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TRANSCRIPT OF PROCEEDINGS

O/N H-1030605

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

PERTH

9.33 AM, TUESDAY, 25 June 2019

Continued from 24.6.19

DAY 27

MR P. ROZEN SC, counsel assisting, appears with MR P. BOLSTER, MS E. BERGIN and MS E. HILL
MR M. BORSKY QC appears with MS M. NORTON and MR J. RUDD for Japara Healthcare

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Good morning, Commissioners. Before I recall Ms Reed this morning, I just want to deal with a minor matter that arose yesterday which I should clarify after some discussions with my learned friend, Mr Borsky. It concerns the exhibit tab 61 which is the report that was made to the Department of Health in relation to – the belated report that was the subject of some evidence yesterday.

COMMISSIONER TRACEY: This is the 27 November one?

MR ROZEN: I'm sorry?

COMMISSIONER TRACEY: The 27 November report.

MR ROZEN: Yes. And the reference in that to the police attendance on 27 November, the Commissioners will recall that the issue arose. I made a call for any documents that related to that. The issue – cutting a long story short, the issue has gone away in the sense that we will not advance any submissions to the effect that the notation concerning the attendance by the police on 27 November was in any way incorrect or misleading or inaccurate. That will be no part of the submissions that counsel assisting will make in the case. On that basis, I recall Ms Reed.

<JULIE ELIZABETH REED, ON FORMER OATH [9.35 am]

<EXAMINATION-IN-CHIEF BY MR ROZEN

COMMISSIONER TRACEY: Ms Reed, you remain under your former oath or affirmation.

MS REED: Yes, I understand.

MR ROZEN: Ms Reed, you told us yesterday that you retired from your employment with Japara in, I think it was early January 2017.

MS REED: That's correct.

MR ROZEN: And in your statement you say at paragraph 15 of your statement, following your retirement you had no ongoing relationship with Japara until February 2019 – this is paragraph 15 of your statement:

> *...when I was requested to assist with aspects of the response to this Royal Commission.*

And that's part of the statement that you've made to the Commission.

MS REED: Yes, it is.

MR ROZEN: I notice your reference to "ongoing relationship" and I'm not interested in splitting hairs about that, but it's the case, isn't it, that subsequent to your retirement, in fact, shortly after your retirement you did come back in a consultancy role to assist with a complaint that had been made by Ms Hausler. Do you recall that?

MS REED: No, I don't recall that, and I don't believe that's correct.

MR ROZEN: Okay. Perhaps if I could ask you to have a look at tab 139, please, which will come up on the screen in front of you. I just ask you to read the first sentence there, please.

MS REED: Yes.

MR ROZEN: Does that jog your memory that you did come back to assist with the Noleen Hausler complaints?

MS REED: There were two occasions when I went to head office. The first one was to orientate the new person who had taken over my position.

MR ROZEN: Yes.

MS REED: And the second time was to spend two hours with her just going through the history.

MR ROZEN: Okay.

MS REED: But I wasn't involved in any of the preparation of any responses or anything.

MR ROZEN: I understand. Perhaps if you just – we can short-circuit this if you look at tab 141, please, which I will ask the operator to bring up. Do you see that's an email from you to Wendy Waddell what role was Ms – sorry, I withdraw that. This is an email that you have sent on 23 January and you, underneath the salutation, you say:

> *The attached is a summary re Mitcham and Mr Hausler.*

Do you see that?

MS REED: Yes.

MR ROZEN: Yes. And that's right, isn't it, you prepared a summary.

MS REED: Yes, I did.

MR ROZEN: Yes. And that was pursuant to this return after your retirement to assist with responding to the complaint by Ms Hausler; is that right?

MS REED: I wasn't directly involved in that. I was just giving them a history.

MR ROZEN: Okay. And the report that you refer to or sorry, the summary that you refer to in that email, I think, and I will clarify this with you, is behind tab 142, if that could be brought up, please. Do you see that document headed:

Key facts re Mr Clarence Hausler and his daughter Noleen Hausler.

MS REED: Yes, I do.

MR ROZEN: Yes. That's a report, isn't it, that you are referring to in your email that I just took you to of 23 January 2017.

MS REED: Yes, it is.

MR ROZEN: Yes. And it was a comprehensive report prepared by you to assist Japara in understanding the history.

MS REED: That's correct.

MR ROZEN: Yes. And you did your best to be as comprehensive as you could be, drawing on your memory and presumably looking at relevant documents to produce that summary?

MS REED: That summary was pretty much from memory.

MR ROZEN: Yes. Okay.

MS REED: I didn't have access to a lot of documents or anything.

MR ROZEN: I see. I just want to ask you about one aspect of that. It's on the second page which is the page ending .7469 toward the bottom of the page. Do you see that the last heading on the page is:

Pre notification of the assault on 9 September 2015.

Do you see that? It has been highlighted for you on the screen now, Ms Reed.

MS REED: Yes.

MR ROZEN: And this is a topic that we spent some time discussing yesterday the – what was done by Japara in response to Ms Hausler's complaint of 2 September 2015. Do you recall we discussed that yesterday?

MS REED: Yes, I do.

MR ROZEN: Yes. And you told us that as part of your investigation of that complaint you spoke to a person who is being referred to as TL. I think it has been explained to you who that is.

MS REED: Yes, that's correct.

MR ROZEN: Yes. You would agree with me, wouldn't you, that there's nothing in your summary that refers to any discussions with TL, is there?

MS REED: No, there isn't.

MR ROZEN: And just so it's clear, from the answers you gave yesterday, that conversation that you say you had with TL was essentially the investigation, wasn't it? There were no other steps taken to investigate the complaint, were there?

MS REED: Well, TL had spoken with Ms Hausler to get her side of what had happened.

MR ROZEN: Yes.

MS REED: And that was the investigation, really.

MR ROZEN: Yes. And that was your source of any further facts over and above what was in the written complaint.

MS REED: What we already had.

MR ROZEN: So it was a pretty important part of the narrative, wasn't it?

MS REED: I was writing this from just memory, most of it.

MR ROZEN: I see.

MS REED: And they had all of those documents available to them to refer to.

MR ROZEN: Right. But there are no documents, are there, that detail any discussions between you and TL at this time?

MS REED: I can't recall.

MR ROZEN: Okay. And are there any documents that record any discussions between TL and Ms Hausler, do you know?

MS REED: I can't recall if there were.

MR ROZEN: Okay. So your explanation for there being nothing here about any conversation between yourself and Ms TL or between Ms TL and Noleen Hausler is that you just didn't recall that at the time you prepared this document. Is that your evidence to the Commission?

MS REED: I would have presumed that TL had written up in the progress notes. I didn't check the progress notes, so I could – I can't say.

MR ROZEN: You would expect there to be a record in the progress notes of such a conversation, would you?

MS REED: That she had spoken to her, yes.

MR ROZEN: Yes. Now, if I could just ask you about a couple of things arising from your evidence yesterday. You will recall we had a number of questions and answers about whether or not as at 2 September or within a few days, whether or not you should have reported the incident that was described in the written complaint. I don't want to go over that ground now, but my question is: if it was serious enough for you, Japara, to give a directive to the agency for that agency nurse not to come back to Mitcham, doesn't that suggest that it was serious enough to be reported to the department?

MS REED: When Ms Hausler spoke to TM, she asked – she asked her not to have the carer look after her father again. TM said to her that she would ring the agency and ask for the – for the carer not to come back to the facility. And that's what she did.

MR ROZEN: I asked you some questions yesterday afternoon about whether you had seen the report of 27 November that went to the department concerning this report. And your evidence yesterday was you hadn't seen it before it went in. Do you recall saying that yesterday?

MS REED: To the best of my recollection, yes.

MR ROZEN: Okay. Do you recall now whether you saw it any time after it was submitted. Was it part of a report that came to you in any capacity; do you remember?

MS REED: I would have seen it later on.

MR ROZEN: Okay. Are you able to say when, and if you're not I'm not asking you to guess.

MS REED: I can't recall.

MR ROZEN: All right. Ms Reed, I want to ask you about a different topic, which concerns the reporting of the earlier incident. So you know there was an incident on 31 August involving Mr Lucas and Mr Hausler, and then there was the subsequent matter on 9 September - - -

MS REED: That's correct.

MR ROZEN: Two incidents involving Mr Hausler. They both led to criminal charges being laid against Mr Lucas, and we know that Mr Lucas was sentenced in the Magistrates Court on 6 June. Can I ask you to look at tab 167, please, if that could be brought up. This is an email from you, copying in Ms Jones, dated 12 September 2016, and it's a report of that incident on 31 August 2015, isn't it?

MS REED: Yes. That's correct.

MR ROZEN: And you say in the third paragraph:

> *This is being lodged now, as we were unaware that there was a previous assault on 31 August 2015 until we were made aware of this via an article in the Adelaide Advertiser.*

Do you see that?

MS REED: Yes. I do.

MR ROZEN: Yes. And that was the case, was it, that you first found out that there was this incident which led to a criminal charge more than a year earlier? You first found out in The Advertiser?

MS REED: Do you want me to explain that?

MR ROZEN: Please.

MS REED: Can you pull up the statement, or the email that I sent on 11 September, please, to the ELT?

MR ROZEN: I'm sorry. Can you say that again, please?

MS REED: The email that I sent to the executive leadership team on 11 September 2015.

MR ROZEN: I'm just – I'm not sure of the tab number of that. I will just try to find it. Whilst that's being done, my question is really quite a simple one. Is this right: that you only found out about that report – that incident from The Advertiser?

MS REED: We found out that he had been charged with an assault on 31 August through The Advertiser.

MR ROZEN: I see. But he had already been sentenced, hadn't he, in relation to that, on 6 June?

MS REED: He had.

MR ROZEN: Yes. And I take it you weren't at court that day.

MS REED: No, we were not.

MR ROZEN: No representative of Japara went to court?

MS REED: No.

MR ROZEN: Why is that, Ms Reed?

MS REED: When – earlier, when we had been speaking to the police to get court dates, they had told us that Ms Hausler would keep us informed of court dates. And I believe Rachael was asking her on a regular basis about court dates, and we weren't informed of the court hearing on 6 June.

MR ROZEN: I see.

MS REED: So we weren't able to attend.

MR ROZEN: Your evidence is you didn't know about it.

MS REED: We didn't know.

MR ROZEN: Okay. But you could have made your own contact with the police, presumably, to find out about the court dates. There was nothing stopping you doing that, was there?

MS REED: We had done that in the past and we had been told David Nelson to – that Ms Hausler would keep us informed.

MR ROZEN: I see. They told you it was inappropriate to contact them, did they?

MS REED: Well, they said that it was her case and that we needed – she would keep us informed.

MR ROZEN: I see. Now, I want to ask you about a series of meetings between Ms – sorry, before I do that, you asked me if we could bring up your memo of 11 September 2015. Do you still need me to do that, to assist you in any way, Ms Reed?

MS REED: Well, I think it's important, because - - -

MR ROZEN: Okay.

MS REED: - - - Ms - - -

MR ROZEN: Sure. Tab 44, if that could please be brought up. Is there any particular part of this that you would draw the Commission's attention to?

MS REED: Could we go to the second page, please?

MR ROZEN: Yes. So that's the one ending .2532.

MS REED: And you can see down at the first dot point, the dark dot point - - -

MR ROZEN:

We had a discussion with Noleen Hausler.

MS REED: Yes, that – that section.

MR ROZEN: By "we" there, you're not suggesting, are you, that you had the discussion with Ms Hausler, or are you?

MS REED: Yes, I – I am. That I did have that discussion – this discussion with her.

MR ROZEN: I see. Yes.

MS REED: So if you go down to the third dot point, when we had the meeting with Ms Hausler she said that she had observed Corey on the footage, changed her father on his own and thought he had been a bit rough. When I asked why she didn't report it immediately to us for actioning, her reply was:

I knew he would do something worse, so I left the camera there to catch him.

When I commented that we may well have prevented the assault, she had informed us – if she had informed us of the first incident, Noleen stated that she stood by her decision. So it wasn't presented to us as an assault; it was presented to us that he had used inappropriate manual handling, and that that was all that we were aware of at that time. We didn't see any footage of that, so we didn't know that it was anything more than that.

MR ROZEN: Just so that we're clear here, Ms Reed, this discussion that's being summarised here was the discussion on 10 September, wasn't it?

MS REED: Yes. It was.

MR ROZEN: Yes.

MS REED: That was just after the police had left.

MR ROZEN: Yes. And it was during that discussion that you told – sorry, can we go back to that page, please. I think it was the previous page that was on the screen. No, my apologies. It was that one. If the second page there could just be highlighted? See that second dot point there:

> *We informed Noleen that filming people covertly was illegal and not acceptable.*

MS REED: Yes. I do.

MR ROZEN: Yes. You said that to Ms Hausler in the context of the footage that you had all just watched about her father, in which her father was assaulted, yes?

MS REED: I actually said it to Ms Hausler - - -

MR ROZEN: Yes.

MS REED: - - - in the context of – the police had asked us not to discuss anything about the CCTV footage, and Ms Hausler had left the office and informed a couple of the staff about it. And when she came back to me – with me, I reminded her about not discussing it and that it – it was illegal to be filming people.

MR ROZEN: Yes. And not acceptable.

MS REED: It wasn't acceptable to do it.

MR ROZEN: I see. And did you think that that was a little insensitive, Ms Reed, in the context of the footage that you had just watched?

MS REED: I think emails are very two-dimensional and don't portray, really, what you're trying to – or what you have said to people.

MR ROZEN: No, I think we are at cross-purposes.

MS REED: And I don't think I was insensitive to Ms Hausler. I was feeling for her quite a bit.

MR ROZEN: You don't think it was insensitive to raise, then and there, questions of illegality on her part on 10 September?

MS REED: What I was repeating to her was what police had told us, and trying to stress to her that she did need to keep it confidential.

MR ROZEN: You say the police told you that it was illegal for her to have been filming?

MS REED: They did, in the meeting that we had with them. Ms Hausler was present. They – they commented that they thought it was illegal and they weren't sure if they could use the footage in court.

MR ROZEN: So you thought it was a good idea to emphasise that to her, did you?

MS REED: What I wanted to impress on Ms Hausler was that it was important to keep it confidential.

MR ROZEN: I see. Now, can I ask you about a series of meetings that took place starting in early November 2015 between Ms Musico and Ms Jones, on the one hand, and Ms Hausler on the other hand. You're aware of the weekly meetings that I'm talking about?

MS REED: Yes. I am.

MR ROZEN: You were provided with minutes of each of the meetings - - -

MS REED: Yes. Post the meetings.

MR ROZEN: - - - as they took place. Yes. And we know from the evidence of Ms Jones and Ms Musico that the first of those meetings was on 3 November 2015. And they told the Commission that they thought the meetings were very valuable and were helping to rebuild the relationship between Mitcham, on the one hand, and Ms Hausler on the other. You understand that's the evidence they have given?

MS REED: I didn't – didn't listen to it, but - - -

MR ROZEN: I will ask you - - -

MS REED: I agree.

MR ROZEN: - - - to accept that's what they've said. And that was the feedback to you too, wasn't it?

MS REED: Yes.

MR ROZEN: Yes. On 9 November, so within less than a week of the first such meeting designed to rebuild the relationship, you sent an email to Ms Hausler, didn't you?

MS REED: Yes. I did.

MR ROZEN: Yes. I ask that tab 177 be brought up, please. Now, I accept from the first line that you were responding to an inquiry from Ms Hausler. That was the case, wasn't it, about whether there was a policy concerning video surveillance?

MS REED: That's correct.

MR ROZEN: You went on in the second paragraph to tell her there wasn't a policy, and that:

> *It has clearly been explained to you on numerous occasions that by covertly filming in a resident's room you would be seriously breaching multiple Acts, including but not exclusive to the Aged Care Act 1997 and the Occupational Health and Safety Act.*

Do you see that there?

MS REED: Yes. I do.

MR ROZEN: What section of the Aged Care Act was Ms Hausler breaching, did you think, by filming?

MS REED: I can't quote the exact section, because it was our legal advice that she had – it would be a breach.

MR ROZEN: I see. I won't ask you to divulge any of your legal advice but will the answer be the same in relation to the Occupational Health and Safety Act?

MS REED: Yes. It would be.

MR ROZEN: Did you have any section in had mind? Did you talk to Ms Jones before you sent this email to Ms Hausler?

MS REED: I don't recall.

MS REED: Okay. She told us that you didn't. Do you have any reason to disagree with that evidence?

MS REED: I don't recall.

MR ROZEN: Okay. So I suggest to you that the tone of the email and the accusatory form in which it has been written, accusing her of illegal conduct, was counterproductive to the rebuilding of the relationship that Ms Jones and Ms Musico were working so hard to achieve. What do you say to that, Ms Reed?

MS REED: I – I think, as I said before, emails are very two-dimensional and don't really express or convey what was meant a lot of times.

MR ROZEN: Do you think that that email was counterproductive to the work that Ms Musico and Ms Jones were undertaking to rebuild the relationship?

MS REED: No. I don't.

MR ROZEN: You sent another communication, a letter, on 9 December, which accused Ms Hausler of other illegal conduct. You accused her of stalking the staff. Do you recall doing that?

MS REED: Do you have that letter?

MR ROZEN: Tab 77, if that could be brought up, please. I'm sorry, 72. My apologies. Do you see the fourth paragraph:

> *It is also unlawful for you to keep our staff under surveillance without their permission and with the intention to cause our staff serious apprehension or fear. Stalking is an offence that carries serious penalties.*

MS REED: Yes, I do see that.

MR ROZEN: Yes. That was even more inflammatory, wasn't it, don't you think, Ms Reed?

MS REED: This was the letter that was sent on legal advice.

MR ROZEN: I see. You didn't have to send it though, did you, Ms Reed?

MS REED: Well, I – we had sought legal advice and that was what we were advised to do.

MR ROZEN: I see. And did you think that Ms Reed intended to cause your staff serious apprehension or fear?

MS REED: There was – there were numerous occasions where staff had complained about feeling very uncomfortable and intimidated by Ms Hausler and had reported that they thought she was filming them on her mobile phone.

MR ROZEN: Okay. Try answering my question. Did you think that she was intending – do you think she was intending to cause the staff serious apprehension or fear?

MS REED: Well, I can't speak for her intentions.

MR ROZEN: The suggestion in your letter was that that was her intention though, wasn't it?

MS REED: Well, as I said, this is the letter that we had prepared on legal advice and that we sent on that advice.

MR ROZEN: Okay. And I suggest to you again, this was entirely unhelpful in the context of the work that Ms Musico and Ms Jones were doing of having weekly meetings to try and rebuild the relationship with Ms Hausler. What do you say to that, Ms Reed?

MS REED: In hindsight, yes, it probably was.

MR ROZEN: Thank you. One of the issues that arose in those meetings was the difficulty that had arisen in terms of the relationship between Ms Hausler on the one hand and the caring staff at Mitcham on the other because the staff hadn't been told about the circumstances of the assault or the reasons why Mr Lucas' employment had ended. Do you recall that being a topic raised during the meetings and minuted and sent to you?

MS REED: I do.

MR ROZEN: You do. And the minutes record Ms Jones going to you in December, and asking you what your position was in relation to that, would you be prepared to tell the staff. Do you recall that?

MS REED: Can I see the meeting minutes, please?

MR ROZEN: Sure. Tab 186, please, operator. Do you see in that last paragraph there, if that could just be highlighted, please,. Just so that it's clear for you, the redacted first word is the name of the representative of ARAS, the advocacy service - - -

MS REED: Yes.

MR ROZEN: - - - that was assisting Ms Hausler, and you will see there that he – this is the fourth line – indicated that:

> *He could not understand this. He could not understand why the staff hadn't been told as it's now a matter of public record and the knowledge would give staff a better understanding of the impact of the incident on Noleen which may encourage greater empathy for her.*

Do you see that?

MS REED: Yes, I do.

MR ROZEN: You read that when the minutes came to you, I take it?

MS REED: Yes.

MR ROZEN: Yes. But as is recorded there, after consultation with you, the message back was that you didn't support this and would not be officially informing the staff of the details of the incident. Do you see that in the third and fourth lines?

MS REED: Yes, I do.

MR ROZEN: And that was the case, wasn't it?

MS REED: There - - -

MR ROZEN: You did say you wouldn't tell them.

MS REED: There was a reason for that and that was the staff had been informed that had there had been an incident in September 2015, at a staff meeting and through education with them. What Ms Hausler was asking was about the details of the incident and we had been asked by the police not to discuss the case.

MR ROZEN: Well, let's just unpack that if we can, please, Ms Reed. You had been asked by the police not to discuss the case on 10 September because Mr Lucas hadn't been apprehended at that point. That's the position, isn't it?

MS REED: Yes.

MR ROZEN: But once he had been apprehended, that request no longer held, did it? He had been well and truly apprehended by December, hadn't he?

MS REED: Well, I was still mindful of that, but the other aspect to it is that staff, you know, we're governed by HR rules and policies, too, and staff have a right to confidentiality so it wasn't up to us to discuss the details - - -

MR ROZEN: What, Mr Lucas had a right to - - -

MS REED: - - - about Mr Lucas.

MR ROZEN: He had a right to confidentiality even after he had been dismissed? Is that what you're saying?

MS REED: Well, he hadn't been found guilty by a court of law either.

MR ROZEN: So it was concern about him that prevented you telling the other staff about the details?

MS REED: It was concern about breaching privacy and confidentiality.

MR ROZEN: Of Mr Lucas?

MS REED: No, of the legislation, and the OH&S, you know, over staff – HR regulations and laws.

MR ROZEN: I see. But the point that was being made at the at the meeting is correct, isn't it, the failure to tell the staff led to suspicion on the part of the staff about Ms Hausler; why is she here so much all of a sudden. Is she keeping an eye on us, what's this all about. You understood that was the underlying issue, didn't you?

MR ROZEN: The staff had been told that there had been an incident. They knew Corey had been dismissed. They knew that they were monitoring Mr Hausler more frequently because of the incident but we didn't give them details of the incident. So they were aware of why Ms Hausler was visiting more frequently.

MR ROZEN: Ms Reed, I suggest to you that when we put this evidence together, your email of 9 November, your letter of 9 December which I think you've already told us was ill-advised, your response to this perfectly reasonable request for the staff to be given more detailed information; I suggest it's clear that you had no interest in rebuilding the relationship with Ms Hausler.

MS REED: I did have an interest in building the – rebuilding the relationship with Ms Hausler, and that is why we were having the weekly meetings and why Rachael was available to her at all times, really, by phone, email, meetings, daily contact when she visited.

MR ROZEN: I would ask you, please, to have a look at tab 91. I'm going to take you to another topic which is the guardianship application that Ms Hausler made. You're familiar with what I'm talking about, Ms Reed?

MS REED: Yes.

MR ROZEN: Yes. And you will see in the bottom email, bottom part of that email there's an email from Ms Jones to you on 2 March 2016.

MS REED: Yes.

MR ROZEN: And she wrote:

> *Hi Julie, I've attached a few notes I have located as evidence that Noleen puts Clarry at risk by her actions.*

I will just pause there for a moment. That's the task you had given her, was it, finding such evidence?

MS REED: I had been requested by the legal team to provide any documents that we might need at the guardianship hearing.

MR ROZEN: Okay. So try and answer my question if you could, please, Ms Reed. You tasked Ms Jones with finding evidence that Noleen puts Clarry at risk by her actions; is that right?

MS REED: Yes, I did.

MR ROZEN: Yes. And she wrote:

There's not as many as I hoped, unfortunately. I've also attached a bit of a summary about each attachment.

And your response, top of the page:

Thanks Di, every bit helps.

What did you mean, "every bit helps", helps what?

MS REED: The lawyers.

MR ROZEN: The lawyers. I see. So you had instructed the lawyers to, what, develop a strategy to respond to Ms Hausler's application to be the guardian?

MS REED: Sorry?

MR BORSKY: I'm sorry to interrupt, Commissioners, but that question my learned friend just put perhaps inevitably strays into privileged communication.

MR ROZEN: I won't pursue it. I suggest to you, Ms Reed that what you were asking Ms Jones to do was essentially find some dirt on Ms Hausler to be used in opposition to her application for guardianship; is that a fair summary?

MS REED: No.

MR ROZEN: What do you think Ms Hausler was doing to put her father at risk by her actions?

MS REED: We had had discussions with Ms Hausler about attending to her father on her own with the door shut and no assistance from care staff. So there were those sorts of things that were happening.

MR ROZEN: Ms Jones was one of your quality managers responsible for the quality of service provision within Japara; is that right?

MS REED: Yes.

MR ROZEN: And you thought this was an appropriate use of her time, did you?

MS REED: Well, Ms Jones was there and involved with Mitcham. I wasn't in – at Mitcham or in South Australia.

MR ROZEN: None of the work she was doing here was intended to in any way improve the care being provided to Mr Hausler, was it, Ms Reed?

MS REED: I'm not really sure what you mean by that.

MR ROZEN: I will spell it out. This was all part of a battle, wasn't it, you were waging with Ms Hausler?

MS REED: It wasn't a battle that we were waging. We might have had personality conflicts at times, however, I was always professional with Ms Hausler.

MR ROZEN: I see. You don't doubt, do you, that she was motivated throughout this entire period by concerns for the care of her father, do you?

MS REED: I don't doubt that Ms Hausler was motivated by concerns for her father but I think sometimes some – some treatments and interventions and that that Ms Hausler asked us to implement were a little misguided.

MR ROZEN: Finally, Ms Reed, can I ask you to have a look at tab 98, please, if that could be brought up. This is an email you wrote to Mr Sudholz, your boss, 11 July 2016.

MS REED: Yes.

MR ROZEN: And who – and you wrote:

So you can see how much info we have to send to defend the business.

Do you see that?

MS REED: Yes, I do.

MR ROZEN: Just for some context for you, if tab 99 could be brought up, please. That's a letter sent to the Aged Care Complaints Commissioner and I will ask you to accept from me that it's signed by Di Jones on 11 July 2016 so the same date as your email and that's what you're referring to, isn't it?

MS REED: Yes, it is.

MR ROZEN: The work that was done.

MS REED: Yes.

MR ROZEN: And it's a very long and detailed response; is that right?

MS REED: Yes.

MR ROZEN: Yes. And I suggest to you that the reference to "defending the business" is, of course, the business of Japara. Do you see that? That's right, isn't it, it's the business of Japara you're referring to?

MS REED: Yes.

MR ROZEN: Yes. And that was how you saw your role at Japara, wasn't it?

MS REED: No. It was part of my role.

MR ROZEN: Yes. No further questions, Commissioners.

COMMISSIONER TRACEY: Ms Reed, just taking you to back to the application that had been made by Ms Hausler to the South Australian tribunal with a view to obtaining a care order on behalf of her father, I take it that Japara was aware that that application had been made; is that right?

MS REED: That's correct. We were – do you want me elaborate?

COMMISSIONER TRACEY: Well, I just want you to tell me whether the company had become aware that the application had been made?

MS REED: Yes.

COMMISSIONER TRACEY: All right. Now, at some point the company decided to involve itself in those proceedings and to that end, instructed lawyers to act on its behalf; is that right?

MS REED: Yes.

COMMISSIONER TRACEY: All right. And the purpose was to oppose the application; is that right?

MS REED: The purpose was – can I elaborate on why we did that?

COMMISSIONER TRACEY: No. No. Just tell me. It either was or it wasn't the intention of Japara to oppose the application. Instructions were given to lawyers.

MS REED: Only if – only if that was required.

COMMISSIONER TRACEY: I beg your pardon?

MS REED: Only if it was required.

COMMISSIONER TRACEY: What does that mean? Required by whom?

MS REED: Well, by – for us. Or for Mr Hausler, actually.

COMMISSIONER TRACEY: Well, she obviously wanted it so why would it be necessary for you to be involved?

MS REED: Ms Hausler already had enduring medical power of attorney and financial power of attorney. She was applying for guardianship with special powers.

COMMISSIONER TRACEY: Yes.

MS REED: We were contacted by someone from the Guardianship Board and we were told that the reason Ms Hausler had given – and I believe there's an email from Rachael detailing those reasons. Can we pull that email up?

MR ROZEN: It's tab 71, Commissioners. Sorry, 171.

MS REED: When I read this email from Rachael and saw what the reasons were I was concerned that what had been told to the board was not correct. So I decided we needed to have legal representation there.

COMMISSIONER TRACEY: But for the purpose not of opposing the application but of ensuring that the board was provided with accurate information relating to matters within the knowledge of Japara; is that right?

MS REED: That's correct.

COMMISSIONER TRACEY: And no other purpose?

MS REED: No.

COMMISSIONER TRACEY: And certainly not for the purpose of opposing the application?

MS REED: Well, I have to say no.

COMMISSIONER TRACEY: When you say you have to say no, you know what instructions were given to the lawyers?

MS REED: I have concerns about why Ms Hausler would be applying for guardianship with special powers when she already had all of the medical power of attorney and enduring power of attorney, and there have been previous issues where Ms Hausler had asked us to implement things for her father that were not appropriate. We had to get specialists in and other people to talk with Ms Hausler so that she understood why we weren't implementing those, because they weren't best practice and they weren't – they were not beneficial to her father. So I was concerned that the guardianship with special powers may be a way for Ms Hausler to

override advice by the doctor and by the specialists and people we were liaising with her with. So if it did come to that, then I – we would have opposed it.

COMMISSIONER TRACEY: I see. And we have been told that, apart from the last 15 minutes of the proceeding, no one from Japara was present at the hearing; it was simply legally represented. Does that accord with your recollection?

MS REED: No. Ms Jones was running late and she did attend that Guardianship Board hearing.

COMMISSIONER TRACEY: Anything arising out of that?

MR ROZEN: Yes. Thank you, Commissioner. You will see in that email in front of you, Ms Reed, that in the final paragraph, the very last sentence starting, "She advised", if that could be highlighted please:

> *She advised they can also offer to come in and sit on our weekly meetings, to help facilitate them, and she will be in touch if she has any further questions.*

MS REED: Yes, I see - - -

MR ROZEN: Did you note that - - -

MS REED: - - - that.

MR ROZEN: Did you follow up the invitation of the public advocate to come and sit in on the meetings and assist?

MS REED: No, because Ms Hausler cancelled all the weekly meetings from that date forward.

MR ROZEN: Did you invite the public advocate to come and assist?

MS REED: No, because TK – sorry, the ARAS advocate was assisting Ms Hausler.

MR ROZEN: I see. But that was a perfectly sensible offer, I suggest to you, and it could have helped build the relationship. Don't you agree?

MS REED: It may have.

MR ROZEN: Yes. Finally, what underlay the opposition to the application for guardianship was a concern that if Ms Hausler was successful in becoming her father's guardian that might assist her in her quest to put the video camera back in the room. That was what this was all about, wasn't it, Ms Reed?

MS REED: Our primary concern has always been Mr Hausler and his wellbeing and his care.

MR ROZEN: Could you answer my questions, please? Underlying your concerns about Ms Hausler getting special powers was a concern that it might help her to get the video camera back in the room, wasn't it?

MS REED: There was a consideration of that too.

