clinically defined as a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. Dementia is not a normal part of the ageing process, however, age is the strongest known non-modifiable risk factor for dementia with the majority of those developing the disease over the age of 65.

20 Studies suggests that while the Australian public has a positive attitude towards dementia misunderstandings about it are common, and knowledge about dementia and how to interact with and care for people living with dementia is poor. The Commission has also received evidence that people living with dementia can be stigmatised, resulting in feelings of loneliness, uselessness and embarrassment. This can have implications for the care that people living with dementia receive in residential aged care facilities and in the broader health system. In the February hearing, the president of the Australian and New Zealand Society of Geriatric Medicine, Associate Professor Edward Strivens explained that people living with dementia may experience changes in their ability to perform activities of daily living, such as mobility, hygiene and nutrition.

30 People with dementia may have difficulty communicating which can result in an attempt to express their needs through actions and behaviours which may not be readily understood by family and carers. Behavioural and psychological symptoms may include agitation or extreme restlessness, physical and verbal aggression, wandering, social and/or sexual disinhibition, delusions, apathy, depression and/or anxiety. These behavioural and psychological symptoms are sometimes called BPSD, but advocacy groups are encouraging a move away from this term. They can also be called neuropsychiatric symptoms of dementia. It is likely that 90 per cent of people living with dementia will experience at least one such behaviour or symptom at some time.

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In her evidence in February the CEO of Dementia Australia, Maree McCabe, described the experiences of daily life of a resident with one of the common forms of dementia including perceptual disturbances, inability to understand requests, misinterpretation of social contexts, non-recognition of staff, reversion to one's first language and mobility issues. On the last day of this hearing the Commission will receive evidence from Trevor Crosby, a person living with Lewy body dementia regarding his experience. The Commission will also hear evidence from Kate

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Swaffer who is an advocate for the interests of people living with dementia, an expert, and moreover is herself living with dementia.

5 Further detail regarding the nature of dementia is set out in the Royal Commission
dementia background paper. This paper also details information regarding the
prevalence of dementia in Australia. Figure 3 now displayed shows the estimated
prevalence of dementia by age and sex. It shows that instances of dementia
increased dramatically after the age of 70 roughly doubling every five years. About
10 0.1 per cent of the population under 65 has dementia compared to about 5.2 per cent
of the population aged between 65 and 70, and 28.8 per cent of the population 85 or
older. In general, the prevalence of dementia is higher for women than men in all
ages.

15 The Australian Institute of Health and Welfare acknowledges there is no national
data directly recording the prevalence of dementia. It estimated in 2018 that there
are 376,300 people living with dementia. Figure 5 now displayed shows the number
of Australians projected to have dementia between 2010 and 2030. By 2030, about
550,000 Australians are expected to have dementia with 42.8 per cent of those aged
20 85 or older. It doesn't appear on the graph but by 2057 this number is expected to be
around one million Australians. There have been some reports over the last five
years of a decline in age specific prevalence and by inference incidence of dementia
in some high income countries, including Australia. The reasons for this reported
decline and its level of reliability are not yet well understood.

25 On the other hand, in the February hearing, Ms McCabe of Dementia Australia
flagged concerns that estimates about the current and future prevalence of dementia
may be underestimated because of the difficulties in diagnoses, late diagnoses, and
stigma. I will turn to the topic of good dementia care. The real-life implications for
people living with dementia and their families were evident from the testimony of the
30 last witness in the February hearing, Barrie Anderson. Mr Anderson gave moving
evidence that he had cared for his wife, Grace Anderson, since her diagnosis with
dementia in 2002, and about his experience supporting her after her move into
permanent residential care. After his wife lost the power to speak, Mr Anderson
explained how he tries to communicate with her – and I quote:

35 *I have learned that it is vitally important that I look into Grace's eyes. They
are the windows of the soul. Grace has no other way of telling me that she is
happy, sad, fearful or in pain.*

40 Dementia cannot be reversed, and while the progression of some forms of dementia
such as Alzheimer's disease may be delayed by dementia drugs such as
cholinesterase inhibitor, their efficacy is limited. Care of people living with
dementia is generally focused on preventing, recognising, and managing common
symptoms and behaviours. It is at this point that challenges can arise. Figure 1 from
45 the paper now displayed is commonly known as the Brodaty triangle. It is a seven
tiered model of service delivery based on severity and prevalence of the
neuropsychiatric symptoms of dementia ranging from no dementia through tiers of

increasingly severe behavioural disturbances to the propensity for violence in a small number of individuals. Each tier is associated with a model of intervention. Low level interactions may prevent the need for the more intensive interventions when disturbance becomes more severe.

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In the February hearing Associate Professor Strivens explained that the neuropsychiatric symptoms in question are often an expression of unmet need, including untreated pain, interaction with the physical environment, and unmet psychosocial needs. Maree McCabe's evidence reinforced this point, adding that environmental factors such as too much stimulation or lack of privacy or an institutionalised environment may have an exacerbating effect. According to Associate Professor Strivens the starting point should always be non-pharmacological management based around identification of the areas of unmet needs, person-centred care and enablement principles.

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Medical or pharmaceutical-based interventions should be the last resort, and even then should be for time limited specific indications where non-drug treatments have failed. They should not be purely for restraint or to substitute for proper assessment of causes, staffing requirements or educational needs of staff. This is consistent with a body of expert evidence which we expect to lead in this hearing from an array of eminent experts. During the hearing the Commissioners will also hear from frontline personal care workers, nurses and other health practitioners on what is required to provide appropriate dementia care. I want to turn to the topic of restrictive practices. Some providers in the essential aged care sector attempt to manage challenging behaviours shown by some people with a range of restrictive practices.

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These are interventions either physical or pharmacological that have the effect of restricting a person's free movement or ability to make decisions. Definitions of what is a restrictive practice vary. Restrictive practices have been the focus of serious concern and controversy for some time. They were a key issue in the Australian Law Reform Commission, Elder Abuse: A National Legal Response report. And as the Commission noted:

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While there is a national framework for reducing and eliminating restrictive practices in the disability sector, there has been no explicit regulation in the aged care sector.

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Not until recently – I'll come to that in a moment. The national framework in the disability sector is the product of agreement of relevant Commonwealth, state and territory Ministers in 2014. Concerns about restrictive practices in the aged care sector are not of recent origin. This begs the question: why hasn't there been a similar initiative in aged care to the framework which exists in the disability sector? Common restrictive practices in residential aged care that are physical in nature include clasping a person's hands or feet to stop them from moving, applying lap belts, leg, wrist, ankle, vest restraints or bed rails, locking over-bed or chair tray tables, seating residents in chairs with deep seats or rockers and recliner that the resident cannot stand up from, and the removal of mobility aids.

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Restrictive practices may also include locking or otherwise confining a person in a residential facility or specialised unit. The background paper on the use of restrictive practices identifies a lack of data evidencing the extent to which physical restraint is used in residential care in Australia. A series of studies published between 1997 and 1998 regarding physical restraint in a sample of residential aged care facilities found that 15 to 26 per cent of residents in the participating homes were being restrained at the time of the survey. Physical restraints pose significant risks to life, health and wellbeing of residents.

Adverse impacts of physical restraint on a resident can include the following five categories. First, the physical effect of restraint in contact with the body, for example, bruising, direct skin injuries and pressure injuries. Secondly, physical effects of being immobile, for example, pressure injures due to extended periods sitting or lying; also respiratory complications. Urinary incontinence and constipation, under nutrition and increased dependence in activities of daily living.

Thirdly – and closely related to the second category – deconditioning, particularly impaired muscle strength and balance which can contribute to falls and increased frailty and immobility. Fourthly, psychological effects, for example, agitation, depression, fear, shame, anxiety and the loss of dignity. Finally, risks associated with attempts to escape from restraint, for example, injuries resulting from falls such as fractures or head trauma and the risk of strangulation.

I turn now to the topic of the over-prescription and over-administration of psychotropic medicines and the issue of chemical restraint. There are no data directly evidencing the number of prescriptions of psychotropics to people living with dementia in residential aged care. The office of the Royal Commission’s background paper on restraint identifies a number of Australian studies that provide an indication of the prevalence of chemical restraint or like practices. A 2009 study carried out in 44 residential aged care homes in Sydney found that about half the residents were being prescribed psychotropic medications. A more recent national Australian study of residents in residential aged care facilities found nearly two-thirds were regularly taking psychotropic medication.

Researchers at the South Australian Health and Medical Research Institute have compiled a matched database of the 98,000 people entering residential aged care across Australia in a two year period from 2013 to 2015 focusing on antipsychotics. Antipsychotics are one of the families of psychotropic pharmaceuticals. An analysis undertaken for the Commission shows that some 9200 people in this cohort who had not received an antipsychotic in the previous 12 months were dispensed an antipsychotic within three months of entering residential care. Of these, almost 4500 were still receiving the medication nine to 12 months after entry. It’s necessary to consider also medical consultations regarding mental health. We’re now displaying exhibit 1-13. This graph shows two key results of a 2011 Australian Bureau of Statistics project analysing Medical Benefits Scheme, MBS data against Australian census data.

There was a steady decline in access to MBS subsidised mental health related in Australians aged 65 and older, but a very steep increase in the proscription of PBS subsidised mental health related prescription medicines, and antipsychotics in particular were progressively prescribed in higher levels increasing with age. Over-
5 prescription is a theme that will be explored in this hearing. The effectiveness of the use of antipsychotics as treatment for dementia has been questioned. For example, the Commission has heard evidence regarding the Banerjee report prepared for the United Kingdom Department of Health which found that for every 1000 people
10 living with dementia treated with antipsychotics for 12 weeks, between nine to twenty per cent will experience some reduction in symptoms but at the risk of an additional 10 deaths, 18 strokes, and worsening mobility and falls risk in six to twelve per cent.

Operator, we can take down exhibit 1-13 now. Thank you. The literature canvassed
15 in the background paper identifies key adverse outcomes in relation to the prescription of psychotropics, including sedation, gait disturbances and increased risk of falls and fractures, urinary tract infections or incontinence, constipation and associated risk for faecal impaction and bowel obstruction, increased cognitive
20 impairment and confusion, increased risk of respiratory complications such as pneumonia, stroke and heart rhythm abnormalities which have been associated with increased risk of death and increased risk of cerebrovascular events including stroke.

I want to turn now to the alternatives to restraints and restrictive practices. Whether
25 physical or pharmacological restrictive practices are ever justified in residential aged care is a contentious issue. Guidance on strategies and non-pharmacological interventions to negate or mitigate the need for restraint by managing the underlying causes of challenging behaviour requires consideration of the care approach and environmental, psychosocial and physiological measures. Part of the complexity
30 associated with the use of restraints arises from the patchwork nature of the regulatory regimes that apply. This topic is surveyed in detail in the background paper on restraints.

The Minister for Senior Australians and Aged Care issued a media announcement the
35 day before the Royal Commission's ceremonial opening hearing in January foreshadowing a strengthening of regulation of the use of restraints in aged care, and saying there had been extensive examination of this important issue over the preceding 18 months. On 2 April 2019, the Minister made a new instrument under the Aged Care Act, the Quality of Care Amendment (Minimising the Use of
40 Restraints) Principles 2019 which is scheduled to commence on 1 July 2019. Those amending principles must be considered in light of another amendment scheduled to commence on 1 July 2019. The new Single Quality Framework to be incorporated in the Quality of Care Principles 2014. Standard 8, organisational governance, includes a requirement for a clinical governance framework that minimises the use of
45 restraint.

In this hearing the Commission will hear evidence regarding the neglect that is being endured by residents of aged care facilities and in particular those with dementia who

- in many cases cannot express their needs or raise complaints. These are some of Australia's most vulnerable people. A range of clinical care issues arise including poor practices regarding management of pain, mobility issues, injury risk and treatment, incontinence and hygiene, skin integrity care, oral and dental care,
- 5 nutrition and eating, hydration, the risk of choking known as dysphagia, and medication issues. The evidence also points to difficulties people are experiencing regarding access to primary and allied services, deficits in social connection, dignity of risk, and quality of life, resident safety, and end of life care.
- 10 The Commission will also hear evidence about why these problems exist and opinion on what changes are required to ensure the standard of aged care in Australia meets the expectations of the community. As part of its first term of reference the Commission is required to inquire into the extent of substandard care in residential care and aged care generally. In relation to the availability of data for people looking
- 15 to enter aged care, the Carnell Paterson report observed that the absence of reliable comparable information about care quality in residential aged care is a striking feature of the current system. Some insight regarding substandard care can be gleaned from the data of the aged care complaints commissioner.
- 20 According to the evidence of Ms Anderson, the total number of complaints received by the complaints commissioner in relation to residential aged care from June 2012 to December 2018 – shortly before the new commission commenced – was 23,955. In 2017/18, of the 4314 complaints received about residential care, the common
- 25 issues were about medication administration and management, personal and oral hygiene, and staff numbers and ratios. To date, this Commission has received 3741 submissions from the public. It is too early to draw conclusions regarding the extents of substandard care from these submissions. However, it is apparent that the common issues raised regarding residential care relate to staffing, neglect and dignity, personal care, medication management, nutrition, clinical care, physical and
- 30 emotional abuse, and loneliness and disengagement.

Last week, the Australian Nursing and Midwifery Federation published a report of a self-selected survey of aged care staff which places dementia care at the top of the list of their issues of concern related to substandard care by a large margin. In early

35 January of this year the Commission wrote to 981 residential care providers seeking information about incidents of substandard care at their facilities for the past five financial years. Of the responses considered by the office of the Commission to date, residential aged care providers have reported over 112,000 incidents of substandard clinical care, nearly 68,000 incidents where medication management was inadequate,

40 over 35,000 occasions of personal care being deficient and over 12,000 cases of inadequate nutrition.

In previous hearings, the Commission has received evidence regarding the role of the Aged Care Quality and Safety Commission, and the Department of Health as

45 regulators of the aged care system. The Commission, the Royal Commission, has also received evidence regarding the availability and extent of the data held by those regulatory bodies that may assist the Royal Commission in its task of understanding

the nature and extent of substandard care in residential aged care. This matter will be explored further in relation to dementia care in this hearing, and more broadly in future hearings.

5 I will now conclude, Commissioners, by outlining our proposal for the conduct of
this hearing. Across the eight days of this hearing, we anticipate that the
Commission will hear from around 40 witnesses. These will include people who are
able to provide valuable insight into their experience with residential aged care
including residents and their families, personal care workers, nurses, doctors, and
10 aged care providers. Further, the Commission will hear evidence from expert health
practitioners, and the Department of Health, and the Aged Care Quality and Safety
Commission. The hearing will begin with accounts from people living in the
residential aged care system, and then turn to accounts from people living with – and
about people living with dementia and their carers.

15 These personal accounts are expected to provide powerful and compelling insights
into the experience of residential aged care in this country, particularly for those
living with dementia. Commencing this afternoon and on Tuesday, Wednesday and
– and on Tuesday, Wednesday this week and Monday of next week, the Commission
20 will inquire into allegations of poor care and mistreatment by certain providers, and
we will hear evidence from those providers. These case studies are expected to shed
light on particular issues relevant to the quality and safety of personal and clinical
care provided to residents living with dementia.

25 Those providers and particular staff and health professionals involved in those case
studies have been put on notice of the substantive issues in those case studies, and
many of them will be called to give evidence. It is very important for the
Commission to hear the perspectives of the provider staff and the other professionals
on these matters and the nature of the challenges they face. At the commencement of
30 each of these case studies members of the counsel assisting team will make brief
opening remarks. There will be no detailed oral closings. The findings sought in
each case study will be set out in written submissions to be made available to parties
with leave to appear in relation to that case study a week or so after the entire hearing
has concluded.

35 Next week, the Commission will hear evidence from aged care workers, nurses,
clinical experts, innovative aged care providers, policy advocates and representatives
from the Department of Health, and the Aged Care Quality and Safety Commission.
The experts we intend to call include Scientia Professor Henry Brodaty AO of the
40 University of New South Wales, Professor Joseph Ibrahim of Monash University, Dr
Juanita Westbury of the University of Tasmania, Associate Professor Stephen
Macfarlane of Dementia Support Australia, Mr Glenn Rees of Alzheimer's Disease
International, and the Australian Government's Chief Medical Officer, Professor
Brendan Murphy.

45 I will now briefly describe our proposal for document management in this hearing.
The solicitors assisting the Royal Commission have prepared and made available to

you, Commissioners, five tender bundles. There is a general tender bundle, documents from which will be displayed from time to time during the hearing. I wish to tender the general tender bundle as a single exhibit. Documents in that tender bundle may be referred to by tab number according to the accompanying index which will now be displayed.

COMMISSIONER TRACEY: The general tender bundle - - -

MR GRAY: If the Chairman pleases, I need to note that the following three documents will not be tendered now but will be omitted from the tender I'm now seeking. Documents 73, 95 and 96. Thank you, Commissioner.

COMMISSIONER TRACEY: Subject to those deletions, the tender bundle will be exhibit 3-2.

EXHIBIT #3-2 GENERAL TENDER BUNDLE

MR GRAY: Thank you, Commissioner. In addition, there are four separate tender bundles, one for each of the case studies. Only you, the Commissioners, those attended by the particular case – I beg your pardon – those affected by the particular case study, and also the office of the Royal Commission, counsel and solicitors assisting, and the Commonwealth parties currently have access to the tender bundle relating to that particular case study. We plan to tender each case study tender bundle at the commencement of the case study in question as a single exhibit. Again, once each case study tender bundle has been tendered, documents in that tender bundle may be referred to by a tab number according to the applicable index which members of the counsel team will have displayed on the screen at the commencement of the relevant case study.

We have put the relevant parties on notice that we intend to tender and may publish the documents in these tender bundles, some of them in a redacted form. Those parties have been given an opportunity to object to the publication of documents, including on the basis of confidentiality. Commissioners, during the course of this hearing, you may be asked to consider applications for a direction that particular documents not be made public pursuant to section 6D(3) of the Royal Commissions Act. Any such application should be made in accordance with part G of practice guideline 1 of this Royal Commission. It may not be possible for you to hear and determine such applications during the hearing, and they may have to be determined on the papers afterwards.

At the end of the hearing on Friday next week, I will present a closing address which will reflect the themes covered by this hearing. This will be followed by written submissions which the counsel assisting team aim to complete soon after the hearing. Parties with leave to appear will have seven days, we propose, from the date of counsel assisting's submissions to provide you with their own responding written

submissions before you make any findings. At the conclusion of the hearing, I will be asking to you make directions in that regard. Could I now ask for a brief adjournment, perhaps of about 15 minutes duration.

5 COMMISSIONER TRACEY: Yes. The – I understand there has been a problem with the web stream that will need rectification. So the Commission will adjourn until we're advised that the problem has been resolved. Please adjourn the Commission.

10 **ADJOURNED** [10.42 am]

15 **RESUMED** [11.20 am]

COMMISSIONER TRACEY: Yes, Mr Gray.

20 MR GRAY: Thank you, Commissioner. We're ready now to call your first witness, and our first witness is Ms Darryl Hilda Melchhart, M-e-l-c-h-h-a-r-t, and Ms Melchhart is already in the witness box.

25 <**DARRYL HILDA MELCHHART, AFFIRMED** [11.21 am]

<**EXAMINATION-IN-CHIEF BY MR GRAY**

30 MR GRAY: Thank you. Operator, please bring up document WIT – thank you. Just for the record I will read it into the transcript, WIT.0113.0001.0001. Ms Melchhart, are you able to see an image of your statement on the screen in front of you?

35 MS MELCHHART: Sorry, could you speak up. I can't hear you.

MR GRAY: Are you able to see an image of your statement on the screen in front of you?

40 MS MELCHHART: I'm able to see it, yes.

MR GRAY: Is that a statement that you've made for the Royal Commission?

45 MS MELCHHART: It is.

MR GRAY: What is your full name?

MS MELCHHART: Darryl Hilda Melchhart.

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

5 MS MELCHHART: No, the statement is correct.

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

10 MS MELCHHART: Yes.

MR GRAY: Thank you. Commissioners, I tender Ms Melchhart's statement.

15 COMMISSIONER TRACEY: The statement of Darryl Hilda Melchhart dated 27 April 2019 will be exhibit 3-3.

**EXHIBIT #3-3 STATEMENT OF DARRYL HILDA MELCHHART DATED
27/04/2019 (WIT.0113.0001.0001)**

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MR GRAY: Ms Melchhart, what is your age?

MS MELCHHART: 90.

25

MR GRAY: What sort of work did you do?

MS MELCHHART: Bookkeeping.

30 MR GRAY: Are you now retired?

MS MELCHHART: Yes.

MR GRAY: When did you move into residential aged care?

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MS MELCHHART: August 2014, 8 August.

MR GRAY: At that time, when you moved into residential care, were you mobile?

40 MS MELCHHART: Yes, I was fairly mobile, but I still had to use a walker and things like that.

MR GRAY: And what's your current mobility?

45 MS MELCHHART: Much the same, but I'm a bit frailer.

MR GRAY: Okay. If you don't mind my asking, how are your mental faculties?

MS MELCHHART: Pretty good, I think.

MR GRAY: How would you describe your state of health otherwise?

5 MS MELCHHART: Sorry. I don't understand - - -

MR GRAY: How would you describe your state of health otherwise?

10 MS MELCHHART: Pretty good. I do have a heart condition. That's all.

MR GRAY: And is that angina?

15 MS MELCHHART: I don't exactly know what it is, but I had rheumatic fever, and that means I've got a heart valve trouble, I think.

MR GRAY: And do you sometimes have to take – I beg your pardon, I will get the name right, Glyceryl trinitrate spray, GTN spray, for that heart condition?

20 MS MELCHHART: I don't think so. I don't know that.

MR GRAY: You don't have to take a spray sometimes for your heart condition?

MS MELCHHART: The GTN spray?

25 MR GRAY: Yes, the GTN spray.

MS MELCHHART: Yes, I do. Only if I get pain.

30 MR GRAY: Yes. And have you been told by your doctor about the importance of that spray?

MS MELCHHART: Yes, I keep it on me at all times.

35 MR GRAY: And what are the risks if you don't have the spray with you when you have pain?

MS MELCHHART: Well, I could have heart failure and die, or I could go to hospital, an ambulance they'd call.

40 MR GRAY: Do you also have regular pharmaceuticals, regular medicine - - -

MS MELCHHART: Yes, I do.

45 MR GRAY: - - - for that heart condition.

MS MELCHHART: Yes, I do.

MR GRAY: And are they diuretics?

MS MELCHHART: Yes, they are, but I keep the spray on me all the time in my handbag.

