Royal Commission into Aged Care Quality and Safety

Submissions on Brisbane Hearing:

Earle Haven Case Study

By the Commonwealth

4 September 2019

BRISBANE HEARING – SUBMISSIONS OF THE COMMONWEALTH

EVIDENCE IN RELATION TO THE EARLE HAVEN CASE STUDY

1. The events of 11 July were exceptional circumstances, which were distressing for those involved and presented a risk to the wellbeing of the residents of Earle Haven.

2. At its core, the Earle Haven events concerned a private commercial and contractual dispute involving an abrupt and disproportionately drastic cessation of vital services. It is also the case that more integrated regulatory oversight with greater information sharing between and within the Commission and the Department, would have increased the likelihood that the risks associated with the approved provider, given in particular the business model that they had adopted for the delivery of care and support to residents, may have been reasonably anticipated and prompted further investigation. It follows that such oversight would have provided more opportunity for a different regulatory response.

3. That such an incident should come to pass in what was the home of a large number of vulnerable people is highly regrettable, and the Aged Care Quality and Safety Commission (**Commission**) and the Department of Health (**Department**) acknowledge to those residents and their families the impact on them, including the distress and the significant disturbance to their lives. The Department and Commission[1] offered immediate support to residents and their families including:

   (a) supporting the Queensland Department of Health find suitable alternative accommodation for residents;

   (b) conducting welfare checks for residents to address their individual concerns;

   (c) setting up an emergency hotline to provide information regarding the incident for residents, their families and carers, and the general public;

   (d) appointing two nurse advisers to People Care in order to provide clinical support to the relocated residents and to assist with the relocation process to permanent alternate locations, which is still ongoing. The nurse advisers commenced on 12 July, and a nurse presence will continue until all residents have been permanently relocated;

   (e) appointing six social workers to provide reassurance and support to residents and their families immediately following the incident;

   (f) conducted two residents and relatives meetings; and

   (g) provided weekly updates to residents and relatives about the status of People Care and their Earle Haven facilities.

[1] Unless otherwise stated, a reference to the 'Commission' should be taken to include its predecessors.

History of engagement with the approved provider

4. The Commission and the Department had a history of sustained engagement with this approved provider. As is identified in Counsel Assisting's submissions, the Commission and the Department took regulatory action throughout 2016 and 2017 as a result of the approved provider's failure to comply with the Accreditation Standards and the Home Care Common Standards for their residential and home care services. Counsel Assisting accepts that the Commission's and the Department's level of regulatory scrutiny until June 2016 was appropriate.[2] In December 2017,[3] following the approved provider's return to compliance, it was removed from the Commission's and Department's monitoring lists.

5. It is submitted that regulatory scrutiny of the approved provider continued through reviews and assessments by the Commission and the Department and did not functionally diminish following the removal of the approved provider from the relevant monitoring lists in December 2017.[4] Such reviews were undertaken on a regular basis and there were six reviews or visits by the Commission over 18 months. Details regarding these reviews or visits are included at **Annexure A**.

6. The Commission's and the Department's compliance functions are primarily focused on ensuring the care and well-being of care recipients and in particular, the quality of care that is provided to care recipients. They are not overly preoccupied with minimum standards and procedural steps with managing approved providers back to compliance 'at all costs'.[5] In determining what actions are appropriate, the Commission and the Department consider not only quality and safety issues, but also the disruption to quality of care that would occur when a service's approved provider status is revoked.[6] In particular, the Commission and the Department are aware that the closure of a residential aged care service would require moving frail elderly people and note that trauma and disruption from relocation increases the risk of adverse events.

7. The Department and the Commission therefore assess and implement compliance action that is proportionate to the risks identified and the responsibilities of approved providers under the *Aged Care Act 1997* (Cth) (**the Aged Care Act**) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) (**the ACQSC Act**).[7] The Commission's and the Department's focus is on putting arrangements in place that rectify non-compliance, help protect the safety and wellbeing of care recipients and that otherwise meet the needs of care recipients.