MR ROZEN: Yes. And you were concerned to protect Japara from any further unpleasant surprises coming from video, weren't you?

MS REED: It – it – it was a complex issue with the CCTV and we were seeking legal advice around it.

MR ROZEN: Thank you, Ms Reed. No further questions, Commissioners.

COMMISSIONER TRACEY: Yes. Thank you Ms Reed. You are excused from further attendance.

MS REED: Thank you, Commissioner.

<THE WITNESS WITHDREW [10.19 am]

MR ROZEN: I call Andrew Sudholz.

<MARK ANDREW SUDHOLZ, SWORN [10.20 am]

<EXAMINATION-IN-CHIEF BY MR ROZEN

MR ROZEN: Mr Sudholz, can you please confirm your full name for the transcript.

MR SUDHOLZ: Yes. Mark Andrew Sudholz.

MR ROZEN: And you made a witness statement for the purposes of this Royal Commission, dated 13 June 2019?

MR SUDHOLZ: Yes.

MR ROZEN: And the code for that is WIT.0229.0001.0001. Have you had an opportunity to read through your witness statement before coming along and giving evidence?

MR SUDHOLZ: This witness statement? Yes.

MR ROZEN: Yes. And is there anything in it you wish to change?

MR SUDHOLZ: No. There isn't.

MR ROZEN: Sorry, Mr Sudholz. And are the contents of your witness statement true and correct?

MR SUDHOLZ: Yes.

MR ROZEN: I tender the statement, Commissioners.

COMMISSIONER TRACEY: Yes. The statement of Mark Andrew Sudholz – what date does it bear, Mr - - -

MR ROZEN: Twel – sorry, 13 June. I'm sorry.

COMMISSIONER TRACEY: Dated 13 June 2019 will be exhibit 5-13.

EXHIBIT #5-13 WITNESS STATEMENT OF MARK ANDREW SUDHOLZ (WIT.0229.0001.0001) DATED 13/06/2019

MR ROZEN: Mr Sudholz, you're the chief executive officer of Japara Healthcare Limited?

MR SUDHOLZ: Yes. I am.

MR ROZEN: And you founded the company in 2005?

MR SUDHOLZ: Yes, with other shareholders.

MR ROZEN: Yes. And the business has grown dramatically since that time, from one facility to, presently, 49.

MR SUDHOLZ: Yes. It has.

MR ROZEN: Initially only in Victoria; is that right?

MR SUDHOLZ: Mainly in Victoria, but we are now Australia-wide.

MR ROZEN: Yes. You are also a board member of a number of industry associations? Or, sorry, two industry associations?

MR SUDHOLZ: I am.

MR ROZEN: The Aged Care Industry Association.

MR SUDHOLZ: Correct.

MR ROZEN: And The Aged Care Guild.

MR SUDHOLZ: Correct.

MR ROZEN: Japara provides care services for approximately 4000 residents - - -

MR SUDHOLZ: Yes.

MR ROZEN: - - - in the 49 homes that you've already referred to?

MR SUDHOLZ: Correct. Yes.

MR ROZEN: And it employs about 5500 people?

MR SUDHOLZ: Approximately 5500 people. Yes.

MR ROZEN: Publicly listed company?

MR SUDHOLZ: Yes. We listed in April 2014.

MR ROZEN: And you tell us in your statement that the company has approximately 8200 shareholders.

MR SUDHOLZ: Yes.

MR ROZEN: And you've provided us, in response to questions from the Royal Commission, with some financial information, which I will just ask you about briefly. If tab 203 could please be brought up. Sorry, Commissioners. Would you just excuse me a moment. Sorry, I think it's 204. My apologies. Just – we will do it by means of the document ID. My apologies, Mr Sudholz. It's JAH.0121.0001.0001. Sorry, Commissioners. That's it. Thank you very much. My apologies, Mr Sudholz. And apologies, Commissioners. That's some financial information that you provided to the Commission, attached to your witness statement, Mr Sudholz; is that right?

MR SUDHOLZ: Yes. It is.

MR ROZEN: And what that shows us – and it's perhaps a little bit hard to read, but the total revenue and other income for the most recent financial year is $373 million – sorry, $373,188,000; is that right?

MR SUDHOLZ: Yes. Correct.

MR ROZEN: And net profit after tax, $23,327,000?

MR SUDHOLZ: Yes. Correct.

MR ROZEN: Are you able to tell the Commission what proportion of income comes by way of Commonwealth subsidy?

MR SUDHOLZ: So at the bottom of that schedule the proportion of residential aged care services revenue to our revenue is 99.4 per cent.

MR ROZEN: But that's not – is that the entire Commonwealth subsidy or is some of that resident contributions that you've included there?

MR SUDHOLZ: I would need to come back to you exactly on that, but I - - -

MR ROZEN: All right.

MR SUDHOLZ: My understanding of that is that it's the Commonwealth funding.

MR ROZEN: Okay. We might ask you, if you wouldn't mind, to clarify that for us through your solicitors, if you could, please. I don't think it's controversial, but it would be helpful to have that information. Thanks. Now, Mr Sudholz, you've been present in the hearing room for the entirety of the hearing, have you not?

MR SUDHOLZ: I have.

MR ROZEN: And you've heard some evidence about the operations of Japara, concerning Ms Hausler, which would be of concern to you, I suggest.

MR SUDHOLZ: Sorry, could you repeat that question?

MR ROZEN: Yes.

MR SUDHOLZ: I didn't quite hear it.

MR ROZEN: Are you concerned about the evidence that you've heard from the point of view of the company's values?

MR SUDHOLZ: No. I think there are – I am concerned about aspects of Mr Hausler and Ms Hausler's situation. But in respect to the quality care for the company, no, I'm not concerned.

MR ROZEN: Okay. Perhaps my question wasn't clear enough. I'm not so much concerned at the moment with the evidence about the quality of care, but, rather, the evidence about some of the internal communications between senior staff members. Any of those communications cause you concerns?

MR SUDHOLZ: Yes.

MR ROZEN: Which ones in particular?

MR SUDHOLZ: I think, in respect of some of the documentation I've seen, the wording around some of the documentation could have been better put, and that gave me some concern.

MR ROZEN: Infelicitous language was used. Is that what you're saying?

MR SUDHOLZ: Not so much the language that was used, but – particularly in respect of the legal letters that we had, I think that could have been – the wording of that. So not so much the exchange of the message but the wording around the message, I think, could have been better in those legal letters.

MR ROZEN: Could tab 38 please be brought up, Operator. Just while that's happening, you will recall the evidence about the email from Ms Keevers to Julie Reed, attaching Ms Hausler's written complaint, Mr Sudholz?

MR SUDHOLZ: Yes.

MR ROZEN: And I draw your attention specifically to the second last paragraph there, which starts:

Can you vet the response?

Perhaps if that could be highlighted, please. Do you recall this evidence about Ms Keevers' writing:

I've dated it the 5th, so it looks like we thought about it seriously.

MR SUDHOLZ: I recall seeing this in the hearings, yes.

MR ROZEN: Yes. Cause you any concerns, Mr Sudholz?

MR SUDHOLZ: This matter was principally being dealt by Julie Reed - - -

MR ROZEN: Yes.

MR SUDHOLZ: - - - and the quality manager, Di Jones, together with Kim Keevers and when Rachael came on as a facility manager. And I am not the author to these correspondence, so I think you're better off – I know you're asking me the question but I don't know when these emails have gone and what the intent of the email between those parties were. So I expect that these emails represent the policies and procedures of the firm and I believe they do.

MR ROZEN: One of the values of the firm – there are five, aren't there, Mr Sudholz? Five values?

MR SUDHOLZ: Five values.

MR ROZEN: Stated values. They're in a number of documents including the staff handbook.

MR SUDHOLZ: Yes.

MR ROZEN: One of them is honesty, isn't it?

MR SUDHOLZ: So at the moment, our values are around the word "create", and those values are compassion, respect, excellence, accountability, teaming and enjoyment. And the values that you talk about are the values that were applicable to the company in that time from probably 2015 to 2017, I believe.

MR ROZEN: We've got rid of honesty.

MR SUDHOLZ: No, certainly not, no. Respect, the word "respect" as we go underneath those values are honesty, integrity and others, but honesty and integrity is in the word "respect". So we've changed our values to respect, because I think respect is a very important element of our industry. Respect for all people that work in the industry - - -

MR ROZEN: Yes.

MR SUDHOLZ: - - - across the workforce and the residents and their family as well as the operators in the industry.

MR ROZEN: And integrity which was a value as at September 2015 is gone, too, from the current set of values; is that right, Mr Sudholz?

MR SUDHOLZ: Sorry, I couldn't hear the question.

MR ROZEN: Integrity was a value in September 2015, wasn't it, a stated value?

MR SUDHOLZ: Yes. Integrity was. Yes.

MR ROZEN: It's no longer a stated value; is that your evidence?

MR SUDHOLZ: No, integrity is a – it is a value of the company. Absolutely.

MR ROZEN: I see. Let's go back to September 2015; there's no doubt that honesty and integrity were stated values at this time, weren't they?

MR SUDHOLZ: Correct.

MR ROZEN: Do you think that what Ms Keevers wrote to Ms Reed was consistent with the values of honesty and integrity?

MR SUDHOLZ: Well, as I said, I wasn't the author to this email, so I don't know what the intent of it was so I could not make a comment on that.

MR ROZEN: Mr Sudholz, it's abundantly clear, isn't it, that Ms Keevers was writing to her boss that she had dated the response a particular date, so:

It looks like we thought about it seriously.

I will unpack that for you and suggest what she was saying is we haven't taken it seriously but we will make it look like we have by putting the date of the 5th on it. Do you think it means anything other than that?

MR SUDHOLZ: I couldn't say.

MR ROZEN: If that's what Ms Keevers was meaning, and I understand you're saying you don't know, but if that's what she was meaning, that would be deeply concerning, wouldn't it, for a quality manager to be saying that within your organisation?

MR SUDHOLZ: I think – as I say, I'm going to repeat myself. I don't – I'm not the author of this document, right, and if I was the author of the document I could answer the question but I'm not the author of the document.

MR ROZEN: I'm asking you to accept a hypothetical, that that's what she meant. She meant we're dating it the 5th - - -

MR SUDHOLZ: Yes.

MR ROZEN: - - - so it looks like we've taken it seriously, even though we're not. If that's what she was intending, that would be deeply concerning to you as the CEO.

MR SUDHOLZ: Yes, if that was the case.

MR ROZEN: Yes. And similarly, if that's what she was intending, it would be deeply concerning to you that Ms Reed didn't ask her about that when they met the following day to discuss the email.

MR SUDHOLZ: Yes.

MR ROZEN: You would expect her to say, "Surely you don't mean what it looks like what you've written in that email", or something like that, wouldn't you?

MR SUDHOLZ: So as the CEO, I've got a lot of a responsibilities and - - -

MR ROZEN: Sure.

MR SUDHOLZ: And as I say, in respect of these emails, I'm not the author of them and I don't know the substance behind them.

MR ROZEN: Yes.

MR SUDHOLZ: So you're asking me a question which, with due respect, I just can't give you the answer on.

MR ROZEN: I see. So your evidence is this, is it, you're just entirely neutral on this email because you don't know what Ms Keevers was really meaning. Is that your evidence?

MR SUDHOLZ: No.

MR ROZEN: Well, what is your evidence about this email, Mr Sudholz? Does it concern you?

MR SUDHOLZ: Well, I will try and repeat myself, I guess. I look at this email, I understand what it says, but I'm not the author of the email. I don't know what was behind the circumstances of it. It might have a different meaning. So I look at that letter and, as I say, I'm not the author of it, so I can't respond on what you're saying.

MR ROZEN: Can you suggest any other meaning apart from the one that I have suggested to you, Mr Sudholz?

MR SUDHOLZ: Other meetings?

MR ROZEN: I'm sorry? Other meanings.

MR SUDHOLZ: Other meanings.

MR ROZEN: Can you suggest another meaning to what Ms Keevers wrote other than the one that I suggested to you?

MR SUDHOLZ: Well, it is important that in the organisation structure that we do get – so we do take everything very seriously, and it is important that we do get the correspondence and the response letter absolutely correct. So it is not unusual to get that outcome, that people will review correspondence to check for its accuracy and maybe that was what she was meaning.

MR ROZEN: You will recall that there was evidence given yesterday that the incident described by Ms Hausler in her written complaint of 2 September, which is what this email communication was about, was not reported to the Department of Health at the time?

MR SUDHOLZ: The incident on the - - -

MR ROZEN: 1 September.

MR SUDHOLZ: 1 September.

MR ROZEN: That is being described in the complaint that is attached to this email.

MR SUDHOLZ: Yes.

MR ROZEN: The written complaint.

MR SUDHOLZ: Yes.

MR ROZEN: You recall that wasn't reported to the Department of Health within the 24 hour period required by the Aged Care Act.

MR SUDHOLZ: So Ms Reed's evidence was that she found that that didn't need to be reported.

MR ROZEN: Yes, that's right. And it was because it was characterised in the communication between herself and Ms Keevers as rough handling. Do you recall the evidence she gave about that?

MR SUDHOLZ: Yes, I do recall it.

MR ROZEN: Now, your position on that is that there's no distinction between rough handling and reportable assaults, isn't it?

MR SUDHOLZ: That's - - -

MR ROZEN: You don't recognise that distinction.

MR SUDHOLZ: That's correct.

MR ROZEN: Ms Reed was wrong in saying that because it was rough handling it didn't need to be reported; is that right?

MR SUDHOLZ: No. And the reason I put it in my witness statement at that particular time is what I believed at that particular time.

MR ROZEN: Yes.

MR SUDHOLZ: We go through changes in policies and procedures based on changes in our industry, whether it's through the Aged Care Act or regulations and we change our policies and procedures. In my witness statement I've given evidence towards what those policies – what those committees are and we have under those committees 22 policies, and we upgrade those 22 policies on a regular basis to ensure they are in line with where the industry is and they are align with our mission to

provide the best possible care to our residents. On the – I can't say the exact date but it was somewhere around 2018 we changed, for instance, our policy on incident reporting. And so following that policy there was greater understanding and knowledge of what rough handling was, because it became a terminology that was more consistent with what was happening in the industry. We are talking about a period back in 2015 so there is a big time difference between what Ms Reed said and what I said because I'm saying this as at today following changes in our policies and procedures, and what I put in my witness statement is absolutely correct. I do not believe there is any instance in this industry where rough handling is acceptable and it needs to be reported.

MR ROZEN: You've got no doubt this should have been reported within the 24 hour period - - -

MR SUDHOLZ: Sorry?

MR ROZEN: You've got no doubt this should have been reported within the 24 hour period, Mr Sudholz.

MR SUDHOLZ: No, that's not what I said.

MR ROZEN: You accept Ms Reed's judgment, do you, that it was not a reportable matter?

MR SUDHOLZ: I did because Ms Reed and others in the facility take those issues and it's their judgment as to what they should do with it and then they report it up through our reporting processes, so in that sense, yes, I do.

MR ROZEN: Have you read Ms Hausler's written complaint?

MR SUDHOLZ: Yes, I have.

MR ROZEN: You have.

MR SUDHOLZ: Yes.

MR ROZEN: And you stand by that, that it was not a reportable matter as described in that complaint?

MR SUDHOLZ: No, what I said is at the time that it occurred the reason I understand Ms Reed did not report it is because she felt that it was a non-reportable incident.

MR ROZEN: And I'm asking your view and is your evidence that you accept her judgment?

MR SUDHOLZ: I do.

MR ROZEN: Is that what it amounts to?

MR SUDHOLZ: I do, because I am not a clinical nurse.

MR ROZEN: I see. You don't have to be a clinical nurse to see the unreasonable use of force concerning an 89-year-old man, do you, Mr Sudholz?

MR SUDHOLZ: No. But I didn't see that.

MR ROZEN: You have attached to your witness statement a lengthy document which I'm going to ask you some questions about. It's tab 209 and this is your table of mandatory reports, Mr Sudholz, so you know where I'm taking you. I'm not sure if it has been explained to you or not, Mr Sudholz, but the names in the document that you've provided to the Commission have been replaced by pseudonyms; do you understand that?

MR SUDHOLZ: Yes.

MR ROZEN: All right. If at any point in this questioning it's unclear to you what I'm referring to because of the pseudonym, please let me know. It's not easy to follow but - - -

MR SUDHOLZ: Mr Rozen, I do have tinnitus in my ears so if I ask a question, it's the reason I'm not quite picking up what you're saying.

MR ROZEN: All right.

MR SUDHOLZ: So I apologise for that.

MR ROZEN: I will do my best to keep my voice up. I'm not normally criticised for being too quiet, Mr Sudholz. Now, I'm going to ask you about a few of the entries in your document, AS10, and just so that it's clear what it was that you were responding to, you were asked by the Commission's solicitors to detail all of the mandatory reports that have been made by Japara between 1 September 2015 and the present time, or the date of the notice.

MR SUDHOLZ: Yes.

MR ROZEN: Is that right?

MR SUDHOLZ: Correct.

MR ROZEN: All right. If I can, first, take you to page 0005, this is the Bayview facility. Where is that located, Mr Sudholz?

MR SUDHOLZ: That facility is located at Carrum Downs in Melbourne.

MR ROZEN: And we can see that there's a number of reports. If we look at the first one at the top of the page:

Resident alleged husband hit her.

Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: On 15 December 2015. So some of the reports included do not concern staff aggression directed at residents. That's the case, isn't it?

MR SUDHOLZ: That's correct.

MR ROZEN: Right. I'm going to confine myself to those that do concern allegations of staff aggression directed to residents. Do you understand?

MR SUDHOLZ: Yes.

MR ROZEN: And you will see that on that page, the next entry, 15 January 2016:

Resident alleged that staff member forced her head and neck down while changing her into her nightie.

MR SUDHOLZ: Yes.

MR ROZEN: Do you see that?

MR SUDHOLZ: Yes, I do.

MR ROZEN: And that was a matter reported on that day to the police.

MR SUDHOLZ: Yes.

MR ROZEN: We see that from the last column, and the pseudonym that's given to the alleged perpetrator is TD. Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: Then if we go to the next entry, 12 February 2016, so about four weeks later, a report:

Resident alleged that staff member threw the call bell at her hitting her on the right knee.

Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: Again, the staff member is the same person with the pseudonym TD, do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: And then we have a third entry on the next line, two months later, 16 April 2016:

Resident alleged that staff member slapped her across the face.

Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: And once again, alleged perpetrator TD.

MR SUDHOLZ: Yes.

MR ROZEN: Under the policies that existed at this time within Japara there was a requirement for there to be an internal investigation into any such incident that was reported to the department, wasn't there?

MR SUDHOLZ: Yes.

MR ROZEN: Yes. Are you in a position to say whether or not such an internal investigation occurred in relation to these three matters?

MR SUDHOLZ: No, I don't have the knowledge around that but I'm happy to come back to you with that information.

MR ROZEN: No. Thank you. You would expect, though, in accordance with the applicable procedures, that such an investigation would have occurred?

MR SUDHOLZ: Yes.

MR ROZEN: Is that the case?

MR SUDHOLZ: Yes.

MR ROZEN: My question is this. If, in fact, such an investigation had taken place, how is it that there were three incidents involving the same carer in a period of just over three months? Are you able to explain that to the Commission or would you need to look at the investigation reports?

MR SUDHOLZ: No. I don't have that knowledge, I'm sorry.

MR ROZEN: All right.

MR SUDHOLZ: But I'm happy to – as I said before, I'm happy to find out the circumstances around that.

MR ROZEN: It's concerning, isn't it, Mr Sudholz?

MR SUDHOLZ: Concerning - - -

MR ROZEN: Well, that the one - - -

MR SUDHOLZ: - - - about what?

MR ROZEN: - - - staff member was able, apparently – and I under they're only allegations, but the one staff member had been involved in those three incidents, despite the fact that there had been investigations into that staff member?

MR SUDHOLZ: Well, I think we followed the right process, if you – I'm not sure whether that's the question, but we have followed the right process there.

MR ROZEN: You think you've followed the right process - - -

MR SUDHOLZ: It was - - -

MR ROZEN: - - - did you say?

MR SUDHOLZ: It was an allegation.

MR ROZEN: Yes.

MR SUDHOLZ: And it got reported, and it got reported within the 24 – let me just check – 15, 16. It got reported within the 25 – 24 hour period that's required.

MR ROZEN: Yes, no doubt about that. My question is a different one, though. What else did you do, other than reporting it? It's whether the internal investigations had addressed whether there was a problem with TD. That's what I'm getting at, Mr Sudholz.

MR SUDHOLZ: I understand the question - - -

MR ROZEN: Do you understand?

MR SUDHOLZ: - - - but I don't have the knowledge - - -

MR ROZEN: Okay.

MR SUDHOLZ: - - - to that detail.

MR ROZEN: So if the Commission was to ask you for copies of the investigation reports into those three incidents, you would expect that they would be available to us, would they?

MR SUDHOLZ: I would expect that they would be, yes.

MR ROZEN: Yes. And can we expand that? Would you expect that there would be an investigation report into each of the mandatory reports included in your table AS10?

MR SUDHOLZ: Well, if the allegation – so this is a list of allegations of suspected abuse.

MR ROZEN: Yes.

MR SUDHOLZ: So if the allegation is – is not that and it's not substantiated - - -

MR ROZEN: Yes.

MR SUDHOLZ: - - - then probably not.

MR ROZEN: So your evidence is that the investigation reports might reveal, in respect of these allegations, that they were unfounded, for example?

MR SUDHOLZ: Correct. Yes.

MR ROZEN: So in the end we would have to see what those investigation - - -

MR SUDHOLZ: I think so.

MR ROZEN: - - - reports say - - -

MR SUDHOLZ: Yes.

MR ROZEN: - - - as would you? You see, the reason I'm asking this, Mr Sudholz, is we know about one case. We've looked at it - - -

MR SUDHOLZ: Yes.

MR ROZEN: - - - forensically and in detail.

MR SUDHOLZ: Yes.

MR ROZEN: And we've heard about the investigations that were conducted in respect of the three incidents involving Mr Hausler.

MR SUDHOLZ: Yes.

MR ROZEN: Do you understand? The ones on 31 August, 1 September and 10 September. And those investigations, I suggest to you, were fairly cursory. Do you agree with that?

MR SUDHOLZ: I – I think what I said before is – is what I believe.

MR ROZEN: Yes.

MR SUDHOLZ: So the incident that had occurred on Mr Hausler on 31 August that was recorded in writing and received on 3 September, when that incident was reported it was reported and Julie Reed became involved with that, together with our quality manager and the other staff members, and they took a view that that incident wasn't reported at that stage, based on the information that they had.

MR ROZEN: Can I take you to the page number that ends in .0016, concerning the Elanora facility. What state is that in, Mr Sudholz, do you know? Do you know where the Elanora facility is?

MR SUDHOLZ: It's in Victoria. Melbourne.

MR ROZEN: Right. And you will see that there are three reports there. The first I draw your attention to is 2 November 2018. Do you see that in the second line?

MR SUDHOLZ: Yes.

MR ROZEN: Involving a resident, HI.

MR SUDHOLZ: Yes.

MR ROZEN: And the allegation is:

> *Rough handling by staff during the course of assisting with activities of daily living, reported by daughter.*

Do you see that?

MR SUDHOLZ: Yes. I do.

MR ROZEN: And then three months or so later, on 5 February 2019, another allegation involving HI:

> *Resident accused carers of rough handling.*

Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: And then a third incident involving the same resident, third allegation, 4 April 2019:

> *Daughter commented that there was a bruise of unknown cause and believed this was due to rough handling.*

Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: The reports were all made in recent times, 2018, 2019. Does that reflect the changed approach at Japara that you spoke about earlier, where rough handling is now more likely to be reported than was the case in 2015? Is that the explanation for that?

MR SUDHOLZ: No.

MR ROZEN: No?

MR SUDHOLZ: No.

MR ROZEN: What does that term mean within Japara, "rough handling"? It's not a term we see within the legislation, is it?

MR SUDHOLZ: No. It isn't.

MR ROZEN: What does it mean to you?

MR SUDHOLZ: I've got it in my witness statement, if you would like to – me to read that out.

MR ROZEN: Sure.

MR SUDHOLZ: If you could put it up for me, please?

MR ROZEN: I will bring it up for you, I'm sorry. Paragraph 59, I think, might be the one, on page .0010. Thank you. The bottom of the page there, para 59, is that what you're referring to, Mr Sudholz?

MR SUDHOLZ: Yes. So my understanding of rough handling is a resident being subjected to unnecessary physical force. It is not acceptable under any circumstances. That's the definition. I think I went on to explain a little bit more around that.

MR ROZEN: Don't you think the incident on 1 September that was the subject of Ms Hausler's complaint falls squarely within that definition? Unnecessary physical force?

MR SUDHOLZ: As I said before, it's a definition that I – that's my definition.

MR ROZEN: Yes.

MR SUDHOLZ: There are many other definitions of rough handling, but that's my definition.

MR ROZEN: Okay.

MR SUDHOLZ: And in my definition I do say that:

Rough handling is a resident being subject to unnecessary physical force.

So in terms of how that goes in respect of Mr Hausler, then, as I said before, Julie Reed and the quality managers, on the information that they were given at that particular time, took a view on what that event was. And I didn't have any knowledge of that event. I didn't see the event.

MR ROZEN: I understand. Can we go back to your table, please, which is document 209. And can I just go back to that Elanora reference that I was asking you about.

MR SUDHOLZ: Yes.

MR ROZEN: There are three incidents that I've taken you to, all involving the one resident being the subject of rough handling by, on each occasion, different carers. Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: Each of those was considered serious enough to be the subject of reports - - -

MR SUDHOLZ: Yes.

MR ROZEN: - - - by Japara to the police and to the Department.

MR SUDHOLZ: And that was the decision taken by the facility manager and the quality manager, who was responsible at that stage. Yes.

MR ROZEN: It's a concern, isn't it, as you sit there now, that there were three such allegations involving the one resident in a short period of time?

MR SUDHOLZ: That was over a period of five months. Yes.

MR ROZEN: Yes. And it's a concern, isn't it, Mr Sudholz?

MR SUDHOLZ: In the respect of the timeframe, what's – or in respect of the activity?

MR ROZEN: Well, you tell us.

MR SUDHOLZ: Well, no, I'm not concerned.

MR ROZEN: You're not concerned?

MR SUDHOLZ: Well, based on the information I've got in front of me, I'm not concerned. And can I explain why that would be?

MR ROZEN: Yes.

MR SUDHOLZ: So in this schedule that we have, it's a schedule of allegations of suspected abuse.

MR ROZEN: Yes.

MR SUDHOLZ: You had stated that there – it's 298 abuse issues or allegations, I think - - -

MR ROZEN: Yes.

MR SUDHOLZ: - - - was the number. In that process – and you look through the allegation and the suspicion around that, it is quite often that it is unfounded, you know? So it isn't abuse at all. It's just an allegation and it becomes unfounded, and we go through that in detail. And then, as you mentioned before, there's resident-on-resident abuse. And if we go through all of these within that schedule, based on my information, and I will be pleased to give the Commissioners an updated report on this, the number of actual assaults – actual assaults, not alleged or suspected, but actual assaults is much much less than that.

And the number at the moment that I understand is under 100. So when I look at that, I am – don't have the information around me to determine that, but I will get back to you, as I mentioned before, on what that comprises. And under that basis, it isn't 298 assaults that Japara has had over four and a half years. It is a figure much less than that. And that is the table that we have got in front of us.

MR ROZEN: Once again, Mr Sudholz, you assume there, in accordance with the procedures in place in Japara at this time, that each of these matters would have been the subject of an investigation?

MR SUDHOLZ: Yes.

MR ROZEN: And that if we asked you, there would be reports in respect of these investigations?

MR SUDHOLZ: Yes.

MR ROZEN: Yes. Because in the absence of that information, I will make this quite clear, we're interested in systemic issues here. The Commission is concerned to examine where there are systemic problems - - -

MR SUDHOLZ: Right.

MR ROZEN: - - - in relation to abuse in nursing homes. Do you understand - - -

MR SUDHOLZ: Yes. Yes.

MR ROZEN: - - - that's part of our - - -

MR SUDHOLZ: I understand that. Yes.

MR ROZEN: - - - terms of reference. And, superficially at least, it looks like trends in these documents that you've provided us with, where you've got one carer that is the subject of different allegations and then on other occasions you've got one resident that is the subject of different allegations.

MR SUDHOLZ: Yes. Yes.

MR ROZEN: And we know, of course, in the case of Mr Hausler, that we've gone well beyond allegations, haven't we? We've got - - -

MR SUDHOLZ: No, it was – it was a terrible thing.

MR ROZEN: - - - proven assaults: three in 10 days.

MR SUDHOLZ: Yes.

MR ROZEN: Yes. That has got to be disturbing to you, Mr Sudholz. Three assaults in 10 days.

MR SUDHOLZ: Yes. Yes.

MR ROZEN: And we know that in relation to the first two there were not investigations and, therefore, the third incident was allowed to occur, wasn't it?

MR SUDHOLZ: So in respect of that – of that situation, Julie Reed and the staff at the facility, as I said before, on the information that was available to them, took the decision regarding the allegation. You've heard her evidence and she – and she took the view that – and others that it wasn't a reportable situation.

MR ROZEN: Can I take you to the entry for the Mitcham facility, please, which you will find at page 0035. We see on that page the three incidents involving Mr Hausler. Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: The first three entries there. And then there's a further entry some – on 29 November 2016, do you see that, involving KR? Reported physical assault by - - -

MR SUDHOLZ: KR?

MR ROZEN: KR.

MR SUDHOLZ: Yes. Yes.

MR ROZEN: - - - is the – yes. Reported physical assault by registered nurse to resident.

MR SUDHOLZ: Yes.

MR ROZEN: And, once again, your evidence, I assume, is that you would expect that that matter had been investigated in accordance with the protocols applicable?

MR SUDHOLZ: Yes.

MR ROZEN: And, of course, the purpose of those investigations is to identify if there are any systemic problems, isn't it? That's one of the reasons why these investigations are conducted?

MR SUDHOLZ: Absolutely.

MR ROZEN: So systemic issues might involve that, "We're employing the wrong sort of staff", for example, might be one issues you would be concerned to consider?

MR SUDHOLZ: Yes. Or could be training. So we have - - -

MR ROZEN: Yes.

MR SUDHOLZ: - - - very detailed training programs, and maybe that we need to instigate better training. So, you know, they're – continuous improvement in the business is absolutely imperative. And if there is something in the business that isn't working, we need to understand it and we need to come up with a solution and in – better processes, if that's required. So it might well be that the training element needed to be improved, but I don't know.

MR ROZEN: Mr Sudholz, have you had cause to reflect on how it was that Mr Hausler was assaulted three times in a 10-day period?

MR SUDHOLZ: How it was?

MR ROZEN: Yes. How could that happen within your organisation by two different carers?

MR SUDHOLZ: I don't have the knowledge as to the – well, sorry, no ..... how did that happen? I don't actually have the knowledge of – I certainly have the knowledge of Mr Hausler but when you say "how it happened", I'm not sure what, in terms of the policies or the procedures, is that what you're asking?