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MR GRAY: Yes, so the diuretics are regular and the spray is as needed; is that right?

MS MELCHHART: Right. Yes.

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MR GRAY: And if you don't mind my asking, how is your state of continence?

MS MELCHHART: May – could you please repeat the question.

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MR GRAY: How is your continence?

MS MELCHHART: Old age it is, it's not so marvellous.

MR GRAY: And you're on the diuretics?

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MS MELCHHART: Yes.

MR GRAY: So is incontinence an issue for you, Ms Melchhart?

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MS MELCHHART: A little, yes.

MR GRAY: Yes. And what about blood tests is that part of what your GP - - -

MS MELCHHART: I have to have a blood test before I go to the cardiologist.

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MR GRAY: All right. So just tell the Commissioners about the cardiologist; you have a regular cardiologist, do you?

MS MELCHHART: I do, and before I go – five days or so before I go, I have to have a blood test which he gets before I go to visit him.

35

MR GRAY: Yes. And how often do you visit the cardiologist, generally?

MS MELCHHART: Six months, unless I've had a bit of trouble then I'd go more, you know, with the next appointment he could make for me.

40

MR GRAY: Do you also have a GP?

MS MELCHHART: I do.

45

MR GRAY: And does the GP come to you?

MS MELCHHART: He comes to me. Nearly every fortnight or more if something is wrong.

5 MR GRAY: Is that the same GP you had before you moved into residential aged care - - -

MS MELCHHART: No.

10 MR GRAY: - - - in 2014?

MS MELCHHART: No, it's one we obtained when we were dissatisfied with the one the hospital provided.

15 MR GRAY: Thank you. Is the GP a GP who visits a number of other residents in the same home?

MS MELCHHART: One other resident at the moment.

20 MR GRAY: Yes. I'm going to ask you a few questions that refer to the residential aged care home but I'm not going to ask you to name it. In fact, please don't name - - -

MS MELCHHART: All right.

25 MR GRAY: - - - the aged care home.

MS MELCHHART: I will try not to.

30 MR GRAY: Okay. How many GPs – do you know how many GPs visit that aged care home, roughly?

MS MELCHHART: About five I think, approximately.

35 MR GRAY: Yes. And what about the cardiologist; does the cardiologist come to you or did you just - - -

MS MELCHHART: I go to him.

40 MR GRAY: You've got to go to him. And do you have help when you have to travel outside the aged care home?

MS MELCHHART: Only my carer and friend, Kerry.

45 MR GRAY: And is that Ms Roe?

MR GRAY: Yes.

MR GRAY: So without Ms Roe would it be difficult to get to the cardiologist?

MS MELCHHART: Yes, I would have great difficulty, because I have no relatives or family.

5

MR GRAY: Can I also ask, do you have a condition requiring once daily application of cortisone cream?

MS MELCHHART: Yes.

10

MR GRAY: So in terms of your medications, there's the diuretics that are regular, there's the once daily application of cortisone cream, there's the occasional use of the GTN spray.

15 MS MELCHHART: Yes.

MR GRAY: And do you occasionally need pain relief?

20 MS MELCHHART: Occasionally, yes, we do get given pain relief, sometimes it's not enough so I have to ask for some more.

MR GRAY: Yes. And is that usually paracetamol.

25 MS MELCHHART: Paracetamol.

MR GRAY: Do you have the occasional need for Coloxyl?

MS MELCHHART: Yes.

30 MR GRAY: So those are occasional medicines?

MS MELCHHART: Yes.

35 MR GRAY: Are there any other regular medicines, Ms Melchhart?

MS MELCHHART: Fluid reduce – reduction, I don't know if that's the right – same as the other one.

40 MR GRAY: Yes, like a diuretic?

MS MELCHHART: Yes.

45 MR GRAY: Now, I want to ask you about that residential aged facility again without asking you to name it.

MS MELCHHART: All right.

MR GRAY: Is the aged care facility in suburban Melbourne in [Redacted].

MS MELCHHART: It is.

5 MR GRAY: And about how many residents live there?

MS MELCHHART: About 135.

10 MR GRAY: Please tell the Commissioners about the part of the facility where you live; is it known as a wing?

MS MELCHHART: Wing, I suppose, yes, I suppose it's – a wing.

15 MR GRAY: About how many residents live there?

MS MELCHHART: 90 in one, and the – 45 in the other.

MR GRAY: And are you in the one with 90 or - - -

20 MS MELCHHART: No, the old wing is 90; the new wing has got 45.

MR GRAY: Which wing are you in?

25 MS MELCHHART: New one – the old one. Sorry.

MR GRAY: The old one with about 90 people in it?

MS MELCHHART: Yes.

30 MR GRAY: Have you always, since moving into that aged care home, been in that wing?

MS MELCHHART: And always the same room.

35 MR GRAY: The same room. I just want to ask you about friendships and social connection at the aged care home. When you first moved there, in general how were your social connections and friendships with other people in that part of the aged care home?

40 MS MELCHHART: Well, if we have social occasions, both wings come together, but it's not enough – not enough activities that are going on to keep people occupied, their minds occupied as well.

45 MR GRAY: When – about how often are there occasions like that to keep people's minds occupied?

MS MELCHHART: It depends on when there's public holidays, when there's nothing on, or weekends when there's nothing on, and otherwise you would get always Monday we have lotto, Tuesday have quiz. And then Wednesday they might have church which I don't believe in, and Friday we have happy hour. So there's a few, but if holidays come up there's nothing.

MR GRAY: Okay.

MS MELCHHART: Is that what you wanted to know?

MR GRAY: Well, I also wanted to ask you, casting your mind back to 2014 when you first moved in, you mention in your statement that when you first moved in you felt you had a pretty good level of friendships.

MS MELCHHART: Yes.

MR GRAY: With other people.

MS MELCHHART: Yes, that's right.

MR GRAY: Could you tell the Commissioners a bit about that and has that changed, and has that changed in recent years?

MS MELCHHART: It has changed because, of course, some of them have got five years older and their mental capacity is much reduced. But other than that, it – people are – there's a lot of them there that don't – you can't talk to anymore. So you're sort of sitting on your own and – and it's getting worse, and then they've got a new wing that has come now, haven't found any of them yet but there will be people amongst those you could maybe come together with, otherwise there's only one or two in the old wing.

MR GRAY: There's only one or two people with whom you can maintain a level of friendship?

MS MELCHHART: Yes, that's left.

MR GRAY: Why is that? Why after those years has it come to the point where they can't speak with you anymore?

MS MELCHHART: Yes, that's right.

MR GRAY: And why is that?

MS MELCHHART: There's one – well, I've got one woman I play dominos with on Saturdays and Sunday and, you know, she was quite – well, she still is quite skilful with the game, but you can't talk to her anymore. So I write a little note so she can read it because she's got deafer and she's a bit – not so capable as she was

before. She can still play dominos so we can still have a good game, but that's how it is. There's a few others and some of them have died off, of course, that's a penalty of old age.

5 MR GRAY: Yes. Could I ask, in that wing of the aged care home, are there also people living with dementia?

MS MELCHHART: Yes, there are.

10 MR GRAY: Yes.

MS MELCHHART: And there's some of them quite vicious at times as well.

MR GRAY: Well, in your statement you mention some violence.

15

MS MELCHHART: Quite often violence, yes.

MR GRAY: Could you tell - - -

20 MS MELCHHART: Coming into your room and things like that.

MR GRAY: Could you tell the Commissioners some examples of what has happened to you?

25 MS MELCHHART: Well, there was this woman, she goes around saying you can't understand what she's saying, but she came up and tried to take my walker away. I hung onto it naturally, and she starts hammering on my – on my hands like – like mad. I couldn't hang on any longer, I had to let it go. She took the walker somewhere away in the other side. So I had to ask one of the carers to go over and
30 get it for me because I couldn't get up and go without the walker. And then what else is, I've forgotten what else, me personally, she can get really vicious and there's – were some men who – one of them is I think is – looks as if he's not all there any more, who used to also be vicious. He'd go with his walker into you like this.

35 MR GRAY: I see.

MS MELCHHART: They should all be kept separate, I think.

40 MR GRAY: So in the aged care home where you live and in the area or wing of the aged care home where there are about 90 people, are you able to estimate about how many people have their mental faculties, and about how many don't have their mental faculties?

45 MS MELCHHART: They keep coming and going you know; they're dying off. I would say 10. 10.

MR GRAY: Who – who you're referring to as - - -

MS MELCHHART: 10 who you could still talk to.

MR GRAY: Who you can still talk to. And you mentioned a minute ago something about your idea that people should be in separate areas of the nursing - - -

5

MS MELCHHART: I think so.

MR GRAY: - - - or of the aged care home. Could you just - - -

10 MS MELCHHART: Because it's not very pleasant hearing all these people going on. Once I had someone sitting alongside me on a couch, and she suddenly says "I'm hungry" and she starts screaming out for a biscuit or a sandwich. The lady who lives in my room next door, you know, in the room next door, she's all the time pressing the button and saying "Coffee and biscuits please, coffee and biscuits please", and it could be 4 o'clock in the morning.

15

MR GRAY: Yes. Now, with regard to the people you mentioned in the area of the aged care home who you think should be separate from where you are, and where certain other people who do have their mental faculties, where they are; are they able bodied? So those people who you referred to that you're a bit afraid of; are they able bodied or not?

20

MS MELCHHART: Well they're - most of them are able bodied but once they get old they get much more aggressive, I've found. They could have been different people altogether before.

25

MR GRAY: I want to ask again about social connection and friendships, and you mentioned that there's only perhaps 10 people who can still talk in that part of the aged care home, and - - -

30

MS MELCHHART: Yes.

MR GRAY: - - - about two or three with whom you have a level of friendship; is that right?

35

MS MELCHHART: Yes, but there would be a few more who are probably all right, I just don't have - I haven't come across them because they might have just come in or they might have just gone away.

40

MR GRAY: Are you able to move freely - - -

MS MELCHHART: Yes.

MR GRAY: - - - with your walker around the wing and meet people?

45

MS MELCHHART: We can. Yes.

MR GRAY: And are you able to move around the facility as a whole into the new wing with 45 people?

MS MELCHHART: Yes, we are.

5

MR GRAY: You mentioned in your statement that – this is right near the end of your statement – you say staff don't have time to engage properly and they're overworked at times.

10 MS MELCHHART: Yes.

MR GRAY: Can you tell the Commissioners - - -

15 MS MELCHHART: I think that's probably – that's what it is. Some of them are very caring, and others have got so many to do before a certain time, showering or something and they're rushing you through, and doing all the things you don't want them to do.

20 MR GRAY: So just in an average day, how much time do you think you get to be able to speak with one of the carers; are you able to estimate that?

MS MELCHHART: You could go and speak to them whenever you like if you know where they are. They'll always answer you and talk to you.

25 MR GRAY: Do they bring you your meals in your room or do you go up to the dining room.

MS MELCHHART: No, I go up to the dining room.

30 MR GRAY: I want to ask you some things about what you've said in your statement concerning the attitude of some of the staff towards you as a person, since you entered aged care. You've made a few remarks about whether you have a voice, whether you feel you have a voice and you've given some examples.

35 MS MELCHHART: That's another thing. They treat you quite often, especially the nurses who are giving you your medication, they don't take you – if you say something, you – I should have that medicine in my hand so I can take it anytime, like the ATN spray, they want to hang on to it, say "I'll give it to you when you need it", but that's no good because they could be way over there and I could be way over
40 here.

MR GRAY: Well, specifically in that vein you mentioned your GTN spray.

MS MELCHHART: Yes.

45

MR GRAY: Was there an incident, either late 2018 or early 2019 - - -

MS MELCHHART: Yes, there was.

MR GRAY: - - - about your GTN spray.

5 MS MELCHHART: Very much, yes.

MR GRAY: Could you please tell the Commissioners about that.

10 MS MELCHHART: Well, I said – I looked at my spray and saw it was going to be out of date so I went down to the nurse and said “Would you order me another one?”. And she said “It’s not on the chart.” I said “I must have that spray and if it’s out of date I should have a new one”. She said “No, no, it’s not on the chart”, and that was it. She took my spray away. I mean, I could have still used it. And I had to wait
15 until my doctor came to get another one and he went straight over in – really worried that I could have had some trouble while I didn’t have the spray and he told her and she said “She’s got to have that spray”.

MR GRAY: How many days were you without a spray?

20 MS MELCHHART: I would say probably three or four. Not long but it could be a time when I need it.

MR GRAY: Yes. Did you ever find out why that happened; was there a mistake in the chart?

25

MS MELCHHART: No, she thinks that she could have – she should be having the stuff and deciding when I use a spray and when I don’t. Well, I can’t keep running around looking for her when I have an attack.

30 MR GRAY: Yes. And why is that; is that because there might be a delay in somebody responding? If the – if you - - -

MS MELCHHART: Of course, it’s a known angina spray and that happen. It could happen now; I’ve got one in my purse.

35

MR GRAY: Yes.

MS MELCHHART: And then by the time you get a nurse or somebody to give it to me, that might be it.

40

MR GRAY: Yes. And was there a similar incident with the cortisone cream that you need to apply daily?

45 MS MELCHHART: Yes, that’s right. Cortisone apparently is a bit dangerous or something like that, and I was told to use this cortisone cream, and they kept either forgetting or the nurse wasn’t there to get the cream so I didn’t get it. And I was

having a rash; I've still got the rash but it's not as bad anymore but I need it all the time.

5 MR GRAY: And did you find out whether there was some sort of error in the medication chart there or was it simply the attitude?

MS MELCHHART: It was the same thing; they think they should have it, and I'm not capable of – of administering it.

10 MR GRAY: You also mention requests for paracetamol when you've been in pain and Coloxyl when you've needed that.

15 MS MELCHHART: That's not so difficult because paracetamol they will give you, but you've got to run and find the nurse and ask for it, and then she wants to know why, etcetera, etcetera.

MR GRAY: You've also mentioned some examples about appointments and the need for blood tests prior to those appointments.

20 MS MELCHHART: Those – those medical records I've got to take with me whenever I go. What I'm taking so the cardiologist or whoever I'm visiting can know what I'm on already before he prescribes anything new. And you ask them for the paperwork in the morning, tell them, and problem is they know that they've got the appointment, maybe at quarter past 4. So they just don't bother about getting
25 them ready and they go off shift. But I asked them three times in one day for the paperwork, and I didn't get it, and we had to fax it through to the cardiologist, and we'd go there and meet him, and this happens quite often.

30 MR GRAY: So you're saying that the requests you've made and the information you've given to the staff about your own medical needs - - -

35 MS MELCHHART: Yes, I asked them – asked them for a copy of the paperwork, and they say "I'll get it for you", but you go back again and say "I haven't got the paperwork" and they say "But your appointment is not until quarter past 4" But I've got to be picked up by Kerry's husband, taken there and I wait an hour or so because he's got to go to work and Kerry's still at work, and so she comes, meets me there later on. But if I don't have the paperwork when I leave the premises, then what happens? We had to get them faxed through to the doctor one day.

40 MR GRAY: So what's happening in your opinion? You mention having no voice. What's your opinion about what's happening here?

45 MS MELCHHART: They – I say I need the paperwork by quarter to 1, and they think she's – what's she talking about, her appointment is not till 4 o'clock. I tried to explain what I – why I need it early and she doesn't listen. She thinks I don't know what I'm talking about.

MR GRAY: What's the underlying problem; are they just not putting any reliability or any weight on what you say, or what is it?

5 MS MELCHHART: It's hard to say. They're doing a job. Some of them are very good; some are not.

MR GRAY: I want to ask you about privacy. You mentioned a couple of points in your witness statement about privacy. Firstly, you mentioned staff - - -

10 MS MELCHHART: Sorry?

MR GRAY: Staff of the aged care home coming into your room.

15 MS MELCHHART: Staff.

MR GRAY: Yes, and privacy.

MS MELCHHART: Yes.

20 MR GRAY: So Ms Melchhart, can you tell the Commissioners – this is at paragraph 10 – can you tell the Commissioners something about that and your concerns relating to your privacy, and staff entering into your room?

25 MS MELCHHART: Well, that's right. I'm a very bad sleeper. I don't know if it's because of my breathing or what it is, but I can't sleep. I sleep about an hour, and then I wake up. But sometimes we've had staff come in to your room, and they open the door and look to see if you're in bed. And I've said, "I get to bed on my own, nobody helps me. Why do you have to do that?" "We have to do that". I say, "No, you don't have to do it because I won't get back to sleep for the rest of the night."
30 So I've told them about it, and most of the nurses don't bother doing that, but every now and again you get a nurse that – that's it for the night.

MR GRAY: All right.

35 MS MELCHHART: Is that what you wanted to know?

MR GRAY: Yes. That was what you mentioned in your statement and also - - -

40 MS MELCHHART: And in the morning at 5 o'clock they come in as well, and to bring pads in and put them in the thing behind the door. That wakes you up but I'm usually awake at 5 o'clock so it's not so bad.

MR GRAY: Do they ask permission to come in on those occasions?

45 MS MELCHHART: They knock on the door and walk straight in.

MR GRAY: They don't wait for a response, they just knock.

MS MELCHHART: No.

MR GRAY: At least they knock.

5 MS MELCHHART: At least they knock, yes.

MR GRAY: Could I ask you about your safety concerns. You did mention something about those earlier in your evidence when I was asking you questions.

10 MS MELCHHART: Sorry?

MR GRAY: Safety.

MS MELCHHART: Safety, yes.

15

MR GRAY: Now, could I ask you something more about that. You mentioned a couple of incidents or certainly you gave some detail about one incident concerning walking frame.

20 MS MELCHHART: Yes.

MR GRAY: Where are these incidents taking place? Are they in your room or elsewhere in the facility?

25 MS MELCHHART: Sometimes. Mostly it's outside when you're walking around. But we've had them come into your room. I've had one walk into the room. She walks over to – straight in and over to where I had a jewellery box like that. And she must have been here before because she knew exactly where that box was, and she started going like that and to pinch the jewellery and I put it back and told her to
30 leave the room. And she saw a cup and she thought the cup had something in, so she tried to throw the contents at me, but there was nothing in the cup so she tried to hammer me with the cup. I mean, it's laughable now but at the time I was a bit apprehensive.

35 MR GRAY: Yes. Have you asked the staff of the aged care home to try to prevent this?

MS MELCHHART: Everybody knows what she's like. It's just a matter of picking the right time to avoid her. Trying not to be in contact with her.

40

MR GRAY: Have there been any requests that you know of for the staff to keep a particular eye on her, one-to-one care for her so that she doesn't enter people's rooms.

45 MS MELCHHART: Well, they do keep an eye on them if they can. The staff does try to help but it's very difficult to give – you're in your room and they come in. How do you know that they're going to come into your room?

MR GRAY: Could I ask you how that's left you feeling about what's your home, your bedroom and your - - -

5 MS MELCHHART: That's right; it is our home, and we should be entitled to lead a normal life like other people.

MR GRAY: Can I ask you about supplies; you mentioned continence pads.

10 MS MELCHHART: Yes, I do.

MR GRAY: Could you tell the Commissioners what your concerns have been around supply of continence pads.

15 MS MELCHHART: Terrible difficulty in getting them out of them, continence pads. They're supposed to deliver them, like I said, 5 o'clock in the morning they come in. And it's up on a - on the little sheet behind your door how many you're supposed to receive, but you get one of this, and nothing of that and some big things that other people use. It's very difficult. You have to - eventually I've been on to the manager of the place and she's arranged now to - for someone to give me
20 additional tablets - pads. Is that what you wanted to know?

MR GRAY: Yes. Thank you. And that was in your statement as well and you've explained of some that. You mentioned at one point in time where you understood you only were allowed three a day.
25

MS MELCHHART: That's right.

MR GRAY: Of the incontinence pads.

30 MS MELCHHART: Yes. Since then I've been able to change it a little bit and with Kerry's help.

MR GRAY: And what's happening with other residents in the aged care home?

35 MS MELCHHART: They have the same problem. Everyone has it, it's not just me. Only I decided it's time to complain about it.

MR GRAY: And let me get this clear: does this mean that people are being left in wet pads when they - - -
40

MS MELCHHART: Only when I - they've told me, I don't know it personally, but I had a friend who - she saw I had some pads that I'd just been given in my little basket underneath my wheeler and she said, "I haven't got any, and that's why I didn't come up to the happy hour the other day." I would have liked to have given
45 her one but I thought no, you'll have to fight for herself, but she's got three daughters but they don't come in very often.

MR GRAY: Now, just got a couple more questions, Ms Melchhart. One is about the food. You mentioned that it's bland.

5 MS MELCHHART: Very bland. They don't use any salt or pepper. But they do have salt and pepper shakers on the table but some food you don't – you need to have it put in the cooking, and they don't use any spices. There's no – I've never had
10 curry since I've been there. So you're just straight out plain food. If you get vegetables, there's no butter in the vegetables. Potato, mashed potato, no butter in the mashed potato. It's so sticky and dry. If you go to the cook or the chef and ask for certain things, he tries his best to give it to you, but he can't do it for 135 people.

MR GRAY: Have you been able to maintain your appetite for that food even though it's bland?

15 MS MELCHHART: Yes, I have.

MR GRAY: How is your observations about how other residents fare with that; do they lose their appetite or maintain it?

20 MS MELCHHART: Most of them are complaining about it, but like I said, they try to help people, some of them, but how can you help 135 people with different tastes?

MR GRAY: And what's the issue, according to what you found out? Is it money or what is it? Is it expense? You mentioned something said by the chef when you
25 suggested pork belly.

MS MELCHHART: Staff – shortage of staff perhaps. Money is largely. I've had various suggestions of food that we could have, and they've – they said it's too much, costs too much.
30

MR GRAY: What's usually on the menu then; you mentioned that potato, and you mentioned some vegetables.

35 MS MELCHHART: When they have mashed potato, yes, I like potatoes of all kinds and mashed potato, I don't mind at all. But when they have mashed potato, I don't eat it anymore because it's like sticky, I don't know what. There's no fat in it.

MR GRAY: What else is generally on the menu?

40 MS MELCHHART: Fish. I don't mind going to a fish and chip shop but the fish they have there is very dry. It doesn't taste nice at all. What else was the – I didn't understand quite what you meant.

MR GRAY: What else do they serve; what other foods, what other meals?

45 MS MELCHHART: They do have a variety.

MR GRAY: Yes.

MS MELCHHART: I don't know exactly what – how to answer that question.

5 MR GRAY: That's all right. A couple of things, you mention physio and dental. What's happening with physio now; was it originally included in your care but now you've got to pay for it?

