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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

ADELAIDE

10.00 AM, WEDNESDAY, 20 MARCH 2019

Continued from 19.3.19

DAY 12

MR P. GRAY QC, Counsel Assisting, appears with DR T. McEVOY QC, MR P. BOLSTER, MS E. BERGIN, MS B. HUTCHINS and MS E. HILL
MR J. ARNOTT appears with MR A. FLORO for the Commonwealth of Australia
MS T. BIRSS appears for witness Patetsos

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioner, I would call a witness who has been given the pseudonym BC.

COMMISSIONER TRACEY: Yes.

DR McEVOY: Now, this witness, Commissioner, is offsite, as it were, and so she will take an oath or make an affirmation where she is at the moment. So that will be attended to now, I think.

<BC, SWORN [10.32 am]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Sorry, Commissioners, just bear with me for a moment. Operator, if we could bring up please, WIT.0033.0001.0001.

Now, ma'am, I will call you witness or BC or ma'am at various points. I hope you won't take offence to me referring to you in any of those ways. But could I ask you whether the statement that you see there, that you have, is your statement?

BC: Yes, that is right.

DR McEVOY: And do you wish to make any amendments to that?

BC: No.

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

BC: Yes, they are.

DR McEVOY: Commissioners, I seek to tender the witness statement of BC.

COMMISSIONER TRACEY: Statement of BC dated 15 March 2019 will be exhibit 2-33.

EXHIBIT #2-33 STATEMENT OF BC DATED 15/03/2019 (WIT.0033.0001.0001)

DR McEVOY: Thank you, Commissioner.

Now, ma'am, could you tell the Commission what your profession is.

BC: I'm a registered nurse.

DR McEVOY: Yes, and how long have you been a registered nurse?

BC: Since 1991.

DR McEVOY: And what sort of nursing have you done predominantly in that time?

BC: A mixture of things, surgical. My main focus has been in palliative care and I had some time off with raising small children. I've done - - -

DR McEVOY: I'm sorry, did you say your main focus has been in palliative care?

BC: Yes, that's my main interest.

DR McEVOY: Yes, and is that a continuing interest?

BC: Yes, it is.

DR McEVOY: Now, you've referred in your statement to your business, a business that you created. I might refer to that as BD, if that's convenient to the extent that I need to. Could you tell the Commission a little bit about that business: the number of staff, contractors, what type of work, sorts of clients; that sort of thing?

BC: I started the business in 2016. The original idea was to provide home palliative care for people who wanted to die in their own homes. We employ a variety of different people, often on a casual contract because you couldn't offer permanent work. I did a majority of the work. We've since employed a full-time bookkeeper and human resource manager. We've got several registered nurses that work for us on a casual contract, and one on a permanent part-time contract. And we've got around 15 to 20 support workers who work for us fairly regularly. We decided – I decided at some point after 2016 to apply for home care packages, because it was becoming increasingly obvious that people who were on a pension were unable to pay for services if they were choosing to die in their own home.

There was limited resources for them to have a registered nurse in their home or have respite for their loved ones. So we thought if we apply for packages, it may give some funding for some hours to them, and we had heard rumours about the possibility of a level 5 package for people who may require terminal care. So that was the original reasoning behind us applying for the home care package.

DR McEVOY: And so the clients that you then developed, were they entirely palliative care clients?

BC: Some were, and some were perhaps what you put in the palliative arena, and by palliative, I mean the definition that is used in palliative, if you wouldn't be surprised that someone was going to die within the next six months, you could classify them as palliative. So although some were well and still functioning and enjoying life, they possibly could go into the palliative umbrella – under the palliative umbrella. So we looked after clients like that. A few clients we looked after were terminal and their families couldn't afford to have nurses in the home. So I did a lot of pro bono work to assist them dying at home. And I would source services that were around and create brokerage agreements with some organisations so, like carer support, so we could continue caring for them in their homes so they could die at home.

DR McEVOY: Can I ask you, when you made your first application to be able to deliver the home care packages?

BC: I think it was around two thousand – beginning – toward the end of 2016.

DR McEVOY: Yes. And how did that go? How long did it take for you to be approved?

BC: We had to have several tries. The language wasn't familiar to me and - - -

DR McEVOY: So when you say the language wasn't familiar to you, or, yes, I think you said the language wasn't familiar to you, what do you mean by that?

BC: The type of questions they asked; I had to do a lot of research to understand what was expected of an approved provider. So although we didn't get in on the first round, I did work in our organisation to ensure that we would meet the criteria in subsequent applications.

DR McEVOY: Anyway, you were telling me about the process and so one of the features of the process was that you found some of the language difficult to comprehend. In what way was it difficult to comprehend? You've been a nurse, obviously, for some years and so presumably it wasn't the medical aspects of it that you were concerned with.

BC: No, it was some of the terminology. I can't think of anything off the top of my head but just some government speak that I wasn't familiar with. And we had to develop policies like work, health and safety policies, and risk assessment policies and all sorts of things that were included in the questions to become an approved provider. So whilst applying for that position, we worked on those – on those things to meet the guidelines.

DR McEVOY: So it was really the language, the management language, if you like, that was language you were not so familiar with?

BC: Yes. Yes. I had never worked in a position in government department or – and it was unfamiliar language to me. The clinical stuff I could understand. It was just

around risk assessment and work, health, safety and all that sort of thing that wasn't familiar.

DR McEVOY: Now, I'm going to ask you to be shown a document. I'm going to read it out at this end so it can be brought up on the screen. And those sitting with you, I think, will be able to hand you a copy of it so you can see it too. Operator, the document I want brought up is CTH.1002.1016.2502. Do you have that in front of you, ma'am?

BC: Not as yet. Yes. Yes, now I do.

DR McEVOY: Okay. So you see that this is in relation – this is a letter dated 5 May 2017 and it's in relation to your application for approval as an approved provider. And you will see there underneath the heading Decision, the words:

> *On the basis of the information supplied I am not satisfied that the applicant meets the requirements of the Act in respect of the applicant's suitability to provide home care.*

You recall getting that letter?

BC: Yes. Yes, I'm sure I did. I can't remember exactly but yes, I'm sure I did get that letter.

DR McEVOY: And do you recall how long it was after your initial application that you received that letter, roughly?

BC: It was a long time. I can't tell you exactly how many weeks or months but it did take a long time. I think they had 90 days to respond, and I think perhaps there was an extension on the response. I remember speaking to someone in the application area and they had a lot of applicants. So they were taking a long time to get through them all.

DR McEVOY: I'm going to show you another document; operator I would like you to bring up CTH.1002.1016.1731 and I will have that shown to you, BC. You should be able to see that. I should say for general reference, Commissioners, there is in fact a non-publication direction in place in relation to all of these documents and so those following them, in particular, the media should have regard to that direction as we work through the documents. So you see that email there, ma'am, of 6 February 2017, can you recall receiving that document, receiving that email?

BC: Yes. Yes. Yes. Yes, I do.

DR McEVOY: Did you – I mean, you've said in your statement, I think you've said this at about paragraph 12 that there was – as far as you are aware, as far as you were concerned – limited information from the government about the application forms on how to become an approved provider. You've said you felt you had the relevant

expertise and the relevant systems, but you had trouble with the language. Did you ask the approved provider section of the department for assistance?

BC: Yes, but they – I wasn't really able to get any. They sort of said it was our application and we had to do it. They were – the people I spoke with really were the ones that just dealt with the paperwork; they weren't able to guide us on filling out the forms.

DR McEVOY: Well, when you say they said you – they were not able to give you any assistance, do you recall who you were speaking to and what they were saying with any specificity?

BC: I was speaking to people at the approved provider who answered the phones. I can't remember names, I'm sorry.

DR McEVOY: All right. Now, in the end, your application was accepted, was it not?

BC: Yes.

DR McEVOY: And do you recall, roughly, when that was?

BC: I think it was around February 2018.

DR McEVOY: I'm sorry, you think it was when?

BC: I think it was February 2018.

DR McEVOY: I'm asking you about when your application was accepted.

BC: I'm not sure, sorry.

DR McEVOY: Do you recall receiving further requests for information during the process before acceptance of your application?

BC: I remember – I remember being told that the application needed further paperwork and the process was frustrating because I had the paperwork available but I was told then that they had changed the questioning on the application forms, so I would have to redo the whole application form. If I was asked for any further paperwork to – for a particular application, I would have sent it in but I can't remember any particular incidents.

DR McEVOY: Perhaps I will show you a document that might assist your recollection of this process. Operator, could you bring up, please, CTH.1002.1016.1694. Now, BC, can you see that? I wonder if you might be handed a hard copy of that document, because it's an email chain that may be necessary to go back lower down into the document. Are you looking at that?

BC: Yes. Yes.

DR McEVOY: So if you go to the bottom of the first page, you will see there on 6 March 2018 the approved provider application section of the Health Department wrote to you. Do you see that?

BC: I'm just looking now. Yes, I can see that, yes.

DR McEVOY: And if you go to page 3, at the bottom of page 3 of that document, you will see – I should say, operator, this is 1002.1016.1696.

BC: Yes.

DR McEVOY: You see there at the bottom, they're putting to you, they've said - - -

BC: Yes.

DR McEVOY:

> *Thank you for your application which we received as a complete application on 10 August 2017. To assist the delegate in making a decision about your application, further information is required.*

And then they set out the various pieces of further information that are required.

BC: Yes.

DR McEVOY: You recall that?

BC: Yes, I do. Yes.

DR McEVOY: What was your reaction to that further request for information?

BC: Frustration.

DR McEVOY: Yes, and what was the basis of that frustration, would you say?

BC: Well, I felt that we had repeated ourselves in several of the applications. I'm not sure which actual paperwork you are referring to as far as extra information, but I thought we had explained ourselves fairly well in the applications. But, you know, it was the way it was so we just kept adding to whatever it was that they required.

DR McEVOY: So when you say you added to whatever it was they required, you mean by that you provided whatever further information they asked for; is that what you're saying?

BC: Yes. Yes.

DR McEVOY: Operator, could you bring up CTH.1002.1016.1689. Do you recognise this document, ma'am? It may be convenient if you could be shown a hard copy of the document.

BC: Sure, yes. Yes. Yes.

DR McEVOY: So this is a document dated 16 March 2018 from the Department of Health.

BC: Yes.

DR McEVOY: Which you will see is headed Reconsideration of Deemed Decision to Reject Application for Approval as an Approved Provider.

BC: Yes.

DR McEVOY: So you remember that?

BC: Yes.

DR McEVOY: Now, I think at paragraph 14 of your statement, you may have said that you were granted approved provider status in February of 2018. The position appears to be that it was in fact 16 March 2018. Would you accept that?

BC: Yes.

DR McEVOY: So, having obtained the appropriate approval, how did you go about getting your first clients?

BC: We – we had a couple of clients who we were doing some private work for, and pro bono work. And they were just awaiting us to become providers and so they just came on to our books when we were able to upload them on to the portal.

DR McEVOY: Yes, so that's those clients. Were there other clients?

BC: Yes, not for several months. So a lot of the work we were doing was private palliative care and some aged private care. And we had NDIS work as well that we were doing. So the home care package sort of sat there for a while, while we tried to navigate the Medicare portal and ensure that we had – were trying to meet all the home care standards, navigate our way through all of that. We had several brokerage agreements with other approved providers and one of them contacted us and asked us if we would be willing or interested in taking on, or being named as a possible provider for some of their home care package clients, because they were no longer going to be providing home care packages. We were told that the business - - -

DR McEVOY: Do you recall the name of that organisation?

BC: It was Assist Home Care. And we had – they didn't have – or we provided some registered nurse care for them. So a few of their clients were known to us for wound dressings or clinical nursing care. So when they asked us if we would be willing to be named as a possible provider for their clients who would need to transition out, we said, yes, that we would be prepared to do that. I believe that Assist Home Care were being partly purchased by a Queensland group and – that were focusing on disabilities. But I believe that home care packages was only a small portion of their business. And so we agreed to be named as a possible provider for their home care.

DR McEVOY: And were you aware of why it was that they were wanting to transition some of their people over to your organisation?

BC: We were told that they weren't going to be providing home care packages and we were told that the Queensland group that were purchasing them were not home care providers. But didn't – weren't approved to provide packages. So they weren't able to continue on with that. It was a little bit confusing and, in hindsight, I think I was quite naive in understanding the process that was involved. I believe now that – and I knew that Assist Home Care were being considered by the Quality Agency and I knew that the director was having some issues. But at that stage we hadn't met anyone from the Quality Agency, so I wasn't quite sure exactly what the background of all of that was. But that was a separate issue, I believed at the time.

DR McEVOY: How were you aware that Assist Home Care were being considered by the Quality Agency and that the director was having some issues?

BC: He had mentioned "Watch out for them, they're very fastidious" and I – you know, I knew of them. I knew that at some stage we would have to meet the standards and show that we were meeting the standards. But we hadn't met them and we – we – I wasn't sure exactly what he was talking about. It was just a passing comment. And he was no longer interested in supplying home care packages.

DR McEVOY: Did you – did he mention sanctions at all?

BC: No. No, not in our initial conversations, no.

DR McEVOY: So can you recall, approximately, roughly, when you were having these exchanges with Assist Home Care?

BC: June/July 2018. Yes, I think it was around those months. It was just phone conversation and often a phone conversation would involve, "Could you please organise to go and see Mr Smith who has got an ulcer on his leg and needs – it needs some attention. Could you do a wound care plan and, you know, by the way, we – you know, we're having issues with this or we're being" – I knew about the purchase of the business. We also had been contacted by this Queensland group about possibly being purchased, or a partnership, going into a partnership, which is a common occurrence to receive emails from larger groups who are wanting to

purchase smaller providers. And I had had several of them. And I hadn't entertained the idea but I knew what he was talking about when he said that he was being, going into partnership with DJ Health, I think their name is, or was.

DR McEVOY: So this was all happening in, I think you said, about June 2018, around those months.

BC: Approximately. Approximately, yes.

DR McEVOY: Now, you subsequently got an email, didn't you, telling you that you were going to have to have an assessment contact. Can you remember that?

BC: Yes, I don't remember when I had that email but, yes, I believed that the Quality Agency made contact with all new providers and made the appointment to introduce themselves or – I can't remember the exact content but that was my belief.

DR McEVOY: But it was, would it be correct to say that it was after this initial period in June 2018 when you were having dealings with Assist?

BC: Yes.

DR McEVOY: And, in the course of 2018?

BC: Yes.

DR McEVOY: If I suggested to you that that email was received by you on 9 October 2018 in relation to an assessment which had been arranged for 31 October 2018, does that sound about right?

BC: Yes. Yes.

DR McEVOY: So I want to ask you some questions about what you thought that was all about. I think you said a moment ago that you thought they made contact with all new providers. Was that all you thought or did you think anything more about that?

BC: I knew that there was self-assessment, and myself and my colleagues sat down and worked through the self-assessment. We were quite honest with where we felt we needed to improve and where we thought our strengths were. And I - - -

DR McEVOY: This was a self-assessment that they asked you to fill in, was it, to complete?

BC: Yes.

DR McEVOY: Had they given you any information about what was involved in the assessment?

BC: Not to my knowledge, no.

DR McEVOY: Can I just take you to paragraph – it's really starting at about paragraph 25 of your statement, where you set out the fact of this investigation, and in paragraph 27 paragraph 27 you say:

> *On 19 October one of the staff received a phone call from the Quality Agency where she was reassured that the visit was informal and we would be treated in a friendly way.*

BC: Yes.

DR McEVOY: You can recall having that conversation, can you, with you a member of your staff?

BC: Definitely. I remember feeling very relieved because I was a bit confused about the visit. I wasn't quite sure what it entailed. I thought they would go through our self-assessment and – but I had heard rumours about the way some providers had been treated during these interviews so I was feeling a bit anxious. But my staff colleague said that they had had a very friendly conversation and it was nothing to be concerned about.

DR McEVOY: And then you say in paragraph 28 that shortly before, you had signed a lease and you made a request of the assessor for them to wait until you had actually moved into the office. Do you recall that exchange?

BC: Yes.

DR McEVOY: Was that a communication - - -

BC: Yes.

DR McEVOY: I'm sorry, was that a communication that you had with the assessing agency yourself?

BC: Yes. Yes.

DR McEVOY: And can you just elaborate a little bit on that conversation?

BC: Well, as I said earlier, we were trying to work through the home care standards and ensure we were doing the right things and we had worked from home for a number of months and it worked well, but we felt that we needed to move into an office and we had saved some money to do so, and we had rented an office on [REDACTED] and it met, we felt, some of the requirements. So I had spoken to a particular lady on the phone and said, "We've rented this office so is there any way we can postpone our meeting until you can gauge, you know, what our office is like and whether or not it meets the requirements and, you know, the fire alarms and the

extinguishers and the wheelchair access, all that sort of stuff." I thought it was important for any kind of Quality Agency interview. It wouldn't have been a fair interview if it had been in my home because that's not where we were going to be working from.

DR McEVOY: And do you recall with any precision what the person you were speaking to said in response to that suggestion you made?

BC: They were quite adamant. No. No, they weren't prepared to wait and they would be in at 9 o'clock on the due date. And I think I said something like, "Well, it won't be accurate because we're not going to be working from that area" but, you know, I was confused, I didn't know what they were trying to achieve by assessing us or – I thought maybe that it was more of an informal meeting if they didn't really mind where we were working from. It was all rather confusing.

DR McEVOY: In paragraph 29 of your statement, you might just want to have a look at that, you refer to the fact that the day before they were to arrive, or before the day they were to arrive, you asked whether the start could be delayed until 9.30 so that the RN, the registered nurse with some particular client care plans, would have time to get into the office. Do you recall making that request?

BC: Yes.

DR McEVOY: And how did that go?

BC: They turned up at 8.55. They said no. And because the RN who had the care plans lives the other side of town, and with traffic, she wasn't going to have enough time getting there by 9 am. And they just said "No".

DR McEVOY: Okay. And so they turned up at 8.55, and did the RN – what time did the RN end up turning up?

BC: I told her not to. I said, "Don't worry about it, they're here already. Forget it." So just – I didn't understand exactly what it was that they were looking for. I was confused about whether or not this was an introducing themselves exercise, or an assessment of sorts. But in my mind I thought, "They can't possibly assess us in this location without some of our paperwork." So I just – I just said, "Don't bother coming."

DR McEVOY: You said to the RN, "Don't bother coming".

BC: Yes.

DR McEVOY: And she did not come?

BC: No.

DR McEVOY: So if you look back at your statement in paragraph 30, you give a bit of evidence about how the visit proceeded, and you make the observation that they walked in, unpacked their bags and they started asking questions quickly. Then you say:

I found their manner and demeanour very confronting.

Do you see that?

BC: Yes.

DR McEVOY: What do you mean when you say you found their manner and their demeanour very confronting?

BC: It seemed like they had a pre-organised agenda. We've got a very friendly group of people, and we have a very relaxed atmosphere in our working day and they just started firing questions at us from the minute they sat down, and it was chaotic.