MR ROZEN: Or staffing arrangements.

MR SUDHOLZ: Staffing arrangement.

MR ROZEN: Was there a report to the board about these three incidents?

MR SUDHOLZ: Yes. Yes, there was.

MR ROZEN: Was there? And did it identify any systemic issues that needed to be addressed?

MR SUDHOLZ: Well, we put in extra training. We followed up this issue and we put in other places to improve what was there so we put in extra training modules for the staff.

MR ROZEN: Yes.

MR SUDHOLZ: Yes.

MR ROZEN: That was the recommendation arising from the report, was it, that this was a lack of training issue?

MR SUDHOLZ: Well, I don't know whether it was a lack of training per se, but it was to make sure that the training around – particularly around elderly abuse was kept up to speed and consistent, so I'm not sure whether it was lack of training. I think it was to ensure that our training processes were being embedded appropriately.

MR ROZEN: Finally, Mr Sudholz, you were personally quite involved in dealing with concerns raised by Ms Hausler, weren't you, in 2016?

MR SUDHOLZ: I was involved but I wasn't – so yes, I was involved.

MR ROZEN: Did you get involved as the CEO in every complaint raised by a resident's family at one of your facilities?

MR SUDHOLZ: No, I don't get involved in every incident but I do get involved in the facilities. So throughout the 49 facilities, I visit them on a regular basis, I talk to residents and I talk to staff. In some instances I will go to resident and relative meetings. In other instances I will visit a facility to celebrate maybe a resident's birthday when they turn 104, for example, I will travel to the facility and celebrate that. It's a good way for me to really understand what's going on the ground so I do try and do that. In respect of the Mitcham facility I was involved in understanding the occurrence – occurrence on that and having the report up to the board around that.

COMMISSIONER BRIGGS: Mr Sudholz, do you, as a matter of course each month – excuse me, I've got a cold – look through the incidences of assaults that have occurred month on month?

MR SUDHOLZ: We do on a month on month basis, yes, Commissioner.

COMMISSIONER BRIGGS: And what is the governance structure around looking at those assaults and instituting follow-up action?

MR SUDHOLZ: So at the board level we have the incident reporting mechanism and so in – at the board every month there is a report on incidents in all of our facilities, and that's that schedule that we see in front of us, and there is a summary provided by our current – equivalent of the executive director of care but that's a group executive of care and commercial, Wendy Waddell, and in some instances we will have other people come into the board to report specifically on a particular incident. So the board is well informed on what these incidents are and what transpires out of them.

MR ROZEN: Are you confident, Mr Sudholz, that Japara has sufficiently rigorous investigation-conducting methodology, or investigation capacity to get to systemic issues in relation to staff on resident assaults?

MR SUDHOLZ: So answer – I will answer the question in two ways. Yes, to the first part of the question. No, to the second part of the question. The second part of the question, the reason I say no is that if we go through the 49 facilities on that schedule and we look at the allegation or suspicion of abuse, and we work through what is an allegation and it's unfounded and you can see reasons why that occurs quite easily, across the 49 facilities and around 4000 – 4000 residents, the allegation of abuse that comes to substantiate it, and we – then we deal with, is less than 100 over four and a half years. I don't believe that is systematic – systematic at all. I think that is – I have nothing to benchmark that against, so good businesses have benchmarking across all the sectors that we have.

I don't have any benchmarking to say whether that is better or worse than industry. But I don't believe that we are doing anything other than providing good corporate governance and good care to our residents, and under no circumstances is abuse acceptable to the industry or to Japara. And I apologised to Ms Hausler and – on the

basis of what happened to her father. It was a terrible incident and we all were aggrieved by it and we all didn't want it to happen, but it did. And that's an example of what we have to get rid of in this industry, right, but we do work in a people industry. I employ four – 5500 people across my portfolio and what we have to do is train them. We have to have the quality in the workforce, we have training, we have to get the technology around them to make sure that abuse does not occur in any of our facilities. In respect of Japara's I don't believe that's a big number. I think it's a small number when you look at four and a half years across that number of residents. The allegations that we take through our procedures are correct, they are good, they are strong. And there is no systematic problem in Japara, in my view.

MR ROZEN: Just a few bad apples, Mr Sudholz?

MR SUDHOLZ: Criminal, Corey Lucas was a criminal.

MR ROZEN: Yes.

MR SUDHOLZ: It can't get much worse than that.

MR ROZEN: I suggest to you that watching the videos which you've done with us in the hearing yesterday - - -

MR SUDHOLZ: Yes.

MR ROZEN: - - - taking into account three assaults across 10 days involving two different carers - - -

MR SUDHOLZ: Yes.

MR ROZEN: - - - it suggests a culture of impunity, at least within the Mitcham facility. In other words, staff members considering they could behave that way without fear of being found out.

MR SUDHOLZ: Well, no.

MR ROZEN: What do you say?

MR SUDHOLZ: I don't agree with that. So the times I went into the facility, I felt – so with the exclusion of Mr Hausler because I came into the facility obviously after that – after that event I spent some time in the facility. And when I went into the facility and looked at the staffing and I spoke to the residents, and their families, the majority of them were very positive about the care that we were providing in that facility. And an example of what we do, we have resident surveys both within Japara and external Japara that Japara participates in. And we have had surveys Mitcham at a high sample rate, in the 65-70 per cent and in one of those – in most of them, but I can recall only one, the residents' response to the care that Japara was providing was excellent. They made comments about good lifestyle. They made comments about

the quality of care. They made comments about the staff that we had looking after them, right.

So I rely on those metrics. I'm not in the facility every day of the year, but I do rely on those metrics and that gives me comfort that excluding the Mr Hausler event, that the care in Mitcham is good and strong. It's reflected by – and there is an email, I think, in the evidence that reflects on the fact that the facility is a 100 per cent occupied. You can only get 100 per cent occupation in this industry if the industry and the community knows that you're providing care. That's how we have residents referred to us, through the – through the referral network, through the community, through the hospitals, through the GPs. If we're not providing good care, they know about it and they don't refer to us. And we're 100 per cent full and we – and it wasn't 100 per cent full before we took it over. We spent – as you know, we spent a substantial amount of money in cleaning the place up, in terms of providing – Julie Reed has given you that evidence in cleaning the place up.

We then – we changed the staffing on it. We put in better food services, and we changed the kitchen which was a disgrace, and the food preparation improved dramatically. And the majority of the residents that live in Mitcham are really, really happy and the staff have great relationships with, and those relationships are so important in giving best outcomes for our residents and we have programs around that. So you asked me the question and I think Mitcham is doing well. If we look at it individually, I've given you the individual situation. I do not believe there is any systemic issues in Japara. Less than, say, 70 out of 4000 residents over four and a half years does not tell me that it's systemic.

MR ROZEN: What was the financial position with Whelan when Japara purchased Mitcham; are you able to tell us - - -

MR SUDHOLZ: Sorry?

MR ROZEN: Were Whelan in financial trouble when Japara purchased the Mitcham facility?

MR SUDHOLZ: I'm not aware of that.

MR ROZEN: You don't know.

MR SUDHOLZ: No, I don't know the circumstances. I did the negotiation with Mr Whelan but I'm not aware of the circumstances there.

MR ROZEN: Okay. Now, you've included in your witness statement an apology to Ms Hausler, haven't you?

MR SUDHOLZ: Yes.

MR ROZEN: And as you sit there now, Mr Sudholz, you accept, don't you, that Ms Hausler was motivated throughout the period we've been examining, 2015/2016, she was motivated throughout that period by a concern for her father's safety and wellbeing, wasn't she?

MR SUDHOLZ: Absolutely, yes.

MR ROZEN: However, that hasn't always been your position, has it, Mr Sudholz?

MR SUDHOLZ: I think my position has always been that way.

MR ROZEN: I see.

MR SUDHOLZ: But there have been instances where circumstances may have led me to think, well, I'm not – I'm not – I have never felt that Ms Hausler has got the best intentions for her father. That has been the situation.

MR ROZEN: So you've never described her approach as vexatious, for example?

MR SUDHOLZ: So I did – I believe I have described her – a circumstance that I went through resulted in me saying to the – writing an email that said that it was vexatious and if I can explain that it will give the context of it.

MR ROZEN: You know what vexatious means, don't you?

MR SUDHOLZ: I do. I do know what vexatious means.

MR ROZEN: Without any cause.

MR SUDHOLZ: Well, that is not my interpretation of vexatious, so I haven't got the dictionary in front of me, I'm sorry, but if you want me to get it up I will give it to you.

MR ROZEN: No need.

MR SUDHOLZ: I'm sure vexatious means more things than that. So I think it was around mid-2016 that I attended a facility manager meeting which I do – as I have evidenced, I do regularly throughout the facilities as best as I can, because we work 24 hours, seven days a week. And on the mid – I think it was mid-2016 we had a resident and relative meeting that I was attending. And in that meeting there were a number of people who were very abusive, very aggressive towards me, shouted me down, and showed little respect to me as the CEO of a big organisation. And I found that disappointing, and I was quite distraught about that. In actual fact, one of the residents or one of the resident's family members stood up to support the company because of the nature of the abuse that was coming from these individuals.

I then subsequently wrote to a couple of people, including my board, on the occasion of one – of Mitcham becoming 100 per cent occupied which was a very big result for us, you know. There were a lot of things going on at that time, and the negativeness that was coming through on Mitcham was difficult. There's no doubt. So to get to 100 per cent after the investment we had made, the training and the programs and the policies that we've put in was a fantastic result and sometimes you need to be proud about those results. So I wrote to the board and told them about that and at the same time I mentioned the word vexatious in the context of what I went through in the resident and relative meeting. It was our home, it was our residents, and it was our staff, and I don't believe anyone should have had the ability to come into our home and attack and criticise me as they did. And that's the word for vexatious that I used in that email.

MR ROZEN: Can tab 128, please, be brought up. I ask you to have a look at this email, Mr Sudholz, on the screen. It's an email you sent on 14 November 2016, do you recognise that?

MR SUDHOLZ: Yes.

MR ROZEN: Who are Linda Nicholls, David Blight and Richard England?

MR SUDHOLZ: They are board members of Japara.

MR ROZEN: I see. And you wrote:

> *Hi all, you will be pleased to hear that we have achieved 100 per cent occupancy at Mitcham ACF for the first time ever despite the ongoing complaints and vexatious approach by Noleen Hausler and her activist group.*

That's the email that you've just been referring to.

MR SUDHOLZ: I believe it is, yes.

MR ROZEN: And that's how you considered Noleen Hausler's approach in November 2016, vexatious?

MR SUDHOLZ: As I explained, in the context of – so that email was in the context of what I just explained in the – in the meeting that I had.

MR ROZEN: Could you have a look, please, at tab 139.

MR SUDHOLZ: I think.

MR ROZEN: An email written to a senior employee, Mr Woodley, and others:

> *Hi all, the issues with Noleen Hausler continue. I have asked Julie Reed to assist us given her extensive knowledge of the circumstances we are dealing*

with and Julie's responses to the various departments in respect to the complaints Noleen Hausler has been making. It is most likely this will escalate to a legal claim as lawyer –

Perhaps that should be –

...has asked for a mediation to settle the matter with compensation. This has been about financial gain to her and the action she has taken is for the purpose of putting us under pressure and forcing a settlement, which we will not do.

Do you see that?

MR SUDHOLZ: Yes.

MR ROZEN: And that was an accurate reflection of what you thought at that time, that this was about money for Ms Hausler?

MR SUDHOLZ: That's what she asked for, yes.

MR ROZEN: And this was just a couple of weeks after the passing of her father?

MR SUDHOLZ: Yes.

MR ROZEN: It reads like a battle cry, this email, Mr Sudholz; what do you say to that?

MR SUDHOLZ: Sorry, I didn't hear the question.

MR ROZEN: It reads like a battle cry, you know, we are not going to give up, we will fight Ms Hausler.

MR SUDHOLZ: Well, I'm sorry, but that certainly wasn't my approach.

MR ROZEN: I see.

MR SUDHOLZ: That was in respect to documentation I had received in respect to compensation.

MR ROZEN: Is the apology you make in your statement really a sincere apology, Mr Sudholz?

MR SUDHOLZ: Yes, it is.

MR ROZEN: No further questions, Commissioners.

MR SUDHOLZ: Can - - -

COMMISSIONER TRACEY: Mr Sudholz, does Japara have a policy about the utilisation of CCTV in its facilities?

MR SUDHOLZ: At the time of the incident, Commissioner, we did not have a policy on CCTV.

COMMISSIONER TRACEY: I'm more interested in the present?

MR SUDHOLZ: In the present situation we have done quite a deal of work. It's a very – so my position is that elder abuse behind closed doors has to stop. It's not acceptable under any circumstances. But on the other hand, it's a very complex and difficult position that we have gone through when we have spoken to a number of stakeholders over the years about how this might occur on – or might not occur. So it's the workforce, the people who are prepared to work or not under those circumstances, it's how the residents feel, how their families feel. It's the unions that get involved. It's the privacy issues, and then there's the legal issue as well. And we have experienced a lot of complex situations over this period of time as we've considered how we can improve outcomes for our residents.

At the present time, we think we're in a position to run a pilot study in one of our facilities where we have spoken to all of those stakeholders and put in place processes and documentation that if the resident and the family would like to have that happen, we can offer it to them. That pilot has not yet kicked off but we are only weeks away from it, I believe. The take-up, Commissioner, on it, is very, very, very small. It's three residents in a very large facility at the present time. But like any pilot, you learn by it and if it works, then it might be that we can do it in our other facilities and move on from there. So we have not sat still in this issue. We have continued to advance on innovation.

One thing that is an adjunct to that, we have – we have a partnership around digital health with a university and a number of other people, around technology that would improve the care that we provide to our residents using specialised glasses, right, and it's quite innovative, it hasn't been seen. And we're going to have to invest heavily to get it done, but that might be another answer to not having cameras in rooms because people have got the glasses on and they do amazing things. So I'm happy to – it's obviously a Japara initiative but I'm happy to share that with the Commission to show you what we are actually doing. We are not standing still on this issue.

COMMISSIONER TRACEY: Yes. Thank you.

COMMISSIONER BRIGGS: Can you hear me? Yes. I found the evidence over the course of the last day and a half disturbing in many ways, and there's an issue about defensiveness within the Japara organisation or, in particular, this home about taking responsibility for instances of substandard care.

MR SUDHOLZ: Right.

COMMISSIONER BRIGGS: I'm interested in how seriously the organisation, firstly, selects its staff and trains those staff and oversees those staff in its institutions on a day-to-day basis. Do you want to comment on that?

MR SUDHOLZ: Yes. So in staff selection, that is done through our human resources division and we have specific roles and responsibilities defined for different staff members, right, so we go through a detailed interview process with them. We will then do reference checking around them, depending on circumstances, and then once the new staff come into the facility or – and existing staff, there is an induction program, and that induction program is to educate them on the policies and procedures, and within the firm and outside the firm. And then during the course of the year, there are various training modules that we put our staff through. So those training modules might be incident reporting, manual handling, elder abuse, it might be a real estate issue. So we have a number of those training modules set up in the business, some of them are done in technology. I will use an example.

In respect of the new standards that are coming out which apply on 1 July, for which the industry probably isn't quite ready for, we have our normal training modules that people go, but we've created an app on the telephone and it's quite unique. It's a user-friendly app but it's to train our individual staff up in the field on the new standards so that they are bed ready for the new standards when they come in, 1 July. And that's an example of using technology in training and I only use it for that. So we do have detailed training processes in place. For senior management we have KPIs and they, as you would be well aware, KPIs and that's how they are measured at the end of the year in performance management, right. If we find there is an issue in respect of the quality of one of our staff, we will go through the appropriate human resources processes to deal with that and that may well finish up with a termination. It may well – if I'm talking about a negative thing, it may well finish up with a termination, it may well finish up with a warning depending on those circumstances. That's all held within our human resources area.

COMMISSIONER BRIGGS: The question is, however, isn't it, when you referred earlier in your evidence today to Mr Lucas being a criminal, what responsibility, as you – do you as the CEO take for his criminal activity in your facility?

MR SUDHOLZ: Well, we take full responsibility for that.

COMMISSIONER BRIGGS: I'm pleased to hear that. Do you have a concept around the professionalisation of care? I read in your witness statement, an example of person-centred care was giving people breakfast at a time they felt like it in the morning. What else do you think feeds directly into professional care that delivers on person-centred care?

MR SUDHOLZ: So I think the first thing on person-centred care is being able to establish a care plan for the resident which is around clinical care, but also around lifestyle and other activities. So you are defining a care plan that is specific to the

resident's outcome in the regulated environment that we work within, right, and I think that is person-centred care for the resident. Person-centred care means more than that just for the resident. It means how you interact with the resident's family, if they wish to have that interaction, and how you provide a care plan for the resident that the resident's family is happy with as well. So we will - - -

COMMISSIONER BRIGGS: As a result of this Royal Commission do you think you're going to institute further changes within your organisation to improve the quality and safety of care delivered?

MR SUDHOLZ: Yes.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising out of that?

MR ROZEN: There's nothing arising. I've no further questions for Mr Sudholz.

COMMISSIONER TRACEY: Mr Sudholz, thank you very much for your evidence. You're excused from further attendance.

MR SUDHOLZ: Thank you. Could I say something, Commissioners?

COMMISSIONER TRACEY: Yes, of course.

MR SUDHOLZ: And it just goes back to Mr Rozen's comment about am I sincere about my apology to Ms Hausler.

COMMISSIONER TRACEY: Yes.

MR SUDHOLZ: I'm absolutely sincere. It's an event that I regret and I wish it didn't happen. I think everyone does, and I have apologised in my statement. But I am absolutely sincere, and again I apologise to Ms Hausler, I'm sorry it happened, I'm sorry that you had to go through the circumstances that you did and I'm disappointed we let you down.

COMMISSIONER TRACEY: Yes. Thank you, Mr Sudholz.

<THE WITNESS WITHDREW [11.26 am]

COMMISSIONER TRACEY: The Commission will adjourn for 15 minutes.

ADJOURNED [11.26 am]

RESUMED **[11.49 am]**

COMMISSIONER TRACEY: Yes, Mr Borsky.

MR BORSKY: Commissioners, if I may, as we understand from our learned friend, Mr Rozen, that concludes the Japara witnesses that will be giving evidence before the Commission today. There is one further witness, Mr Stuart Woodley, and we received a request for a statement from Mr Woodley late last week. One has been provided. We were informed yesterday that Mr Woodley will be called to give oral evidence before the Commission. As we understand it, arrangements have been made for Mr Woodley to give evidence from Melbourne by video tomorrow morning, so if the Commissioners please, we would seek to be excused from attending here for the remainder of the afternoon but as a matter of curtesy, I wanted to raise that with the Commissioners before we all disappeared.

COMMISSIONER TRACEY: No, that's perfectly all right.

MR BORSKY: Thank you.

COMMISSIONER TRACEY: Thank you for the courtesy of raising it. Yes, Mr Bolster.

MR BOLSTER: Thank you, Commissioners. There's a change of direction and we move to an example of person-centred care through the evidence of Mr Jason Burton who I call.

<JASON BURTON, AFFIRMED **[11.50 am]**

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: If the document WIT.0214.0001.0001 could be brought up, please. Mr Burton, do you recognise that as a copy of your statement? It should appear on the screen in front of you.

MR BURTON: Yes, I do.

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

MR BURTON: No, I do not.

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

MR BURTON: Yes, they are.

MR BOLSTER: I tender Mr Burton's statement, Commissioners.

COMMISSIONER TRACEY: Yes, the witness statement of Jason Burton dated 4 May 2019 will be exhibit 5-14.

EXHIBIT #5-14 WITNESS STATEMENT OF JASON BURTON DATED 04/05/2019 (WIT.0214.0001.0001)

MR BOLSTER: Thank you. Now, Mr Burton, you are currently the head of Dementia Practice and Innovation at Alzheimer's Western Australia; correct?

MR BURTON: Yes, I am.

MR BOLSTER: Could you tell the Commission what your responsibilities involve in that role.

MR BURTON: My role at Alzheimer's WA is really across our whole approach to dementia, our philosophy, our care services, how we do our business, really, and ensuring that the way we do it is in line with the values and beliefs of our organisation and the expectations of our clients.

MR BOLSTER: You mentioned exploring and implementing innovation.

MR BURTON: Yes.

MR BOLSTER: Could you give us an ample of how you do that.

MR BURTON: So I think our innovation is around the way that we view and learn about the lived experience of dementia, and so it's – it's challenging the old thinking and the old paradigms of what it is to have dementia and find new and innovative ways of us being able to support people better.

MR BOLSTER: All right. We will come back to that in some considerable detail later. You also say that you work to support a consistent application of the dementia philosophy and care culture of the organisation. Could you just introduce what you mean by that at this stage.

MR BURTON: Yes, so our organisation has a way of viewing the lived experience of dementia within that person-centred framework that we're going to talk about, and really it's ensuring that the right – that it flows right through the organisation and everything that we do and the culture that we have.

MR BOLSTER: Could you speak briefly to the research strategy.

MR BURTON: Yes, so as part of our responsibility that we feel to support people living with dementia and the people who support them, we have a strong research focus at Alzheimer's WA where we partner with research organisations and researchers from around the world to look at evidence-based practice and particularly our key focus on knowledge translation and both generating the evidence of what works well and then actually finding ways to put that into practice.

MR BOLSTER: All right. And presumably when you say that you are developing partnerships and collaborations that's just an aspect of that research work, is it?

MR BURTON: It's part of the research work but also in our wider work as well that we do as an organisation, so we have international collaborations where – we like to think of ourselves as a learning organisation and that means we're constantly looking for best practice, new innovations, new ideas, new ways of working and so we have lots of partnerships with organisations from around the world.

MR BOLSTER: All right. We might come back to some best practice innovations towards the end of the examination. I just want to focus for a minute on you and your experience. So you've been at Alzheimer's for nearly 19 years now.

MR BURTON: Yes. It's been my pleasure to have been a staff member at Alzheimer's WA since the year 2000.

MR BOLSTER: Before that, you had worked as a registered nurse in the United Kingdom.

MR BURTON: Yes, so my first experience in this space was as a nursing assistant in a big old psychiatric hospital, and then I went on to become – to do my nurse training and become a registered mental health nurse and then specialised in dementia in that space.

MR BOLSTER: And in that practice did you come across, perhaps, the more extreme cases of dementia that you had to care for?

MR BURTON: I wouldn't say extreme cases of dementia because that's not my belief. I would say I met many people who were very distressed who were living with dementia in situations that were very challenging for them.

MR BOLSTER: All right. You're familiar with the Brodaty triangle.

MR BURTON: I am.

MR BOLSTER: Are we talking then about the people at the top of that triangle?

MR BURTON: And, again, I wouldn't necessarily subscribe to the Brodaty triangle because that's not my belief and philosophy of the lived experience of dementia, but certainly the people who are most challenged and often the least supported, yes.

MR BOLSTER: Yes. Okay. Well, let's pause there, talk about Alzheimer's Western Australia; what's the difference between Alzheimer's Western Australia and Dementia Australia?

MR BURTON: So just a very quick history lesson. Throughout the country approximately 35 years ago a number of Alzheimer's organisations were formed and they were formed as independent organisations with their own board and management structures, and it has been that way for – since that time up until a couple of years ago. We became a federated organisation so although we were all separate individual organisations we were federated together, shared a brand, shared commonality, but still run as separate organisations. A couple of years ago some of the organisations – all of them except for us – decided to form together to form one organisation which became Dementia Australia. For a variety of reasons, our board decided that that wasn't in the best interest of people living with dementia in Western Australia for us to joint that – that merger, and so we remained an independent organisation.

MR BOLSTER: And the organisation is an approved provider of aged care.

MR BURTON: Yes, we are. We're an approved provider of community care services and so we provide a wide range of community care services under the CHSP and home care package funding, and NDIS as well for younger people with dementia but we don't have any residential care services.

MR BOLSTER: What are your dementia specialist houses; what goes on there?

MR BURTON: So one of the, I guess, innovations and journeys that our organisation went on was to look at how we can provide out-of-home services for a person living with dementia in the very best environment that we can. Not residential, but where the person is still at home but can come to us, whether it be for a day or for a week or two weeks. And so we developed – we had a community day centre which was quite a traditional model of day centre where people would go for the day and get entertained, we would feed them and then they would go home. But we always felt there was something missing in the model that we had.

And so we really went on a journey of changing the model to provide a care environment that's really focused on the wellbeing of the person whilst they're with us for the day or the week. It provides the carer with a break and that's very important for the carer to have some time out from their caring role but equally important it actually provides a really nourishing and fulfilling environment for a person with dementia to come and spend time with us.

MR BOLSTER: So for how many days a week would someone typically come to one of your specialist houses?

MR BURTON: Usually, yes, if they're coming as a day client, then it's usually one or two days a week. But as I say, we do have short stay there as well and people can

come to us for a week or two weeks. I think the most we've had is about four weeks when a family member was going overseas for a family commitment but usually one to two weeks for short stays is normal.

MR BOLSTER: But there's into residential component?

MR BURTON: Not under the residential care funding. Our funding for those short stays are under community care funding.

MR BOLSTER: Right. Okay. So they would stay for a two weeks on, effectively, a respite basis?

MR BURTON: Yes.

MR BOLSTER: So how different is walking into a specialist house – a dementia specialist house from a fairly typical residential aged care facility; what would we notice if we walked into one of your houses?

MR BURTON: I think – we have a term for it and we call it complexly simple. It looks like you're walking into a house; it looks like you're walking into a friend's house. It's hard to differentiate who's staff, who's volunteers, who's clients in the house. People have meaning and purpose and roles within the house. And so it's really a very de-institutionalised environment that's set up around the individual needs of each person that comes in the house and supported by staff that really understand that concept.

MR BOLSTER: All right. I want to shift focus to the topic that really is central to these Perth hearings and that is person-centred care, and I wanted to get from you some historical background to the development of that concept in clinical terms. And you studied in the United Kingdom at the University of Bradford with Professor Kitwood; correct.

MR BURTON: Yes, that's correct.

MR BOLSTER: And tell us about his work.

MR BURTON: So Professor Tom Kitwood was at Bradford University, as you mentioned. And, really, his work in the late 1980s was – was the foundation work for what we've now come to understand by person-centred care and dementia care. His work was – at the time was quite controversial because we were in a very biomedical, and some would argue we still are – a very biomedical, clinical focus on dementia and its pathology. And Kitwood – Kitwood's work was really challenging that – that understanding of what was happening for a person living with dementia.

His work was based around others' work in the – previous to that and very much within the humanistic psychology field. So Maslow's work in the 40s, around that – many people would have heard of the Maslow's hierarchy of needs, which started to

touch on that we're not just physical beings but we're also spiritual and emotional beings as well, and that's a very important part of what life is about for us. And then Carl Rogers built on Maslow's work in many ways in the 60s and 70s, and looking at that human psychology approach and, really, the fundamental human needs that we all have and that we – we intrinsically share, to a greater or lesser degree.

And what Tom Kitwood did in the 1980s was really – he had a deeper understanding based around his work with people who had dementia, around how the dementia was impacting the person, but not from a pathological point of view. So not from the neurons or the cells being damaged in the brain, but really from the sociological aspect of having a condition like dementia and what it meant to you as an individual based on a whole range of things that make us all individual human beings.

MR BOLSTER: Just pausing there, till his work came to be recognised, how would you describe the practice of dementia care?

MR BURTON: I think generally I would have to say it was – it was around management of a person with dementia, and we still hear that term a lot in – unfortunately, in aged care and dementia care, but it was really around managing what was seen as symptoms of the brain damage that a person might have. And often we use labelling terms to describe those symptoms or those responses that a person was having, and then we would put that behaviour or that response down to the brain being damaged when, in reality, what Tom Kitwood started to show us was that this is a very complex situation, where there will be a whole range of factors influencing how a person is behaving or how they're responding to their dementia experience.

MR BOLSTER: In your statement you refer to the concept of the person not being there - - -

MR BURTON: Yes.

MR BOLSTER: - - - in traditional dementia care. Could you just expand upon that, please?

MR BURTON: Certainly. So the – just to give you an example, the very first book that I ever read as a student nurse was called Alzheimer's a living Death. And I think that sort of helps to explain the – the paradigm of dementia, that somehow a person was being diminished and was becoming a lesser person because their cognitive functioning was declining and that, in fact, all that was left was a shell, just an object to be – to be cared for and nothing was left of the person. And that was a very strong paradigm back, right – really right up until the 90s. And, you know, I think you don't have to scratch the surface of institutional care too deep to see that that paradigm still exists in some places.

MR BOLSTER: We will come back to that when we talk about your training and your educative role. But you mentioned the five key human needs that were identified by Kitwood: comfort - - -

MR BURTON: Yes.

MR BOLSTER: - - - attachment, inclusion, occupation and identity. Explain how they are engaged when we're talking about someone living with dementia?

MR BURTON: So again, I think one thing I would like to state is that part Kitwood's work, particularly, was around the us and them. And we often think of people living with dementia as somehow different to ourselves, and – and that's just a misnomer. We're not; we're all the same. It's just that if you develop a disease that has cognitive impairment and get diagnosed with dementia, the ability to self-actualise in those areas gets diminished and so you become much more reliant on other people to actually be able to help you to facilitate to meet those needs.

Whereas for us without cognitive impairment, not all the time but usually, if – you know, if we feel that we need to have some of those needs met, we can actually go out and do something about that. So if I'm feeling that I haven't connected with anybody for a long time or I'm lonely, I can ring my friend or I can get on – in the car and go and see a friend or a family member. But if you're living with dementia, that ability to do that might be diminished and, therefore, you're relying on the outside world being able to support that.

MR BOLSTER: Is this a fair thing to say, that a carer needs to engage those needs in place of the person who can't themselves?

MR BURTON: I think it – they need to facilitate the ability for the person to meet those needs. These are very personal tools and so you can't impose this. It's not an intervention that you do; it's really about facilitating and creating an environment, where – if we take – sense of identity is a really good example. So as we grow through our lives, we develop our own sense of identity as a person, who we are, what's important to us, what roles we've had in our life, how we respond to things. All of those things make up our own sense of identity.

Now, if we develop dementia and we find ourselves particularly in a care environment or in a situation where that identity starts to get eroded because we're no longer allowed to do the things that we used to do or things are taken away from us or are deemed to be too risky, our driving licences are taken away, maybe the family no longer asks you to come and cut the grass, which they used to do, all of that – all of that impact starts to really diminish the personhood of a person. And so, really, it's about us understanding what's important for that individual, what is that sense of identity about for them, and then getting really creative and innovative in how we set up our care environments and our care interventions and interactions to help put some of that back in an opportunity for somebody to reinforce that sense of identity for them.

MR BOLSTER: Well, what's best practice in terms of ensuring that someone's identity is maintained when they have dementia and they're in residential aged care?

