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TRANSCRIPT OF PROCEEDINGS

O/N H-1245082

THE HONOURABLE T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

SYDNEY

10.02 AM, MONDAY, 10 AUGUST 2020

Continued from 17.7.20

DAY 83

MR P. ROZEN QC appears with MR P. BOLSTER as counsel assisting
MR LOCKHART SC appears for BaptistCare
MS M. ENGLAND appears with MS EPSTEIN for Anglican Community Services, Grant Millard and Erica Roy
MR M. FORDHAM SC appears with MR FRASER for the State of New South Wales
MS A. DOECKE appears with MR T. GOLDING for the State of South Australia
MR A. McKEOUGH appears for Mable
MS K. MORGAN SC appears with MS BARNETT for the Commonwealth of Australia
MS J. BURNS appears for the State of Victoria

COMMISSIONER PAGONE: I would like to begin by acknowledging the Ngunnawal people, together with the Gadigal people of the Eora Nation, the traditional custodians of the land on which Commissioner Briggs and I respectively sit. We pay our respects to their elders, past, present and emerging. Today we begin the hearings into some aspects of the impact of COVID-19 on aged care. The focus of these inquiries will be outlined by counsel in a moment, but it is important to say something about the context in which the hearing is being conducted.

The timing and the scope of the hearing on this topic are not ideal. The circumstances in which this hearing is conducted from today is very different from those on 14 May when we announced that we would inquire into certain issues arising from the responses to the pandemic. We find ourselves today in extraordinarily difficult times with the nation as a whole and for those within or affected by aged care in particular. We had planned to schedule this hearing as late as possible within the timeframe available to us for completion of our report in February. However, the impact for the country so far and for many in aged care, has been tragic in ways that were unimagined a few months ago. The full impact is not yet known.

We extend our sympathy to everyone who has lost a loved relative or friend to COVID-19. We extend our sympathy and understanding also to those who have not been able to spend time with their relatives or friends in aged care because of the restrictions introduced to deal with the pandemic. We feel your losses and your absences deeply. We have heard many of your stories and have been moved by them. There are many questions which have been raised which we will not be able to answer within the time frame and resources we have available to us but we do thank all of those who have come forward to help the nation understand something of the extent of the impact and the appropriateness of the responses in the context of aged care.

We need also to acknowledge the willingness of many who have supported and deepened our understanding in this inquiry. It has not been easy for elderly Australians, their family members, aged care providers, staff, external advisers and government officials, to respond to our need for information, at the same time as dealing with the reality of the pandemic on the ground and we thank all of you for your assistance. Mr Rozen.

MR P. ROZEN QC: Good morning, Commissioners. I appear with Mr Paul Bolster to assist. I too would like to acknowledge the Gadigal people of the Eora Nation, the traditional custodians of this land and pay my respects to the elders, past present and emerging. Commissioners, COVID-19 is the greatest challenge the Australian aged care sector has ever faced. We all watched with horror the stories of large-scale death in what are called long-term care homes in the northern hemisphere in February and March of this year. The Australian aged care sector and the government agencies that fund and regulate it were on notice about the particular vulnerability of the elderly residents in our own care homes.

More recently we have seen the unfolding disaster in more than 100 of Victoria's nursing homes. According to the daily data released by the Australian Government Department of Health, between 8 July and yesterday over 1000 residents have been diagnosed with COVID-19. Of these people, 168 have died; grandparents, parents, siblings and friends, a human tragedy. Presently, 68 per cent of all COVID-19 deaths in Australia relate to people in residential aged care. The evidence that you will hear is that this makes Australia the country with one of the highest rates in the world of residential aged care deaths as a proportion of deaths from COVID-19. As much as we have been distressed by these stories of human suffering, we have been impressed by the stories of the care workers who have worked in unimaginable conditions to provide these residents with the care they need.

These workers display commitment, courage, dedication and most of all love. As a community we owe them a great deal and we should honour the work they do but not just by praising them. Talk is cheap. They deserve to be properly rewarded, properly equipped, properly trained and properly led. And most of all they need to work in an aged care system that supports their work. Commissioners, on 20 March this year you decided to suspend our hearing program in light of the emerging COVID-19 crisis. On 31 March the Prime Minister wrote to you. In part he asked that in engaging with government and private entities and in exercising any compulsory powers, that you take into account that they are the frontline of the fight against COVID-19.

In light of the COVID-19 crisis and these matters, on 20 April 2020 you wrote to the Prime Minister seeking an extension of time in which to complete your report. A reason for that request was the desire to include in your inquiry some consideration of the impact of COVID-19 on the aged care sector. On 14 May you announced an inquiry into certain issues arising from the responses of the sector and the government to COVID-19 with a focus on lessons learned from the COVID-19 response. As part of that inquiry, you met with the Aged Care Quality and Safety Commissioner and representatives of the Commonwealth Department of Health on 17 June 2020.

As Commissioner Pagone explained in a statement made on 30 July 2020, this Royal Commission does not have the resources or the time to conduct an inquiry that would do justice to the recent events in Victoria's aged care homes which continue to change and develop. An investigation of the Victorian situation would have required us to impose upon aged care providers and the Victorian and Commonwealth governments in a way that would necessarily have distracted from their focus on the unfolding crisis. This would have been entirely inappropriate at this time. Because of this, we consider that it would be inappropriate for counsel assisting to refer by name to any Victorian providers and we will not do so. This would only be appropriate, in our view, in an inquiry dedicated to investigating the circumstances in Victoria and, as explained in your statement, Commissioner Pagone, it is a matter for government whether there is to be any separate inquiry into the situation in Victoria.

This Royal Commission, of course, was not established to establish the impact of COVID-19 on the aged care sector. It was established in 2018 to examine the quality of aged care services provided to Australians, the extent and causes of substandard care, and what can be done to strengthen the system of aged care services to ensure
5 the services are of high quality and safe. This hearing is part of that examination. It is not an inquiry into the causes of the deaths from COVID-19 in aged care facilities. That is the role of state coroners. This hearing will instead focus on the response to the COVID-19 pandemic in aged care and what can be learnt from this experience for responding to future pandemics, infectious disease outbreaks or other
10 emergencies. The two principal areas of focus will be, first, preparedness and, second, balancing infection control with quality of life.

The hearing will include consideration of the role and responsibilities of state, territory and federal governments in responding to such crises in aged care services,
15 what should be done and by whom in the future to support the aged care sector to respond to pandemics, infectious disease outbreaks or other emergencies, the balance between managing risks posed by a future pandemic or infectious disease outbreak and maintaining the overall health and wellbeing of aged recipients, including their mental health and quality of life, the measures taken by the health and aged care
20 sectors to respond to the pandemic, including transporting infected residents to hospital, the impact of those measures on older Australians receiving aged care services, their families and their carers, challenges faced by the aged care sector, including those relating to management, workforce and access to personal protective equipment and other related matters.
25

Commissioners, the COVID-19 pandemic has starkly exposed all of the flaws of the aged care sector which have been highlighted during this Royal Commission. Those flaws have been revealed by evidence led in the Royal Commission and were outlined in the interim report in October 2019. It is hardly surprising that the aged
30 care sector has struggled to respond to COVID-19. As we explained in our submissions in February of this year, the deskilling of the aged care workforce was identified as a likely consequence of the lack of regulation of staffing in aged care, for instance, the requirement for one registered nurse to be on duty in a home at all times was removed in 1998. As Prof Kathy Eagar, Professor of Health Services
35 Research at Wollongong University, has been quoted as saying:

> *Most people would be surprised to know that you don't have to have a nurse on the staff to run a nursing home.*

40 The consequences of a shortage of clinical skills in aged care homes for care, quality and resident safety had been demonstrated time and again in the case studies this Royal Commission has examined. The case studies have shown the consequences of a system in which providers have the ultimate say concerning the numbers and skill mix of their workforce and can choose between paying the hourly rate of a university
45 educated nurse and that of a care worker with or without a certificate III. Successive inquiries have identified the gradual erosion in clinical skills in the residential care sector. Proposals to introduce minimum resident to staffing ratios, such as we have

in public hospitals, childcare and public sector residential aged care, have been resisted by both the Commonwealth Government and the sector alike, including during this Royal Commission.

5 It can be seen, Commissioners, that the aged care system we have in 2020 is not a system that is failing. It's the system operating as it was designed to operate. We should not be surprised at the results. Commissioners, since your call for submissions on 28 April 2020, we have received 364 submissions concerning COVID-19 and its effects on the aged care sector. Submissions have been made by
10 concerned family members, people receiving aged care services, aged care providers, people working in aged care, people providing frontline health services, governments and various peak bodies. Submissions have been received from across the country, with the greatest number coming from people based in New South Wales, followed by Victoria. The last week before submissions closed on general matters also saw a
15 sharp increase in submissions from each of these states. In addition to written submissions, the Office of the Royal Commission has fielded 87 telephone inquiries directed to concerns about the impact of COVID-19 on the aged care sector.

These submissions are a window through which we can see the effect of the
20 pandemic on aged care residents. They reveal the extent of concern about the impact of COVID-19 and about the measures put in place to protect those receiving care. Many of the submissions were received before the situation in Victoria escalated, a situation all of us have been watching with grave concern. Many of the issues raised in submissions have been aired in the media. However, they warrant briefly being
25 repeated. Isolation is the strongest theme running through the submissions with people raising concerns about being unable to visit loved ones and the effect of a loss of social interaction, including through the reduced or modified activities in residential care services.

30 Commissioners, in submissions, you've been told about spouses and children cut off from their parents and partners, unable to support their care in the way they did before the pandemic. It is unsurprising perhaps that after isolation, it is concern about unmet needs of care recipients that is the next most common theme in the submissions. Concerns are also raised about nutrition, hydration, medication
35 management and access to allied health services. The submissions remind us that the aged care workforce faces significant pressure.

As well as low staff numbers and a casualised workforce they refer to inadequate training on infection control and inadequate access to and training in the proper use
40 of personal protective equipment. Workers have been criticised for doing, they say, the best they can in the most difficult circumstances the aged care sector has confronted. Confusion about, and interpretation of guidelines is another clear theme in the submissions as, too, is the confused and inconsistent messaging from providers, state and federal governments begging the question who is in charge.
45

The submissions you have received clearly demonstrate that the issue of COVID-19 and its impact on those receiving aged care services, their loved ones and on the

sector itself is at the forefront of the community's mind. Commissioners, direct experience witnesses have been an important part of all of the Royal Commission's hearings. Today you will hear from Merle Mitchell who is an aged care resident in Victoria. Ms Mitchell will give evidence about the impact the restrictions on visitors have had on the mental health of residents. Since her facility was locked down in February this year, she has only seen her daughter twice in person. Once in a room with a glass partition and once through a window on her birthday.

Tomorrow you will hear from Ms Virginia Clarke whose father passed away in April from COVID-19 at Newmarch House where he had lived since 2013. Ms Clarke will say she was generally happy with the communication from the provider until March of this year. She will describe the impact on her father of the lockdown which commenced on 23 March 2020, and she will explain that on the day before her father passed away she was asked to update his end of life form. She will explain that she spoke to her father about whether he wanted to be transferred to hospital and the dilemma this caused. And she will say that she does not think her father was even told that he was COVID-19 positive.
Ms Clarke makes a number of suggestions for the future based on her experience.

The third direct experience witness has been given the pseudonym of UY. UY is the eldest daughter of an Italian man with motor neurone disease who entered residential aged care in June 2019. She will explain that her father had high care needs, was non-verbal and had mild dementia. UY will describe the impact on her father of the lockdown that was instituted at the home in response to the pandemic. Her daily visits had to be conducted through a window which caused her father great anxiety and confusion. UY will explain that her father deteriorated quickly and on 6 June went to sleep for six days and passed away. She also reflects on her experience and makes recommendations about improvements.

How well prepared is the Australian aged care sector for COVID-19. On 29 July 2020 as COVID-19 was raging through a large number of nursing homes in Melbourne with devastating consequences, Commonwealth Health Minister Greg Hunt was quoted as saying that:

> *Aged care around the country has been immensely prepared.*

We will be scrutinising how well-prepared aged care actually is to cope with the pandemic. As we will shortly explain, in a number of important respects the evidence will demonstrate that the sector has been under-prepared. While we readily acknowledge that COVID-19 presents an enormous challenge to governments and the aged care sector that in many respects is unprecedented, we will be asking if greater attention to preparation may have saved lives and could save lives in the future. This pandemic is clearly here to stay for the foreseeable future. It is of the utmost importance that those overseeing the aged care sector and those operating it learn all they can so that they have the weapons for the fight.

While there was a great deal done to prepare the Australian health sector more generally for the pandemic, the evidence will reveal that neither the Commonwealth Department of Health nor the aged care regulator developed COVID-19 plan specifically for the aged care sector. Professor Joseph Ibrahim, a specialist medical practitioner in geriatric medicine and Professor of Forensic Medicine at Monash University has been researching the Australian aged care sector for two decades. He will give evidence on Wednesday. Professor Ibrahim will say that there needed to be to articulated strategy for the aged care sector which drew on and coordinated national expertise about infection control and the sector. Such a strategy would have identified the gaps in the aged care system and the likely limits on its ability to cope with the pandemic.

The Australian health care sector's COVID-19 emergency response plan of 7 February 2020 made little reference to the aged care sector and the particular vulnerability of its residents. It noted that additional strategies may be required to support at-risk groups including aged care. Professor Ibrahim's evidence will be that there was insufficient consideration of the particular vulnerabilities of the aged care sector in the country's COVID-19 planning early in 2020. He will say that among the steps that should have occurred were (a) a national audit of all residential aged care facilities to judge their level of preparedness, (b) proper dissemination of the lessons to be learnt from the outbreaks in Sydney homes in March and April 2020, and a systemic approach to providing clear, clinical and infectious diseases advice to residential aged care facilities through a national coordinating body established for this purpose.

The Australian Health Protection Principal Committee, AHPPC, is the main source of advice about COVID-19 in Australia. The committee released 45 COVID-19 statements between 17 March and 3 August of this year. A statement released on 17 March 2020 gave general advice to a number of sectors including residential aged care. There have been three statements specifically directed at the aged care sector since that time: 21 April, 19 June and 3 August. By comparison, there have been eight statements about children and schools in the same period.

Commissioners, before its statement about the Victorian aged care sector dated 3 August 2020, the most recent aged care statement from this committee was on 19 June 2020. That statement provided advice about the need to loosen the restrictions on visitor access:

> *...based on the low levels of local transmission –*

of the virus. As the committee noted in an update two days later on 21 June 2020, community transmission of the virus increased steadily in Victoria from mid-June 2020, however, there was no updated advice for the aged care sector from the committee between 19 June 2020 and 3 August 2020. A crucial period of six weeks during which the number of new daily infections in Victoria grew from 25 to 413. There was no advice about how the sector should respond to the risk posed by aged

care workers who may be COVID-19 positive yet asymptomatic, particularly those who work in multiple facilities.

Commissioners, we readily acknowledge that the Commonwealth Department of Health has released many updates and has hosted webinars for the aged care sector concerning COVID-19 since 31 January 2020. Many of these contained very valuable general information and no doubt they have assisted providers to prepare for an outbreak. The department drew to the attention of providers in early March 2020 the guidelines for responding to COVID-19 in aged care facilities prepared by the Communicable Diseases Network Australia which included much useful information to help them prepare for the pandemic. However, in light of the very high stakes for residents in aged care homes we will be asking whether everything that could have been done to protect them was done.

In particular we will be focusing on the two aged care outbreaks in Sydney earlier this year and asking if the lessons that emerged from them have been appropriately distilled and conveyed to the sector. So what was done to prepare the sector? What has the aged care regulator done? Its statutory functions include educating the sector and monitoring its performance. Commissioners, as you are well aware the Aged Care Quality and Safety Commission was established in January 2019, and its responsibilities and powers were expanded at the start of this year. Commissioner Janet Anderson has provided us with a statement and will give evidence on Wednesday. Commissioner Anderson has a range of functions including to educate and inform approved providers of aged care services about their responsibilities and to monitor the quality of care they provide.

The Commission has statutory powers and as at 30 June 2019 had 472 staff. And since May of 2019 the commission has had the benefit of a chief clinical adviser, Dr Melanie Wroth from whom you will also hear on Wednesday. Regulating the aged care sector as it confronts COVID-19 has been and continues to be this regulator's biggest test. What did the commissioner do to protect the sector and what has she done by way of regulating the sector. We have already noted the regulator did not have an appropriate aged care sector COVID-19 response plan. Given that it was widely understood that recipients of aged care services were a high-risk group, this seems surprising.

On 17 March 2020 Ms Anderson wrote to all residential aged care providers and invited them to participate in a survey assessing their preparedness for an outbreak of COVID-19 in an aged care home they operated. Providers were asked to answer 23 questions including:

> *Does the service have an infection control respiratory outbreak plan? Have staff at the service been educated on the policies and processes for all aspects of outbreak identification and management, particularly infection control. Does the service have a plan for communicating with staff, residents, volunteers, family members and other service providers during an outbreak?*

And the services were also asked the general question:

Overall, how would you rate the services readiness in the event of a COVID-19 outbreak at the service?