DR McEVOY: Yes, what sort of questions, do you remember?

BC: "Where's your care plans?" And they just went through the home care standards and demanded to know, "Where this was, where that form was, where are our folders for this client." They criticised our service agreement which I had had done by legal contract, a contract lawyer. And they just kept firing questions at us. And just, when we would start to answer one, they would fire another question at us. So it was very confusing and confronting.

DR McEVOY: Are you suggesting that they would ask you questions and then, effectively, not let you answer the question before they asked you another question. Is that the effect of what you've just put?

BC: Yes, definitely. Yes. And so we were running around between the photocopying machine trying to show them the evidence that they were looking for, for one thing. And then they were on to the next thing. And the two – my two co-workers are both – have Chinese backgrounds and their English is great but they found some of the language, the way they were speaking too fast and – they couldn't understand some of what they were saying. And they were – they felt very upset by the way that they were being spoken to.

DR McEVOY: How many of them were there? That is to say, how many of the assessors were there?

BC: Two.

DR McEVOY: And when you say your staff felt very upset by the way they were being spoken to, is that a function of the rapidity of the questions, or is it a function of tone or volume or all of those? Can you just elaborate a little bit on that.

BC: All of those.

DR McEVOY: What else characterised the visit?

BC: Just unfriendliness of the – of the staff that were asking questions. They – the staff I have are very, very polite and they are very courteous. And they were not being treated in that way. They felt they were not being treated in that way. We had a half-hour break for some lunch, and I went outside and they were both very close to tears. And I was trying to reassure them saying, "This is fine. This is all going to be positive feedback about things that we can do to improve our organisation, and we will take this with us and ensure that we do a good job with the clients. So let's take this as something positive and use it to improve our organisation." I vividly remember that and I was trying to calm them down. And then we went back in and the meeting continued with more questions.

DR McEVOY: I think you accepted the suggestion that there was – you were concerned about the tone and the volume. Can you just be a little bit more explicit about what you mean when you say you were concerned about the tone and the volume of the questioning?

BC: Look, perhaps not volume. I don't think that they spoke loudly or anything. It was just – it felt like we were being interrogated, and we were confused as to why. They weren't particularly polite, and we felt that they were quite condescending and that we should understand all of this and "Where's this form? Why don't we have this form?" And whenever I questioned the need for a particular form, or the language that they were using, I was criticised. And I thought, "How could I possibly not understand – how could I" – I was confused. I was generally – it felt like I had a walked into a parallel universe.

DR McEVOY: When you say that you – you said, I think, that if you questioned the need for a particular form or the language that they were using, you were criticised. What do you mean by that?

BC: They just kept pointing back to the home care standards and saying things like, "Well, surely you understand this" or - - -

DR McEVOY: And you were familiar with the home care standards?

BC: Yes, yes, we had several copies printed and on the table and I think I had some copies laminated. So I accepted that – and we – we document in our self-assessment that we did need to improve on some things and that we were endeavouring to do so. There was no question that I thought we were perfect in any way. But I felt that – and the clients thought the care we were giving was – was, I believed, exceptional. But we did need to improve on some of the paperwork. I agreed with them. And so I took the opportunity as something that we could really learn from. I didn't expect to be so heavily criticised for it.

DR McEVOY: And so I think you said they came at about 8.55, and I think you made some reference to breaking for lunch. Do you recall what time you broke for lunch, or would have broken for lunch?

BC: It was about 1 o'clock, I think.

DR McEVOY: So you say - - -

BC: But we were exhausted.

DR McEVOY: You say they had been there for about four hours when you broke for lunch; is that about right?

BC: Yes, possibly, yes.

DR McEVOY: And did you resume with them after lunch?

BC: Yes.

DR McEVOY: And do you remember roughly how long you think you resumed for?

BC: Maybe another three hours.

DR McEVOY: So - - -

BC: I can't remember exactly.

DR McEVOY: Do you recall how long they gave you or you took for lunch?

BC: Only 20 minutes or so.

DR McEVOY: And did they make - - -

BC: We - - -

DR McEVOY: I'm sorry.

BC: We didn't eat. We were rather traumatised. We didn't – we didn't know what was going on. So I had given them tea and biscuits, and things like that. They may have had their own lunch, I'm not sure. I can't remember.

DR McEVOY: And so they were asking you these questions, you've said, and they were asking you, were they, to look at particular documents. I think you've mentioned some of the care plans.

BC: Yes.

DR McEVOY: And did you have care plans in place by this stage?

BC: We had some, yes. Yes, some. Not all of them. And a mistake had been made. When we – when we got new clients I made all of the staff go and visit them. So the bookkeeper and the human resource manager went out to visit every new client so that when a client rang up, they would know exactly who they were talking with on the phone. So the – all the staff got to know all of the clients. And on a couple of occasions that human resource manager had taken out the home care agreements and he had asked a couple of the clients to sign them. And I had recognised that that was inappropriate because we didn't have a full care plan in place for them. So I had said, "Well that's not a legal document because they haven't yet got their care plan fully established."

So the process would have been repeated but they were very critical of us for getting that done and I had said, "Look, it was a mistake. The exercise will be repeated." But it was just part of the process that we believed would be in the best interests of everyone. It was for all of the clients and all of our staff.

DR McEVOY: And so what did they say to you before they left?

BC: I asked them, "Have we done something wrong?" I didn't understand why they were – why they spoke in the manner that they did. I asked, "Have we done something wrong?" And then I said, "Has this got something to do with taking on some of these clients from Assist Home Care?" And they said no, it didn't. They said that they visited all new providers and they – they just said goodbye and left and we all just - - -

DR McEVOY: In paragraph - - -

BC: - - - collapsed.

DR McEVOY: I'm sorry, just say that last sentence or so again?

BC: Just that the staff and I just went on the couch and just fell on the couch and just went "Oh my God, what just happened"; something to that effect.

DR McEVOY: One of the things you point out in paragraph 34 of your statement is that they told you that you didn't have any involvement with a peak body. Can you remember that? What was that conversation about?

BC: Just, "Who is your peak body?" Like, who do you – "what organisation do you belong to, to get up to date information?" And at that stage we didn't belong to anyone, that I could recall off the top of my head. Subsequently, I remembered some of the things that we do have in place, and they wrote down the name LASA for me. One of the ladies wrote the name down and suggested that we be in contact with them. And as soon as they left, I rang LASA and organised a meeting.

DR McEVOY: Did she tell you why she thought you should get in touch with them?

BC: Just so that, as a provider, we can have up-to-date information and just one of the requirements. We – I thought she was saying we had to be involved with a peak body. We were getting the SA Health emails regularly, and I think in numbered section 35 I've mentioned who else we were involved with. But we didn't – we weren't involved with LASA prior to that meeting.

DR McEVOY: Do you recall whether it had been suggested to you at the time you applied that it was necessary to become a member of a peak body?

BC: Possibly. Possibly. And it was something that I would have worked through at some stage. It just hadn't happened.

DR McEVOY: So in paragraph 35 - - -

BC: We - - -

DR McEVOY: I'm sorry, go on.

BC: We were – we had paid membership for ACHS to become certified and the paperwork involved with that is quite substantial. And I thought that we would just do one thing at a time and we were working through ACHS certification so the peak body membership may have happened down the track or it may not, it wasn't on my mind – at the front of my mind at the time.

DR McEVOY: So if you have a look, ma'am, at paragraph 35 of your statement, you make the observation that reflecting back, you had already had some involvement with related bodies. Do you see that?

BC: Yes. Yes. Yes.

DR McEVOY: And what do you say the significance is of that reflection after the visit from the assessors?

BC: I think – I think we – we – it sort of kept abreast of what was going on through the emails through SA Health and keeping our skills up to date with palliative care. And I had recently done a four day PEPA course with QEH and done - - -

DR McEVOY: What's that, sorry?

BC: It's a four-day course with Palliative Care SA, and you go around parts of Adelaide with a palliative care team and visit clients who are in palliative stage, some in the terminal stage of life, and usually they have a three-month period of life left. And it's a really valuable learning tool, and I had done that. And one of the other RNs I work with was doing it as well. So we're keeping abreast of what was

going on in palliative care in South Australia. And the NDIS work we were doing also was answering some of the questions about quality standards and all that sort of thing as well. So we were moving in a direction – obviously it wasn't fast enough, though, for the Quality Agency.

DR McEVOY: Commissioners, in my assessment, I've still got at least half an hour to go with witness BC. If you are minded to take the morning break - - -

COMMISSIONER TRACEY: Yes, it may be convenient to give the witness a break. We will resume at a quarter to 12.

ADJOURNED **[11.29 am]**

RESUMED **[11.58 am]**

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioners, thank you for that additional time. We have just had a few document issues which we have had to resolve. I can see that witness BC is still there.

Now, ma'am, I think where we broke off before, we were dealing with the end of the assessment visit that you had on 31 October 2018. Do you recall that?

BC: Yes.

DR McEVOY: Now, what I want to do now is to ask you to have a look at an email that you were sent by the assessors. I'm not going to have it brought up on screen because it hasn't yet been appropriately anonymised but I think that you – or those with you will have a copy to show you, and the witness has a copy and I think my learned friends for the Commonwealth also have a copy. I will just record, Commissioners, that the number – without it being brought up, operator – is CTH.4000.1003.2094. So if the witness could be shown that document. Now, you will see that this is an email to you from the then Australian Aged Care Quality Agency dated 19 November 2018, and you will see that it refers to an assessment contact having been conducted, and that there's a report attached. Do you remember getting that email?

BC: I'm sorry, I can't quite remember this particular email.

DR McEVOY: Okay. What is attached to that email is another document which, again, I will show to you – and, Commissioners, just for the record, that is CTH.4000.1003.2096. So, ma'am, you see that's a document headed "The Assessment Contact Advice" and that was attached to that email I just showed you.

BC: Yes. Yes, I've got that.

DR McEVOY: Now, you recall receiving this, I take it?

BC: I can't recall getting this email, I'm sorry. It's quite possible I did.

DR McEVOY: Yes. Well, just have a read of it and you will see there, about halfway down the first page that it's observed that:

> *The following expected outcomes of the Home Care Standards were not met by your service.*

Do you see that there?

BC: Yes, I do.

DR McEVOY: Regulatory compliance, there were some issues there, information management systems, continuous improvement, physical resources, service access, etcetera. And then if you - - -

BC: Yes.

DR McEVOY: Then if you go over the page you will see there are a few more points made, assessment care plan development, those sorts of matters.

BC: Yes, yes.

DR McEVOY: Would I be right to say that you recall at a general level that these issues were raised by the Aged Care Quality Agency.

BC: Yes. On a general level, yes.

DR McEVOY: Yes. Okay. Now, can you see that heading halfway down page 2, Improvements where it says:

> *A revised plan for continuous improvement is to be submitted by 30 November 2018 showing how the Home Care Standards will be met.*

BC: Yes.

DR McEVOY: So do you recall being informed that you had to submit such a plan?
.

BC: Yes. Yes, and I believe we did, yes.

DR McEVOY: Yes, okay. Now, the next document – and Commissioners, it's just to be borne in mind that this is from the Aged Care Quality Agency. The next

document to be considered is CTH – and you can bring this up, operator – CTH.1002.1002.0055. And if the witness could perhaps be shown that hard copy of that document, if one is available.

BC: Yes.

DR McEVOY: So this document which is, in fact, a little earlier in time; the earlier document having been provided to you on 19 November. This document from the Department of Health which is dated 8 November, if you look at the first – about halfway down the first page, it says that:

> *The relevant officer is satisfied that you haven't complied or are uncomplying with one or more of your responsibilities under part 4.1.2 or 4.3 of the Act. Because of your non-compliance there is an immediate and severe risk to the safety, health or wellbeing of service users to whom you, as an approved provider, are providing home care and it is appropriate to impose sanctions.*

Do you see that?

BC: Yes.

DR McEVOY: And you recall receiving that notification from the department?

BC: Yes.

DR McEVOY: And then if you turn over to part A, there are listed a series of sanctions. I need not read them out but there's one, two, three, four sanctions.

BC: Yes.

DR McEVOY: And if you have a look at – it's page 5 of that document, that is to say 0059, so you see part C.

BC: Yes.

DR McEVOY: There's a finding that there's an immediate and severe risk.

BC: Yes.

DR McEVOY: Do you recall what you did when you saw that?

BC: I nearly collapsed.

DR McEVOY: And why was that?

BC: The language – we – it was so inflammatory, we – I did everything for our clients. I couldn't understand why they would use the word "severe risk".

DR McEVOY: Had you been given any opportunity to respond to that finding?

BC: No. I remember saying to – what's – [REDACTED] – sorry, I've forgotten the surname – [REDACTED] I remember saying I – I haven't been given the opportunity to respond to the Quality Agency's findings, and I don't understand how you can use the words "severe risk" in relation to the support that we give our clients. And she said that she had the authority to override any opportunity I had to respond.

MR ARNOTT: Commissioners, I apologise for interrupting the witness's evidence. My name is Arnott, I appear for the Commonwealth. The name of a Commonwealth officer was just mentioned in answer to witness BC – a question put by counsel assisting to witness BC which is subject to a non-publication direction. I request that the Commission make a non-publication direction in relation to the name given by BC in the answer she just gave.

COMMISSIONER TRACEY: Yes, the name of the Commonwealth officer just mentioned by the witness shall not be published. A formal order to that effect will be made in due course.

MR ARNOTT: I'm grateful.

DR McEVOY: I should indicate, Commissioner, that the feed was stopped at that point so it has not gone any further than the hearing room.

COMMISSIONER TRACEY: Thank you.

DR McEVOY: Now, ma'am, you will recall also from looking at this, that one of the sanctions is that you are required to appoint an adviser and to appoint an administrator.

BC: Yes. Yes.

DR McEVOY: So did you do that?

BC: Yes. I rang LASA, and I thought we had become members but we hadn't paid their membership fee, so I think we weren't counted as members as yet. So they gave us the name of a person to contact regarding some assistance with meeting the standards.

DR McEVOY: Yes, and do you recall the name of that organisation, ma'am?

BC: ACMA, A-C-M-A.

DR McEVOY: And so you contacted them, I take it?

BC: I can't remember whether I contacted them or if they rang me but the contact was made.

DR McEVOY: And what happened then?

BC: I can't remember what day of the week it was but it must have been toward the end of the week because they organised a meeting on a Sunday and they were – said that they were going to come and help us meet the requirements to get over these sanctions.

DR McEVOY: And did you know what their role was going to be? Can I direct your attention to paragraphs 41 and 42 of your evidence.

BC: Yes, I'm reading that.

DR McEVOY: What was your state of knowledge about the role that they were going to play in your business at this point?

BC: At this point just that we were going to employ them to help us meet the standards that the Quality Agency felt we hadn't met.

DR McEVOY: And were there discussions with you about the terms of their retainer?

BC: I believe so; on the day – the Sunday that we met, it was discussed and - - -

DR McEVOY: So in paragraph 44 of your statement, you talk about the quotation that you received from them.

BC: Yes.

DR McEVOY: That was $165,000 for six months work, you say.

BC: Yes. I was told - - -

DR McEVOY: Sorry, go on.

BC: That was mentioned on the Sunday when we met them. I was told that that was the standard price for fixing up this kind of problem that we had.

DR McEVOY: And did you have access to those funds?

BC: I borrowed the money.

DR McEVOY: And what was your reaction to that quotation?

BC: I was – I was really overwhelmed but I didn't see an option, because a couple of the clients that we had, one in particular, I promised that I would be with her when she died and I didn't know how I was going to be able to keep that promise if I didn't pay this money.

DR McEVOY: Now, you say there in paragraph 44 that they asked you for the first $35,000 up-front. Were you able to - - -

BC: Yes.

DR McEVOY: - - - pay that immediately?

BC: I was able to borrow the money and I can't remember how many days afterwards I paid it.

DR McEVOY: So thereafter there commenced your relationship with ACMA. You've given evidence in your statement, in a number of paragraphs of your statement, following on from about, at paragraph 44, about the nature of the relationship with ACMA. Do you want to make some comments to the Commission about how that developed?

BC: It was very – on the Sunday we had the meeting, I was very concerned about the – them working with us because of the available space in our office, and they said to us that we could work in their office if need be. So I thought that's good because it won't be too squashy in the office. And they said that they would have a registered nurse come to check the clients, and I thought that was unnecessary but I just went along with it because I said to them, "I just need to get these sanctions met so that we can continue on with the work that we're doing." They saw themselves to be a very well-known, very reputable organisation that had a great deal of experience in this kind of work.

DR McEVOY: If you look to paragraphs 49 and 50 of your statement on page 6, you talk about the first meeting that you had with the department, and that you say in paragraph 50 that you attended that meeting, and that somebody sat next to you. Who were you talking about there? Are you talking about – well, can you indicate who you are talking about there?

BC: The director of ACMA.

DR McEVOY: Yes. And you make the observation that communications with this person felt like that person worked for the department and you were confused about what his role was. Can I just ask you to unpack that a little bit. When you say communications with that person, what do you mean, what are you really saying there?

BC: He spoke of a lot of people that are involved in the department and was promoting the department a lot. It was only the second time I had met him apart from the Sunday meeting. There was – I didn't speak to him a lot at that – at that first meeting, other than to talk about what the sanctions involved. There was a subsequent meeting in another room where they had invited clients of ours to come, or family members to come if they had any concerns about the care we were providing. None – no one turned up for it, because they weren't concerned about the

care. And a couple of the clients were quite cross that these sanctions were being put upon us because it was interfering with their care, they believed.

So in the second meeting, I was asked if I wanted to stand up at a podium and I said, "There's no one here to talk to", and there were quite a few people from the complaints area, I believe, who came and spoke with me. They were very nice to talk to and very – very thoughtful. And my – ACMA team disappeared and one of them was handing out her card to the government staff, introducing herself. And the director was down the back having a chat with all of the government people, and I was left sitting on my own wondering why I was paying all of this money to them, because they weren't supporting me at that time, and I was absolutely terrified.

DR McEVOY: Operator, can I ask you to bring up CTH.1002.1008.0729. Now, ma'am, this is an email chain which I'm going to ask you to just cast your eyes over. It may be convenient if those assisting you where you are, are able to give you a hard copy of this, if one is to hand. It might just make it little easier for you to look at. So, operator, perhaps if we go to the second last page, that's 733, which has got at the top on Tuesday, 20 November 2018 at 12.42. BC, are you looking at this on the screen or are you looking at this in hard copy?

BC: I'm looking on your colleague's screen.

DR McEVOY: Okay. So you will see there that the person from ACMA is writing to you on the subject of national criminal history checks. Do you see that?

BC: Yes, I do.

DR McEVOY: And do you recall an exchange in relation to this issue?

BC: Yes, I do.

DR McEVOY: And then if you go to the preceding page, which is 0732, you will see further communications from the ACMA person to you, 21 November 2018. Do you see that?

BC: Yes, I do.

DR McEVOY: And you see at the bottom of that page, you've indicated that you will deal with this issue immediately. Do you see that?