MR BURTON: I – I think, first of all, you have to know the person. If you don't know the person, then it's almost impossible to really be able to respond to the individual. So if I don't know you, I don't know what your sense of identity is and what's important within that. Then it becomes very difficult for me to – and it becomes trial and error, really, trying to find something that will work. So the first point has to be an understanding of the person. There, secondly, has to be consistency of relationship, because you can't just do something to somebody, you have to do it with them. And to do it with them, there has to be a sense of trust and security in this relationship between the two people.

And so you – you know, we have to have that staff consistency because you can't keep doing that with strangers. And then we get to the very practical sense of how do we create environments that actually give people opportunity to do the things that will reinforce sense of identity? So if it was me, and part of my sense of identity was always around, maybe – tending the garden as an example, if I don't have the opportunity and the support to continue that activity, that will just continue to diminish my sense of identity. So it's very complex but it's also – there's some key factors that are involved in it.

MR BOLSTER: Kitwood discussed the role of social malignancy.

MR BURTON: Yes.

MR BOLSTER: How should we understand that in terms of the approaches that people have to people living with dementia?

MR BURTON: I think social malignancy is probably one of the least understood and most impacting situations that we find in dementia care, in my experience. And, really, social malignancy, as Kitwood described it and as we've continued to evolve our understanding of it, is about how I feel about myself as a person living with dementia that has been directly influenced by the people around me.

MR BOLSTER: Yes.

MR BURTON: So if I'm – if I've been objectified, if I've got – had my autonomy and choice taken away from me, my rights to citizenship – if I'm dismembered and I – this is a term that one of my colleagues uses in the States, we are social human beings. Most people have to feel a connection to other people around them, otherwise it causes great distress and harm emotionally and physically; it has been proven in the research. So you know, social malignancy occurs when those relationships are not equal and they're not – they're not a trusting relationship and they don't have any authenticity to them.

I'm a care worker; you're a care recipient. I'm coming in to do a task, which might be to shower you; I'm going to do that task. I have no consideration for how you're feeling during that task or how you're feeling after that task; I will measure the success of my outcome on whether we completed that task. That creates a social malignancy environment for the person with dementia, who will respond accordingly. It's not the dementia, it's not the pathology of the brain that's causing that; it's the social environment and the care environment that has been set up for the person.

MR BOLSTER: Another critical term that you refer to in paragraph 32 of your statement is the concept of personhood. Where does that fit in? How does that illuminate how we view the delivery of person-centred care?

MR BURTON: Again, personhood is absolutely critical, because it is that sense of who you are as a person; that is very much influenced by the people around you. And I've seen and I've heard many many stories of people who find themselves in care environments where their personhood gets so diminished so quickly because the environment around them is just not responding to them as a person and is not giving them what they need, that they basically give up on life and deteriorate very quickly.

MR BOLSTER: Could you give us an example of that?

MR BURTON: Yes. So I remember, back in my clinical days in the UK, having a referral. I was a mental health nurse and was often called in by the doctors in the – the nursing homes particularly for people who were in distress and were being really challenged by their environment. At the time, we used to call it challenging behaviours. And we've kind of moved – we've changed the term to BPSD, but basically kept it in the same framework – that we blame the behaviour on the dementia when, in reality, the behaviour and the response of the person is very much a communication of distress.

And I remember going to see a client where they had said to me he came in, he was walking, he was talking, he was talk, he was verbalising, he was – he was active, and within three months he basically had shut himself off from the world and his physical health was failing badly. And when I actually looked at what was going on for this gentleman, it was a combination of a very deprived care environment where he – you know, the staff were very task-focused, it was very institutional, and the use of antipsychotic medication, which they had – you know, again, he had moved into this care environment, he had responded in the way is that any of us would.

It's – I often liken it to normal behaviour within an abnormal environment. And so he responded. He got angry. He was – you know, he didn't want to be there and he was clearly going to do his best to get out of the place, which was quite a normal response when you saw the place he was in, and so they put him on antipsychotic medication, which had a really detrimental effect on him, alongside the fact that he – give up the fight and he had basically taken himself off to die, and he died a few months later.

MR BOLSTER: You develop the concepts of Professor Kitwood through the work of Professor Brooker - - -

MR BURTON: Yes.

MR BOLSTER: - - - in paragraph 33. And you identify four elements in delivering person-centred care in – at the top of page 9 of your statement.

MR BURTON: Yes.

MR BOLSTER: Do you have that in front of you?

MR BURTON: Yes. Yes.

MR BOLSTER: Can you talk us through that and how it complements or adds to the five critical factors that we were just talking about?

MR BURTON: Sure. I think one of the things I would like to say before I do that is just that I think part of the – the difficulty around person-centred care and its application that I've seen over the years is that person-centred care, in essence, is a philosophy.

MR BOLSTER: Yes.

MR BURTON: It's not a model of care. And I think – my experience has been that the two get very mixed up.

MR BOLSTER: Yes.

MR BURTON: And so it's really a values-based system of how we view the people that we care for – or that we're in a position to support, and so it's very much a philosophical standing that, as an organisation or as a practitioner or as a family member, that we take. And then we have care models that come in to actually implement person-centred care, and I think we will probably talk about one of those shortly. Dawn Brooker's work was really building on Kitwood's work and started to look – in this frustration that we had, one of the great travesties in this sector was that Tom Kitwood died whilst he was developing this philosophy and – and so the actual application of it kind of had a bit of a hiatus and a gap because of that, but others have taken this on board and really started to develop it, and Dawn Brooker is one of those out of the University of Worcester.

And Dawn's VIP model that has put together is a great resource for aged care to actually understand that much deeper level of person-centred care and how you can go about changing your models to represent that. She covers off on four areas. One of them is value, and that's the value – intrinsic value that we see in another human being, regardless of cognitive function or physical ability. And the rights of that person and the human rights of that person – and we very quickly take away the

human rights of people living with dementia in lots of different ways. The right to citizenship, the right to social connection, all of those things. So this intrinsic value that we put on and we share and that we – we support, not give, because it's there, it's intrinsic to who we are, but that we make sure that we support and protect.

MR BOLSTER: Just pausing there. Under value, you also point out the need to value those who care for the people living with dementia.

MR BURTON: Yes.

MR BOLSTER: Could you speak briefly to that? What does that entail for staff or family?

MR BURTON: Yes, so the nature of person-centred care is that it's, you know, and again I think one of the – one of its falling downs has been has it's been often focused on the direct care interface and what happens with the care recipient. In our experience and in my work it's really about everybody, and so it's about who you are as a staff member. As an individual, what do you bring to this relationship that you're having with a resident or a client. Staff – we have to respect that staff members are individuals, they have rights, they're not robots, they don't have an on/off switch, you know, so they will bring things as well and we have to support them through difficult times at home maybe and that's going to influence their care environment.

So you know, it's about having a culture that sits across everything we do, both with the care recipient, with the staff member, and families are absolutely integral into this. We've already heard in this hearing where care partnerships can fail and part of our approach and part of the person-centred belief system is that the people who know the person best are the greatest resource, and so it's really important that care partnerships, and we value care partnerships and the role that carers and family, friends and the community wider can actually bring in supporting a person living with dementia.

MR BOLSTER: Let's talk about the next element, and that's individuality.

MR BURTON: Yes.

MR BOLSTER: I think we've dealt with that to a degree when we talked about identity.

MR BURTON: Yes.

MR BOLSTER: They're essentially one and the same thing, aren't they?

MR BURTON: They are. I think why Dawn has put a key focus on this is that we often – like, in – institutions like homogeny. So reality is we like to be able to box people up, we like to be able to put labels on them and then we like to treat them all

the same, and then we get confused when we have different outcomes. It's what institutions do. So I think why Dawn put a key focus on that was that dementia is a very individual experience, it's not the same. It doesn't matter – part of the biomedical model approach would have us believe that you can test people on their cognitive functioning, give them a score, put them into a stage of dementia which is a nice neat box and then provide services based on that stage theory.

That's just simply not the case and that individuality of experience is critical because if you develop Alzheimer's disease today and I develop Alzheimer's disease today our journeys will most likely be very different and how we respond to them will be very different so we have to look at the individual.

MR BOLSTER: That would seem to be wrapped up in the perspective which is the next point of Professor Brooker.

MR BURTON: And it very much leads into that, so the perspective from the person's view, the world that they're living in – Dr Al Power has a really good definition of dementia which we use in our organisation, which is that dementia is – it changes the way a person experiences the world around them. So it doesn't change the person per se; it changes the way they experience the world around them, and we have to be able to understand that perspective, step into that world to be with the person with dementia where they're at at that moment in time and they need us to be, so that's what that perspective is really about.

MR BOLSTER: Now, the fourth item that Professor Brooker identifies is recognition of relationships.

MR BURTON: Yes.

MR BOLSTER: And we've heard terminology: relationship-centred care, person-centred care, what's the difference between the two or are they really the same thing.

MR BURTON: I think there's commonalities across all of the philosophies and models, really. I mean, you know, there are definite commonalities and I think all of the models would first and foremost put relationships at the centre of it, because when you're dealing with human beings it's about relationship. And so in Dawn Brooker's VIP model it's really about having an authentic relationship and in the work that we do at Alzheimer's WA it's about providing the right culture and environment that supports staff to have that authentic relationship.

This is extremely challenging work, it's emotionally draining, it's physically hard work sometimes, and staff just do not often have the resource and support to actually step outside traditional boundaries, move away from task focus and actually genuinely form authentic relationships because it causes grief when you lose somebody because you've had a relationship with them, and boundary issues can get blurred and you have to be really careful about that as well. So it has got its challenges but at its heart it has to be authentic.

MR BOLSTER: Just pausing there, a staffing model in an aged care facility that had a high turnover of staff, that had agency staff coming in, that had carers who rotated from floor to floor; all of that would seem to be at odds with the sort of approach that you're describing there.

MR BURTON: Absolutely. You cannot do person-centred care, in my opinion, when you have consistent staff changing. There has to be a consistency of relationship. It's the only way that a staff member will get to know and to genuinely really care about the person that they're responsible for, but likewise and equally important that the person with dementia can actually get to know the staff member. And we often assume because the person has got quite marked cognitive impairment and memory difficulties that they just they don't know, and everyone is a stranger. That is not the case in my experience. They do know, they might not be able to tell you a staff member's name but you can tell which staff members they're connected to and they're not.

MR BOLSTER: We'll just touch on it now but we will come back to it in some detail later; the basic qualities of staff, what is essential to deliver this sort of relationship or person-centred care? Just briefly on what the focus is there.

MR BURTON: Yes, so I will share the staff attributes that we look for in our organisation which I think is a really key component to getting this right and being able to deliver it. If you don't attract and retain staff with the attributes that you're looking for to be able to deliver this care then it's just not going to be possible. So the key attributes that we're looking for, really, is warmth in a person. As I said, for us it's about relationship, it's about being able to be with somebody living with dementia, so we need somebody who's warm, you know. And not – it's kind of a fuzzy word and there's more science behind it than that, but it's really about a person who's got a level of emotional intelligence and warmth to them that other people will connect with.

MR BOLSTER: How do you audition for warmth?

MR BURTON: That's a great challenge. I wish I had the right answer because I would share it with the industry and we'd get this right more than we get it wrong. I think it's partly experience, to be honest. It's partly language that people use. It's partly – we ask questions about the person, not just about the jobs they've done in the past or what experience they've got, but we want to know about you as a person and through that we try to measure these sorts of attributes. And it's hard and sometimes it's not until a person is in the environment that you can really judge it, and we have mechanisms to measure that when they're in the environment.

A positive outlook is a really important one. As I said, in talking about living well with dementia which we do a lot, we're not sugar coating that this is a difficult journey for most people. It's difficult for the person living with dementia and it's very difficult for the family and so we're looking for staff who can deal with that

difficulty but still maintain a positive outlook on the role that they play in the caring relationship.

MR BOLSTER: What has the traditional role or view of those relationships been?

MR BURTON: I think it has been a – generally, and again I'm going to talk very generally here, but I think it's kind of been a very task-focused, staff-dominant role. I'm a staff member, I'm here to do a job and you will comply to that. And I think, you know, when we talk about institutionalised care which is the flip side of person-centred care, that's very much still in evidence when you find institutional care. So it's really about – we have a saying in the work that we do in our capacity-building arm where we're working with culture change with other organisations, and we challenge staff to think about, are you a staff member working in somebody's home or is the person a client who's living in your workplace? And I think that's the – there's a significant difference in mindset and culture around that. So certainly moving from that to a more positive outlook about this journey and this relationship they're going to have.

MR BOLSTER: Traditional professional roles require detachment, independence, in a sense to be aloof: lawyers, doctors, accountants, nurses. So it really turns that idea on its head, doesn't it?

MR BURTON: It does; it's very challenging. I spent 10 years in the NHS working as a nurse where – and was trained originally to be taught that you're the nurse and they're the patient and you have this great distance between you. It never felt comfortable to me and through the work of Kitwood and others I learnt why it was so uncomfortable to me. And I think you – you know, it makes the job much, much more challenging but much, much more rewarding when you can break down those barriers and you can break down those boundaries. Of course, there has to be a professional responsibility, clinical care responsibility, all of those things, duty of care, all of those issues are really key, but I think you're doing yourself a great disservice and your clients, residents, patients, whatever it might be, a great disservice if you're not stripping that away and challenging yourself to be something more than just the professional.

MR BOLSTER: Thank you. Now, in paragraph 35 you identify nine person-centred care core values. Now, I think we've covered quite a few of them. There were two that I just wanted to talk about briefly. The first of those is the fourth last which is:

The experience of the person is more important than the completion of the task.

Was there anything you wanted to add about that?

MR BURTON: Yes. I mean, again, I think all of these are critical but there are some really critical ones and this is one of the really critical ones because we have traditionally, and continue to be, a very task-focused sector in the way that we

provide care and support and so – and in many ways it's how we measure our success. And I think until you change the paradigm of what success is in a care environment or a care relationship, then you're not going to move away from this. So if a – if a care worker is judged by whoever that success is you have all 10 residents showered and at breakfast for 8.30 because that's when the catering staff are delivering breakfast, then that's a measure of success in a task-focused environment.

Now, if those 10 people are absolutely distressed, no longer sitting at the table because they're so distressed, confused and don't know what's going on and, you know, just unhappy and in a state of ill-being, then you still succeeded because you did your showers and you got the people to the dining room. In a person-centred environment we want to look at the experience of the person during this process.

MR BOLSTER: The other point I wanted to raise was the second last and this is, I think, where you are in disagreement or you challenge the triangular classification. Allowing for the fact that that is really a medical way to classify for the purposes of perhaps a psychogeriatrician, your point really seems to be focused on delivery of care from a nursing perspective. So would you care to comment on your second last dot point, namely that:

> *The needs of the individual are more important than the labelling of a stage of dementia.*

MR BURTON: Yes, I mean, this is a very broad area. I think I will just hone it down to really the most obvious example of this, which is in the way and paradigm that we have around what we've traditionally called challenging behaviours or behavioural and psychological symptoms of dementia which is the latest tag that we've given it. I think in the biomedical model we've very much focused on the person is having this behaviour or communicating in this way which is the way that we look at it. We don't look at it as abnormal behaviour due to dementia; we look at it as a communication by the person and often they're communicating an unmet need and a state of distress. It's not always the case but in my experience it's the majority of the cases.

And so in our biomedical approach what we then do and what we – in many ways why BPSD was created was to justify a medical pharmaceutical response and once we pay lip-service to saying that we should try everything else first or that we should have non-pharmacological interventions, I think at the crux of it we still believe that the way a person with dementia is living their experience and how they're communicating that to us is a pathological response, not an actual humanistic response, and so – and so we see large uses of chemical and physical restraint to people in response to that, instead of looking at what is the experience of the person with dementia. Let's not label them with a label that suits our purpose. Let's actually see what's going on for the person.

MR BOLSTER: All right. I want to turn now to the work of Alzheimer's Australia, so you, firstly, have your own work force to educate - - -

MR BURTON: Yes.

MR BOLSTER: - - - on a continuing basis, and presumably the philosophies that we've been talking about are embedded in the culture of that organisation.

MR BURTON: Absolutely. Again, I think one of the key things that I've learnt on this journey has been that person-centred care at the interface of care can only exist if the organisational culture of person-centredness is in place. Practitioners will do their very best to be as person-centred as they can, but if they're working in a care culture and a care environment of their organisation that doesn't support it, it's extremely difficult to sustain it. I think part of what we see in the high staff turnover we have in aged care is people just disenfranchised where – I mean, we've heard some really, you know, distressing case studies of where it's gone wrong, but the majority of people working in aged care generally, and especially in dementia care, are very caring, compassionate, inspirational, passionate people who want to do the best for their clients, and they're looking for care environments that will allow them to do that.

So I think unless our culture is right as an organisation, the board support that culture in our policies and procedure, our decision-making, our senior management and our leaders at the ground and then our care staff actually with the hands-on; if all of those pieces are not in place then it's very hard to see the end outcome of person-centred care take place and, again, that's why it's so sporadic and so challenging for many organisations.

MR BOLSTER: All right. And Alzheimer's WA provides consulting services to care providers across the State.

MR BURTON: Yes, so as well as our direct care service provision that we do in WA we also have a large capacity-building arm to the organisation which provides education and consultancy work to help support organisations to really challenge themselves to embed this approach within their organisation and within their care environment. And I know the Commission was in, up north last week and heard from the Bidyadanga community and the amazing work that Faye and her team have been doing and that was a partnership with us where we went in and supported them to actually find the answers with their community. We didn't find the answers for them, we just supported them using what we've learnt in our person-centred approach to help them find the right answers for their community and the outcomes of that have been really significant.

MR BOLSTER: When you go into an organisation and they tell you we deliver person-centred care - - -

MR BURTON: Yes.

MR BOLSTER: - - - and you have a look at what they do and the way they do it, how often is their description of their services backed up in practice?

MR BURTON: That's a hard one to quantify. I think there are places that are doing amazing work in this space. I think there are places that are saying they're doing it and they're not even close to doing it, and there's everything in between. I think, as I say, I think generally – genuinely, people want to do it; I just think they're challenged to do it.

MR BOLSTER: Okay. The ones that do it, what are the key things; how important is leadership in an organisation that actually does it?

MR BURTON: It's critical. And it's leadership at all levels. It's leadership – it starts with the board. If the board are not buying into this and making corporate decisions and setting corporate policy and direction that doesn't have this as an end outcome, then there will be a disconnect. It moves into the executive team and the CEO. It's really about behaviour as much as anything. Walking the talk and believing in what this philosophy is about and actually having it at heart and intrinsic to who you are as person and then behaving in a way that actually represents that and shows it to everybody and that's what leadership is about, I think, in this space.

MR BOLSTER: So when you go into an organisation and you engage with them to deliver person-centred care what do you do on the ground to achieve it?

MR BURTON: It's a combination of things, really. It's really developing champions that will lead it in their organisation is a really critical part, I think.

MR BOLSTER: At what level do those champions operate?

MR BURTON: It depends on the organisations, they're all different, but a lot of it is at that leadership at the support worker level. So whether it be the registered nurse or the OT or whoever in the nursing home is directly supervising and leading the staff, that's a really critical position because they have to really understand this and embed it in their practice and in their behaviour and their communication. They have to know what they're actually looking for and when they see when it's not happening and then how they can respond to that in a positive way that encourages the staff who are doing the hands-on care to actually challenge themselves to do it differently. But that leadership has to flow through the organisation; there's no doubt about it.

MR BOLSTER: Right. And what is your message when you go in and you talk to the staff, to the carers on the ground, and the nurses above them; how do you engage with them?

MR BURTON: I think there's some key factors that we've learned in our change management approach to this work because it's change management. We're asking people to move from one space to another, and that's really a change process, that we support them in doing. The first thing is not to be critical. You know, as I said, the

majority of people in this sector are really kind and compassionate people and want to do the best. So we're very, very careful not to be critical of where they're at now but we want them to be able to move to a better place that they want to be at so we actually work with them to set a vision for that. What is your vision, what do you want to be, how do you want to get better, and we try and encourage them to include the clients and the families in setting that vision as well.

And then once we've done that we can practically look at the barriers; what are the things that are going to stop you getting there, how are we going to overcome them. Let's not use them as an excuse not to do this. Let's get creative about how we overcome them, and then we give them the practical tools, tips, education to actually start that movement to get them to where they want to be.

MR BOLSTER: How long does that process take?

MR BURTON: Most of our partnerships are around six to 12 months, but that's a start point. It's a real start and culture change and culture development is never-ending; that's the reality. I mean, in Alzheimer's WA we've been on this journey for 20 years and we still have a long way to go and a lot to learn. We do really, really well but there's still areas that we would like to get much better in, so it's a commitment to continuous improvement in a cultural way, not in a clinical way.

MR BOLSTER: In the limited time we have left, you are also an RTO.

MR BURTON: Yes.

MR BOLSTER: And you deliver cert III and cert IV courses in aged care that are focused on dementia?

MR BURTON: Yes.

MR BOLSTER: How are those courses different from the sorts of courses one might enrol in at a TAFE on the east coast or in South Australia or elsewhere in Australia?

MR BURTON: Yes. I think, not surprisingly, our focus is not – is less on the pathology of dementia and the clinical presentation of dementia but really on the lived experience of dementia and person-centredness, and how you can actually go about that. We really, both internally in the way we develop our own staff and externally in the way that we work in partnership with other organisations, we're really honing in on three areas. I think we do one of the areas a lot currently in aged care training and not so great in the other two. The first one is around emotional intelligence, and by that I mean empathy, understanding, feeling a sense of care, feeling a sense of what it must be like for a person living with dementia.

I think a lot of the distressing case studies we've heard, it's fundamentally down to objectification of a person with dementia: we stop seeing them as being human

beings. You need a high level of emotional intelligence to challenge that paradigm. The other area that we work in is around knowledge, and that's general knowledge around a whole area of things to do with ageing and dementia. I think that's where most of our current aged care training is at; it's around imparting knowledge in people. The third area that we work in is skills; what are the skills that you need to actually be able to care for somebody in a person-centred way, in a very practical way, in terms of communication and use of touch and use of validation, reminiscence; all of those skills that you need in getting in that space to be with somebody with dementia.

MR BOLSTER: Finally, towards the end of your statement at paragraph 51, you deal with choice and control. What are the key things that the Commission needs to know about choice and control, bearing in mind that we've heard from Professor Ibrahim about dignity of risk related issues. How does choice and control operate in your concept of person-centred care?

MR BURTON: I think it sits at the heart of autonomy for somebody, having the right and, as I say, I think we very quickly strip away the human rights of people living with dementia. We assume that they're no longer able to provide any – any choice or control. We use convenient terms like informed consent. My experience is that often people, given the right environment, are quite capable of making choices, and that continues a long way into the dementia journey, but again if you come at a paradigm that this person is somehow no longer who they were and therefore can't make a choice then we stop even looking for opportunities to give choice. That strips away somebody's autonomy and then we're back into that state of ill-being.

So at a very practical level it's really looking for every moment, every opportunity; can we find a way to give this person the opportunity to have that choice.

MR BOLSTER: Finally, you would understand that we give witnesses an opportunity to indicate important matters that they think the Commission needs to consider in this particular area. Is there anything that you want to raise with the Commission?

MR BURTON: There's a couple of things. I think, first of all, I hope I've conveyed today that at the heart of person-centred care is culture. It's the culture of the organisation, it's the culture of the leaders, it's the behaviour of the leaders in the organisation. Without that, care staff will find it very difficult to actually implement person-centred care at the coalface. So culture of organisations and how we support organisations to develop that culture, and I think the new set of standards are going to help. I think they really are. I'm very pleased to see the direction of the new standards, but it will only help if we have measurable outcomes that we can judge how far we're going on this journey to actually genuine consumer choice, consumer control and best outcomes for people.

The last statement I would like to make is just in acknowledgement of my organisation. The board, the executive team are just amazing leaders. We've been

on this 20 year journey. You know, I think the impact that we're having on the lives of people living with dementia is really significant in Western Australia and that's very, very special. My colleagues who are doing the work are just inspirational. They live and breathe this, they behave in this way and they provide the care and support that we do to people living with dementia and their support partners. They just are clear examples that this is very achievable. Many people say to me, this isn't achievable, we don't have the resources to do it. Having more staff, having more registered nurses will not deliver person-centred care in my opinion. Changing our paradigms, changing our culture, changing our organisational expectations and outcomes is what will do it.

MR BOLSTER: That's my questioning, Commissioners.

COMMISSIONER BRIGGS: Thank you for that evidence, Mr Burton, and your witness statement which I found incredibly interesting. What tools are around to enable us to measure outcomes today, and do you think those tools need further development?

MR BURTON: Yes, I do. I think in terms of what tools are available, there's a broad range of tools. A lot of tools are developed for research purposes, not necessarily for care outcome purposes, in my experience. I think if you look at a good example of where I think we're still falling down in this space, is if you look at quality of life tools, really quality of life tools are often designed through a Delphi approach where we ask numerous people what quality of life means for them and then we will come up with 10 statements about what's important to quality of life and then we'll measure against an individual how much they attain those statements.

Now, it might be that they're fine, but it might be that actually what means quality of life for me as an individual is not contained in those statements at all. I think part of the problem we have with the tools we use is they do tend to be quite homogenous in that way and not looking at the individual and what the individual's goals are and what do they want to attain and what does quality of life mean for them. And I think if we can develop a much more individualised approach to measuring outcomes, then we will see – I think we will see as being able to measure how successful we've been in delivering person-centred care because the outcomes will be there to see.

We do have tools like dementia care mapping which are observational tools, again developed by Kitwood in Bradford, and they can be really useful. They are resource intensive but they can be really useful to get a fly-on-the-wall view of what's happening within a care environment for each individual, and they look at two things. They look at the activity that the person is involved in, and then the state of wellbeing or ill-being that the person is in during that activity. And they can be really telling about just what the care environment is and how much wellbeing or ill-being is there and how active or non-active people are within that environment.

COMMISSIONER BRIGGS: Do you know of anywhere in the world where these tools are being developed in an individualised way?

MR BURTON: I certainly know there are pockets of areas and I think a lot of care environments and care organisations that are really deeply embedded in this are developing their own work, and certainly we do as well. We use some tools that are developed by Eden – the Eden Alternative model that we use in some of our work but we also look at that personalised approach in goal attainment and satisfaction within what's happening for the individual. And the staff as well because that's really important. So we tend not to measure staff in terms of the work they do. We tend to measure in terms of their satisfaction with the organisation or their job role but not necessarily the outcomes of the work that they're doing.

COMMISSIONER BRIGGS: The Commission may well wish to work with you and others on developing the best tools to measure these outcomes as we go forward.

MR BURTON: Absolutely. We would be more than happy to share what we're doing.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything else?

MR BOLSTER: Nothing. Thank you, Commissioners.

COMMISSIONER TRACEY: Yes. Mr Burton, thank you so much for your evidence.

MR BURTON: Thank you.

COMMISSIONER TRACEY: We're deeply grateful to you for your insights into this very complex area.

MR BURTON: Thank you. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you very much.

<THE WITNESS WITHDREW [12.44 pm]

MR BOLSTER: Commissioners, the name of the next witness is known to the Commission but she will be known as Ms EA. Her evidence will be given without showing her face on the video screen. I call EA.

<EA, SWORN [12.45 pm]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: If the document WIT.1139.0001.0001 could be brought up. Thank you. Ms EA, is this a copy of your statement?

EA: Yes, it is.

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

EA: No.

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

EA: Yes.

MR BOLSTER: I tender Ms EA's statement.

COMMISSIONER TRACEY: Yes, the statement of EA dated 10 June 2019 will be exhibit 5-15.

EXHIBIT #5-15 STATEMENT OF EA DATED 10/06/2019 (WIT.1139.0001.0001)

MR BOLSTER: Ms EA, you wish to read your statement.

EA: Yes.

MR BOLSTER: Perhaps if you could begin at paragraph 4. Thank you.

EA:

My partner, EB, is 70 years old and she has younger onset Alzheimer's disease, a form of dementia. EB worked for over 14 years in the public sector and then in the private sector and retired in 2010. EB and I have been together for over 35 years and I'm lucky to have a very close circle of support. I would not have been able to care for EB at home for as long as I did without the support of our family and friends. In October 2010, EB was formally diagnosed with younger onset dementia. She was 61 years old. For about 18 months to two years before that, EB was suffering from depression and anxiety. I suspected that EB was showing early signs of dementia.

In the first instance, her GP explored other possible explanations for her symptoms. It was possible the memory and personality changes could be a symptom of depression. I think doctors have to be very careful to diagnose dementia where there are a number of possible explanations for the symptoms. EB was also very young for a diagnosis of a dementia. After the diagnosis, we

were both overwhelmed with sadness and anxiety. EB went into denial, and I saw this as an important strategy to help her to cope. I immediately wanted to find out what was available to help us.

This is about our introduction to Alzheimer's WA:

While the assessment was being done, one of the professionals involved recommended that we make contact with Alzheimer's WA. It wasn't really until about 2013 or 2014 that we finally got in touch with Alzheimer's WA. The first contact we had was with a short-term support group for people in the early stages of a diagnosis of dementia and their carers and partners. EB didn't want to go, but she came along because I asked her to.

Everyone sat in a circle and some people told their story. EB would sometimes say something or often say nothing at all. Some of the participants acknowledged their dementia, they used the word and talked about how they managed it. Some people spoke about the issues that we were struggling with and about how they were or weren't coping. The group itself was quite helpful for me and the facilitators of the group were fantastic. EB didn't really want to be there; she's not really a person who likes groups and is better one to one.

EB would say something like she didn't have Alzheimer's and that she was angry at being made to be there. She did not raise this in the group session, but would raise it with me and with the facilitators. The facilitators didn't try and talk her out of her denial of having Alzheimer's. They reinforced that she was allowed to be angry and that they appreciated her coming, even if she didn't need or want to, and asked her if she was okay to stay for me, which she did. I learned from this approach.

During the breaks, the facilitator would come over, take EB aside and speak to her about how she was feeling. That was really important and carried out in a way that engaged EB and made her feel as comfortable as she ever could be. After that first group, EB and I started going to a group that operated out of Mary Chester House, a day centre operated by Alzheimer's WA for people with dementia. That group was primarily for people with the diagnosis, but did they did allocate a half an hour for the carers to talk to each other and get some support, which was so needed and valuable for me. Again, EB was reluctant to join the group and came along because I asked her to.

The balance of people in this group was older and some of the activities felt a bit like activities a child might engage with. EB didn't enjoy them that much and nor did I, really. She would tell me, but she would not express this in the group openly or disrupt the group, but would not participate and be very quiet. It was quite important to me to be able to split off for a half an hour and talk about issues affecting us both and also about some successes other carers were experiencing in coping with dementia. Again, the facilitators would often take EB aside and talk with her and acknowledge how she was feeling and let her

express how she was feeling, and I would often find EB in a long one-to-one conversation with one of the facilitators.

In that group, one of the activities that did engage EB was art exercises. As carers in that group, we talked about the benefit of using art in dementia treatment and group activities. Soon after, EB and I joined a program called Artistic Adventures, run by Alzheimer's WA and based at Mary Chester House. It was a fantastic program and EB really engaged with the coordinator and the activities. It was non-threatening, something we could both enjoy, and it was targeted towards people with dementia and their carers.