5

2345 residential aged care services responded to the survey. Operator, please display tab 9 from the general tender bundle at page 0008. A report of the survey dated 20 May 2020, part of which is displayed on the screen now, was prepared, although it may be the case that the regulator had the results earlier than that date. According to
10 the report, 99.3 per cent of services – 99.3 per cent of services said they had an infection control respiratory outbreak plan. 92.6 per cent of services said that staff at the service had been educated on the policies and processes for all aspects of outbreak identification and management, particularly infection control. 99.5 per cent of services said they had a plan for communicating with staff, residents, volunteers,
15 family members and other service providers during an outbreak.

Operator, if you could please focus on the pie chart on page 8, which I think is – yes, that's it. Thank you. If that could be expanded. 99.5 per cent, depicted by the purple component of the pie chart, claimed that their infection control respiratory
20 outbreak management plan covered all areas identified in the survey. And 99.5 per cent of services – if you could go to the pie chart on the following page, please, right at the bottom of the page. That's it. Thank you. 99.5 per cent of services assessed their services readiness in the event of a COVID-19 outbreak as either satisfactory, 56.8 per cent – that's the blue part of that pie chart – or best practice, 42.7 per cent.
25 That's the green part. Only 0.5 per cent of services considered they were in need of improvement.

Commissioners, we anticipate that Prof Ibrahim will be highly critical of this survey. He will say that too much knowledge on the part of providers was assumed in the
30 questions. We will ask Commissioner Anderson what lessons can be learnt from the survey's very optimistic and positive responses. In light of the subsequent events and given the regulatory action taken by the Commissioner against Newmarch House's operator on 6 May 2020, were the sector's views about its state of readiness realistic? Was the sector properly informed about what readiness for an outbreak of
35 COVID-19 actually involved and what lessons can be learnt about this for the future?

Commissioners, Dorothy Henderson Lodge in Sydney was the first Australian aged care home to experience a COVID-19 outbreak. It's an 80-bed facility which employed 78 staff. On 3 March 2020, a personal care worker employed by
40 BaptistCare, the provider which ran the home, was diagnosed as COVID-19 positive and within two days, four residents and two more staff had tested positive. By the time the outbreak was declared over on 7 May 2020, 16 residents had tested positive, of whom six had passed away. Five staff members who had contracted the virus all recovered. No regulatory action was taken against the provider.
45

On 11 April 2020, a staff member employed by Anglicare, Sydney at Newmarch House in Sydney tested positive for COVID-19. Newmarch House had 89

occupants. By 15 June 2020, when that outbreak was declared contained, 37 had tested positive and 17 had died of COVID-19. The 34 staff who tested positive have all recovered. On 6 May 2020, the Aged Care Quality and Safety Commissioner issued a statutory notice to Anglicare, requiring it to agree in writing to four conditions within 24 hours. Failing agreement, Anglicare faced revocation of its approved provider status. The Commissioner had also taken earlier regulatory action against Anglicare on 23 April 2020. The notice to agree issued to Anglicare was justified by the regulator on the basis that there was, and I quote:

> *…an immediate and severe risk to the safety, health and wellbeing of care recipients at the service.*

The notice referred to concerns about whether the provider had suitable processes and systems in order to control transmission of the virus at the service. Commissioners, we note that at its most accreditation audit in September 2018, Newmarch House had passed all 44 expected outcomes, including 4.7 infection control, and it was one of the providers that had rated itself as best practice in the survey in March. By the time the regulatory action was taken on 6 May, the outbreak at Newmarch House had been raging for over a month and 16 of the residents had passed away. The evidence of Dr Branley, who treated many of the residents at Newmarch House, will be that the infection control processes and the staffing situation had improved considerably by early May compared to earlier in the response. We will ask why the regulator acted when it did. Was the regulatory action too little, too late?

You will hear from a number of people who responded to these two outbreaks. You will also hear about reports by experts in infection control that have been prepared, which have examined the responses of the providers to the outbreaks. Two reports into the Dorothy Henderson Lodge outbreak were completed in mid-April. There were three reports into the Newmarch House outbreak and the evidence will be that three further reports are in preparation. You will also hear from senior managers at both Dorothy Henderson Lodge and Newmarch House. The managers will describe what worked well and where they had difficulties.

Before outlining some issues discussed in the reports, we note that media reports in recent weeks have described webinars at which the Aged Care Minister has responded to the concerns of family members of residents in care homes in Melbourne facing outbreaks. In at least one case, the Minister was asked if an investigation would be conducted into the circumstances. It may come as a surprise to some that the aged care regulator has not investigated the circumstances of the Dorothy Henderson Lodge and Newmarch House outbreaks. Incident investigations are normally one of the key tasks of any regulator for obvious reasons. An investigation into the facts can inform future regulatory action and policies development.

In light of the ABC's Four Corners program about Newmarch House in June of this year, Mr Yates of COTA called for the aged care regulator to be given greater

powers of investigation. We also have concerns about whether the regulator's powers of investigation are adequate, for example, the regulator's authorised officers are only able to enter the premises of a provider with the provider's consent and any consent may be refused or withdrawn without the need for a reason. Even when aged care authorised officers enter a care home, any questions they ask are not required to be answered. A person asked a question may refuse to answer it and they are not required to have a reason for doing so. Similar limitations are imposed on regulatory officials exercising powers for a regulatory purpose, and while such officials are granted broad search powers under the Aged Care Quality and Safety Commission Act, those powers may be rendered nugatory by the withdrawal of consent for the official to be on the premises.

Comparable regulators in fields such as workplace or airline safety have no such limitations on their powers and it's not as if these statute provisions have sat on the statute books for decades, waiting to be modernised. The Act establishing this regulator was passed on the eve of this Royal Commission. The limits on the regulator's powers reflect contemporary government policy. We will explore with Commissioner Anderson whether the reason for her failure to investigate the outbreaks is explained by deficiencies in her powers or some other reason.

Commissioners, we surely have no hope of fighting COVID-19 and protecting the residents in our nursing homes if the various levels of our governments are not working together. There are notorious problems associated with the relationship between the health system which is run by the states and the Commonwealth-run aged care sector. These so-called interface issues were always going to be brought into stark relief by an outbreak of COVID-19 in the residential aged care sector. Was sufficient planning undertaken for how the interface would operate in the event of such an outbreak? Who would call the shots? For example, who would decide when it is appropriate for a COVID-19 positive resident to be transferred from an aged care home, which falls under the jurisdiction of the Commonwealth, to a hospital, which falls under the state system? And in what circumstances and by what process would the state's expert infection control resources be made available to Commonwealth-funded homes?

Subsequent events, including the response to the Newmarch House outbreaks, suggest that these and many related questions were not adequately addressed in planning and they should have been. In his statement, the Chief Executive Officer of Anglicare, Mr Millard, says that at least initially, the roles and responsibilities of the various state and Commonwealth authorities assisting Anglicare to respond to the Newmarch House outbreak were unclear. He says there was often confusion about designation and decision-making authority. Specifically, it was unclear who had the authority to resolve disputes about crucial questions of clinical care, including whether residents should be relocated. In the report Mr Millard provided to Anglicare's board on 6 May 2020, he said, and I quote:

> *Over the course of the outbreak, there has been a frustrating level of dysfunction in the collaboration between Newmarch House, Anglicare*

Management and the numerous government departments, agencies and hospital employees at both federal and state level with an interest in management of the outbreak.

5 He went on:

Anglicare has looked to these authorities for their expert advice in dealing with the outbreak but this advice has often been conflicting. Further, there is a lack of clarity regarding which of these authorities has responsibility for decisions
10 *and how this authority intersects with Anglicare's responsibilities under the Aged Care Act to manage the home.*

Mr Millard's perception is consistent with the contemporaneous emails and notes that have been examined by the staff of the Royal Commission and that are included
15 in the Newmarch tender bundle. By contrast, the evidence of Mr Lye of the Commonwealth Department of Health will be that he did not consider there was any lack of clarity about roles and responsibilities. That perceptions about this central question on the part of the two of the major players involved in the Newmarch outbreak could be so different is itself a cause for concern. Commissioners, it's
20 difficult to learn a lesson if you don't think there's one to learn.

The hearing will explore this difference of opinion and what has been done subsequently to ensure that providers are clear about this important topic. What does the experience of Newmarch House tell us about how well the Commonwealth and
25 New South Wales governments work together. What were the lessons, were they disseminated to other providers and to other states and territories. Why was there no Commonwealth/State aged care forum at which the lessons were discussed and shared. We will ask Professor Ibrahim if the national coordinating body that he proposes could have been such a forum, and has the protocol that was established
30 between the Commonwealth and New South Wales governments after the Newmarch House outbreak been replicated in other states. What practical steps have been taken to ensure any mistakes made in New South Wales are not repeated elsewhere.

Commissioners, a vexed issue since the pandemic first emerged in March has been
35 the extent to which there should be limits imposed on visitors to aged care homes. Family members and friends provide great comfort to residents and often help with feeding and other care needs. This is partly a reflection of the staffing shortages in many homes. As noted, the direct experience witnesses from whom you will hear will describe the anguish they and their relatives suffered as a result of limitations on
40 visiting rights. The earliest advice to the sector from the regulator about visitors was dated 23 March 2020 and referred providers to the advice dated 17 March 2020 from the Australian Health Protection Principal Committee. That advice was to impose a range of limitations, including limiting visitors to a maximum of two visitors at one time per day.
45

The letter from the regulator stressed the need to apply these restrictions with compassion and care, and to be proactive in identifying and minimising other risks

that may arise to residents as a result such as where family members assist at mealtime. The response of the sector, perhaps not surprisingly in light of the first outbreak at Dorothy Henderson Lodge, was to impose far stricter limits on visitors. For example, Newmarch House excluded all visitors on 23 March 2020. Other providers, though, adopted on more nuanced approach which did not involve banning visitors outright. For example, you will hear from Dr Stephen Judd, the CEO of HammondCare, that HammondCare appointed a concierge service to screen visitors. He will explain this approach sought to balance the risk of COVID-19 infection against the risk to vulnerable older people that would arise as a result of them being isolated for an extended period.

The issues of visitors came to a head when the Prime Minister spoke in April of the importance of aged care visits and threatened the sector that new regulations would be imposed requiring them to open their homes to visitors if they did not lift restrictions. This in turn resulted in an industry code for visiting residential aged care homes during COVID-19 which sought to strike a balance between the risks of COVID-19 and loneliness. The first version of this code was dated 11 May 2020. While encouraging providers to allow greater visitation rights the code acknowledged that it would be appropriate for the rules to be tightened when an outbreak occurs in the home or declared outbreak clusters have occurred within the home's local area. A review of the code on 29 May 2020 noted that:

> *In response to the code there has been a stark improvement and increase in the availability of visits to residents while still ensuring that residents are protected from COVID-19 by strict procedures to safeguard their safety.*

As noted earlier, the Australian Health Protection Principal Committee advised on 19 June 2020 that there should be a further relaxation of restrictions and that there was no need for staff to supervise visits. No advice was provided at that time about the need for visitors to wear masks. Commissioners, we will explore the difficult questions that arise in seeking to balance protection of the physical health of residents while also recognising the importance of mental health and general quality of life, and we readily accept these are complex issues. Commissioners, one of the strong themes that emerges from the reports into both the Dorothy Henderson Lodge and the Newmarch House outbreaks is the importance of infection control expertise.

At Dorothy Henderson, Ms Kathy Dempsey from the New South Wales Clinical Excellence Commission and another expert in infection control were employed on day one of the outbreak. They provided advice and training to staff about personal protective equipment use. They monitored progress and assisted in the de-escalation plan at the end of the outbreak. You will hear from Ms Kathy Dempsey. Witnesses from the home's operator, BaptistCare, will describe this help as invaluable. You will hear that the position at Newmarch House, however, was quite different. There was a lack of high-level infection control expertise until at least two weeks into the outbreak. The lessons were and remain clear: we must have a mechanism to get this expertise on the ground on day one in any home with any outbreak.

Commissioners, infection control should be core business for aged care facilities. Hong Kong, which has been one of the best performers in the world in its response to COVID-19 in long-term care homes, has required government-trained infection control officers to be employed in care homes since the SARS outbreak in 2003. The need for a dedicated infection control manager in all Australian nursing homes was recognised in a 2012 coronial inquest in Victoria. After a lengthy and thorough inquest into the deaths of four residents from gastroenteritis at a Melbourne aged care home, then State Coroner, Jennifer Coate, recommended that the Victorian Department of Health, in consultation with what was then called the Commonwealth Department of Health and Ageing, require aged care facilities to have a designated infection control manager.

Commissioners, based on the evidence at this Royal Commission to date, it's not apparent to us that this recommendation was implemented across the sector. There are undoubtedly providers with excellence infection control systems but there are also a number that have systems to deal with influenza and gastro that are not robust enough to deal with the COVID-19 outbreak. We will ask witnesses about that and about the broader question of what processes those in charge of the aged care sector have for responding to coronial recommendations generally. If they don't systematically respond to such recommendations, it can hardly be a surprise that we don't have an aged care system that meets the community's expectations.

Commissioners, a report dated 14 April 2020 by Professor Lyn Gilbert, a senior researcher at the Marie Bashir Institute for Infectious Diseases and Biosecurity into the response of Dorothy Henderson Lodge included the following advice:

> *Access to an experienced infection prevention and control specialist was critical in this outbreak but may not be available to all aged care facilities especially at short notice. Ideally, COVID-19 outbreak management plans for individual aged care facilities should be developed in advance with the assistance of an infection prevention and control professional and/or an infectious disease specialist. It should be based on context-specific risk assessment.*

Professor Gilbert's report then set out the details of what such assessment should cover. There have been media reports, Commissioners, that this report has not been made public. It should have been published as it contains a number of important lessons to help the aged care sector. It should not be the task of counsel assisting this Royal Commission to make such a report public but we readily do so, and we have included it in the Dorothy Henderson Lodge tender bundle which I will shortly tender. A report of high-level infection control review concerning the Newmarch House outbreak was produced on 1 May 2020, also by Ms Kathy Dempsey. Ms Dempsey's report concluded that the dedication and commitment of the staff were outstanding and that the report she produced was not to be intended to be a reflection on their effort. However, the report did:

...provide an opportunity to review an approach when providing increased staff and external staff. The overall governance, including at a clinical level, needs careful consideration, planning and execution.

5 Ms Dempsey's report continued with the observation that:

The presence of an infection prevention and control practitioner early on in an outbreak that can be on site coordinating, managing, educating and working with public health cannot be underestimated in these circumstances.

10

Commissioners, we will be asking what steps those who oversee the aged care sector are taking to disseminate the findings and recommendations of these reports to the sector. For example, are they checking to see if providers have COVID-19 management plans that meet the stipulations of Professor Gilbert. Have providers
15 been informed by the Department of Health of Professor Gilbert's recommendations. Has Professor Gilbert been asked to prepare a template plan that could be adapted for use of individual facilities, and are providers being educated about how to implement such a plan and who is responsible for providing this education.

20 Specifically, Commissioners, what steps are being taken by those in charge of the aged care sector to source infection prevention and control experts as proposed by Ms Dempsey in her report dated 1 May 2020? Such experts could be deployed at short notice to nursing homes facing a COVID-19 outbreak. Such experts generally work for state health departments and in our universities and our world class research
25 centres. Has a list been prepared and the relevant contact details given to providers? If the Commonwealth can directly engage aged care employment providers, such as Mable and Aspen, why is it not engaging infection control experts? These are all matters that the national coordination body proposed by Prof Ibrahim could have addressed earlier this year. They should be addressed immediately.

30

Commissioners, a crucial part of the management of any crisis is communication. In the context of COVID-19, an aged care provider must communicate clearly and openly with its residents and their families. A particularly concerning aspect of the Newmarch House response was poor communication. We all saw the images on the
35 news of relatives camped outside Newmarch House in April, seeking the most basic information about their loved ones. Tragically, we have seen similar scenes outside homes during the recent outbreaks in Melbourne. Once again, some families have been unable to ascertain even whether their loved ones are alive or dead. That this can happen in Australia in 2020 is unacceptable. That it is happening again so soon
40 after Newmarch House is unforgiveable.

It is to be recalled, Commissioners, that when providers were asked by Commissioner Anderson to self-assess their preparedness for COVID-19 in March, 99.5 per cent told the regulator they had a plan for communicating with family
45 members and residents during an outbreak. Newmarch was no exception. We will examine, Commissioners, what was done by authorities in the sector after Newmarch to ensure that basic communication by providers was improved. Has the lesson been

learnt that having a written plan is one thing but whether it can be implemented in a crisis in a humane manner is the real test?