BC: Yes, I did, yes.

DR McEVOY: Then if you go back up, to 0731, further exchanges in relation to this issue.

BC: Yes, I've got that.

DR McEVOY: And then if you go to the preceding page, that's 0730, you will see that the person from ACMA has written to you explaining the significance of national criminal history checks. Was this something that you were unaware of?

BC: No. We know that staff have to have them.

DR McEVOY: So what was the issue here, really?

BC: There was one – one registered nurse who – whose criminal check wasn't on my desk. I had seen it – I had seen her criminal checks previously, and he was insisting that it be on my desk and I couldn't get it before the time that he wanted it, and there were emails going back and forth about her not being able to work until I had seen it and I said, "I've seen it, I just don't have it in front of me at the moment." And he was becoming very authoritarian about it, and I said, "I'm comfortable for this staff member to work. I've seen her police check in the past and I know she's" – she had another job at another nursing home in quite a high position and I know that she had a proper police check there as well. So I couldn't see – I thought he was being quite pedantic.

DR McEVOY: You will see, if you go back to the first page, that's 0729, that this chain of email correspondence between you and ACMA was forwarded to an officer of the Department of Health. Do you see that?

BC: Yes. Yes. I didn't realise that at the time.

DR McEVOY: So you didn't realise that at the time. What do you mean by that exactly, that you didn't realise it had been provided to the department; is that what you're saying?

BC: Yes. I had no idea he had provided that to the department. It was an internal issue. It was - - -

DR McEVOY: So you don't recall instructing him to provide that to the department; is that the position?

BC: No. Why would I instruct him to do that? That was internal issue. I knew well that the registered nurse is highly trained, a very experienced RN who was going to do the wound dressing of a gentleman; she had been for several months on. I don't – I didn't know that he sent that on to the department, and I don't know why he would have.

DR McEVOY: You didn't – I withdraw that. Now, Commissioner, I should tender that train of emails. CTH.1002.1008.0729 - - -

COMMISSIONER TRACEY: I'm wondering about this, Dr McEvoy. There are a whole lot of documents that have already been referred to and have not been tendered.

DR McEVOY: Yes.

COMMISSIONER TRACEY: This is going to be out of sequence. Would it not be better to prepare a bundle and tender the lot?

DR McEVOY: Yes. We will do that, Commissioner, thank you.

COMMISSIONER TRACEY: In chronological order.

DR McEVOY: Yes, we will attend to that. Operator, can I ask you to bring up CTH.1002.1007.2482. Can I ask you, ma'am, to have a look at that email. Do you recall that?

BC: No, I don't.

DR McEVOY: Did you instruct ACMA to provide this information to the Department of Health?

BC: No, I don't, and I challenge what they've written. From the few words I've read it's very defamatory and I challenge it. And I wonder why I was paying ACMA, if they were working for the department.

DR McEVOY: And did that report, that confidential report; would you say that that assisted you to demonstrate to the department that you were meeting your obligations?

BC: No, it's defamatory. It's just wrong. We couldn't work with the ACMA staff. They were in our face in the office saying - - -

DR McEVOY: Commissioner, that will also be included in the bundle in due course. Operator, can I have you go to THC.0001.0002.0007. Can you remember this document, ma'am?

BC: Not in particular, no. No, I don't think so. I recognise their logo.

DR McEVOY: Perhaps if, operator, you could go to page 0010.

BC: No.

DR McEVOY: You see there the reference to fees, payments and terms. Do you remember this aspect of your engagement with ACMA?

BC: No. It was a very confusing time. I can't remember seeing that. No.

DR McEVOY: You see there that under stage 1 there's a reference to a total fixed price of $163,680.

BC: Yes.

DR McEVOY: And then you see under underneath that there's stage 2, continuous improvement and training. And then at the bottom, there's a total figure of $257,136. Do you see that?

BC: Yes, I can now. Yes.

DR McEVOY: Can you remember, in broad terms, what the revenue of your business was at about this time?

BC: I would be guessing; it would have been about $30,000, maybe.

DR McEVOY: $30,000 - - -

BC: We had enough to pay our bills, and we were earning money but we weren't earning a lot. We have subsequently brought on new clients so we are in a bit better of a financial position, but we would have been turning over maybe $50,000. I'm guessing.

DR McEVOY: Maybe $50,000 over what period, would you say?

BC: Maybe over 12 months. We weren't making a lot of money but we were paying staff and I wasn't being paid. I was – my work was pro bono for the company, I put money back into the company. So I wasn't drawing a weekly wage.

DR McEVOY: Can I take you to paragraph 63 of your statement. So you got to a point, did you, where you decided you weren't going to do these home care packages any more?

BC: The registered nurse wasn't getting on well with the staff. The office that we had been offered with ACMA wasn't available because it turned out it was their accountant's office. It wasn't available for us to use. So they were in our very small office all the time. The boardroom that we have got access to wasn't always available. So it was very uncomfortable. And after a very upset staff member came in crying, I decided with great reluctance that we would no longer provide the home care packages. And I went and explained that to the ACMA staff and they said, "Okay" and they said – one of the directors, I think she said, "Can you just give me a time to get a price list together for what it's going to cost to transition the clients out. And we will need a contingency plan to talk to the clients."

And I said, "I'm going to take my staff out for coffee to debrief" and I did so. And I was – I was very upset about it, and we had the coffee and I sent them home. I can't remember what time it was. I sat in the car and I rang the department, the Commonwealth department lady whose name I can't mention, and I spoke with her on the phone and I explained that we weren't going to continue. And then I spoke to a couple of clients in the car, and said, "I can't do it, I'm so sorry" and they were

lovely. And during the time I was on the phone with the department and other clients, I was getting text messages from ACMA, one of which was what time am I coming back, the other one was, "Where's the blood pressure machine?"

And I rang back at some stage. It was around lunchtime. And I said, "Why are you continuing to ring? You know, we have stopped the home care packages, we need a bit of time to debrief and take this all on." And she said, "We need the blood pressure machine for a client." And I said "Well, I'm just close to that client's house, what do you want the blood pressure machine for?" And- because I keep all that equipment in my car. And she said, she has had chest pain since, I don't know, early in the morning. And I said – I asked her what time did you call the ambulance, and I was really upset and adrenaline hit me as it does when someone is experiencing chest pain, and I said what time did you call the ambulance and she said to me, "I'm not going to discuss that with you on the phone." And I said, "What are you talking about? She has got chest pain, I'm going to see her".

And she said to me "Can you not go and see any of the clients until we have a contingency plan." And I just thought, "Why would you not just deal with someone's chest pain before you deal with a contingency plan?" Anyway I raced over to the lady's home and started to do some observations and she was with a friend. And the chest pain was probably the exacerbation of a lung infection she had. And she had chosen not to go to the general practitioner that day. She wanted to go the next day, and I was doing some – she had been unwell. She was an unwell woman, and had experienced a lot of pain, and I had been to her home a lot to help her with getting her pain to a controllable level. And while I was doing the observations, the ACMA staff knocked on the door. And I just went, "You've got to be joking." And they asked me to come out to the car park and discuss a contingency plan. And I said, "You can't be serious. This woman has had chest pain since 9 o'clock this morning and you've done nothing about it", and I sacked them. I said, "I can't work with you people any more. This is ridiculous, what registered nurse hears about the client's chest pain, sits down and documents in detail about the chest pain, and doesn't do anything immediately about it". And that was it. And then I think I rang – sorry, the lady whose name I can't mention from the department again and said, "I'm not working with them". And then I – I said I was there with another adviser, and I may have rung LASA, I can't remember, but somehow I got a second adviser that afternoon because I just thought their service was substandard, and I couldn't understand why I was paying so much money.

DR McEVOY: Well, let me just - - -

MR ARNOTT: Commissioner, I'm sorry to interrupt again, but the witness BC did mention the name of the Commonwealth officer again and I seek a non-publication direction in relation to - - -

COMMISSIONER TRACEY: I'm sorry, Mr Arnott, you are going to have to speak up. I don't think there's a microphone - - -

MR ARNOTT: I'm sorry, Commissioner. Witness BC just mentioned the name of the Commonwealth officer again in her answer and so could I seek another non-publication - - -

BC: My apologies.

COMMISSIONER TRACEY: Yes, well, the same order applies in respect of the second utterance.

MR ARNOTT: Thank you, Commissioner.

DR McEVOY: I should indicate, Commissioner, that the feed was stopped for that.

So, ma'am, you said that you had to get a second adviser, how did that go?

BC: It was a similar situation with very high fees and very little work on their part. I did all the work. And I just – I didn't – I didn't think the service was of any value to us at all.

DR McEVOY: Can I just ask you, operator, to bring up CTH.1002.1016.3173. Do you recall that email?

BC: I can't ..... sorry, I'm just reading your colleague's - - -

DR McEVOY: I'm sorry?

BC: I'm just reading your colleague's on the computer. Yes. I remember that.

DR McEVOY: Do you just want to explain what was going - - -

BC: I signed a service agreement with a second adviser in a hurried manner. I had not paid enough attention to the fact that he wanted his money within two days of sending out an account. And included in his payment, he wanted a screenshot of the transfer of money into his account. He also wanted $5000 surety. So I – he had seen our accounts because he had been the adviser for Assist Home Care. So he knew a lot about the clients who had been transferred to us. So he had seen our bank and he knew that we had the money in the bank to pay the – his – his account. And he sent an account – I paid the $5000 to him and then within, I think he had done about 18 hours of work, he sent an account on a Wednesday afternoon. And I was so busy, I didn't – I didn't see it straightaway. By the Saturday morning, he was texting me, asking me to pay it. And I said to him, "Can I please have some time to spend with my family. It's a Saturday morning. Your account will be paid. You know that we've got the money in the account."

And he just – he just didn't stop. He texted me. And then he sent a letter to the department saying he couldn't work with me because of honesty and because I hadn't paid the account with him – this was on the Sunday afternoon he emailed the

account, and I received that email and said, "I actually paid your account about three hours ago". And he – when he sent another email to the department saying, "It's okay now", he will continue working with me because I paid the account, and he told me off for not sending him a screenshot of my payment. Consequently - - -

DR McEVOY: So - - -

BC: Sorry.

DR McEVOY: Sorry, go on.

BC: Consequently, his behaviour became unworkable because I was actually doing all the work transitioning the clients to their chosen providers, and I was visiting the clients. He didn't speak to one client. I think he – I beg your pardon, he did speak to one client who was inquiring about some money. I asked him which clients he had spoken to, and he, at that stage, hadn't spoken to any of the clients. And so I was still visiting all the clients and ensuring – speaking to their new providers, and ensuring that their care was continuing on in much the same way it had been. And then I, once again, spoke to the department and said, "I can't work with these people that are charging me $280 – I believe he was – an hour for doing so little work". And I was told that I would have to find another provider by 5 o'clock in the afternoon even though - - -

DR McEVOY: Yes, go on.

BC: I think we had four clients still that were transitioning out. We had dates for them to transition out and we had – there was just one client who was a bit tricky with whether or not she was going to continue with the home care package or go under the NDIS. But the department insisted that I get another adviser and the gentleman who was our second adviser had several thousand dollars of ours in credit. And several weeks later he still hadn't returned our money and in the end I had to say, "If you don't return the money by such and such a date, I will be seeking remuneration through the small claims court." It just seemed there was one rule for these people, and another rule for us and it was really traumatic. And it blurred the lines about who they were actually working for: the department or the provider.

DR McEVOY: So you were – you say you were transitioning out with those four clients, and - - -

BC: Approximately.

DR McEVOY: Yes. And the department – after you had decided that you couldn't work with the second adviser, the department said that you needed to have an adviser because you still had those clients. That's the position?

BC: Yes. I was told that according to the Aged Care Act it was a very strong position – the adviser's position was a very strong one, and it was necessary and I had to do it. And - - -

DR McEVOY: So you then got a third adviser, did you?

BC: Yes. Yes, I did.

DR McEVOY: And how did that go?

BC: She is delightful. She has been very professional, very easy to work with, very kind. Very affordable and is just very, very good at what she does. And is – shares my opinion of the lack of regulation around the advisers and the prices that they're charging.

DR McEVOY: And I think in paragraph 76 of your statement you say that you were being charged about $100 an hour by her.

BC: Yes.

DR McEVOY: So in paragraph 77 of your statement, you say you wrote to the department, imploring them to do something about these advisers and auditors and you say you've received no response. Did you have any discussions over the phone or any other discussions with the department about this?

BC: I can't remember if I had discussions. I just felt that I couldn't discuss anything with the department. They were completely inflexible and were not prepared to do – take on anything I had to say. They weren't interested, and I implored them to do something about a possible – if they had any – any ability to do anything about a level 5 package for palliative care for pensioners, if they, you know, please do something about it so that people can die in their own homes, with financial support. And I didn't – I think maybe I got a "Thanks for your email" response, or something.

DR McEVOY: Operator, could I ask you to, please, to bring up CTH.1002.1007.3400. Just take a moment, ma'am, to familiarise yourself with that email.

BC: Yes. Yes.

DR McEVOY: Do you recall sending that?

BC: Yes, I do.

DR McEVOY: So there's a reference in the third paragraph of that email to offers to "buy my clients".

BC: Yes.

DR McEVOY: What's all that about?

BC: The news that we were not going to home care packages spread rather quickly and I started receiving calls from other approved providers wanting to take the clients. And one provider suggested that you can buy the clients, and I said that's a bit tacky. And how can that work with consumer-directed care and he said, "No, it's a known practice." The advisers all brought me pamphlets and brochures which I proceeded to throw in the rubbish bin. ACMA had already spoken to another provider prior to me deciding to discontinue providing home care packages and they walked in with 20 beautifully presented media packs for another provider and they said they took the opportunity to discuss it with another provider because they thought maybe I wouldn't continue. And the second provider told me that he had a relationship with – he had a relationship with a well-known provider and he would like me to suggest that our clients go to that provider.

DR McEVOY: Now, you just said "and the second provider told me that he had a relationship"; you mean adviser?

BC: I meant auditor. I meant auditor, sorry.

DR McEVOY: Right.

BC: The second chap who was our auditor had a relationship with an approved provider and wanted me to suggest that the clients go to that provider and I said, "No, it's consumer directed", and so I didn't recommend any provider who had offered me money or fees for service, or whatever. Just – I just said to everyone to choose who they wanted, and I knew a couple who I had brokerage agreements with and who I think are quite good providers. So a few went to them.

DR McEVOY: So you sent this email to the department on 15 December 2018. Did you have any response to it?

BC: No, I don't think so.

DR McEVOY: Are you aware of whether the department ever did anything in relation to your articulation of these concerns?

BC: No. No.

DR McEVOY: Are you aware of whether the department ever visited any of your clients to ask them about the quality of the care you were giving them?

BC: No. No. I was still in contact with some of those clients. In fact, some of them – two of them I still do work for in a private capacity because their packages

don't offer them enough care. So we go in and do private care. So they've not told me about any visits from anyone.

DR McEVOY: Now, turning to your advisers and your administrators, aside from the matter you refer to in paragraph 63 of your statement, did they ever visit your clients?

BC: No. No, they were – the female one refused to. She said she would speak to one man on the phone. The registered nurse did visit with me some of the clients, and she spoke to them on the phone. But the director of ACMA didn't see any clients. I don't think he spoke to any, either.

DR McEVOY: Would you mind telling the Commission, ma'am, what sort of administration fees you're charging clients?

BC: 15 per cent for everything. A flat fee.

DR McEVOY: I think you've said, did you, that you've still got two clients that you're dealing with.

BC: We're not charging them. We don't charge them. One of them is – has been in respite so we've still got to handle her money to her credit. She may be going to the NDIS, I'm not sure. But her money is just sitting there waiting to be transferred. We don't charge her anything.

DR McEVOY: So you're still paying - - -

BC: .....

DR McEVOY: I'm sorry, go on.

BC: We don't charge on top of anything, and other providers I've spoken with said that if they charged 15 per cent they would have to close their doors. But we were able to make a comfortable living on a 15 per cent flat fee. So that 15 per cent includes my phone calls to organise bandages or wound dressings or equipment for the client. It includes organising a lawn mowing man, and we don't charge extra on top of the service. A lot of providers insist on using their own handymen and things because they charge a fee on top of the fee. So if the handy people have got police clearances and they're known to the client, we're happy to use them. We go for the cheaper option but 15 per cent is a perfectly adequate amount of money for any provider, I think.

DR McEVOY: So just going back to this one client that you say you have still got who is in respite care at the moment, are you still having to pay an adviser at present?

BC: Yes. The department – the department are asking her to do jobs on my behalf. So I'm having to pay her, but they are not consulting me about it.

DR McEVOY: What sort of jobs are they asking her to do on your behalf?

BC: To see whether or not she wants to continue having a home care package and we have been told by her social worker that she doesn't. She wants to go under the NDIS. So the department are emailing my adviser and asking her to do all these jobs that inevitably I'm going to have to pay for.

DR McEVOY: Commissioners, I have no further questions of this witness for the moment. A couple of matters arising, I think: one is the request for a direction not to publish pursuant to section 6D(3) of the *Royal Commissions Ac*t. I have a draft form of order here which, if it's convenient, I can provide to you over the luncheon adjournment to be made. The other aspect of this is that I apprehend that my learned friend for the Commonwealth does wish to cross-examine. I haven't had an opportunity to speak to him about that, having heard the evidence of the witness. Perhaps in all the circumstances and given the time, it might be desirable if I do that now over lunch and I can indicate to the Commissioners at 2 pm what the position is there, and you can decide how to proceed.

COMMISSIONER TRACEY: Mr Arnott, is it your wish to apply for leave to cross-examine?

MR ARNOTT: It is, Commissioner.

COMMISSIONER TRACEY: Yes, and on what issues?

MR ARNOTT: Commissioner, there are certain factual matters which were put by witness BC in relation to her interactions particularly with the Quality Agency in connection with the visit on 31 October, in the lead-up to that and at that session, which I want to ask her some questions about, and show her some additional documents.

COMMISSIONER TRACEY: Well, we are minded to grant you leave in respect to the conduct of the assessors and her interaction with those assessors.

MR ARNOTT: Yes.

COMMISSIONER TRACEY: But it will, unless you persuade us otherwise, be limited to that subject.

MR ARNOTT: Commissioner, that's all that I would seek leave to address.

COMMISSIONER TRACEY: And how long would you be needing the witness for, for that purpose?

MR ARNOTT: I think it will be 15 to 20 minutes.

COMMISSIONER TRACEY: Yes. Can we maintain the link at 2 o'clock for that purpose?

DR McEVOY: I would think so, Commissioner. If it is only to be 15 minutes, I wonder whether it would be better to do it now?

COMMISSIONER TRACEY: Yes. I think that would be the better course. The witness has been in the box all morning and to bring her back for 15 minutes in an hour's time, I think, would be undesirable. So Mr Arnott, you have leave to ask those questions now.

MR ARNOTT: I'm grateful to the Commission.