10 MS MELCHHART: We got twice a week and we didn't pay extra. I don't know what happened. They changed physiotherapist, physiotherapy and when they got the new one, you don't get it anymore, except when you first – when she first meets you, she says, "Walk up that hill", because you've got to go up a hill to go to the dining room. You walk up there and she – and she – and you walk back. She says "You're all right". And I said "Can't I have any physiotherapy?". And she says "You don't
15 need it, and it will cost you so much" – she didn't mention an amount, but it would cost more if I wanted anything extra.

MR GRAY: But you previously had been getting physio; is that right?

20 MS MELCHHART: Yes, it had been twice a week we'd been getting taken for walks and for exercise and going up and down on the rails and things like that. That's all gone.

MR GRAY: You've been missing out. Has that affected your mobility?

25 MS MELCHHART: Probably, yes, of course, if you're limited to the area you can go. You can't only walk in your – in the – in the area, whereas they used to take you for a walk outside and things like that to get you more moving, you know, more exercise.

30 MR GRAY: And finally, what about dental? Have you always had to travel outside the aged care home to get dental care?

MS MELCHHART: Sorry?

35

MR GRAY: Dental care.

MS MELCHHART: Dental care, yes, always have to get it outside. But there is a dentist, I think, who comes but I haven't seen him.

40

MR GRAY: All right. Commissioners, subject to any questions you might have those are the questions I have for Ms Melchhart.

45 COMMISSIONER TRACEY: Ms Melchhart, you've made a great effort to be here today and to give us your evidence which is very important to our understanding of how things work on a day-to-day basis in a nursing home. We are enormously

grateful to you for having taken this trouble and we will certainly give close attention to the evidence that you have given. Thank you very much for your attendance.

MS MELCHHART: Thank you.

5

<THE WITNESS WITHDREW [11.57 am]

10 MR GRAY: Will the Commissioners now adjourn as planned?

COMMISSIONER TRACEY: Yes. I think we will take a shorter adjournment than planned. I see it's almost midday. We will come back at 10 past 12. Please adjourn the Commission.

15

ADJOURNED [11.58 am]

20 **RESUMED [12.11 pm]**

COMMISSIONER TRACEY: Yes, Ms Hutchins.

25 MS HUTCHINS: Commissioners, the next witness you'll hear evidence from is Ms Merle Mitchell AM. On Wednesday last week, 1 May 2019, Ms Mitchell's evidence was given in a hearing before the Commission held before Commissioner Tracey in Glen Waverley in Victoria. A video of this evidence will now be played. Operator, please play RCD.9999.0037.0001.

30

COMMISSIONER TRACEY: This is a formal hearing of the Royal Commission into Aged Care Quality and Safety. It has been convened at premises at Chesterville Road in Glen Waverley to record the evidence of Ms Merle Mitchell. That evidence will be led by counsel assisting the Commission, Ms Brooke Hutchins, and the recording will be played at a formal sitting of the Commission to be held in Sydney next week. Ms Hutchins.

35

MS HUTCHINS: Thank you, Commissioner. I call Ms Merle Mitchell. Ms Mitchell, could you state your full name?

40

MS MITCHELL: Merle Valma Mitchell.

<MERLE VALMA MITCHELL, AFFIRMED [12.13 pm]

45

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Could you please state your full name.

MS MITCHELL: Merle Valma Mitchell.

5 MS HUTCHINS: How old are you, Ms Mitchell?

MS MITCHELL: 84.

10 MS HUTCHINS: Where do you live?

MS MITCHELL: At the Waverley Valley Aged Care.

MS HUTCHINS: Have you prepared a statement dated 27 April 2019?

15 MS MITCHELL: I have.

MS HUTCHINS: And is that the document in front of you now?

20 MS MITCHELL: It is, indeed.

MS HUTCHINS: Do you wish to make any amendments to the document?

MS MITCHELL: No.

25 MS HUTCHINS: To the best of your knowledge are the contents of the statement true and correct?

MS MITCHELL: Absolutely.

30 MS HUTCHINS: Commissioner, I tender Ms Mitchell's statement which is document WIT.0107.0001.0001.

35 COMMISSIONER TRACEY: The statement of Ms Merle Mitchell dated 27 April 2019 will be exhibit 3-1.

**EXHIBIT #3-1 STATEMENT OF MS MERLE MITCHELL DATED
27/04/2019 (WIT.0107.0001.0001)**

40 MS HUTCHINS: Thank you, Commissioner. Now, Ms Mitchell, you currently reside at Glen Waverley Aged Care. Could you please describe for the Commission the circumstances that led you to move into this facility?

45 MS MITCHELL: I'm sorry. Could you repeat that?

MS HUTCHINS: Certainly. Would you be able to describe for the Commission the circumstances that led to your moving into this aged care facility.

5 MS MITCHELL: Sure. My husband and I had lived independently up until I came
into this – or we came into this facility. We had been looking for somewhere where
we could find a place where I could live independently, and Eric could get the help
he needed. He suffered from post-polio syndrome which meant that much of what he
had suffered as a polio sufferer in – when he was seven years of age came back when
he was in his early 80s. And then he had a fall; he was in hospital. I came home
10 one day from visiting him. I, too, fell and broke my back. So that meant that the
criteria we had set down to find a place had to go by the board. We had to find
something very, very quickly and so we could no longer find a place where we could
get both of those services. And we had to move out of the community that was so
much part of our lives for so long, and we had to move to Glen Waverley.

15 MS HUTCHINS: And what – how is your health now?

MS MITCHELL: Mobility-wise, it's not good. Otherwise, it's – it's okay, but I
20 find it very difficult to get around. So I need that care to help me for getting out of
bed and having a shower in the morning and getting into bed again at night.
Otherwise, I'm very fortunate, yes.

MS HUTCHINS: And how did you find the experience of moving into Waverley
25 Valley?

MS MITCHELL: Terrible. There's a shock when you move into aged care. There
is the shock of loss because what happens is it is so quick. There's not the
recognition of loss because loss is not just death. Loss is loss of your way of life. It
can be – it wasn't for me because I was lucky – it – I was able to retain my interests.
30 My community at Springvale kept in touch with me, and for that I'm forever
grateful. There's the feeling of suddenly I'm in an institution. I have to follow what
the institution wants, the time to get up, the time to have meals and there's no –
there's no choice. So you lose your choice totally when you come into aged care.
And that's one of the things that needs to change.

35 MS HUTCHINS: And did you feel that you were supported by Waverley Valley in
your experience of loss when you moved into the facility?

MS MITCHELL: Not really. No, no. No, it was my – my family and my friends
40 who supported me. It was my family and friends who made sure that I actually
retained my cognitive abilities. I have seen other people come in here and lose that,
and without the support that I had got from my friends and my family, I think I too
would be in that same situation today.

45 MS HUTCHINS: Are there further steps that you think facilities like Waverley
Valley could put in place to assist yourself or other residents who might not have
family support and friend support?

MS MITCHELL: Yes, I think so. I watch many of them actually lose their cognitive ability when they come in. Staff don't have time to provide that sort of support for you. So people come in and they're told this is your home now. Well, it's not. It's an institution, and it's where you live. But it's not a home, and no matter how many times they tell you, it's still not your home. So my answer always to anyone who tells me that is, "This is where I live but it's not a home."

MS HUTCHINS: In your statement, Ms Mitchell, you touch on a recommendation that you think staff may be assisted by further education or training in relation to counselling, and bereavement counselling. Would you like to explain for the Commission a bit further about that?

MS MITCHELL: Yes. I think every facility should have a counsellor, both for the residents and for the staff. They did employ a counsellor here and at one stage when I agreed that perhaps it would be good if I had a session with a counsellor, it was arranged and one came. She sat down with me for 10 minutes, looked at her watch and said "Oh dear, I've got a meeting", and off she went and that's the last I saw of her. And so I haven't gone down that road again, yes.

MS HUTCHINS: Have you been offered any external counselling services?

MS MITCHELL: No, but I've arranged one for myself, yes. Yes.

MS HUTCHINS: And is that a government-funded service or something that you've needed to contribute to yourself.

MS MITCHELL: I will have to contribute to that, yes.

MS HUTCHINS: Certainly. You said earlier that a residential aged facility like Waverley Valley here is not your home, and it is an institutional facility. What is the main differences or experiences that you have here that would differ from life outside?

MS MITCHELL: Well, I haven't got my own things around me. I have got a lot of things around me but I can no longer reach out and grab an atlas if I hear something on the news. I can no longer reach out and get my favourite book because there's a limit in how much you can actually bring with you. And there's just that feeling that this isn't a proper life, and so there is that feeling that the quicker it's all over, the better it is for everybody – yes.

MS HUTCHINS: Do you feel like you're in control of your ability to receive the services that you might need or the medical or health attention that you might need?

MS MITCHELL: If I pay for it, yes. So if you come into a facility like this, you can pay for extra services, which I do, and that costs \$50 a day, and for that I get an exercise session with an exercise person for about half an hour a day, five days a week, and a paper. And I do get soup before my meals.

MS HUTCHINS: Are you aware, if you don't pay that extra \$50 for those services, that residents who don't have those additional funds; they don't receive those?

5 MS MITCHELL: Yes, they don't receive them. And there's a further – you know, there is a further problem because some of the residents who do have those services, and are very class conscious, tell me, well, we're better than the others you know because we can actually afford to pay more.

10 MS HUTCHINS: In relation to the receipt of medical attention, do you feel if you express to staff that you're not feeling well or you have any issues that your concerns are adequately addressed?

MS MITCHELL: It depends because a lot of - - -

15 MR BOLSTER: Commissioners, there's one option if this is going to be extended. I have a witness who is ready; if he's here we could perhaps interpose him.

COMMISSIONER TRACEY: I think that is desirable until this problem with the video is resolved and we can resume the video once that problem is solved.
20

<THE WITNESS WITHDREW [12.26 pm]

25 MR BOLSTER: I will just make some inquiries and make sure he's available.

COMMISSIONER TRACEY: Yes. Thank you, Mr Bolster.

30 MR BOLSTER: My concern is he may have gone for an early lunch, given the timetable we had otherwise agreed on.

COMMISSIONER TRACEY: Well, we'll see how we go. I'm afraid the technology is defeating us this morning.

35 MR BOLSTER: Commissioners, I call George Akl, that's spelt A-k-l.

COMMISSIONER TRACEY: How is that surname pronounced?

40 MR BOLSTER: Akl.

COMMISSIONER TRACEY: Thank you.

45 **<GEORGE AKL, AFFIRMED [12.29 pm]**

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Commissioners, just for the record I think we will aim to finish this examination at about one. That's what I had planned. If the document number WIT.0108.0001.0001 could be brought up. Thank you. Mr Akl, if you look to the screen on your right, you will see a copy of your statement and that should have
5 some sections blacked out, and do you recognise that as the statement that you made on 26 April?

MR AKL: Yes, I do.

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

MR AKL: No. No, I don't wish to make amendments but I just would like to just make it clear that I'm here not as a condemnation of my dad's care. I was very happy with my dad's care. This is just – I'm just here to just – about – just to bring
15 up the issue of lack of policy around English – people with English as a second language, and the human consequence of that that I felt.

MR BOLSTER: We will get to that.

20 MR AKL: Okay.

MR BOLSTER: We will deal with that in some detail.

MR AKL: Sure.

25

MR BOLSTER: Now, I tender Mr Akl's statement, document number WIT.0108.0001.0001.

30 COMMISSIONER TRACEY: The statement of George Akl dated 26 April 2019 will be exhibit 3-4.

**EXHIBIT #3-4 STATEMENT OF GEORGE AKL DATED 26/04/2019
(WIT.0108.0001.0001)**

35

MR BOLSTER: Now, Mr Akl, in the draft – in the copy of your statement that does not have the black marks and redactions, there is reference to three service providers who provided service to your father, and we're not going to mention them for the
40 purpose of this hearing. You understand that.

MR AKL: I do.

45 MR BOLSTER: Yes. So the aim is to develop your father's experience and your experience of the care he received. So Mr Akl, your father was born in Egypt?

MR AKL: He was.

MR BOLSTER: And what year was he born?

MR AKL: 1944.

5 MR BOLSTER: And he came to Australia in 1966?

MR AKL: Yes, he did.

MR BOLSTER: And he was an educated man.

10

MR AKL: He was, yes.

MR BOLSTER: Could you tell the Commission the sort of education that he had, and what his skills, qualifications, what his work history was like.

15

MR AKL: He was – he was educated in construction. He had degrees in mechanical and civil engineering and a master's degree in building science. He worked on large-scale building projects for the public service in Melbourne around rail and housing commission, and yes, he was quite high in his – quite high ranking in his position.

20

MR BOLSTER: From the time you knew him as a child, he spoke English fluently.

MR AKL: He spoke English fluently, yes. He studied in English at school.

25

MR BOLSTER: In school in Egypt?

MR AKL: Yes.

30 MR BOLSTER: And he never had any problems communicating with people in English until he got sick.

MR AKL: That's – that's correct.

35 MR BOLSTER: All right. And I want to talk now about how that happened. So that was in 2015.

MR AKL: Yes, around then, yes.

40 MR BOLSTER: And what was his personal situation at that time?

MR AKL: He was living alone in – on the central coast of New South Wales. He – I'm not quite sure when exactly he started showing these symptoms but I imagine in about April from what I'm – what I can make out from speaking to people living in his area. And yes.

45

MR BOLSTER: And what happened; how did things change for your father?

MR AKL: He started having hallucinations. There was – and the hallucinations began to frighten him. That’s when his neighbour called me and told me that, you know, dad was having these hallucinations. I didn’t know. Dad didn’t want me to know. And then I went down to the Central Coast and, you know, realised that dad
5 had been, I guess, at that stage quite progressed in his – his disease or his hallucinations were definitely a significant part of his world.

MR BOLSTER: You were living in Melbourne at the time.

10 MR AKL: I was living in Melbourne, Yes.

MR BOLSTER: So he had retired up to New South Wales, had he?

15 MR AKL: He – yes.

MR BOLSTER: Okay. Now, he was subsequently diagnosed with a Lewy body dementia.

20 MR AKL: He was.

MR BOLSTER: Could you tell the Commission how did that process pan out; how did he come to be diagnosed?

25 MR AKL: Well, when I first got to the north coast of New South Wales to his home, I took him to the hospital because his medication was all over the place. I just noticed his capsules were – well, he hadn’t been taking his medication properly so I thought I’d take him to the emergency there, and while we were there, the – I can’t remember exactly what happened but where he ended up being – speaking to a psychiatrist there, and spoke to him for about a good hour and a bit.

30 And after the – after that – after that session, the psychiatrist said – suspected that he had Lewy Body from all the symptoms, from the way Dad was walking and the hallucinations. I mean, I think for the whole time we were never really sure if he had Lewy Body, because Lewy Body, it presents with so many different diseases, sorry,
35 so many different symptoms but the way his disease progressed and the way his symptoms laid out, it seemed like he’s got Lewy Body.

MR BOLSTER: So you mentioned the gait; was that the way he walked?

40 MR AKL: Yes.

MR BOLSTER: And what did you see in your father that was unusual?

45 MR AKL: About the way he walked?

MR BOLSTER: Yes.

MR AKL: He shuffled a bit, and – initially he shuffled, and then – and then he just couldn't walk, yes.

MR BOLSTER: Other than that, his health otherwise?

5

MR AKL: He had diabetes, and his health otherwise was pretty good.

MR BOLSTER: So there's a diagnosis; what support and intervention followed that?

10

MR AKL: Well, the – in the – in New South Wales the local hospital assigned a nurse that came and visited dad once – well, once or twice every – once or twice a week.

15 MR BOLSTER: Yes.

MR AKL: And – and then we got – Dad moved into a home care package until – I think a one and two, and then he quickly moved into a three and four.

20 MR BOLSTER: Was he able to access all of the services for level 4?

MR AKL: He was, yes.

MR BOLSTER: So how long did he have to wait for that?

25

MR AKL: Not long because they escalated him in the priority list because he – he needed those services.

MR BOLSTER: You were living in Melbourne though, and there came a time when he couldn't stay at home.

30

MR AKL: Yes.

MR BOLSTER: What was the determining factor that forced him into residential care?

35

MR AKL: Well, he couldn't – you know, he couldn't look after himself, he couldn't toilet himself.

40 MR BOLSTER: Yes, and you brought him down to Melbourne.

MR AKL: Yes.

MR BOLSTER: And you put him into a nursing home in Melbourne.

45

MR AKL: Yes.

MR BOLSTER: Which we won't name.

MR AKL: We won't name, yes.

5 MR BOLSTER: And what happened there with your father's treatment?

MR AKL: Well, dad was okay there for a little while. He seemed – his symptoms got worse; his hallucinations started to get worse. I think he started to get a lot more frustrated, and then one day he thought the building was on fire and threw a chair
10 into the window. It didn't break the window or anything, it was just a plastic chair. But they – he then – they sent him to facility 1.

MR BOLSTER: Facility 1. That was - - -

15 MR AKL: Yes.

MR BOLSTER: Yes. Okay. So from the nursing home to facility 1 - - -

MR AKL: Yes.
20

MR BOLSTER: - - - and that was an attempt to find him some extra services in relation to his condition.

MR AKL: I think that was an attempt to get his medication right because he wasn't
25 on antipsychotic medication until that point.

MR BOLSTER: Right.

MR AKL: And they sent him there to - - -
30

MR BOLSTER: Now, at what point does the English become a problem for him?

MR AKL: I think at that point he was starting to show frustration at – but his English was still fine at that point. I think probably from that point on for about
35 another two or three months it starts to become a big issue for him, or a relevant issue.

MR BOLSTER: All right. Let's get the timing right. So the move to Melbourne was in September 2016.
40

MR AKL: Yes.

MR BOLSTER: And then the episode with the chair is within a month or two of that.
45

MR AKL: About a month, yes.

MR BOLSTER: And then he goes to facility 1, and you start to notice the English decline.

MR AKL: Yes.

5

MR BOLSTER: End of 2016; is that right?

MR AKL: Yes, I guess I start to notice more the Arabic, the difference between him speaking Arabic - - -

10

MR BOLSTER: Yes.

MR AKL: - - - more than his English decline. Like, as he gets visitors and he speaks Arabic he just was different, you know.

15

MR BOLSTER: Tell me, did you and him normally communicate in English or in Arabic?

MR AKL: We communicated both. I tried – my Arabic is quite rudimentary compared to his but enough to communicate, we could successfully communicate. But I tried to keep his English going so he wouldn't lose his English because I realised that that would be significant in his care, but – so yes.

20

MR BOLSTER: So let's talk now about the move to the facility number 2 in Melbourne, and that was the last place that he was at.

25

MR AKL: That was – yes, correct.

MR BOLSTER: And could you tell the Commission about the deterioration of the English while he was there. What did you observe?

30

MR AKL: First, he would just sort of babble, I guess, or not so much babble. His – his English would – I guess, I noticed he would be speaking in English but conceptually in Egyptian and it sort of didn't make sense and his – yes, you know, when he spoke English it felt like he was struggling but when he spoke Egyptian he was quite coherent. He was, you know, people had said that they didn't think he had dementia when he spoke in Egyptian because he was – it was just like he was a different person in the two different languages.

35

MR BOLSTER: Could I ask you to have a look at paragraph 23 of your statement, and you refer there to an occasion when there was an Arabic-speaking nurse who was there at that facility on contract.

40

MR AKL: Yes, that was at facility 1 because he got returned back to facility 1.

45

MR BOLSTER: Right. Okay.

MR AKL: For a few months.

MR BOLSTER: Explain that interaction. How – what did that reveal to you?

5 MR AKL: Well, that revealed – I guess I – you know, he – that interaction, the
nurse was speaking with dad for a good half an hour in proper Arabic which is
beyond me. I can't speak that proper Arabic. And they were just having, like, a
conversation and the nurse said to me that, you know, he didn't think that my dad
10 was – had dementia, that the level of conversation was at that level that – yes, and I
guess, yes, that – that was – to me that was the point where I sort of realised that I
had – that there was just something wrong. That that, you know - - -

MR BOLSTER: So how did you plug the gap between your father and his English?

15 MR AKL: Well, I guess I just spent a lot of time with him. I spent every day with
him. Talking to him and just, you know, we went out a lot as well. I just kept him –
kept him engaged and kept him talking as much as possible.

MR BOLSTER: When you were looking around, so before you went to the final
20 facility - - -

MR AKL: Yes.

MR BOLSTER: - - - facility 2 in your statement; did you try and find a home that –
25 where Arabic was - - -

MR AKL: I did, yes, I've - - -

MR BOLSTER: How did you go trying to find that?
30

MR AKL: I couldn't find anything. There was a couple of places that had Arabic-
speaking people working there irregularly, but there wasn't any – anywhere that –
yes, that was – yes, that – there wasn't anywhere, essentially.

MR BOLSTER: All right. You mentioned that you wanted to highlight the lack of
35 access to second language services for people in the situation of your father where
their second language, in the case it's English, effectively goes, and they revert back
to their first language, their language at birth. What's missing? What needs to
happen in order for people like your father to get adequate care?
40

MR AKL: You know, that's such a big question. I think – I guess, first, it has to be
acknowledged that there's, you know, there's a big difference between people whose
English is a second language, and native-speaking people that once they get into the
health care system or sorry, the aged care system, that there's a divide in
45 communication or not. I think it has to be acknowledged that that's not really fair,
and that there has to be – look, you know, I don't know – what ideally what would
have been great for dad would have been a place where he could – you know, that

people could speak his language, you know, he could experience his culture and engage in his – his way of being.

MR BOLSTER: Yes.

5

MR AKL: I mean - - -

MR BOLSTER: I take to you paragraphs 37 and 38, if they could be brought up, please. You make the point there about connection to his culture and how important that was to him. Was he – did he remain connected to his culture before his illness?

10

MR AKL: Not really.

MR BOLSTER: Yes.

15

MR AKL: I mean, yes, in that, you know, he still liked to eat that food on a – he didn't cook much traditional food for himself, but I guess dad was fairly well-acclimatised in Australia. He was very – yes, you know, he was connected to his culture in that he was connected to his brother and he was connected to his family but he wasn't traditional in what most people would be, but as he got – as his disease progressed he became more connected with his culture.

20

MR BOLSTER: Yes.

MR AKL: Like a lot more, you know.

25

MR BOLSTER: So he went back to the culture of his childhood, the language of his childhood.

MR AKL: The language and the food and the music, and yes, I guess he came – he almost did a full circle and, yes, so, you know, we'd listen to the music of his childhood or Arabic music and, you know, I would buy him food.