During both the Newmarch House and Dorothy Henderson Lodge outbreaks, there were problems with sourcing and the correct use of personal protective equipment, PPE. Our first witness, Professor of Epidemiology at the University of New South Wales, Prof Marylouise McLaws, will explain the necessity of PPE for responding to a COVID-19 outbreak and its correct use. She will explain that an infection control requires a high degree of vigilance and an infection control system will only be as good as its weakest link. Mr Millard of Anglicare will explain the significant difficulty that Newmarch House had in securing the PPE it needed. He found accessing PPE incredibly changing and very stressful for his already stretched workforce.

Concerns about access to and the correct use of PPE have been raised in both the Australian Nursing and Midwifery Federation's May survey of aged care nurses and the United Workers' June survey of its members in aged care. Those surveys paint a different picture of the sector's state of readiness to that included in the provider survey. Did the results cause policy makers to consider if PPE training should be made compulsory and, if not, why not? And is the training in PPE use that has been made available by the Commonwealth appropriate? Prof Ibrahim will raise concerns about its effectiveness and, quite apart from the quality of the training, what proportion of care workers have actually completed it? Commissioner, a policy of transferring COVID-19 positive patients to hospital was followed at Dorothy Henderson Lodge. 13 of the 16 residents who were tested positive were sent to hospital. Of the remaining three, one did not want to go to hospital and was palliated at the home. The remaining two recovered.

We anticipate that Mr Low and Ms Dicks of BaptistCare will say that hospitalisation of positive residents at the early stages made the process of responding to the outbreak a little easier while they were stabilising their staffing. By contrast, at Newmarch House, residents were treated pursuant to a policy known as Hospital in the Home. There was a vigorous disagreement between the Commonwealth and New South Wales officials on this question of hospitalisation of COVID-19 positive residents in the early days of the outbreak at Newmarch House. An email dated 15 April 2020, 4 days after the outbreak began and at a time when there were 15 infections including nine residents, records the Chief Clinical Advisor to the aged care regulator, Dr Melanie Wroth, and I quote:

> *Strongly recommending that infected residents be removed from the site.*

She inquired if the department could offer a separate location, for example, through the private hospital funding initiative. She also noted that the issue would grow as more positive test outcomes are expected. Another email dated 16 April 2020 records a meeting of the Commonwealth and New South Wales officials. According to that email, at the meeting, Ms Amy Laffan, Acting First Assistant Secretary of the Commonwealth Department of Health, said the Commonwealth was, and I quote:

…keen to understand whether hospital beds could be used for residents of Newmarch to ensure appropriate care is being provided.

A process referred to by health officials as decanting residents. The following words
5 appear next to the words "New South Wales Health" in the email, and I quote:

Preference is not to decant residents into hospitals given the precedent this would set. Need to find solutions that enable appropriate care to be provided in the facility. Looking at Hospital in the Home and in-reach palliative care if
10 *needed.*

Dr Wroth's views were support by the Aged Care Quality and Safety Commissioner, Ms Anderson. The Commissioner wrote in an email to the Commonwealth Department of Health also on 16 April 2020, after the meeting at which the New
15 South Wales Ministry of Health raised the concern about setting a precedent, and I quote, the Commissioner said:

We must be vigilant in calling out the elephant in the room if ever we sense it might be present. To be clearer, if there is a view sitting behind the New South
20 *Wales Health's position that aged care residents with COVID-19 should always be cared for in situ and should not be transferred to a hospital in any circumstances, then we must call this out as an intolerable and unsupportable assumption.*

25 Commissioners, we hope to understand what the precedent was that was concerning the New South Wales officials. You will hear from Dr Nigel Lyons, a senior official from New South Wales Health, who was at that meeting. Commissioners, equal access to the hospital system is the fundamental right of all Australians, young or old, and regardless of where they live. Many of the residents in aged care homes
30 worked their entire lives to build the world class health system of which Australians are justifiably proud. They have the same right to accessing in their hour of need as the rest of the community. To put it very directly, older people are not less deserving of hospital treatment because they are old. Such an approach is ageist.

35 The evidence of Mr Millard will be that this stand-off between Commonwealth and New South Wales officials was so concerning that he spoke to the Federal Aged Care Minister, Senator Colbeck, about it. He was subsequently told by the Minister's department to follow the New South Wales Health Department's advice. And on the following day, the New South Wales Health's view held sway. All residents at
40 Newmarch House were treated as part of Hospital in the Home. This was despite the preconditions in the relevant guidance material, such as a written agreement between the hospital and the home and training for the home staff appearing not to have been completed.

45 We will explore if this is the best process for resulting disagreements between various levels of government. Who should have the final say on the question of whether a COVID-19 positive resident is transferred to hospital? And is Hospital in

the Home the best way of responding to an outbreak of COVID-19 in an aged care home and, if it is, what more needs to be done to prepare those homes for its implementation? According to Mr Millard, of the 37 residents who tested positive to COVID-19 at Newmarch House, only two were transferred to hospital. One of those died. The other 16 residents who died of COVID-19 were all treated at Newmarch House. Mr Millard's evidence is expected to be that Anglicare had little or no say about whether COVID-19 positive residents should be transferred to hospital for care.

Commissioners, there's a real question of whether any provider is capable of meeting its requirements under the Aged Care Act in responding to an outbreak of COVID-19 without ready access to the hospital system. That was the conclusion of Mr Millard when he had a chance to reflect on the Newmarch House experience. He told the Anglicare board on 27 May 2020, and I quote:

> *In the event of infection at another Anglicare home, Anglicare would be far more assertive regarding the most appropriate management of COVID-19 positive residents and would strongly push for these residents to be immediately transferred to hospital.*

We will ask Mr Millard why Anglicare was not more assertive in April and what are the lessons of that experience for other providers. In addition to the question of whether residents can receive the best medical treatment in a residential aged care facility, there's the important question of how a provider can meet its work health and safety obligations to its employees in such circumstances. You will recall that 34 staff members at Newmarch House also tested positive to COVID-19. Commissioners, views among experts and state health departments vary on the question of whether to hospitalise residents who test positive to COVID-19. Prof McLaws will say of aged care residents who are COVID-19 positive that:

> *Transfer to hospital is the only appropriate solution that may improve their survival rate and reduce the risk of infection in the remainder of residents.*

Dr Branley, who treated a number of the residents at Newmarch House, considers that such an approach is not in accordance with best practice. Now, the difference of opinion may be explained by the different perspectives of Professor McLaws and Dr Branley. Professor McLaws is an epidemiologist with a broad public health perspective. Dr Branley is an infectious diseases doctor with a focus on what is clinically indicated for individual patients. We will explore these different perspectives. South Australia's Health Department has a policy of automatic hospitalisation and its chief officer, Professor Spurrier, who is part of the first panel this morning, will say that that's the most appropriate public health response, having regard to the limited capacity of nursing homes to implement high-standard infection control. By contrast, the approach in New South Wales is to treat residents on a case-by-case basis.

Commissioners, one effect of an outbreak of COVID-19 in a residential care home is that a large proportion of the staff will need to be stood down temporarily at least while they await test results and possibly for longer. Because of the importance of continuity of staffing to the quality of care, this has the potential to impact very badly on residents and their families. It must be well managed. Replacement staff who will have no familiarity with the service and its residents must be sourced and then inducted quickly but thoroughly. Care plans need to be quickly understood. As noted, the self-assessment survey to which we referred earlier asked providers if they had a plan in case up to 20 to 30 per cent of staff are unable to present for work. 55 per cent of facilities that responded, including Newmarch House, said they did. The remaining 45 per cent, they were developing one.

That figure of 20 to 30 per cent appears to have been derived from the guidelines produced on 13 March 2020 by the Communicable Diseases Network Australia. Those guidelines had been adapted from previous works on influenza outbreaks in residential aged care facilities. Mr Millard will say that in the lead-up to the Newmarch House outbreak Anglicare took a conservative approach and planned to lose 30 to 40 per cent of its staff during an outbreak, however, he will say that even this was an massive underestimate which was totally unrealistic. Anglicare effectively had to stand down its entire workforce at Newmarch House after the outbreak in the middle of April.

Mr Low, the CEO of BaptistCare, will say that Dorothy Henderson Lodge lost almost its entire workforce within 48 hours of that outbreak. Interestingly, Commissioners, the way they attracted agency staff to work at Dorothy Henderson Lodge was to offer them sector pay rates and other improved working conditions. Perhaps the solution to the workforce crisis in aged care is not that complex after all. Were these vital lessons about staffing disseminated to the sector? What systems are now in place? Mr Millard will tell you that he did not know that he would lose such a high proportion of his staff but there's no reason why providers after Dorothy Henderson Lodge and Newmarch House should be left in the dark about this.

It was not until June 2020 that the Commonwealth Department of Health advised providers that 80 to 100 per cent of their workforce may need to isolate in a major outbreak. And even then, Commissioners, this information was located on page 5 of a nine-page document uploaded on 7 July 2020 on the aged care regulator's website with the intended audience identified as "health sector". We note that a link to the document was included in a letter the Aged Care Minister wrote to providers on 7 July 2020. But until that advice was published providers presumably relied on the estimate of 20 to 30 per cent in the survey. Presumably, they're outbreak management plans were based on this erroneous information.

Commissioners, regulators in other fields such as workplace safety publish one-page alerts to disseminate promptly vital safety information that they learn from incident investigations. We will explore with the aged care regulator and the Department of Health whether they could do something similar. This question of staffing would have made a perfect example of how such an approach could work. An alert could

have been published at the end of April at the latest informing providers of the experiences of Anglicare and BaptistCare. Providers could have amended their preparedness plans accordingly.

5 In his statement to this hearing, Mr Lye of the Commonwealth Department of Health explains that an important part of the Commonwealth response to the COVID-19 pandemic has been sourcing additional staff for providers facing outbreak called the surge workforce. After the Dorothy Henderson Lodge outbreak, contracts were entered into between the Commonwealth on the one hand and Mable Technologies
10 Proprietary Limited and Aspen Medical Proprietary Limited on the other. A total of 32 Mable staff and 42 Aspen staff were paid by the Commonwealth to work at Newmarch House in response to the outbreak at a total cost to the Commonwealth which exceeded $1.5 million.

15 Mr Millard's statement tells you that while he was very impressed with the Aspen employees, it became quickly apparent to him that the Mable workers did not have the skills and qualifications that were needed in the particular circumstances. Anglicare's concerns about Mable were communicated to Commonwealth Department of Health on 17 April 2020. How did the department respond; we will
20 pursue that matter with Mr Lye. A further staffing-related issue arose at Newmarch House. It concerned aged care workers who worked at multiple facilities. This issue has attracted much attention in Melbourne in recent weeks and there is media speculation that such workers may be the source of some of the infections in care homes. Mr Lye will explain that the Commonwealth Department of Health advised
25 providers earlier this year:

> *Health and aged care workers were able to continue to go to work at other services if they have had casual contact with COVID-19 cases and are well and/or have directly cared for confirmed cases while using PPE properly*
30 *provided they monitor themselves for symptoms and self-isolate if they become unwell.*

We will ask whether this advice adequately considered the position of a worker who may be COVID-19 positive even though they are asymptomatic. In light of recent
35 developments in Melbourne, this appears to be an important question. Finally, Commissioners, we note that the increase in community transmission of the virus in Melbourne in mid-June of this year led to the reintroduction of stage 3 restrictions and lockdowns of some public housing towers. Professor Ibrahim will say that the risk of an outbreak in an aged care home is extremely high even with very low rates
40 of community transmission. Daily new infection rates in Victoria rose from 20 on 16 June 2020 to 76 on 30 June 2020, however, masks were not made compulsory for aged care workers until 13 July 2020. That was two days after the first recorded death of an aged care resident in Victoria from COVID-19.

45 By that date, the number of new infections in Victoria was 249. The risks of aged care workers inadvertently introducing COVID-19 into their workplaces had been clear since the Dorothy Henderson Lodge outbreak in March. What system was in

place to monitor this increase in community transmission and consider appropriate responses to protect aged care residents. Why did authorities wait until after the first death to take what seems the simple and obvious step of making masks compulsory for aged care workers. If we have the sort of national coordinating body that Professor Ibrahim says should have been in place of March this year, would have been the outcome have been different and given that the experts all say that further cases of community transmission of the virus are quite likely, what are the lessons that can now be learnt?

Commissioners, before I call the first witness, I will tender three tender bundles that contain documents to which reference will be made throughout the hearing. I would seek that they be marked separately please, Commissioner Pagone. The first is the general tender bundle of 68 documents.

COMMISSIONER PAGONE: Yes, that will be exhibit 18-1.

EXHIBIT #18-1 GENERAL TENDER BUNDLE CONTAINING 68 DOCUMENTS

MR ROZEN: The second is the Dorothy Henderson Lodge tender bundle of 15 documents.

COMMISSIONER PAGONE: 18-2.

EXHIBIT #18-2 DOROTHY HENDERSON LODGE TENDER BUNDLE CONTAINING 15 DOCUMENTS

MR ROZEN: And the third is the Newmarch House tender bundle of 117 documents.

COMMISSIONER PAGONE: That will be 18-3.

EXHIBIT #18-3 NEWMARCH HOUSE TENDER BUNDLE CONTAINING 117 DOCUMENTS

MR ROZEN: Commissioners, at this point there are some appearances that are to be announced.

COMMISSIONER PAGONE: Yes, thank you.

MR LOCKHART SC: May it please the Commission ..... counsel appearing for BaptistCare, New South Wales and the ACT .....

COMMISSIONER PAGONE: I'm not sure that I could exactly hear that but I take
5 that to have been Mr Lockhart announcing his appearance; is that correct?

MR LOCKHART: That's right, Commissioner.

COMMISSIONER PAGONE: Yes. Thank you, Mr Lockhart.
10

MS M. ENGLAND: May it please the Commission, my name is England and I appear with leave with my learned junior, MS EPSTEIN for Anglicare community services, Mr Grant Millard and Ms Erica Roy.

15 COMMISSIONER PAGONE: Yes, thank you, Ms England.

MR M. FORDHAM SC: If it please you, Commissioners, my name is Fordham. I appear for the State of New South Wales with my learned friend MR FRASER.

20 COMMISSIONER PAGONE: Yes, Mr Fordham.

MS DOECKE: May it please the Commission, my name is Doecke and I appear for the State of South Australia.

25 MR A. McKEOUGH: May it please the Commission, my name is Alistair McKeough and with leave I appear for Mable.

COMMISSIONER PAGONE: Thank you, Mr McKeough.

30 MS K. MORGAN SC: May it please the Commissioner, Morgan, with my learned friend MS BARNETT. I appear for the Commonwealth.

COMMISSIONER PAGONE: Yes. Thank you, Ms Morgan.

35 MS J. BURNS: If it may please the Commissioners, my name is Jodie Burns and I'm from the Victorian Government Solicitor's Office and I represent the State of Victoria.

COMMISSIONER PAGONE: Yes, thank you, Ms Burns. I think that completes
40 them all, I think.

MR ROZEN: I think that's everyone. Commissioners, I note the time and it was proposed that we would break for morning tea at quarter past 11. I'm in your hands but it may be appropriate to do that now rather than just having 10 minutes with the
45 first panel?

COMMISSIONER PAGONE: Well, the difficulty there is going to be the flow-on effect of taking up the time later on, isn't it?

MR ROZEN: It may be. I'm happy to – we will catch up the time. I'm reasonably confident of that or we could not have a morning break; I'm in your hands.

COMMISSIONER PAGONE: Yes, thank you. Commissioner Briggs, would you like a shorter break now or should we skip the break entirely?

COMMISSIONER BRIGGS: I would like to keep going, if we could please, Commissioner, but I think I might need a five-minute break after the first witness, if that's possible, please?

COMMISSIONER PAGONE: All right. We will do that. Yes, thank you.

MR ROZEN: Thank you very much, Commissioner Briggs. Thank you Commissioner Pagone. I call Professor Marie-Louise McLaws and Professor Nicola Spurrier, both of whom appear by video link.

<MARIE-LOUISE McLAWS, SWORN [11.06 am]

<NICOLA SPURRIER, AFFIRMED [11.06 am]

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioner. Professor McLaws, I will start with you, if I could. Could you please state for the Royal Commission your full name. Can you hear me.

PROF McLAWS: I couldn't then. You wanted me to state something and I didn't hear you.

MR ROZEN: Yes, just your full name. An easy question to start with

PROF McLAWS: My name is Marie-Louise McLaws.

MR ROZEN: Thank you. And Professor McLaws, you are Professor of Epidemiology Health Care Infection and Infectious Diseases Control, School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales in Sydney.

PROF McLAWS: Correct.

MR ROZEN: You are also currently an adviser to the World Health Organisation in its health emergency program experts advisory panel for infection prevention and control preparedness, readiness and response to COVID-19?

5 PROF McLAWS: Correct.

MR ROZEN: And also part of the infection prevention and control guidance development group for COVID-19?

10 PROF McLAWS: Correct.

MR ROZEN: And Professor McLaws, for the purposes of this Royal Commission hearing, have you prepared a precis of evidence dated 22 July 2020?

15 PROF McLAWS: I have.

MR ROZEN: And that appears at tab 2 of the witness materials at RCD.9999.0384.0001. Do you have a copy of that precis in front of you, Professor?