<CROSS-EXAMINATION BY MR ARNOTT [1.00 pm]

MR ARNOTT: Witness BC, my name is Arnott, I appear for the Commonwealth, and I would like to ask you some questions, if I may. Can I start by asking you about paragraph 26 of your statement. Do you have that there in front of you?

BC: Yes.

MR ARNOTT: You refer to receiving an email on 9 October 2018. Could witness BC be shown by the operator document CTH.4000.1003.2088. Ma'am, can you see that document?

BC: Yes.

MR ARNOTT: Was that the email you received on 9 October 2018 that you refer to in paragraph 26 of your statement?

BC: Possibly, yes.

MR ARNOTT: Do you have some doubt about that?

BC: There was a lot of documents. I think it was; I think so.

MR ARNOTT: How did you identify, for the purpose of preparing your statement, that you received an email on 9 October 2018?

BC: I would have gone back through emails that I had – that I had received and that would have been the date, I suppose.

MR ARNOTT: Thank you. Can you see that this email attaches two documents? Let me help you. Can you see at the top of the page it has from, to, date and attachments?

BC: Yes.

MR ARNOTT: And can you see there's two documents attached?

BC: Yes, okay I've got you. Yes.

MR ARNOTT: Can you see that one is an information sheet?

BC: Yes. Yes.

MR ARNOTT: Can you see the other is a letter to care recipients.

BC: Yes.

MR ARNOTT: Could the witness be shown document CTH.4000.1003.2089.

BC: Yes. Yes.

MR ARNOTT: Can you see that that's the information sheet that's attached to that email?

BC: Yes.

MR ARNOTT: Do you recall reading this document on or around 9 October 2018?

BC: It would have been one of many, yes.

MR ARNOTT: Do you recall reading it?

BC: Yes. I will say yes because – yes, some of it is familiar.

MR ARNOTT: Thank you. Can you see at the bottom of the first page it says:

> *Where an assessment contact has been arranged in the form of a visit to a site the approved private provider will be notified at least 14 days prior to the proposed date of the visit. This notice includes the form of words that must be used to inform care recipients about the visit.*

BC: Yes.

MR ARNOTT: Can I ask you at that point to be shown CTH.4000.1003.2092.

BC: Yes.

MR ARNOTT: Do you have there a document that is headed [REDACTED] – I apologise.

BC: Yes.

MR ARNOTT: Commissioner, I uttered some words.

COMMISSIONER TRACEY: We are at a disadvantage because the document hasn't come up. Just bear with us until it can be called up on the screen.

MR ARNOTT: I might repeat the number in case that assists; CTH.4000.1003.2092.

COMMISSIONER TRACEY: Yes, we have it now.

MR ARNOTT: Now, do you see there a proforma letter to be sent - - -

BC: Yes.

MR ARNOTT: - - - to care recipients.

BC: Yes.

MR ARNOTT: And to you see there it refers to:

> *... an assessment team coming to the offices on that date. The purpose of the visit is to assess the quality of care and services that BD – your company – provides to clients. As part of that review the team will talk to management and staff and will look at our systems and processes, and they are also interested in speaking to clients about the care and services they receive.*

And then the numbers are given for the Quality Agency and so on.

BC: Yes I can see it.

MR ARNOTT: Did you, in advance of 31 October, send yourself or cause to be sent this letter to all of the care recipients in the home care program that you were responsible for?

BC: Well, not all of the clients were – had come across the portal yet to us. So not all of them were contacted. Some of them were contacted by phone, and they were consequently spoken with by the quality department.

MR ARNOTT: Yes, okay. Thank you. Now, as at – I think your evidence earlier was as at 31 October 2018, BD, your company, was operating out of your home; is that correct?

BC: That's correct.

MR ARNOTT: And how long had you been operating out of your home?

BC: Since the inception, which is 2016.

MR ARNOTT: So by - - -

BC: We only had a few clients. We worked in other people's homes. There was no need for an office until we started working with the home care packages.

MR ARNOTT: Okay. Now, can I ask you another question about your statement. You say in paragraph 36 you received a report. Do you see that?

BC: Yes.

MR ARNOTT: And then in paragraph 38, you say that you were then sanctioned by the Department of Health. Do you see that?

BC: Yes.

MR ARNOTT: So your evidence is that before being sanctioned, you had received the report referred to in paragraph 36?

BC: Yes, just within a couple of days, before, I believe.

MR ARNOTT: Yes.

BC: I can't remember the dates, I'm sorry, but yes, it was only a matter of days.

MR ARNOTT: Okay.

BC: And I had started to prepare a response.

MR ARNOTT: Thank you. Could the witness please be shown document CTH.1002.1001.3863.

BC: Yes, I've got that.

MR ARNOTT: You have the document there?

BC: Yes, I do.

MR ARNOTT: It's a document headed Home Care Assessment Contact Report.

BC: Yes.

MR ARNOTT: Is this the document that you received and that you refer to in paragraph 36 of your statement?

BC: I believe so, yes.

MR ARNOTT: Thank you. Now, can you see on the first page the date of the assessment contact, 31 October 2018; can you see that? And can you see there that the time the visit commenced was 9 am and the time that it concluded - - -

BC: It was actually 8.55.

MR ARNOTT: Thank you. And the time that it concluded was 1.30 pm. Can you see that?

BC: Yes. I would say that's inaccurate.

MR ARNOTT: Can you see at the bottom of the page there's the name of a team leader which has been blacked out and the name of a team member who has been blacked out?

BC: Yes.

MR ARNOTT: Do you recall that it was two officers from the agency that attended your site?

BC: Yes.

MR ARNOTT: Yes.

BC: Yes.

MR ARNOTT: This report says that they started their visit at 9 am – you say 8.55 – and they concluded their visit at 1.30 pm. A period of four and a half hours between the two officers is nine hours in total. Can you see that in the report?

BC: Yep. I can see that they've written that.

MR ARNOTT: And what I would like to ask you, witness BC, is that the recollection that you set out in paragraph 32 that the visit lasted six or seven hours is incorrect.

BC: I would disagree with that.

MR ARNOTT: What I would like to put to you is that the visit actually concluded at 1.30 pm.

BC: I would disagree with that.

MR ARNOTT: Now, if you could go over the page, please, to page 3 of the document.

BC: Yes.

MR ARNOTT: Can you see there a page that's headed Audit Trail?

BC: Yes, I can see that.

MR ARNOTT: And can you see that the interviews that were conducted by the agency are there identified?

BC: Yes.

MR ARNOTT: The reference to the director is to yourself.

BC: That's right.

MR ARNOTT: And then the accounting and finance manager and the human resources manager are the two people that worked with you in your home office?

BC: That's correct.

MR ARNOTT: Then on the right-hand side, can you see Care Recipients?

BC: Yes.

MR ARNOTT: Does it accord with your recollection that the Quality Agency spoke to five of the care recipients you were responsible for during this inspection?

BC: I don't know how many they spoke with. I wasn't there when they called them. I do know that one of the recipients wasn't home and he wanted to speak with them because he was unhappy about the sanctions. He rang up and asked to speak with them. The person there wasn't available, and she didn't return his call.

MR ARNOTT: On 31 October you hadn't yet been sanctioned, had you?

BC: No, no, I'm talking about further down the track.

MR ARNOTT: I see. And then the registered nurse – can you see there that the Quality Agency records an interview with the registered nurse?

BC: Sure. Yes, got that.

MR ARNOTT: Your evidence to the Commission was that you told the registered nurse not to come into the office on this day. Is that correct?

BC: There was no point so – yes. Yes

MR ARNOTT: And so did the agency speak to the registered nurse via telephone?

BC: I don't know. I wasn't privy to that phone call.

MR ARNOTT: And you will see there that then there's interviews with support staff, and there's three interviews. Can you see that?

BC: Yes. Yes.

MR ARNOTT: That's a reference to interviews with actual support workers who are employed or engaged by BD to provide the home care services in the home of the care recipients you were responsible for.

BC: Yes, that was – I believe some of the staff they spoke with were some of the staff that had come over from Assist Home Care that may not have known us as well as other staff. Some of the staff that had previously worked for Assist were coming over with the clients to continue their care.

MR ARNOTT: Were the staff that the Quality Agency spoke to on that day staff who were providing services to the care recipients BD was responsible for at that time?

BC: They would have been but they would have been brand new staff, I suspect.

MR ARNOTT: Now, can I ask you to go over to page 4 of this document. And can you see about halfway down the page there's a bullet point that says:

> *The company director and management staff interviewed were not aware of their responsibilities under the Act.*

BC: Yes, I can see that.

MR ARNOTT: Can you see that it continues:

> *Management said they are still trying to work out what the home care package and related processes and systems are and have not yet developed a system to ensure that they are up to date with all aged care related legislation and guidelines or of those relating to an approved provider of home care packages.*

Do you see that?

BC: I dispute it, but yes I can read it.

MR ARNOTT: Do you deny saying that to the Quality Agency on 31 October?

BC: Those words, no, in that way at all. I would have said – and as I explained earlier in our self-assessment, we were still learning about some things, yes. But I didn't – the way that they've worded it makes it sound like we had no idea what we were doing.

MR ARNOTT: Now, can you see at the bottom of the page it says:

> *We viewed 12 home care agreements. All had been signed by the care recipients but not by the provider and there was no information about their individual budget. The care plan attached to the agreement was also signed by the care recipient but was blank in relation to the services that were to be provided.*

BC: I think I brought that up earlier in my evidence when I discussed that there was some mistakes made when the staff went out to introduce themselves and had got clients to sign forms, and I explained to them that they weren't legally binding so we would have to do them again.

MR ARNOTT: Your evidence before, wasn't it, that you were aware at this date that at least some care plans for care recipients under your care had not been completed. That was your evidence you gave to the Commission earlier, wasn't it?

BC: Some, yes. But we still didn't have all of the clients from Assist Home Care through the portal yet.

MR ARNOTT: And you were - - -

BC: We weren't – sorry, go ahead.

MR ARNOTT: Please continue.

BC: No, I've finished.

MR ARNOTT: And you were aware, as at 31 October of the contents of the Home Care Standards; is that right?

BC: Yes, we were. We've heard that they were changing so I was a bit confused about what the updated home care packages – Home Care Standards was going to include but, yes, we – we had them.

MR ARNOTT: Was there some uncertainty in your mind as to whether you had to comply with the Home Care Standards as they were at that time?

BC: No. No, I just didn't know if we were going to have to go around and change everything that we were doing because they were changing the standards.

MR ARNOTT: Were you aware as at 31 October that item 2.3 of the Home Care Standards required the completion of a care plan?

BC: Yes.

MR ARNOTT: But nevertheless it hadn't been done for all of the care recipients under BDs care.

BC: That's right.

MR ARNOTT: Thank you.

BC: When we – when the clients came over from Assist Care, they came with absolutely no paperwork whatsoever, so we had to go out and interview each client individually again. Assessments had been done, we were in the process of doing all the work that is set out in the Home Care Standards. We didn't have the time to complete it by the time the Quality Agency knocked on our door at 8.55 on 31 October.

MR ARNOTT: Can I ask you to go to page 13 of this document, please. Can you see there a section about a third of the way down, that's a heading Staff Interviewed Said They Do Not Receive Documented Information About Clients. Do you see that heading?

BC: Yes.

MR ARNOTT: And do you see there that it says:

> *All staff interviewed said that they do not have access to care plans or documentation relevant to care recipients. Staff said they find out about care recipients' care needs and other information through either talking with the care recipients themselves or a call from the service provider, and staff said the office - - -*

BC: So I would suggest that that came through from Assist Home Care. I don't know who they spoke with but the, as I've explained, the care plans we hadn't had the opportunity to do for all of the staff – for all of the new clients. We had to start from scratch. So if the Quality Agency spoke to staff who had transitioned over from Assist Home Care, I'm not surprised that they had said what they've said.

MR ARNOTT: Do you see it continues:

> *Staff said that the office does not provide them with information about the care or services required for each care recipient and that the only information they get is the time and day they are required to see a care recipient.*

Do you see that?

BC: I reiterate what I just said to you.

MR ARNOTT: At the bottom of the page do you see the final bullet point. It says:

All care recipients interviewed –

that was the five care recipients identified at the beginning –

said that they do not recall having a representative from the service - - -

Sorry.

COMMISSIONER TRACEY: There's no "not" there.

MR ARNOTT: I apologise, I withdraw that.

They do recall having a representative from the service visit them when commencing services, however, they could not remember if this was included in an assessment of their needs and requirements. All confirmed they had not been provided with a care plan.

Do you see that?

BC: I reiterate what I earlier said.

MR ARNOTT: Now, can you go over the page, please, to page 14. Do you see an underlined section about halfway down saying:

[REDACTED] does not have care plans developed that are based on assessed needs. All care recipient files did not have a completed care plan. Care plans were not completed or were left blank, however, were signed by the care recipient.

Do you see that?

BC: Yes, I do.

MR ARNOTT: And at the bottom of the page, can you see that it states:

We viewed care recipient agreements that contained care plans that showed the following.

Can you see that?

BC: Yes, I can.

MR ARNOTT: And the names of the care recipients are blanked out but you can see there, about 10 or so agreements that were reviewed, sorry 12 agreements.

BC: Yes, all of them. These are all clients who came from Assist Home Care.

MR ARNOTT: And can you see there that in that list, there's two clients who had a level 3 package. Can you see that?

BC: Yes.

MR ARNOTT: A level 3 package requires an intermediate level of care?

BC: Yes.

MR ARNOTT: And there's three care recipients who have a level 4 package, can you see that?

BC: Yes, but one of them was – two of them – two of them were in respite. So the first lady – the other – the lady at the bottom were in respite. They weren't – and their packages had been suspended. And the other lady who is on the level 4 package had a care plan which was in her home, and it's one of the care plans I wasn't able to get to the Quality Agency.

MR ARNOTT: Now, I think your evidence to the Commission has been that by around 4 December 2018 you had made the decision to no longer provide home care services through BD; is that right?

BC: That's correct.

MR ARNOTT: And do you recall a meeting on 5 December involving your adviser, GG, and the department at which planning was made and assistance was given by the department to assist you to transfer the care recipients under the care of BD to other providers?

BC: I'm sorry, I'm not sure – could you repeat that? I'm sorry, on the 5th of, I don't think I had a meeting on the 5th.

MR ARNOTT: Okay. Nothing further, Commissioners.

COMMISSIONER TRACEY: Thank you. Dr McEvoy.

DR McEVOY: Nothing by way of re-examination, Commissioner.

COMMISSIONER TRACEY: All right. Well, now, we have got to deal with the tender document issue, which has arisen because of the separation of witness and courtroom. What I want those instructing you to do, please, is to assemble a bundle of all the documents that you've taken witnesses to and that Mr Arnott has taken

witnesses to, with a covering sheet identifying those documents in chronological order. And when they're tendered, I will assign an exhibit number to each of them. And may I remind you that a similar arrangement was put in place yesterday in relation to Mr Holmes' documents and they will need to be tendered at some stage.

DR McEVOY: Yes, we do need that tender that as well, Commissioner, yes, thank you.

COMMISSIONER TRACEY: All right. How are we placed logistically for the rest of the evidence for today?

DR McEVOY: Well, we have obviously gone over a little. I think Ms Dowling will be the next witness after lunch and it may be, Commissioners, that subject to your convenience we would ask you to sit a little longer today to accommodate the over run.

COMMISSIONER TRACEY: Are you reasonably confident that if we sit a little longer today that we will complete the list of witnesses who you've proposed to call today?

DR McEVOY: I may need to take some instructions about that. I'm not sure - - -

COMMISSIONER TRACEY: Well, you might let us know the answer to that. I'm proposing to adjourn until 2.15, and if you work on the basis that we are, in principle, willing to sit on for a reasonable time - - -

DR McEVOY: Thank you Commissioner for that indication.

COMMISSIONER TRACEY: Yes, the Commission will adjourn until 2.15.

<THE WITNESS WITHDREW [1.25 pm]

ADJOURNED [1.27 pm]

RESUMED [2.25 pm]

COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: Commissioners, I call Marie Dowling.

<MARIE BEATRICE DOWLING, AFFIRMED [2.25 pm]

<EXAMINATION-IN-CHIEF BY MS HILL

MS HILL: Thank you, Ms Dowling. I will now proceed to ask you some questions. Ms Dowling, could I ask you to please state your full name.

MS DOWLING: Marie Turin Beatrice Dowling.

MS HILL: And what is your age?

MS DOWLING: I'm 84.

MS HILL: And you're legally blind?

MS DOWLING: Yes.

MS HILL: And you are wearing a hearing aid?

MS DOWLING: Where do I live?

MS HILL: You wear a hearing aid? You've got an aid in for your hearing?

MS DOWLING: Sorry, can you say it again?

MS HILL: Certainly. You wear a hearing aid?

MS DOWLING: Yes.

MS HILL: And you've got that in today?

MS DOWLING: Yes.

MS HILL: And as we just did, if you can't hear me at any time, please just say so.

MS DOWLING: All right. I will. I'm fine at the moment.

MS HILL: Where do you live, Ms Dowling?

MS DOWLING: In North Fitzroy, Victoria.

MS HILL: You prepared a statement dated 15 March 2019?

MS DOWLING: Yes.

MS HILL: Madam Associate, if I could ask you to hand to the witness this document.

MS DOWLING: Thank you.

MS HILL: Commissioners, that document, document ID WIT.0077.0001.0001, is displayed on the monitors.

Ms Dowling, have you just been handed a copy of your statement?

MS DOWLING: Yes.

MS HILL: And you see the signature on the last page there? Do you see a space for your signature?

MS DOWLING: I did sign it on the last page, yes.

MS HILL: Thank you, Ms Dowling. Are there any changes you seek to make to your statement?

MS DOWLING: No.

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

MS DOWLING: Yes.

MS HILL: Commissioners, I tender the statement of Marie Dowling.

COMMISSIONER TRACEY: Yes, the statement of Marie Dowling dated 15 March 2019 will be exhibit 2-34.

EXHIBIT #2-34 STATEMENT OF MARIE DOWLING DATED 15/03/2019 (WIT.0077.0001.0001)

MS HILL: Ms Dowling, you've travelled from Melbourne to give your evidence to the Commission in Adelaide today?

MS DOWLING: Yes.

MS HILL: How was that?

MS DOWLING: Good, thank you.

MS HILL: And you've said you live in a retirement village – you live in a retirement village in North Fitzroy.

MS DOWLING: That's right.

MS HILL: Do you live by yourself or do you live with other people?

MS DOWLING: No, I live by myself.

MS HILL: How long have you been living there for?

MS DOWLING: How many years?

MS HILL: Yes.

MS DOWLING: Nine. Almost nine years.

MS HILL: And you used to live in Albert Park, didn't you?

MS DOWLING: I did.

MS HILL: How long did you live in Albert Park for?

MS DOWLING: I lived myself there for 30 years, and my late husband lived only 19 years there. He died 20 years ago this year.

MS HILL: Your late husband being Mr Colin Watson.

MS DOWLING: Colin Watson, yes.

MS HILL: And have you got any relatives in Australia? Do you have any family members that live in Australia?