30

MR BOLSTER: And when that wasn't available to him, when he was by himself, when you couldn't be there - - -

35

MR AKL: Yes.

MR BOLSTER: - - - did he communicate with you about how that felt?

40

MR AKL: Yes. He – you know, I guess, I worked really hard in conjunction with the facility and with – with his carers that we devised a plan to minimise the frustration that he had, and so he did have frustration around that, but that was minimised but that took a lot of work.

45

MR BOLSTER: How did that play out? How would he get frustrated when you weren't there?

MR AKL: Well, he couldn't communicate and he loved talking and yes, he – you know, he just was – I guess his frustration sometimes would trigger his psychosis and – and I mean, I guess another thing with dad was that his disease progressed really rapidly and so it was – he was always very vulnerable in that one medication would
5 work and then eventually a month or two later would stop working, and so there was always – there was always that vulnerability and that – that was almost relentless and so, you know, those frustrations, I guess, were amplified because he was in that sort of condition.

10 MR BOLSTER: Was there a point where he completely lost his English?

MR AKL: I mean, yes, like, he babbled – would turn into babble.

MR BOLSTER: Yes.

15 MR AKL: And there was a point, yes, where it just, yes, he just lost it.

MR BOLSTER: How long after that, after he was in facility 2 did that happen?

20 MR AKL: Look, that's difficult to say because – because I – I worked really hard to maintain – to help him maintain that English, so we kind of developed a code where he could still communicate and – and because there was consistency in the staff of facility 2, you know, he had enough English and it was enough for him to be sort of
25 cared for but not particularly engaged.

MR BOLSTER: Yes. I'm interested when you say that you developed a code. I don't know whether you heard senior counsel's opening this morning. There was evidence in the Adelaide hearing about a husband with his wife and she lost the ability to communicate and the way they communicated was touch and other ways.
30 Is that an experience that you can – that you had with your father?

MR AKL: Yes. Yes. Touch and, I guess, certain words and feelings. And I mean, I – I think dad just eventually drifted into a routine. It got to the point where his
35 frustrations just sort of wavered off and - - -

MR BOLSTER: Yes.

MR AKL: Yes, I don't know; it's really hard to put it all into context because it all happened very quickly. There was every – you know, in the beginning every couple
40 of weeks there was a significant shift and then - - -

MR BOLSTER: So it was very rapid. The diagnosis was in '15, and your father passed away September of last year; correct?

45 MR AKL: Yes.

MR BOLSTER: All right. Is there anything that you want to tell the Commission that you haven't already mentioned about your father's experience that is important to you?

5 MR AKL: Look, I just – I guess it's just, you know, dad was a big communicator
and he was really good with people and he was really well loved and – and, you
know, was very charismatic and – and, you know, he just – it just didn't – it seemed
that he had more to give than the opportunity that he had, you know. I think had he –
had he been able to communicate and, you know, have engaged communication for a
10 bit longer, it would have made a significant – a very significant – had a significant
effect on his wellbeing and on his frustration on – and on his will to live, you know.
He just – I think when he got to the point where he couldn't engage with the world
properly anymore, with the whole – when he couldn't speak to people anymore, he
didn't feel like, you know, he was that person and he was all – he never lost sight,
15 you know, he never lost himself up until he died.

He didn't lose consciousness of who he was or who I was or where he was or
anything like that, maybe up until the next couple of weeks until he died. And that
was really frustrating for him to have to be in a world where he couldn't be himself,
20 and he wasn't ready to give that up. Like, he still had the ability to communicate.
There just wasn't a space for him to communicate properly.

MR BOLSTER: Commissioners, that's the examination from my perspective.

25 COMMISSIONER TRACEY: Mr Akl, we are most grateful to you for having
shared your deeply personal experience. We've heard about reversion to first
language, but we haven't had, before you, any direct evidence of its effects and how
it works, and what can be done to alleviate the effects. Your evidence will be of
great assistance to us in thinking through how cases such as your father can better be
30 dealt with in the future and we're most grateful to you for your evidence.

MR AKL: Thank you.

35 <THE WITNESS WITHDREW [12.54 pm]

COMMISSIONER TRACEY: We will make up some time by resuming at a quarter
to 2. Please adjourn the Commission.
40

ADJOURNED [12.54 pm]

45 RESUMED [1.50 pm]

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Commissioners, I understand the technical difficulties with the video recording of Ms Merle Mitchell's evidence have been rectified and we're in a position to continue on with that evidence now if it suits you.

COMMISSIONER TRACEY: Thank you.

MS HUTCHINS: Thank you.

<MERLE VALMA MITCHELL, ON FORMER AFFIRMATION [1.50 pm]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS MITCHELL: It depends because a lot of the greatest difficulties is staff ratios. So if I need something in the middle of the night, because there's only one nurse responsible for 170 patients I wait a very, very long time. I am lucky that I do get my own GP, and that all just happened unexpectedly. He came in to see me, to see how I was, and I said, as I desperately needed him to become my GP, because GP visits here tend to be quick, and the interview is carried out in the middle of meal times. So there's no privacy and there's no in-depth consultation. So I'm very – I'm one of the fortunate ones who has a GP who is prepared to travel to visit me.

MS HUTCHINS: In your statement, Ms Mitchell, you refer to an incident that occurred around 27 January 2016 where you had made some complaints to staff here about pain that you were experiencing at the time. Could you please explain for the Commission the circumstances around what happened at that time?

MS MITCHELL: This is – this is early when I was first here and I had come from hospital and I knew there was something wrong and I asked to have some more treatment to probably go back to hospital because that treatment was – that pain was so intense. So three of the senior people, including one of the physios, came in and said, "It's all in your head, there's nothing wrong." My friends happened to be here one day when I was trying to get out of bed, and one of them said, "If you don't get Merle to hospital, you will be guilty of elder abuse." And within – and then one of them disappeared and within half an hour the ambulance was here, and sure enough, I had a crushed disc and a broken back. So that – that meant that I had another three weeks in hospital and three weeks of physio.

MS HUTCHINS: So a matter that you raised earlier, and you touch on in your witness statement also is the issue of staff ratios and whether there's sufficient staff available to be able to assist you when you require - - -

MS MITCHELL: Yes.

MS HUTCHINS: When you require assistance. Are you able to point any other examples to the Commission of instances where you feel like you don't receive the services or assistance that you need because of the lack of staff or - - -

5 MS MITCHELL: There are – there is a problem with staff ratios in two important times in the day. There's a real problem when people are getting up in the morning and being showered. Staff have to get through before breakfast. They have to do at least two and sometimes three patients. So it has to be done very, very quickly. Going to bed at night I have a lot of problems because there are things that I need
10 done, and constantly I have the staff coming and saying, "Will you turn the light out now?" No. We're not ready yet. And most nights that will happen on at least five occasions. Now, staff ratios in hospitals are now down to one nurse for every six. Here, it's one for 70 and I think, as they are doing here, and that is cutting shifts short at meal times and at those two vital times in the day really does create a lot of
15 pressure on staff, and on the residents as well.

MS HUTCHINS: And how do you find your interactions with staff at the facility? Are you able to provide some comments about your observations on the attitudes of staff members?

20 MS MITCHELL: There are some staff members who are absolutely superb. They observe what needs to happen. There are great role models and I reckon there's about a third of them like that. There are a third of them that are here because of the pressure of Centrelink or because they can't get jobs in their own field; they've
25 come out here as international students. And there are about a third of them who are absolutely bored to tears, and I can tell that because they sit there – stand there at meal times yawning. Or else getting into a cluster of three people and talking to each other, rather than sitting down and talking to people. And that also happens with the way in which people are fed. If they need help with – with eating – I saw a staff
30 member the other day sit on the table and shovel the food into the person's mouth, and she was yawning at the same time and not bothering to talk to him about what he was being fed.

MS HUTCHINS: Do you think that the staff here are appropriately trained to know
35 how to care for you in a way that you would hope and expect?

MS MITCHELL: No. I think that's one of the big things the Commission has to look at, is the training. I think the work that RMIT is doing at the moment is going, hopefully, to actually make a difference. The length of time of the training courses is
40 far too short and doesn't cover the really important things like observational skills, anticipating what it is that people need. There is no training in bereavement. There is no training in gentle handling of people who might be in pain. There's an enormous amount to be done in relation to training.

45 MS HUTCHINS: Changing topics to access to services outside of the facility, and in particular lifestyle activities that are offered to you also within Waverley Valley, do you feel that the services you're offered in this regard meet your needs?

MS MITCHELL: No. I constantly ask for more challenging activities. The lifestyle people work really, really hard. Too much is expected of them; if they want anything extra they have to raise the money themselves. So they run the coffee shop, you might have seen as you were coming in, and the money goes to their work so the facility doesn't provide any of that assistance. I have asked for discussion groups where we could actually discuss issues of the day, but they say to me, "You're the only person who's got the capacity". And my response always is, "Maybe I've got that capacity because I've been lucky enough to have friends who have kept me in contact with the community. Otherwise I think I, too, might be like a lot of the people who I've seen come in here and lose – lose their cognitive capacity.

MS HUTCHINS: Thank you. Finally, Ms Mitchell, I would like to ask what you see as the most important things that the Commission should be looking at for change that would make a real difference to you, say, living in a residential facility?

MS MITCHELL: Ratios. Ratios. Ratios. Ratios. Everybody will tell you that. There's so much more that could be done for all of us. If the staff even had time to sit down and talk to people. They don't have time to talk to residents because they're under so much pressure to be able to fill their requirements.

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

COMMISSIONER TRACEY: I would like to pursue a couple of matters. I'm particularly concerned about the provision of medical services.

MS MITCHELL: Yes.

COMMISSIONER TRACEY: I think from what you said there is, as it were, an in-house visiting general practitioner who comes periodically, you said, during meal times.

MS MITCHELL: Yes. He was here all the time. He's permanent.

COMMISSIONER TRACEY: Permanent but he conducts his consultations not in the privacy of a – of a suite or - - -

MS MITCHELL: No.

COMMISSIONER TRACEY: Just in the dining room.

MS MITCHELL: Yes.

COMMISSIONER TRACEY: Well - - -

MS MITCHELL: And that's also when you actually arrive as a resident. So he gets all your details then in the dining room.

COMMISSIONER TRACEY: And we heard that best practice involves the establishment of care plans, to which doctors, nurses and carers all contribute, and that those plans are periodically revised and updated. Have you experienced here that sort of regime?

5

MS MITCHELL: I've been here for two years before I actually got a care plan. So my first care plan was carried out – I came in here in June 2016, and I had the first one last year.

10 COMMISSIONER TRACEY: And you mentioned that in that period, you had had to go to hospital for some - - -

MS MITCHELL: Yes.

15 COMMISSIONER TRACEY: - - - significant treatment. Are you aware of whether the hospital, upon your discharge and return here, provided the facility with all the medical details that was necessary to ensure your ongoing care?

MS MITCHELL: I'm sorry, I do not know. I can't answer that question.

20

COMMISSIONER TRACEY: Nobody – the resident doctor didn't come to you and say, look, I've just - - -

MS MITCHELL: No.

25

COMMISSIONER TRACEY: - - - got this report from the hospital and - - -

MS MITCHELL: No.

30 COMMISSIONER TRACEY: - - - and we need to do this, that and the other to assist you.

MS MITCHELL: Yes.

35 COMMISSIONER TRACEY: Nothing like that.

MS MITCHELL: No.

40 COMMISSIONER TRACEY: At some point in that period your own former GP - - -

MS MITCHELL: Yes.

45 COMMISSIONER TRACEY: - - - reappeared on the scene and has, I take it from what you said, continued to visit you - - -

MS MITCHELL: He has.

COMMISSIONER TRACEY: - - - and look after you.

MS MITCHELL: Yes.

5 COMMISSIONER TRACEY: When the doctor visits you, does the facility provide some privacy for the consultations?

MS MITCHELL: Yes.

10 COMMISSIONER TRACEY: Yes.

MS MITCHELL: Yes.

15 COMMISSIONER TRACEY: And is that in a medical suite or in your room or - - -

MS MITCHELL: No, he comes into my room.

COMMISSIONER TRACEY: He comes into your room - - -

20 MS MITCHELL: Yes.

COMMISSIONER TRACEY: - - - where you can have a private consultation.

25 MS MITCHELL: Yes.

COMMISSIONER TRACEY: And what if, for example, that doctor prescribes some medication for you, is one of the registered nurses available to ensure that that prescription is filled and provided to you?

30 MS MITCHELL: Yes, yes. So he goes – after he sees me, he goes straight back to the nurses’ station, fills out the prescription and it gets sent off to the pharmacy that provides all the pharmaceuticals here, yes.

35 COMMISSIONER TRACEY: And we’ve been told that in facilities such as this it’s only registered nurses who can administer prescribed medication to these people.

MS MITCHELL: Yes, that’s true.

40 COMMISSIONER TRACEY: Have you been provided with your medication in a timely way regularly or have there been gaps that shouldn’t have occurred?

45 MS MITCHELL: I’ve been – when I – when my doctor has prescribed one, that’s been filled very quickly. The only time when I have had difficulty in getting what I need, if I had a medication that is parent – patient request at night, that’s when I’ve had to wait a long, long time because some of my medication are only – only to be taken when I need them.

COMMISSIONER TRACEY: I assume they include pain relief?

MS MITCHELL: Yes.

5 COMMISSIONER TRACEY: And have you had to wait long periods from time to time to get relief you need?

MS MITCHELL: Half an hour, yes.

10 COMMISSIONER TRACEY: As we came in this morning, we passed a hairdressing salon, a gymnasium facility.

MS MITCHELL: Yes.

15 COMMISSIONER TRACEY: Are they available to all residents or are they part of the \$50 a day extra?

MS MITCHELL: If you have your – a hair – if you go to the hairdresser, you have to pay extra for that – so you - - -

20

COMMISSIONER TRACEY: To the hairdresser.

MS MITCHELL: To the hairdressers, yes.

25 COMMISSIONER TRACEY: But that facility is available.

MS MITCHELL: Is available, yes.

COMMISSIONER TRACEY: What about things like podiatry, oral health?

30

MS MITCHELL: Those two are provided by the facility, yes. I'm presuming it's not just the special services but I don't know that, yes.

COMMISSIONER TRACEY: And you indicated that there are people here who simply can't afford the extras - - -

35

MS MITCHELL: That's right.

COMMISSIONER TRACEY: - - - that have to be paid for. Have you noticed any downside to that, by which I mean are these people obviously lacking in assistance that they need simply because they can't pay for it?

40

MS MITCHELL: Yes, I think everybody needs the exercise classes that I get on a one-on-one basis on a daily basis to keep up their mobility. So I think there are many people who are missing out.

45

COMMISSIONER TRACEY: That completes the matters I wish to raise with you.

MS MITCHELL: Can I just raise one more?

COMMISSIONER TRACEY: I was going to ask you: is there anything you wish to add that you would wish the Commission to have regard to?

5

MS MITCHELL: I think more needs to be done about the mental and emotional impact of actually moving into an aged care facility. And that gets back to training and, again, to the ratios. Because the ratios are so low, nobody really has the time or inclination to actually think about what it is they're doing and what it is that they need to do. And I think also there needs to be much more done in the selection of staff to do the training to work in these facilities. So we've got an enormous number of people who come in here who come because Centrelink tells them if they do the course and come and work in here they will meet their job obligations. And you've got a number of people who come in as international students, not able to get the work that they are qualified for and so they know that if they do the course then they will be able to get work.

So it really all does get back to that: training and ratios. They would be my two big things that I would emphasise needs to be looked at.

20

COMMISSIONER TRACEY: Well, we've certainly taken that on board and it will be a matter that the Commission will be looking at very seriously in the course - - -

MS MITCHELL: Good.

25

COMMISSIONER TRACEY: - - - of its deliberations and the recommendations we ultimately make to government, but it has been very helpful to have your insights, as it were, from the inside.

MS MITCHELL: That's true, isn't it?

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COMMISSIONER TRACEY: We've heard from a lot of experts who say how treatment and training and things of that kind should occur, but what we haven't had thus far is the insight of somebody who's seen it working on the ground, and we're enormously grateful to you for the time and trouble you've taken to prepare your statement and to give your evidence, and this recording, as I indicated at the outset, will be played to a full session of the Commission in Sydney next week, and will be formally part of the Commission's evidence. Thank you very much.

MS MITCHELL: Thank you.

40

<THE WITNESS WITHDREW

[2.14 pm]

45

MS HUTCHINS: Thank you, Commissioners. I seek for the video to be marked as an exhibit. That's number RCD.999.0037.0001.

COMMISSIONER TRACEY: Yes. The video of the evidence of Ms Merle Mitchell will be exhibit 3.5.

5 **EXHIBIT #3-5 VIDEO OF THE EVIDENCE OF MS MERLE MITCHELL (RCD.999.0037.0001)**

10 COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. Next, we call Ms Dilum Dassanayake. Her full name is Eresha, E-r-e-s-h-a Dilum, D-i-l-u-m, Dassanayake, D-a-s-s-a-n-a-y-a-k-e. That was an E at the end.

15 **<ERESHA DILUM DASSANAYAKE, AFFIRMED [2.16 pm]**

20 **<EXAMINATION-IN-CHIEF BY MR GRAY**

MR GRAY: Operator, please display WIT.0109.0001.0001. Ms Dassanayake, what is your full name?

25 MS DASSANAYAKE: Eresha Dilum Dassanayake.

MR GRAY: Please look at the screen. Do you recognise that as a statement you've made in this Royal Commission?

30 MS DASSANAYAKE: I do.

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

35 MS DASSANAYAKE: No, I don't.

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

40 MS DASSANAYAKE: Yes, it is.

MR GRAY: I tender the statement, Commissioners.

45 COMMISSIONER TRACEY: Yes. The statement of Eresha Dilum Dassanayake dated 1 May 2019 will be exhibit 3-6.

**EXHIBIT #3-6 STATEMENT OF ERESHA DILUM DASSANAYAKE DATED
01/05/2019 (WIT.0109.0001.0001)**

5 MR GRAY: Thank you, Commissioner. Ms Dassanayake, I'm going to be asking you questions about your mother – I'm not going to mention her name, and could we start with your mother's age. What's her age?

MS DASSANAYAKE: She's 87.

10

MR GRAY: 87?

MS DASSANAYAKE: Yes.

15 MR GRAY: What's your linguistic and cultural background?

MS DASSANAYAKE: She's Sinhalese from Sri Lanka.

MR GRAY: What are her languages; what have been her languages?

20

MS DASSANAYAKE: English and Sinhalese.

MR GRAY: What about her cultural habits of dress and food?

25 MS DASSANAYAKE: She always wore a sari until recently and, of course, we have our own cuisine and she is a Christian so - - -

MR GRAY: And what was her profession while she was in her working years?

30 MS DASSANAYAKE: She was a nurse.

MR GRAY: And you mentioned that she's Sinhalese; what is her actual migration background to Australia? Can you tell the Commissioners a bit about that?

35 MS DASSANAYAKE: Yes, she actually studied nursing in Sri Lanka, then she went to London to further her study. Then she had me, went back to Sri Lanka and then we came here in 1976.

40 MR GRAY: And it's the case, is it, that there were some moves across the states, South Australia, WA?

MS DASSANAYAKE: Yes. We started in Adelaide, then my parents went to Geraldton and then Perth. And following the birth of our first son, they moved to Sydney.

45

MR GRAY: Thank you. Can I ask about your mother's current health and her medical condition.

MS DASSANAYAKE: She is bedridden as of July 2017. She was diagnosed with Alzheimer's 14 years ago. These days she doesn't talk very much or she certainly can't answer questions very well, and she hasn't known me for nearly two years, as to who I am.

5

MR GRAY: Before that time, I understand that your late father was looking after your mother.

MS DASSANAYAKE: Correct.

10

MR GRAY: And then when he passed away, you looked after - - -

MS DASSANAYAKE: Yes, six years ago he passed away and she moved in with us.

15

MR GRAY: Yes.

MS DASSANAYAKE: Which is five people, yes.

20

MR GRAY: Thank you. Would you tell the Commissioners a bit about your experiences there, your efforts. What was the experience of caring at home for your mother living with dementia?

25

MS DASSANAYAKE: I had to be on a very steep learning curve, learning about dementia, and I had got some information from my father who told me how to manage the condition. So when we – we quickly bought a house which was gated to ensure that my mother doesn't go wandering. However, as it turned out it wasn't large enough so we ended up renting an apartment nearby so that we could divide ourselves and the children could spend half the time while I spent 95 per cent of the

30

time with my mum, looking after her.

MR GRAY: Yes. And how did it come about that you in the end have made the decision that she is to go into residential care. That must have been a difficult decision. Can you explain that?

35

MS DASSANAYAKE: It was an extremely difficult decision, and now I still regret it because of what has happened to her. But I had three young children and it was very hard with her – she was still quite mobile but with the double incontinence it was becoming quite hard for me to manage everything.

40

MR GRAY: Was that the trigger, the double incontinence, was that the trigger for the decision?

45

MS DASSANAYAKE: Yes, that's – yes, I think that's probably the main one but it's also having young children who were in primary school and trying to manage all that, because I could not leave her alone to drop them off and pick them up from school or other activities.

MR GRAY: Now, you mentioned she was still quite mobile at that time. Can you go into that in a little more detail. So upon entry into the residential aged care system, if I can put it that way, how mobile was she?

5 MS DASSANAYAKE: She was just using a cane at that stage, and we were trying to encourage her to use a walker which even she happened by the time she went into residential care.

10 MR GRAY: And you mentioned double incontinence; what other aspects of her care needs can you mention?

15 MS DASSANAYAKE: In terms of the double incontinence, at that stage it wasn't that bad because she could say, "I need to go" and you just had to be there to take her. That's the thing, she was quite aware of the fact that you didn't want to have a fall so she was quite careful, wanted to ask for help when she wanted to use the bathroom, you know, negotiating things. But she was very independent as well, but at the same was quite aware that she did not want to have a fall and break a bone. So she did ask for help.

20 MR GRAY: Yes. And what about her mental acuity, her recall of things at that time?

25 MS DASSANAYAKE: That was going down quite rapidly after my father's – father passing away. There was a fast decline, I would say.

MR GRAY: Right.

MS DASSANAYAKE: Yes, but she still knew who we were.

30 MR GRAY: Yes.

MS DASSANAYAKE: Knew our names, knew our birth dates, all that sort of stuff at that stage.