20 PROF McLAWS: I do.

MR ROZEN: Have you had an opportunity to read through that before giving your evidence this morning?

25 PROF McLAWS: I have.

MR ROZEN: And is there anything in it that you would like to change?

PROF McLAWS: No, I think everything is fine, yes.

30

MR ROZEN: And are the contents of that document true and correct?

PROF McLAWS: Yes.

35 MR ROZEN: Commissioners, I tender the precis of evidence of Professor McLaws dated 22 July 2020.

COMMISSIONER PAGONE: Yes, that will be exhibit 18-4.

40

EXHIBIT #18-4 PRECIS OF EVIDENCE OF PROFESSOR MCLAWS DATED 22/08/2020 (RCD.9999.0384.0001)

45 MR ROZEN: If I could turn to you, Professor Spurrier, you are the chief health officer for South Australia?

PROF SPURRIER: No, I'm the chief public health officer for South Australia.

MR ROZEN: Thank you. And for how long have you held that position?

5 PROF SPURRIER: Since August 2019.

MR ROZEN: You are a public health physician and a paediatrician?

PROF SPURRIER: Yes.

10

MR ROZEN: And you have worked for South Australian Health for 29 years?

PROF SPURRIER: Yes.

15 MR ROZEN: Presumably in a variety of other positions before your current appointment?

PROF SPURRIER: Yes, that's correct.

20 MR ROZEN: All right. By virtue of your role in South Australia, you are a member of the Australian health Protection Principal Committee?

PROF SPURRIER: Yes.

25 MR ROZEN: And that's chaired by the Commonwealth Chief Health Officer?

PROF SPURRIER: Yes.

MR ROZEN: And the solicitors acting for South Australia have been good enough
30 to provide at very short notice a copy of your CV, which is RCD.9999.0430.0001. And I won't go through the remainder of that but that should perhaps be tendered, probably in the tender bundle, I think or it will be in due course if it isn't presently. Professor Spurrier, you haven't provided a witness statement or a precis but the South Australian Department of Health has provided the Royal Commission with a
35 general submission about COVID-19 and its impact on residential aged care facilities; is that right?

PROF SPURRIER: Yes.

40 MR ROZEN: And I will ask you about some of that in a moment but for convenience it's found in the general tender bundle at tab 27. Professor McLaws, if I could start with you, please, and ask you some, what are probably for you very basic questions about COVID-19, the nature of the virus and the methods of transmission. They're set out in some detail at paragraphs 2 and 3 of your precis. I won't ask you
45 to read those out, but towards the bottom of paragraph 3 – sorry, the third line down in paragraph 3 you say this:

Asymptomatic cases test positive for SARS-CoV-2 RNA for one to two weeks while symptomatic cases with mild to moderate disease test positive at least three weeks and severe cases for longer than three weeks.

5 And that reference to SARS-CoV-2 is a reference to COVID-19 as the rest of us refer to it; is that right?

PROF McLAWS: Correct.

10 MR ROZEN: Yes. Continuing with what you say in paragraph 3, you say that:

This has implications for infection prevention for staff and prevention of transmission to residents, amount of personal protective equipment required, required dedicated staff and continued environmental cleaning.

15

Can I ask you in particular of what, in your opinion, are the implications for infection prevention of that observation that asymptomatic cases test positive for one to two weeks.

20 PROF McLAWS: The asymptomatic proportion is difficult. It has been estimated anywhere between 13 per cent and as much as 50, 60 per cent but that's often been done incorrectly because a number of facilities haven't been followed for seven to 21 days to ensure that asymptomatics are truly asymptomatic, and they're not in the pre-symptomatic phase. But the problem of asymptomatics – and let's say there are
25 around somewhere between 20 per cent, 30 or even greater, can be problematic because it means that they could be still shedding. Now, we had a – we have had three WHO meetings, first in February, one in July and then one two weeks ago, where we still don't know the importance of asymptomatics for infection prevention and control.

30

We're not sure how they drive the pandemic, let alone how they drive it within a built environment such as residential aged care facilities. But if all residents aren't tested on a regular basis, then you won't know how many are asymptomatic and positive and potentially shedding virus which means that you won't know to put
35 them away from other residents and other staff members.

MR ROZEN: Does that also have implications for staff members who may be COVID positive but asymptomatic as well? Does that have possible implications for that cohort?

40

PROF McLAWS: Correct. Absolutely. And it's particularly important when you understand that workers, carers, often work across multiple facilities not just in Australia but world-wide and it's usually because they're paid poorly. So if they do work across facilities, it is difficult to control the spread if they are asymptomatic as
45 well, so they need to be tested regularly. But they also need to really wear a face shield, a face mask or both to ensure that they're not acquiring it and they also are

not spreading disease to not just the residents but also the visitors and other staff members.

MR ROZEN: All right. I will come back to that issue in a moment if I could but if I
5 could just clarify one technical matter. You used the expression “shedding”. Can you just help us with understanding what that means in this context?

PROF McLAWS: Yes, yes. So you mostly acquire COVID from expiration, from people who are breathing out, but you can acquire it, of course, from saliva and
10 sputum and, we think, faeces, but not as much, and not blood and not urine. So, of course, if the elderly don’t swallow very well, they can build up saliva and they often touch their face or their faces have to be wiped as well. So virus can be found in saliva and mucus that is coming out of a resident’s mouth or nose.

15 MR ROZEN: I will just ask you about a couple of other terms which are referred to in a number of the witness statements that have been provided to the Royal Commission. Firstly, the notion of the incubation period of the virus. Firstly, what is an incubation period of a virus? What does that mean?

20 PROF McLAWS: So there are two periods that are important with COVID, as with any other infectious disease, and that is the incubation period and the serial interval. An incubation period is the time from exposure to a case, to then developing symptoms. And that can be for, on average, for most people, five to six days. It can be up to 14 days and, in rare events, longer than that. The serial interval is when you
25 become infectious to others and new evidence is coming out that, of course, you’re infectious potentially between day 3 and day 5 after exposure. So on average, 50 per cent become infectious on day 4 and they haven’t developed symptoms yet, which makes it difficult for infection control.

30 MR ROZEN: Two other matters I would like to ask you about. Firstly, false positive tests for COVID-19, that is someone who tests positive but perhaps on later testing is found not to be positive. Is that a scenario that is common?

PROF McLAWS: It’s not common but it can occur. It depends what tests are being
35 used. In Australia, we don’t use antibody tests which have common problems but mostly in Australia, the tests are looking for RNA. But that RNA can be live or it can be dead. So sometimes you can have a false positive. Sometimes you can have a false negative because it often depends exactly when you might do the test. And that’s why you have to do tests commonly, potentially weekly, for staff and for
40 residents.

MR ROZEN: You anticipated my next question which is the false negative test. That’s a phenomenon of which you are familiar, I take it, that that can happen?

45 PROF McLAWS: Yes, but it happens less often with the test that’s used in Australia. So if you test negative, the probability of you having a false negative is low.

MR ROZEN: Is the probability a little bit higher in relation to particular groups who may be difficult to test? So it has been said that some of the elderly residents of aged care facilities can, for a variety of reasons, be difficult to administer a test to. Does that mean that the rate of false negatives might be higher amongst that group?

5

PROF McLAWS: Yes, that is true. Sometimes they find it difficult to have a swab put deep into their – the back of their throat or up their nose, particularly if they've got onset dementia or are confused or anxious and, in fact, one of the symptoms that they've described in the elderly, who weren't confused before they got COVID but
10 after they've got COVID or as they're becoming more symptomatic, can be confusion as well, which makes it difficult to do the test.

MR ROZEN: One final matter for you, Professor McLaws, at the moment, and that is you were asked some questions about the differences between COVID-19 on the
15 one hand and infectious diseases, such as gastroenteritis and influenza, which are commonly experienced in residential aged care facilities, and at paragraphs 6 and 7 of your precis of evidence, you address that point. Are you able briefly to explain to the Commissioners what the key differences are from an infection control point of view?

20

PROF McLAWS: Well, with diarrhoea, for example, the patient is obviously infected, they don't have a period where they are infectious to others. You mostly acquire this from small particles from faeces, either as the staff member is cleaning up the resident or as they're flushing the toilet if they don't close the lid and it gets
25 aerosolised. So it's easier to prevent infection transmission within an aged care facility if you're very careful about how you dispose of incontinence.

With flu, still, some people get infectious at least 24 hours before they become symptomatic. However, with flu, staff are vaccinated, which cuts down the risk for
30 staff of acquiring flu but also the elderly and the visitors can be vaccinated. There is a small proportion of those who are vaccinated who never elicit an immune response so they can still get influenza, so there's a small probability of transmitting it. But this disease is different, COVID, because you can't vaccinate it and you can be infectious day 4 after exposure, having no symptoms at all.

35

MR ROZEN: Is a practical consequence of that difference, particularly the absence of vaccinations, or residents and staff and visitors who ought to be – can be expected to be vaccinated against influenza, the significance of that is that infection control methods and processes necessarily need to be much more strict as part of a COVID-
40 19 response than what might be necessary for influenza; is that right?

PROF McLAWS: Yes, that's correct. So there's no vaccine so you have to be very stringent with environmental cleaning. You can catch COVID-19 from fomites, from high touch areas that have been contaminated with the virus. That can happen
45 also with influenza but we believe influenza is mostly transmitted by small droplet nuclei that hang in the air for longer. But with this one, you can catch it from high touch areas. The virus can live on hard surfaces, such as metals and bed railings, for

example, for or up to three to six hours. It can be easily inactivated. However, that means constant cleaning of the environment.

Good hand hygiene constantly, with soap and water or alcohol-based hand rub, works very well, inactivates the virus. But you have to have very good training. Even in hospitals, some of my research shows that when healthcare workers, highly trained nurses and doctors, are thinking high order medicine and nursing, they fail to hand hygiene at the 85 per cent required rate and sometimes fail hand hygiene as low as 50 per cent of the time or even 30 per cent of the time. So you've got workers, carers, that are basically caring for the elderly as if they are family members and they don't see a risk between themselves and the elderly necessarily. They've got a bond and they may fail to hand hygiene as often and as scrupulously, so it takes a lot of training and awareness.

Then, of course, you can acquire COVID in the air, particularly if the air is still and there's not a lot of airflow change. And in hospitals, the airflow change needs to be at least 40 to 80 litres per second per patient, and in most homes, it's nowhere near that. Sometimes it's even less than three litres per second per person in a home, and residential aged care facilities are basically a shared home. They may have heating to keep the levels of temperature at a comfortable rate. They won't be opening up windows to get good airflow and decontamination, as is often suggested in offices and dental practices and the like, if they don't have the airflow that hospitals have where they will be looking after COVID patients.

So it is very difficult to decontaminate air. Although we believe that you catch this mostly from droplets sized particles, it is not unreasonable to expect that there's a mixture of sized particles. We're not sure how important the smaller particles size is but they're the ones that hang in the air for longer. So you do really need good airflow change. That may not be possible in some of the older built environments for residential aged care facilities.

MR ROZEN: Thank you. Prof Spurrier, you have been waiting very patiently there whilst I've been talking to Professor McLaws. If I could bring you into this discussion and, particularly, if I can ask you about the implications of that, the developing science that you have heard Professor McLaws talk about. I assume you accept that through the course of the year, the science has been developing, that we've learnt more. We collectively have learnt more about the virus. What I want to ask you about is, from a public health perspective, applying the precautionary principle, what does that mean at a high level in terms of an appropriate public health response? Perhaps you could start by explaining to us the meaning of the precautionary principle in this context and then give us some understanding of its application in relation to COVID-19.

PROF SPURRIER: Yes. Thank you. So I will just describe the precautionary principle but I also had a slightly different opinion to a couple of things that Professor McLaws raised, which I would like to also address. So in terms of the precautionary principle, basically in public health, we often do things that may not

appear from the general public's perception to be necessary and I guess what we are trying to do is weigh up risks. So it's always looking at the risk involved in a particular setting and then trying to make a value judgment using science as much as possible to err on the side of caution. And that is in terms of making sure that we're
5 keeping as many people healthy in a population as possible, or in – or if you're focused on a particular part of the community, that number of people as much as possible. So it's always staying on that rather cautious side.

Now, this can become, of course, difficult when you have got different requirements
10 from different parts of our society and, also, there are a variety of things that can make people ill. And particularly with this pandemic, on the one hand we are trying to reduce the spread of the virus and the reason is, obviously, we want to save lives. But by doing that, one of the ways we do that is by restricting people's movements and we have had to put restrictions on businesses. That has an obvious effect on
15 reducing people's livelihood and restricting our economy which in itself, of course, makes people ill. So it is quite a difficult challenge in public health but the precautionary principle is basically erring on the side of caution when you may not have all the evidence. And as you inferred in your introductory remarks, this is a novel virus and we are learning more about it all the time. But I guess from day dot,
20 we have been trying to use as much evidence as we can. We have been building that evidence and we have tried to be as cautious as possible in that space of not knowing everything.

MR ROZEN: Of course, the precautionary principle is not a matter of choice in
25 your work; it's a statutory requirement, is it not, under the South Australian Public Health Act?

PROF SPURRIER: Yes, so that's one of the principles of our Public Health Act and also the proportionate principle as well.
30
MR ROZEN: Is there one more key principle that is relevant here, the population focused principle?

PROF SPURRIER: Yes, so, of course, we have got individual people in our
35 community which, when I have my hat on as a paediatrician, is my clear focus but when you're working in public health and you're looking at the whole of the population and, therefore, what might be unjust for one person, i.e. requesting them to be in hotel quarantine, may be being done for the wellbeing of the whole population.
40
MR ROZEN: And that balance, as I read the population principle in section 10 of the South Australian Public Health Act requires decisions and actions that are taken under the Act to be actions that are necessary to protect and improve the health of the community, and in taking those actions, the health of individuals should be
45 considered. That's the balance that's struck - - -

PROF SPURRIER: Yes.

MR ROZEN: - - - from a public health point of view; am I understanding that correctly?

PROF SPURRIER: Yes. Yes.

5

MR ROZEN: You mentioned a moment ago, Professor Spurrier, there are a couple of matters that you wanted to raise in relation to the evidence that has been given by Professor McLaws. Is now a convenient time for you to do that?

10 PROF SPURRIER: Yes, thank you. So I think this issue of asymptomatic people with no symptoms whatsoever is a very important one but we don't know everything about it. And we don't know to what extent, as far as I am aware, how much of a risk they are in terms of transmitting the infection. And this is important because if we – when we're testing people and we are trying to increase the rate of testing, it
15 means that we would be needing to test a large number of people who do not have symptoms. And the implication of that is we could be doing a lot of wasteful testing. Now, of course, I've got this, you know, sort of population-wide perspective and all of our resources are finite, and same with our testing resources.

20 And if we continue to be testing asymptomatic people unnecessarily, what it does is reduce the turnaround time of our test results. So we saw this in Victoria where, when they had very high rates of testing, their turnaround time became longer and longer. And then we don't get the ones that we really need back quickly. So our focus has definitely changed as AHPPC; we were very interested in doing quite a bit
25 of asymptomatic testing, and in fact we have a surveillance plan here in South Australia which did include testing health care workers and aged care workers in a surveillance framework, ie, when they didn't have symptoms as Professor McLaws has suggested.

30 However, we are really now wanting to focus on people with symptoms and, in fact, when you do speak to people that might have been considered asymptomatic, they often do have some very mild symptoms, albeit even if it's just a headache. So I think that's worth making the point. The second thing was being asked about a definition of "shedding". One of the ways we use that term from a diagnostic point
35 of view is that we do know that people shed the virus for quite long periods of time, and we have had patients here in South Australia who we can test them and they will still have a positive PCR result weeks and weeks – six, eight weeks after the initial infection. That doesn't mean they are infectious to other people.

40 We know from – there's some good evidence from China that the virus probably stops being viable which means it can – is alive about day 7 or 8. So whilst we can get a positive test result from somebody way out from their time that they had their initial symptoms, it doesn't necessarily mean they are infectious. So, again, the interpretation of a PCR test is very, very important. And you did ask about false
45 positives and false negatives.

MR ROZEN: Yes.

PROF SPURRIER: When we have a large amount of testing in a community – and in our state we have had very few cases, so again it's very, very dependent on the number of cases that you have. Any positive in South Australia has probably a higher likelihood of being a false positive than a real positive just on a statistical basis. And the other thing that it might be worth the Commission knowing is that when you take a PCR or a swab test, so you swab the back of the nose and throat, you're getting a small amount of the virus RNA. And that is amplified up and then a probe, a genetic probe is used to test that. And so the number of times you have to cycle to increase that amplification gives an indication of how much virus is there.

But it's not a yes or no from a laboratory point of view. There's some – an interpretation required and we do know that some laboratories have a different way of interpreting it, which was why we do get some possible, you know, positives or likely positives that they then go and run on a different platform to ensure that it is correct. I can say from a South Australian perspective SA Pathology has, I think, had two false positives which, you know, given the number that they've done, is a very, very small number. So I think we should be feeling very reassured that PCR testing for COVID in Australia has a very low rate of false positives and is a very sensitive and specific test.