MS DOWLING: No. I'm by myself in Australia, with no relatives.

MS HILL: And before you retired, what sort of work did you do?

MS DOWLING: I was a librarian.

MS HILL: Could you tell the Commissioners a bit about your time as a librarian.

MS DOWLING: Yes. Thank you. I trained originally in the UK and I came to Australia in 1964, and I've worked in Camberwell, the city library, as it was then, and in Williamstown where I was chief librarian. And then in a college of what is now is the Catholic University.

MS HILL: When did you retire, Ms Dowling?

MS DOWLING: In 1989.

MS HILL: And what led you to retire?

MS DOWLING: My eyesight, I had failing eyesight from about 1984.

MS HILL: And what does mean for your vision, Ms Dowling?

MS DOWLING: Well, the first problem was myopic macular degeneration from having long eyes and very short sight, and that means that the centre part of your retina is very scarred and clouded. And then about 20 or so years ago, I got glaucoma, the same cause: long eyes pressing against the optic nerve, and that reduces the field of vision.

MS HILL: Is it fair to say you've been living with vision difficulties since 1984/1985?

MS DOWLING: I'm sorry, can you repeat that?

MS HILL: You've been living with vision impairment since 1984/1985?

MS DOWLING: Yes, since I retired – it was minor at first, which is why I retired, you know, five years later in '89. But since 1984 there has definitely been problems, yes.

MS HILL: And what's it like today, Ms Dowling?

MS DOWLING: The quality is not good. I mean, I can perceive the general scene and objects and people. But whether they have their glasses on or not, or sometimes even whether they're a male or female figure, I can't tell. It's just a poor quality and clouded.

MS HILL: Did you come to access My Aged Care?

MS DOWLING: Did I?

MS HILL: Did you access My Aged Care?

MS DOWLING: Yes, I have.

MS HILL: What prompted you to access My Aged Care?

MS DOWLING: Well, it was – I had, for some years, been having council help. It was called personal care, first in Albert Park and then in North Fitzroy. And I knew that would come to an end because I had been told by the Yarra Council they were given a two-year extension of their services, most of the municipalities in Australia were. But I knew that it would come to an end and I thought that it was a service, the only one known to me, that I could get help in the house and knowing that, with my age, I would need possibly greater care than I do now. And that's why I quite soon prepared to get into My Aged Care.

MS HILL: How did you access My Aged Care?

MS DOWLING: Well, I really had only the telephone to make inquiries on. And it was very difficult, actually, but I did get in eventually.

MS HILL: What was difficult about it?

MS DOWLING: The fact that it was all online and very tiny, and I can't – I have never been online. I can't access online services due to my poor vision. I wish I could, of course I used computers as a librarian. But it's just not possible now. And that made it very, very hard. I did read, after a fashion, some of the material that was sent out by My Aged Care, and I took care to get everything I could. I went out of my way and – however, it lot of it was pretty vague and it was quite hard, a difficult process.

MS HILL: Did you request letters from My Aged Care?

MS DOWLING: Did I?

MS HILL: Request letters, written?

MS DOWLING: Well, I was given to understand that this sort of help, by having – on the phone, I was given to understand that this was not what would happen; that it was all online, and they could talk to me on the telephone but I got very few items in writing.

MS HILL: Madam Associate, could I ask you to show Ms Dowling this document.

Ms Dowling, could I ask you to take a look at that document.

MS DOWLING: Yes.

MS HILL: Is that a letter that you received from My Aged Care?

MS DOWLING: Yes, eventually.

MS HILL: And is that letter written to you in a form that you can read?

MS DOWLING: Yes, it is.

MS HILL: And what is it about the form?

MS DOWLING: It's black on white. It's large point size of the characters and the spacing is very good. Spacing is a real issue because I tend to wander up and down to the next line. So that's good.

MS HILL: I tender that, Commissioners, and it has a document ID number of MDO.0001.0001.0005.

COMMISSIONER TRACEY: Now, it's best described, is it, as a letter from My Aged Care to Ms Dowling. Does it have a date?

MS HILL: 23 March 2018.

COMMISSIONER TRACEY: 23 March 2018, thank you. The letter from My Aged Care to Ms Dowling dated 25 March 2018 will be exhibit 2-35.

EXHIBIT #2-35 LETTER FROM MY AGED CARE TO MS DOWLING DATED 25/03/2018 (MDO.0001.0001.0005)

MS HILL: As the Commission pleases.

Ms Dowling, could I ask you to put those papers to one side.

MS DOWLING: Yes.

MS HILL: Thank you. Did you ask a friend or a neighbour or anyone for help with My Aged Care?

MS DOWLING: Look, I discussed the matter with friends and people in the retirement village, but I didn't ask them to do anything for me because my belief is that, had I had someone, maybe, but I didn't have someone close to me who could explain it all the time. Now, in a retirement village, most people are there because there is a problem of some kind, either financial or physiological and that's why they come in. And they have their own families, their own problems. And I felt that I had to get across the detail of My Aged Care somehow, or I wouldn't comprehend fully and be able to respond in an appropriate manner and really find out what the scheme had to offer me. So I believed that I had to be responsible for myself and for somehow gaining that knowledge which was very, very difficult.

MS HILL: Had you been asked about your disability by My Aged Care?

MS DOWLING: Had I been asked?

MS HILL: About your disability by My Aged Care?

MS DOWLING: No. No. No, not at all. You're all very much equal on the phone, and nobody ever asked me. I actually made efforts to get large print. It's not the full answer because I have – it's difficult to read anything, to be honest, to look fixedly at anything tends to induce eye strain and other problems. But I made them aware,

certainly. But the trouble is, I got a different person on the phone every time. There was no continuity in relation to me of any kind of service at that stage.

MS HILL: You spoke to your local MP about the problems you were having, didn't you? Did you speak to Adam Bandt, MP about the problems you were having?

MS DOWLING: About the?

MS HILL: Difficulties you were having.

MS DOWLING: On the phone?

MS HILL: With My Aged Care.

MS DOWLING: Did I tell them? Yes, absolutely.

MS HILL: And did you speak to your local member of Parliament?

MS DOWLING: Yes, in the end I went to Adam Bandt who is the member for the seat of Melbourne and – shall I explain why, precisely?

MS HILL: Certainly. Please do, Ms Dowling.

MS DOWLING: It was actually about a problem that I had with the income test that I went, and coincidentally to looking into that problem, I was elevated to a higher level, I believe, a public service level, not a call centre level. And I found out that there was a director of information for the Health Department whose job it is to put material on the health system into a usable form by disabled people. But the fact that I was disabled did not weight with anyone at this stage at all. There seemed to be no recognition of the fact that I was registered disabled.

MS HILL: How did you feel when you found out that there was that branch available to you?

MS DOWLING: How do I feel about?

MS HILL: Finding out about that special area for your call to be taken to?

MS DOWLING: Special area? Sorry.

MS HILL: The director of information - - -

MS DOWLING: No, I contacted her. I was given her direct phone number, and she – either she contacted me – I can't remember which way around – or I contacted her, and it turned out she has a separate unit whose, as I say, job it is to render the material usable. And she did send me some material. Now, this was fairly late in the piece. And – yes.

MS HILL: In your statement, Ms Dowling, you say:

I had been feeling such anguish and desperation.

MS DOWLING: Yes, I did. I did. You see, I had tried my best, and there seemed to be a lot of referring to other people who might be able to help me. And then they turned out, really, not to be all that helpful. I did the rounds, and people would say, "Go to the providers. Go to the providers. They know more about the scheme, or go to the assessors." You see, the first thing I had was the assessment for My Aged Care and – however, the assessors are extremely busy doing so many assessments with so many people in the queue for My Aged Care that I – I really didn't feel it was fair to – and their knowledge was limited anyway. They are assessors, not experts on the scheme itself.

MS HILL: In April 2018, you were offered a home care package.

MS DOWLING: Yes.

MS HILL: How long had you been waiting?

MS DOWLING: I had been waiting for a year, about a year to get an offer.

MS HILL: What did you do once you received the offer?

MS DOWLING: Well, I had started earlier. I redoubled my efforts to go to providers, of which I was sent a list. I was sent a list of providers but I really had no idea which providers would be suited for my special needs, really not that special, it's widespread in the community, but I went to various local charities and only to find out that, no, that wasn't what they did. They did other activities that I wasn't eligible for. I contacted Vision Australia, and I wasn't eligible for the scheme – their part of My Aged Care. They seemed to have – they have clients, and those clients who are receiving services unique to Vision Australia can get the help if they're already using the services of Vision Australia. Then they can come under Vision Australia's section called My Aged Care. But that's not – I don't need to go to Vision Australia. I'm not really eligible for those services. So I just was really desperate and didn't know what to do, really. I didn't know where to go with it at all.

MS HILL: How much time did you have to do this?

MS DOWLING: Did this process take? Well, it took months. It's hard to put a figure on it, but I had been looking and the vagueness of the scene out there, you know, in the community, these providers and so on, I just couldn't get across it.

MS HILL: Did you have any help?

MS DOWLING: No. At this stage, no.

MS HILL: Did you get any help?

MS DOWLING: I did eventually because my assessor was originally doing my assessment at St George's Hospital in Kew which is part of the St Vincent's network of hospitals. Then she moved to St Vincent's in Fitzroy, the main St Vincent's hospital and she noticed that there was a young man whose job it was – I think he was employed for a short period of time, like three months, or maybe six months, I can't remember now – to engage both staff and clients in My Aged Care. That's what he was there for. And he was part – for convenience and taking messages and so on – he was part of St Vincent's at home unit which is the part of the St Vincent's Hospital that provides care in the home after discharge of hospital patients from St Vincent's. So she happened to inquire about him, see what – find out what he was doing, and put in, really made it happen, that I could apply for help and that lasted for three weeks.

Now, I should explain that why was I so laid back and going around looking at providers and so on; when I got my extension of time – because I was by no means ready after the first time – period of time I was given, I did get an extension. This was all done on the phone, with no paperwork attached to it whatsoever. And I asked when the extension was for and they said, "Till August 2018." So I tended to relax a bit and think, "Well, okay, that's fine." It was a number of months at this stage. It was just before the expiry of my first period. And to find out from the assessor who took an interest in my case and was now at St Vincent's- the same assessor who did my assessment – that my funds would expire and my offer would be withdrawn on 24 May, was a huge shock.

And luckily it was more or less coincidental with my getting the help from the young man at St Vincent's, and he was helpful. He came to my home, and suggested people I didn't really know. I mean, it's very hard when everything is online. It's virtually impossible for someone with my poor vision on their own to go to each website of each provider and try and assess them that way. I had tried physically going to charities or help, people who were providers, I thought, and that didn't work either. And that's very limited. I have a limited capacity for doing that anyway. And I was really at the end of my tether when this young man came on the scene and suggested two providers, both of whom turned us down because I need ongoing help, preferably by the same provider – people who come to my house and they couldn't – they just couldn't undertake to provide that.

They didn't have enough continuity of staff or, indeed, enough staff in the inner north Melbourne area to take me on. Then the young man suggested Uniting, formerly UnitingCare and I said, "Well, yes, that was one of the ones I had hoped to look at." And things happened very quickly. I spent hours on the phone trying to find things out and I finally went with UnitingCare.

MS HILL: How did you feel to have these accessibility issues?

MS DOWLING: Look, I felt, really, absolutely at a loss and unable – being unable initially to find help, it was so stressful. And I really felt – sorry, I've got a word and it will come in a minute – depersonalised, worthless, unable of course to organise my own care, and I really felt demoralised by the entire process. And I think it is not fit for purpose, and I can explain further if you have questions on that.

MS HILL: Yes, please. Please do.

MS DOWLING: Well, I think it's really useless to have My Aged Care only accessible online. It's targeted absolutely at people over 65, I understand, many of whom have never used a computer. The other thing, why am I by myself, I am a migrant. I came in 1964, as I say, and many migrants have no family in Australia. And distance is a problem if they have. You really have to have someone on the spot on an ongoing basis to engage them in something as complicated as getting into My Aged Care. And I really think that it's hard, it's too hard, and it's untenable for disabled persons to be just cast into this game, this chance of getting into My Aged Care with a disability. Some people may be able to do it because their disability is no hindrance to their accessing online, etcetera, etcetera, making phone calls.

But I wasn't in that position, and I think it would be necessary, in my view, for every disabled person trying to access My Aged Care to be eligible for suitable help at the expense of the Commonwealth in order to assist them to get into My Aged Care. As we were saying, I live in a retirement village, and so many mainly elderly women, have said, "It's just too hard. I – I will just give up. I will stay as I am and my daughter will have to keep coming up from the country", or whatever their arrangements are now, they resolve to continue with them because it's just all too hard. And they can't do it.

MS HILL: Ms Dowling, what's your message to this Royal Commission?

MS DOWLING: My message to the Royal Commission is that a review be held into the engagement of disabled persons in My Aged Care. We expect, of course, that all persons now on the National Disability Insurance Scheme on turning 65 will come into My Aged Care. It's the only thing; that's all there is. And I think their advantage would be that they have already possibly established their care systems while under 65. Now, the over 65s to which I belong are huge in number due to the migration in the fifties, sixties and seventies. And it's really difficult. A lot of – and leaving that aside, many people, certainly in my retirement village, do not have the level of education either to be able to cope with the existing arrangements. They require help anyway.

But I will limit myself to the disabled sector. I think there should be a thorough review with engagement of people who already are in the scheme, and those who wish to – those on the waiting list, I suppose, those who – hopefully those who fail to get in, because they just found it all too hard. I mean, this – this was – there has to be some help for disabled people. I take no joy at all in asking for help. I should know these things. I was a librarian. I should be able to do it, and because of my

vision, I can't. And because I was a librarian, I think I'm across the various avenues of help which I approached such as Vision Australia, of course, the major one in Melbourne anyway. So I really think that a review is essential.

MS HILL: Thank you Ms Dowling. I've concluded my questions. The Commissioners, who are seated to your left, may have some questions for you.

COMMISSIONER TRACEY: I only have one question, Ms Dowling, and that is, you have told us that you have a care provider now. Is the care you are receiving of a standard that actually assists you in the way that you wish?

MS DOWLING: Yes and no. I will explain, if I may. I was allocated to level 2 of home care, which only provides me with my existing – with my present provider three-and-a-half hours a week. That is barely enough to do essential tasks like reading the incoming mail and other documents, filing, etcetera, computer work. I need to be – have access to computer work through my care person. But this is far too little. I should have been on level 3, in my opinion, initially. But I have since been assessed for level 3 and I am on the waiting list for it, and I believe the waiting list for another level is another year at present. So I don't know that it will be a great improvement. The other thing I could do, but I feel unable to do, is shop around for a better provider. I don't believe – I like the provider I'm with. The problems are two: one is the hours I've referred to. The other is the variable quality of staff they send. They – some of them are largely untrained.

Some of them are very good because they already have the skills. I don't know that it's due to the training they've had from the provider or – I require a higher level of service than the ordinary cleaning, shopping and showers level. And quite a few of the people on the staff of my provider don't approach a computer at all. They may have a phone and they can Google things on their phone but there's more to it than that. They don't do keyboarding, you see, or proper computer searching. So I think the hours need to be improved for me. And I'm also 84, so I don't know that I will go on enjoying my present level of fitness for how long – I don't know. But my needs will undoubtedly increase. Does that answer the question?

COMMISSIONER TRACEY: Yes. That has been very helpful, Ms Dowling, as has all of your evidence, which we are most grateful to you for having come and given us, and in particular knowing that you have travelled this long distance to come to give the evidence. We are most grateful to you, and we will give earnest consideration to what you have told us.

MS DOWLING: I would like to thank the Commissioners and all the staff for all – for being here at all, for the wonderful help that I have been given right from day one of getting on to the – on the phone on to the Royal Commission. The contrast between the help I've received here and the lack of help I received getting into My Aged Care is so stark, I can't emphasise it too much. This is how it should be. And thank you so much.

COMMISSIONER TRACEY: Thank you, Ms Dowling. The Commission will adjourn for five minutes.

<THE WITNESS WITHDREW [3.06 pm]

ADJOURNED [3.06 pm]

RESUMED [3.15 pm]

COMMISSIONER TRACEY: Yes, Ms Bergin.

MS BERGIN: I call witness BA. Witness, have you got a copy of your statement in front of you? Witness, have you got a copy of your statement in front of you?

BA: Yes, I do.

MS BERGIN: And do you have any amendments to make to your statement?

BA: Yes, please. On page 2, paragraph 13, it should be 31 May 2018.

MS BERGIN: Yes.

BA: Also on page 6, paragraph 49, it should say four people on level 4 packages.

MS BERGIN: Yes.

BA: And also on page 7, in the conclusion, it's on 28 February 2019.

MS BERGIN: Yes.

BA: That's all, thank you.

MS BERGIN: Thank you, witness. Now, I understand there's a solicitor with you, who will now administer an oath or ask you to make an affirmation.

BA: Yes.

<BA, AFFIRMED [3.16 pm]

<EXAMINATION-IN-CHIEF BY MS BERGIN

MS BERGIN: Witness, subject to the amendments that you've just described, are the contents of your statement true and correct to the best of your knowledge and belief?

BA: Yes, they are.

MS BERGIN: I tender the statement of witness BA document WIT.0076.0001.0001.

COMMISSIONER TRACEY: We haven't got it on the screen yet so I haven't got a date to assign to it for the purposes of the exhibit list. Can you assist me with that?

MS BERGIN: I think the date is 8 March 2019, on my copy.

COMMISSIONER TRACEY: The one that has just come up on the screen looks like 8 March 2019.

MS BERGIN: Thank you, Commissioner.

COMMISSIONER TRACEY: Yes, the witness statement of BA dated 8 March 2019 will be exhibit 2-36.

EXHIBIT #2-36 WITNESS STATEMENT OF BA DATED 08/03/2019 (WIT.0076.0001.0001)

MS BERGIN: Thank you, Commissioner. Now, witness, your identity is subject to a non-disclosure order as is your business name so I refer to you as witness BA and to your company as BB Pty Ltd, if that's okay.

BA: That's fine. Thank you.

MS BERGIN: Thank you. Now, witness, what is your current role?

BA: I am the chief operating officer of BB.

MS BERGIN: What qualifications do you have?

BA: I am a registered nurse. I have a bachelor - - -

MS BERGIN: When did you - - -

BA: I'm sorry.

MS BERGIN: Sorry, please continue.

BA: I have a Bachelor's in nursing.

MS BERGIN: When did you start BB Pty Ltd?

BA: In 2017 it was registered, but I started BB in 2018.

MS BERGIN: Okay. So when – I think in your statement you refer to the date of May 2017, so let's go through the application for approved provider status. When did you apply for approved provider status for BB Pty Ltd?

BA: I applied in May 2017.

MS BERGIN: And how long did it take you to get your application together?

BA: It took me about six months.

MS BERGIN: What assistance did you have in putting together your application for provider status?

BA: I had no assistance.

MS BERGIN: What assistance would have been useful for you at that time?