35 MR GRAY: What about in respect of eating and drinking?

40 MS DASSANAYAKE: That was fine. I always asked her to make her own breakfast in the morning using a microwave which she managed to do all that time by herself, and I encouraged her so she would keep those habits and practices going for as long as she could.

45 MR GRAY: Okay. Now, looking at your statement, I just need to clarify to the extent that you can there in the box, did your mother move into residential care in late 2015?

MS DASSANAYAKE: Yes, she did.

MR GRAY: Yes. And she was at a particular residential aged care facility for a time. Was that until August 2016; is that right? Or is that - - -

5 MS DASSANAYAKE: No, August was when she went into respite care at the second facility. That was respite care. Then she was in hospital because of the illness and then she ended up in – entered residential care at the end of that year.

MR GRAY: Thank you.

10 MS DASSANAYAKE: Yes.

MR GRAY: Now, with respect to that residential care facility where she went for respite care, was that then the facility she moved into?

15 MS DASSANAYAKE: That was the second one, sorry.

MR GRAY: That was the second one.

20 MS DASSANAYAKE: Yes.

MR GRAY: With respect to the first one, you say in your statement you weren't impressed with the level of dementia care at that facility.

25 MS DASSANAYAKE: Yes, I wasn't impressed because I didn't think people knew how to deal with someone with dementia. I didn't like the way they addressed her. But now looking back I think my expectations are a lot higher because I expected there to be trained nurses to be there to look after the – the residents and particularly those with dementia. So now I know this is more the norm and my expectations were a lot higher than they should have been.

30 MR GRAY: So is the point you're making there the presence of numbers of trained nurses, as opposed to personal care workers?

35 MS DASSANAYAKE: Yes, that's correct. Because I made an assumption that nursing homes had trained nurses to look after the elderly who were quite vulnerable and many do have dementia which is a different way of caring for people as well.

40 MR GRAY: Now, could I ask then about the second facility. I'm not going to mention the names of any of these facilities, and I would ask you not to either. Can I just ask – you say something in your statement about this – did you have a cultural fit in mind in choosing the next facility - - -

MS DASSANAYAKE: Yes.

45 MR GRAY: - - - for your mother.

MS DASSANAYAKE: There was, yes. That was the main reason that I chose that facility. Food was appropriate. I could – it was better than what I could provide. And I just – yes, it just felt right. I just thought there would be people that she could speak to because my knowledge of dementia is that you would revert back to your
5 mother tongue but in my mother’s case English is her first language but she speaks both languages even now.

MR GRAY: Right. And what about food and dress; were these relevant factors?

10 MS DASSANAYAKE: Food, dress, it was encouraged so I was quite happy with that because I myself had tried to get her out of wearing a sari because I was told the expectations are that, you know, we need them to be safe, we don’t want them falling by tripping on the walker and the sari, so I forced that on her. And I remember her crying and saying, “Why are you doing this to me?”, you know. She’d never worn
15 pants.

MR GRAY: Just to be clear, when you had that interaction with your mother about not wearing the sari because of tripping risk, as you understood it, and her crying about it, was that in respect of the first facility or was that in respect of the second
20 facility?

MS DASSANAYAKE: It was the first facility.

MR GRAY: The first one.
25

MS DASSANAYAKE: Yes.

MR GRAY: So moving to the second one was an advantage.

30 MS DASSANAYAKE: It was and in fact, the then deputy director said to me, “Please bring saris in. Even if she doesn’t wear it, it’s good for her to practice putting it on”. Mind you at that stage she was still putting her own sari on, she could do it, she was capable of doing it.

35 MR GRAY: What’s the relevance – perhaps I can guess myself, but what’s the relevance of these comforting cultural practices for somebody who is living with dementia?

MS DASSANAYAKE: I think it’s less disturbing because especially with dementia
40 what I found with her is any change in the scenery or too many people around just triggers her, makes her anxious, makes her angry, agitated. That’s what I found so it was good to have these sort of familiar surroundings for her.

MR GRAY: And with respect to food, is it essentially the same point, Ms
45 Dassanayake?

MS DASSANAYAKE: Yes, very similar, yes, same.

MR GRAY: Have you noticed, what, that different foods have not been a helpful contextual trigger, but that familiar foods are helpful?

5 MS DASSANAYAKE: I think it is helpful but I do have to say like towards the end of my father's life, I think we transitioned like I think he – he said to me, you know, you have to look after her, and he kind of understood things might be quite difficult and some of the things that we did was change the meals, you know, get used to other meals that she might have to face in the future. So he prepared her for that, yes.

10

MR GRAY: How successful do you think that preparation was with respect to food, to get your mother used to the idea of different foods?

15 MS DASSANAYAKE: She was fine with that, I would say, given how she's going now, yes, she's all right.

MR GRAY: Okay. Now, with respect to the second facility, you do mention as well as those upsides that there were some problems that developed. Could I just ask you to – this is at paragraphs 14 to 18 for the benefit of those looking at the screens, but could I just ask you, Ms Dassanayake, about some of those matters. You do single out a manager's language and attitude towards the dignity of your mother.

20

MS DASSANAYAKE: Correct.

25 MR GRAY: Would you please elaborate on what you mean by that?

MS DASSANAYAKE: I had gone down with my mum to see the manager at the time and she, in front of my mother, said "she's demented, she doesn't understand what we're talking about or saying". And I was just appalled that she could say that in front of my mother, and remembering that at that stage cognitively my mother was a lot better than what she is now. And I just thought it was an inappropriate thing for a manager of a facility with dementia patients should be saying to anybody.

30

MR GRAY: And what about with respect to the ability of the facility's staff to provide the direct care to the people who are living with dementia there?

35

MS DASSANAYAKE: Yes.

MR GRAY: You've got some points you make in your statement. Can you elaborate on those?

40

MS DASSANAYAKE: I do. I think even though I had lowered my expectations by this stage I still felt like people didn't have the training, didn't do what I had done at home for Mum in terms of informing her, this is what I'm going to do, can we do this together. But on the other hand I also had sympathy for carers in terms of their time that was available for them to look after them, and everybody seems to be rushing. And the residents seem to be – fall by the wayside. But I did have one incident

45

which shocked me which was my mum complained that the walker gets taken away from her. And so when I asked one of the carers they said, well, we're sick of – you know, having to give it to her because she's walking around all the time, and I've taken it away to keep her safe.

5

MR GRAY: And what was your reaction to that, a deprivation of her mobility aid?

MS DASSANAYAKE: I was angry, I think that's what I have to say. Because my mother, I think she has – she suffers from osteoporosis, and one of her things was “I must exercise, I must keep moving to keep my bones strong”, so that's one of the things she did, was to walk, that was her exercise. And she was stuck on the first floor, she just went around just walking, and that's what she did when she wasn't reading a magazine or doing something else. So she was still aware at that stage “I need to keep doing this”, and before her illness she was always a very active person. She has never sat down for half an hour to watch a TV show for instance, so - - -

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MR GRAY: And were you able to intervene with management to get it back?

MS DASSANAYAKE: Yes, I did. I did.

20

MR GRAY: Well, look, that was another of the aspects you mentioned in respect of her personal equipment. You also refer to the security of the medicine trolley.

MS DASSANAYAKE: I do it. It's because - - -

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MR GRAY: What were your concerns?

MS DASSANAYAKE: A couple of times I found medications on her bed and on her side tables which I knew weren't her medications. And I just assumed it was because she probably went wandering into other people's rooms and picked up medications. But then on two occasions I actually took photographs of the medication trolley not being attended to, and it was, you know, easy for anybody to come and pick up the medications.

30

35

MR GRAY: And the medication trolley was what, not locked and it was able to be accessed by anyone.

MS DASSANAYAKE: No, everything was on the top, yes, all on the top.

40

MR GRAY: Now, did you take that up with management?

MS DASSANAYAKE: I did. Simply because it was the same person doing it on weekends so at that stage I only went to see her mostly on weekends and pick her up and bring her home.

45

MR GRAY: Yes.

MS DASSANAYAKE: So I was told that the particular RN would be told, you know, to make it secure in the future, and I assume that did happen.

MR GRAY: Okay. Now, in your statement you mention a move to a third facility.
5 You say March 2016 but I'm imagining it must be March 2017; is that correct?

MS DASSANAYAKE: No, 2016.

MR GRAY: 2016.
10

MS DASSANAYAKE: Yes.

MR GRAY: Okay. And with respect to that facility, you mention – yes, thank you, paragraph 19, and if we go back to paragraph 11 perhaps, sorry, Ms Dassanayake, I
15 will just ask you to comment on this. In paragraph 11 you refer to your mother being placed in respite care.

MS DASSANAYAKE: Sorry, it must be 2015 then.

MR GRAY: Thank you.
20

MS DASSANAYAKE: Is that right, yes, sorry.

MR GRAY: So paragraph 11 should refer to 2015?
25

MS DASSANAYAKE: '15, yes.

MR GRAY: Thank you. So if we go back to paragraph 19, where you referred to the move in March 2016 to a third aged care facility, she has been there in that
30 facility - - -

MS DASSANAYAKE: Since then.

MR GRAY: - - - over the three and a half years or so, three and a bit years.
35

MS DASSANAYAKE: Three years. Yes.

MR GRAY: Now, one of the matters you mentioned is access to the GP. Could I just ask, with respect to the other experiences in the other two facilities, did your
40 mother have a continuity of access to a particular GP at that time?

MS DASSANAYAKE: In the second facility she kind of did because my parents lived far out west in Sydney, so I couldn't have that particular GP look after her, but while she was living with me I used to take her to that particular GP for continuity,
45 but once she entered the second facility I took her to our family doctor, and then she just happened to service this particular nursing home. So in that sense she did have continuity for the time that she was there.

MR GRAY: And were those consultations a mixture of you taking your mother to the GP's rooms and the GP visiting?

MS DASSANAYAKE: Yes.

5

MR GRAY: Now, with respect to the third facility, how was the continuity of primary health care for your mother?

MS DASSANAYAKE: Well, that was completely broken because her previous GP could not visit that, the third place, and so you were just given a list to choose from. And interestingly, I was just told, you know, here's the list; you can choose somebody, ring them up and then see if they're willing to take your mother on. But one RN said to me, this one, "They're quite racist so don't send your mother there".

MR GRAY: Right. And you just said a minute ago you choose one, or you were told choose one and see if they will take your mother on. Was there an amount of picking and choosing on the part of the GPs?

MS DASSANAYAKE: I think so because you just got the list given and I just went on asking some of the carers, you know, who do you think is good, you know, who should I - - -

MR GRAY: And what about on the part of the GPs themselves, could they in effect decline to provide primary health services to one of the residents if they so chose?

25

MS DASSANAYAKE: I would assume that they wouldn't, but I've learnt since then that they can decline. and they will.

MR GRAY: Can you elaborate on that experience for the Commissioners, please.

30

MS DASSANAYAKE: Well, at this facility, my mother has lost two GPs. I think because I've asked too many questions, I've demanded answers, and I think that's been part of the problem. One – the first one it was because I was told that she would go on an opioid patch which I agreed to because the GP rang me up and said "She's in a lot of pain, we can't work out what it is, so it's best that she goes on the opioid patch". Because she also has osteoarthritis and osteoporosis, because of the arthritis, she was given Panadol Osteo three times a day for a number of decades, I would say. And when I came one day I saw that she was on Panadol Osteo still, and I didn't realise that that was something that is normally done, but I asked the RN, she wasn't sure and she advised me to ring the GP and check with her.

40

So when I asked her about it, she said, "Yes, of course, you can do that", but I said, "Well, why wasn't I told?" So I can take the blame because maybe I didn't ask the right questions but the upshot was it became quite a heated discussion and she basically told me not to play doctor and to leave the doctoring to her, and it's – I don't know what's best for my mother.

45

MR GRAY: Yes.

MS DASSANAYAKE: And then a few days later the director rang me up to say,
5 “Sorry, this particular doctor will not be treating your mother anymore, you have to
find another GP”.

MR GRAY: Operator, I will ask you to bring up paragraph 65 of Ms Dassanayake’s
statement. That’s on page 14, and if we can call out paragraph 65. Ms Dassanayake,
10 is paragraph 65 the detail of the incident you’re referring to concerning the
medication with both the opioid patch - - -

MS DASSANAYAKE: Correct.

MR GRAY: - - - and the Panadol.
15

MS DASSANAYAKE: Yes.

MR GRAY: What was the effect it was having on your mother that was concerning
20 you?

MS DASSANAYAKE: When I came to visit her, she had her head down on the
table asleep or very tired, and at that stage she was still very mobile with her walker
and I was quite worried she might have a fall because she was so sleepy and dopey.
But at that time I guess I didn’t realise it was the medication that was causing it. I
25 wasn’t sure and that was part of the reason why I talked to the RN.

MR GRAY: Yes.

MS DASSANAYAKE: To find out.
30

MR GRAY: And if we go to paragraph 66 and call out paragraph 66, you refer to
some later, this is later advice from the hospital; is that right?

MS DASSANAYAKE: Yes, it is.
35

MR GRAY: Now, what was the hospital’s reaction to the opioid patch?

MS DASSANAYAKE: Yes, she became ill and she went into hospital and they
took her off everything to work out, you know, what was causing – I assume – I can’t
40 remember exactly but I think it was because she was maybe falling or going to fall
off the chairs and stuff. I can’t remember what the incident was, so they took her off
all the medications and reintroduced one by one and then they felt, because by this
time her appetite was not very good, and then they told me – and it’s in her hospital
notes, that it was suppressing her appetite and that the opioid patch will possibly, you
45 know, cause her to have a fall because she was a walker. I mean they saw her in
hospital, you know, any opportunity she was on her walker and getting around.

MR GRAY: So that was the later advice - - -

MS DASSANAYAKE: Yes.

5 MR GRAY: - - - as to the effect of the opioid patch - - -

MS DASSANAYAKE: Correct.

10 MR GRAY: - - - and the recommendation - - -

MS DASSANAYAKE: Yes.

MR GRAY: - - - was that it would be ceased.

15 MS DASSANAYAKE: Yes, it would be ceased. They did not think it was necessary, and just to continue with Panadol.

MR GRAY: What actually happened with respect to the opioid patch; did it ever appear again in your mother's treatment in the facility?

20

MS DASSANAYAKE: It did. About a week or two later when I visited her, I happened to be changing her, and I noticed that the opioid patch was – there was a patch on the back of her shoulder. And so I went to – by this time we had an acting director at the third place and I said to her, “Look, what’s going on?” I know the notes – not only did the notes say that she’s not to have the opioid patch; I actually emailed to say, “Please note it says no more opioid patch to be applied and just to revert back to Panadol three times a day”. And the response was, “I’m sorry about that, we had an agency nurse. They must have done it.”

25

30 MR GRAY: So were you given an answer as to what had happened? Was there an error in the notes or was it simply staff – agency staff failing to read the notes? Did you ever get to the bottom of it?

35 MS DASSANAYAKE: So my recollection was that I went with a copy of the hospital notes because I had a copy and this specifically states no opioid patch on my mother. And they said, “Well, I think somebody didn’t read the notes”. But I said, “Do you not have clinical notes that get changed because surely people’s needs change as time goes on”. No answer. So my understanding was that the transfer of information wasn’t taking place sufficiently for things – for the proper clinical care of people, because to tell me that an agency nurse made a mistake; I don’t think it’s good enough because there should be systems in place where that simply doesn’t happen.

40

45 MR GRAY: I want to, in effect, go back in time to some of the other matters you were raising. Operator, if you please go back to paragraph 26. One of the other matters, just before I ask you about paragraph 26, was not only with respect to

primary health but with respect to specialist care in the dental and eye health areas; were there issues there with respect to your mother getting access to those services?

5 MS DASSANAYAKE: In terms of eye care she had an eye surgeon who looked after her because she has glaucoma so she needs to have special eye drops which are administered twice a day. So even while she was at the third centre, I used to take her myself while she was mobile enough. I used to take her, I think, every three to six months where she was tested and given medications, and there were changes in medication because some of them were not becoming as effective.

10 MR GRAY: Just stopping you there.

MS DASSANAYAKE: Yes.

15 MR GRAY: For how long were you able to carry on transporting or taking your mother - - -

MS DASSANAYAKE: Until July 2017, yes; after that she has been immobile.

20 MR GRAY: Yes, since her illness in July 2017.

MS DASSANAYAKE: Yes.

25 MR GRAY: And it's just too difficult to be – you can't lift her, obviously, bring her into the car?

MS DASSANAYAKE: No, she is completely bedridden now.

30 MR GRAY: So what's happened with eye care since then?

MS DASSANAYAKE: There's – nothing has happened because I can't take her there, and we have had an optometrist but my understanding is that for her condition the optometrist is not necessarily equipped to deal with it so I've just continued with the eye drops. I asked the GP to prescribe it and that's where we are.

35 MR GRAY: But in effect you can't have an ophthalmologist review your mother's glaucoma since July 2017.

40 MS DASSANAYAKE: Yes, my understanding is that isn't available but they have organised an optometrist to be there but my Mum hasn't been seen by one yet.

MR GRAY: And with respect to dental?

45 MS DASSANAYAKE: Again, I used to take her to the dentist myself, our family dentist, and I only just took her to get them cleaned every six months. But since she has been at this facility, this is after she was unwell, so that's 2017 to, say, end of last year where they introduced dental care which I believe is organised by the nearby

hospital. She had a huge cavity that had to be filled which was quite difficult for the dentist to manage and I had to be there to hold her but, yes, they did a great job. But she does not get her teeth brushed, the few that she does have. Even now it is not happening.

5

MR GRAY: Can you explain to the Commissioners any conclusions you formed about why that might be the case? Why isn't she getting her teeth brushed?

10 MS DASSANAYAKE: I think it's probably twofold. One is that in the state that she is now it's very difficult because she probably doesn't like somebody going and doing things, but there are times when I've been there where I ask her, you know, "Here's your toothbrush; can we brush your teeth?", and she will do it. But I don't think the staff have the time to do that. But I have asked on many occasions and I've
15 emailed them saying please, can you at least – they have these sponges that they can put in there and that's the best they can do.

MR GRAY: Yes.

20 MS DASSANAYAKE: But that's not happening. I know it's not.

MR GRAY: So with respect to that, the difficulties of being able to have your mother open her mouth for them to brush her teeth - - -

25 MS DASSANAYAKE: I think it's - - -

MR GRAY: Is that what you're saying; that it's very difficult for these carers to be able to - - -

30 MS DASSANAYAKE: No, it's not so much that. It's how you approach her, I think, because, you know, for her, somebody putting something in – there's a huge interference. So I think it's about coaxing her, just like the eating, you know. We used to come up with stories and say can we do this or, you know, it's time to – there's another family member of her roommate who comes in and says,
35 "[REDACTED] you've got to eat today because you've got to go to work", and then she does it. So - - -

MR GRAY: Now, can I ask you a bit more about the eating, eating being so critical to overall health. You at various times in this journey have observed weight loss - - -

40 MS DASSANAYAKE: Yes.

MR GRAY: - - - on the part of your mother.

45 MS DASSANAYAKE: Yes.

MR GRAY: Can you explain to the Commissioners the circumstances in which that occurred and what you did about it?

MS DASSANAYAKE: Okay. I'm not sure exactly when that – in fact, I think when she ended up in hospital quite sick in July 2017 is probably when she was weighed, and then I realised she had lost 19 kilograms since March 2016 to that - - -

5 MR GRAY: July 2017.

MS DASSANAYAKE: - - - July 2017. Actually probably it was a little bit, she was a little bit heavier than that but progressively towards the end of that year she lost all that weight. So when she got sick in 2017 it was because she was severely
10 dehydrated. In fact, I had not gone for four days to see her because I had the flu so I did not go to see her, and when I turned up I found that she was severely dehydrated. She was barely speaking and this was a woman the weekend before, I had seen her walking with her walker. And so I said “What happened?”, and she was trembling and then I asked, you know, “Have you checked her blood sugars?” That hadn't
15 happened, and I said “I think she has the fever, has she had Panadol?” And nothing had happened and then I – and then I said “Well, can we call a GP?”

So her GP in attendance which was the second one that we had by that time, apparently had gone on leave. So we had to wait for a locum and the following day
20 I'm told the locum is not available. So I said “Well, can we now have an after-hours doctor”, and finally somebody came on the Saturday who ordered blood tests. But she was not in a state to even get blood out of her and anyway we could not do that till the Monday, or that is what I was told at least. So therefore it was Monday or Tuesday before a GP attended to her, and I still was not happy with what happened
25 and therefore I decided to take her to hospital.

MR GRAY: And what happened then? This is by the way, if the operator can bring this up, paragraph 37. A brief account of what happened then with the
30 hospitalisation of your mother, how long did it last, what was picked up, what was the results?

MS DASSANAYAKE: She was severely dehydrated. She ended up staying there for nearly five weeks. She was placed on a drip, of course, and I think she also had the flu and while she was there I think she picked up a few other things so she was
35 quite sick and she was on a couple of antibiotics and other medications but it was mostly antibiotics. But it was trying to get her strength up so that she could actually eat because she just wasn't responding to anything. She wasn't able, and didn't have an interest, and I honestly thought that she would not be leaving the hospital at that stage.

40 So – however, there was a consultant there who was very good, kept me informed and said to me, “Look, we have to try and give them – give things that she likes such as –” at that stage she liked really sweet stuff, and she was very good at instructing the nurses and saying, “Can you please make sure this patient gets ice-cream if that's
45 what she will eat or jelly.”

Another thing that I realised is that she preferred to have diluted juices. She didn't want to have juices that were full strength. So those were things that I learnt about her in the hospital context, and even though she left hospital, my understanding was that she would not last very long, but towards the end they said, well, if she's going
5 back, there's nothing much more that we can do, the infections are gone so now it's time for her to go back to care.

MR GRAY: Just before we get to that, can I ask about a couple of – if we go to paragraph 38, you have more detail in your statement about these matters. If we call
10 out paragraph 38, please, operator. Can you speak to or explain the beginnings of the pressure sores - - -

MS DASSANAYAKE: Yes.

15 MR GRAY: - - - that were picked up by the hospital?

MS DASSANAYAKE: Correct.

MR GRAY: And what was the lead-up to that? What had - - -
20

MS DASSANAYAKE: So my mother – so on that – by the time I saw her on the Friday I assumed she had been in bed for four to five days because I didn't see her during the week. And it was four days after that ended up in hospital. It didn't occurs to me to check for anything like pressure sores but once we went to hospital
25 and the hospital said, look, she has got two huge blisters on both her ankles, and these are pressure sores. And they also rang, trying to get information because they didn't have information like what her fluid intake was and my mother at that stage had said to me when we were going to hospital that her stomach was hurting. And I'm someone who asks every day what did she eat, has she opened her bowels, that
30 sort of stuff, and they said yes, yes, but she was very sick. And eventually it turns out after an X-ray that the hospital rang and said, what's going on, you know, because there's a problem, and they said she hasn't opened her bowels for five days.