As part of this program, EB and I would go to an art gallery each month with volunteers from Artistic Adventures who came to help. I understood that they and the volunteer art gallery guides were trained to know how to engage people with dementia in a specific way to achieve good outcomes. The guides would lead a tour around different parts of the gallery and then take people aside individually to talk about the art and ask what they thought. We both enjoyed this activity and the fellowship of others involved.

As part of this program, the coordinator also ran an art group based at Mary Chester House just for the people in the program who had dementia. This is where EB discovered a love of art and sculpturing and where she could draw, paint, colour in and explore her skills, working at her own pace. The group participants all had dementia of some kind and the coordinator facilitated the artistic activities. EB just loved it. Being able to work on her own art at her own pace was very important to her. If she didn't want to participate in a group activity, she could paint on her own and rejoin the group later.

EB and I were experiencing person-centred care. The people running each of the groups, including Artistic Adventures group, were prepared to work with EB at her own pace and level of comfort. They didn't argue with her when she said she didn't have Alzheimer's or dementia. They let her express out exactly how she was feeling, even when those very negative feelings about being involved in the group. The art group coordinator let everyone participate in the program in the way that worked for them, which for EB was often painting in a different corner of the room. That started EB on adult colouring in books, and she would spend hours colouring in at home while I was doing other things.

We were both devastated when the funding was no longer available for that program and it ceased. I was told that the funds used for this program had to be directed to other programs run by the organisation. We were prepared to pay privately, but there were not enough people in the group able and willing to pay. Around the same time as EB was going to Artistic Adventures, she was spending time with the support worker from Alzheimer's WA Volunteer Program, working at a wildlife centre. EB had been a long-time volunteer at

the wildlife centre. This is a place for injured wildlife to be treated, cared for and, if possible, rehabilitated into the wild.

EB was one of their best volunteers, and as her dementia advanced the manager called me and told me that helping EB was taking up a lot of their time as she no longer had the capacity to do some of the tasks that she had previously completed on her own. They linked me to the Alzheimer's WA Volunteer Program. Alzheimer's WA had a program where they recruited support workers who, amongst other likes, liked caring for animals and who could accompany EB to and support her with the work at the wildlife centre. It sounded perfect, but EB didn't necessarily want to be helped or accompanied and she wasn't happy about it.

During her career, EB was a highly regarded person who had management positions and supervised staff and supported people in her care. She is a strong, independent and private person. It took a lot of negotiating to get EB to agree to a support worker and give it a try. It took several tries to find someone she liked and who was the right match for EB and who wanted to volunteer with wildlife. Eventually, EB met and engaged with a support worker and that started a wonderful working relationship that went for over four years for one day each week.

The support worker was well prepared, with a good care plan and knew a lot about EB before they met. She loved animals too. And together they formed a good team, with the worker gently and respectfully supporting EB with those tasks she couldn't perform any more alone and those she just needed some help with. She would also negotiate different tasks with the wildlife centre, as time went by, that she and EB could manage. The worker also spoke and interacted with EB in a way that was respectful. EB does not like being fussed over or being called deary or sweetheart. I got to know the support worker well and we developed a good relationship and understanding.

Eventually, despite the support, EB started struggling with most tasks at the wildlife centre, and she was aware that other volunteers were doing the tasks she used to do. We all agreed that she would no longer go to the centre and her support worker facilitated a special celebration of EBs service and an acknowledgement gift, which helped her to leave in a good way. Fortunately, we were able to negotiate with Alzheimer's WA to keep having the support worker come to spend time with EB on the day she used to go to the centre. The worker would come and take EB to other kinds of wildlife and animal experiences, such as the zoo or other wildlife sanctuaries, and to the park and just out and about generally.

After some time, it became increasingly difficult to find something that EB wanted to do with her support worker and she started to push back ongoing. I was experiencing the same at home, with EB not enjoying and pushing back on activities and outings. We all decided there was no point in continuing this

support. At that time, EB was attending Mary Chester House Day Centre one day each week. Fortunately, Mary Chester House had the capacity at the time to offer EB an extra day, so that EB attended two days each week, to give me some respite.

Mary Chester House:

While she was still involved in the volunteer program in early 2016, EB agreed to attend a day centre in our community one day a week. This centre was not run by Alzheimer's WA. It didn't go well. All the people were in their 80s and EB was only in her 60s. She felt out of place and disengaged and was really distressed. She refused to go after a couple of times. We had tried it because I really needed a break and it was conveniently located close to our home. We decided to try Mary Chester House instead and were lucky that they had a vacancy on one day each week in the day centre program.

The staff there quickly figured EB out. They asked me about EBs work history and social history, her interests and what she needed, what she liked to do. I told them about her love of animals and gardening and that she was not a TV watcher and that instead she liked the outdoors and working. I told them about how she needed to feel useful and busy and that she was not really a group person and engaged more willingly in one-to-one conversations. So when EB wanted to walk around rather than sit, the staff let her do that and asked her to help with tasks, such as hanging out the washing or setting the table or wiping the dishes.

The manager brought her two little dogs in and that was, for a long time, so helpful towards persuading EB to go to Mary Chester House. Mary Chester provided activities that were stimulating to a mobile and younger person, like EB. They went out for coffee, on bus trips, to exhibitions in museums and historic old houses, to the beach and for walks and concerts in the city. Back at Mary Chester House itself, you could find people heading off to the gym down the road, to the men's shed to do some carpentry, doing jigsaw puzzles, listening to music or sitting in the sun in the beautiful garden area, chatting to each other, or on their own with a support worker.

When EB no longer wished to go out with her support worker to the wildlife centre and as EBs health declined she started going to Mary Chester House for two full days per week. As I've said, EB had become difficult to engage in any activity by this time. She didn't get upset or be disruptive to others or the activities; she just would not engage in it or show any enjoyment.

The staff there worked very hard to keep her engaged and involved. She was best in a one-to-one activity and every effort was made by staff to provide that. EB was always happier when I picked her up at 3 o'clock than when I dropped her off at 9 am. Mary Chester also made an effort to engage with, inform and support carers. Often I would ask EB what she did on a particular day and

would get little or no information. I kept up to date with EB through the daily newsletter sent out by Mary Chester House which captured what had happened at Mary Chester House each day, including photos. Sometimes I would ask EB what she had done and she would say "Not much", and then it would turn out they went to a lake to feed the ducks or for a long walk along the beach.

The activities were often activities that would engage people like EB who were losing the ability to communicate and who needed to find alternative ways of connecting with other people. Talking about now EBs changing health. Eventually it became increasingly difficult for me to look after EB and her behaviour threw up many challenges for me at home and in the community. The staff at Mary Chester House were always available to speak with me and it was so important for me to have that opportunity. They saw some of that behaviour and understood some of what I was going through at home.

By this time Mary Chester House were offering some overnight respite. I was desperate to find some respite care that was suited to EBs age and stage of Alzheimer's that was flexible and could include overnight stays. The staff at Mary Chester House told me that EBs behaviour would be difficult for them to handle overnight. They were not staffed or resourced to care for a person with EBs level of need and behavioural changes overnight. Mary Chester House put me in contact with another organisation providing flexible day care services and overnight respite. This organisation was very well staffed at night. It had two experienced care workers on at night with four people with dementia. All were mobile and physically well like EB.

They understood how to engage, negotiate and care for someone like EB and allow her to be as independent as she could be. Like Mary Chester House, this took a lot of time and patience and they were good at it. While EB would push back on going she would settle quickly and she always came home happier than when she went and relaxed. Talking about the value of relationships. Constructive relationships are really important to providing quality care. You have keep trying to connect with a person even as they change and the dementia progresses and especially when they withdraw. EB agreed to try going to Mary Chester House in the first place because of her rewarding relationship with her support worker which was based on EBs love of animals, nature and the outdoors.

When you walk through the door of Mary Chester House two mornings a week there were people all around saying "Good morning, EB, good morning EA". They took the care and the time to make eye contact with me and with EB, to show her into the room, offer her a coffee and to point out photos to us of her participating in activities which had been pinned up on the walls. It is certainly difficult and time consuming to give people a lot of one-on-one time when there are 12 to 14 clients at once and limited resources. Just these small things and taking a minute or two to sit down and talk with someone is so important to most of us when we are needing reassurance in a world that is so

complex and so confusing. More resources would help to sustain this kind of care.

As EBs carer I felt I was a partner with Alzheimer's WA in her care and support through all of the programs provided to us. I was asked about EB and kept informed about her activities and any issues. I always felt I was welcome to be involved in the activities of Mary Chester House such as special morning teas or evening events. Through all our time with Alzheimer's WA the staff were accessible when I called for advice or help. At Mary Chester House I could just knock on the manager's door or if she was not free the coordinator would help. It is rare to meet such a professional, patient, caring – sorry – it's rare to meet such a professional, patient, caring and compassionate group of staff in one place as I did at Mary Chester House.

As another example of person-centred care, Mary Chester House asked me to be involved in introducing EB to the day program and in the development of the care plan with EB and their staff member. I asked the manager to consider another approach for us. EB had already been going to the Mary Chester House for the artistic adventures for over 12 months and had met some of the Mary Chester House staff and seen other clients and what they do at Mary Chester House. I told Mary Chester House that EB is a strong, independent and private person and does not appreciate a fuss. At that time, EB had the ability and the courage to tackle new or difficult situations without me being involved.

I suggested it would be better to keep it low key and for EB to be able to go in alone and get to know the place in her own time, rather than having me there with EB to develop the care plan, that the manager and I should do it together and the staff could go through it with EB without me if needed and when the time was right. The manager agreed with this approach. In regards to communication with staff about EB, I knew that the manager of Mary Chester House regularly met with her staff and briefed them on new clients and other issues. My experience at the other community program we tried was different. There was less time and resources offered and dedicated just to getting to know someone.

I believe that all of the relationships she had through Alzheimer's WA improved EBs quality of life. For example, artistic adventures that unlocked EBs artistic skills. The way the staff in Mary Chester House understood EBs needs and interests that led to her spending a lot of time outside going for walks, participating in activities and being constantly stimulated, even as her dementia advanced and her abilities deteriorated. These activities pushed EBs boundaries in a good way and gave her the best opportunity to be engaged in the world for as long as she could. Once the staff understood EB, they could be more creative and adapted activities they suggested for her. As she became less engaged in conversation and activities, I remember that they played a nature DVD, in the hope it might spark something with EB.

Terms of understanding EB:

As I've already said, EB is a strong, independent and private person. She has never been a person who sits. She is not interested in television or reading unless it's about wildlife or nature. Her activities are outside in the garden, walking the dog, she would go for hours walking the dog, and going to the theatre and going out with friends. She is physically capable of being active, as are most of the clients at Mary Chester House.

From the beginning, Alzheimer's WA took EBs background, personality, likes and interests seriously. As I've already mentioned, as her carer I felt I was treated as a partner in her care and supported through all of the programs provided to us. EBs long-term and deep passion for animals and nature and her desire to contribute to the wellbeing of others was understood and supported. Alzheimer's WA supported our goal to maintain EBs participation at the wildlife centre for as long as possible and as far as they could. They supported her to contribute to the work at Mary Chester House. The staff also used EBs passion for animals, the gardens, the outdoors as a vehicle to engage her in activities at Mary Chester House generally.

I remember that when EB first joined Artistic Adventures, the staff offered her outlines of dogs or other animals to colour in and pictures of dogs and other animals to copy. That was very important and they knew to do that because they took the time to get to know EB by spending some time with her and me. I told the staff at Mary Chester House about EBs work history, as I think it's important in understanding her. A big part of one of her jobs was caring for and supporting vulnerable people and ensuring their welfare, and her clients liked and respected her.

Mary Chester House then understood why EB was always keen to be with staff, looking for a way to be involved with them and to help. They facilitated her to do that. In the early days at Mary Chester House, I was told that EB had looked out for one of the other clients who was finding the going stressful and had taken them under her wing. The way that EB was cared for at Mary Chester House and in the other programs we were involved with fits into my understanding of person-centred care.

In particular, understanding and acknowledging the stage of life and stage of dementia that a person is in and creating activities and programs to suit that, knowing a person, taking who they are into account when planning for them and being able to develop the specific programs for younger adults, or to be flexible in the existing programs is very important for people with younger onset dementia, as dementia-specific programs are often set up for an older and more frail demographic. We must normalise the life of a person with dementia as far as possible. This includes knowing what gets them up in the morning.

Excuse me. Sorry.

We must normalise the life of a person with dementia as far as possible. This includes knowing what gets them up in the morning, what makes them happy and fulfilled and what they like or love doing. Through this knowledge, we must strive to keep them engaged with the world we are all striving to live with, to live in, and for as long as we can. One of the reasons I was prepared to submit this statement is that I wanted to, and I know that EB would want to contribute to the knowledge of the Royal Commission about what good care and good work looks like. This is what I've experienced through Alzheimer's WA, and I'm grateful for the opportunity to make a statement to the Royal Commission.

MR BOLSTER: Thank you very much, Ms EA. I understand there are things that you want to tell the Commission about the way it should approach this issue, moving forward.

EA: Yes. Yes.

MR BOLSTER: What are they?

EA: Yes. I can't emphasise enough how important it is to a person with dementia and their family to be cared for with a person-centred approach. As I've already said, this approach truly seeks to know the person behind the dementia and then to engage them as far as possible in day-to-day life that is rewarding, that normalises their life and that keeps them engaged in the world as they deal with their dementia. In my experience, person-centred care turns a day centre or a support group or a support worker or a residential aged facility – aged care facility into a living and breathing experience.

My partner and I have been lucky as we have known services with the leadership and staff with the skills and the will to make person-centred care happen. However, these services and staff are often dealing with 14 or 15 clients with different needs, and many with high care needs, and with their families who are trying to make sense of it all. Then there's the governance and the accountability processes, which we know are so important but which can chew up the time that's needed for caring. I sincerely hope that this Royal Commission and the Commonwealth Government will bring about improved aged care services, services that are safe and models of care that facilitate the person-centred approach. In particular, that we will see services that are properly resourced and able to respond to the growing number of families, like mine, who are living with dementia. Thank you.

MR BOLSTER: Thank you, Ms EA. I have no further questions, Commissioners.

COMMISSIONER TRACEY: You, towards the end of your statement, explained to us why you wished to give this evidence today. We fully understand that and we're very grateful to you for sharing with us some deeply personal reminiscences and the

experiences that you have engaged in with your partner and with Alzheimer's WA. We have heard some very disturbing stories in the course of this Royal Commission, but it is also important that we hear, as we have done from you, how care for aged persons in this community can be done well and can be done better with the provision of adequate resources. And please be assured that we will be very conscious of your evidence when we're making our recommendations to government.

EA: Thank you, Commissioners. Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until 2 o'clock.

MR BOLSTER: Thank you.

<THE WITNESS WITHDREW [1.16 pm]

ADJOURNED [1.16 pm]

RESUMED [2.00 pm]

COMMISSIONER TRACEY: Yes. Ms Hill.

MS HILL: If the Commission pleases, I call Chris Mamarelis.

<CHRIS JOHN MAMARELIS, SWORN [2.01 pm]

<EXAMINATION BY MS HILL

MS HILL: Mr Mamarelis, could I ask you to please state your full name.

MR C.J. MAMARELIS: Chris John Mamarelis.

MS HILL: And what is your occupation?

MR MAMARELIS: I'm the CEO of Whiddon.

MS HILL: And how long have you been in that role for?

MR MAMARELIS: I've been at Whiddon for eight years.

MS HILL: Whereabouts is Whiddon based, Mr Mamarelis?

MR MAMARELIS: Whiddon is located – our corporate office is located in Glenfield, in Sydney, in New South Wales.

MS HILL: And could you please describe to the Commissioners who is Whiddon?

MR MAMARELIS: Yes. The Whiddon Group is a large not for profit organisation. We operate in residential aged care, community care and retirement living. We have and we care for around 1600 people in our residential aged care homes. We have another 200 packages in community care and around 300 residents in our villages also. We have about 19 locations through New South Wales and South East Queensland. We're known also for being a regional provider of aged care, with homes in Bourke, Walgett, Wee Waa, Narrabri, locations such as that.

We have our largest canvass, if you like, in Glenfield, where we care for over 600 residents on a co-located site, with retirement living, about two and a half thousand employees, 300 volunteers. And, I think, finally, Whiddon is known as being a progressive organisation. We've been recognised by our peers and – within the industry and outside the industry for innovation, and we've won awards and been recognised for the work we do.

MS HILL: Karn Nelson is the Whiddon Group's general manager of strategy and innovation; is that correct?

MR MAMARELIS: Yes. Correct.

MS HILL: What does Ms Nelson's role involve?

MR MAMARELIS: Ms Nelson's role is involved in innovation and research into the programs that we are delivering, and enhancing our care delivery program. So she conducts research. She's working with universities and other industry partners to evolve our approach to care and align itself with our philosophy. So it's really about that level of work, introducing new programs to Whiddon and to the care delivery and enhancing our model of care – again, with research and evidence-based programs and work.

MS HILL: And why is that role important?

MR MAMARELIS: The role is important to Whiddon because we are continually trying to innovate as an organisation and we are continually trying to innovate our approach to care. It's a tone that's set at the top, from the board down, that we – we want to deliver and enhance care outcomes, and we've realised that in order to do that – we've made a decision that we needed research and an evidence-based approach. So we had to dedicate an executive and resources in order to do that.

MS HILL: And Ms Nelson reports to you as CEO.

MR MAMARELIS: Correct.

MS HILL: Are you aware that Ms Nelson has prepared a statement for the Aged Care Royal Commission, dated 30 May 2019.

MR MAMARELIS: Yes. I am.

MS HILL: And Ms Nelson is currently on leave and not able to be here today; is that right?

MR MAMARELIS: That's correct.

MS HILL: Commissioner, the statement of Ms Nelson of that date is exhibit 5-6. It was tendered earlier on in this hearing. Mr Mamarelis, the Whiddon Group changed its focus in 2015; is that correct?

MR MAMARELIS: That's correct.

MS HILL: Why was there that change of focus?

MR MAMARELIS: Well, back in 2015 we had gone through some level of renewal as an organisation with our management team and we – obviously, as most organisations do, we go through a strategic planning process. So working with the board and our management team, we made the core focus of all of our objectives as an organisation – we really wanted to call out that enriching the client journey, enriching the experience of our residents was our main focus and our main priority. So in order to achieve that, we had to re-engineer, if you like, our processes, and that's where the journey began.

MS HILL: And so what did you actually do, Mr Mamarelis?

MR MAMARELIS: So part of that strategic planning process, we created a number of directions that were designed to – to help us reach that objective. And one of the core objectives was related to our delivery and our approach to care. So we evolved a new model of care. We brought in more resources to support the research and innovation outcomes that we wanted to achieve as an organisation, that we thought were necessary to support that. We also invested in cultural change. Our values program, called The Whiddon Way, which was to really support our staff and our team members to understand what was expected culturally from the organisation as well – so a lot of restructuring from the organisation and reinforcing these directions from the top down, from the board level down, through the organisation, in order to meet these objectives.

MS HILL: Are you able to describe to the Commissioners what that new model of care is?

MR MAMARELIS: Yes. MyLife is Whiddon's model of care. It's a framework that is designed to put at its heart the individual, the person that we're caring for. And as I said, it's very closely aligned with our strategic vision of enriching the – the client journey and the resident journey. So through MyLife, the – one of the core focuses is really dragging us away from the clinical task-focused approach to care and moving us into something that is much more holistic and something that embraces quality of care at a much higher degree. And what we are talking about is we're looking at areas such as wellbeing, we're looking at areas such as re-ablement and social connections. And this is the core focus of the MyLife model. And what we have seen through delivery of MyLife are a number of core areas, and one of those has been the implementation of our relationship-based approach to care.

We've also seen a plethora of programs implemented that are designed to focus on these higher order needs, if you like. So wellbeing programs, creative ageing programs, pet companion programs, gardening programs, a whole host of initiatives that go beyond pure clinical care. And another really important aspect of MyLife has been the introduction of the ASCOT tool, which was a tool that was research that Karn Nelson was heavily involved in. And we brought that out from the UK, and the special thing about the ASCOT tool is that it measures wellbeing. And we are, I believe, the first in Australia to embrace it as a – as a tool. We are moving beyond the clinical traditional measures that are associated with aged care and now moving into measuring multiple domains in the wellbeing spectrum.

MS HILL: With relationship-based care being the central tenet of that model, why is it that Whiddon prefer relationship-based care as opposed to person-centred care?

MR MAMARELIS: I guess from a – in terms of the naming convention or the naming that – that has been taken up, we obviously wanted to place the focus on relationships. Relationships are central to what we're doing. There are some similarities, of course, with person-centred care, but the focus was on relationships and gaining a richer understanding. So that was – if you – would you like me to talk about a bit about relationship-based care - - -

MS HILL: Certainly.

MR MAMARELIS: - - - in that context? So in the context of relationship-based care, the core premise is to form deeper and richer relationships between the care recipient and the caregiver, the employee. And it's with those insights that are gained – it's a pretty simple premise that with the insights gained through those deeper relationships, we're able to gain a deeper and richer understanding of the outcomes that we're trying to aim for with our clients and residents. So it's that knowledge that – that we gain.

In terms of relationship-based care as an approach, it requires a consistent model of rostering. So we have to have staff – smaller groups of staff caring for smaller clusters of residents. We have to ask staff to commit themselves to certain number of shifts, so there can be familiarity, again – and to develop those relationships.

Another aspect of relationship-based care outside of the staffing model is the My Buddy program. And My Buddy really is a framework that gets – that assists staff and the care recipient to get to know each other better. And there's a process there to – to allow that relationship to evolve.

And the other aspect which is a really lovely aspect of relationship-based care is the Best Week initiative. And the Best Week is about setting goals and the My Buddy and the care recipient work together to set these goals. And the goals can be very simple. It could be accessing a magazine subscription that a resident lost touch with, or it could be more advanced, like going on a fishing trip, going to the beach, visiting someone in another town that they haven't been able to get to because of their frailty. So some really wonderful outcomes through this goal setting. And, again, enhancing our model of care by focusing on wellbeing and this – this more holistic approach to care.

MS HILL: From your organisational perspective, what does all that mean for the type of care that is ultimately delivered?

MR MAMARELIS: In terms of the care that we're delivering, and – and, as I said, we are trying to – at the top of our strategic goal as organisation is life enrichment, and we're trying to drag practices away from this clinical task-based approach to care and move into this space of life enrichment. And life enrichment doesn't come with providing just these lower-order care needs. It doesn't come with accommodation and a bed and a meal and basic clinical care. It comes with – with enhancing wellbeing, it comes with re-ablement, it comes with social connections and – and that's really what we're trying to do. And we're seeing – we're seeing results and we're – we're seeing those outcomes firsthand.

MS HILL: What has the shift in focus since 2015 required you to do as a CEO?

MR MAMARELIS: As CEO, I'm responsible for every aged care resident that we care for. I'm responsible for every home care client that we visit, and I'm responsible for every retirement village resident as well. So as CEO, my focus and my leadership is really important in the organisation, in setting the tone and setting the culture. As CEO, it has been really important, given the cultural shift, that we have to take to empower our people and give them licence to start thinking in this different context and – and to take them on that journey with us.

So communication, re-enforcement, providing resources to allow this and – and, as I said, just really letting the team members know that this – this approach is okay. There's also – I have to work closely with the board and I have to take the board on this journey with us, and that also involves good reporting structures, good governance around the way we do things and keeping the board informed of our progress with this journey that we're on.

MS HILL: You've referred to seeing the results. How do you measure the outcomes, ultimately, of the model?

MR MAMARELIS: If we're looking at the outcomes of relationship-based care, there's probably three areas it's touching. We've – we have results in – in the submission that was made that – that we will focus and we will show you the results at the resident and the client level. There are results for employees and we also have results back from our families. In terms of the resident outcomes and the client outcomes that are a part of this program, we've seen improved levels – or lower levels of anxiety, lower levels of depression, and there's data there in the submissions to support that.

We have also seen higher levels of physical function, which are somewhat connected to these outcomes, that are supporting activities of daily living. So these are some beautiful outcomes that we have quantifiable results on that – that are attributable to residents. At an employee level, we believe there's greater job satisfaction, and the data is telling us there's lower staff turnover, which, in this industry, is extremely important. Staff also reported, I believe, less handover stress at the end of shifts because they had better understand of their role and they knew that the next person coming onto the shift understood the resident needs that – that little bit better. So there was less handover stress.

Team members also came back to us and told us that they were engaged with what they were doing. They understood what – what these outcomes were and they could see them firsthand, which was really important. In terms of feedback, what was really important is we introduced a – a Net Promoter Score rating to our – there's a host of other surveys and other data available, but we introduced NPS ratings to – to gain a broader aspect of the customer feedback within the organisation. And what was really pleasing is we had – my understanding is we had very positive outcomes and feedback from families, which is traditionally difficult in this sector. So across three spectrums we saw a good cross-section of results tell us this was – was delivering what we wanted it to.

MS HILL: Is it your view that the model is working well?

MR MAMARELIS: Yes. I believe the model is working well. The model is about three years – in terms of its maturity, it's about three years down the track. And some sites are doing, you know, fantastically well with implementation, and other sites are taking a bit longer. So like anything, there are different degrees there. With 19 location, regional, rural and remote settings, there's a variety there, but I believe it's working well. The results speak for themselves. And when you talk to residents, families and staff firsthand, you get that feedback.

MS HILL: Are there areas that you need to improve upon, from your view?

MR MAMARELIS: At an organisational level?

MS HILL: Yes.

MR MAMARELIS: At an organisational level, the – the financial aspects are, obviously, always challenging. We're in a financially-challenged industry, so that's a – that's a constant challenge when you're talking about increasing staffing capacity, your workforce and you're increasing that level of funding there. Transient staff, casual workforce, that's a challenge because you are looking for consistency of staffing. And when you're – when you're seeing staff turnover and you're seeing high levels of casuals come in, that can be challenging.

We're in a – rural and remote locations – so trying to get a registered nurse to Bourke, we've been trying for four months unsuccessfully. So when you're trying to get the skilled workforce in certain locations there are challenges. And if you're talking about consistency of staffing to enhance relationship-based care, we need to find other ways to – to deliver that as well. So at an organisational level, they're the – probably the core things. And obviously we've got this cultural shift that – that we need to take our team members in the organisation on.

MS HILL: What steps are you taking, Mr Mamarelis, to achieve consistency of staff?

MR MAMARELIS: We have – I think the core – one of the core aspects of that was our – our values program. And the values are centred to the relationship and the relationship-based care. So the values program and – and implementing the values program was critical. There's a lot of training and education that has to occur with staffing. There's a number of leadership, both at a clinical leadership level and outside of that that we have to put in, in terms of an enhanced framework, to support staff to get there as well. So it is a big investment in your people in order to take them on this journey.

MS HILL: How do you support the people that are working for you, Mr Mamarelis?

MR MAMARELIS: In terms of providing support to our employees – as I said, there's – there are educational structures and frameworks there to support people, at a whole heap of different levels. There are a number of different scholarship programs that have an outreach into some of the regional and rural and remote locations and we know, through that, some of these people wouldn't gain access to that level of education without those – the scholarships that we provide. Obviously, without footprint, online learning is critical. So we have a learning management system that was implemented through this strategic plan. And through that we're able to introduce the concepts of MyLife and relationship-based care as well. So again, there's a heavy investment in – in the workforce in order to achieve these outcomes.

MS HILL: Can I turn, then, to financial matters. What are the financial implications of the MyLife model of care for the Whiddon Group?

MR MAMARELIS: We estimate that in the initial establishment of MyLife and relationship-based care that we – we spent around $600,000, and that was focused on

having dedicated managers involved in rolling out the program, education of staff, investing in the MyLife training of the staff. And it was about $600,000. If you put that into context, it probably represented in that particular year somewhere between three to five per cent of our earnings for that year. As we progress, going forward, we're seeing the – more pressure on costs, particularly in terms of labour, and we're looking at around an additional $200,000 per year, it seems to be emerging, as additional cost, and that has got to do providing more time for the MyLife buddies to do their planning and providing more time for leisure officers to get involved. So there are – there are financial pressures that are evolving as a result of this implementation.

MS HILL: How do you fund the MyLife model of care?

MR MAMARELIS: MyLife is predominantly funded out of our – out of – out of our earnings. We have some bequests that we receive that we can direct bequest funding to as well. The majority would be coming out of our – our earnings, though.

MS HILL: Do other aspects of your business subsidise the MyLife care model?

MR MAMARELIS: The only other aspects – the only consolidated earnings from residential aged care, community care and retirement living. So retirement living would play some role in subsidising it. As I mentioned before, there is some access to bequest moneys, which we put to specific programs. I think that would be the core funding, you know, split.

MS HILL: Do you say that the MyLife model of care is sustainable for the Whiddon Group?

MR MAMARELIS: From Whiddon's perspective, we make it sustainable. And what I mean by that is we have a very challenging financial environment. Whether you're a not for profit or a for profit, there's enough data to tell everyone that at the moment. So we make the model sustainable. I think that if we could we would invest further into it. I think we would get better – even better outcomes if we put more staff and we could invest in that. But, obviously, from a board perspective, from a CEO perspective, financial stewardship is also part of our role. And in getting that – that balance right, something has to give. So we make it sustainable, although I wish we could do more.

MS HILL: Would it be different if you were a for profit organisation?

MR MAMARELIS: From the perspective of a for profit organisation, I think they have competing financial priorities which add another layer of complexity to this puzzle. So for profits have shareholders who require dividends because of the money they invest in them; shareholders pay tax. So once you remove that – each for profit would have to be assessed separately, but I think it would make things more complicated. If Whiddon, for example, had to pay income tax, if Whiddon had to distribute returns to shareholders, I think that the ability to deliver this program

would be compromised. In saying that, as a not for profit we're given the freedom and we're given licence to invest in social dividends and – and to deliver these social outcomes. So that's the freedom we have that not for profit – that for profits don't have.

MS HILL: You referred on several occasions to the challenges that you face in your role. What are those challenges, Mr Mamarelis?

MR MAMARELIS: In the context of what we're trying to deliver with relationship-based care and the model of care, I guess there are – there are a number of challenges. Look, I think I've spoken at length about the financial viability. Just when you're trying to plan around this – and we've just gone through a budget cycle, and you're trying to plan for additional staff to – to facilitate relationship-based care, you need consistency of funding. And I can reflect over five or six years where – we've had a funding freeze one year, the next year it has come in. There's so much uncertainty. The last quarter we received 9.5 per cent. So trying to plan around this is extremely extremely difficult. So the financial viability needs to be addressed if we're going to see more of this sort of thing occur in the industry.

I also think that the workforce – I've mentioned the workforce. There's huge challenges with consistency of staffing, with high levels of casuals, the transient workforce, accessing skilled workers out in rural and remote parts of the country. I think that's an issue. The other real problem we have is ACFI. When I talk about ACFI, I'm not talking about the dollar figure attached to ACFI. The problem with the ACFI funding model for an organisation such as ours that is taking a wellbeing and a re-ablement approach, is ACFI incentivises acuity, it incentivises getting sicker, it incentivises getting more frail. And that's just counterintuitive to what we're doing as an organisation and what we're trying to achieve as an industry. So there's a really dangerous unconscious message that has being sent from the government through ACFI funding in – incentivising frailty and acuity. And I think that the last part of that equation is about this cultural change.