MR ROZEN: Thank you. That's very helpful. Professor Spurrier, are you in any position to make an observation about the numbers of false negatives from the data in South Australia?

PROF SPURRIER: Well, to be able to call a false negative, you then need to have had some evidence that that person is, indeed, a case. And so we do have a process; if we feel very, you know, committed to the fact that that person has the sorts of symptoms that would be COVID and we don't have any other explanation, we will re-swab people. And I'm aware of one instance in South Australia where somebody – that did happen to somebody fairly recently where they were negative. They had symptoms and then a couple of days later, we swabbed them and they were positive.

What I can't tell you because I didn't have enough sample left is whether they actually had two respiratory viruses, and in fact the earlier symptoms were simply had no virus or, you know, rhinovirus or RSV or one of the other viruses that we have, because that would have been the other explanation for that. But I think if we had a large number of false negatives we probably wouldn't be doing so well in Australia as we currently are.

MR ROZEN: Yes, Professor Spurrier, could I ask you about two matters that are raised in the very helpful submission that South Australia Health has provided to this Royal Commission. It's found at tab 27 of the general tender bundle. I wonder if you have a copy of it in front of you; I should have asked you that.

PROF SPURRIER: Yes.

MR ROZEN: All right. I'm pleased to hear that. Could I, please – if that could please be brought up. It's AWF.600.01744.0001. If I could ask you, Professor Spurrier, to turn your attention to page 8. I'm not ignoring the first seven pages but we have limitations of time and I assure you it's all very helpful. Towards the bottom of that page, or from about the middle, you talk about the potential for – sorry, the need, rather, for there to be a clear governance framework when there are so many different agencies involved, both Commonwealth and State and aged care providers, and unless there's a clear set of ground rules as to who is responsible for what, there's the obvious potential for confusion and therefore that will detract from the ultimate response to an outbreak, particularly in an aged care facility.

Immediately above are a series of dot points at the bottom of the page, do you see that, about three-quarters of the way down the page you say, or the submission says, rather:

> *A clear governance framework would have been beneficial. One that defined the roles and functions of each body impacting on the aged care sector and establish communication points where information, feedback and directions are exchanged.*

And you identify various matters covered there. The evidence before the Royal Commission will be that after the second of the outbreaks in New South Wales, that is, the second of the major outbreaks, the one at Newmarch House in April, that a protocol was agreed between the New South Wales and Commonwealth governments, which governed the matters that you are there describing in relation to future outbreaks, and that protocol is part of the evidence here. Is there such a protocol in place in South Australia?

PROF SPURRIER: So we certainly have a COVID outbreak plan for aged care and disability care, and it's very important that you have a plan that's in place way before you need it, and it is agreed by everybody. And it's also important that you have opportunity to exercise that plan either on desktop but preferably by some mock scenarios as well. And I think it's important that the Commissioners understand that we have not had an outbreak in a nursing home in South Australia at all. We have had one instance in our first wave of COVID-19 where an allied health worker who had travelled overseas tested positive but there was no transmission from that person to anybody in the aged care facility so it was not defined as a cluster or an outbreak. So it is, yes, so we certainly do have a plan.

But I think the other thing that has been absolutely key for us in South Australia is that we've been meeting with the industry leads over a long period of time, so have very strong relationships with them. And these are – and I'm not sure if it's listed in here but they are Leading Aged Care Australia, Aged Care Industry Association, Aged Care SA and Multicultural Aged Care and our lead in aged care meets with these people on a weekly basis. This has meant that we have had a much – I guess, a really good understanding of the various pressures on that industry and their ability to be able to deal with a positive case in their setting.

MR ROZEN: Thank you. I'm not sure if I expressed my question as clearly as I could have. I certainly understand there's a COVID-19 response plan in South Australia. What I was asking was a narrower question than that; whether there is a protocol or some similar document that governs the relationship, for example, between the Commonwealth Department of Health and your area where you work in relation to a response to an outbreak in a residential aged care facility. Are you satisfied that those roles have been appropriately designated for the purposes of a South Australian response?

PROF SPURRIER: No, I can't say I am sure whether or not we have a framework but I would like to take that on notice, please.

MR ROZEN: Sure. If you could do that. If I could ask you to turn your attention to page 11 of the submission, please, and you will see halfway down the page there's a heading RACF COVID-19 Pandemic Support Initiatives. Point 2 there refers to the management of COVID-19 in residential aged care facilities process, which was released on 5 June 2020 and developed in collaboration with the aged care sector. And then there's a discussion in (3) of the contents of that policy and if I could read that out, it says:

> *The policy outlines that all residents testing positive to COVID-19 would be transferred to a public hospital to reduce the risk of transmission to other residents and that the SA Health rapid response plan will be triggered if there is one COVID-19 case in a residential aged care facility or other congregated living environment. The policy will also consider issues uniquely associated with regional and remote RACF and ensure that it is relevant to and feasible for those services.*

Now, in the media, Professor Spurrier, there have been comments made by some of the representatives of the peak aged care bodies that that's a policy they would like to see applied in other jurisdictions. You may be familiar with that sort of commentary. I take the point you made earlier that you haven't had an outbreak in a residential aged care facility, so it's a fair comment, isn't it, that this policy has not actually been tested at any time in South Australia?

PROF SPURRIER: Yes.

MR ROZEN: But I wonder if you can assist the Commissioners with understanding the thinking behind it, and is it predicated on a view about the limited ability of a residential aged care facility to apply the sort of infection control requirements that Professor McLaws was talking about? Is that what underlies the policy here or is it something else?

PROF SPURRIER: There's a number of things and that's one of them. So in South Australia, again, it is very dependent on the geography but also the way one's health care system is set up and each State is slightly different. But very early on we decided in South Australia we would take the advice of the WHO and this was

information that was provided to us after the WHO had done an investigation into China and their dealing with the pandemic. And one of the learnings from this was that it is best to treat all your COVID-19 patients in the one hospital or in a limited number of hospitals. And so, of course, we are a much smaller State and we have a networked health service. So we very early on decided that the Royal Adelaide would be our COVID-19 hospital.

Obviously, children would be at the Women's and Children's, and if we had pregnant women that would be at Flinders Medical Centre. And the reason for that is what they had learnt in China was that, of course, you can get transmission between patients and to staff and it's much better to have everything in the one spot where you have got focused expertise. And fortunately, we have the new Royal Adelaide which is very well set up with individual rooms, negative pressure rooms and the like and also an extensive intensive care. So if we see it in that context I think it's useful. So then getting back to the question of having a positive patient in an aged care facility, yes, definitely we had heard very loudly from the sector – I just need to make people aware, as a paediatrician I obviously haven't worked with elderly patients from a clinical perspective, I haven't worked in an aged care facility but my understanding is that the personal care assistants do not have tertiary qualifications and are often fairly untrained.

It's often a casualised workforce and often – and sometimes, I should say, of people from non-English speaking backgrounds as well. And that don't necessarily have the training in the use of PPE. One of the things when you use personal protective equipment that is always helpful is if you actually understand microbiology and you understand how infections are passed from people one to another. So if you don't have that basic understanding, even if you've been trained in how to wear a mask and how to put on gloves and such like, you're not always going to be doing that at the same level as people that have that full understanding of infectious diseases. So we felt that it was – if we had a resident in an aged care facility, that it would be very quickly that that would spread to not only other residents but also other workers in that facility.

We're also mindful that aged care facilities are all quite different. There are some that do have – you know, might have ways of being able to isolate a resident or a number of residents in a separate part of the facility but we couldn't be making that assumption about all aged care services. So we weren't – we couldn't be confident that the actual infrastructure or the environment was set up in that way. One of the other considerations for us and one of my teams looks at health licensing. So since 2018 in South Australia we, SA Health, have provided licensing of health services. So we have got quite a strong infection control team. And they take an enormous amount of effort when they go to a new hospital or a new day surgery to make sure that the doors are in the right place and that the sinks are in the right place and such like. There's actually quite a lot to providing an environment which has extremely good infection control.

And we knew that that is not the case in many of the aged care facilities. So this is the reason why we put in our guidelines to – that we would transfer any positive resident straight into the Royal Adelaide Hospital. Now, of course, that is – has some difficulties associated with it. Obviously, we need to make sure our transfer is going to happen quickly and slickly. And I happened to be in Mount Gambier last week and was talking to the health services and also I had a roundtable with the aged care facilities down there, and what we do want is to have the person transferred as quickly as possible and we will be using the Royal Flying Doctor Service to do that rather than have the person go into the hospital and then have a secondary transfer out.

So I guess what we have tried to do with our plan is to work through all of the different scenarios to make sure that it would be feasible. Now, this doesn't necessarily, and may not necessarily work in other jurisdictions but because of the way we have a networked health system we felt that this was the safest option.

MR ROZEN: Just a follow-up question, if I could, about that. It probably goes without saying but the ability to transfer a COVID positive resident from an aged care facility to hospital is going to necessarily depend on the availability of beds at any given moment.

PROF SPURRIER: Yes. Yes. Yes, so we have, again, a very detailed plan of how we will take existing patients from the Royal Adelaide and decant that and a ramp down. And in fact, we had a practice of that when we closed our old Royal Adelaide and moved everybody to our new Royal Adelaide, so fortunately we have a lot of learning from that experience. So again, part of our plan is that we will have room for the aged care residents when and if we need it.

MR ROZEN: Thank you. Just one last question on this topic for you, Professor Spurrier, and I will come back to you Professor McLaws. If tab 10A in the general tender bundle could please be brought up. And I'm not sure if you've got this in front of you, but this is a South Australian Health document entitled Management of COVID-19 in Residential Aged Care Facilities. You would be familiar with this, Professor Spurrier?

PROF SPURRIER: Yes.

MR ROZEN: If you can focus your attention about a third of the way down that page, there's a paragraph that commences:

> *If a resident tests positive to COVID-19 they will be transferred immediately to hospital by ambulance. This is a public health response to ensure the resident has access to appropriate medical care if needed and to protect other residents and staff from exposure.*

If I can pause there, that is consistent with the evidence you have just been giving based on the submission that I was asking you about.

PROF SPURRIER: Yes.

MR ROZEN: The document then goes on:

5 *The resident's family substitute decision-maker will be notified immediately. If a resident has an advanced care directive and they are unable to make their own decisions, their health care wishes will be respected in the hospital setting.*

Can I just ask you about the thinking underlying that, and what I mean by that is if
10 the advanced care directive, for example, is that they don't want to be hospitalised, how can it be respected in a hospital setting?

PROF SPURRIER: Yes, that's a very good question. So what we're seeing here is this requirement from a public health perspective and taking into account the
15 precautionary and the proportionate and the population health requirements in public health to override the request of an individual patient. However, we would absolutely want to support the advanced care directive and this is why we have this statement. So one shouldn't make the assumption that being taken to hospital is about being given higher level tertiary health care, clinical care. It's actually about
20 putting the person who is infectious into a safe environment so that they are not able to pass that infection on to other people. So it's exactly the same reason when we have somebody with a mild clinical infection of COVID in the community, say a young person in their 30s tests positive and we say, well, you need to remain in your home in isolation for the required number of days. And we will enforce that.
25
We give them an order and the police will check on them to ensure that that's complied with. And they are checked, they have a medi hotel – a medi – a hospital at home system wrapped around them so that they get their health care in the home setting. Now, that person's rights as a citizen of South Australia have obviously
30 been overridden by the requirements in this pandemic to not pass on the disease. So normally we don't obviously enforce people into home detention but we are now to avoid the spread of disease. So this is the same here. We are requiring that this person go to the safest place in terms of not spreading the disease any further to other vulnerable residents in that home.
35
MR ROZEN: And finally, Professor Spurrier, is that a practical example of a population focused principle that we discussed earlier?

PROF SPURRIER: Yes, exactly. And I suppose it's also worth noting is our
40 hospitals are very, very familiar with palliative care and the use of advanced care directives and there should be no misunderstanding that being taken to hospital is about being provided with a higher level of care than what that person requests.

MR ROZEN: Thank you. Finally, if I can come back to you, Professor McLaws.
45 In paragraph 9 of your precis of evidence, you make the observation about the necessity for hospital transfers of COVID-positive residents in aged care facilities. Is

the underlying principle there essentially as Professor Spurrier has described? Is there anything you would like to add to that evidence?

PROF McLAWS: Yes, I concur with that. I would just like a correct a misunderstanding. My initial description of the people shedding was those in residential aged care facilities. The positive and negative and asymptomatics were all associated with aged care. I'm not suggesting that we test asymptomatics in the community. It was all aged care and their staff. But yes, one of the problems is that aged care is basically a shared home. The built environments are all different, from cottage to a larger complex. But none of them are set up with best practice for infection prevention and control.

MR ROZEN: It's said by some in support of the proposition that an outbreak can be appropriately dealt with in a residential aged care facility, that facility, for example, has individual rooms, with individual ensuite bathrooms and other such features. There might be the ability to internally cohort, that is, to divide groups positive from negative. What do you say; do you accept that there may well be residential aged care facilities where it is easier to address a COVID-19 outbreak and therefore the need for hospitalisation might correspondingly be reduced? Perhaps if I could ask you, Professor McLaws?

PROF McLAWS: I think that that would be very difficult. It sounds easy when you put it to me but in fact it's very difficult. In a hospital with best practice, what you would find is that staff do not share their care between positive and negative patients. That's best practice. Best practice is you do not have negatives anywhere near positives. So if you could put them totally in a different building that might be okay but, of course, often these rooms or units actually belong or are being given to the residents for the extent of their life. So to move them out so that you could cohort positive people into rooms that have single bathrooms might be okay, but it may cause a lot of distress and disharmony.

But one of the other problems is you have to set it up as they did in SARS in 2002 an area where you could don and doff PPE in separate areas so that you're not ..... the corridors that are potentially now dirty areas. What you need to do best practice is to put on your personal protective equipment, go into the room and then exit in a different manner or take your personal protective equipment off before you exit. But you have to have your mask still on because you don't have enough correct air flow chain to ensure that you're not breathing in particles as you leave the room. Then leave. Where is the handbasin for immediate hand hygiene? I guess you could set up an alcohol-based hand rub and a separate area that you walk to. But it's just not been best practice, best practice to potentially have a separate entry and exit. But they don't always have that in hospitals anyway.

But certainly in an infectious diseases ward, they've set it up so that you're not potentially contaminating your gear and so leaving with your dirty gear on. And you'd have to have staff that have been trained and purposefully trained for infection control of a serious respiratory infection such as this.

5 MR ROZEN: Thank you, Professor McLaws. I will just ask you if you can talk as close to the microphone as you are able to because you are just a little bit hard to hear at our end, and I'm told that the technical support people that the problem is at your end rather than ours. Just one final matter, Professor McLaws, concerning the community transmission increases that we saw in Victoria starting in the middle of June, so I would ask you to accept that the data is that from 16 June there were 20 new cases in Victoria and that gradually increased so that by 1 July, there were 73 and by 8 July, there were 149. We know that masks were made compulsory for aged care workers on 13 July, by which time the number was 249. The question is a
10 simple one: should masks have been made compulsory earlier, in your view?

PROF McLAWS: Absolutely. Masks were universally required in Victoria in the beginning of July. So I am not sure why the residential aged care facilities were considered any different to hospitals, given what we know around the world and
15 what we have known about Newmarch House and anywhere else. So it seems a little unusual that that occurred. And I was looking at the data as the numbers were increasing anyway and, in fact, universal mask use for healthcare workers at the beginning of July was a bit late as well because the numbers in aged care and health providers were starting to ramp up by, well, early July. Before then, June, 25 June,
20 Newmarch had happened and in May, some numbers were starting to occur in residential aged care facilities already in Victoria.

So one of the problems as an outbreak or epidemiologist, it's best to act pre-emptively rather than reactionary and, often, that means putting in place infection
25 precautions such as you've mentioned previously on the precautionary principle. But that's what you do in outbreak investigation and you respond rapidly. One or two cases as they started to increase in June should have been an alert that this is potentially a problem. Now, there could have been in – I'm only going on the public data that I could look at from Victoria but, nevertheless, whether they were staff or
30 residents, that heralds to me a potential problem and a mask is a very cheap and effective method. We now, of course, require healthcare workers in hospitals to wear facial goggles to protect their eyes as well.

MR ROZEN: Finally, Prof Spurrier, if I could just bring you in on this point,
35 because when the Minister for Health, Mr Hunt, announced on 13 July that aged care workers in Victoria would be required to wear masks, he said it was on the basis of advice from the Australian Health – I forgot the name – their Health Protection Principal Committee of which you are a member. Are you able to assist the Commissioners in understanding what was the trigger that triggered that advice by
40 the committee, why was it made when it was made rather than earlier, as Professor McLaws suggested that it should have been?

PROF SPURRIER: Actually, I'm afraid I can't answer that question because AHPPC is a subcommittee of National Cabinet and I can't provide that information
45 outside without seeking prior approval. I'm sorry.