MR GRAY: This hadn't been relayed either to you or to the hospital?
35

MS DASSANAYAKE: No, and I asked the questions because I am somebody who asks, especially because I hadn't been there. Even though I was sick, I would ring and ask, "How is she doing?"

40 MR GRAY: All right.

MS DASSANAYAKE: And then they – and also let them know that she's got pressure sores on her heels and there was another little one on her back, on the lower
45 back.

MR GRAY: Well, you then, from paragraph 40 of your statement go into what you did, but can you just tell the Commissioners what you did as a result of this

experience, once presumably you had recovered from the flu, and you missed those four days of care with your mother and she ended up in [Redacted] Hospital, what did you then resolve upon?

5 MS DASSANAYAKE: I stopped everything and decided that I had to be with her at least three times a day. Whilst she was in hospital I was there most of the time and neglected my children, my family. I felt I had to do that, and I was very worried. I guess my understanding at that stage when she was at hospital was that she would not – she wasn't going to make it through because she looked so ill and unwell and
10 had lost so much weight.

MR GRAY: With respect to the pressure sore or pressure injury issue - - -

15 MS DASSANAYAKE: Yes.

MR GRAY: - - - what was her experience with the facility in the three months or so after hospital?

20 MS DASSANAYAKE: Yes, so when I was in hospital they asked me what the conditions were like for my mother, what kind of mattress did she have, is there a seat for her. And I said I don't know what the mattress is like, it's just a foam mattress. And they said, no, she's got to have this, what we have in hospital which is an air mattress that circulates the air.

25 MR GRAY: So this is the hospital asking you about what are the conditions before July 2017 for your mother?

MS DASSANAYAKE: Yes, yes.

30 MR GRAY: What was the question about the seat?

35 MS DASSANAYAKE: There was, because then they said to me look when she gets back and recovers a bit then she can move on to a chair, but I was in shock that she was completely bedridden, I didn't know what was going to happen. They said don't worry, she will be up again, she can go on a chair and that's fine. And so I rang up the director at that time and I asked them and they said no, you've got to get your own, we don't have any here.

40 MR GRAY: In terms of the mattress.

MS DASSANAYAKE: No, the chair.

MR GRAY: The chair.

45 MS DASSANAYAKE: Yes. But once she got back then we had a replacement acting director because the other person went on maternity leave, and then she is the one who instigated and I said, "Look, this is what the hospital said." And this

person, I have to say, was very proactive. She came in, she was only there for about six to eight months and she saw the place was not up to speed on so many areas, and then she is the one who started the – getting a new mattress, the air mattress. And then I noticed that when it was up there was no air in the middle and it was hitting –
5 my mum’s back was hitting a hard surface, and it took three different mattresses and three months for me to get the mattress that I have now which is working a lot better.

MR GRAY: Can you share with the Commissioners your reflections on the importance of leadership in this facility and any other facilities you’ve had
10 experience of. You mentioned that proactive temporary director who was in place for eight months or so.

MS DASSANAYAKE: Yes.

15 MR GRAY: What’s been your experience of the importance of leadership, clinical care managers, directors of care; those sort of roles.

MS DASSANAYAKE: Yes, I mean, one of the first things that – I mean, I noticed straightaway as soon as she came she just looked at the place and she just said, okay,
20 and I heard her say to the staff, “If you don’t like to be on my organised bus you’ve got to get off”, and I thought well, that’s a bit rough but then I had a chat to her and she said, “Well, look, so many things aren’t happening here, I need the residents to be fed, they need to have their fluids and you know from your own experience that your mother hasn’t been looked after very well”. So she instigated things like having
25 proper handovers where it wasn’t just between the registered nurses at shift changes, but between other carers as well, which made a huge difference.

And that way I kind of knew when I asked somebody, “Did my mum eat today?” They said she had, blah, blah, blah; they had this stuff. And then she had only half a
30 glass of fluid so we will make sure she has something later on. So those were the changes and things like getting the mattress, like, that wouldn’t have happened with the previous manager; it just wouldn’t have happened.

MR GRAY: I will ask you, before that proactive manager was in place, I
35 understand there was a period where the, in effect the director, the person in the director’s position was on parental leave; is that correct?

MS DASSANAYAKE: That’s correct.

40 MR GRAY: If we call that paragraph 28. Are you making a connection between that and the poor mobility that your mother had to suffer in the period after hospitalisation?

MS DASSANAYAKE: I do because when she came back, yes she was bedridden
45 for five – five weeks in hospital and then for a period of, I think, eight months she never left her room because, one, there was no chair, because I assume that’s how she would get to the dining room. But she was just in her room in bed and I was

assured that she will be turned every two hours, which surprised me because I didn't think that would happen but there was a nurse educator who came from the hospital to check on these things. They said it was happening, and they had to fix up the pressure sores otherwise they wouldn't have gone away, so things, yes, so that –
5 those things happened but she never left her room.

And then when the acting director came, she said, "No, I think we can have her up in the afternoons by sharing one of the chairs from one of the other residents", and that's when that started to happen where in the afternoon she would at least have
10 dinner in the dining room, otherwise she was in the – in her room all the time.

MR GRAY: You mentioned the turning regimen, did that apply even once the air mattress solution had been found?

15 MS DASSANAYAKE: Yes, it does, especially now, it's still important, because she's quite bony, there's nothing there. So if she lay on her back all the time it wouldn't be appropriate; she will still – it's possible that she will get pressure sores. So at the moment they're supposed to be turning her still two hourly at night-time but I don't know how that happen was one staff member for 37 residents.
20

MR GRAY: Are you talking about the night shift there's only one staff member for 37 residents.

MS DASSANAYAKE: Correct.
25

MR GRAY: And how many of those residents have a reasonably advanced level of dementia care that they need?

MS DASSANAYAKE: Bedridden, at least more than half.
30

MR GRAY: You mention access to physio. You've got something to say about that. This is, if we could call up the next paragraph, please, operator, paragraph 29. You wish to elaborate, Ms Dassanayake, about the physio services?

35 MS DASSANAYAKE: Yes, when I looked at the contract for the third facility, things like physio were included, and I was happy at that and I remember telling my mother, you can do your exercises now, because she, even in her 70s, and in her sari used to go to a gym to do weight-bearing exercises because she was so cognisant of the fact that she needed to keep her bone strength up. And so I was happy that would
40 happen, but when she was bedridden there was nothing offered of that nature at all which I think would have helped her at least get a bit of strength back and faster, but now I think it's far too late.

MR GRAY: In the next paragraphs, 30 to 33, you refer to falls risk.
45

MS DASSANAYAKE: Yes.

MR GRAY: And you have mentioned a number of falls that your mother has had. What are the conclusions you formed about what the facility should have been doing or should be doing about falls risk? What could it do better?

5 MS DASSANAYAKE: Well, in terms of one of the times that my mother fell, when I asked her, you know, “Why did you go to the bathroom without asking for assistance?”, she said, “Well, nobody comes near me, nobody hears me”, so she decided to go to the bathroom by herself. She had a fall, and I don’t know how long after, the cleaner found her in the bathroom. So then and now, my thoughts are that
10 there just isn’t enough people watching out for, particularly for the mobile people who will wander along the corridors. They do have cameras but I don’t know what they do because I’ve seen two people fall and die in recent times. And so I just feel like they need to be safe. It is their home and it’s not happening, and I’m not sure if staff ratios will help. I think it would go towards helping this issue. However, I
15 think they also need to care, care enough about the residents to look after them.

MR GRAY: So with respect to those incidents that you’ve witnessed where you’ve seen people fall and die, what’s been – have you actually seen them lose their balance and fall, is that - - -

20 MS DASSANAYAKE: No, I didn’t. What – the first case that I’m referring to, the person was having dinner, then they just got up and walked out of my sight, out of the dining room. And there was one – one carer in there feeding another and there was about seven residents in there and I was there with my mother. I heard a thud,
25 so the carer didn’t even hear it because probably the noise levels in the dining room, I don’t know, and I said you’d better go and have a look. Another resident yelled saying, “Something’s happened”. So by the time they got there, he had already hit his head. I’m not sure what the cause of death was, but what I’m saying is like, he had the fall, the impact may have had something to do with it, I don’t know, but yes.

30 MR GRAY: Yes.

MS DASSANAYAKE: And the second case, again, it was another wanderer who is around all the place and very chatty, but nobody noticed that she was missing and
35 then found her – they had found her later in a pool of blood, and she also died a few hours later.

MR GRAY: And do you know whether that person was being monitored generally?

40 MS DASSANAYAKE: I don’t know.

MR GRAY: And whether it was just a lapse in monitoring her?

45 MS DASSANAYAKE: I don’t know.

MR GRAY: In paragraph 31 you mentioned an interaction with another resident, and the name has been redacted.

MS DASSANAYAKE: Yes.

MR GRAY: Could you elaborate on what you were told about that incident and what the implications are for your mother?

5

MS DASSANAYAKE: Once when I visited my mother, the then deputy director told me that my mum had a fall because she got pushed by another resident because my mum tried to enter his room. And I said, "How could that happen?" And they said, "Well, she went into the wrong room" and they didn't want her there and they pushed her. And I said, "But you're supposed to look after her because she's got dementia and she doesn't know which is even her room", and then I was basically told, well, if you want 24 hour care you need to get a 24 care nursing person here. And I guess the dilemma for me is like felt I could not give her 24 hour care, and that's why putting her in a nursing home will be safer for her, but with me she didn't have a fall ever, and she's probably had about six to eight falls when she's been out of our home.

10

15

MR GRAY: I want to ask you about this particular interaction, after this incident. Firstly, was this incident before July 2017?

20

MS DASSANAYAKE: Yes, yes.

MR GRAY: So your mother was still mobile.

25

MS DASSANAYAKE: Yes.

MR GRAY: But she was suffering with some cognitive impairment because of her dementia.

30

MS DASSANAYAKE: Yes.

MR GRAY: And it's in that context that she tried to enter somebody's room, and you don't doubt that that was probably the trigger. Is that - - -

35

MS DASSANAYAKE: Yes. And I'm sure the other person, you know, did do that because their space was being invaded.

MR GRAY: Yes.

40

MS DASSANAYAKE: I understand that.

MR GRAY: And the reaction of - was this management who was telling you about - - -

45

MS DASSANAYAKE: The deputy director at the time, not a career, not the RN, the deputy director at the time.

MR GRAY: Now, what is this proposal for 24 hour care and how does that relate to the agreement between you and your mother on the one hand and the facility on the other? Is it stipulated in the agreement that if you want one-to-one care you've got to pay for a 24 hour carer; is that how it works?

5

MS DASSANAYAKE: Not that I'm aware of, and I wouldn't think that would be – given the amount that we do pay.

MR GRAY: And were you able to get a 24 hour a day carer?

10

MS DASSANAYAKE: We could not afford it.

MR GRAY: Yes.

15 MS DASSANAYAKE: It's just not possible.

MR GRAY: And did the deputy director use any particular expression for this arrangement such as specialling?

20 MS DASSANAYAKE: Sorry?

MR GRAY: Was any particular term used for this arrangement? No.

MS DASSANAYAKE: No.

25

MR GRAY: It was just proposed that - - -

MS DASSANAYAKE: Yes.

30 MR GRAY: - - - you could pay more - - -

MS DASSANAYAKE: If this was what I wanted then you have to get your own nurse.

35 MR GRAY: Now, you mentioned dehydration, and it was a great concern of yours and you mentioned that earlier in the lead-up to your mother's hospitalisation - - -

MS DASSANAYAKE: Yes.

40 MR GRAY: - - - in July 2017. What are your conclusions about the adequacy of drinks being offered to your mother more generally, not just in that period where she clearly was dehydrated but more generally? Did she need a lot of time to consume fluids?

45 MS DASSANAYAKE: Even now she doesn't need a lot of time but she just needs to be encouraged. She – I have now got her to a stage where she can hold a cup and

feed – drink herself but somebody needs to be there saying “Keep going [REDACTED] you know, you’re nearly done”, and make sure it doesn’t spill.

5 MR GRAY: We will just suspend the audio of the webcast, just to omit your mother’s name from - - -

MS DASSANAYAKE: Sorry.

10 MR GRAY: No, not at all.

MS DASSANAYAKE: So it is, yes, she’s able to do that and yes, she’s now at a point where she can hold something. She wasn’t a few months ago. That – it’s encouragement and I don’t think it takes as long as like feeding her but certainly she can drink.

15 MR GRAY: Do you have any observations about other residents in the facility? Are they being given adequate encouragement to drink do you know?

20 MS DASSANAYAKE: No, I don’t think so. I mean, every bedside has a jug with – a jug with water and a glass, but that needs to go to the person because most of these people are not able to get out of bed and get their drink. So that’s where it fails because every morning I see them picking up the jug and getting a new jug but it’s full, so - - -

25 MR GRAY: What about food? Is food delivered to many of these people in their rooms?

30 MS DASSANAYAKE: Some people. I think it’s their preference. I’ve said with my mother at dinner and lunch I prefer her to go into the dining room because she was a very sociable person, and I remember when she was bedridden she used to say to me, “Why am I stuck here? I can hear everything down there, I’d like to go there.” So for that reason I like her to be in the dining room unless there’s a risk of infection or she is unwell. But there was one incident I’d like to mention where at lunchtime, which is served at 12 o’clock, but at 12.45 there was a meal that still
35 wasn’t fed to a resident. And then finally after 45 minutes, a carer came, started feeding and I said, “Don’t you think you should warm it up”, so that’s the level of – I don’t know if it’s not understanding needs. To me they’re simple things, just simple commonsense and to just have a warm meal.

40 MR GRAY: Yes. It’s clearly going to be far less appetising to say the least if it’s been sitting there for 45 minutes.

MS DASSANAYAKE: Especially a pureed one, yes.

45 MR GRAY: Now, you do mention specifically some food you characterise as not very nutritious and you say that’s the norm, is it?

MS DASSANAYAKE: Until now, in the third facility, has had several changes but until about, say, six months ago, dinner, it was normal to have party pies, sausage rolls, and just sausages. Mashed potatoes is the norm, and as the first witness said, I don't think there's anything in there except a whole lot of potato and I'm not sure
5 even if there's milk in there, so it's not very appetising.

MR GRAY: You also mentioned some foods not suitable for people without a lot of teeth. Do you mean tough meat or - - -

10 MS DASSANAYAKE: So my understanding with the meals is there's the pureed, and then what I prefer for my mum is to have soft food where if there is meat it's chopped up finely so she can consume it, and my mother can consume something like that, and then they have a normal meal. So just about two weeks ago, I had a bit
15 of a discussion with the manager to say, "Look, can we make this happen all the time instead of me coming in or my children ringing up and saying, look, she can't eat this because there's large pieces of meat, what do we do". For us, the default meal is egg sandwich, and she would have that sometimes four out of seven days because the meal cannot be consumed by her. That has changed though with the new
20 management, a lot.

MR GRAY: At paragraph 42 you mentioned that from admission to January 2018 your mother's weight fell 19 kilograms, all the way down to 31 kilograms.

MS DASSANAYAKE: Correct.

25

MR GRAY: But there has been a good recovery since then.

MS DASSANAYAKE: Yes, since – in January 2018 she was still 31 kilograms according to their records, and now she's 42 kilograms as of last month.

30

MR GRAY: What do you put that down to, that improvement?

MS DASSANAYAKE: I will – my family will take credit for that. We have been there up to three times a day to feed her.

35

MR GRAY: You mentioned there has been some regulatory action about the facility. I don't want to ask about the details but you've - - -

MS DASSANAYAKE: My understanding was in the last July they were sanctioned
40 for poor service. And then, of course, there was a huge overhaul in terms of management and new staff were brought in. And I guess that's, when there was several meetings happening with families and management and the owner is when I kind of realised how bad things really were because my feeling was that I'm expecting too much, I'm complaining too much, and, you know, perhaps, you know,
45 I wasn't being very fair. But then I realised that that wasn't the case, there was far worse situations in other parts of the facility.

COMMISSIONER BRIGGS: Might I just ask: throughout your evidence today, you've talked about your mother going to hospital.

MS DASSANAYAKE: Yes.

5

COMMISSIONER BRIGGS: You talked about the dentist, she would have been in an ambulance at one stage, as you said to get to hospital.

MS DASSANAYAKE: Yes.

10

COMMISSIONER BRIGGS: Do you think any or each of those health care providers might have either talked to the residential care facility or to the regulator about the quality of care or lack thereof that your mother may have been receiving?

15

MS DASSANAYAKE: I'm not sure if they had but when she was seriously ill for that five week stay in hospital the impression I got was that – because I did speak to the doctors, I felt desperate, I just said help me because things have to change. They just said “Look, our hands are tied, it's got nothing to do with us”, and I also got the impression that they had no idea how bad some places could be. Things like the mattress, like, I think the two doctors that I spoke to just thought isn't it normal for them to have these air mattresses, and I said, “Well, obviously not”. And I remember that the chair stuff, I said, “Can you please ring the facility and tell them, she needs to have a chair” because I just knew that me asking them, that it wasn't going to get anywhere.

25

COMMISSIONER BRIGGS: So there are questions here about what's adequate or even a minimum standard of care that might be provided, and from your evidence you say that's clear amongst the health services providers. It's also clear amongst the families who are saying there's a problem but the system is so fragmented that those concerns aren't necessarily joining together to raise an alarm bell.

30

MS DASSANAYAKE: Correct. Can I also mention one other thing is that prior to the sanctioning taking place, they were notified of when there was audit happening and when that happened, we knew because when we walked in there were extra staff who had come in from holidays and the meals were different. So that was one of the issues I think with the auditing system, they didn't get the real picture of what was happening every day. But on the other hand, the issue is if families aren't notified we won't get opportunity to talk to the auditors because we're not going to get a call saying – or not everybody can come in and have a chat and say look, this is the real story, because when those auditors were coming in, I did get the opportunity to speak to them on two occasions, and, you know, and I felt I was heard. But the first time I felt like, you know, they didn't really want to listen to me or I just really felt like I was, you know, not – they didn't want to hear me, but the second and third time it was a much better response and - - -

45

COMMISSIONER BRIGGS: Is there anything that you're aware of that's like a family or a resident's consultative body within the facility?

MS DASSANAYAKE: There is within the facility but until recently all the meetings were at 2 o'clock. For working people that is not a possibility. It's all right for me because I don't work anymore. Now they're alternating between 2 and 6 pm but as I've referred to in my submission, people are scared to talk and I was quite
5 shocked when somebody said "Can you please make sure the staff do not know we've made these complaints". And I said "Why?", "We don't know what they'll do to them". And I have to say I must have been very naïve but I didn't think any harm would happen but they are scared and from what I've seen in the media, maybe we have a reason to be scared.

10 COMMISSIONER BRIGGS: Mr Gray.

MR GRAY: Thank you, Commissioner. Ms Dassanayake, I want to now turn to some observations you've made in your statement on the particular topic of dementia care, and starting at paragraph 49 under the heading Dementia Care and the Use of
15 Antipsychotic Medications, you express some concerns about what I might call vocal and physical aspects of the interrelation between care staff and residents.

MS DASSANAYAKE: Yes. Yes.
20

MR GRAY: Would you care to elaborate?

MS DASSANAYAKE: Yes, I guess part of it came about because even I noticed that my mum was becoming agitated with certain people coming into the room. My
25 understanding was maybe it was because she had male carers coming in, and that was making her upset and then some of the male carers, their voice was quite stern and she didn't like being told, you know, what they were going to do, if that happened. Sometimes carers don't say anything, they're just here, they're there to do a job, they do it and they go. And my mother did not respond very well to that and
30 not being able to see them, their face as they talked to her. So all those things used to agitate her and she would respond sometimes quite physically. And - - -

MR GRAY: So just stopping you for a moment, by this time your mother's
35 glaucoma has become pretty bad and she's really not able to see them.

MS DASSANAYAKE: No, she can still see, that's not the issue, it's the demeanour in which people address her, you know, it's not that she can't see. But, you know, people used to stand on the side of the bed and talk and that just disturbs her a great
40 deal because she can't – probably her peripheral vision is not very good but, yes, that's part of the issue. And then the stern voices, that can happen with male or female carers.

MR GRAY: How would she react?

45 MS DASSANAYAKE: She would get very agitated, she would hit out and this is when probably the scratching incidents takes place.

MR GRAY: And did this particularly happen around changing clothes?

MS DASSANAYAKE: Yes, changing the nappy is a constant challenge, I think, for the carers, simply because she values her privacy, even in the state that she's in, she
5 still wants, you know, to do things her own way, which is a problem, but then there are plenty of carers who talk to her and say to her, "We have to do this now", you know, you're dirty or you need to get ready to go somewhere, and then quite a few of them say to me, she says "Thank you, darling, for doing that for me", so it is possible.

10

MR GRAY: So there's a way to maintain your mother's dignity - - -

MS DASSANAYAKE: Correct, yes.

15 MR GRAY: - - - at the same time as providing these very difficult intimate care services.

MS DASSANAYAKE: Yes, there is.

20 MR GRAY: It's just that only some people can do it.

MS DASSANAYAKE: Yes. And at this facility there are quite a few who are really caring, knows how to deal with it, and my mother is familiar with these people and I think that makes a difference, even though their memory is short memory, I
25 think there's something in there that, you know, okay this person makes me feel safe so I'll be all right.

MR GRAY: Yes. You mentioned concern about psychotropics and you've referred in particular in the heading to antipsychotic medications. And you've got an
30 example of a prescription you were very concerned about. Can you please explain what happened.

MS DASSANAYAKE: Yes. One Friday the RN said to me, "Look, your mother has been getting agitated and scratching some carers and I have to let the GP know".
35 I didn't think much of that, and this is when we had the acting director who that same day I spoke to her and she said to me - I raised my concerns, I said, "Look, I'm a bit worried that she's hurting people, what can we do", and then she mentioned to me, "Look, there's the possibility of chemical restraints, however, there are a lot of other ways to deal with these things before we go - take that path". And then she
40 mentioned that we could consult Dementia Australia to give us - give them recommendations on how to handle that.

So I left the Friday thinking okay, that's what we're going to do. But when I arrived on the Sunday, the RN on duty just mentioned to me, saying, "She's on some new
45 drugs". I said, "What drugs?", and they said, "It's risperidone" and I said, "What's that?", I don't know what that is, I don't - why is it being given. And I was told then that's because she is becoming agitated and this would help to calm her down. I was

not happy with that, and I told her then and there, you know, can you please tell the chemist to cancel that prescription because I do not want that to be administered to her at all.