BA: I think if I had some assistance with the guidelines of what the Department of Health and Ageing were expecting from an approved provider.

MS BERGIN: How many staff did you have at this time?

BA: I had no staff. It was just myself.

MS BERGIN: Okay, and how long did the approval process take?

BA: It took about six months.

MS BERGIN: And after you – when were you approved?

BA: I received my approved provider status in October 2017.

MS BERGIN: And how many clients did you get in the first few months as an approved provider?

BA: Three.

MS BERGIN: And how many carers did you have at that time?

BA: I had three, three carers.

MS BERGIN: And did you have any administrative staff?

BA: No, I didn't.

MS BERGIN: When was your first contact with the Quality Agency?

BA: It was on 31 May 2018.

MS BERGIN: What did that involve?

BA: I had two Quality Agency assessors come to the office and just run through some paperwork and speak to my staff and speak to my clients.

MS BERGIN: And were you aware why they had reached out and made contact with you?

BA: My first phone call was they had notified me that they were coming out on 31 May and that they said that this was a normal process for approved providers for an initial review.

MS BERGIN: So after you had been operating for, this was after you had been operating for about seven months, what size was the business by this time?

BA: I had nine clients.

MS BERGIN: How many staff members did you have?

BA: I had about 11 but each of my clients had one – a carer, that would go to the client. It was one carer to one client.

MS BERGIN: Okay. What happened during the initial review by the Quality Agency in May 2018?

BA: They just basically came to the office and they – we went through some paperwork, whatever paperwork I had in place at that time and they had – I had some staff there that they could interview. I also gave them a list of all my clients and their phone numbers and their representatives so they could have a discussion about the services they were receiving from BB. They asked me about myself and what I was about, I was involved in BB, and I basically just answered all their questions, and I just showed them as much as I could on that day.

MS BERGIN: Did you get a report from them?

BA: Yes, I did.

MS BERGIN: And what did the report say?

BA: The report said that I had not met, I think it was 16 out of 18 of the Home Care Standards.

MS BERGIN: And what happened after that?

BA: I waited for – I put a report together and I sent a folder of evidence to the Quality Agency, showing them what I had put in place since the first review.

MS BERGIN: So when you talk about what you had put in place since the first review, what had you done during that period?

BA: I was aware that – from that quality review that there was a lot things that were missing and I needed to fix. So I contacted a friend that I knew from a residential facility and asked them if they knew anyone that could help me get some of the process and systems into place, and I was recommended a consultant. So I immediately rang that consultant and within a couple of hours, I had policies, procedures ..... that I needed, that were going to help me on the road to compliance.

MS BERGIN: When you mentioned just a moment ago that you were recommended a consultant, who gave you that recommendation?

BA: So, it was a colleague that I worked with in the residential facility, and he used to basically do our fees and he has been in the aged care industry for a long time.

MS BERGIN: And when you say that – sorry, keep going, please, witness BA.

BA: So I – I just gave a phone call and I asked, you know, I told them that I had the Quality Agency out and I needed then to get some help and if he knew anyone at all and he said to me, yes, he did.

MS BERGIN: When you mentioned - - -

BA: And he gave me a phone – sorry.

MS BERGIN: When you mentioned that within a couple of hours you had policies and procedures in place, what policies and procedures were they?

BA: Yes. Corporate governance, clinical governance, financials, work, health and safety – things relating to the Home Care Standards.

MS BERGIN: And what charge was there – was there a fee that you had to pay to the consultant for that work?

BA: Yes. Yes.

MS BERGIN: What was the fee for that work, can you remember?

BA: I think the initial invoice was about 26,000.

MS BERGIN: What was your next contact with the Quality Agency?

BA: So after that, that initial review, I received a report, obviously, saying that I had not met – if I wanted to respond I would have to respond within seven days, which I did. In that time, I had put a lot in place with the help of the consultant. I then sent off my report within the timeframe that was asked of me. I then received a phone call from the Department of Health and Ageing saying that they would be imposing a sanction.

MS BERGIN: What were the requirements of that sanction that you received?

BA: I had to appoint a nurse adviser and nurse administrator immediately or I would have to have my licence revoked.

MS BERGIN: How did you respond to that sanction?

BA: I said that I would try – I would get an adviser and an administrator and I would notify them by 5 o'clock, I think it was, the next day that I had to advise what – what my next steps would be.

MS BERGIN: So did you appoint an individual nurse adviser and an individual administrator or did you appoint one person to carry out both functions?

BA: I had already had the consultant so I rang the consultant and I said the department had requested that I get a nurse administrator and nurse adviser, and the consultant then introduced me to a nurse adviser and an administrator.

MS BERGIN: Were you given a quote for these people?

BA: No.

MS BERGIN: So were you aware at that time what costs might be involved?

BA: No, not at that time, no.

MS BERGIN: What happened following the sanction? Were there further reviews by the Quality Agency?

BA: Yes, so I had the consultant come in once a week to BB and put in process and systems in place, and then we had – I had a phone call from the Quality Agency saying I had a timeframe for improvement of three months. So within – so every month I would have a quality review visit, which is what happened. The first one was – sorry.

MS BERGIN: When were the quality review visits?

BA: So I had one in June. I had one in July and the last one was in August.

MS BERGIN: What was the state of play by 22 August review?

BA: By 22 August I had met all my standards.

MS BERGIN: And at what point – did you apply following that to have the sanction lifted?

BA: I didn't apply straightaway to have my sanction lifted. I waited until October.

MS BERGIN: How did you apply to have the sanction lifted?

BA: I filled out an application, basically called uplift of sanction. I also wrote a lengthy report about what had been happening after the timeframe for improvement, what new developments we had, how – how the business was going and why is it that we need to lift the sanction.

MS BERGIN: So when was the sanction lifted?

BA: It was lifted on 21 November.

MS BERGIN: So during the period of the sanction, did BB Proprietary Limited receive any complaints about quality of care from clients?

BA: No.

MS BERGIN: During this period, did any of your clients choose to leave the service of BB Proprietary Limited?

BA: No.

MS BERGIN: To what extent are you aware from communications with the Quality Agency, that they contacted your clients while the sanction was in place?

BA: I was aware of all the contacts that the Quality Agency had contacted my clients and the department.

MS BERGIN: Are you aware - - -

BA: I was aware - - -

MS BERGIN: Sorry, please continue, witness.

BA: Sorry. The department and the Quality Agency were very informative and they did notify me about everything that they were doing and why they were doing it.

MS BERGIN: Did you have – are you aware whether the clients reported satisfaction with the quality of care they were receiving from BB Proprietary Limited?

BA: As far as I know, I am – that my clients were satisfied with the care.

MS BERGIN: Why do you think that the clients were satisfied with the clinical care?

BA: When the Department of Health and Ageing rang the clients and notified them that BB was in sanction, my clients rang me and said to me that they had received that phone call and were – I had some clients say, "What's going to happen; are you still going to be our provider". And I notified them that there is going to be a meeting and they could come to the meeting and if they had any concerns, they could come and speak to the department and Quality Agency - - -

MS BERGIN: So I take it - - -

BA: The delegate who sanctioned me.

MS BERGIN: Please continue, witness.

BA: The department had invited all the clients to come for a sanction meeting and they would notify them of what was going to happen to BB. But no one – none of my clients came.

MS BERGIN: When you say none of your clients came, none of your clients came to the meeting at which you were present.

BA: No one – no one came to the meeting, and throughout the sanction when the quality assessors rang the clients they always gave them feedback that the clients were very satisfied and we had some good feedback about the services.

MS BERGIN: Now, what did the – you mentioned that you had a nurse adviser and administrator engaged to assist - - -

BA: Yes.

MS BERGIN: - - - you respond to the conditions of the sanction. What was charged for that work?

BA: Two and a half thousand dollars a day.

MS BERGIN: What was the total spent you spent in responding to the sanction through appointing the administrator or adviser?

BA: 120,000.

MS BERGIN: Is that the amount that you paid?

BA: Altogether, yes.

MS BERGIN: What was the – did you negotiate with the department or the Quality Agency as to how often the administrator or adviser would be required to present at BB Pty Ltd?

BA: Yes, I did. When I received the quote from the consultant for two and a half thousand dollars a day, I rang the Department of Health and Ageing and I asked them how many days would I have to have the nurse adviser and administrator. And they advised me that it was up to me about how many days I would need them at BB. So I said – so I basically told the consultant that I would have them only one day a week.

MS BERGIN: So is it your evidence, just to summarise, witness BA, that within the course of 13 months, you were approved as a provider, got your first nine clients, were visited by, or had contact with the department and the Quality Agency, were subject to a quality review, were subject to a sanction, spent $120,000 as required by the sanction and then had the sanction lifted. Is that an accurate summary of your evidence?

BA: Yes. Yes, it is.

MS BERGIN: And through that process, what do you say about the disruption that was caused to your clients?

BA: I don't feel there was any disruption caused to my clients because behind the scenes there was a lot of work done at BB but the care and the service delivery was still the same, the same – it was the same staff that went out. It was the same service. Everything, basically, was in the same – same form for my clients and the staff.

MS BERGIN: Now, continuing on with the topic of quality of care, witness BA, you say in your statement at paragraphs 49 through to paragraph 53 that you care for many people on different levels and with different needs.

BA: Yes.

MS BERGIN: I want to ask what is it like for a provider when you are caring for a person who is on a package that is, for example, lower than their needs as set out at paragraph 52?

BA: It's very difficult but because I am a registered nurse, I can provide a lot of the hands-on care myself. I think it would be different if I wasn't a registered nurse; it would be a lot harder. But I went out, and I still go out to a lot of clients and I do my own clinical care, if there's complex care needs and I don't have the proper skill mix to care for that client, whether it's a package 1, 2, 3 or 4.

MS BERGIN: Do you have an example of a package, a client who is on a level 2 package who might have demanding care needs?

BA: Yes.

MS BERGIN: Could you tell - - -

BA: I had a client who was on a – was approved for a level 4 but was assigned a level 2 and he had advanced dementia and was bed-bound. He was ..... he was needing thickened fluids, a pressure mattress. He was very, very frail, and he was on a level 2 package, and so we had – he needed assistance, you know, seven days a week. So we had two carers go out in the morning and two carers go out in the evening. I negotiated with the daughter that she might need to pay some – pay something from her pocket in order for us to be able to deliver the proper services for her father. She said that she really couldn't afford to pay anything from her pocket, even though she was aware of the basic daily care ..... assist. So I approached the hospitals, and I asked them if they can assist with the bed and a lifter and a pressure mattress, and we were successful in that. So he did get a pressure mattress and a lifter and a hospital bed. We also got assistance from a local hospital for thickened fluids, just to help alleviate the pressure of the cost. I went out and I did all the dressings that he needed, but he passed away and he still hadn't received his level 4 package.

MS BERGIN: Who paid for the pressure mattress?

BA: The hospital.

MS BERGIN: And how is he – is he still with us?

BA: No, he's not. He passed away, but he didn't his level 4 package but he passed away at home and he had a – he had a dignified death.

MS BERGIN: How are things going for you now, witness BA, and BB Proprietary Limited?

BA: I received a quality review visit on 28 February 2019 and we have passed all our standards with no recommendation - - -

MS BERGIN: What reforms would you – sorry, please continue, witness BA, I'm having a little bit of trouble hearing you so I apologise.

BA: Sorry. So I – we have doubled business. We have had our quality review visit and we have passed our review with no recommendation. We have increased staff. I think it's going very well. All my staff are still with me and my clients are still with me bar the one that passed away.

MS BERGIN: So in light of your experience with the sanction process, what reforms would you suggest the Royal Commission consider?

BA: Sorry? Sorry?

MS BERGIN: In light of your experience since becoming an approved provider and responding to the quality review, the assessment contact report, the sanction and having the sanctions lifted, in light of that experience, what reforms would you like the Royal Commission to consider in relation to the sanction process generally?

BA: Okay. For me, the sanction process wasn't a bad thing. It was – it sort of helped me put the processes and systems that I needed to properly get the guidance I needed. The only thing I would say is that before the Quality Agency deemed something that was clinical risk, that they really did a lot more investigation.

MS BERGIN: Would it have been helpful to have more information about the expectations of approved providers and perhaps more assistance in setting up processes at the outset following your approval?

BA: Definitely, yes.

MS BERGIN: What information would have been helpful to you?

BA: I think if – I think if there was a set of policies that the department could give an approved provider and maybe a list of agencies that could assist them to set up the business because that's where I was – that was where I was – had a lot of trouble with because it was my first – it's my first business. Clinically, I knew what I had to do to provide the care in the community. It was just the business side of setting up the business and what software was recommended. Also the cost; when you go through a sanction, it's very expensive, and consultants can vary from price to pricing. And some of the qualifications that consultants have aren't any more than what you have. So I think that's something to look at.

MS BERGIN: Thank you very much, witness BA, and BB Proprietary Limited. That conclusion my examination of this witness. Thank you, Commissioners.

COMMISSIONER TRACEY: Mr Arnott, do you have an application?

MR ARNOTT: No, I do not.

COMMISSIONER TRACEY: Very well. Thank you, witness BA, for your evidence. We are most grateful to you for that evidence and we apologise for any inconvenience to you for you being called rather later in the day than we had expected. Thank you very much.

BA: Thank you very much.

MS BERGIN: Can this witness be excused please, Commissioners?

COMMISSIONER TRACEY: Yes, you are excused from further attendance from the Commission.

BA: Thank you very much.

<THE WITNESS WITHDREW [3.45 pm]

MS BERGIN: If the Commissioners could just bear with me while I collect my notes for my next witness. We request a short adjournment please, Commissioners.

COMMISSIONER TRACEY: Yes. Very well, the Commission will adjourn for five minutes.

ADJOURNED [3.46 pm]

RESUMED [3.55 pm]

COMMISSIONER TRACEY: Yes, Ms Bergin.

MS BERGIN: I call Mary Patetsos.

<MARY PATETSOS, AFFIRMED [3.55 pm]

<EXAMINATION-IN-CHIEF BY MS BERGIN

MS BERGIN: I just ask my learned friend to announce her appearance for the Commission.

MS T. BIRSS: Ms Birss, Commissioners. I act for Ms Patetsos, and I appear pursuant to leave granted, I believe, on the 16th of this month.

COMMISSIONER TRACEY: Thank you for announcing that appearance.

MS BERGIN: Operator, could you bring up document WIT.0084.0001.0001. Ms Patetsos, there should be a hard copy of your statement on the table in front of you and a copy of the first page on the screen. Is this your statement?

MS PATETSOS: That's correct.

MS BERGIN: Do you wish to make any amendments to your statement?

MS PATETSOS: No, I do not.

MS BERGIN: Are its contents true and correct to the best of your knowledge and belief?

MS PATETSOS: Yes, they are.

MS BERGIN: I tender the statement of Mary Patetsos, document WIT.0084.0001.0001, and the identified annexures.

COMMISSIONER TRACEY: Yes, the statement of Mary Patetsos dated 12 March 2019 will be exhibit 2-37.

EXHIBIT #2-37 STATEMENT OF MARY PATETSOS DATED 12/03/2019 AND IDENTIFFIED ANNEXURES (WIT.0084.0001.0001)

MS BERGIN: Thank you, Commissioners. Ms Patetsos, what are your professional qualifications?

MS PATETSOS: I'm a university trained social worker and I've got postgraduate qualifications in sociology.

MS BERGIN: What are your current professional roles?

MS PATETSOS: I am the chairperson of the Federation of Ethnic Communities Councils of Australia. I also hold a number of other non-executive director roles, some of which I've stated in the submission, including as chairperson of Aged Care Housing Group, which is an aged care provider in South Australia and Victoria.

MS BERGIN: And you are here as a representative of FECCA.

MS PATETSOS: That's correct.

MS BERGIN: What does FECCA stand for?

MS PATETSOS: FECCA is the Federation of Ethnic Communities' Councils of Australia. FECCA has been in existence for 40 years. We are a federation of over 30 other councils, State and Territory representatives and their affiliate members. So up to between 1500 to 2500 ethnic community groups form the basis of FECCA and our members are – so the governance arrangement is a federation, and I'm an elected chair. It's a voluntary role.

MS BERGIN: What is the focus of FECCAs work?

MS PATETSOS: FECCA – FECCA is the peak national body that represents people that are born overseas in countries where English is not the first language, representing CALD and linguistically diverse people. And we represent them in all aspects of their interests. So we will speak about their rights as citizens, their rights as permanent residents and we also represent them in areas of social policy, and aged care is a major part of our work. We do a lot of work in disability. We represent women who are at risk. And we also are very involved in ensuring that young people in new and emerging communities, those communities that have arrived in Australia recently, are able to participate actively in the Australian community.

MS BERGIN: You mentioned that FECCAs membership includes a federation of 30 other councils, State and Territory representatives and their affiliate members; could you please describe that further for the benefit of the Royal Commission.

MS PATETSOS: I will try to. So our federation has members from every State and Territory. So every State has a peak organisation who has a chairperson, they're separately incorporated associations. They have their own governance arrangements, so they have their own organisations, and it's their chairperson that sits on my board, and I am elected by that group of 30. Underneath them there are a number of ethnic community organisations so you would be aware of the Greek community of New South Wales, the Latvians of Victoria, the newly arrived Cambodian communities; so all those ethnic organisations that form to represent the communities are members of our State and Territory members.

We have also extended membership to regional and rural community groups so hence why there is more than the six states plus the territories because we have regional representation. So it is a true federation with a very significant base. So when FECCA speaks on behalf of our federation, we speak on behalf of the direct members and their affiliates. We consult with the entire base. And it is an organisation that has its origins in representing the community at a grass roots level.

MS BERGIN: Is it correct to say that the other groups that are members of FECCA are also incorporated organisations?

MS PATETSOS: That is correct and their role is often different from ours. We are actively involved in policy development and we do some advocacy as well. Their roles differ across the state and territories and the regions, depending on the locational needs that they have in their communities. And some of them are also providers themselves of aged care. So some of our members have provider status, both in home care, residential. So - - -

MS BERGIN: Thank you, Ms Patetsos, for that very fulsome explanation. Now, what is FECCAs role and what does its work involve?

MS PATETSOS: In aged care, so we receive Federal funding to undertake our work program, which is to ensure that the aged care system is cognisant of the needs of CALD older people and that we are able to provide feedback to communities about how the aged care system works, and much more importantly provide that back to government and also to providers. So we are able to provide data where it exists. We provide as much qualitative and quantitative data as is available to justify our positions on certain things and we also consult on behalf of government. So it's easier for consultations to occur with CALD communities through their own structures, and government often uses FECCA to undertake those consultations on their math.

We have worked over the years very closely with the department and that relationship has been one of equal respect and we have advocated on our community's behalf to the department and we work in a way that ensures as much of that information is listened to as possible.

MS BERGIN: What role does FECCA have in the trial of the system navigator?