[2] Counsel Assisting submissions at [169]

[3] See decision of the former Quality Agency on 27 December 2017: CTH.1002.1011.7331, CTH.1002.1011.7332, CTH.1002.1011.7333, CTH.1002.1011.7308, CTH.1002.1011.7310 and CTH.1002.1011.7319.

[4] Counsel Assisting submissions at [58] and [171]

[5] Counsel Assisting submissions at [2017]

[6] The Commonwealth notes that the *Aged Care Act 1997* (Cth) does not allow the Commission or the Department to 'close' a facility. The Department is able to revoke approved provider status, which will in turn mean that the provider will no longer be eligible to receive Commonwealth funding for residents of all facilities it operates. The approved provider may continue to operate its facilities without Commonwealth funding. Also see T.4422:40-46.

[7] Counsel Assisting submissions at [217]

8. In most cases, approved providers rectify identified areas of non-compliance and return their service to a satisfactory level of quality and safety. In those circumstances, regulatory tools such as engagement and communication with approved providers are effective.

9. Where the Commission or the Department identify higher levels (or a serious level) of risk, the Department may apply sanctions on the approved provider in a much shorter timeframe, or the Commission may reduce the time for which an approved provided is accredited. The Department may also organise for the closure and subsequent revocation of approved provider status and has done so on five occasions since September 2017.[8]

10. In the context of this case study, the Commission and the Department accept that the regulatory response was shaped by deficiencies in information-sharing, follow through and assessment of identified risks. In particular, the circumstances associated with this particular outsourcing arrangement warranted closer examination at the time it was made known to the Commission and the Department. This is because:

    (a) the approved provider had outsourced its central functions to a subcontractor to such an extent that it had no role of the management of the service;

    (b) the subcontractor did not have appropriate experience in operating a residential aged care service;

    (c) the subcontractor was not itself an approved provider as was known to the Commission; and

    (d) the approved provider did not have appropriate governance structures in place.

11. The Commission and the Department accept that there is a significant risk where an approved provider subcontracts substantial parts of its responsibilities to a third party (such as the management of a residential aged care facility). This is particularly where an approved provider such as People Care enters into an arrangement such as the one described in paragraph 10 above.[9]

Work done to address the issues identified in this case study

12. As noted above, this case study identified some limitations to the Commission's and the Department's regulatory processes. As witnesses appearing for the Commission and the Department noted:

    (a) there remains a degree of structural separation between the complaints resolution and quality assessment and monitoring groups of the current Commission, including that the two groups currently operate in separate locations and maintain different IT systems.[10] This is currently being addressed in the manner discussed at paragraph 17 below;

[8] T.4422:40-46. We note that since the time this evidence was given the Department has revoked the approved provider status of two further providers.

[9] T.4278:3-7

[10] T.4260:16-17

(b) the conduct of the approved provider in 2016 should have invited further consideration by the former Quality Agency and the Department as to the approved provider's suitability (this conduct included Mr Miller's lack of responsiveness to members of the former Australian Aged Care Quality Agency (**Quality Agency**), and subsequent concerns provided by the adviser to the former Quality Agency and the Department);[11]

(c) the former Quality Agency, the Commission and the Department ought each to have done more to obtain information regarding the demarcation of responsibilities between the approved provider and the "*contract arrangement to manage the aged care residential facilities"*;[12,]

(d) the information collected at a meeting with the approved provider by the complaints resolution group within the Commission ought to have been passed to the quality assessment and monitoring group within the Commission and, equally, the quality assessment and monitoring group needed to show greater curiosity in informing itself appropriately.[13]

13. In addition, in the immediate term, the Commission and the Department are considering the following changes to their regulatory approaches:

(a) the Commission is currently developing a change in assessment methodology in accordance with which an assessment team is required to immediately notify their supervisor if they identify high levels of restraint in response to the risk screening questions;[14] and

(b) the Department is updating the notification form that approved providers use to notify it of material changes. That form will now require notification of, among other things, changes to management company contracting arrangements.[15] Collection of this data will feed into the risk profiling tool and allow for more efficient, effective and targeted regulatory activity.