5 MR GRAY: Was that RN formally seeking your consent or just mentioning - - -

MS DASSANAYAKE: No, I was told she was on a new medication, not asking me, no, because the script had already gone to the chemist.

10 MR GRAY: And were you able to intervene before it was actually administered to your mother?

MS DASSANAYAKE: Yes, I was.

15 MR GRAY: At 51 to 3 you refer to some examples of good care and I think you're referring again to this active - - -

MS DASSANAYAKE: I am.

20 MR GRAY: - - - eight month or so director.

MS DASSANAYAKE: Yes.

25 MR GRAY: Was this after the - this medication incident that you mentioned?

MS DASSANAYAKE: This was in that three/four day space where it was a Friday, where the incidents happened, the scratching.

30 MR GRAY: Yes.

MS DASSANAYAKE: On the Sunday I was told this was happening. So again I think there was lack of communication because on that Friday I spoke to the deputy director.

35 MR GRAY: Yes.

MS DASSANAYAKE: But the full-time RN on the Friday had referred the GP to see my mother and start on the risperidone.

40 MR GRAY: When you spoke to the director - - -

MS DASSANAYAKE: Yes.

45 MR GRAY: - - - is it the case she didn't know about that?

MS DASSANAYAKE: No, she didn't know about that. She said the referral I asked the RN to do was to Dementia Australia to come and do an assessment of my mother.

5 MR GRAY: What were the director's strategies and how did they go?

MS DASSANAYAKE: I have to say I didn't bring up the issues who did what, I just left it at that stage, and she just said, look, this person from Dementia Australia is coming now, and then that person rang me up and said, "Look, this is my assessment,
10 which is I don't think your mother has been addressed by carers when they change", and then I asked directly, "Look, is this drug something that she needs to take?" And they said, look, it's advisable especially with dementia patients that it not be administered at all, and there are other ways of dealing with the agitated
15 situation and the deputy director then said to me that she had directed the carers to make sure that everything is ready when they washed my mum because that's when she got most agitated because she was exposed, and they'd put a towel over her, quickly wash her and let her wash herself, and then that will be much better for her. And that's what was adopted while that director was there.

20 MR GRAY: And how did those strategies work?

MS DASSANAYAKE: Much better. And they said to me "Yes, we gave her a flannel. She washes herself, and she's much better".

25 MR GRAY: The scratching stopped?

MS DASSANAYAKE: Yes. Most of the time, not all the time.

MR GRAY: Now, just before concluding, you've mentioned in paragraphs 73 to 5
30 concerns about personal hygiene care, in particular around faeces. These are matters that you've taken up with the nursing home.

MS DASSANAYAKE: Yes.

35 MR GRAY: With the residential aged care facility.

MS DASSANAYAKE: I have. Even up until two days ago it's still an issue, and what I'm finding is that I go to feed her, I feed her breakfast every day, and I find her hands covered in faeces. And I've brought this up on many, many occasions and
40 emailed sent photographs of her hands and the state it's in. And the issue is when you try to clean it actually hurts her a lot once it's dried on her hands. So once she's agitated, I can't feed her. So I've kept saying to them, "Look, you need to stop this issue from occurring, which – what happens is that she's, I believe, left in a nappy, dirty nappy for a while, and she gets annoyed and tries to take it off herself to – and
45 that's what she does, she's trying to take it off. And so then whoever comes and changes her, the hands are not cleaned properly. So what's happening over the last –

yesterday and the day before, is that she's taken into a shower very early in the morning so that I'm happy.

MR GRAY: Yes.

5

MS DASSANAYAKE: But I think there needs to be another way of resolving this issue. I mean, for me the reason why I want her hands clean, besides it being dirty, is that we eat with our hands, and I would like her to start using her hands to eat a bit of toast and, you helping herself a bit more.

10

MR GRAY: Yes.

MS DASSANAYAKE: That's my reason, and it's unhealthy.

15 MR GRAY: It's a matter of not only personal hygiene but of maintaining some independence.

MS DASSANAYAKE: Yes.

20 MR GRAY: And some capability and avoiding deconditioning of these skills.

MS DASSANAYAKE: That's right. Yes.

25 MR GRAY: Thank you. Look, you conclude your statement with references to your observations about direct care staff and whether they're really adequately supported and trained for the jobs they're asked to do.

MS DASSANAYAKE: Yes.

30 MR GRAY: Do you wish to elaborate on those points for the Commissioners before we conclude your evidence?

35 MS DASSANAYAKE: Yes, I do, in the sense that the sheer fact that there's such a huge turnover I feel that it's because working in a nursing home is not an attractive option for many people. And the other issue is that I think I'm very concerned that people that, who are there as carers are not adequately trained to the point where I've noticed that they're not able to see – to recognise when my mother was sick for instance, like she was shaking, she was severely dehydrated.

40 MR GRAY: Are we talking about July 2017.

MS DASSANAYAKE: Even after, no, it's happened since then as well, and there's no recognition that this person is unwell and something needs to be done which I find quite frightening.

45

MR GRAY: What about the RNs, aren't they observing?

MS DASSANAYAKE: Yes, they are there but I don't know what's happening and, again, I think it's the quality because now we have different RNs with the new management that's in place, and they seem to be a lot more proactive and I've noticed now with other residents being – their wound care and all that seems to be
5 happening a lot better because I'm around poking my nose into things to find out what's happening and how things are being done and I've noticed a substantial change in that sort of area. And until five months ago there was only one RN for 67 people. Now, there's two RNs but this is only until 3 o'clock in the afternoon. At night there's only – there is an RN which I – I don't know if it's unusual but there is
10 an RN for 67.

MR GRAY: The night shift.

MS DASSANAYAKE: Sorry?
15

MR GRAY: The night shift - - -

MS DASSANAYAKE: Yes, the night shift. And two carers: one for upstairs, one for downstairs. So as I said before, I don't see how one carer could possibly change
20 – reposition every two hours that many, just upstairs alone. I don't know what the situation is downstairs. I don't see how it's possible for anybody to do that sort of work.

MR GRAY: Thank you. Unless you have any further questions, Commissioners,
25 that concludes Ms Dassanayake's evidence.

COMMISSIONER TRACEY: Ms Dassanayake, you've been on a long and very difficult journey, a deeply personal one caring for your mother. You've been an excellent historian, if I may say so, and as a result your evidence has been extremely
30 helpful to the Commission in understanding what is going on in some aged care facilities. We're very grateful to you for giving us those insights. Thank you very much for coming.

MS DASSANAYAKE: Thank you, Commissioners.
35

COMMISSIONER TRACEY: You're excused from the witness box.

<THE WITNESS WITHDREW [3.32 pm]
40

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Commissioners, I understand you're willing to continue sitting without
45 a break.

COMMISSIONER TRACEY: We'll sit on till 4.30. If you tell us you need more time, let us know.

5 MR GRAY: In fact, Commissioners, we will probably be able to rise a bit after 4, I suspect, because I'm only intending to call one witness in the particular case study we're starting with.

COMMISSIONER TRACEY: Yes.

10 MR GRAY: And rather than start the next witness and leave her evidence half unfinished.

COMMISSIONER TRACEY: We're in your hands.

15 MR GRAY: Thank you. I think we will probably be able to rise about 4.15.

COMMISSIONER TRACEY: Very well.

20 MR GRAY: The first case study concerns Garden View Aged Care Proprietary Limited. It's a case study which raises issues around restrictive practices, particularly in the nature of physical states. There are also issues raised concerning the antipsychotic risperidone but the focus of the case is on physical restraints and how it comes to be that a facility that has policies, is documenting what it does, has care plans, does assessments, how it comes to be that that facility, faced with
25 challenging behaviour on the part of a resident, has seen fit to adopt practices which seem surprising in the area of physical restraints. Now, of course, it will be for you to decide in the end what you make of the evidence in this matter, but I put it – I will put it clearly at the outset that the evidence suggests such a level of physical restraint being applied to the resident in question, Mr Terrence Reeves, that we will be asking
30 you – I anticipate, if the evidence unfolds as I expect, – to make findings that the degree of physical restraint applied to Mr Reeves was wholly inappropriate, unjustifiable on any view and really is at quite a serious level of mistreatment.

35 Now, the issue concerns a period of just a number of weeks, six weeks or so of respite residential care when Mr Reeves' wife, Mrs Lillian Reeves, went on holiday. And the chronology begins in May 2018. On 1 May, Mr Reeves is admitted into Garden View, there are assessments, there are care plans. There are progress notes in relation to Mr Reeves' progress in the care of Garden View. The evidence will be, in my submission, to the effect that there was about a week where it's evident that the
40 facility was trying hard to care for Mr Reeves, and Mr Reeves was suffering a reversal, in effect, of what was day and what was night and was restless at night. There's no doubt that Mr Reeves presented some challenging behaviours to the facility and it was doing its best over a certain period of time to provide one-to-one care at times, and to keep Mr Reeves as occupied as possible and to look after him.

45 But then at a certain point it seems to become too difficult and that's where I will stop summarising the evidence and I will leave it to you once you've heard the

evidence to make up your own mind. Some weeks later it's uncontroversial that Mr Reeves, having walked into this facility, Garden View, a mobile man with only a degree of difficulty around toileting, insofar as he needed to know where the toilet was but he didn't actually have incontinence and he could toilet himself, after this
5 period of six or so weeks, by 7 July, say six weeks – it's really two months – by 7 July he's leaving Garden View, really, in a severely deconditioned state with very limited mobility. He's lost the power of speech that he had before he went in and he's incontinent.

10 And we're going to be hearing evidence from three family members of Mr Reeves: his wife, Lillian Reeves, his daughter, Michelle McCulla, and his other daughter, Natalie Smith, about the course of those events, in particular, the key witness really is Ms Michelle McCulla. She has provided a very detailed statement to the Royal Commission and the narrative by and large hangs off Ms McCulla's statement.
15 However, for Mrs Lillian Reeves' convenience, I wish to call Mrs Reeves first. Her evidence will be of relatively short compass by comparison with Ms McCulla's evidence, and I anticipate Mrs Reeves' evidence will take us to about 4.15. There are probably two, perhaps a few other issues but probably two main issues we need to explore with Mrs Reeves that are not the subject of direct evidence in Ms
20 McCulla's statement.

And furthermore, Mrs Reeves, as Mr Reeves' wife, was understandably regarded as the authorised representative of Mr Reeves. I understand there may have been a guardianship arrangement or something of that kind. We can ask Mrs Reeves about
25 that. So in effect, she is the main person to ask about matters of consent and the like, and there's an important issue in this case concerning consent, consent to restrictive practices of both a physical and chemical variety, and there are some uncertain issues around the facts in this case relating to consent which will need to be explored in the evidence. So without further ado, I will ask the operator to bring up the Garden
30 View case study tender bundle.

As I flagged in the opening, Commissioners, we propose to present you with an index like this at the start of each of these four case studies and to tender a compendious exhibit constituted by all of the documents in the index, and thereafter,
35 we're just going to refer to the documents by tab number. The tab appears, the tab column is over on the left-hand side of the page. And this particular case study doesn't raise too many issues relating to redactions and the like. That may be a little different with some of the case studies to come. This particular case study has already been the subject of media attention and information provided to the media
40 from both the perspective of family and the perspective of the aged care approved provider. So without further ado I to seek to tender as a single exhibit the Garden View case study tender bundle in accordance with the index.

COMMISSIONER TRACEY: Yes, the Garden View tender bundle will be exhibit
45 3-7.

EXHIBIT #3-7 GARDEN VIEW TENDER BUNDLE

MR GRAY: Thank you. I call Mrs Lillian Reeves. Before we proceed with Mrs
5 Reeves' evidence, there are some parties who wish to announce their appearances.

MR A. CROSSLAND: If the Commission please, Crossland, I act for Mrs Reeves,
Ms McCulla, and Ms Smith, with the Commission's leave.

10 COMMISSIONER TRACEY: Yes. Thank you.

MS D. HOGAN-DORAN SC: With the Commission's leave, Hogan-Doran, and I
appear with my learned friend, MS STANLEY, for Garden View Aged Care and its
two staff members.

15

COMMISSIONER TRACEY: Thank you, Ms Hogan-Doran.

MR S. BECKETT: If the Commission please, my name is Beckett, and I appear
with the Commission's leave for Drs Burkitt and Wong.

20

COMMISSIONER TRACEY: Thank you very much.

<LILLIAN SONYA REEVES, SWORN

[3.42 pm]

25

<EXAMINATION-IN-CHIEF BY MR GRAY

30 MR GRAY: Thank you, Mrs Reeves. What's your full name?

MRS REEVES: Lillian Sonya Reeves.

MR GRAY: I just ask that your statement be brought up on the screen. It's
35 WIT.0141.0001.0001. And can you see the statement there on the screen. Do you
recognise that to be copy of the statement you've signed today in this Royal
Commission?

MRS REEVES: Yes, it is.
40

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

MRS REEVES: They are.
45

MR GRAY: Commissioners, I tender that statement.

COMMISSIONER TRACEY: The statement of Lillian Reeves dated 6 May 2019 will be exhibit 3-8.

5 MR GRAY: Commissioners, I beg your pardon, I misstated the date of the statement. I mistakenly believed it to be signed today but it is, in fact, signed and dated 26 April 2019.

10 COMMISSIONER TRACEY: Very well. I will correct the announcement of the tender name to reflect that change of date.

EXHIBIT #3-8 STATEMENT OF LILLIAN REEVES DATED 26/04/2019

15 MR GRAY: Thank you, Commissioners.

Mrs Reeves, what's your age?

20 MRS REEVES: Just turned 66.

MR GRAY: And your husband, Mr Terrence Reeves, is known as Terry.

MRS REEVES: Terry.

25 MR GRAY: What's your husband's age?

MRS REEVES: 72.

30 MR GRAY: How long have you been married?

MRS REEVES: Forty – almost – this year will be 45 years.

MR GRAY: And how many children do you have?

35 MRS REEVES: Three.

MR GRAY: What was your husband's work?

40 MRS REEVES: He worked for Telstra as a technician.

MR GRAY: When he retired did he take another job for a short time?

45 MRS REEVES: Yes, he retired in 2000 from Telstra, and then he was contracted back to Telstra on a contract basis.

MR GRAY: And did he eventually move from Telstra into retail for a while?

MRS REEVES: He did, into – yes, into private, yes.

MR GRAY: And then what happened; did you have plans to go travelling and something intervened?

5

MRS REEVES: Yes, we did, yes. Just the normal plans that retirees will have of travelling and going around, and then he was diagnosed with dementia.

MR GRAY: And what sort of dementia was he diagnosed with?

10

MRS REEVES: He just fits under the Alzheimer's umbrella as just dementia, yes.

MR GRAY: And what effect did that have on your plans and on your life together, if you can break it down for the Commissioners say for the first two or three years after the diagnosis; how did things go then?

15

MRS REEVES: Sure. In the first three years it was good; he was very well aware of what he had. And I think – we did a lot of travelling in the first few years, we had to hurry it along, and it wasn't until five years after diagnosis that there was significant decline in his capabilities.

20

MR GRAY: So about how many years ago was this decline?

MRS REEVES: About three, four years ago, three. You could see he was starting to forget things, and you would have to repeat them several times for him to – and he would go, "Yes, that's right, I remember now". So it was a slow progression.

25

MR GRAY: And what were your living circumstances? Where were you living? I don't want you to give your address but whereabouts were you living and were you in a house together with your husband?

30

MRS REEVES: Yes, we were in a house, yes.

MR GRAY: Double storey?

35

MRS REEVES: Yes, it was a two storey house. Yes. He managed quite well, he managed up and down stairs; he did that quite well.

MR GRAY: And your children, Michelle, Natalie, and Ian, do they all live reasonably nearby?

40

MRS REEVES: They do, yes.

MR GRAY: They're not right next door or anything, are they?

45

MRS REEVES: No, they're not. No, but they were within – at that time they were within 15, 20 minutes.

MR GRAY: And there's grandchildren in the family, too?

MRS REEVES: Yes, there is, there's three grandchildren.

5 MR GRAY: So in that period over that, I think you said three or perhaps four years or so, where you've been living with the decline in your husband's condition, have you been – how is it – have you been able to support him at home until about mid last year.

10 MRS REEVES: Yes. I've always looked after him at home, yes.

MR GRAY: And up to May last year, how was that going? Can you describe the average day for the Commissioners in the period, say, between March and May; how was your husband's condition then, and what did you have to do for him?

15

MRS REEVES: He would – we would get up in the morning, I would lay out his clothes. I would help him with the shower, just turning on the taps and – and getting the temperature right for him was – and then he would go in and wash himself and do everything and come out and dry himself. When he had finished I might have to just
20 tighten the taps he wouldn't quite get that right, but he would look after himself, he would brush his own teeth. He would try and do his hair. I would play out his clothes because clothes were a mishmash, so I would get him the shirt and his pants, and he would put them on. Sometimes the shirt would come on where the collar was here, and I would say "Does that not feel right?", and he would say, "No, it feels
25 strange", so we would turn that around. But he was still – he was still quite capable, you know.

MR GRAY: Now, what about his continence?

30 MRS REEVES: He was quite, he was good. Towards the end, in the last six months before May he would – I would have to direct him. He would say, "Where's the bathroom?", and I would have to say, "Well, you remember, it's just down here", and I would show him and he would go "Yes, that's right, I remember where that is". But once he was there, he would take care of himself and it was fine, but it
35 was getting to the point where he would forget where it was, which room it was in, so I would direct him to the proper room.

MR GRAY: What was his regular medication regime?

40 MRS REEVES: He was just on galantamine which is just to stop the progression of the dementia.

MR GRAY: And no other regular medication; is that right?

45 MRS REEVES: Nothing regular, no.

MR GRAY: He had a bit of high cholesterol, I understand.

MRS REEVES: He did, but I had taken him off statins a long time ago because there was – I had read something about dementia and statins not being good, so I took him off the statins and we did it through diet and his GP was very happy with – with his levels.

5

MR GRAY: Yes. Now, in respect of some of the documentation, there are references to depression but is that something that you had any knowledge of?

10 MRS REEVES: No. No, I don't think so. I don't think he was actually depressed. I – no, I don't think he was depressed, no. He was aware of his condition and what had happened. His mother had dementia. So he knew the road he was heading down. But I don't think he was depressed. He seemed to be the sort of person that did the best he could at that time so - - -

15 MR GRAY: Now, I want to ask you about a drug branded as Risperdal and it's actually a form of – it's a brand of risperidone.

MRS REEVES: It is.

20 MR GRAY: I want to ask you whether you had ever had a prescription for it for your husband.

MRS REEVES: Yes, I did.

25 MR GRAY: And what were the circumstances in which you were prepared to use that, and did you use that? Can you tell the Commissioners what your history was with respect to risperidone and your husband before May 2018?

30 MRS REEVES: He – he knew we were going out somewhere. I would pack maybe an overnight bag and I'd say "We're going somewhere". He'd become a bit agitated. He was unsure of where we were going and what was actually happening. So I did give him half a risperidone to settle him but I found him quite drowsy and – so I only ever did that maybe once or twice. I didn't think it worked too well for him. I think talking him through what we were actually doing and sitting him in the car and
35 saying, this is what we're doing, worked a lot better than the risperidone.

MR GRAY: Thank you. And did you once use a full tablet?

MRS REEVES: I did. I did.

40

MR GRAY: And what happened?

MRS REEVES: He was just almost unconscious. So I never did that again. We ended up not even going out that particular day.

45

MR GRAY: And was this – perhaps I will just ask you a couple of questions about this. Are you very close with your children, particularly your daughters.

MRS REEVES: I am. Yes.

MR GRAY: Do you really talk a lot about the care you're giving to your husband and his needs?

5

MRS REEVES: Yes. And they would come over constantly and help out and do things, and when my son could he would be there, so yes, we are very close.

10 MR GRAY: And so was that in effect common knowledge – was that story about the risperidone common knowledge?

MRS REEVES: Yes, it was.

15 MR GRAY: Between you and your daughters.

MRS REEVES: Yes.

20 MR GRAY: Now, I want to ask you about the period leading to May 2018. In the period before that, did you make plans to go overseas with your brother?

25 MRS REEVES: I – I had to find – yes. I had to find respite before I could commit to the trip but my sister had said to come away with her and her husband on an organised tour, and I had never had a break in all those years of looking after him. So I thought respite was good. I had given – I was given 60 days of respite, and I thought it was a good opportunity to give him a break from me, and me a break.

MR GRAY: When you say you were given 60 days, did you have to go through an ACAT assessment process for your husband?

30 MRS REEVES: Yes, I did. Yes, I did.

MR GRAY: Was the result of that assessment that you were entitled - - -

35 MRS REEVES: To 60 days or 62 days, I'm not quite sure. Yes

MR GRAY: And it's respite for you - - -

MRS REEVES: It is.

40 MR GRAY: - - - represented by your husband going into residential respite care; is that right?

MRS REEVES: Into care, that's correct.

45 MR GRAY: Was there a fee to pay on your part as well?

MRS REEVES: There is. I think it's 50 dollars and so many cents per day. So there is a fee, yes.

5 MR GRAY: Yes. And there's some subsidy, is there, some funding as well from the government; is that right?

MRS REEVES: Yes, there is.

10 MR GRAY: And so did you make arrangements for Terry to go into respite care at Garden View?

MRS REEVES: Yes. Yes, I did.

15 MR GRAY: Did you make those arrangements in about March; is that right?

MRS REEVES: Correct.

20 MR GRAY: Was that a difficult decision for you and the rest of the family to reach, to put your husband - - -

MRS REEVES: Yes, it was.

MR GRAY: - - - into respite care.

25 MRS REEVES: Yes, because I was quite concerned how he would cope. Being in the later stages of dementia, I wasn't sure whether he would settle because he seemed to - I was his main carer so he gravitated to what I would help him with. So it was concerning.

30 MR GRAY: Yes. And was it a bit of a family decision; is that right?

MRS REEVES: It was, yes.

35 MR GRAY: With consideration - - -

MRS REEVES: Yes.

40 MR GRAY: - - - given to how often he could be visited by family members and so forth?

MRS REEVES: Yes, yes.

MR GRAY: Could you elaborate on that?

45 MRS REEVES: After the first week I said to all three of my children that I wanted someone there at least - if not every day, every second day, I want someone there

because I was starting to feel a little bit uncomfortable. But I had already committed to a trip, so I thought by them all going on a regular basis he would be represented.