MS PATETSOS: So the navigator trial is a recent announcement of government. The Federation of Ethnic Communities' Councils is a partner of the Council of the Ageing. We will be oversighting the roll out of the navigator pilots in a number of pilot areas, I think it's eight and they are CALD-specific. So we will be involved in that process. So it's an example of where a collaboration has evolved between COTA, the Council on the Ageing, and us to make sure that the navigator trial does pick up on specific needs of older people of CALD background.

MS BERGIN: Your statement at paragraph 18 is predicated on considerable consultations undertaken by FECCA. Could you please describe what consultations FECCA has undertaken in this regard.

MS PATETSOS: Sure. In this particular reference I was actually starting to refer to the document that I speak to, I'm not sure where it is, but it's the diversity framework one, I'm not sure what paragraph it was in; 15. So - - -

MS BERGIN: I might pause you to ask the operator to bring up that document, if that's of value. It's RCD.0011.0018.0001. Is this the diversity framework that you were just referring to?

MS PATETSOS: That's correct.

MS BERGIN: I tender that document please, Commissioners.

COMMISSIONER TRACEY: Yes. The Department of Health document entitled Aged Care Diversity Framework dated December 2017 will be exhibit 2-38.

EXHIBIT #2-38 DEPARTMENT OF HEALTH DOCUMENT ENTITLED AGED CARE DIVERSITY FRAMEWORK DATED DECEMBER 2017 (RCD.0011.0018.0001)

MS BERGIN: Ms Patetsos, you were just saying that in this particular reference in paragraph 18 you were referring to the diversity framework.

MS PATETSOS: That's correct. Well, we undertake consultations over a range of things, so in particular, the requirement to contribute to the diversity framework required us to go to all states, territories and regional areas and to discuss with older people of CALD background, what their particular concerns were in terms of accessing the aged care system both in terms of home care and residential. And how we could capture the gaps that they were experiencing, and some of the issues and problems that they had, that they were aware of themselves as people with lived experience or, in fact, their families and friends. So the consultations took three to six months.

I think three months was the collection of data and then another three months to pull it all together and it was probably one of the most extensive consultations that FECCA has done because we were so committed to making sure that the diversity framework which is now exhibited, would capture what needed to be – the stories that needed to be told as thoroughly as possible. FECCA has worked in this space for a very long time and there are many issues that we have been made aware of from our communities that we have highlighted both to departments and to peak provider organisations, like ACSA and LASA and the guild. We have raised many issues many times and it was FECCAs view that the preparation of the framework would provide us the best opportunity to capture those in one place, and to try again to get the needs of CALD people adequately addressed, properly addressed.

MS BERGIN: I might take you to the diversity framework now, Ms Patetsos. Operator, could you please bring up page 7 of the Diversity Framework, page 7 and page 8. If you could bring up page 7 on the left-hand side of the screen and page 8 on the other side of the screen. Thank you, operator. Ms Patetsos, could you please explain to the Commission the work that the diversity framework sets out on these pages.

MS PATETSOS: Yes, I can. So the diversity framework, once we achieved overall consultation, and I must point out at this point that the diversity framework includes other vulnerable groups. So at this stage the diversity framework includes communities from Aboriginal and Torres Strait Islander communities as well as LGBTQI communities. So the three groups work together. So we work together to identify from a human rights perspective what important outcomes we needed to identify to ensure that the aged care system became responsive to groups that were complex. And the column on the far left, the outcome for consumers, was that process of consultation condensed into what we believed to be a succinct range of outcomes that were critical non-negotiables to achieve for a consumer.

What we then identified were there were in fact responsibilities, and the top column is actually identifying who is responsible and we identified that government had a responsibility to make sure that it set up a system and it obligated the system to perform in a particular way and that that involved a legislative framework and regulatory framework that captured some of the obligations. That peak organisation, which is the aged care sector – the – ACSA, LASA and the guild as peak organisations that represented the system, had a responsibility that they were as responsible as the provider groups and that the providers themselves – mainstream providers in particular, were required to service 100 per cent of the Australian population. So 36 per cent of older Australians are born overseas in a country where English is not the first language. That's not three per cent; it's 36 per cent.

So the point of this is that 36 per cent of Australians who come in contact with aged care providers are a population. They're the people that we should be looking for. This is not an add-on. That it is core business for them and the fact that they failed to meet their needs is a significant shortfall. We then also thought that consumers and families and the carers and representatives, which includes ethno-specific organisations, had a responsibility to ensure that they also took responsibility for their own care. So if something was inadequate, not good enough, that they were able to report it and that ethno-specific organisations are members, took that responsibility seriously and worked through FECCA to continue to put pressure on the providers, the peaks and government.

MS BERGIN: Just to draw out perhaps a couple of outcomes for consumers from this table, operator, could you please zoom in outcomes 5 and 6. Could you please explain, Ms Patetsos, further for the Royal Commissioners, what outcomes 5 and 6 are directed towards?

MS PATETSOS: So – yes, I can. So it's very difficult for someone who is an elderly person who is suffering from dementia, who is losing language, so for many people in their late 80s and early 90s and late 90s who are suffering from dementia, English loss – loss of English is a very key phenomenon of that disease. So it's a medical condition and one of the symptoms is that you lose the things that you learnt last in life. So you basically could have been, in your 50s and 60s and as a younger working adult, totally capable of communicating in English, and by the time you are elderly, you may not be. So respectful and inclusive serves, it's our premise that you can't actually deliver a service for someone who has lost language as a result of degenerative disease unless you have effective communication tools. And by that we mean interpreters, use of material that allows communication, bilingual and bi-cultural staff.

It's not reasonable to expect someone who has lost language capacity to be cared for by people who they can't understand and it's not reasonable to expect that person to depend on their family to interpret for them. So I use that as an example in terms of respectful and inclusive because it is the most obvious example. But, of course, there are many other examples of how a service can fail to meet the expectations of an individual. Consumer directed care focuses on the individual. As individual, we are

the components of parts of us that include our culture, our language and our faith. And to try to ignore that or not focus on that for people of CALD background defeats the very purpose of consumer directed care in the first place.

COMMISSIONER TRACEY: What does culturally safe mean in the context of paragraph 6?

MS PATETSOS: So cultural safety is a concept that's used across the groups that we're talking about, as the place where people feel that they can exercise who they are freely. It's a concept that was actually introduced to our thinking by the representative from the LGBTQI community who referenced very clearly that many people who are, who identify as LGBTQI struggle to live that through their aged care experience. So it was a concept that we picked up and we also acknowledge that for some people of CALD background they will accept anything that is given to them because they are in vulnerable positions. But in fact if they had their choice, they would – services to them would be delivered very differently.

So they don't feel that they can express themselves either because of cultural differences, language or in fact faith differences. And so they just deny that of themselves. So they accept the norm because they don't think it's safe to say, well, I actually would like it differently. One of the reasons for that is that their engagement with aged care is unknown to them. They don't know that they can ask. So they don't understand their own – they don't understand the rights that they have and that they can ask for things to meet their specific needs. They're vulnerable and they are the least likely people to complain, which I think I've spelt out. And also the least likely people to ask for things to be done differently. So that's what we mean.

COMMISSIONER TRACEY: Thank you.

MS BERGIN: Operator, could you please turn to the foreword page of this document. And could you please zoom in at point 7 and the content below that. Ms Patetsos, you mentioned that this report was, or this framework was the work of a number of different groups. Are these the groups identified here?

MS PATETSOS: Yes.

MS BERGIN: So each of those groups had input into the diversity framework; is that right?

MS PATETSOS: That's correct.

MS BERGIN: To that extent, as you explained, it's a diversity framework applicable to CALD groups but also more broadly to other special needs groups as defined by the Aged Care Act is that right.

MS PATETSOS: That is correct. And Senior Rights Service and Australian Association of Gerontology were there as experts who had a capacity to research and

to provide some insights into complaints processes. And we are currently – the framework has currently moved on from the three groups that it has dealt with to now look at homelessness and those that suffer from lack of socioeconomic capacity. So we have now moved on to the work to do with capacity to pay as a pressure, and also the lack of housing for some older people.

MS BERGIN: Thank you, Ms Patetsos. I now want to turn to the topic that you have mentioned already in your evidence and that is the topic of data. You mentioned in your statement at paragraphs 18 and 20 that there's a lack of accurate data about CALD groups. What data is available and what limits does the data have?

MS PATETSOS: The lack of data is a critical factor in determining whether older people of CALD background are actually using the aged system. So it's baseline data that we can't get access to sometimes, and sometimes it just doesn't exist. So the data that is available is obviously through the ABS. I know that My Aged Care collects some data which is very difficult to access and the department obviously has some data as well. The extent to which providers collect data is hard to track and, in our mind, the lack of data basically points to us being unable to capture exactly what is the percentage of older people who are using the aged care system accurately.

We know in NDIS that there is very low uptake of NDIS by CALD consumers. We think it's a bit better in aged care but we believe that that's probably the case of necessity rather than the system opening itself up to older people, you know, in a way that works for them. It's just that the need is there.

MS BERGIN: You say that's driven in part by market forces?

MS PATETSOS: That's correct.

MS BERGIN: Operator, could you please bring up document RCD.9999.0026.0001. Could you please highlight or bring up the first point 5 of that page. Ms Patetsos, I'm going to ask you to explain this summary of the census data which I understand you or someone for you has prepared.

MS PATETSOS: Yes. So, basically what it says is that – it exactly goes to the point that we understand once we analysed the data that 36 per cent of older people from CALD background are born in countries that don't have English as a first language. The breakdown of the data here is that the RoGS, the government data, it does not reflect what we believe to be the case. So there is a gap between what we are seeing as government collected data so that we can compare total population at ABS with usage of services by certain community groups. So we know the Department of Health struggled to collect CALD data, and that's reflected in this summary.

MS BERGIN: Just to step through that, the data collected by the ABS, is that based on where the person completing the census form – does that ask where the person completing the census form was born?

MS PATETSOS: Yes, it does.

MS BERGIN: What are some other criteria of CALD indicators that might be appropriate for data to be collected about?

MS PATETSOS: Well, preferred language is the most important data piece that we require because your place of birth indicates exactly that. And your language, preferred language, by the time you are 87 may be completely not related to your place of birth. So it's difficult to match data and then match needs because the data is not fully available and the data has gaps in it.

MS BERGIN: So to the extent that someone might have been born, for example, in Australia but speak a language other than English as their first language; is that data collected by the ABS?

MS PATETSOS: Born in Australia and speak a language other than English at home? It does collect that. But the bit of data that's needed from the system is preferred language. I mean, to point, you may have learnt German at school.

MS BERGIN: I did learn German at school.

MS PATETSOS: You know that, and you may prefer speaking German. When you are elderly, you may be quite happy to use English as your first language, so it's preferred language at that point in your life.

MS BERGIN: Now, you mentioned the statistic of around 33 per cent or 36 per cent of the total Australian population being born overseas earlier in your evidence.

MS PATETSOS: Yes.

MS BERGIN: And that's borne out by your summary, and is that statistic derived from the 2016 census data?

MS PATETSOS: It is, '15, I think it is, 2015.

MS BERGIN: 2015. Thank you. I just want to ask you to explain, please, your table 2.

MS PATETSOS: So this is direct from the ABS. So it's Australia's top 20 overseas-born population, so basically there are a total number of 509,563 people born in China, which is two per cent of the total born overseas. Over 65, you get a number there, and at the percentage of that population group over the age of 65 by country of birth and it goes down, yes.

MS BERGIN: So to give an example, looking at the Italy row, it says 114,070 people over 65. That refers to, that number describes the number of people born in Italy who are over 65, is that right?

MS PATETSOS: That's right. So a lot of the northern Europeans, which would have arrived between the wars, and a lot of the southern Europeans that arrived after World War II are now ageing and they're a very ageing population, and it's those communities that are very high numbers and it's those communities who have significant care needs that need to be addressed. And slowly that will feed through to, you know, so we will soon be seeing higher numbers of people that arrived post-Vietnam and from South-East Asia. So it basically follows Australia's migration patterns, and you will get that sort of ebbs and flows of numbers.

MS BERGIN: Thank you, Ms Patetsos. Operator, could you please bring up table 3 in that document. Table 3 is headed "Established Communities Tend To Have A Higher Proportion Of People Aged 65 And Over". Could you please explain that proposition for the Royal Commission.

MS PATETSOS: Well, if you take my own community, so there's a total number of people born overseas, and then as you go across the total percentage of that in terms of over 65 is 62,585. And then the total percentage of the group by country of birth is – so you see that the Greek community that arrived after World War II has a significant proportion of people that are ageing at the moment and that their care needs will probably peak in the next 20 years, and as their generation, the children who are bilingual and speak English relatively well, they may be – identify still as of Greek descent but their language and cultural needs will be different because they're mostly born in Australia. So it follows, as I said, migration patterns.

MS BERGIN: Migration patterns. So, Ms Patetsos, taking that example of your ethnic group, is a correct interpretation of the first row that 66.8 per cent of Greek people living in Australia who were born overseas are over the age of 65?

MS PATETSOS: That's correct.

MS BERGIN: Now, at the foot of that document - - -

MS PATETSOS: So if I could say something, sorry. So that would mean if we go back to my previous point that for mainstream providers, this group is their client base. So we're talking about significant numbers. So when we ask them to reflect seriously on how they provide care for this group, it is because the numbers are very important and are not an add-on to their business. It is their core business to do this.

MS BERGIN: So this information is important – as important for providers as it is for government to understand the client base of approved providers?

MS PATETSOS: Yes. Because if we have a consumer-directed care system that is a market-driven system and these numbers reflect the market, and the consumer profile, then if you are a business and you're not addressing their needs, then surely in a real competitive market, they would not be your customers. They would go elsewhere. But we know in aged care where people are vulnerable and the market is not perfect, then people have less choice than we believe them to have. We also

know that while at 65 they may be rational consumers because they are still going on overseas holidays and having a relatively good time, by the time they're 88 and vulnerable with dementia, the rational consumer in them disappears and we have far less capacity to make choices at that age.

MS BERGIN: Now, at the foot of that table, you've got a reference:

Notable exceptions are Vietnam, China and India.

Are those percentages the percentage of total that are overseas born? What do those percentages represent?

MS PATETSOS: That is a very good question, not explained well here by my staff.

MS BERGIN: Would you prefer to come back to the Commission at a later date?

MS PATETSOS: Yes, I would prefer to get it correct rather than take an educated guess.

MS BERGIN: Thank you, Ms Patetsos. Now, turning to table 4, newer and emerging communities tend to have a lower proportion of people aged 65 and over. Could you please explain table 4. Operator, are you able to bring up table 4 on the screen? Do you have a copy of table 4 before you in the witness box, Ms Patetsos?

MS PATETSOS: No, sorry, I don't. No. I've got about everything else.

MS BERGIN: Perhaps we can come back to that if there's a technical problem.

MS PATETSOS: I could probably speak to it without speaking to the numbers. Okay. Yes. Sorry, could you repeat the question?

MS BERGIN: Yes, certainly. So the heading is Newer And Emerging Communities Tend To Have A Lower Proportion Of People Aged 65 And Over. Could you please explain this table for the Commissioners.

MS PATETSOS: Okay. So many of the communities that are on the left-hand column that was on your screen are new arrivals. So they arrived in Australia in the eighties, nineties and 2000s. They arrived as young refugees or as skilled migrants and they arrive as young family members and they do bring older family members out. But the numbers are relatively small. The point with the table is that while their numbers are small, they will be coming through as older people in time but also that there are numbers of older people over the age of 65 in those communities and that these smaller communities have very little support. So while the larger post war communities have very sophisticated community organisations that assist them to bridge the gap between themselves and the aged care system, these communities have very little community infrastructure.

So the older people from these communities, while their numbers are smaller, their need is greater because they're new arrivals, their English is probably poorer and they don't have the community supports and infrastructure around them that may facilitate their care.

MS BERGIN: Ms Patetsos, is this summary based on country of birth data obtained from the ABS 2015 census?

MS PATETSOS: Yes, it is.

MS BERGIN: I think you mentioned earlier in your evidence that preferred language is another measure of CALD criteria.

MS PATETSOS: Yes.

MS BERGIN: How does country of birth data underestimate CALD groups and their presence in the aged care market?

MS PATETSOS: Well, country of birth – like all statistics, you need to look at the range of indicators to get a full picture of a community. So you would look at country of birth. You would look at preferred language. You would look at faith identification. And have – that would give you a more complete picture. In the time that we were able to put this together, we used one indicator only. It was also the only one that mostly was used by government. So we were most able to equate figures with figures. So the preferred language is critical because of the point I made earlier, which is that if you can't meet people's communication needs, it's a fundamental issue that you need to do and achieve before you can actually then go on and address anything else. So we would prefer to use preferred language.

MS BERGIN: What are the main barriers for making progress in this space for aged care client records and other health and human services sectors?

MS PATETSOS: Look, it's an – collection of data is an issue because there's issues of privacy and people wanting to identify or not. So we are very firm of the view that, and it's often put to us that the reason why this data is not collected is to protect the consumer's privacy and their right to not identify. I have put to the department often and providers that the collection of data, if explained to a consumer that it's de-identified that it won't be used, etcetera, etcetera – often, people absolutely agree to provide data. If you don't explain it and you simply, sort of, put a form in front of them, and you give them an option, then, mostly, people don't fill that – that form out correctly. We're like – we are like that, and, no doubt, families and consumers are exactly like that. So I would say that to – to provide a system and to understand – that – that works and to understand how it works, the provision of adequate data from the ABS through to anything that government can collect through to the providers is essential. Because, without it, we don't know who is there and who is not.

MS BERGIN: So given that, what are the limits of research into ageing and data collection by researchers and how is this significant to the issues before this Royal Commission?

MS PATETSOS: One of the key concerns I have in my work with the health care system and it's not – it is the same in aged care, is that often consumer – research into the needs of older people excludes people from CALD background. It is more expensive for a researcher to research someone with an interpreter than without, and so much of the research that's available, which is why FECCA has undertaken it ourselves – and even the university research is limited, and the limitation is sometimes specified and sometimes it's not, is limited by a lack of data that includes CALD people. So the health and wellbeing of CALD people in – in most research is not included as part of the – the sample. So when you read a bit of research on health outcomes, that group of people, so 36 per cent in the case of aged people and 30 per cent in the case – case of health research, does not include any information on the health or wellbeing outcomes for CALD people.

MS BERGIN: So does this mean that we don't know, for example, if the policy impacts reform are different on CALD people as opposed to the general population?

MS PATETSOS: That is – that is our view.

MS BERGIN: And would that also apply to the question of whether they sign up for end of life care or other - - -

MS PATETSOS: Absolutely, yes. So we – we just don't know.

MS BERGIN: Now, turning to the topic of access, how is access a specific and, perhaps, a special issue for CALD groups?

MS PATETSOS: Well, I think access to the system is complicated for everybody, particularly those who are unfamiliar with it and who don't have English as a first language. There has been significant amounts of discussion between FECCA and the National Aged Care Alliance with the department on the adequacy of My Aged Care as a point of access for older people, particularly for those who don't have English as a first language, so – and who are not computer literate and who are not comfortable working through a portal. So it would not – misstating this would not be a surprise to anyone.