MR ROZEN: That's all right. I know you are not here to speak on behalf of the committee. It is the case, isn't it, that there was no published advice by AHPPC on that issue at that time; is that right?

PROF SPURRIER: Yes, I just – if I could make another point on the use of masks?

MR ROZEN: Yes, please.

PROF SPURRIER: So we're obviously in a different situation in South Australia but, again, looking at what we have learnt already in Australia, so we will be looking at making masks mandatory in aged care facilities for times when staff are doing close care, so 1.5 – you know, within that 1.5 to 2 metre range because of the vulnerability of the residents. Now, that is definitely very precautionary given that we don't have any, or at least any major problems, with the disease in our State. But some of the reasons behind that, and we have spent some time talking to the industry, is actually getting people used to wearing the masks and getting them used to using PPE and also getting the residents used to seeing somebody wearing a mask as well, rather than it happening all of a sudden. So this is something that our Police Commissioner, who is our State Commander, is considering and that may well be put into a direction. It isn't at the moment.

MR ROZEN: Thank you very much, Prof Spurrier. Thank you, Professor McLaws. Commissioner Briggs, do you have any questions for the panel members?

COMMISSIONER BRIGGS: Thank you counsel. Yes, I do. The first is quite a straightforward one to Professor McLaws and that is in the case of elderly residents who are confused with dementia or other conditions, can the COVID test be effective using faecal matter?

PROF McLAWS: Not every COVID patient will excrete virus in their faecal material. Certainly, I've been doing work in wastewater sampling for packaging and I know that some of my colleagues are testing it for COVID. One of the problems is that not every person excretes it and when they do, it doesn't mean that they are either infectious – it could mean they were infectious so ..... so it doesn't tell you which – what phase of the infection they are at.

COMMISSIONER BRIGGS: Thank you. My second question is specific, firstly to Prof Spurrier but I might ask the same question of you, Professor McLaws. Prof Spurrier, if you were in another State, say, Victoria, would you be recommending compulsory hospital transfers for any people in aged care diagnosed with COVID-19?

PROF SPURRIER: I can't answer that question because I am not familiar with the healthcare system of that State. Now, it is very dependent on knowing how your hospitals are set up and how they are networked and what the governance is for that system. So I really find that is an impossible question for me to answer.

COMMISSIONER BRIGGS: Thank you. What about you, Professor McLaws? We can't hear you at all, I'm afraid.

PROF McLAWS: Sorry. Let me just check my - - -

5

COMMISSIONER BRIGGS: You are better now. We could hear you then.

PROF McLAWS: Okay? Is that better? Sorry.

10 MR ROZEN: Yes. Thank you.

COMMISSIONER BRIGGS: Yes.

PROF McLAWS: Okay. From a WHO perspective, I will make it very clear that
15 it's very difficult to keep negative residents safe. So regardless of each State's ability to take residents into hospitals, they need to be decanted, they need to be removed and put somewhere else that's safe, looked after by highly trained staff. Given that, both negative and positive residents have equity. They do have a right for good health and care, which basically means that negative residents have a right
20 to remain negative. So we do know from New South Wales' experience, from the United Kingdom, Ireland, Hungary, the US, Germany, and I could go on, that the evidence is that the attack rate once you get a patient – sorry, a resident that is positive in a residential aged care facility, it's very difficult to keep the rest safe, and the attack rate can go from anywhere between very negligible up to 100 per cent so
25 it's very difficult.

So I would be suggesting that the positive resident needs to be put somewhere away from the main building, either in hospitals, in purpose-built facility that has proper or can have proper airflow change. During SARS 2003, they didn't know if they were
30 dealing with aerosolised or droplet particles but they made this SARS designated hospital, negative air pressure rooms, 100 per cent in 72 hours. They begged and borrowed proper filters and they put in proper air conditioning so that they could provide negative air pressure. Now, I'm not suggesting that this is an aerosoled transmitted infection but you never know if you're going to have to do an aerosol
35 generating procedure.

Secondly, we have at WHO – I can't tell you. I've signed five confidentiality agreements but I can tell you that at the moment, we are seriously talking about the problems of regardless of what size the particle is, of a very low airflow and how it
40 does encourage transmission regardless of whether it's through droplet or air aerosoled particles. So my stance is you need to either put them in what's called ICU pods, but one of the problems is you can't even hire those to put them on some of the campuses because they are – some of these aged care facilities are cottages or homes, but there are such things that you can hire to keep people in a very safe place and
45 keep healthcare workers safe while they are caring for them. Other than that, a hospital is the best place for them. Thank you.

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Just one .....

5 COMMISSIONER BRIGGS: That's it from me.

MR ROZEN: Thank you, Commissioner Briggs. Just one matter arising from that evidence that you just gave. You used the expression, Professor McLaws, "attack rate". Is that the rate at which the virus spreads, essentially, is it?

10

PROF McLAWS: Correct, yes. Sorry for that. It's the proportion of cases that occur within an aged care facility. So of all of those that are in an aged care facility, you may be able to prevent 99 per cent or you may get 100 per cent of residents acquiring COVID.

15

MR ROZEN: Thank you. Commissioner Pagone, do you have any questions for the witness?

COMMISSIONER PAGONE: Thank you, Mr Rozen. Professors, thank you both
20 very much for your assistance in our inquiries. It has been exceptionally helpful and a very informative way to begin the process this morning. So I thank you both very, very much indeed for the time you have made available and for the evidence you have given us today. Thank you.

25 PROF McLAWS: Thank you.

COMMISSIONER PAGONE: Mr Rozen, we might have a briefer adjournment, perhaps 10 minutes.

30 MR ROZEN: Yes.

COMMISSIONER PAGONE: And we will resume in 10 minutes time.

MS DOECKE: Commissioner, it's Ms Doecke from the State of South Australia.
35 May it please. May I be excused from further attendance in this hearing block.

COMMISSIONER PAGONE: Yes, of course. Thank you.

MS DOECKE: Thank you.

40

PROF SPURRIER: Commissioner, I did have one other thing I could add but I wasn't sure if I was going to be asked for an opportunity.

COMMISSIONER PAGONE: Well, I think you should add it if you can.

45

PROF SPURRIER: Thank you. So this is another consideration for why it would be preferable to have a positive case in an aged care facility shifted. One of the

things that we noticed in South Australia, and I think was noticed in other States, was that when we – in our initial directions across the nation to shut down and lock down nursing homes and restrict visitors, it meant that, of course, there was not that other set of eyes in terms of the residents' family to see how things were going for that
5 particular resident.

And, unfortunately, there was an overreach, which you may be aware of, so that some facilities shut down completely and the families were not able to visit. One of the things that I have noted, and I'm sure people are also aware of, that in Victoria
10 when they have now had the crisis with some of the aged care facilities, it has been very difficult for family to be able to see their loved one and that's obviously extremely traumatic. One of the positives about having a positive COVID patient in a hospital setting, because of the more sophisticated use of PPE, it would allow, I believe, a better ability for the family to spend some quality time with their loved
15 one. Thank you.

COMMISSIONER PAGONE: Yes. Thank you. That was a very important addition. Thank you. And for that additional remark as well. And I formally need to excuse you from further attendance, so thank you and you are excused.
20

PROF SPURRIER: Thank you very much.

<THE WITNESSES WITHDREW [12.14 pm]
25

COMMISSIONER PAGONE: We will adjourn now for 10 minutes.

30 **ADJOURNED [12.14 pm]**

RESUMED [12.25 pm]

35
COMMISSIONER PAGONE: Mr Bolster.

MR BOLSTER: Thank you, Commissioner. I call Ms Merle Mitchell.

40
<MERLE VALMA MITCHELL, AFFIRMED [12.25 pm]

<EXAMINATION BY MR BOLSTER
45

MR BOLSTER: Ms Mitchell, could you state your full name, please.

MS MITCHELL: Merle Valma Mitchell.

MR BOLSTER: And where do you live?

5 MS MITCHELL: In Glen Waverley, in the Waverley Aged Care Facility.

MR BOLSTER: Have you prepared a statement in this matter?

MS MITCHELL: I have.

10

MR BOLSTER: And have you got a copy of that in front of you now?

MS MITCHELL: No, I don't actually, but it's in my head.

15 MR BOLSTER: Okay. All right. For the record, Commissioners, the statement is document ID WIT.0107.0001.0001, and I tender that statement.

COMMISSIONER PAGONE: Is that not part of the bundle already?

20 MR BOLSTER: No.

COMMISSIONER PAGONE: All right. That will be exhibit 18-5.

25 **EXHIBIT #18-5 STATEMENT OF MERLE MITCHELL (WIT.0107.0001.0001)**

MR BOLSTER: Now, Ms Mitchell, you gave evidence in May last year in which
30 you described your experience of having lived in residential aged care since 2016.

MS MITCHELL: That's correct, yes.

MR BOLSTER: And the facility you live in is located in Glen Waverley in
35 Melbourne?

MS MITCHELL: That's correct, yes.

MR BOLSTER: How many people live with you there at that facility?

40

MS MITCHELL: I think it's about 130 at the moment.

MR BOLSTER: Has that facility had any positive COVID-19 cases amongst the residents that you're aware of?

45

MS MITCHELL: No. We've been very lucky. We haven't had any.

MR BOLSTER: And what about the staff?

MS MITCHELL: And we haven't had any staff person with it either.

5 MR BOLSTER: All right. And you, as you say in your statement, you're currently living in state of lockdown; that's correct?

MS MITCHELL: That's right. That's correct.

10 MR BOLSTER: Tell us what does the word lockdown mean for you and the other people that are living in your facility at the moment?

MS MITCHELL: Well, it means that I'm in my own room. The only time I can go out of this room is when I've got a physio session, and that happens four times a
15 week. Otherwise, from the time I wake up to the time I go to sleep, I'm sitting in my own room in my one chair.

MR BOLSTER: Do you have a window?

20 MS MITCHELL: I can look at a brick wall, but that's all; there's nothing else to look at.

MR BOLSTER: Can you see a tree or a garden from where you are?

25 MS MITCHELL: No, I can't, not the way the building is constructed, yes.

MR BOLSTER: And how long have you been in lockdown?

MS MITCHELL: We went down – overall, it's been a couple of months we've been
30 in lockdown; once for about three weeks and then we had two weeks without being in lockdown. And then suddenly we were in lockdown again. So we've been in lockdown for quite a long time.

MR BOLSTER: When did you last – well, I withdraw that. Your daughter, she has
35 helped in you in the past with a lot of the things you need to get done to live; correct?

MS MITCHELL: Yes. Yes, but she's not allowed to come any more.

40 MR BOLSTER: When did you last have some physical contact with her?

MS MITCHELL: I was lucky enough to have a birthday a couple of weeks ago and I saw her then, and that was only through an open window that was two inches open. But that's the last time. And - - -
45

MR BOLSTER: Was she - - -

MS MITCHELL: Yes, sorry.

MR BOLSTER: Was she outside in the cold, was she?

5 MS MITCHELL: She was, indeed. I was in the warm place but struggling with the sound – with the noise in the room behind me.

MR BOLSTER: Now, are you able to have any video contact with your daughter, and speak to her that way?

10

MS MITCHELL: Yes, I can but I would rather use the phone. So I use the phone, yes.

MR BOLSTER: Is that enough for you, to talk on the phone or on the computer?

15

MS MITCHELL: No, I'm a people person. I like to see people in, you know, as they are, not through – not through the phone, yes.

MR BOLSTER: What about – sorry, you go on.

20

MS MITCHELL: But I understand why we're in this situation and that we've got to put up with it until the – until things change, yes.

MR BOLSTER: So in your statement you say that the lockdown originally

25 happened in about February of this year.

MS MITCHELL: Yes, that's right.

MR BOLSTER: How has the lockdown changed over time? Has it been relaxed in

30 any way?

MS MITCHELL: No, it has got worse. The first lockdown, my daughter was able to visit, and we used a glass screen between us. Prior to that, she was able to come once a week to help me with things that I needed help with. And then that

35 progressed to just one visit with a glass wall between us, or a glass screen. And now we can't have any visitors at all.

MR BOLSTER: Now, was there any talk about the lockdown coming to an end in May and early June when things were looking relatively good on the COVID front?

40

MS MITCHELL: We probably hoped that it was going to go away. That was, yes, nobody said it is going to go away, we just hoped that we would go back to where we were.

45 MR BOLSTER: How were you kept informed by the facility management about what was going on?

MS MITCHELL: The general manager sends out a letter every Monday to let us know where things are at and that's when he details who we can have as visitors and who we can't.

5 MR BOLSTER: And you mentioned that there's a rule about what has to happen if you go outside to see a doctor; do you recall that?

MS MITCHELL: That's right. Yes, I have to go into isolation for two weeks. In isolation means I go into a very small room without a window. This is my first
10 experience. And I don't see anybody except the people who bring the food in to me. So it really – it's a real lockdown, yes.

MR BOLSTER: How many people are you aware of that take that option when they have to go and see a doctor or get some treatment?
15
MS MITCHELL: People are encouraged not – not to keep those appointments and so they have to go without, yes, as I have done with two fairly essential appointments that I have but I've decided it's better not to go.

20 MR BOLSTER: Does your GP visit you in the facility?

MS MITCHELL: Yes, he does, yes.

MR BOLSTER: When the GP comes, he or she, do they wear a mask or personal
25 protective equipment?

MS MITCHELL: Last time I think he did, yes. He wore a mask, yes.

MR BOLSTER: And does the facility encourage you and the other residents to wear
30 a mask?

MS MITCHELL: No. All of the staff wear them but not – but not the residents, yes.

35 MR BOLSTER: So the staff wear the full face mask, do they?

MS MITCHELL: Yes, I think.

MR BOLSTER: Or do they wear one of these surgical masks?
40
MS MITCHELL: Yes, it's a surgical mask that they use, yes.

MR BOLSTER: And no one has suggested that the residents should wear the masks at this stage?
45
MS MITCHELL: Not at this stage no, unless they're going out and then they take a mask with them, yes.

MR BOLSTER: Ordinarily, would you be going out to visit friends, even though you are living in the facility?

MS MITCHELL: Yes, I'm a great user of the multipurpose taxis where I can have
5 my wheelchair. I can be wheeled in my wheelchair up into the taxi and taken to wherever I need to go but I'm missing that very, very much, but I understand why.

MR BOLSTER: Have you observed there to be more or less staff available to help you during this period?
10
MS MITCHELL: It's about the same. I have sent a number of messages to say because of the extra responsibilities that the staff now have, they really need to put, at times, particularly in the mornings, at mealtimes and going to bed times, they need extra staff. But that hasn't happened.
15
MR BOLSTER: Can you give us an example of the sort of extra responsibilities that you have seen the staff - - -

MS MITCHELL: Well, because we all eat in our rooms, for example, they have to
20 bring our meals to us and have to collect the tray after we have finished. And so if we're having a cup of tea, they have to bring the cup of tea around to us. There's much more responsibilities that they have.

MR BOLSTER: You mentioned that the physio can come in and see you.
25
MS MITCHELL: Yes.

MR BOLSTER: Is that a regular appointment?

30 MS MITCHELL: Yes, four times a week. But we have lost our masseuse, so no longer can I have the massage which is very much part of my care plan. She has been told that she is not an allied health worker and so she can't practise any more.

MR BOLSTER: Is the physio able to make up that gap that you're missing with the
35 masseuse?

MS MITCHELL: No, not really, no. No, it's a real gap now.

MR BOLSTER: And what does that mean for you?
40
MS MITCHELL: I guess it means that it just – I just don't get the relaxation of my muscles that Kim was able to give me. So I try and do it for myself as much as I can. But I really think that they are a very essential part of anyone's care if they have mobility problems.
45
MR BOLSTER: What about getting your hair done and other personal choice matters?

MS MITCHELL: Well, hairdressers are banned; they're not allowed to be here. And that causes enormous problems for lots of people. Where this was their only job that they had, yes.

5 MR BOLSTER: When were you last able to get your hair cut, Mrs Mitchell?

MS MITCHELL: I reckon a couple of months ago now. I was due to get it when we went into lockdown on the very day that they brought it in, so the timing was not good.

10

MR BOLSTER: What's it like living in aged care in Melbourne, as you see the numbers around you in the other facilities going up day by day? How does that affect you?

15 MS MITCHELL: Well, I think I've got to the stage of being accepting. You know, I know I'm here until I die, so every morning when I wake up I think "Damn, I've woken up" but I'm here until I die, so I've got to make the best of it and that's what I try to do. Which is not to say that I'm not being cared for, but I am sure if you really asked most people here they would all say they would rather be dead rather than

20 living here, if they're honest, that is.

MR BOLSTER: What have you seen of the effect on the people that live with you? How do you see them coping with the lockdown?

25 MS MITCHELL: I think for those with dementia it has been very difficult. I don't think they understand why the lockdown, why family are not coming with them – coming to see them. Many people here had family who came in every day, at least once a day. They helped with feeding people. They helped with all sorts of little things, just companionship really, and that has all gone and I think that's – that's had

30 a very, very bad effect on those people and their families.