And I think we've seen enough evidence regarding the need for good compliance and good risk measures in aged care. It's obviously a necessity. However, this culture of risk in compliance can also become a barrier. And in our case and examples that I draw on, if I have a resident who's palliating, who used to be a pilot, wants to fly over his farm for one life time – one last time, we want to make that happen. If I have a resident who grew up with horses and is now too old to get out to see them, we want to bring the pony into the aged care service. And if we have a 95 year old lady who wants to take a ride on a Harley Davidson, we're going to make that happen. So we want a culture that says yes, but we're surrounded by a culture that's always looking for ways to say no. That's a huge challenge.

MS HILL: How do you overcome that challenge, Mr Mamarelis?

MR MAMARELIS: We find ways to say yes. We manage the risk – we have to manage the risk responsibly. We have to engage with the community, we have to

engage with family members as well, and we have to manage that risk. But as an organisation and without people, you have to have a can do attitude because the culture of aged care can suck you up and you will do none of this.

MS HILL: Commissioners, that concludes my examination of Mr Mamarelis.

COMMISSIONER TRACEY: Thank you. Could I ask you about a couple of matters? The first is that you have 300, I think you said, volunteers. What role do they play in the organisation and in assisting the people in care?

MR MAMARELIS: The role of the volunteers at present, for – in the case of Whiddon, is an evolving role. They're vital in supporting some of these additional – these non-clinical outcomes that I was talking about. So whether it's enhancing lifestyle or being involved in some of our programs, that's – that's really a critical function for volunteers. What we're looking at as we – as we look forward and we look at some of the budget challenges, we see that we need to really advance our volunteer model and get it to a more sophisticated level, because it has to replace wages that we can't fund anymore. So that's the role, looking forward. But volunteers are vital in enhancing this holistic approach to care, because your care workers are being tied down in so many other things. So that – that's really the – they play a vital role. As I said, Whiddon needs to really take that to another level as we go forward.

COMMISSIONER TRACEY: How do you go about recruiting volunteers and ensuring that they're suitable for the sort of work that you ask them to perform?

MR MAMARELIS: A lot of our volunteers at present, under the current structure, are recruited locally. And when you consider our rural and regional locations that are very close-knit, that – that obviously assists. The whole word of mouth process assists there. Volunteers still have to go through stringent processes in – in getting clearances to work with – within – in the aged care setting, so that's obviously part of the process. I think, again, as we go forward, volunteers have to be inducted at a higher level in terms of engaging with our programs and some of the things that we're doing. That requires more structure, more system, more investment in order to do that as well, and, yes, it's another important aspect of the volunteer journey.

COMMISSIONER TRACEY: And on another matter, you have a structured care arrangement with people living in villages and then moving through the system to where they require residential aged care on a full-time basis. Am I right in thinking that most people want to stay in their own homes for as long as possible?

MR MAMARELIS: Yes. I think that in terms of the – what I've experience with people entering aged care, people don't want to come into aged care. It's an event that brings them in – into aged care. It's some sort of a health event. So, yes, I think that's the – that's the reality. The home care that we provide certainly enhances and enables residents and clients to stay at home, which is a great aspect. Having a fully-integrated offering, being able to offer a retirement village, being able to offer

community care, being able to offer residential aged care is wonderful, because we're able to adapt the needs of the clients as they evolve and mature. And it's certainly an area we want to integrate even further. One of the challenges with that, of course, is different legislation, jumping between Retirement Villages Act, Aged Care Act, different levels of compliance and then enterprise agreements can cause a lot of headaches between staff shifting into different roles. So there are some barriers there as well.

COMMISSIONER TRACEY: And am I right in thinking that the cost of providing those services increases incrementally as one moves from home care to full-time residential care?

MR MAMARELIS: Yes. Obviously, with full-time residential care there is a lot of other – labour costs associated with that just before you start. There's infrastructure costs and, you know, there's a scale of our operation. So yes, you are right in – in that assumption as well. I think one of the things I didn't mention and the – the beauty of relationship-based care, though, is in an environment we're starting to talk a lot more about smaller-scale living, and there's certainly benefits to smaller-scale living. Relationship-based care is adaptable on the large – larger scale. And with something like 200,000 plus beds out in Australia at the moment, the majority of are in larger-scale buildings that aren't going anywhere for 20 or 30 years. So being able to adapt that model in there is really good, because we can get the quality of care that we're after and maintain some level of efficiency in residential aged care, which does drive higher levels of cost.

COMMISSIONER BRIGGS: Mr Mamarelis, thank you for your testimony and for the witness statement which I found very interesting. I suppose the thing that struck me over many years is the tendency for Australians in particular to adopt an industrial-based model to just about anything, so things become a series of transactions and so on. And the health system is known for that and moving people through that system as quickly as possible. We know that at certain stages of people's lives they do however need health care-type services in residential care. And I'm wondering if you could give us your view about how you blend the need for the provision of those services with a relationship-based model, please.

MR MAMARELIS: I think – just to put the disclaimer that Karn is the subject matter expert on this. From my own perspectives, I think to start with there are so many barriers in terms of accessing the different health services and again there's State health services, there's federal health services, there's even local council deliver some. So multi layers makes accessing them extremely difficult. Collaboration is another real challenge and I've recently just gone through some of that myself. So there's a real issue with access and integrating those health services just before you even start. I think in delivering the sort of outcomes that we want, we need more flexibility for the system – from the system. We need less confusion from the system which is multi-layered.

We need to really, through the health system, support the fully integrated approach to care. I think it's just a multi-layered and complicated health system that we're dealing with and we're trying to bring our employees on our journey who are under our roof and that can be difficult enough. Trying to get into these other aspects of the health system is near impossible. So there is a lot of work to do in that regard. Thankfully, as an organisation I think we can still meet our objectives, working with these barriers, although it goes without saying that they do create challenges.

COMMISSIONER BRIGGS: One of the things I'm particularly interested in is the role of the registered nurse in this system. And we've heard, well, we've seen the direct evidence that what is happening at the moment in the sector is that the proportion of staff in the system that are registered nurses or enrolled nurses is coming down and the proportion of personal care workers is on the way up. And you or anyone might say that's a good idea because the personal care workers can focus on the relationship-based model. Where do you see the role of nursing in the system?

MR MAMARELIS: I guess the first point of clarity is within our relationship-based care model it applies to all of our employees, so it's the care workers, the registered nurses, the people in the kitchen, the domestic – people working in domestic care; all of those areas it applies to, and that's central to the relationship. Given the close personal nature and the close working relationship that the registered nurse has, I think they're pivotal to providing that care and enhancing that relationship-based approach. There are insights that the registered nurse gains through their relationship that are so beneficial. I think the challenge comes – and when you talk to registered nurses, they've told me first hand, we just want to be able to do what we were trained to do and provide care, but they're so caught up in compliance and paperwork and that's one of the barriers to doing that. So my view is the registered nurses are absolutely pivotal to supporting this approach that we're taking.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising out of that, Ms Hill?

MS HILL: No, Commissioner.

COMMISSIONER TRACEY: Mr Mamarelis, thank you very much for your evidence. If I may say so, it was a breath of fresh air.

MR MAMARELIS: Thank you.

COMMISSIONER TRACEY: And we're very interested in models that may be used to improve the lot of people in aged care across the system, and this is certainly one that we will be taking into account.

MR MAMARELIS: Excellent.

COMMISSIONER TRACEY: Thank you very much for your evidence.

MR MAMARELIS: Thank you. Thank you.

<THE WITNESS WITHDREW [2.34 pm]

MS HILL: Commissioners, the next two witnesses are Kevin Chester and Carolyn Jubb and they will give evidence in a panel form. I call Kevin Chester and Carolyn Jubb.

<CAROLYN JUBB, SWORN [2.35 pm]

<KEVIN CHARLES CHESTER, SWORN [2.35 pm]

MS HILL: Thank you Ms Jubb and Mr Chester. Ms Jubb, if I may commence to ask you, if you could please state your full name.

MS JUBB: Carolyn Jubb.

MS HILL: And if I could just ask you to raise your voice slightly. How old are you, Ms Jubb?

MS JUBB: I'm 54 years old.

MS HILL: And whereabouts do you live?

MS JUBB: I live in Largs, a suburb of Maitland in New South Wales.

MS HILL: And what is your occupation, Ms Jubb?

MS JUBB: I'm a leisure and lifestyle officer.

MS HILL: What qualifications to you hold in respect of that role?

MS JUBB: I have a diploma in leisure and lifestyle.

MS HILL: Where do you work, Ms Jubb?

MS JUBB: I work at the Whiddon facility at Largs.

MS HILL: You prepared a statement dated 5 June 2019?

MS JUBB: Yes.

MS HILL: Operator, could you please display document ID WIT.1138.0001.0001. Ms Jubb, do you see a copy of your statement on the monitor before you?

MS JUBB: I do.

MS HILL: And are the contents of that statement true and correct?

MS JUBB: Yes.

MS HILL: Are there any changes that you would seek to make?

MS JUBB: No.

MS HILL: Commissioners, I tender that statement.

COMMISSIONER TRACEY: Yes, the witness statement of Carolyn Gaye Jubb dated 5 June 2019 will be exhibit 5-16.

EXHIBIT #5-16 WITNESS STATEMENT OF CAROLYN GAYE JUBB DATED 05/06/2019 (WIT.1138.0001.0001)

MS HILL: Mr Chester, I turn to you; could you please state your full name?

MR CHESTER: Kevin Charles Chester.

MS HILL: How old are you, Mr Chester?

MR CHESTER: I'm 79 years old.

MS HILL: And where do you live?

MR CHESTER: At Largs, at the same complex as the aged care home.

MS HILL: And you've travelled to be here today.

MR CHESTER: We did, yes.

MS HILL: How did that go?

MR CHESTER: Pretty long.

MS HILL: And you're retired, Mr Chester.

MR CHESTER: I am, yes.

MS HILL: And you've previously served in the army; is that right?

MR CHESTER: Yes. That's right.

MS HILL: That was for a period of about – a total of 20 years.

MR CHESTER: Yes.

MS HILL: And you had several overseas tours?

MR CHESTER: Yes.

MS HILL: What were they, Mr Chester?

MR CHESTER: I spent two years in Malaya and a year in South Vietnam.

MS HILL: And you've also held various jobs including postal work and the like.

MR CHESTER: Yes, in between army service.

MS HILL: And you prepared a statement dated 3 June of this year?

MR CHESTER: I did, yes.

MS HILL: Operator could you please display document ID WIT.1137.0001.0001. Mr Chester, do you see a copy of your statement there on the monitor?

MR CHESTER: Yes, I do.

MS HILL: Are there any changes that you would seek to make to that statement?

MR CHESTER: No.

MS HILL: Are the contents of that statement true and correct?

MR CHESTER: True and correct.

MS HILL: Commissioner, I tender that statement.

COMMISSIONER TRACEY: Yes, the witness statement of Kevin Charles Chester dated 3 June 2019 will be exhibit 5-17.

EXHIBIT #5-17 WITNESS STATEMENT OF KEVIN CHARLES CHESTER DATED 03/06/2019 (WIT.1137.0001.0001)

MS HILL: As the Commission pleases. Mr Chester your wife is Marie Chester.

MR CHESTER: That's correct, yes.

MS HILL: And you and Marie have three adult children.

MR CHESTER: Yes, we do.

MS HILL: Mr Chester, could you tell the Commissioners the story of how you and Marie met.

MR CHESTER: Yes, well, it's – I was actually just returned from Vietnam service and I was down at the local hotel at Paterson which is a little rural town in New South Wales, and I saw my wife playing the piano in the lounge. I was in the bar and I could see through a hatch at the – where she was playing the piano. And being musically involved myself, I sort of virtually took to her and I actually saw this fellow standing next to me and they looked – there was a resemblance between Marie and this gentleman. And I said to him, I said "That's a nice looking woman out there". I said "Do you know her?" and he said "I should. She's my sister". So I plucked up the courage, so I walked out and made myself known to her, and I play guitar myself, and I have done for most of my life, and I asked her would it be okay if I come and played a tune with her.

She played at this hotel every Saturday night as I found out later on. And she said that would be fine. So I turned up the next Saturday, on Saturday night and we had a tune together and it all went well and from there on was virtually the start of a 20 year playing episode that we went on with for the next virtually nearly 20 years, yes.

MS HILL: Operator, could I ask you to please display the photo at tab 31. It's in the general tender bundle, 5-7. Mr Chester, do you see a photo displayed in front of you on the monitor?

MR CHESTER: I do, yes.

MS HILL: Could you describe the photo?

MR CHESTER: That was a fireman's ball in Maitland Town Hall in 1967 as is written on the photograph, and yes, that was our second date.

MS HILL: Where does Marie live, Mr Chester?

MR CHESTER: Where does she live now?

MS HILL: Yes.

MR CHESTER: At Largs Aged Care Home.

MS HILL: Where is that compared to where you live?

MR CHESTER: I live in the independent living unit there in the same complex at Largs.

MS HILL: So how often do you get to see Marie, Mr Chester?

MR CHESTER: Every day.

MS HILL: Are you able to describe a typical day for you and Marie?

MR CHESTER: Yes, well, normally I get up there around – I get up in my own unit down there and I do I what I do in the mornings. Then I head up there around about 9.30 or so and we go up to the coffee shop which is in the facility, we sit and have coffee and we just talk about anything and everything. So that's a typical morning up until lunchtime, and then Marie goes to lunch at the home and then I go home and spend the afternoon alone.

MS HILL: Does Marie still play the piano?

MR CHESTER: No, she's forgotten how to play, and it's so – I couldn't believe it, that she could just lose it all like that after she had been playing for, you know, for something like – I think she started at high school when he was about 14. The nuns taught her and she played piano really well and played up until we gave it away at the end of 1988, I think, the music part of the business, playing around the pubs and the clubs, all around the place. And after that, she wasn't – didn't go anywhere near a piano, but by the time she got to the age she is now, or even back a couple of years, we tried to get her to play a piano at one of her nephew's lunches which we attended and she sat at the piano and she just could not play.

And I was dumbfounded because, you know, how can a person lose something like that? But that was the way it was and she – she realises it now. I've tried to get her to play in the meantime and – because there is a piano at the facility, but she doesn't want to make a fool of herself because she knows she can't play so she won't go near the piano, so that's all about that, yes.

MS HILL: Before Largs, has Marie lived in other residential homes?

MR CHESTER: Yes, she's – she did a short stint in the old – what they used to call the old Maitland nursing home which is a very old place and was very crowded. But we went in there to give her some respite to get her used to being in a nursing home with others and she did a fortnight there but she stuck is out and when she come out she didn't want to go back there because it was too crowded. The room she was in, there was four residents in that room with a shared bathroom. So that was that one. The second one which was early in 2016, a brand new Opal one they built at Rutherford in New South Wales. She said she would like to go in there. So we went in there for a trial and the first night she was there, she had a traumatic experience.

She got out of bed in the middle of the night, had a fall, got her watch caught on either the bed or the walker which was next to the bed and stripped all the skin off her arm, ended up in the hospital.

She spent four days, I think, in the hospital, and then when they released her from the hospital, the patient transport people, she said, "Where are we going?" They said, "You're going back to the home". She thought they said "You're going home", which is back to me. And she – they took her back to the home. Anyway, I went up there the next morning and she was a basket case. She could not – she was so traumatised and I had to take her out of there. I had to – I went down to see the office and the office people said, "No, well, you signed all these papers and everything" and I said I had gone through the contract and everything and I saw there was a cooling off period in there. And I revoked that or invoked that cooling off period of 14 days. I said, "That lets us out of here. We've only been here a week" because I didn't want her to stay there. Because I thought if that's going to happen on the first night in the middle of the night in a strange place for somebody who's disabled, it's not good.

So I actually said we're going home. So I went and showed the – the manager in the office. I said here's – it says here that we've got cooling off period and we're going to invoke that. She said I didn't even know that was written in the paperwork, and that's not a very good thing. The point is that actually happened so we went home. I took her home with me again. So we continued to look around other places and put our name down. There's a place called Benhome in Maitland which has been there many years and is a nice old place but you had to put your name on a list. We went to the Catholic home at Campbells Hill which is at Maitland itself, just above Maitland. And there was no vacancies there because it was full up and you had to put your name on a list.

So we kept on doing this, we went to Largs and we fell in love with Largs but naturally we couldn't get in there, put your name on a list. So we went to Raymond Terrace and we actually got an offer from Raymond Terrace in October 2016 it was, and we had another inspection there and she made up her mind that she would go into East Maitland at Green Hills. So we tried – she had to share a room with another lady which wasn't too bad but it was very – it wasn't – no room in there. It had a bed space, a little wardrobe and a little bedside table and that was it. But she was willing to put up with that, so we put up with that for five months and then we got the word from Whiddon, you can transfer over to us, so it was hallelujah.

So we jumped on. I went and saw the manager of East Maitland and told her. She said, "Good on you. It's a better place than ours and you're doing the right thing". So away we went to Whiddon, and that was in March 2017 and Marie has been a resident there ever since.

MS HILL: Why did you choose Largs, Mr Chester?

MR CHESTER: Sorry?

MS HILL: Why did you choose Largs at Whiddon?

MR CHESTER: It was a great place. It's a really nice area. It's quiet. It's got a country aspect about it which we like because we're country people, and it was peaceful and quiet. But the home itself is just – it's just a terrific atmosphere. It had just been renovated and extended and it's – the vibes there were there for us. It felt good. It felt friendly. It felt – and once – it didn't take me long although to get to know the admin staff, all the nursing staff, all the residents in the place. They all know me, I know all of them and you get the good feeling about the place and that's the main reason why I wanted to be there.

MS HILL: Ms Jubb, you're a leisure and lifestyle officer at facility at Largs.

MS JUBB: Yes.

MS HILL: Could you describe our relationship with Kevin and Marie.

MS JUBB: Well, our relationship is very, very good. We've become very good friends. Marie and I get along really well because – I think because Marie is just a nice quiet lady and I'm fairly quiet so I think that they probably have matched us because right from the start when I first arrived almost two years ago we seemed to hit it off really well. So once we set up the buddy system, then Marie became my – my person, and yes, and because Kevin comes in almost every day, I see them both every day, and yes, we've become very close.

MR CHESTER: Yes.

MS HILL: And as Marie's buddy, what do you do, Ms Jubb?

MS JUBB: So with Marie as my buddy most days I will come and have a bit of a chat with her. Depending on how she is on the day, if she's not feeling all that well, she has days where she's not feeling as good as other days, I might just pop in, say hello, see if there's anything she wants to tell me. Other days where she's feeling a bit brighter and wants to come out and sit down in the lounge area or somewhere I will sit down and have a bit of a chat with her and when Kevin is in of a morning having morning with her, sometimes I will just duck my head in and sit down and have a chat with them both so, yes.

MS HILL: Mr Chester, what observations do you make of Marie and Ms Jubb's relationship?

MR CHESTER: The buddy relationship, is that what you mean?

MS HILL: Yes, Mr Chester.

MR CHESTER: I think it's a great thing because they've got somebody there for them all the time, somebody they can go and talk to if they only want to talk to

somebody, somebody to spend time with, have coffee with. If they're feeling a little bit down and lonely they've got a buddy, and that's what it's all about, yes.

MS HILL: What care does Marie receive more broadly, Ms Jubb?

MS JUBB: Care as in from the care staff?

MS HILL: Yes, Ms Jubb.

MS JUBB: So Marie does need quite a bit of care. She's – her mobility is very poor. She has problems with feeling dizzy quite regularly so sometimes of a morning if she's not feeling 100 per cent she might stay in bed for a while and maybe not get up till lunchtime some days but then there are other days where she's a little bit more able and the care staff will either wheel her out of her room for breakfast or lunch, and then other times, yes, she's not as good. She will stay in her room during the day.

MS HILL: Do you have much to do with other care staff or the nurses where Marie is, Ms Jubb?

MS JUBB: Only as far as communicating with them. Sometimes I will ask the care staff how Marie is doing for the day, especially if it has been a weekend and I'm coming in on a Monday. I quite often check in if she has had any episodes where she's really not been well. Just recently when I was about ready to leave to go home from work at 4.30 in the afternoon, Marie had actually come out with her walker and she was looking a little bit pale and I sort of quickly raced over to her and she said she was feeling quite dizzy so I sort of held on to her and got one of the care staff – alerted one of the care staff to bring a wheelchair around and we both sat her into the wheelchair. So, you know, helping them out, we help them, they help us, and yes.

MS HILL: Operator, could I ask you to display tab 33 of exhibit 5-7 from the general tender bundle. Do you see that will photo on the monitor before you?

MS JUBB: Mmm.

MS HILL: Could I ask you to describe that photo to the Commissioners.

MS JUBB: That photo is from Marie's Best Week and we had morning tea together with Kevin as well and I presented Marie with a handmade letter M that I had cut out with my jigsaw and painted up and decorated for Marie because she likes pretty things, so I put a bit of lace on it and some flowers on it for her and a few little diamantes and presented that to her on the day so she could hang that on her door.

MS HILL: What's the Best Week that you refer to, Ms Jubb?

MS JUBB: The Best Week is a program we have at Largs where we have a week of special activities for each resident and in that week we will have – on the Monday we

quite often have our engagement specialist come in and he has a bit of one-on-one time with the resident. He will have a bit of a chat, a bit of a laugh with them, a bit of a reminisce on things. On the Tuesday, mostly we will have usually a morning tea or something for the resident there. Whether that's just staff or buddy sitting with them or family coming in, which was this day. On the Wednesday we usually try and make that a lunch day so we will have family coming in to have a lunch which we usually provide at the facility.

We usually set that up in a special room, sunroom so that's nice and private for them. And then Thursday we have usually allocated for massage day, so we do a massage, whether that be a hand massage or a foot massage, and then the Friday is, I guess, free to listen to some favourite music or have someone special come in that they're wanting to see and that type of thing.

MS HILL: Has Marie had a Best Week?

MS JUBB: Marie has had a Best Week, yes.

MS HILL: And what did you do for Marie?

MS JUBB: So for Marie we did have our engagement specialist come in on that day, had a chat with her and spent some time with her. And on the Tuesday which is the day here on the screen we had morning tea with some nice little pink cupcakes. I presented her with a little gift which is the letter M that's there. On the Wednesday was your luncheon day. Marie was hinting that she likes pineapple and salad and chicken and all those things, so we decided to make it a tropical lunch for her, so she wanted the roast chicken so we had roast chicken. We had our chef organise all that, a nice tropical salad for her with the pineapple in it, and the salad – a fruit salad for dessert. We set up the sunroom with a Hawaiian-type theme so we had the blue backdrop. We had a sun up here, and a seagull over here. I put together a big palm tree out of cardboard to sit in the background and we put photos of Kevin and Marie around the room and played some of Marie's favourite music for the day.

And then Thursday was massage day. We had our DDCS come and do a massage with her oils, so she had a nice hand massage. And Friday we listened to some music that had been recorded of Marie and Kevin of their days in the pub where Marie played the piano and Kevin was on the guitar singing, so yes.

MS HILL: What was your experience of Marie's Best Week, Mr Chester?

MR CHESTER: Yes, well, as Carol stated there, it was a brilliant day – well, a brilliant day for me on the Wednesday which was the luncheon, and it was good to see her pampered. She was pampered for a week with the hair, the nails, the massaging, the fellow that comes to entertain the residents with his banjo – banjo, no, mandolin, I think it is, and sing a song for her and stuff like that, so it was a really good week.

MS HILL: What's your experience, Mr Chester, of the care that Marie receives?

MR CHESTER: Well, I think it's really good because, as I said, I've been around a couple of the others that we were – had a bit of time with and I think Whiddon – the nursing staff, to me, is second to none. I mean, they really do a great job. And they even invite me at times to be in with them so with part of her care if there's something, if I like, I could make an example of, she had a bad diarrhoea problem and we went to a gastroenterologist and got some special Questran powder they call it to mix up which controlled that problem that she had. And they didn't know about this. So I typed up the directions of how to present it to her. And so that was my part in helping with the care in that particular situation, yes, but there's other situations.

MS HILL: Mr Chester, have you worked in other aged care facilities?

MR CHESTER: No.

MS HILL: Sorry, Ms Jubb have you worked in other aged care facilities?

MS JUBB: Yes, I have worked in a couple of other aged care facilities.

MS HILL: Were they residential settings?

MS JUBB: They were residential. One of them was a disability facility rather than aged care.

MS HILL: How does your current workplace compare to the previous work that you've been involved in?

MS JUBB: I feel more comfortable working where I am. It seems to be a much more relaxed atmosphere. It's more of a teamwork there. I feel like other places I've been, it's been more segregated with different roles so, you know, your kitchen staff didn't really relate with your laundry staff and your laundry staff didn't relate with the care staff and it just seemed to be more separated, whereas Largs, we're all together as a family there and we help each other out more so it's a much more friendly environment, and we have had lots of comments about how friendly the staff are by residents' families that come in as well.

MS HILL: Do you report to a manager or a supervisor in your role?

MS JUBB: I work together with the coordinator. We sort of plan the programs together and I guess after the coordinator, then I would be reporting to the manager from there.

MS HILL: And what is your relationship like with those people?

MS JUBB: Well, we have a recently new manager. She's coming along really good, but yeah, my coordinator, we – we work really well together and communicate really well.

MS HILL: Do you have other buddies aside from Marie?

MS JUBB: I do have another buddy, another resident at Largs as well. He has fairly recently been appointed to me. So I'm still in the process of learning about that resident and sorting out all the information I need for him as well. So - - -

MS HILL: And how do you do that, Ms Jubb?

MS JUBB: We had a sheet, my life sheet, which we take around. It's a form with questions on it that we take around and we will ask the resident different questions, try and get a background about what they used to do, things they like and don't like. Yes, so just basic questions about their life which we fill in on the paperwork and we also give them a little bit of an idea of our background as well. So there will be questions on there about where we lived and things like that as well so - - -

MS HILL: Are you familiar with the term relationship-based care, Ms Jubb?

MS JUBB: Yes.

MS HILL: What do you understand that to mean?

MS JUBB: Relationship based care is more about coming together as a family and being able to relate to each other as a friend rather than just a – a person that you have to care for. It's about really looking after them more as an individual and learning about what they like and what they don't like and basing – as an activity officer, we like to base our activities around that person's interests. Yeah, so - - -

MS HILL: Are there challenges for you, Ms Jubb, in providing relationship-based care?

MS JUBB: Probably the biggest challenge is some residents that aren't able to participate in a lot of our activities. Sometimes, you need to probably give them more one-on-one time with those residents, and if they're a little bit more difficult, to try and find things to interest them. That's where it's probably more difficult.

MS HILL: What support do you need, Ms Jubb, to be able to provide relationship-based care in your work?

MS JUBB: I – well, at the moment, I guess just being able to have the time, especially with people that, as I was just saying, a bit more difficult to find things for. Just to have a bit more time to really relate to them, but, yeah, just – I mean, it's pretty – pretty good where we are. We get a fairly good amount of money to go out

and do things that we want to do. Bu, yeah, I – I guess the staffing – if they had more time to spend with their buddy would be really good, yeah.

MS HILL: Do you feel supported in your role, Ms Jubb?

MS JUBB: Yes. We do feel supported, and like I say, with the Largs facility, everyone's so friendly and work together as a team. So it's really good to have that support from everyone there because everyone tries to help everyone out. Sometimes, there's things that you might not know about a resident, that they might not have told you, but they'll tell somebody else, and then that person will come and tell you, "Oh, did you know this about this person?" And you will say, "Well, no, I didn't," you know, and then you might find something else out yourself and you will say to the other care staff, "Did you know this about this person?" So it's good to get that feedback so we can provide better care for the residents.

MS HILL: Mr Chester, what's important to you about the care that Marie receives?

MR CHESTER: I'm sorry?

MS HILL: What's important to you about the care that Marie receives?

MR CHESTER: Well, I mean, there is – that's why she's in aged care home to receive that care because she has a disability. She has – what – when carol mentioned before, she's wobbly and loss of balance. She's got cerebellar ataxia which is no balance whenever she stands. She's got to be holding something or she will just keel over. And she's also – what was the other one. She's got AF which is atrial fibrillation which, when she first stands, she's got low blood pressure and that also helps – well, doesn't help, but goes toward this feeling of dizziness and maybe feeling like falling over. But the care she – that she receives there is the – is the best that they can do for what her – what her condition is.

MS HILL: Are you and Marie supported to be together, Mr Chester?

MR CHESTER: Are we - - -

MS HILL: Supported so that you can be together.

MR CHESTER: Supported in what way?

MS HILL: So that you can spend time with each other.

MR CHESTER: Oh, yes. Yes. Yeah. As I say, I go up there every day and I'm welcomed to go up into the – into their lodge up – up there. I live down below in one of the units, and it makes it so easily to go up there and spend time with Marie, and to be close to her and be involved with whatever is going on, I join with their activities at times just to be a part of the friendly atmosphere. And it just means much to me and to her that I do come every day and we can spend time together.

MS HILL: Operator, could you please display the photograph at tab 32 of exhibit 5-7 of the general tender bundle. Mr Chester, do you see that photo on the monitor before you?

MR CHESTER: Yeah, I do, yeah.

MS HILL: Could I ask you to describe that photo for the Commissioners.

MR CHESTER: Yeah, that photo was taken at Marie's nephew's daughter's wedding in 2005. That was taken at the reception which is in – was in Sydney at the centre above the Taronga Park Zoo. They had a convention centre there where they had the – the – the wedding reception afterwards.

MS HILL: Mr Chester, have you got a copy of your statement there in front of - - -

MR CHESTER: I have.

MS HILL: Could I ask you to turn to the last page. I believe it's page 7.

MR CHESTER: Page 7.

MS HILL: Could I ask you to read out paragraphs 51 through to 53 to the Commissioners, please.

MR CHESTER: Okay. Okay. Para 51. I – starting with:

> *Marie is a lot happier now that I come to see her every day. We will never be apart.*

Excuse me:

> *We are soul mates and we stick together. Each other is all we have to worry about now and it's all that we look forward to each day. We need to be together as much as possible. The other things that make Marie happy and me are coming to her, her coming to me, concerts and music and our children and grandchildren. When our children visit, I bring Marie to my unit and we all have lunch together.*

And the last one is:

> *It is so important to me that Marie – and Marie that we live so close to each other. We are separate, but never apart.*

MS HILL: Thank you, Mr Chester. Commissioners, that concludes my examination of Mr Chester and Ms Jubb.

COMMISSIONER TRACEY: You'll forgive the passing observation, Mr Chester, but with your wonderful voice, I think you'd still hold your own in any parade ground in this country.

MR CHESTER: Yeah.

COMMISSIONER TRACEY: Thank you both for coming so far to tell us about how aged care can be done well and is obviously being done well in rural New South Wales. It has been a privilege to have you here, and we're very grateful to you for sharing your experiences.