MS BERGIN: You mentioned the use of interpreters. How often are interpreters used in the provision of aged care services?

MS PATETSOS: It's unknown.

MS BERGIN: So - - -

MS PATETSOS: So do you want me to expand on that now?

MS BERGIN: Please expand on that. Thank you, Ms Patetsos.

MS PATETSOS: Okay. So – so the use of interpreters would be in that natural thing that should occur. So if we place ourselves in an overseas context, if something was to happen to our health and the place that we were injured did not have English as a first language, we would need access to some communication with the care provider. So that knowledge about us being unwell overseas does not translate when we come back to Australia because the use of interpreters by – by aged care providers, it appears, from anecdotal evidence that we collect through consultations, to be very low, incredibly low. So the reasons for that are complicated. We – we fail to understand the importance of language and the right of someone to understand what's required in their care, for them to understand what it is that they're receiving and what their options are. We also make the use of interpreters complicated and unclear about who bears the cost of it.

So it is our view that communication is a basic human right, and that all people should have access to some form of communication that ensures that they understand entirely what it is that is occurring to them and that they are able to explain to the system where their needs lie, and that that cost ought to be borne by us as a society. It should not be at the cost of the individual to supplement the gap, and it should not be at the cost of the provider because that opens – opens up for the consumer the risk that the provider can choose not to expend that money. So if we take a step back from that, the right to have interpreters should be critical and – and it is my view, and it's a view that comes through the framework and, actually, the action plan, that – and the single quality framework that the lack of use of interpreters should actually, if it's evidenced by the quality standards, that it should actually lead to – to a not meet of a standard. It is the most fundamental. Everything flows from that.

MS BERGIN: So just to tease that out a bit further, "Everything flows from that." So let's take a couple of examples. Might the reporting of elder abuse be one risk?

MS PATETSOS: Absolutely.

MS BERGIN: And are there consequences for isolation, feelings of isolation?

MS PATETSOS: So the consequences for the individual of lack of communication is that they have very limited power to create a situation for themselves where they are safe. So they are unable to communicate to the provider, to the – to the – to the external system and to the world beyond that – complaints, providers or creditors or whoever has come through. So – so – so – so the use of an interpreter to ensure that a person is able to communicate helps to alleviate the risks that you're identifying which is low complaints, isolation, feeling that you don't have choices, staying in a place that's unsafe, etcetera.

MS BERGIN: I might ask you to tease that out a little bit further with me for the benefit of those of us who might not have as much experience with CALD groups. Would this extend to choices such as what food you might prefer to be eating?

MS PATETSOS: Yes.

MS BERGIN: Yes.

MS PATETSOS: Yes, because if you are – if you are not shown the respect of being given a means of communication, you're – you're immediately messaged that things that are lesser value are completely irrelevant. So if you are in an organisation and there is no way of communicating, it is unlikely that you will skip to that to worrying about what you are going to eat for dinner because you will have bigger problems that you'll worry about which is not understanding what is happening to you. So, absolutely, it goes to the Commissioner's point earlier about what cultural safety is, and cultural safety is knowing that you can speak your language and someone will understand you, and that you can then organise your life in a way that meets your needs, and that includes the food you prefer to eat and the way in which you like to, you know, experience your faith or, in fact, the way in which you would like to die.

MS BERGIN: So is it appropriate, for example, for us to think about – when you say the risk of not knowing what's happening to you, would it be appropriate to draw an analogy with being in hospital in a country where you don't speak the language and you need medical attention?

MS PATETSOS: Yes, absolutely. And – and if I can say that, even in that situation, most people are not suffering – so the – the highest area of growth and highest risk are those suffering from dementias. So – so – so the dementia plus the lack of communication, basically, is a – is a fire storm for those people because the confusion that goes with that, you know, with dementia plus the capacity – the loss of capacity makes them incredibly vulnerable.

MS BERGIN: Now, you also mentioned isolation. How else might isolation have a particular bearing on people in receiving aged care services who are from CALD backgrounds?

MS PATETSOS: So – so the isolation is self-explanatory, at one level. The other impact it has is that it creates an environment where, if there is issues of abuse or lack of care, there is no one – there's no set of eyes over it. So people of CALD background who have their friends pass away or distance makes it difficult, are often trapped in their home, and in a home care environment where the care provider knows that that individual is isolated, extremely isolated – not marginally so, but almost 100 per cent reliant on a caregiver, the capacity for that to expose an individual to risk is enormous. So isolation is very sad. On its own, that itself is not good, but the isolation that creates the potential for victimisation or abuse is more than sad. It's actually a high risk for the entire sector.

MS BERGIN: So to further understand this, do people from different backgrounds have different understandings of government and government services and people in professional roles?

MS PATETSOS: Yes, they do because they're often – they're often fleeing countries where government has not been trusted. It's the reason they've left in the first place. And so their – their interpretation of the role of government is very different, that they – they are afraid of complaining because they're afraid of losing everything that they are getting. So you get this – this sort of – this affect which is that they are needy, that they are dependent, that they are vulnerable, and then you get this situation where they will not complain because if you complain, then you're likely to get nothing so - - -

MS BERGIN: How can the reform of the system being considered by this Royal Commission address the issue of isolation of CALD groups?

MS PATETSOS: So while – while reform of the system has gone on for some time, this Royal Commission, I am hoping, I am very hopeful, will provide the platform for some significant in principle relook at the system. So, in some ways, aged care is reform exhausted and, in many ways, we have set it up so that it suits the generation that is coming through, rather than the generation that is there now. It's almost like we're trying – generation X is trying to sort it out for themselves, rather than looking after those that are frail at the moment. I – I'm heavily invested and keen to – to point out that one of the key elements that I believe continues to protect CALD providers is the ethnic community groups and the CALD consumer groups that represent them and provide a bridge between them and the bigger system of mainstream providers.

So mainstream providers are not uniform. Some do this very well and some do not. While they all catch up to do it well together, the availability of CALD providers that provide programs, like the Commonwealth Home Support Program and other programs that bridge a CALD vulnerable person to the system and act as advocates and navigators for CALD people who can pick up the phone, who can navigate the portal on their behalf, and who can communicate to family about what is going on, and who can do that in – who are bicultural and bilingual.

So while the system is sorting itself out, the important role of those CALD providers and ethno specific providers must be highlighted because as the system – as aged care consolidates and we get the bigger players, those that are publicly listed companies, and the very little providers who don't have any infrastructure, trying to service a community, those community based organisations that are set up and who give voluntary hours by the bucket load to make sure that their communities are well looked after, must stay in place. It is, in my view, that any decision by government to streamline services in any way that takes away their capacity to look after their communities would be highly risky.

MS BERGIN: So turning, then, to the role of providers and cultural awareness, to what extent are providers aware of cultural needs of older CALD people?

MS PATETSOS: It varies. So the truth is it would be unfair to say anything other than it varies. As I said, some providers attempt to do this really well and other

providers do not. There is one thing that absolutely needs to be understood, is that undertaking a care plan that identifies language and cultural differences with no actions attached to it is not good enough. So, often, it's pointed that care plans, an individual care plan, is the way in which CALD consumer needs are looked after. You know, someone says that person prefers Italian; it's written down; that they prefer to eat this is written down. And then the accreditation or the quality standards people come through, they see some signal of that, and it's almost like it's a box ticked.

There is no evidence to say that what is written in care plans is the experience of older people. So – so their awareness between – so then it's done to meet the standards and to tick the box. It's not actually making a difference on the ground. The other thing that's really important is that My Aged Care, as a website, as a portal, needs to be very careful that it doesn't overpromise and under deliver. So one of the big things that we have identified is that My Aged Care providers on My Aged Care are saying that they can do a lot, almost everything. It's a little bit like going on looking for a hotel, it says it has got a pool, but when you get there, it's not too crash hot. So My Aged Care needs to clearly identify any capacity that a provider is saying it can do via My Aged Care. After all, it is a government – government website. So when providers tick things, people think that it's real. The inadequacy of that website to accurately defend – reflect capability in a provider is critical.

MS BERGIN: What training is offered by providers to workers, if you're aware of it, about CALD needs of older people and, again, this is something that might differ across the sector.

MS PATETSOS: It is. So – so – so some providers provide some cultural sensitivity. Others may do nothing.

MS BERGIN: What training is available for providers on the topic of quality and safety of aged care service delivery to CALD people?

MS PATETSOS: So providers can bring in specialists that can do that type of training. The Commonwealth has funded PICAC which it partners in culturally – I've always called – I've called them PICAC for such a long time. They has – they have got a bigger, sort of – someone can look that up. PICAC is what we call them.

MS BERGIN: We can look that up. We can look that up. Thank you, Ms Patetsos.

MS PATETSOS: We can – you can look that up because it's one of those acronyms that I have now forgotten what the original was. So the PICAC provide support to mainstream providers to ensure that as much as possible is done for CALD consumers. So they're a federally funded program and do that to the best of their ability given the resources that are available to them.

MS BERGIN: What are the – for someone researching the market, either for their parents or for themselves, what are the indicators or are there any indicators that a provider has expertise or cultural sensitivity?

MS PATETSOS: So the key indicators, of course, is – is a recognition that workforce matters. So if you have – if you say that you are able to look after a particular group, that you have some – made some attempt to match the workforce with that group's needs, evidence of training of staff, evidence that there is a capability in the management, a board – board commitment. So the organisation's governance structures reflect a commitment to diversity, an investment in diversity which includes putting in resources to ensure that community groups are catered for. So there's a – there's a – there's a range of indicators that highlight good practice versus poor practice versus no practice.

MS BERGIN: So once an aged care recipient finds an aged care provider that understands their cultural needs, if they have issues in the service, what are the risks of that? Are there special circumstances that apply to CALD people?

MS PATETSOS: So CALD people face two risks. They face – they face a decision in home care to perhaps go to a CALD specific provider, someone who speaks their language and can meet their needs. If that works for them, that's great. When it doesn't, it creates an environment of a very thin market. So if you happen to only speak Latvian, and the Latvian service is not meeting your needs at all well or, in fact, is putting you at risk, your choice of where you go next is very thin, in that, you then have to think about what your options are. So you're more likely to stay with that provider, so you're trapped.

The other side is that if you go to a mainstream provider and the provider is not meeting your needs, but is actively marketing to you and you don't feel you have a choice, then you stay there as well. So what we do know is that there's data that does show very little movement between providers. So once – once you're somewhere, you're likely to stay there. It's only the very well informed consumer that makes decisions about moving provider to provider. So I would say that consumers and their families need to be made aware that their package is mobile with them, and that they can move safely from a place that they are unhappy to a place that is better for them. That's not happening to the degree that it should be.

MS BERGIN: Ms Patetsos, you mention at paragraph 70 of your statement that there's a misperception in the general community that people from CALD backgrounds are not wanting or needing care because they prefer family care, and the reciprocal that there's a misperception that white Anglo-Saxon people don't look after their families and ethnic families do. Could you please explain that further to the Commissioners.

MS PATETSOS: So, for some time, there was a view that – you know, traditionally. It was traditional that families of certain backgrounds would all look after – you know, the extended family was in place and everyone was happy, and that

these Anglo-Saxons, well, they just don't do that. That's why they need nursing homes and we don't. None of that is true. There's no other way of explaining it really. So older people are looked after by families across the country and they do the best that they can, and when they become more vulnerable, their experiences of their family supports and everything that happens to them is not specific and not identifiable by ethnic group. That there is as many people caring for people from every background. It – it serves a purpose to perpetuate that myth to basically say, look, the system didn't need to accommodate for them because they were looking after themselves. There is – it has happened to them as has happened to everybody else that women are now actively working and the caregiver framework has – requires a look at because it's not there for everybody, not just them.

MS BERGIN: Ms Patetsos, what can this Royal Commission do at this relatively early stage of hearings to ensure that CALD groups needs in relation to aged care quality and safety is heard during the forthcoming hearings.

MS PATETSOS: So I thought about that a fair bit and I take – I mean I – I thank you for the privilege of being able to represent the communities that I do here today and – and – and hope I've done them justice. I also don't think there is one point of truth, nor do I think that it is good enough to hear from one entity only. I encourage the Commission, wherever possible, to get people with lived experience and community members themselves to speak to you because I think that adds weight to what we have to say. And to also ensure that, where there is opportunity to do that in languages other than English, that that is enabled. Even myself, I could see the difficulties of finding a consumer voice here, and I just think it's really important because without that, all I can provide is the experience I have as a professional person in the space.

MS BERGIN: Thank you, Ms Patetsos. Before I deal with just a couple of small administrative matters, was there anything further you wanted to say to the Royal Commission in conclusion?

MS PATETSOS: I do, and it is in my – in the – in the submission statement, I do want to point to the Commissioners – point out to the Commissioners that the issue of CALD workforce is touched on. What we do know is that an increasing number of people in the lower paid jobs, in the workforce, aged care workforce are people from CALD background. It's very important to recognise that for these people they are filling – they're Australians. They're filling in work that other Australians won't do, and that's why they're so heavily represented.

It's – the aged care workforce is not necessarily an attractive place for – it's not an option that attracts many young people. So the workforce is incredibly diverse, and I would encourage a look at that workforce and the training of that workforce and capability of that workforce, and I dare say also that that workforce probably, well, I shouldn't – that workforce experiences levels of racism for a variety of reasons that are complex, and working conditions that are poor. It's a very vulnerable group of people, but as FECCA, we represent consumers, but we also represent the many

community – younger community members that are – that are the workforce of the aged care sector. So I just would like to point that out to you.

MS BERGIN: Thank you, Ms Patetsos. Now, my instructing solicitor has passed me a note that says Partners in Culturally Appropriate Care. Is that PICAC?

MS PATETSOS: That's the one.

MS BERGIN: That's the one. Thank you. Now, finally, you mentioned the 2016 census data, and I have been provided with a link. Operator, could you please draw up RCD.9999.0025.0001. Thank you, Operator. If you could turn to the third page, please. If you could zoom in at the start – at the top of that page, the country of birth data. Now, is this the data that – in part, was this part of the data that you were drawing upon in your summary table that I tendered earlier, Ms Patetsos?

MS PATETSOS: That's correct.

MS BERGIN: I tender the ABS2016 Census Quick Stats.

COMMISSIONER TRACEY: Yes, the ABS – did you say 2016?

MS BERGIN: It's headed 2016 Census Quick Stats. It may be that the data is drawn down from the 2015 census and the summary was prepared in 2016. Operator, could you please go to the first page of that document?

COMMISSIONER TRACEY: Yes. That – so – yes. It is 2016 census. So I will simply identify the exhibit as ABS2016 Census Quick Stats, and that will be Exhibit 2-39.

EXHIBIT #2-39 ABS2016 CENSUS QUICK STATS (RCD.9999.0025.0001)

MS BERGIN: Thank you Commissioners. Commissioners, that concludes my examination of this witness.

COMMISSIONER BRIGGS: Ms Patetsos, thank you very much for your very interesting presentation. In earlier evidence before the Royal Commission, we've heard some suggestions, and I'm not sure whether you know whether this is true or not, that the CALD communities have focused their attention often on CHSP services, as well as residential care, but there's a gap in service provision in this area around home care packages; is that correct?

MS PATETSOS: That's correct.

COMMISSIONER BRIGGS: Okay. And is that because there hasn't been sufficient engagement with the communities by the government to see that kind of sponsorship emerge, or what would be the reason for that?

MS PATETSOS: I think that's exactly right. I think that – that moving to the packages is a elevated level of involvement and understanding that is absent and requires – is often triggered by – by – by assessment requirement that – that means that people have got to get through to a medical system before they are actually accessing packages. So I do believe that the packages are harder to access for communities. They're less understood, and for many community members, the waiting lists have made them unable to access them in a timely way and also place many on packages that are lower than their actual needs which is a phenomenon across the – across the sector.

COMMISSIONER BRIGGS: This is something I probably should know, but I don't. Does My Aged Care have an automatic language interpretation on the screens?

MS PATETSOS: I don't actually know the answer to that directly. I believe that it does, but I've never gone through it myself to test exactly how it works. If I had my CEO here, they would be able to answer that question.

COMMISSIONER BRIGGS: I will do it tonight.

MS PATETSOS: Yes, yes. No, I will – I will too.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Nothing arising?

MS BERGIN: Nothing arising. Thank you, Commissioners. May this witness please be excused.

COMMISSIONER TRACEY: Yes, thank you very much for your evidence. We are most grateful, and thank you for travelling the distance you have to come and give it to us.

<THE WITNESS WITHDREW [5.00 pm]

COMMISSIONER TRACEY: Thank you. Are there some administrative matters?

DR McEVOY: Just very briefly, Commissioner. You will recall that we discussed earlier during the examination of witness BC the desirability of preparing a list of documents to be tendered. That has now been done, and I will have my instructor hand up to you, Commissioners, that list.

COMMISSIONER TRACEY: Thank you very much.

DR McEVOY: Commissioner, you will see that the relevant documents to which I took the witness are listed in the order in which I took her to them, beginning on page 1. If you go to page 2, you will then see a list of four documents that were the subject of a Commonwealth tender. There are, then, a series of about half a dozen documents which I didn't squarely put to her, but which involve her and are relevant. For the most part, they are Commonwealth documents. You will see at the bottom of page 2, her organisation's application for approval. Going over the page, further regulatory documents, an email at the bottom, and then the second last document is one of the invoices that are relevant. We have sought to include those in the tender, if that's convenient, Commissioner.

COMMISSIONER TRACEY: Yes. Thank you. Well, I'm not going to read out, individually, each of these documents, but the sequential numbering will start with the first document identified on the first page, the letter from the Department of Health to BC titled Application for Approval as an Approved Provider dated 5 May 2017, which will be Exhibit 2-40.

EXHIBIT #2-40 LETTER FROM THE DEPARTMENT OF HEALTH TO BC TITLED APPLICATION FOR APPROVAL AS AN APPROVED PROVIDER DATED 05/05/2017

COMMISSIONER TRACEY: And the numbers will run sequentially from there until the last document.

DR McEVOY: Thank you, Commissioner. The only other thing I should say about this is that some of these documents require redaction before they will be publicly available, but that will happen in the coming day or days.

COMMISSIONER TRACEY: Yes. Now, before we forget about it, what about Mr Holmes' documents?

DR McEVOY: Yes, we are still dealing with Mr Holmes' documents.

COMMISSIONER TRACEY: A work in progress.

DR McEVOY: That's a work in progress, and we will try and do that first thing in the morning.

COMMISSIONER TRACEY: Very well. No other matters for this evening?

DR McEVOY: No other matters, Commissioner, no.

COMMISSIONER TRACEY: Yes. Well, I thank all involved, particularly the staff have been kept well beyond the normal hours, and it was important that we get through as much evidence as we could today and we have achieved that. The Commission will adjourn until 10 am tomorrow morning.

MATTER ADJOURNED at 5.04 pm UNTIL THURSDAY, 21 MARCH 2019

Index of Witness Events

Index of Exhibits and MFIs