MR BOLSTER: What leads you to that conclusion? What do you see in their behaviours and the way they interact with one another?

35 MS MITCHELL: I have had one experience over the last few days of one of the residents who starts off by coming in and saying, "You've got my coat" and I say, "No, no, no, this is Merle's room, you're in a different room now" and so she goes off and she finds somebody to come with me and the next thing I look up and they're sorting through my books to find her coat. And that's – look, I accept that. It's part

40 of their dementia that's creating – and their loneliness if the families are not here and that's their – you know, a natural reaction for them, really.

MR BOLSTER: Last year you were asked about the experience of moving into aged care and I want to read back to you what you said, and I want to get your

45 impression about whether things have changed whether they've got better or whether they've got worse. This is what you said. You said:

It was terrible. There's a shock when you moved into aged care. There's the shock of loss because what happens is it is so quick. There's not the recognition of loss because loss is not just death. Loss is loss of your way of life.

How has what's going on in Melbourne now changed you since you made that statement?

MS MITCHELL: Well, I think I pretty much feel the same way. There has been a change in some of the training of staff but I still have staff say to me, when I say I would rather be dead, and I get growled at for saying that, "You must not say that. You mustn't have negative thoughts." Well, they're my thoughts and I, you know, I own my thoughts. But I think for staff still there's even though they are surrounded by death all the time, it's very difficult to actually acknowledge that people feel that way and they don't want you to be expressing that.

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

COMMISSIONER PAGONE: Yes, thank you, Mr Bolster. Commissioner Briggs, do you wish to ask anything?

COMMISSIONER BRIGGS: No, I don't. Thank you.

COMMISSIONER PAGONE: Thank you. Ms Mitchell, thank you for making yourself available. I know that you have given us a lot of time for two sets of hearings now and you have given us a lot of time for this hearing with the written evidence that you have given us and now this morning. It's very important for the whole nation to hear the evidence of people like you and we're very, very grateful to you for having done that. I do thank you very, very much and I hope that things will improve. Thank you. I think I now must formally excuse you from any further attendance so that you can't be dragged off to prison inadvertently. Thank you.

MS MITCHELL: Thank you.

<THE WITNESS WITHDREW [12.43 pm]

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioner. I call Ross Low and Melanie Dicks.

<ROSS GREGORY LOW, SWORN [12.44 pm]

<MELANIE DICKS, SWORN [12.44 pm]

MR ROZEN: Mr Low, could you state your full name, please, for the record.

MR LOW: Ross Gregory Low.

5 MR ROZEN: And you are the chief executive officer of – I will get it right, BaptistCare New South Wales and ACT; is that right?

MR LOW: I am.

10 MR ROZEN: Thank you. And Ms Dicks, your full name please.

MS DICKS: Melanie Dicks.

MR ROZEN: What is your current position, Ms Dicks?

15

MS DICKS: My current position is the residential operations manager for southern region for BaptistCare New South Wales ACT.

MR ROZEN: And in that capacity, you were part of the expert panel review
20 committee during the outbreak earlier this year at Dorothy Henderson Lodge; is that right?

MS DICKS: I will give you a bit more clarification. I as actually asked by – Dorothy Henderson Lodge sits in the Sydney region for BaptistCare. So .....
25 BaptistCare to come in and support the operations during the outbreak management for Dorothy Henderson Lodge. So came in to support and was – was joint operations manager for the outbreak with the Sydney region operations manager.

MR ROZEN: Thank you. What's your background, Ms Dicks?

30

MS DICKS: My background is as a registered nurse. I've got 27 years experience in health and aged care. I have tertiary qualifications in nursing and health service management, and for the first 30 years I've worked in aged care and not-for-profit in strategic and operational roles.

35

MR ROZEN: How long have you been working for BaptistCare?

MS DICKS: Since January 2019 so about a year and a half.

40 MR ROZEN: Mr Low, I neglected to ask you but how long have you been CEO?

MR LOW: 10 years.

MR ROZEN: Prior to that did you hold another position within BaptistCare?

45

MR LOW: Yes, I had worked for a previous six years and was in a business strategy role and then in to chief financial officer position.

MR ROZEN: And going back further still, if we can, any previous experience in aged care?

MR LOW: I was on the board for four years prior to joining BaptistCare in July of
5 2004.

MR ROZEN: Now, I'm sure the two of you don't need to be reminded that Dorothy Henderson Lodge was the first aged care home in Australia to face an outbreak of COVID-19. The outbreak commenced on 3 March of this year and was declared
10 over on 7 May; is that right, Mr Low?

MR LOW: It is indeed, yes.

MR ROZEN: And BaptistCare ACT and New South Wales responded to the
15 Commissioners' call for submissions about COVID-19 and its impact on the aged care sector. Again, that's right, isn't it, Mr Low?

MR LOW: It is, and, in fact, we had decided even prior to receiving the request from the Commission that we would make a submission under those circumstances.
20

MR ROZEN: And why was that?

MR LOW: Because we had hoped that we would be able to learn – or leave lessons with the industry and in general as to how to cope with an outbreak of COVID-19
25 within a facility.

MR ROZEN: In relation to that, the submission makes clear that in addition to providing the submission to this Royal Commission, you have taken other steps to disseminate lessons that your organisation learnt. Can you briefly summarise those
30 for the Commissioners?

MR LOW: Yes, I attended a forum in Canberra on Friday the 6th of March, and spoke to a large number of the peaks down there, plus the government departments and quite a number of CEOs of larger organisations. That was obviously in very
35 early days and our learnings were still coming. I then did a webinar with ACSA and a further webinar with LASA and have spoken to a number of not-for-profit and for profit company organisations to help them understand how to cope with an outbreak of COVID-19.

40 MR ROZEN: For the benefit of anyone following that is not familiar with the acronyms that we all know in aged care, ACSA and LASA are both peak organisations.

MR LOW: Yes, they are indeed.
45

MR ROZEN: Representative organisations.

MR LOW: Yes.

MR ROZEN: Thank you. Sorry, I might have cut you off there. Are there any other things that you have done that you would like to relate to us by way of
5 disseminating the experiences more broadly?

MR LOW: No, I think that's the main areas that I've been involved with and obviously very involved in crafting the submission to the Commission.

10 MR ROZEN: Yes, I will take you to some aspects of that in a moment but in addition to that submission, BaptistCare Australia has also provided a submission to the Royal Commission, has it not?

MR LOW: It has, indeed.

15

MR ROZEN: And are you able to – sorry, I withdraw that. Were you involved in the development of that submission as well?

MR LOW: To some degree I was but obviously the Dorothy Henderson Lodge
20 submission, which was running concurrently took up a greater part of my time. The BaptistCare Australia is organisations of each of the organisations in each State and Territory, and a lot of that input was predominantly done by Victoria, linked with our own company secretary, out of New South Wales, but also from Victoria – sorry, from Queensland and from Western Australia had significant input to it.

25

MR ROZEN: And in terms of the size of the organisation, in your submission – which I will ask to be brought up, it's at tab 14 of the Dorothy Henderson Lodge tender bundle, exhibit 18-2. Do you have a copy of the ACT and New South Wales submission in front of you, Mr Low?

30

MR LOW: Yes, I do.

MR ROZEN: All right. If you could turn your attention to page 2 of that submission, please, paragraph 2.1. You inform the Commission that BaptistCare is
35 quite a large organisation with more than 160 facilities and programs through New South Wales and the ACT; is that right?

MR LOW: That's correct. They're not all aged care. A number of those are in the community services areas.

40

MR ROZEN: Yes. Are you able now to indicate how many of them are residential aged care facilities of that 160?

MR LOW: It would be probably in the order of 40 or 50 would be aged care.

45

MR ROZEN: Thank you. And this may be a difficult question to answer and if so I apologise but there are also home care clients who are serviced by BaptistCare; is that right?

5 MR LOW: Yes, indeed. We have about 9000 clients throughout New South Wales and the ACT in the home service area.

MR ROZEN: Right, thank you. Now, both the submissions – both the one from the New South Wales organisation and the one from the national organisation, have been 10 very, very beneficial to the work of the Royal Commission and on behalf of the Commissioners, I thank you for them. In the time available, and I'm only going to be able to take you to a few of the key points that are made, but I don't want you to get the impression that the rest of it is not helpful because it certainly is. We also have the benefit here of a report prepared by Professor Gilbert in relation to the 15 outbreak at Dorothy Henderson Lodge which contains very valuable information that we will explore with her later today.

So I would like to start by asking you about the topic of infection control, and the lessons that emerged from your experience. This might be more a question for you, 20 Ms Dicks, than for you, Mr Low, but perhaps – sorry, if I could start with you, Ms Dicks, and draw your attention to paragraph 6.3.3 on page 10 of the submission. What the Commissioners are informed of there, Ms Dicks, is that very shortly after the first notification of the outbreak, you were notified of that by the chief health officer that a staff member at Dorothy Henderson Lodge had tested positive. And 25 there was then an escalation through the North Sydney Local Health District and the public health emergency operations. Am I getting these terms right? NSLHD is North Sydney Local Health District and PHEO is Public Health Emergency Operations; is that right?

30 MS DICKS: That's correct.

MR ROZEN: And within 24 hours that occurred and on 4 March you had infection protection and control specialists from the Clinical Excellence Commission and Dr Branley on site. So dealing firstly with the infection protection and control 35 specialists from the Clinical Excellence Commission, had you had any exposure to the Clinical Excellence Commission before 3 March this year?

MS DICKS: No, we hadn't.

40 MR ROZEN: You didn't have an existing role.

MS DICKS: ..... to the group.

MR ROZEN: What about the Local Health District, had you had some dealings 45 with them?

MS DICKS: So there's a couple of statements in relation to that. So this is not normally my region so I had come as an extra support for Dorothy Henderson. What I can make as a statement is that in my own region and our organisational protocols are that we do work with the public health of the Local Health District during outbreak management and with infection control. So we absolutely have that relationship and so that is the first statement for that. And then they did escalate it to the Clinical Excellence Commission for us.

MR ROZEN: And if I'm understanding what is said in the submission, that process by which you had access to expertise from the Clinical Excellence Commission was initiated by them, by New South Wales Health; is that right?

MS DICKS: That's correct. Absolutely.

MR ROZEN: Can you tell the Commissioners, from your perspective – and I should just clarify, on what date did you become involved in the Dorothy Henderson response? Were you there from day one, Ms Dicks?

MS DICKS: No, I became involved 24 hours later in the evening of 4 March. So I commenced on the 3rd. So it was 24 hours before I came on site and by that particular point, Public Health Emergency Operations and the Clinical Excellence Commission had commenced their involvement with supporting us through the outbreak.

MR ROZEN: All right. Can you just give us an overview of that role; how did that work on the ground, the work of the Clinical Excellence Commission staff?

MS DICKS: So the Clinical Excellence Commission specialist came on site. That was Kathy Dempsey and she was absolutely working in conjunction with public health who had also come out on site in the prior 24 hours and public health from Northern Sydney Local Health District had come out as well. So with the collaboration of the information that she received, she looked and reviewed our infection control program. She identified the local elements of the aged care service as well, so the specific support for people with a dementia diagnosis was a key element of that assessment and made an assessment and recommendations to infection control practices and procedures that we implemented.

MR ROZEN: And that involvement, was that just on 4 March or was that an ongoing involvement in responding to the outbreak?

MS DICKS: So they came on site initially and regularly to provide auditing for us and was a regular contact and provided support and advice, not always on site, sometimes through telephone.

MR ROZEN: All right. And you've said there that they were complemented in that role by Dr Branley who is an infectious diseases specialist, so he is obviously a physician, not an infection control specialist in the way that Ms Dempsey is. Are

you able to explain how those two roles complemented each other from what you could see in the response to the outbreak? What was it that Dr Branley brought that Ms Dempsey wasn't doing and vice versa, if you like?

5 MS DICKS: Dr Branley brought information and knowledge around COVID-19. He had participated in outbreaks internationally prior to that point. So he had provided some information and suggestions in relation – information and suggestions in relation to the management on site given his practical experience. So the Clinical Excellence Commission was able to provide the parameters. They were also dealing
10 with New South Wales Health at that particular time because Ryde Hospital had already commenced their outbreak as well. So the interaction between Dr Branley and Kathy Dempsey and New South Wales Health, it was a learning environment. There was a lot of information that wasn't known about the virus at the time and how the infection control procedures applied to it. So it was very collaborative to have
15 that opportunity initially because it was the first outbreak in aged care.

MR ROZEN: Yes. At 6.1.1 of the submission on page 15, if I could just ask that the bottom of the page be brought up. The submission there makes the point that you had well-established infection control policies and processes in place that were
20 consistent with your obligations as a provider. I want to try and unpack that a little bit if I can. Had those policies and practices been put in place to meet the previous infection control outcome of number 4.7 in the previous aged care standards; is that the point you're making there? Does that make sense? You know before 1 July 2019 we had a previous set of Aged Care Quality Standards. Are you familiar with
25 that? I'm sure you are.

MS DICKS: I am.

MR ROZEN: The accreditation standards, one of them dealt expressly with
30 infection control, 4.7.

MS DICKS: I understand. So what I'm hearing from you is your question is, were the infection control procedures responsive to the previous standards and not the current ones? And the answer to that is no, we had infection control procedures in
35 place that respond to the current standards. The challenge that – and what we were trying to represent in this submission was that the crisis nature of the COVID-19 outbreak was unlike previous outbreaks that we had experienced.

MR ROZEN: Yes .

40

MS DICKS: So aged care organisations regularly have to manage influenza and gastroenteritis outbreaks. The presentation of COVID-19 and the immediate crisis, particularly in relation to the contact assessment and loss of staff, challenged our infection prevention and control management in a way that we hadn't seen prior.

45

MR ROZEN: I understand. I'm just trying to identify what the differences were to your previous outbreak experience. So there's the impact on the staffing. It has been

said that one of the significant differences between an infection control response to COVID-19 on the one hand compared to influenza on the other is that with influenza, you have at least got a critical mass of staff that have been vaccinated in relation to influenza. Are you able to comment on that?

5

MS DICKS: So on the differences?

MR ROZEN: Yes.

10 MS DICKS: Absolutely. So there are a number of differences and the timing of Dorothy Henderson's outbreak is also important. We were the first community contact transmission of the disease as well. So it was only within the previous week that the first cases had been identified in Australia. So we had commenced an outbreak management of a virus which nobody knew all of the answers in relation to.
15 So – and it was not usual for us to lose a high contingent of our staff to contact tracing because you wouldn't normally – you wouldn't normally lose that many staff in an influenza outbreak or a gastro management, so that was one of the first significant differences.

20 The concern and the distress of the community was the second element that we were dealing with at that time, and it was an unknown outbreak and the management of it and concerns around how health services and – health services may be able to support the community, particularly community that may need to access acute care services. So that was a consideration in the conversation as well. And what
25 subsequently became an issue was the ability to access resources, such as personal protective equipment as well, which we normally import internationally for some of those elements, so supply of those. None of those things had been a challenge in previous outbreak managements that I had been involved in.

30 MR ROZEN: I understand. Can I bring you in there, Mr Low, in relation to the impact on the staffing question. Was one of the challenges that you faced with Dorothy Henderson managing the fear of the staff and can you tell the Commissioners a bit about that? How did that manifest itself and what did you do?

35 MR LOW: Yes. A lot of the staff had an immediate concern, in a sense, about their own wellbeing and, particularly, with regards to those that then would go home to their family and would they be transferring the virus out to their homes. So one of the things that we did was to create a video with Dr James Branley and Kathy Dempsey to help us or help people begin to understand how to work with the virus
40 and, particularly, to use their hands, as he would say, as the vector and the sense was up through the face, so as long as you keep your hands very clean and clear and continue to wash your hands regularly, then the spread of the virus is very low in relation.

45 That had an enormous impact on our other staff as well because other facilities were also being concerned about, you know, would they pick up a virus in a community sense and bring it into that individual facility. So that way of looking at the video

right across our organisation was very helpful, as well as being, obviously, very helpful for Dorothy Henderson Lodge.

MR ROZEN: There was no Commonwealth-funded surge workforce available to you, was there?

MR LOW: No, not at all. In fact, I am sure from us, the development of the surge workforce became, you know, a priority and certainly a criteria for any further outbreaks.

MR ROZEN: Were you able to draw on staff from other facilities as a relatively large-scale aged care provider?

MR LOW: Yes. I put a plea out to our staff and we had quite a number of volunteers to come across. We were also working with the New South Wales Health and they were able to give us a number of carers and registered nurses. And we, in a sense, begged and borrowed people from all over the place, once we had lost our staff, to create that gap until we were able to then work in with Healthcare Australia as a provider of the resources going forward.

MR ROZEN: At paragraph 6.4.5 of the submission on page 13, you detail or list a number of strategies with Healthcare Australia to attract agency and other BaptistCare staff and they involved increasing pay rates, aligning them to acute sector pay rates and other adjustments to working conditions. A simple question: did those strategies work? How did you find that?