14. However, the evidence does not bear out the submission made by Counsel Assisting that the Service Provider of Concern (**SPoC**) list *"does not have a prominent role in the operations of the* [Aged Care Compliance Branch]*".* The status of the SPoC list and the role it plays in informing the Department's compliance functions at an operational level was detailed in the statement given by Mr Anthony David Speed on 23 July 2019.[16]

15. Ms Brammesan identified the consequential role the list plays in the functions that she performs.[17] However, the Commission and the Department notes that whilst the SPoC (and the Commission's Homes of Interest list) are instructive mechanisms by which risks associated with approved providers are managed, they are not the only avenues for information sharing and collation. The Memorandum of

[11] T.4262:33-36
[12] Exh bit 8-1: Tab 58; T.4268:36 – T.4269:23
[13] T.4273:9-39 and T.4765:17
[14] Counsel Assisting submissions at [187]
[15] Counsel Assisting submissions at [222] to [224]
[16] Exh bit 8-26: at [9] to [15]
[17] T.4412:34 – 4413:42

Understanding between the Department and the Commission (**MOU**) outlines a number of mechanisms through which information should be shared between the Department and the Commission. It sets out a tiered approach ranging from formal referrals to ad-hoc data requests. A requirement under Schedule 1 to the MOU is that officers of the Commission and the Department hold regular case management and liaison meetings, as well as frequent individual communications, to share information regarding approved providers.[18]

16. The issues raised by this case study are already the subject of significant planning and reform. Implementation of that reform is ongoing, and some of the issues raised by this case study predate those review and reform processes. In particular, the proposed transfer of regulatory functions from the Department to the Commission is designed, at least in part, to improve the communication between those functions. This is discussed further in paragraph 18 below. In preparation for the proposed transfer of functions to the Commission, from 1 July 2019 the Department has consolidated all operational compliance functions into a single branch within the Department.

Information collation and sharing

17. In particular, information collation and sharing are undergoing structural reorganisation and improvement. [19] For example, the organisational, physical and technological separation between the complaints resolution and quality assessment and monitoring groups of the Commission are already being addressed. Additionally, in the short term, the Commission is working to address transitional issues with the consolidation of two agencies from 1 January 2019 through processes requiring the examination of complaints information by the quality teams for risk assessment, investigation and intelligence purposes.

Legislative and operational reform

18. The suite of current reforms to address these issues include:

    (a) the merging of the functions of the former Aged Care Complaints Commissioner (**Complaints Commissioner**) and the former Quality Agency into the Commission with effect from 1 January 2019, and the proposed transfer from 1 January 2020 of additional regulatory functions of the Secretary of the Department (including the approval of providers of aged care, compliance operations and the imposition of sanctions, and receipt and review of compulsory reporting of assaults);

    (b) the development and implementation of a new information technology system for the Commission that will support Commission-wide access to its information;[20]

[18] For example, referrals of the nature discussed at T.4418:12-28 and meetings of the nature discussed at T.4519:33-34 and T.4522:9-14

[19] Exh bit 8-44: 21(c), 22 and 40

[20] T.4273:5-15

(c) from 1 July 2020, the implementation of a risk profiling tool and information sharing tool that will collect data from a range of sources and subsequently assist the Commission to better calibrate the scope, frequency and intensity of its monitoring activities for residential aged care services.[21]

19. The Commission and the Department have provided further submissions in respect of their reform agenda, including how these reforms will impact the current system.

20. The Commission and the Department accept that they could improve its oversight of risk factors, including those uncovered through prudential compliance processes. Prudential information and timeliness of reporting compliance issues by approved providers will be among the many risk factors that will form part of the risk-profiling tool. This risk-profiling tool will ensure that the findings from prudential compliance processes are integrated and considered alongside other risk factors. While that reform constitutes part of an effort to introduce systemic improvement, the question of whether or not in this particular case that lack of alignment was causative of the events of 11 July is a separate matter.[22] This is a matter that will be examined as part of the review discussed at paragraph 24 below and the Commission and the Department will fully address that issue once there has been an opportunity for all of the relevant facts to be ascertained and assessed.