MR CHESTER: Thank you, sir, and thank you, ma'am.

<THE WITNESSES WITHDREW [3.08 pm]

COMMISSIONER TRACEY: I see from the daily program that a short adjournment is sought.

MS HILL: Yes, Commissioner.

COMMISSIONER TRACEY: Now – yes, very well. The Commission will temporarily adjourn.

ADJOURNED [3.09 pm]

RESUMED [3.24 pm]

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Thank you, Commissioners. I call Bryan Lipmann AM and Kate Rice who will give evidence as a panel.

<BRYAN DAVID LIPMANN, AFFIRMED [3.24 pm]

<KATE RICE, AFFIRMED [3.24 pm]

<EXAMINATION-IN-CHIEF BY MR ROZEN

MR ROZEN: Make yourselves comfortable, please. Mr Lipmann, can you, for the transcript, tell us your full name, please.

MR LIPMANN: Bryan David Lipmann.

MR ROZEN: Bryan with a Y?

MR LIPMANN: With a Y.

MR ROZEN: And Ms Rice.

MS RICE: Kate Rice.

MR ROZEN: Thank you. Mr Lipmann, you're the CEO of Wintringham.

MR LIPMANN: Correct.

MR ROZEN: Is Wintringham the full legal title?

MR LIPMANN: Yes.

MR ROZEN: It is. And how long have you held that position?

MR LIPMANN: I start the company in August 1989.

MR ROZEN: Right. And can you tell the Commissioners a little bit about Wintringham, please.

MR LIPMANN: Yes. Wintringham is a service for elderly homeless people, or people at risk of becoming homeless.

MR ROZEN: Yes.

MR LIPMANN: That's our sole target group. Do you want to know the history of it or – I'm not sure what you want.

MR ROZEN: I might just – we just hit the pause button there for a moment and we'll come back to a bit about the history before – just introduce myself to Ms Rice. Ms Rice, is that how you'd like to be addressed, Ms Rice?

MS RICE: Yes, that's fine.

MR ROZEN: Yes. Thank you.

MS RICE: Yes, thanks.

MR ROZEN: And you also work for Wintringham.

MS RICE: Yes. Yes.

MR ROZEN: And in what capacity?

MS RICE: So I'm currently the residential care manager of a site in Coburg in Melbourne of 51 residents.

MR ROZEN: For the purposes of the Royal Commission, Ms Rice, have you made a witness statement dated 13 June 2019?

MS RICE: I have.

MR ROZEN: And do you have a copy of the statement with you there?

MS RICE: I do.

MR ROZEN: All right. It will also come up on the screen in a moment. Operator, it's WIT.1136.0001.0001. Have you had an opportunity to read through that statement before giving evidence this afternoon?

MS RICE: Yes.

MR ROZEN: And is there anything in it that you wish to change?

MS RICE: No.

MR ROZEN: All right. I tender – sorry, and are the contents of the statement true and correct?

MS RICE: They are.

MR ROZEN: I tender the statement of Ms Rice, Commissioners.

COMMISSIONER TRACEY: Yes. The witness statement of Kate Rice dated the 14th of June 2019 will be exhibit 5-18.

EXHIBIT #5-18 WITNESS STATEMENT OF KATE RICE DATED 14/06/2019 (WIT.1136.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR ROZEN: I think it's 13 June.

MS RICE: Yes.

MR ROZEN: If I said 14 June, my apologies. It's – sorry. It's 14, I stand corrected. It is 14, I'm sorry. And, Mr Lipmann, have you also made a witness statement for the purposes of the Royal Commission?

MR LIPMANN: I have.

MR ROZEN: And that's a statement dated the 11th of June 2019?

MR LIPMANN: Yes, that's right.

MR ROZEN: And is there anything in your statement you would like to change or amend?

MR LIPMANN: Well, just something petty.

MR ROZEN: Go on.

MR LIPMANN: On page 4, I love Wintringham with all my heart, but I don't necessarily say Wintringham in Wintringham.

MR ROZEN: Thank you. So very last line, as much as you love it, just one Wintringham will do.

MR LIPMANN: That will be sufficient.

MR ROZEN: So we will delete the second Wintringham.

MR LIPMANN: Mmm.

MR ROZEN: Anything else you'd like changed?

MR LIPMANN: No.

MR ROZEN: Okay. And are the contents of the statement, with that change made, true and correct?

MR LIPMANN: Correct.

MR ROZEN: I tender the statement of Mr Lipmann dated the 11th of June 2019.

COMMISSIONER TRACEY: Yes. The witness statement of Bryan David Lipmann dated the 11th of June 2019 will be exhibit 5-19.

EXHIBIT #5-19 WITNESS STATEMENT OF BRYAN DAVID LIPMANN DATED 14/06/2019 AND ITS IDENTIFIED ANNEXURES

MR ROZEN: Now, Mr Lipmann, we will go back to the question I asked you a moment ago and you volunteered to tell us briefly, if you could, please, about the history of Wintringham. What brought you to establish the company?

MR LIPMANN: Well, I – I suppose it started in about 1969.

MR ROZEN: Yes.

MR LIPMANN: I headed off to Western Australia with my girlfriend on an old motorbike which blew up, but we eventually got here, broke and ended up doing some farming work. So for 14 years, I was a jackaroo and a shearer, a slaughterman. And, eventually, changed my profession and became a social worker. Probably the first slaughterman in history to become a social worker, and I got a job at Gordon House which was the largest night shelter for homeless people in Australia, and it was 300 people living in a 10-storey building. It's really difficult, as I tried to explain in the statement, just what that place was like.

It was – there was acts of wanton kindness, but there was also appalling violence and it's really difficult to imagine anyone living there, but particularly frail elderly people. But I – I guess I didn't notice it as much until my parents got frail and sick, and then I needed to get them services, and I was amazed at the quality of the services – aged care services in Australia because I knew nothing about it and they got terrific care. So I was going to visit them, and then coming back to Gordon House where my old guys were dying, often been bashed or raped or murdered, in fact. So with the great encouragement of a man, Peter Hollingworth, I tried to create a new organisation. I left Hanover and – and tried to create Wintringham.

MR ROZEN: You mention in your – in your statement at paragraph 16, that part of the process involved approaching the Aged Care Minister at the time, Mr Peter Staples.

MR LIPMANN: Yeah.

MR ROZEN: What were the circumstances in which you came to talk to Minister Staples and what was the conversation?

MR LIPMANN: Well, I – you'd have to remember it was 30 years ago. I was a relatively young fellow and I met a lot of people in a lot of hurry, so I can't exactly explain how I got to so many different Ministers and politicians, but I certainly was pretty determined to get something done. At the time, when I raised the issue to – to government that there were old people dying in the night shelter, they said that they were homeless and aged, and there was a very fine homeless service system in this country called the SAP system and – and, there, they would be cared for. But SAP was never designed for aged frail people. It was designed for crisis accommodation, and I wrestled with that for a while and eventually decided that what I should say to them, was that they weren't homeless and aged, but they were aged and homeless.

So that switches the paradigm, so then you start to say that they're aged and, therefore, eligible for aged care, just as much as saying they're aged and Greek or aged and a war veteran or aged and living in ..... they're – they're aged, and that argument was accepted by Peter Staples and he became a champion of Wintringham which was very – it's very interesting. I was just discussing that a few minutes ago with some other people. You can have great ideas and you can be both firm and forceful in those ideas, but at some stage along the line, you need powerful people to sign on, and whether they do it voluntarily or whether they're forced is two different issues, but Peter enthusiastically volunteered to assist, and I just don't think I could have started Wintringham without the assistance of Peter Staples.

MR ROZEN: Thank you, Mr Lipmann, and that ability to win friends and influence people has become a bit of an art form by you, hasn't it? Particularly the – you mentioned that public servants and others that have been very supportive and assisted you over the years.

MR LIPMANN: Yeah, I – I wanted that to be noted in the statement because it's true. The aged care system is designed for people, as far as I can understand, who are about 85, middle class, white Anglo Saxon with an aggressive daughter to lobby on their behalf. I don't mean that in a pejorative way. I just mean it's – invariably, it's the daughters or daughters-in-law that do the work. Our guys are quite different. They're more likely to be 65, working class, male, resistant to care and that opened up a really important issue for, I guess, the way that we've run Wintringham in the – in the – into – interspersed 30 years because the first two years, I was the only employee and, now, we've got about 700, but I – I came to see myself as a housing worker into which we brought aged care services which is quite different. So when my mum went into aged care she transferred from a house to aged care. So the only real difference was the care. For our guys, the real issue is the – is the housing in and, often, they have to be encouraged to accept the care. So it's a bit of a generalisation, but I've always seen myself primarily as a housing worker.

MR ROZEN: Now, you mentioned your guys. They're mainly men, but there are women at – who are housed at Wintringham.

MR LIPMANN: Yes. They are – the community care is probably more female and Kate ran that for a while and can speak to that, whereas our residential is more male. I – I didn't quite finish my last statement. That's my fault. In the process of getting it started with an $18 billion industry, there's a lot of – I guess, not mundane, but step-by-step approach to running such a huge industry. For Wintringham to come up with such a different client group which, clearly, the Aged Care Act was never intended for. It was an enormous challenge.

It's one thing for a Minister of government to say, yes, you're eligible. It's altogether another issue to say how that's going to work, and that process, over 30 years, I've had nothing but terrific support from senior bureaucrats in Canberra, and it really should be acknowledged that, again, I couldn't have done it without them. We've been – it's been a collegiate affair. Lots of vigorous arguments, discussions,

but the bottom line, they accept that elderly poor or at risk of homelessness or homeless are entitled to aged care, as much as any other outlier group.

MR ROZEN: Now, we did have some discussions or, rather, the Office of the Royal Commission spoke to you about the possibility of a resident or two coming - - -

MR LIPMANN: Mmm.

MR ROZEN: - - - over with you. That proved too difficult, as it turned out, but we've got the next best thing, I suppose which is a video that was produced externally to Wintringham. Do you want to just tell us briefly about the circumstances in which the video came into existence, and then we'll play it.

MR LIPMANN: Yes. Minister Wyatt was the aged care Minister up until a few months ago. Has, in a terrific initiative, I guess, perhaps because of his un-Aboriginality, but looked at how diverse groups access aged care. And so he set up a committee to work with giving the industry and consumers ways to get into aged care that might not normally fit. And so the first three were LGBTI, Aboriginal and CALD, and now it's working on the homeless and I'm working with that group. And Craig Gear from an old person's network facilitated a meeting here in Canberra and – I'm always in Canberra – in Perth, and as part of that, he – he – he asked if he could photograph a – record some of our residents, which I was a little bit against. I didn't think it was needed, but he persuaded me and he was right. It really did make a – a huge difference, and it had an – a – a great effect on the personnel there and certainly encouraged the Minister to visit himself. And just before you do it, can I ask – just say one thing.

MR ROZEN: Of course.

MR LIPMANN: We get an awful lot of visitors coming from interstate and overseas, and we're always a little bit toey about it because it is people's homes and you probably haven't had this statement before, but I just wanted to acknowledge the way, Commissioner, and your staff have visited twice and shown great respect to our staff and residents, and I really appreciate that.

MR ROZEN: Be an appropriate time to play the video, Mr Lipmann. It's tab 23 in exhibit 5-7, the general tender bundle. It's about nine minutes I think; is that right?

MR LIPMANN: I don't know.

MR ROZEN: I think it is.

VIDEO SHOWN

MR ROZEN: Thank you, operator. Ms Rice, I didn't really ask you much about your role as a manager. Can you tell us about your time with Wintringham, please.

MS RICE: So I've been at Wintringham, now going into my 18th year.

MR ROZEN: Yes.

MS RICE: So a very long time in my - - -

MR ROZEN: What's - - -

MS RICE: - - - social work career, I suppose.

MR ROZEN: Yes.

MS RICE: And I've worked in four different jobs in the company. Usually under suggestion from Bryan about trying something new or putting my skills into another area of Wintringham so that's probably kept me fresh and kept me going for so long, yes.

MR ROZEN: And what's your current role?

MS RICE: So currently I manage one of our homes, residential aged care homes in a suburb in Melbourne, inner city suburb called Gilgunya , so I've done that for – this is my fifth year.

MR ROZEN: Right. And is that a similar set-up to the one in Port Melbourne that Commissioner Tracey visited?

MS RICE: Yes, very similar. So just slightly bigger, but certainly in terms of its design, the staffing concept and the small house model, it's very similar, yes.

MR ROZEN: And how many residents live at Gilgunya?

MS RICE: So I've got 51 residents there.

MR ROZEN: Yes. And how does that compare to the numbers at Port Melbourne.

MS RICE: So Port Melbourne is 30.

MR ROZEN: Smaller.

MS RICE: Yes.

MR ROZEN: Okay.

MS RICE: A bit smaller. 35, sorry. Yes.

MR ROZEN: And we saw in the video the design, the accessibility and so on. How important are those features of the houses, that style of design? How important are they in terms of the care, provision of care?

MS RICE: So I think they contribute to our ability to do our job and to provide really good care, but I think – as I've often thought, I think we can do good care regardless of the buildings and the environment, but I think the buildings and the environment obviously enhance our ability to do it well.

MR ROZEN: Yes.

MS RICE: And are obviously designed with older people in mind, certainly older homeless people but I think from the feedback that I get, that a lot of people would like to live in the places that we operate, regardless of their background circumstance, so a lot of people come in and visit and say, "I would like my parent to live here" or "I would like my family member" and that's regardless of their background.

MR ROZEN: Do you use a particular architect, Mr Lipmann, for the design of the houses?

MR LIPMANN: We have for a long time, Allen Kong who's built a number of our facilities. It's actually interesting – can I talk a little bit about the buildings?

MR ROZEN: Please.

MR LIPMANN: The buildings are primarily natural materials, so instead of concrete there's bitumen, instead of brick there's wood. There is brick but it's much more of a softer design. They're not straight lines, there's lots of curves. And we experiment with small house models. In fact, while some people say they do house models, they often are clustered around a car park. Ours are more clustered around a garden area. One of the things that I did say to Allen at the time of the building is that I wanted something that was going to be hostile to visitors, and it probably needs a bit of explanation. We didn't mind visitors, of course, but we wanted them to realise that they are going into someone's home. And as one of the witnesses earlier today mentioned, we have a very similar view. People should feel that they are working in someone's home, and not living where someone works.

So it's quite – it's quite exciting really when a visiting architect or a visiting dignitary rings to say I've been driving up and down the street and I can't find it. That's a huge compliment, really, isn't it? The other thing about the verandahs is that verandahs are a very old traditional form of Australian architecture which has largely disappeared nowadays with the advent of air-conditioning, but I can remember when I was jackarooing that there was always a big house and always an old fellow in a chair with a moth eaten old dog nearby. And as us jackaroos, we would lean and talk to the guy and learn so much about not only just life because we were just kids, but about early Australia, farming, etcetera. You can imagine if he

was inside the house, as a young fellow I would never have had the courage to knock on the door and ask his wife, can I speak to Mr So-and-so about the past.

So we find the verandahs are a huge way of giving an opportunity to our guys to interact. Because our guys are full of – men and women, full of extroverts, full of very shy people. They're a total cross-section of the community, just like the people in this room. So those people who do want to interact can sit on the verandah. They can meet people as they go past, they can talk to them, they can interact.

MS RICE: Smoke.

MR LIPMANN: Smoke, which is good because they are smokers, unfortunately, and I don't want my young staff picking up smoking-related diseases, but by the same token I don't want to tell the guys that they can't smoke. So it enables a party atmosphere at times or at least, as I've said in my statement, a joyful – it is joyful working and living at our places. Not always but we're not perfect by any means. There are very hard times at times but it certainly facilitates, and I totally agree with what Kate says. I often say to visitors, stop looking in the buildings, look at the care, because the buildings are spectacular, that's true, but that's not the point. I'm quite sure if we took over an institutional place, our staff would turn it into a home very quickly.

MR ROZEN: One of the themes we're interested in this week, perhaps I can address this to you, Ms Rice, is risk and the buzz phrase that one hears of the dignity of risk, and Mr Lipmann, you mentioned the smoking and with the particular cohort of residents that you have, I take it that the challenges of smoking – we heard about alcoholism on the video – present particular challenges for you to strike the right balance. Ms Rice, can you expand on how that's done in a practical sense? You allow people to smoke, you allow people to drink but how do you manage risk in that context?

MS RICE: Well, I mean, it's interesting in the context of all this person-centred care discussion because someone's right or wish to say, drink or smoke or participate in gambling or any of those other activities to us are no less important in a sense to honour than someone who might, you know, want to do gardening, for example. They might just be different interests. So what we really have to do – and we do this very carefully and it takes a long time – is really assess what that person wants to do and if it is to participate in an activity that might cause them harm in a sense, like drinking or smoking, for example, what we need to do is really assess with them and their representatives and occasionally family about allowing that person to do that in a context that's minimising harm to them.

And usually for our residents, it's actually about what they can also afford because we've become very good at knowing and supporting people who are pension only.

MR ROZEN: Yes.

MS RICE: So in reality you have $200 a fortnight left and you take out all their costs and so you really are looking at this is actually how much you've got left. That means you can actually smoke 11 cigarettes a day. It's nuts and bolts stuff.

MR ROZEN: Yes.

MS RICE: And then we work with that resident around setting up a program so that it's manageable financially. It doesn't cause risk particularly to them, and it also manages the behaviours that potentially come with addictions. Because – I've heard Bryan refer to a lot that people are, you know, two day millionaires on the pension because they get paid and all the money has gone within a couple of days and then for us to try and support residents for a full fortnight, for example, who had no money or have smoked all their cigarettes, you're getting a lot of difficulties, so we really manage that as well. And it actually works quite well but people who visit us are quite amazed when we show them our management system of cupboards where we have alcohol stored and managed and distributed as well as cigarettes. But it's a really sensible, respectful way to do it because people can actually get through their week and their day if that's what they're choosing to do.

MR LIPMANN: I guess one of the things that we – we use harm minimisation as a model of care.

MR ROZEN: Yes.

MR LIPMANN: I think it's really important for – I don't know, whoever is listening that Wintringham doesn't deal just with guys who drink heavily. I mean, there is a section of them that do but there's a section in any aged care facility that does it and often they're just not allowed to do it so therefore the behaviours kick in. But, you know, we're more about harm minimisation, so it's saying, we don't necessarily condone your activities but if you're going to do them we want to manage them in a way that will minimise the risk and harm to that person.

MR ROZEN: Thank you. Can I just tease that out a bit more. I think you were in the hearing room before when Mr Mamarelis of Whiddon was talking about 90 year olds riding Harleys and some other similar scenarios. You've got a couple of your own, haven't you, in the statement, Mr Lipmann, involving tattoos and parachuting?

MR LIPMANN: Well, yes, we've got many. I think one of the – before just we go on to some examples I think the theory behind is perhaps of interest to the Commission.

MR ROZEN: Sure. Absolutely.

MR LIPMANN: It's about saying, so we don't use that term person-centred care, we don't necessarily disagree with it, it's just something that I had never really heard of, really, until I was asked to present. But we were asked what that would mean to us and I guess to me it's how I would like to be treated myself. There are – there's a

proliferation of theories and academics, good worthy academics are making a lot of money developing models and ideas about that, but really it's awfully simple what I think Wintringham is. I don't think that anything we or I have done at Wintringham is particularly – it's not rocket science. It's just treating people how you would like to be treated, or put it a slightly different way, how would you like your parent or your grandparent treated. And so it's a matter of getting to know the person and spending time with them.

The other interesting things that Wintringham faces is that we very rarely intersect with families. There's a whole lot of reasons for that, I guess, but we don't have a lot of family connections. I can remember visiting my mum in aged care on Christmas Day and it was like a bun fight trying to get in there. Then I went from there to one of our facilities and my wife and I were the only visitors for the day, so that gives you some idea. And we can talk later on about death because I think that's a really interesting aspect of it. So we replace families with – well, it's not replace, but we put a huge emphasis on recreational diversion. So we have 52, at this stage, recreation workers. They're all trained and they all have a budget. And how they work it is that a resident will come in and the recreation worker will sit with that resident for as long as it takes to find out what they want to do with the rest of their life, and I think this is something that Kate and myself have often talked about.

I guess I'm getting – allowing myself to get side-tracked but aged care should be a lot more than just care. You're living at home and then you – you're living an ordinary life at home no matter how restricted you are and then because of some physical ailment you end up in aged care, but what happened to the other part of your life. That shouldn't just be run by nurses and personal care attendants. They've got a huge role to play, a massive role to play, probably the dominant role, but there should also be a role for life, for joy, for satisfying the needs and the wants that a person still has at an older age. And I think social work is certainly one of those professions that can assist in that and I often wonder what the aged care standards and the Aged Care Act would look like if it was written by social workers instead of nurses but anyway, that's another story.

But we can't do our work without nurses and we have some of the finest nurses in the whole industry working with us and we couldn't literally do our work without them but there is a role for other players as well. A key part of that role is the recreation and we have a number of recreation workers and they will work with each individual to find out what that bucket list of things they want to do, that they haven't got round to doing. And some of them are quite humble but some of them are quite exciting. You wanted some examples, so we had – we had one guy who was very, very reclusive and he really wouldn't engage with our workers but for some reason, somehow or other he got hold of a chess set and he decided that this is something he really wanted to pursue. And so then he presented the worker with an enrolment form for a chess competition which just happened to be in Germany, but our worker, instead of dismissing it and smiling it off and saying that's cute, whatever, he took it to me.

That afternoon I had arranged funding for him to get there, and he flew to Germany, entered the international chess competition, was knocked out in the first round, but had a great experience. We had another instance, I know you'll like me telling you this one, we had an elderly woman in high care. As it turned out she probably only about 18 months to live but she was – she was certainly extremely vivacious and liked to be acknowledged whenever you turned up. And she told the staff one day that she was a clean skin and she wanted a tattoo, something that she had always wanted and never got around to doing it. So again, our staff go through the whole matrix of risk assessment, first off, does she really want to? Is this just a passing whim? And then is she competent to make a decision. So these things take a little while to work through.

And then when that was all satisfied, then they went to the various medicos to see if her skin integrity could cope with a tattoo because she's a frail lady. And they said yes. So she went to the tattoo parlour with our staff, got a tattoo, proudly showed it off to everyone, and when I came a little while later she told me she was going to get another one, but she's not going to tell me where.

MR ROZEN: Thank you.

MR LIPMANN: But lots of stories. One of the stories that actually is the simplest one but actually really inspires me is that we have a large range of housing too, and there was a housing – Ron, who wanted to walk around the golf course and, again, our staff, instead of taking him there, sat down. Danny sat down and worked out a public transport route to get to this golf course and the two of them went the first time. And then after this the guy went on his own. And then he started to see everybody playing golf so he ended up getting a stick and just knocking the ball around. And slowly, the story can go on for as long as you like but eventually he got some sticks and started playing. And the other guys wanted to know what he was doing so he told them so they got some sticks, and it turned out that twice a week these four guys would go to the golf course and play a bit of golf. That all came about because our worker empowered him to find a way to do it himself.

And that's obviously a housing story, let alone an aged care story but, still, it's the same principle, to empower people to make decisions. And that's our staff's role, is to make that happen and not to drop me in the whatever, to protect me so that I will allow them to do these things, but they have to follow all sensible precautions and ensure the client knows what they're doing and that they're capable of doing it. I might say that's probably a little bit easier because we don't have too many families. I could imagine, we had a guy jumped out of an aeroplane, now that's – and you had a woman that did the same thing. That probably would have been much more difficult if family members had said there's no way that Dad's doing that. Whereas with this guy it was his decision solely.

MR ROZEN: Thank you. Ms Rice, can I ask you a little bit about staffing, both recruitment and training; what are you looking for in staff to work at Wintringham?

MS RICE: So certainly one of the things that I always try and do is I try and be involved in the recruitment myself.

MR ROZEN: Yes.

MS RICE: So I think it's interesting because it's probably an historical thing that when I was in the community I would do a lot of the interviews for case managers, etcetera, and then when I moved into a residential care setting, I couldn't quite understand that as a manager why I wouldn't be still involved, whether that's choosing someone who works in the kitchen, cleaning, care staff, nursing. So I always make an effort to be involved in those recruitment processes. And I think for me, what I'm really looking for again is people's interest and commitment to older people. I mean, certainly it's for us an interest or understanding about social justice or poverty or homelessness is, you know, an added bonus but there's a lot of people that apply for jobs with us that haven't had that experience.

They don't really know anything about homelessness, but they might tell me in an interview about the relationship they had with their mum and how they cared for their mother or something in their private life around their respect for older people. So I think it's often those personal answers for me that really jump out about what would make potentially a really good staff member. And I think for me, you can train staff to do lots of the different day-to-day jobs, the practical things, because everyone comes with sort of that ability and I think we can train and teach people how to do a lot of that good care. But I think it's that attitude and view on older people and, again, people are talking about that relationship word that's really important.

MR ROZEN: Yes.

MS RICE: Yes, so often, you know, sometimes I've sat with HR and they will think, but that person really doesn't have any experience. And I just go "No, I just – I just want to give them a go".

MR ROZEN: Yes.

MS RICE: And then you really have to try and – I also look for people who might be interested in a pathway through aged care at Wintringham. Because I think that's what we offer people, too. So I try and excite them about the job because I'm excited about working in aged care. I love it. So I think if I love it, I want to find other people who are equally as excited as me, yes.

MR ROZEN: Mr Lipmann, did you want to add something?

MR LIPMANN: Yes, well, only to say that the by-product of everything Kate says is we have the most amazing staff loyalty. I read in the papers about aged care providers struggling to keep staff or get them. I have a five year reward. It's signed

by the president and myself and a cash grant. I've done 380 of them and it's only for 26 years. I've got - - -

MS RICE: And they have to spend it on themselves.

MR LIPMANN: Yes, strict rules. I've got 152 staff members have been with us for 10 years, 47 longer than 15 and every year those people who have been with me more than 20 years, and we're only 26 years old, I take them to Parliament for lunch. Last year I took 17 people. I mean, this level of staff loyalty, it's so easy just to gloss over, I mean, it's spectacular. I think it's a lot to do with – I don't know what word to use, perhaps it's leadership. I – I tell them that they are special people doing special work and they will go home and they will feel they've done something that very few people ever will. Our guys are rejected by the aged care industry which is a disgrace, it's nothing short of a disgrace.

There was never any reason to set up Wintringham, it should never have been a reason. It still shouldn't be a reason that we exist. Elderly Australians, regardless of income, should have access to aged care services. So for these staff to be doing that in such often difficult circumstances fills me with great pride. I – I am enormously proud of my staff, they are really very special people. That's not just idle comment. That's – you know, that's what I mean.

MR ROZEN: I do. I'm sure we understand that. And from the point of view of the – of the provision of care is that continuity, that long-term employment important?

MR LIPMANN: You're talking to me?

MR ROZEN: Yes, please, or Ms Rice.

MS RICE: Look, it is, and I think again, the consistency of care and support that you can give residents and clients is, that's what's evident, if you keep people on. Someone like me, for example, who has been at Wintringham for so long, it's so lovely because there's – I know and Bryan knows the people too. We actually know the people we look after and we're actually interested, and we can actually support them through a range of different services, from the moment we pick someone up as an outreach worker which might have been in my case to, you know, one day they might be in our highest care home. And so we can track these people and then they know – they know us and they trust us. So we used to have people who were resistant to moving into care, as people talked about today.

There are few people I would meet, almost none, want to move into residential. They want to be in a house or a unit, somewhere of their own. So you know, we used to be able to go to someone like Bryan who actually knew these people from the early years to actually say to them, you've got to trust us, you know, you're not doing okay, there's another option, just trust us, give us a try and we will make sure you're okay. And that actually that relationship with residents over a really long

period of time has really stood us in good stead, I think, because the people we look after actually know us and rely on us and trust that we will be looking after them.

MR LIPMANN: I know it's a generalisation but I have often said that it appears to me that people work in homelessness for a month or the rest of their life. It's like a drug. You get so attached to them. There's no one else around. I did notice, I made a little note about the comment made earlier today about staff consistency. When my mum was in aged care, she had Alzheimer's. She was taken to a hospital because she had a UTI and I don't think she has ever needed to go there but anyway they took her. And over the space of about six days she had something like seven beds and maybe 50 staff went through her life, and – her stay there. And by the time she came back to the hostel she was – she already had Alzheimer's but she was all over the shop and the staff couldn't explain it. And I said well I can. You know, she's confused.

So having consistent staff is terribly important. I was given some really good advice on my first week at work by a dear woman who I'm still very fond of who said, I've only got one piece of advice, she said stay, just stay. Because so many people cycle through your client's lives, if there's one spot, I mean, I still get – I still get phone calls from a bloke saying my pension hasn't come. I mean, it's not often but that's what I'm trying to get at, there's got to be consistency, so when you wander through the site, like you found when you came, people were wondering and started coming up to us, they knew us. This is terribly important.

MR ROZEN: Yes.

MR LIPMANN: Terribly important.

MS RICE: And people leave. It's interesting, so there are some staff who do move on and they actually come back, and we always take people back but it is interesting and they themselves say, look, we thought we would try something else. And we encourage people if they want to look, you know, look elsewhere, do other things, but we've had even a couple of managers, haven't we, Bryan, who've actually returned to Wintringham after going somewhere else and I think realising that it's very unique, yes.

MR ROZEN: The last topic that I want to ask you about and certainly not least important is financing.

MR LIPMANN: Yes.

MR ROZEN: You both talk about the ACFI, the Aged Care Funding Instrument and how that is applicable or not particularly applicable to your situation and I just want to ask you generally about the financing of the Wintringham model. So perhaps you could start, Mr Lipmann.

MR LIPMANN: Yes, well, it's extraordinarily difficult. Aged care, as I said before, is predicated around, let's say it's around me and my mum. You know, I had to pay a accommodation bond which I got back. In between, I was there most days, if not most days at least once a week buying her undies and - - -

MS RICE: Appointments.

MR LIPMANN: - - - flowers. Yes, when she went to a dentist I had to take a day off work so I could help take her to the dentist, calm her down while this strange man put his hand in her mouth, get her back to her home, help get her undressed, into bed. She was quite distraught. By the time she fell asleep it was most of the day gone. Now, of course, that's fine, I do that. But at Wintringham I've got to pay somebody 25 bucks an hour to do that. So there's – clearly there's massive cost differentials. We now have six aged care facilities, and building another two at the moment. They're normally traditionally funded through accommodation bonds. We don't get any bonds. So clearly the capital side of it alone is a massive problem that the industry has not yet addressed.

Every facility I build has to be beg, borrowed and stolen money from all sorts of sources to accumulate enough before we can start. And then you get into the recurrent subsidies, the recurrent subsidies are increasingly being targeted at activities of daily living or clinical care.

MR ROZEN: Yes.

MR LIPMANN: And, again, coming from the nursing model which is – which is fine but that's only part of the life story. Our guys have much more behavioural problems and – and that's not recognised at all. So we have been able to get a homeless supplement, an extraordinarily difficult process to get that, and then recently got it increased a little bit, but it's still nowhere near what it should be. It's really important that I ran this further, pushed this further. Wintringham is taking the most difficult clients that the aged care industry – for profit and not-for-profit – has turned its back on, and they expect us to do it with less money than mainstream.