5 MR GRAY: Well, I want to ask now about the actual day that you took your husband, Mr Reeves - - -

MRS REEVES: Yes.

10 MR GRAY: - - - to Garden View.

MRS REEVES: Yes.

15 MR GRAY: And what you remember of the discussions that day, and we will start I think with what time of day it was. Do you remember roughly what time?

MRS REEVES: It was after lunch.

MR GRAY: And how did the visit go, what happened, who did you meet?

20 MRS REEVES: Natalie and I had taken him in. We walked around with him. We showed him where things were, and he seemed quite relaxed. He sat down and had something to eat. They had served him something to eat and a cup of tea. He said to my daughter, Natalie, at the time, "This is a lovely place but I don't think I'm ready for here". So he knew that he wasn't quite ready to go into full time. We said, "No, 25 no, it's just a little break for you, it's a holiday. It'll be fine, you know". And he was quite happy.

30 MR GRAY: I'll ask the operator to bring up tabs 11 and 12, please. Start with - maybe 11 on the left side, 12 on the right side. And are these photos that are both taken on 1 May?

MRS REEVES: Yes. I think they are. I think that's the day we took him in and I unpacked all his clothes and put them in there, and you can see he's actually making eye contact with the camera. 35

MR GRAY: Yes.

MRS REEVES: And he seems very alert in the face.

40 MR GRAY: Yes, and it's the case, is it, that the photo on the left is a photo taken by Garden View for its admission purposes?

MRS REEVES: Yes.

45 MR GRAY: And the photo on the right was taken by yourselves.

MRS REEVES: Yes.

MR GRAY: A family photo.

MRS REEVES: Family, yes.

5 MR GRAY: And about how long did you stay at Garden View on 1 May?

MRS REEVES: We were there for quite a few hours to settle him so that he wouldn't feel that we had just dropped him off and walked away quickly. So we were there for at least three or four hours.

10

MR GRAY: And did you have discussions with staff members of Garden View?

MRS REEVES: No, not really. I think we had some discussion with the lunch lady. She had a bit of a joke with him; he had a bit of a joke back with her.

15

MR GRAY: Was there an assessment process, an assessment of his needs, did you participate in anything that?

20 MRS REEVES: Not on that particular day. I had – when I first approached Garden View, I had just discussed a few things of how he would like his cups of tea or his coffee, or just certain things like that, and what he liked and what he didn't like.

MR GRAY: Was that in mid-March?

25 MRS REEVES: Yes, it was.

MR GRAY: I'll ask the operator to bring up tab 9, please. Now, I don't know whether you would have been able to see anything being written, but this is a document which seems to be dated 15 March 2018, and I'm getting that from the line
30 "date data collected". Have you seen this document before?

MRS REEVES: I think so. I think that's the one that was – that I actually saw on that – when I had first approached Garden View.

35 MR GRAY: And if we just go to the next page, please, operator, if we just go back one page, please. We see in the middle of that, or about a third of the way down that page under the heading Interim Nursing Care Plan, there's reference to:

40 *Needs reminding and behavioural problems, a little lost, needs supervision, help to initiate.*

Are you able to recall what was said in that regard in respect of "needs reminding"? Or "needs supervision, help to initiate".

45 MRS REEVES: I think I just, I said to them, because it's a new facility for him, he would have to be shown or at least asked, on an hourly basis, does he require toileting and if they could just show him where it was. Other than that, he would

have gone himself. He would have even come out the door himself and then just wandered around. So I did stress that – that part of it to them, and I said that he would feel a little lost in the beginning, trying to get his bearings of where he was.

5 MR GRAY: Can we go to the next page, please, operator. You see up the top there's something:

Sleep pattern, early to bed, has started wandering some nights. Up early, 7 am. Try to reduce daytime nap.

10

Does that help jog any memories about anything said in those respects?

MRS REEVES: I think I would have told them things like that, because I did try to reduce his naps at home. I found that if he napped too long that he would be more
15 disturbed through the night. So I tried to limit – he always had a nap but I would try and limit it. So it is something I may have discussed with them.

MR GRAY: You told them that.

20 MRS REEVES: Yes.

MR GRAY: By the way, how did you do that, did you keep him occupied with activities of some kind?

25 MRS REEVES: Yes, we would go out for a walk, or he would help me down in the kitchen and I would give him some small – something to do and, yes, just certain things.

MR GRAY: Yes. Now, in the middle of the page it actually says:
30

Continence and toileting, incontinent of urine, incontinent of faeces.

But then it says “occasional incontinence”. Are you able to shed any light on any
35 discussion?

MRS REEVES: I don't know that; he didn't go in being incontinent – any incontinence. So that's something they've put down themselves.

MR GRAY: You've made the point that he had to be reminded where the toilet
40 was.

MRS REEVES: Just – yes, he had – he would have to be shown at least.

MR GRAY: Operator, is that the last page of that document? Thank you, operator.
45 Now what's this reference to “on depressant medication”. Is there anything you can share on that matter?

MRS REEVES: No, I don't. He has never been on antidepressant.

MR GRAY: Yes. And what about – just skipping the next few lines about what he likes.

5

MRS REEVES: Well, yes.

MR GRAY: Says when he asks for Lillian, that's yourself, says that she's gone to the shop, back soon, don't worry.

10

MRS REEVES: Yes.

MR GRAY: Is that something that you suggested?

15 MRS REEVES: Yes, yes. While he was at home I did have a carer come in on a Friday that I was entitled to, for a few hours, and they would say to him, "She's just gone to the shop, she'll be back", and that would settle him. And then he may have – in 10, 15 minutes he may have asked that same question again, but it would settle him to know that where I was and that I was coming back so it would have been something I had told them.

20

MR GRAY: And to the best of your knowledge and belief, did you say in this assessment that he was on dementia medication?

25 MRS REEVES: Yes, that he was on galantamine, yes.

MR GRAY: Now – thank you. Putting that process to one side, you don't have any – you weren't involved in another assessment of his care needs.

30 MRS REEVES: No.

MR GRAY: Is that what you say?

MRS REEVES: No.

35

MR GRAY: Okay. So back to 1 May – operator, you can please put that document away – back to 1 May and the afternoon of 1 May when you were at Garden View for three or four hours, how did that finish up and about what time did you leave, do you think?

40

MRS REEVES: It would have been later in the afternoon as it was coming on dusk, and we got up to go and he got up to go and we sat him back down and said, "No, no, you're going to stay for a little while but we will come and see you", and we gave him a newspaper and he started just flipping through that newspaper. And he was fine, he sat there and my daughter, Natalie, and I went.

45

MR GRAY: And then you left; is that right?

MRS REEVES: Yes, we did.

MR GRAY: And during that time you were there, did you go to a place called East Wing?

5

MRS REEVES: No.

MR GRAY: Did you ever see East Wing?

10 MRS REEVES: I did later on.

MR GRAY: Later on.

MRS REEVES: Yes.

15

MR GRAY: Was that in some other part of the facility.

MRS REEVES: It was.

20 MR GRAY: Which was harder to get to.

MRS REEVES: Yes.

MR GRAY: Was it behind a keypad door?

25

MRS REEVES: Yes, it was.

MR GRAY: Now, this is important. Can I just ask you to be very explicit, what happened after you left for the rest of the day? I will just say that again, I'm sorry, that was a bit garbled, on 1 May - - -

30

MRS REEVES: Yes.

MR GRAY: - - - after you had left Garden View in the manner you've just described, what happened for the rest of the day?

35

MRS REEVES: I just went home, and my daughter went home.

MR GRAY: Did you have a communication of any kind with Garden View that day?

40

MRS REEVES: No, I did not.

MR GRAY: Have you ever said to staff of Garden View that you sometimes gave your husband half a tablet of risperidone if he was very upset?

45

MRS REEVES: I didn't, no.

MR GRAY: Did you ever consent to Garden View giving your husband half a tablet of risperidone if needed if he was very upset?

MRS REEVES: No, I did not.

5

MR GRAY: Did you ever consent to Garden View giving your husband a full tablet of risperidone daily?

MRS REEVES: No, never.

10

MR GRAY: On a regular basis?

MRS REEVES: No.

15 MR GRAY: I will ask you to speculate now, that may be of limited probative value, Commissioners but you're entitled to hear about some speculation on this point, in my submission. What would have been your response if it had been proposed to you that your husband be given a full tablet of risperidone per day on a regular basis regular basis?

20

MRS REEVES: No, I wouldn't have allowed that because I had firsthand knowledge of what it would do to him, and it was terrible. And it didn't really help him anyway.

25 MR GRAY: Are you referring now to that one time when you gave him a full tablet?

MRS REEVES: Correct.

30 MR GRAY: Now, I just want to skip forward 10 days to 11 May.

MRS REEVES: Yes.

35 MR GRAY: Did you have a discussion with one of your daughters about a form that Garden View or a nurse at Garden View wished to have you sign?

MRS REEVES: Yes. My daughter, Natalie, rang me and said that she had received a form from Garden View, and it was for restraints and that I would have to sign that.

40 MR GRAY: Okay. Now, what time of day was that, do you recall?

MRS REEVES: It would have been in the evening.

MR GRAY: And in what mode, face to face?

45

MRS REEVES: No, it was over the phone on that particular day.

MR GRAY: All right. Anything else of relevance about the form concerning authorisation of restraints on 11 May?

5 MRS REEVES: No. No. She just advised me of what she had, this form, and that I would have to sign it, and – and we just left it at that.

MR GRAY: All right. Going now to the next day, 12 May, again with relevance to that topic.

10 MRS REEVES: Yes.

MR GRAY: What happened on 12 May?

15 MRS REEVES: I actually saw Natalie on that day and we had gone out with our grandchildren and her nieces and nephews and she – we had talked about it in length about them restraining Terry for short periods of time, and that it was for his safety. She said she had a form. I'm unsure whether that – I didn't get that form so I'm unsure what happened to it.

20 MR GRAY: She said she had a form which, what, she had obtained from Garden View?

MRS REEVES: From Garden View, yes.

25 MR GRAY: Right. Okay, but you had, what, quite a lengthy discussion on the 12th, is that - - -

MRS REEVES: Yes, we went out for lunch and we talked about it over lunch.

30 MR GRAY: And to the best of your knowledge and belief and recollection, what was the substance of what she said concerning what Garden View had said about this need for restraints, and how long it would be and so forth?

35 MRS REEVES: It was – yes, it would be very short periods of time. It was during their changeover shift and during meal times, perhaps. I don't think there was any time specified but it was for very short periods of time that we had discussed, Natalie and I.

40 MR GRAY: All right.

MRS REEVES: And we didn't think that it was for his safety, we didn't think that those short periods of time were – were going to hinder him too much, so we – we discussed that it would be for his safety, we would allow that.

45 MR GRAY: I'm just going to stop there for a minute and go back in the chronology to 1 May because there's a very important question I should have asked you. What was your husband's state of mobility on 1 May?

MRS REEVES: He was very good. He walked very well. He wasn't stooped. He didn't shuffle. He walked very well.

MR GRAY: And how steady was he on his feet?

5

MRS REEVES: He was very steady.

MR GRAY: Did you have any concerns he was a risk of falling?

10 MRS REEVES: No, he had never fallen and we lived in a two-storey house. He managed those stairs without any help from me. And I was quite comfortable with him going up and down those stairs even when I wasn't in the room or in the hallway where he would be using those stairs.

15 MR GRAY: Coming now back to 12 May and your discussions with Natalie, was there anything said by Natalie around the topic of what Garden View had said about the particular risk that Mr Reeves needed to be protected from, in the form of restraint?

20 MRS REEVES: No, they just felt that during changeover shift there wasn't a lot of people that would be watching him, and that it would be for his own safety.

MR GRAY: All right. Was there anything else that happened on the 12th of relevance to this topic of Garden View seeking your consent to restraint on Mr
25 Reeves?

MRS REEVES: No.

MR GRAY: No. Okay. We will now go to the next day, 13 May. Again, with
30 relevance to this topic of Garden View seeking your consent to restrain Mr Reeves, what happened on that day, if we can take it in order? What did – did you go to Garden View?

35 MRS REEVES: I did. I went in the afternoon. I saw him in the dining room, so I went and sat with him. An RN did approach me. She had a clipboard with the form in the clipboard, and she discussed that this was a restraint form and that I would have to sign it. And she was very clear that it was during meal times and during changeover shift and she was very specific in saying that changeover shift took 30 minutes, and that's what he would be restrained for, would be that – that short 30
40 minute period, and maybe during the evening meal time, but that was all that she discussed in time-wise.

MR GRAY: Was there anything that she said about the nature of risk that might
45 justify restraint?

MRS REEVES: No. No. She just said it was for his safety, that it was best that he would be restrained. So he wasn't walking around during their change of shifts.

MR GRAY: Was there anything that she said about the particular kind of restraint?

MRS REEVES: She said it would be a lap sash of some sort that would tie him to a chair.

5

MR GRAY: Operator, please bring up tab 21. Have you seen this document before, Mrs Reeves?

MRS REEVES: Yes. I have.

10

MR GRAY: Now, there are quite a few signatures on this document. Can we just start with a signature in the middle of the page that's been crossed out.

MRS REEVES: Yes.

15

MR GRAY: On the dotted line adjacent to the words "LMO signature"; is that your signature?

MRS REEVES: It is.

20

MR GRAY: Yes. And does your signature also appear further towards the bottom – the second last line adjacent to word "signature" and followed by the words "relationship to resident"?

25

MRS REEVES: Yes.

MR GRAY: Yes, so they're your signatures.

MRS REEVES: Yes.

30

MR GRAY: Now, doing the best you can, to be as precise as you can about the sequence of when markings were made on this document, to the best of your knowledge and recollection - - -

35

MRS REEVES: Yes.

MR GRAY: - - - can you take the Commissioners through what happened with this document.

40

MRS REEVES: Yes, well, she had discussed the 30 minute - - -

MR GRAY: She?

45

MRS REEVES: The RN on duty. I really don't remember her name, but she was the RN. So she – we then looked at the form. She did the ticks, I signed and then she said, "I'm sorry, that's the wrong line". So we crossed that out and she said, "You will have to sign here", so I did sign and she witnessed it.

MR GRAY: Now, when you say she witnessed it, I just – I will ask you to be as precise as you can about the exact sequence in which things were said and done. You mentioned you signed; did you also date?

5 MRS REEVES: I did.

MR GRAY: And then you crossed out the signature.

10 MRS REEVES: I did. I had done it on the incorrect line so I crossed out my signature and I went to the correct line and I signed.

MR GRAY: Okay. Just hold on a minute. When you say the correct line, do you mean the second last line - - -

15 MRS REEVES: Yes.

MR GRAY: - - - near the foot of the document?

20 MRS REEVES: Correct.

MR GRAY: Is that the next thing you did? Was anything else said?

25 MRS REEVES: No. She just said, “I’m sorry, that’s the wrong line. This is where you have to sign”. I did cross that out, I did sign, but I didn’t date it and I didn’t write in relationship. I just signed it and wrote my name.

MR GRAY: Okay, so after you signed it and you wrote your name above - - -

30 MRS REEVES: Yes.

MR GRAY: - - - that signature line where it says “print name of person responsible”.

35 MRS REEVES: Correct.

MR GRAY: That is your writing.

MRS REEVES: That is my writing.

40 MR GRAY: You did that; then what happened? Was something said or done?

45 MRS REEVES: I signed it, I did that, and she signed it and dated it, and she said to me, “I will just fill in this relationship”. She said you have to – we will put in “wife”, and I said fine.

MR GRAY: Okay. And then what happened to the form to the best of your knowledge?

MRS REEVES: She took it then.

MR GRAY: You saw her just take it away.

5 MRS REEVES: Yes, she had a clipboard, she took that, and then I resumed just sitting there with Terry.

10 MR GRAY: Operator, please bring up document WIT.1039.0001.0001. This is a statement of Jayanthi Kannan. Thank you, operator, for interpreting my incorrect code number. Now, do you see there, Mrs Reeves in this Royal Commission, a statement of Jayanthi Kannan dated 26 April 2019?

MRS REEVES: Yes.

15 MR GRAY: Operator, please go to page 0003. Please pull out paragraph 10. Do you see there Ms Kannan is saying her statement, that she made a progress note on 13 May 2018 which said:

20 *Resident was restless and wandering earlier shift. Urinated inside room 27. Staff assisted to change his clothes and mopped the floor. Resident was VB visited by wife before dinner. Wife assisted him with toileting. Noted sitting with wife quietly in central dining. Wife wanted to see resident current med chart and shown as per request.*

25 I'll just stop there. Was that right, did you ask to see your husband's medical chart?

MRS REEVES: As far as I can recollect it would have been something that I would have done but it's not prominent in my mind at the moment, I'm sorry.

30 MR GRAY: Assuming that could be a reference to medication chart - - -

MRS REEVES: Yes.

35 MR GRAY: - - - if you had noticed in amongst the pages of the medication charts, references to Risperdal would you remember that?

MRS REEVES: Yes, I would have.

40 MR GRAY: Do you have any such memory?

MRS REEVES: No, I don't.

45 MR GRAY: Just reading on, the statement continues in its recitation of the progress note:

Also signed the restraint form and written in LMOs book to authorise it.

Commissioners, can I just interpolate that LMO, we understand to be local medical officer or something of that kind – licensed medical officer, or it could be locum but in any event it's a reference to a primary health practitioner:

5 *Wife stayed until dinner and assisted him to rest in bed. But resident got out of bed within few mins and started wandering. Staff took him to East Wing. Resident enjoyed his supper with tea and biscuits. Remains wandering ATOR, at time of report.*

10 Now, do you have any other comments to make about the references to you in that paragraph, apart from what you said concerning the med chart. It is consistent, insofar as it goes, with your account about signing the restraint form but you've added a whole lot of context to that bare fact.

15 MRS REEVES: Yes, correct.

MR GRAY: Are there any other comments you have about the entry?

MRS REEVES: No. No. No.

20

MR GRAY: If we go to paragraph 12 of Ms Kannan's statement – perhaps operator, if you could bring that out of the document, perhaps just expand paragraph 12 a little more:

25 *I was rostered on from 2.30 pm on 13 May 2018. I do not remember seeing Mrs Reeves or speaking to her on that day. I do not think I gave her the form. The progress notes record that one of Mrs Reeves' daughters was given a form two days earlier on 11 May 2018 by registered nurse Lorraine Guinty. Registered nurse Guinty's notes on that day record resident VB visited by*
30 *daughter, given restraint form consent. She said she'll take it home and get her mum to read, sign and bring it when she will visit the facility. Family aware of the resident restlessness and wandering.*

35 And then operator if we could bring up the next paragraph, Ms Kannan goes on to say:

I do not remember having any conversation with Mrs Reeves about the content of the form when she gave it to me.

40 So she's implying that you had the form and gave it to her:

I do not remember having any conversation with Mrs Reeves about the content of the form when she gave it to me and I do not believe I did as my progress notes do not record a conversation. I do not believe I provided any information to Mrs Reeves about the circumstances in which restraints would be used or the
45 *period of time for which restraints would be used.*

If we carry on over the page, please, operator:

5 *If I had spoken to Mrs Reeves about restraints I would have just talked about Garden View's policy and I would have made a note about that conversation in the progress notes in accordance with my practice like I did when I noted Mrs Reeves' request to see the medication chart.*

10 Does any of that alter any of the evidence you've given to the Commissioners about your account - - -

MRS REEVES: No.

MR GRAY: - - - of what happened on 13 May at Garden View?

15 MRS REEVES: No, I signed that in front of her because I knew it had to be witnessed and I signed it in front of her – the RN on duty, and she signed as well to witness my signature.

20 MR GRAY: Would you put that document away, please, operator. I want to now skip all the way forward to your return from overseas.

MRS REEVES: Yes.

25 MR GRAY: And shortly after you returned from overseas is it the case that you went to Garden View and took your husband, Terrence Reeves, out of Garden View?

30 MRS REEVES: I did, we – I came home. My daughters had discussed that, you know, there was – the level of care was not there, and that we had to get him out. So I had a few days to unpack, and get myself back into it. We went and got him on 7 May.

MR GRAY: 7 July.

35 MRS REEVES: Sorry, 7 July, yes, and we took him out. We took him out earlier than he was supposed to come out. He was supposed to stay at least another week after that but we took him out early.

40 MR GRAY: Now, I understand the family had some concerns about a bill from the pharmacist concerning three boxes of risperidone.

MRS REEVES: Correct.

45 MR GRAY: We've got information from the pharmacist that three boxes weren't dispensed to the facility, so I won't ask you about those matters any further.

MRS REEVES: Okay.

MR GRAY: But can I just ask you about Mr Reeves' progress in recovery. As I understand it, there was some recovery. In your statement you refer to a degree of recovery.

5 MRS REEVES: Yes.

MR GRAY: Can you elaborate on that for the Commissioners in roughly what timeframe that occurred?

10 MRS REEVES: Yes, we took him out. We had to almost physically help him out to the car. He was very unwell. I brought him home and it took at least five days for him to become not quite normal, but to get that – that droopy head and the dribbling and that shuffling of his feet, it took almost five days before he became a little more upright, his head no longer drooped, the dribble had stopped, and it was because he
15 was coming off the medications. There was one day that he just laid on the floor and we think it was withdrawals.

MR GRAY: Now, what's Mr Reeves' current – I should ask you, were you able to continue to care for Mr Reeves at home or did a diagnosis of your own intervene?
20

MRS REEVES: Yes, I was diagnosed with a multi myeloma which is a blood cancer, ended up in hospital. They took him as well, and then I could no longer care for him. So he's gone into permanent care.

25 MR GRAY: And I won't ask the name of the facility but what do you have to say about that facility?

MRS REEVES: The facility is wonderful. They don't restrain. They don't medicate. He's free to walk around the halls. He walks a lot. He's allowed to walk
30 out in the gardens. They supervise. He's had no falls. He walks very well. But he never came back 100 per cent after being at Garden View; never came back.

MR GRAY: In what way?

35 MRS REEVES: His speech. He was totally incontinent when he came home. That never got any better, and he's still totally incontinent.

MR GRAY: No further questions, Commissioners.

40 COMMISSIONER TRACEY: Yes. Thank you for your evidence, Ms Reeves. The evidence you've given must have been very difficult for you and we're conscious of that. Thank you very much for your attendance.

MRS REEVES: Thank you.
45

<THE WITNESS WITHDREW

[4.27 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 10 am tomorrow morning.

5 **MATTER ADJOURNED at 4.27 pm UNTIL TUESDAY, 7 MAY 2019**

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