21. The Commission and the Department also agree that it would be beneficial to have broader powers at their disposal to better address some of the issues noted within this case study, as identified in the evidence of Elsy Brammesan[23] and Amy Laffan.[24]

22. In particular, the Commission and the Department consider that it would be beneficial for there to be a clear obligation to require approved providers to advise the Commission of changes to sub-contracting arrangements from the time that the original application for approval was made.

Further reviews

23. While the reforms are underway, the Commission and the Department emphasise the value of a full and detailed review of the specific causative and contributing factors in this case study that led to the events of 11 July 2019. Such detail is important, and will be given careful regard by the Government, the Commission and the Department.

24. The Brisbane hearing commenced within weeks of the events on 11 July 2019. That is not a sufficient window of time for the causes and consequences of that incident to be exhaustively investigated and examined. As indicated in Counsel Assisting's opening to the Brisbane hearing, the independent inquiry by Kate Carnell AO will be considered by the Royal Commission and used appropriately to

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[22] For example, the evidence of Ms Tuccori will be of particular note as set out at 108 and 111 of Counsel Assisting's submissions to the effect that she, a person involved in the management of the facility and preparations for a potential exit of Help Street did not appear to anticipate that there would be a need to relocate residents: *"I would think it would be less likely that that was going to happen because, to me, it seemed quite extreme……* and that she remained *"uncertain of what the outcome would be. I mean if it was to eventuate that HelpStreet were to leave, there was nothing to suggest that Mr Miller wasn't going to offer to pay the staff to complete their shifts for the next, you know, on toward. There was, like a large array of better outcomes."*

[23] T.4423:20-35.

[24] T.4668:19-30.

recommend the way forward. The greater latitude in time and focus afforded to Ms Carnell's inquiry will permit a further assessment of the nature and extent of any relevant deficiencies and limitations in the regulatory and/or administrative approaches and requirements that are used by the Commission and the Department. Accordingly, the Commission and the Department will not presuppose the findings of that review by responding to the range of specific factual findings at this point.

25. Doing otherwise risks assumptions or findings being made on an incomplete factual picture. The evidence before the Royal Commission does not represent a complete account, from all relevant perspectives, of what occurred in the lead up to and during the incident on 11 July 2019. This is for a number of reasons, including:

    (a) relevant and direct witnesses were not summonsed at the Brisbane hearing, including key Commission and Department personnel involved in the response;

    (b) the Notices to Give issued by the Royal Commission did not canvas issues that are now said to be relevant to, or form a factual premise of, inferences and conclusions sought to be made by Counsel Assisting. For example:

        i. at paragraph 165 of Counsel Assisting's submissions, the assertion is made that "there is no explanation of the period approximately 4 hours following his receipt of this email in Mr Zillmann's statement". Firstly, Mr Zillmann was not asked by the Royal Commission to address that time span in his statement. The questions posed of Mr Zillmann under the relevant Notice to Give were highly specific, and were addressed accordingly. Secondly, Mr Zillmann was not called by Counsel Assisting as a witness and questioned on that topic, nor was any supplementary statement on the issue sought.

        ii. at paragraph 58 of Counsel Assisting's submissions, the inference is made that it "appears likely that the level of scrutiny of People Care decreased as a result" of it being removed from the SPoC list. The evidentiary basis for that proposition is unclear, particularly given the detail set out above, and it is not based on any comparative analysis capable of supporting that conclusion. Nor was that put as a proposition to any relevant Commission or Department witnesses.

    (c) Documents produced to the Commission or potentially falling outside of the scope of Notices to Produce and not yet fully analysed, may well add important detail to the timeline or context of the incident.

26. Ms Carnell will be given access to all such relevant materials and witnesses in order for a detailed review to occur. The Department and the Commission will await those findings and work with the Minister for Aged Care and Senior Australians to make them available to the Royal Commission and those affected by this incident.