That's outrageous, no other words for it. That's just simply outrageous. You either say the elderly poor are not entitled to aged care. Make that a statement and stand by it. Or you say they are entitled and if they are entitled, well, then fund it so we can do it. It's really simple.

MR ROZEN: Ms Rice, we traditionally give witnesses an opportunity to say anything finally that they would like to convey to the Commission. Is there any – anything in addition you would like to add? Don't feel compelled to, but it's the opportunity.

MS RICE: Look, I suppose the only comment I would make is that I feel particularly privileged to be a social worker managing a residential care home because I think for me that was really unusual to have an opportunity. I mean, I

always thought it's a nursing job and you have to, you know, have that clinical experience and background. That was my perception even working in somewhere like Wintringham. So I think I've been able to show myself and hopefully Wintringham that there's a role for allied health professionals in this sector in management in running really good homes and I think it's just – for me it's such a great fit for my social work training and background to be able to deliver the sort of care and support that particularly older Australians can benefit from. I think having that social work perspective has been absolutely fantastic and I think it's a real asset in running homes like we do, or running any sort of aged care home, I think.

MR LIPMANN: Yes, we certainly don't want to say one profession is better than any other. That's not the point. Just saying there seems to be a key – a shift much more towards the nursing side and maybe it needs to be addressed a little bit. I have a couple of points I would like to make, firstly - - -

COMMISSIONER BRIGGS: Can I follow-up on that before you go on. Are you aware of there being anywhere in this sector some work done on the skill sets or the capabilities that people might need to run an aged care facility of any kind, or is it just that we've had the historical model of a nurse doing that?

MR LIPMANN: Well, look, I'm not – I do know when I started there was a big battle not to have a nurse running it. I think that we just have to find a way that they can have input. Kate couldn't run it on her own.

MS RICE: No.

MR LIPMANN: Correct?

MS RICE: Yes, absolutely.

MR LIPMANN: So we have a team, we developed our own model how it works but in terms of your answer I don't know. But we – we, Kate is not alone at Wintringham, we have other people. We have an OT in a very senior position. We have a recreation worker who's running a nursing home – a hostel - - -

MS RICE: A psychologist.

MR LIPMANN: A psychologist, yes. So – but we are – it's not – it's not the norm. But it is – the point of my statements is really just to express, it's a thought bubble, I just think that our experience is that other professions could well be of use.

MS RICE: And community aged care does it. That was the thing for me - - -

MR LIPMANN: Yes, that's the interesting thing.

MS RICE: - - - that I didn't quite understand in community care and all the home care packages, it's all an allied health model and then moving into residential was quite different.

MR LIPMANN: Quite opposite. There are two things I want to say. Firstly, we now work in prisons and I think that's a really interesting area. I don't know if the Commission has time to look at that issue. Prisoners currently are outside of aged care and yet are in desperate need. It's the fastest growing cohort in prisons, and it certainly should be – we're very proud, we've been working awfully long and hard to get into it and we have now got a toe in, perhaps a few more than just a toe in, but it's getting there, so that's really important for us. The other one I was going to mention which is, again, just a thought bubble, and dismiss it if you want, but one of my professions is actually I'm an economist. And I always understood that tax concessions were invented to – by economists to encourage the development of services in an unviable market.

So if the government doesn't want to deliver the services itself, it provides tax incentives to an organisation to go into an unviable part of the market and through the tax concessions they remain viable. I go back to my point before. Wintringham shouldn't have needed to exist. When I was at the night shelter I didn't make one placement, one placement in an aged care facility, and to this day it's still extremely difficult to get into mainstream aged care. And yet a lot of these organisations are getting tax concessions. So my little thought bubble is you eliminate the tax concessions and you make it an equal playing field for full profit and for not-for-profit and make it a zero sum game and you take all those tax concessions the government has recouped and direct it at the pointy end of those organisations that want to work with either disability or Koori or homeless.

MR ROZEN: That concludes my questions, Commissioners.

COMMISSIONER TRACEY: Mr Lipmann, it struck me as we were watching that video that five of the six of your residents who spoke were under 65 and would not normally fit within the government funding model for aged care. You made an intriguing comment at one stage during the visit to Port Melbourne about you have your methods of obtaining funding. I'm just wondering, without giving away any trade secrets, how you manage to get round the under 65s.

MR LIPMANN: Well, it's actually very interesting because when I started – first up started Wintringham a lot of the guys were – a lot of the men and some of the women were under 65 and we, in order to get them in, I read the Act and the Act actually doesn't say a date – a day. So – and then I heard that the Koori argument is – has relied on 50 and above, and largely for the lifestyle reasons of premature ageing so I used that same argument. That was accepted. So really any organisation in Australia should be able to take people 50 and above if they're prematurely aged through – through homelessness. The – and that worked reasonably successfully for 20-odd years, 25 years. There were some ACATs teams that were very resistant to that idea and some embraced it greatly. The ones that embraced it realised that we were

actually providing care to clients that they can't place elsewhere, where other ACATs saw their role more as a gatekeeper to the – to the sector.

Where it became a lot more complicated now – and Kate is better off to talk about this than I, but the development of the NDIS and so now we have a significant problem of people who are under 65. Instead of being admitted to aged care they have to go through NDIS first. And that can take a very long time and then receive in some cases a negative result. Meantime, what people need to understand is the resident or the client is not sitting at home with a loving family being looked after through that year where all this is done. They're actually on the streets and they can die or we can lose them. So there is a major issue that needs to be addressed and we would have to say that it's unsatisfactory at the moment.

COMMISSIONER TRACEY: Anything arising?

MR ROZEN: No, thank you, Commissioner.

COMMISSIONER TRACEY: Mr Lipmann and Ms Rice, I think I speak for both of us when I say we're in awe of the work you're doing in the community, and the care you're providing for people who otherwise simply, as you've said, would be on the streets. It's remarkable. And we're exceedingly grateful to you for coming all this way to tell us the story of Wintringham and all that you're doing, and we're, I think, also very grateful to know that your services are in the process of being expanded. Because there's obviously a great need out there. Thank you both very much for coming.

MR LIPMANN: Thank you.

MS RICE: Thank you.

<THE WITNESSES WITHDREW [4.27 pm]

MS HILL: Commissioner, the next witness and the final witness for today is Mr Anthony O'Donnell. Mr O'Donnell's statement was earlier tendered as exhibit 5-1. Mr O'Donnell's evidence was recorded on an earlier occasion on 30 September of this year. I can see that the operator has displayed document ID RCD.9999.0071.0001. If I could seek for that to be tendered as the video recording of Mr O'Donnell's evidence.

COMMISSIONER TRACEY: Yes. The video recording of the evidence of Mr Anthony O'Donnell will be exhibit 5-20.

EXHIBIT #5-2- VIDEO RECORDING OF THE EVIDENCE OF MR ANTHONY O'DONNELL (RCD.9999.0071.0001)

MS HILL: And if I could ask for that to be played by the operator.

PRERECORDING BEGINS

COMMISSIONER TRACEY: This is a formal hearing of the Aged Care Royal Commission convened to receive the evidence of Mr Anthony O'Donnell. That evidence will be received via a video recording of his evidence which will in due course be played at an open hearing of the Commission to be held next month in Perth. The procedures are fairly straightforward. Mr O'Donnell will be asked to affirm his statement and then he will be asked questions by counsel assisting the Commission, Ms Hill, if there are any matters arising that I wish to raise with him. I will do that when her examination has been completed. I will hand over now to the solicitor assisting the Commission to administer the affirmation to Mr O'Donnell.

<ANTHONY PATRICK O'DONNELL, AFFIRMED [4.29 pm]

<EXAMINATION-IN-CHIEF BY MS HILL

MS HILL: If the Commission please, could Mr O'Donnell - - -

COMMISSIONER TRACEY: Please proceed with your questions.

MS HILL: Thank you, Commissioner. Mr O'Donnell, can I please ask you to state your full name.

MR O'DONNELL: Anthony Patrick O'Donnell.

MS HILL: And what is your age?

MR O'DONNELL: 85.

MS HILL: Mr O'Donnell, you've prepared two submissions for the Aged Care Royal Commission, haven't you?

MR O'DONNELL: Yes.

MS HILL: And your original submission was prepared in January of this year.

MR O'DONNELL: That's right.

MS HILL: You amended that submission in April.

MR O'DONNELL: Yes.

MS HILL: And you subsequently prepared a supplementary submission in March and April of this year.

MR O'DONNELL: That's right.

MS HILL: It's that supplementally submission that you've used as a basis for a statement that is dated 30 May 2019.

MR O'DONNELL: That's right.

MS HILL: Could I ask you to take a look at that statement please, Mr O'Donnell.

MR O'DONNELL: Yes.

MS HILL: Is that your statement in front of you?

MR O'DONNELL: That's right, yes.

MS HILL: And if I could ask you to turn to the last page, do you identify your signature on that last page?

MR O'DONNELL: I do.

MS HILL: And at paragraph 8 of that statement, there is annexed to that your original submission.

MR O'DONNELL: That's right.

MS HILL: And paragraph 10 to 126 of your statement adopts the words of your supplementary submission; is that right?

MR O'DONNELL: That's correct.

MS HILL: Are there any changes you would seek to make that to statement, Mr O'Donnell?

MR O'DONNELL: No.

MS HILL: And are the contents of that statement true and correct?

MR O'DONNELL: They are as far as I can tell, yes.

MS HILL: Mr O'Donnell, whereabouts do you live?

MR O'DONNELL: I live in the Waminda Aged Care facility here in Bentley.

MS HILL: And whereabouts is Bentley?

MR O'DONNELL: It's a southern suburb – inner southern suburb of the city of Perth.

MS HILL: Could you describe to the Commissioner how your facility is configured?

MR O'DONNELL: It has, we're in the basement which is rarely used but it is at the moment because of construction but it's essentially five floors of which four are residential and the ground floor is partially residential but mainly to do with administration and with the dining room and the kitchen area.

MS HILL: And could you describe the area in which you live within - - -

MR O'DONNELL: I'm on the second floor in room 224.

MS HILL: And how long have you been living there for?

MR O'DONNELL: Since July 2013.

MS HILL: Mr O'Donnell, you retired in 1994; is that correct?

MR O'DONNELL: Yes, I actually retired in 1991 and then went back to work for one of the – the parliamentarians here in Perth, and worked for him on and off for 18 months and then finally retired in 1994.

MS HILL: What did you do for work before you were retired, Mr O'Donnell?

MR O'DONNELL: I was – I spent about 25 years in the iron ore and the iron and steel industries in England and here, and the last 13 years I had my own business in Kalgoorlie.

MS HILL: What type of care do you receive at your residential care facility?

MR O'DONNELL: When I came in here, I received a minimal amount of care, some of the carers were a bit upset because they didn't – I didn't need any help or anything basic such as showering and so on, so I had minimal care until last October but since the beginning of November when my legs finally failed on me, I've had quite intensive care, most of the time from requiring two carers because I can't move by myself. I have to be lifted in and out of bed, in and out of the wheelchair, in and out of the commode into the bathroom and so on, a minimum of nine times a day.

MS HILL: Do you have a usual routine?

MR O'DONNELL: Yes, I do.

MS HILL: What does that look like, Mr O'Donnell?

MR O'DONNELL: Well, they come in and get me out of bed around about 6.30. If they haven't come by 6.40 I ring for them because some of them are a bit hesitant thinking I might be asleep. And then they put me in the wheelchair and I have things that I do in the morning, routine things and then breakfast is round about 8 o'clock. About 8.30 they take me into the bathroom. They put me on the commode, take me into the bathroom and leave me and then when I want to have the shower they move me from the toilet to the shower. When I finish there, two of them come and lift me back onto the bed because I need to have my right hip dressed. The nurse arrives very quickly. Once that's finished they put me back in the wheelchair and that's it until the next time they need to lift me onto the bed after lunch at 12.30. So it's very intense at that time in the morning and so is the whole of the – the whole of the establishment.

MS HILL: And you referred to "they"; who are you having contact with during those times?

MR O'DONNELL: Mainly the carers. I've got a call button which I can call to be moved from one place to another and the system allows me, if I need two people, to press a different button, one which is assist which brings up a red number on the display of my room number so they know they need two people. This works sometimes.

MS HILL: Are there different categories of people that are caring for you, Mr O'Donnell?

MR O'DONNELL: I wouldn't say they are different categories; there are those with more or less experience.

MS HILL: In your statement you refer to a capital C Carer or a floater or medication assist. Are you able to describe the difference between those roles?

MR O'DONNELL: Well, one of the carers has been confirmed as being medically competent, they're call it med comp, and they deliver medication. And they sometimes wear a jacket which says they should not be disturbed or diverted while they're doing that because it's very important work.

MS HILL: Is that the jacket that you refer to on page 5 of your statement?

MR O'DONNELL: It is.

MS HILL: If I could ask you to turn to that photograph on page 5, Mr O'Donnell.

MR O'DONNELL: Yes.

MS HILL: Was that a photo taken by you?

MR O'DONNELL: Yes.

MS HILL: When did you take that photo?

MR O'DONNELL: That was a few days before I sent it to the Commission.

MS HILL: Why did you elect to bring that to the Commission's attention?

MR O'DONNELL: Well, because what it says on there is wishful thinking. The fact is that the person who is nominated is usually one of the more experienced although in the last few months they have been getting more and more people established as a med comp and more and more people have been delivering medication, the more responsible and more experienced carers, which is why I use capital C places. They're also reclassifying them and not really using the term carer for them; they're calling them AIN or assistants in nursing and this is all part of a number of the things that are happening as the emphasis goes on aged care here for different levels of care required and also because of the pressure that's being put on by the establishment of the Commission.

MS HILL: Mr O'Donnell, could I ask you to describe the photo that you've taken there that's on page 5, please.

MR O'DONNELL: Yes, it shows one of the carers who's doing the medication. He's wearing a vest-type jacket which says on the front of it:

Medication round, please do not disturb.

MS HILL: How does that photo make you feel, Mr O'Donnell?

MR O'DONNELL: Well, I'm happy about the idea that they don't get disturbed, but it doesn't happen, in fact. In fact, this morning the person who has been delivering the medication has participated in two or three of the transfers I've already had.

MS HILL: Do you - - -

MR O'DONNELL: It means they've been dragged away from delivering medication.

MS HILL: Do you receive the same level of care throughout the day every day?

MR O'DONNELL: Not all day. Most of the day I – I do what I want to do. I read a lot. I've got a laptop which is connected to the internet. I have a couple of sessions where I go outside and go down the outside ramp and up again just for exercise and to develop my upper strength again.

MS HILL: Does the care that you receive differ depending on whether it's a weekday or a weekend or a public holiday?

MR O'DONNELL: The care I get doesn't depend on that but there can be delays in receiving it, because of the lesser number of staff available. The manager here has assured me several times and recently that the number of carers available at the weekend are exactly the same as any time during the week. There are no physios. There are less or no activities staff, less administrative staff and so on. But the level of care is, according to the manager, is the same. And I responded to her most recently by saying, yes, well it's a bit erratic because sometimes it is not the same.

MS HILL: What observations do you make, Mr O'Donnell, of the people who are caring for you?

MR O'DONNELL: When I first came here I was impressed that they were – virtually everyone I met was very, very efficient. In recent times there appears to have been a large turnover. You can't really say that because you can't say it with any certainty because people go on holiday, they have babies, and then they come back and they're sick and so on. But the only evidence you have of the high turnover is when you're getting new faces all the time. Of late we have been getting a number of new faces and some of them, regrettably, are not up to the same sort of standard as the ones that I first met when I first came here.

MS HILL: What leads to you make that observation, Mr O'Donnell, about the shift in standard of those people caring for you?

MR O'DONNELL: Well, it's just that they don't have the same type of motivation and initiative that some of the others show and they don't – I mean, we can get a new one arrives and within a matter of a week or 10 days they're au fait with everything. They come in, they know what they have to do, they're observant and they do it. Little things, like filling a water jug, you don't have to say anything to them. Others just walk past it and don't see it. They're the minority, but I see more of them these days than ever before.

MS HILL: Do you have a view as to the training that's available to the care workers?

MR O'DONNELL: Well, I know that a lot of them now are receiving this med comp training, but I do think that, from what I know of it, that the level of training is minimal over a few weeks and then they arrive and they learn the rest on the job.

MS HILL: What observations do you make, Mr O'Donnell, as to what could be done to improve working conditions for those that are caring for you?

MR O'DONNELL: Well, they need – if you're going to have coordination, you've got to have enough people for a start. If you're going to have coordination, you need good communication. Many improvements have been made here while I've been

here over the years, in the addition of a first class call system, but it's no good having a call system if people can't hear it or see it or communicate to each other. So there are a lot of loose ends there still to be wrapped up.

MS HILL: How would you wrap up those loose ends, Mr O'Donnell?

MR O'DONNELL: Well, I'm not the technician, but it needs better phones and better systems of communication. There is – there isn't really a hierarchy. The nurses, who are becoming more numerous, tend to be regarded also as the supervisors, but the nurses are busy doing nursing. They're being asked to go and attend to room 207 or 227 or 203 to do a specific job and they're not – they don't know what's going on on the floor.

MS HILL: In your statement at paragraph 53 you've taken the opportunity to define care from the perspective of the person receiving the care and the perspective of the provider. Could I ask you to read out that paragraph at 53.

MR O'DONNELL: Excuse me:

> *The definition of care on those daytime shifts seems to be centred on making sure that there is something formally set down to do as a series of tasks. Actual care, as in the connecting with residents in order to see to their needs and to interact with them as people, left to summoning of the carer or floating carers by the resident pressing a button. And once the resident immediately is satisfied, it's off to the next most urgent task or call, leaving the parties neither satisfied nor fulfilled.*

Excuse me.

MS HILL: What does that mean for the level of care that you receive presently, Mr O'Donnell?

MR O'DONNELL: It means very little as far as I'm concerned. The few times where I didn't receive the care that I required – in other words when I called for someone, the few times that that occurred that the length of time before I received the care, either from two carers or from one, I complained about it and it was rectified. But that isn't necessarily the case for everybody.

MS HILL: Are ratios the solution to the situations you've described, Mr O'Donnell?

MR O'DONNELL: Well, I have got fairly firm views about that. I don't know what the correct ratios are, but I believe that they need to be established and once they're established, they need to be policed.

MS HILL: And why is that, Mr O'Donnell?

MR O'DONNELL: Well, because the situation at moment where the manager of the place here is telling me there are adequate people over the weekends and public holidays, and there frequently are not. So, you know, if the level is full, if for some reason the local management say, "Oh, well, we don't need that many carers on that particular floor", and it hasn't been sanctioned by the people who've established the ratios, then it needs to be checked and policed.

MS HILL: How does your view of ratios fit in with your definition of care?

MR O'DONNELL: Well, clearly not enough people are giving the care at the moment because the fact is that I can name the rooms where residents at the moment, who are quite cognisant of what their surroundings are, are sitting all day. After they've had their basic tasks fulfilled, unless they press the button for a specific task to be added, they are there, they're sitting there.

MS HILL: What do you say the consequences of that experience is, Mr O'Donnell?

MR O'DONNELL: Well, they just decline. I mean, we've got people in their 90s and we've got – on my one floor we've got three centenarians and several people in their 90s. And I don't – one lady is 105. Now, there's probably no possibility of sitting with her and interacting, who would benefit from more contact with people, human contact.

MS HILL: And why is that important, Mr O'Donnell?

MR O'DONNELL: I think it's self-evident that if people that require that sort of contact are not getting it, then they are going to decline. They don't have anything else to do. Maybe watch their television, maybe do a little puzzle that they've been set, and beyond that, they're – in fact, one of them said to me that she wanted to get out and about in a wheelchair. I've taken that up. It's not my job or my business to do that, but I did it because we're friendly. And the physio assured me that they do try and take her out but that she's not strong enough to operate the wheelchair, and because she's now 104 she doesn't necessarily recognise that. But that's an extreme case. I'm sure there are many others who would benefit.

MS HILL: And what will can be done, in your view, to meet the need for that benefit, Mr O'Donnell?

MR O'DONNELL: Well, we need more people on the floor and we want those people to be trained, to be able to handle and to interact with people, some of whom may have dementia of some kind but who can still – who can still talk to you. They may forget what they've just told you, but they can register. I had one lady – we had one lady here who was a nuisance because she was always ringing for someone to come and talk to her. And when her sons came, she got – after they went she got very agitated but she didn't know why. She didn't remember that they had been, but she got very agitated. And yet I talked to her one day and she told me that she used to work for the Prudential Insurance Company when she lived in Torquay in England

and so on. So she had that memory. She had the ability to communicate with me and she was good doing that. Other times she was very difficult to handle.

MS HILL: Do you have much to do with the people that are living around you, Mr O'Donnell?

MR O'DONNELL: No, I don't.

MS HILL: And is that something that you're content with?

MR O'DONNELL: When I first came I did. I knew the immediate people around me. But in the small length of corridor that I'm in, there's about maybe 10 people in that area. I've lost count of the number of people that I did know and who have passed away or been removed to other areas, and I just don't want to get involved any more. I've got enough things to keep me occupied and I'm fortunate in that respect. I'm probably better to have lost my legs and retained my mental capacities.

MS HILL: What kinds of things keep you occupied, Mr O'Donnell?

MR O'DONNELL: I read a lot. I don't use the internet as much as I used to. I used to, that allowed me to do a lot of research and that kept me occupied, but I haven't been able to do that for quite a long time because I can't sit long enough and comfortably enough to be able to do the sort of research that you need to do the sort of writing that I do.

MS HILL: Is it correct to say, Mr O'Donnell, that food and nutrition is an area of interest in your research?

MR O'DONNELL: Well, yes. Of all the other establishments I've been in, and there's about five or six of them in the residential care places around Perth, I never had any problems with the food, even though I've had my digestive system damaged by antibiotics. When I came to Wilmington, I didn't have any problems at first, but there was a gradual decline. There was a change in managers, and there has been a great deal of decline. And I have had to fight and fight and fight to get the idea of having fresh food, fresh fruit, less sugary things and creamy things on the menus, but most particularly to get nutritious food.

MS HILL: And why is that a concern for you, Mr O'Donnell?

MR O'DONNELL: Well, because I've not been able to get the sort of food that I wanted to and that I thought we should have. And it was just – I don't think it was just the bean counters getting involved with, "How many beans make five? We'll knock that off and we'll change the menu and dress it up to make the menu look attractive". But the reality on the plate is not always the same as the attractiveness of the menu.

MS HILL: Have you voiced these concerns to anyone?

MR O'DONNELL: Yes, many times.

MS HILL: Hand how and to who have you voiced those concerns?

MR O'DONNELL: How many?

MS HILL: How and to who have you voiced those concerns?

MR O'DONNELL: Well, we have a liaison lady for the hospitality group and she passes on anything. I usually do it by word of mouth, if it's trivial or can be easily fixed. And if I want to really highlight it, I send her an email and with photographs of the meal concerned if necessary. I have had two contacts in the last few months with the chief chef who has been trying to meet my needs and has been trying to mend a few fences, but I think we need a fundamental change there.

MS HILL: And what do you say the fundamental change should be, Mr O'Donnell?

MR O'DONNELL: We should buy more local fresh food. That's fish in particular, we should buy – and I think I mentioned somewhere, that one of the meals that we get, once in the four week cycle, is salmon. And the salmon, when I questioned the chef about it, he told me that it comes from Norway, frozen, which to my mind means exactly the way it tastes. That's it's travelled a long way and got very tired.

MS HILL: And what did you do when the found out that the salmon was frozen, from Norway?

MR O'DONNELL: Well, I got a list of the suppliers in this area and sent it to him.

MS HILL: And have you received a response in respect to that, Mr O'Donnell?

MR O'DONNELL: Well, some kind of response. I suggested that somebody needs to get off their backside and go out and do a deal – a Trump type deal with them and get the fresh salmon that's so well – widely available in Australia. Get it onto the menu. And his response was well, he phoned them up and they don't do deliveries, or something like that.

MS HILL: If I could you to turn to paragraph 18 of your statement, Mr O'Donnell.

MR O'DONNELL: 18?

MS HILL: 18.

MR O'DONNELL: Yes.

MS HILL: At paragraph 18 you say that the operative phrase for aged care to contemplate is understanding the requirements of the residents. Why is that the operative phrase, Mr O'Donnell?

MR O'DONNELL: What did you – the operative - - -

MS HILL: The first line in paragraph 18 reads:

"Understanding the requirements of the residents", is the operative - - -

MR O'DONNELL: Well, I must have mentioned that earlier for that to be quoted as the operative phase – phrase.

MS HILL: Why is that important, Mr O'Donnell, that the requirements of residents are understood?

MR O'DONNELL: Well, because what the – what the carers are tasked with, they each have a list. They have to toilet and shower and feed A, B or C residents as soon as possible in the morning, prior to breakfast and then soon after breakfast. And I'm saying that I don't think it's enough just to do that, that that doesn't meet the requirements of the residents. They need more than that, as we discussed a few minutes ago. They need people that understand what they particularly want, those particular residents and it's different probably for each one. Someone who has some contact with them and has some understanding of what they require.

MS HILL: How can the requirements of older Australians be understood in your view, Mr O'Donnell?

MR O'DONNELL: Well, if they're just older Australians, I think it's just by common contact like that. But if they are people who have various levels of dementia, then it needs people who are qualified and know how to communicate with people of that kind.

MS HILL: What are the consequences when the requirements of residents are not understood, Mr O'Donnell?

MR O'DONNELL: You get frustration. You get frustration from the carers because they know that they're just going into that room, doing what – fetching a jug of water or whatever it is, and then hurrying off to the other one. So it's the minimal contact. The residents themselves really want more, in many cases, and the carers want – they're very keen young people, many of them. Many of them from overseas, they come here and they're trying to do their best to interact with the various residents in a way that applies to that particular resident. And it – they get frustrated. If they can't do that, they feel that they're not really doing what they should be there to do, which is to give care. And the residents themselves get frustrated. They're wandering up and down the corridor looking for someone to help them.

MS HILL: Could I ask you to turn to paragraph 123 of your statement, Mr O'Donnell.

MR O'DONNELL: I'm getting there. Okay. 123. That's right, yes.

MS HILL: At paragraph 123, you give the example, Mr O'Donnell, of one of your 101 year old neighbours looking for assistance on a Sunday, close to the time of your writing. Could I ask you to describe that situation to the Commissioner?

MR O'DONNELL: On that particular Sunday I was going to go down in the lift above the dining room in order to go for one of my – what I call my runs. Up one ramp and down another one and back again, to get my body moving. And this lady came into the lift with me. She is – she's hearing impaired and vision impaired, but a pretty vigorous lady but declining very quickly now. Because up to a few months ago she used to be able to walk around with her white cane and go out of the complex and come back, and now she's getting too weak on her legs. She came down in the lift with me and she said on the way down, "It's Sunday, there's nobody here", but she was clearly looking around for someone to talk to. When she got into the kitchen, the people who were working in it – in the dining room rather.

The people who were working there had a word with her and as I went away to follow my route, I could hear them saying to her, "Well, it's Sunday, there's nobody here". So when I had finished and I went back up onto the second floor, we met halfway along the corridor and she still hadn't found anybody. But one of the carers, who was med comp and was delivering medication, spoke to her and said, "Look, I will come along and talk to you in a few minutes. Go back to your room and I will make time to talk to you". Which shows the sort of care that some carers are prepared to give and know how to give, but really shouldn't because she was on – she was delivering medication, but she did.

MS HILL: What observation did you make of your neighbour in those circumstances?

MR O'DONNELL: I thought she was neglected.

MS HILL: And what did you observe your neighbour to need at that time?

MR O'DONNELL: Just some company. Somebody to talk to her.

MS HILL: Can the provision of company, of having somebody to talk to, so your neighbour in that example, be avoided in the current aged care system, Mr O'Donnell?

MR O'DONNELL: It's a very fluid situation but it probably can be, provided there are enough people and those people are trained to do it.

MS HILL: Mr O'Donnell, what motivated you to contact the Aged Care Royal Commission?

MR O'DONNELL: Just the fact that I'd noticed that when the high care low care situation was sort of cancelled and Waminda, which had been a place where people just came and lived before the age of the – the wheel walker, possibly even at the

time there may not have been Zimmer frames here, people were independent. They lived here, and the place had been built to accommodate those types of people. And it had a very, very good reputation at that time for anybody who was interested in people who were in residential care. Once that new regime came in, and it was known in advance that it was coming, because people talked to me when I first was in in 2013, that it was all going to change. It changed slowly but then gathered momentum. And in the last year or 18 months, the number of people who are arriving in a condition in which in previous times they would have been moved on to somewhere else because of their dementia problems, has increased, and it has increased exponentially.

MS HILL: What do you hope to get out of your involvement with the Aged Care Royal Commission, Mr O'Donnell?

MR O'DONNELL: For me, nothing. You know, I'm at the end of my time and I'm resigned to that and I'm not worried about that. But yesterday was my eldest daughter's birthday, and she and her siblings and all the people of that generation are now approaching the time when some of them at least will be thinking about the rest of their lives. Some of them, they have no plan for residential care or anything like it and may be forced into it, as with Mrs Mitchell, who gave evidence to the Commission. You can get forced into it because of circumstances. They're all looking at what's going to happen as a result of this Commission and they're hoping, as I'm hoping, that something positive does come out of it from the bureaucrats and the politicians. And not just that generation that includes my daughters but the following generation who are looking to it. And having seen the media reports of the extreme cases, are hoping to see that that sort of thing is eliminated and the whole standard, the whole concept of aged care is lifted.

MS HILL: Commissioner, that concludes my examination of Mr O'Donnell.

COMMISSIONER TRACEY: Thank you, Ms Hill. Do you wish to tender his statement?

MS HILL: I do, Commissioner.

COMMISSIONER TRACEY: Yes, the witness statement of Mr Anthony O'Donnell, dated 30 May 2019, will be exhibit 5-1.

EXHIBIT #5-1 WITNESS STATEMENT OF MR ANTHONY O'DONNELL DATED 30/05/2019

COMMISSIONER TRACEY: Mr O'Donnell, we are very grateful to you for giving your evidence and, in particular, the insights from the perspective of somebody who is a resident in an aged care facility. It's very important that we understand how

these facilities are conducted and you've given us considerable insight into that in your evidence this morning. We thank you.

MR O'DONNELL: Thank you, Commissioner.

COMMISSIONER TRACEY: I will now declare this session formally concluded.

MS HILL: As the Commission pleases.

<THE WITNESS WITHDREW [5.02 pm]

PRERECORDING ENDS

MS HILL: Commissioner, that concludes the evidence to be called today.

COMMISSIONER TRACEY: 9.30 tomorrow?

MS HILL: Yes, Commissioner.

COMMISSIONER TRACEY: The Commission will adjourn until 9.30 am tomorrow morning.

MATTER ADJOURNED at 5.03 pm UNTIL WEDNESDAY, 26 JUNE 2019

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