Annexure A

Contact / Visit	Details
22 March 2018[25]	The former Quality Agency conducted an unannounced Assessment Contact across a number of Accreditation Standards: (a) Management systems, staffing and organisational development (specifically, comments and complaints, human resource management); (b) Health and personal care (specifically, behavioural management); (c) Care recipient lifestyle (specifically, regulatory compliance); and (d) Physical environment and safe systems (specifically, infection control). The assessors conducting the Assessment Contact identified some potential areas for improvement, which they communicated to care staff who undertook to improve services. The Assessment Contact Report indicates that the assessment team were aware of the contracting arrangements and recorded that a change in senior management was expected, but that there would be *"no changes to current on site management or staff however there will be changes to the home's identity.*"
18 July 2018[26]	The former Quality Agency conducted another unannounced Assessment Contact following a referral received from the former Complaints Commissioner on 26 June 2018, that considered the following Accreditation Standards: (a) Management systems, staffing and organisational development (specifically, human resource management); (i) Health and personal care (specifically, clinical care and medication management); (ii) Care recipient lifestyle (specifically, privacy and dignity); and (iii) Physical environment and safe systems (specifically, living environment and fire, security and other emergencies). The Assessment Contact Report identifies that the assessment team investigated whether the transition to the new management team was appropriate. The team

[25] Exhibit 8-1: Tab 56
[26] Exhibit 8-1: Tab 65

Contact / Visit	Details
	identified that following the change, *"management offered staff the opportunity to be employed to part time and/or permanent employees* [and that] *60% of the staff have transitioned and staff interviewed stated that they are satisfied with the new arrangements."* The report indicates that 17 staff were interviewed as part of the Assessment Contact. The Assessment Contact records that interviews occurred with 16 care recipients/representatives (approximately 18% of total care recipients). Of those, 14 care recipients appear to have been *"satisfied with the availability of staff"*. Two care recipients/representatives *"expressed that they experience delays when staff are busy."*
14 August 2018[27]	The former Quality Agency conducted an Assessment Contact of the home care services provided by the approved provider. No issues were identified during the course of this review.
11 January 2019[28]	The Commission undertook an unannounced Assessment Contact following a referral received from the Department on 26 November 2018, that considered the following Accreditation Standards: (a) Management systems, staffing and organisational development (specifically, human resource management); and (b) Physical environment and safe system (specifically, living environment). The Assessment Contact Report again indicates that the assessment team considered the contracting arrangements in place. The team identified that *"the new team has reviewed the delivery of care and services and implemented a range of improvement initiatives"* including amending the staffing model to allow for a registered nurse to be rostered on each night shift. The report also indicates that the assessment team received information which suggested that the 'management team' and the approved provider were working constructively to resolve the issues associated with meal quality and temperature
4 April 2019[29]	Complaints officers of the Commission attended the residential aged care service to discuss the complaints that had been received and the responses that had been provided to deal with the complaints. These complaints officers recorded their

[27] Exh bit 8-1: Tab 67
[28] Exh bit 8-1: Tab 72
[29] Exh bit 8-1: Tab 78

Contact / Visit	Details
	findings in a file note. The notes indicated that the provider of some services (laundry, catering and domestic services) was changing from the approved provider to a third-party provider. Following this, the Commission complaints officers attended a meeting with care recipients, HelpStreet and the approved provider. The purpose of the meeting was to discuss complaints that had been received and the approved provider's responses to those complaints, including that there were deficiencies in the approved provider's responses to issues raised in those complaints.[30]
25 June 2019[31]	Prior to this date, the Department's compulsory reporting team had made referrals to the Commission in relation to compulsory reports that it had received pursuant to section 63-1AA of the Aged Care Act. Two reports were referred to the quality assessment and monitoring group of the Commission, who followed up by undertaking an unannounced Assessment Contact. The Assessment Contact considered the following Accreditation Standards: (a) Health and personal care (specifically, clinical care); and (b) Physical environment and safe systems (specifically, living environment and catering, cleaning and laundry services). The assessment of the Physical environment and safe systems standard examined the compulsory reports that had been received pursuant to section 63-1AA of the Aged Care. The Assessment Contact Report by the assessment team records that interviews were conducted with 13 care recipients/representatives (19% of care recipients/representatives) who indicated that they were satisfied with the clinical care being provided by the facility. The assessment team did not identify in their report any potential issues between HelpStreet and the approved provider.

[30] Exhibit 8-1: Tab 89

[31] Exhibit 8-1: Tab 95