MR LOW: They did work and I think it was appropriate that we did that because it just gave us that opportunity to take away that question. I think quite a number of them would have said that they were happy to come. That just made it all that more simple and easier for them to make that decision as well.

MR ROZEN: As I'm sure you are aware, Mr Low and Ms Dicks, the aged care workforce is of great interest to the Commissioners in their work even beyond COVID-19. Are there lessons from that experience about how we can perhaps attract and retain more workers in the aged care workforce and particularly those with clinical skills?

MR LOW: I think one of the things we have done since is to gather a list of people that would be able to come to a particular facility if an outbreak took place so that we would not have to send the plea out. We would have the outbreak and we would be able to immediately look at that list, approach those people that work for us currently and say to them that they are now required to be at a certain facility, and they would be able to move across very quickly to take up the roles that we would designate for them. So that has been one of the learnings that we have been putting into place in a sense as a reserve workforce to be able to go forward.

MR ROZEN: Ms Dicks, is there anything you would like to add on that topic of workforce?

MS DICKS: I think the one thing to add to that is these outbreaks have highlighted the need to understand what aged care services do provide as well and the way that that interacts with the health services, and the important interaction that both have a component within the health spectrum as well for that. And at the moment, the respect for the health worker as well for the magnitude of the roles they are undertaking is important in attracting people to the industry.

MR ROZEN: I will come back to that but I think I'm about to go on to a new topic, Commissioners. It might be an appropriate time to break for lunch.

COMMISSIONER PAGONE: Yes. This session is due to go on after lunch in any event, so we will resume at 2 o'clock.

ADJOURNED **[1.09 pm]**

RESUMED **[2.00 pm]**

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: Thank you, Commissioner. Mr Low and Ms Dicks, you can hear me all right, I hope?

MS DICKS: We can.

MR LOW: Indeed.

MR ROZEN: Thank you. We got to a point before lunch where I had been asking you some questions about the impact of the response to the outbreak on staffing, and I want to change topics now and ask you about another matter raised in the submission at 6.9, which is on page 21. If I could please ask you to turn to that. The heading there is Access to Acute Healthcare Hospital, Including Pathology and Ambulance Services. You make the observation which many witnesses are making in this hearing at 6.9.1 that:

> *Interagency dependencies are crucial to aged care and became even more crucial when managing the outbreak.*

You say you had a good experience due to the close working relationship between government stakeholder during this time but there were some challenges. Can I just ask you a little bit about the importance of having relationships in place in advance of an event like the outbreak at COVID? And maybe this is one for you, Ms Dicks,

perhaps not so much in relation to Dorothy Henderson but in relation to your day job, if I can call it that. Can you explain a little bit to the Commissioners about the nature of the relationship? You touched on this earlier about the Local Health District. How important is that so that you've got that groundwork, so that you're not all
5 meeting at the time of the outbreak? Can you deal with that, please?

MS DICKS: Absolutely. Prior to an outbreak, there has to be a good working relationship between the local health districts and aged care providers because of the interchange between our service provision and what they provide. And so many of
10 the services aged care people in facilities use are still sitting in the health services, so there really needs to be an understanding. We can't do it without the health service and nor can the health service do it without aged care services. So an understanding of how operations and the resources occur and how that interaction will happen is paramount to this process.
15

MR ROZEN: I meant to ask you – you go, please.

MS DICKS: Sorry. And it also includes plans and agreement of roles and responsibilities, which is important to predetermine, but at the commencement of an
20 outbreak, all of those issues need to be assessed. So to understand that the right people are making decisions and understand what is happening for the operations because the other component to this is each aged care service, just as each health district, is different, so the partnerships need to understand the local specifics of each service and how they will interact.
25

MR ROZEN: I meant to ask you earlier, Ms Dicks, and I neglected to in the context of infection control expertise. I meant to ask you to reflect on any differences there might have been between the experience at Dorothy Henderson and the later experience you had at Newmarch House when you went over there as part of the in-
30 reach management team that was – that came from BaptistCare. It was a different experience there, wasn't it, with infection control expertise? You didn't have that immediate on-the-ground expertise. Can you discuss the differences from the point of view of responses to the outbreak between Dorothy Henderson and Newmarch House in that respect?
35

MS DICKS: Absolutely. In relation to Dorothy Henderson, we did have infection control expertise that had come from, initially, the Local Health District and then from the Clinical Excellence Commission immediately on outbreak. And what was paramount for us was those relationships and the collaborative approach that we
40 undertook, that we all understood what we were trying to achieve and how we were going to achieve it and understanding the operations, and because I was inherently involved in the evolution of that in Dorothy Henderson, I can say that that was a collaborative relationship that we worked very hard at and understood.

45 When I went into Newmarch, it had been running since 11 April and I went in on the 24th and at that point, there had been infection control support but I identified there was need for more infection control expertise and that's where I contacted Kathy

Dempsey. Part of it was we had had a pre-existing relationship and, being time-critical, being able to put in simple systems or enhance the systems that they had had.

MR ROZEN: Is it the case – Ms Dicks, that is very helpful. Is it the case that, as
5 with any emergency response situation, you need to – as a responder, you need to know what you need and you knew what was necessary because you had had the experience just the month before at Dorothy Henderson. Not every provider is aware of the gaps, if you like, in their response arrangements. I'm wondering if you can reflect on what the lessons are from that experience from a sector-wide perspective?
10 In other words, what arrangements do you think we could have in place now to ensure that it doesn't take a situation like that for a provider to realise they need someone like Kathy Dempsey? What do you think would be useful to have in place as part of preparations now?

15 MS DICKS: I think there's two components to preparations and there's one action at the commencement of a crisis. So the two components, as we have touched on before, is understanding the health services and also understanding their aged care services. Each aged care has a specific profile with response to clients with different components of needs, for example, a resident that's focused on supporting people
20 with a dementia diagnosis relative to other care needs, and that's important for the health service to understand. There's also an understanding of how the community health providers that support an aged care service also interact with health and aged care, so that understanding of how the jigsaw puzzle of support for an older person happens when they're in an aged care service. The second is the development of
25 plans and the interaction of clarity of responsibilities of who will be involved at a time that an outbreak commences and ensuring that the right people with the right delegations are involved in that planning process and agreeing on those plans.

MR ROZEN: And then the third thing I would say is when we get to the point of a
30 crisis, and COVID-19 is a crisis, in an aged care facility that those outbreak plans and emergency plans are rechecked at the time to determine the capacity and the capability to actually implement the job plans. So some of the challenges that we had was in relation to the workforce, the understanding of contact tracing and putting staff into self-isolation challenged the resources of staff for that outbreak plan, just as
35 the access to PPE challenged the job plan as well. So there are three components: understanding, planning of how it's going to happen but at the time of the critical event, assessing the capacity and the capability to continue with the outbreak plan.

MR ROZEN: I understand that. Just focusing for the moment on this quite narrow
40 question of bringing in that sort of Kathy Dempsey type high level infection control expertise, very few aged care providers are going to have someone like that on a full-time basis. It's probably unrealistic to expect that but the expertise is out there. My question for you is – I will be more specific – do you think it might be workable for, say, the Commonwealth Department of Health, in collaboration with the States, to
45 identify the people with that expertise within the State Health Departments, the clinical excellence type organisations, and disseminate out those names perhaps on a regional basis?

So if you are in the western suburbs in Melbourne, "There's three people that we reckon have got the sort of expertise you need. Here is where they are. Here are their phone numbers. Get in touch with them. Invite them over in advance of a problem so they can familiarise themselves with your residential aged care facility
5 and then they will be on call for you, day 1." Do you think something like that might be useful for the sector as a whole?

MS DICKS: Absolutely. Some sort of documentation and communication of a panel of experts of infection control practitioners that could be accessed to
10 participate in development of emergency plans and then also in the participation of an outbreak, because what you need from that specialist is somebody who will oversee the infection control plan as it commences in the outbreak management documents and planning and then monitoring the implementation of the plan itself. So a panel is a good solution, given that there are so many organisations that may be
15 smaller or regional and access to specialist services are limited.

MR ROZEN: Yes. Mr Low, do you have anything to add on that issue; do you see any problems with that sort of approach?

20 MR LOW: No, I think that would be an excellent approach and certainly you saw the benefits or you have read the benefits of having them available to come into Dorothy Henderson Lodge so quickly.

MR ROZEN: Yes. Can I come back to the issue at 6.9.3 in your submission about
25 access to hospital. In the BaptistCare Australia submission, the one that the national organisation has provided, they refer to this question as a contentious one and I want to ask you a little bit about that in a moment. But for the moment, if we can just establish the progression of events at Dorothy Henderson. As you explained at 6.9.3 it seems there were two phases to this question. Initially there was a default
30 hospitalisation of anyone who tested positive, and then that changed through the course of the response to the outbreak. What changed; was it a change of approach internally or was there a change of approach that was externally – that had external effect as in the New South Wales department or the hospitals? Can you help us, Ms Dicks, with that?
35
MS DICKS: Absolutely. So initially and, again, through collaboration and working with the local health districts there was an agreement that those that had been identified as COVID positive – and for us even though some of them had mild symptoms, they all had symptoms during the initial phase. So there was an
40 agreement that they would all go to hospital. During the second week, New South Wales Health and the Local Health District then started to talk about appropriate transfer of residents who may need more clinical support, that was able to provide at the aged care facility.

45 What that provided us with the opportunity was to actually stabilise our outbreak plan and ensure that our resources were working. So aged care services are able to provide clinical support to older people and palliation. Our challenge was initially in

relation to staff, having enough staff on site. So that change in the phase for us was almost directly in relation to us having enough resources to stabilise the service, and externally what was happening in the community at the time was that this was on the escalation of the pandemic in Australia. There was concerns about health services
5 being able to have the capacity to provide acute services to the community. So we were at the beginning of this process where the community was very concerned and there was a level of hysteria and fear in relation to it.

MR ROZEN: Ms Dicks, I might ask you if you could to move that bottle of
10 sanitiser away from the microphone in front of you. Thanks. Thank you. Sorry, back to what you were just saying, and I wanted to make sure I understand this. Are you saying that in that initial phase, being able to send residents even with mild symptoms to hospital assisted you in responding to the outbreak; is that what you've just been saying to us?
15

MS DICKS: So the first component is that there was an agreement that they go to hospital to ensure the support and the care of the resident. There is no doubt that in doing that, that assisted our outbreak management because at that time we were looking to manage our surge. We had to implement a surge workforce as well and
20 ensuring that the operations were consistent so that when, in the second week, New South Wales Health had conversations with us around the appropriate transfer and not transferring all COVID positive residents, we had a stronger support service at Dorothy Henderson to manage that process.

25 MR ROZEN: All right. Can I just understand the first point there; how did it help you in managing the outbreak in that first place?

MS DICKS: So it allowed us to understand our containment. So we were trying to manage the incubation periods and isolation of residents so taking people who didn't
30 have COVID – people who were COVID positive who went to hospital, that obviously allowed us to say that the service had no active cases at that point, and it certainly supported encouraging staff to come as well because at that time staff were fearful to come on site so we had to work strongly and support our staff to ensure their safety, and not having COVID positives helped that in the initial phase. As we
35 moved on and staff felt more assured to the processes that became less of an issue.

MR ROZEN: I understand. Can I ask, with the residents that were transferred, without focusing necessarily on the ultimate outcome for them, because we know a number of them passed away in hospital, didn't they? I want to try and get some
40 sense from the two of you very experienced aged care practitioners about the practicalities associated with moving, for example, residents that may be suffering from dementia or may be particularly frail. Can you reflect on the challenges that that presented to you as a provider? Perhaps starting with you, Ms Dicks.

45 MS DICKS: Absolutely. As you say, there is a number of people who live in aged care facilities that have a cognitive impairment. So changes or rapid changes to their environments or unknown environments is highly distressing to them. So we

certainly try and work with the provider that they're going to or the health service that they're going to and determine the need for transfer and trying to understand what the outcomes that are to be achieved by that transfer. Working again with the family. So we were able to do it on a case-by-case basis and that's certainly our preference, that we understand what the resident or the decision-maker is looking for, for the care provided to the transfer. Because confusion is distressing for someone with a dementia diagnosis.

MR ROZEN: It seems, certainly compared to many other facilities, that you were quite successful and Professor Gilbert says as much in her report, quite successful in confining the outbreak. I think, ultimately, there were 16 COVID positive residents out of about 80 people that were living there. Was that – are you able to say whether the ability to hospitalise that first group in that first week helped you limit the spread?

MS DICKS: Absolutely. I don't think you could say anything less; that anybody who was COVID positive going there in the first place ensured that they got the care they needed and then it allowed us to actually stabilise our workforce as well. So it worked in two – two fashions for it. And then it also allowed us initially to identify areas of containment within the building following the incubation periods that may be COVID negative so it did assist in that initial process, absolutely.

MR ROZEN: Sorry, Mr Low. Can I ask about the impact of that approach on the negative residents; how does the hospitalisation of at least some of the positive patients impact on your ability to provide for the care needs of what is, of course, the overwhelming majority of residents that you had there for whom you are still responsible to provide care needs. Are you able to reflect on that?

MS DICKS: I think everybody received the same care. I would need to understand your question more, because I think everybody received the same level of care and support. People were required to remain within their rooms for the period of time because there was still an incubation period that we needed to work through and that concept of people remaining within their rooms, and that being a distressing process within itself, removal of people to a hospital does allow to put a finite time on incubation if there's no more positives within the building.

MR ROZEN: Yes. Thank you. Is there anything you wanted to add to that discussion, Mr Low?

MR LOW: Only in a sense that in that second time we were certainly able to take into account the resident and their family's view on whether they did or didn't want to be transferred to hospital. And I think, as you drew the conclusion this morning, there were a number that didn't and, in fact, two of our residents of the six actually passed away at the facility with their loved ones being able to be accommodated and visited by the family appropriately PPE'ed but they had that opportunity to say farewell to them and spend as much time as they wished to at that particular point.

MR ROZEN: Does that, Mr Low, emphasise the importance of residential aged care facilities being able to provide high quality palliative care?

MR LOW: It does, and that's something that our people are trained on, is to provide that palliative care, yes.

MR ROZEN: Yes, thank you. If I could turn to the other submission that BaptistCare Australia provided, which is behind tab 15 of the Dorothy Henderson tender bundle. Do you also have a copy of that handy; you do.

MR LOW: Yes.

MR ROZEN: You've been very well prepared; we are grateful to your legal team. If you could turn to page 8 of that submission, please; you will see the page numbers in the top right-hand corner, the last digit of a long code should be 8 and there's a heading Care Reserve Team Surge Workforce. I meant to ask you about this earlier. Do you see in the middle of the page there's a second bold paragraph that starts:

> *Recruiting members of care reserve teams from unorthodox sources of labour have also provided some unexpected benefits.*

Do you see that?

MR LOW: Yes. Yes, we did.

MR ROZEN: Is that something you can speak to, Mr Low?

MR LOW: Yes, I think it was an excellent decision in that obviously quite a number of areas, like running camps, people running restaurants and chefs, etcetera, were out of work and, therefore, we were able to tap into various areas and provide a good workforce who we then trained and buddied them with others within our facilities, not Dorothy Henderson Lodge, but in other facilities so that they would gain the experience that if we needed to have more workers – staff moving across to Dorothy Henderson, then these people that we had taken on board as our reserve would have been able to fill those gaps. So it worked, we believe, very well and, in fact, we decided with potentially a second wave may be hitting New South Wales, that we've kept that reverse workforce on and we will have a review of that on a monthly basis but at the moment we are keeping them on just in case something turns for the worst in New South Wales.

MR ROZEN: Does that, the success of that initiative, Mr Low, does that have potentially two broader implications for the aged care sector, the first one being that the sector needs to think laterally about sources of labour, of increasing the size of the workforce.

MR LOW: Yes.

MR ROZEN: And the second is that, as we all know, one of the very terrible effects of the economic impact of the pandemic in Australia is to leave a lot of people out of work, people who might perhaps never have thought of careers in aged care but do you think there is an opportunity for the nation there to be perhaps retraining and maybe encouraging some of that – the unemployed part of the workforce to be coming into aged care at a time when it is so desperately needed.

MR LOW: I think it has been a very good example of that and certainly would encourage obviously, sadly, it comes at a cost but I think we believe that was a very good insurance policy, in a sense, to make sure that we had sufficient staff to meet any particular outbreak. And I guess at that point we were also sadly thinking about could there be a second outbreak in one of our facilities and, therefore, that reserve workforce would provide other staff to be able to move across into the second facility should it eventuate.

MR ROZEN: Ms Dicks, anything you would like to add to that discussion from your regional manager perspective?

MS DICKS: I think the only thing to add to that, this program worked very well and I think what would complement it, given the current situation of outbreaks that is occurring is ensuring those that are coming into aged care are valued for what they are doing. This is understanding the value that people, if they work in this industry, can make to older people's lives. Everybody works to respond to their values and I think that's an important message that we can share with other people when they work with us in aged care.

MR LOW: And to reinforce that, I think we have had a number of those reserve workforce people say "would there be opportunities potentially for us going forward?". So I think they have begun to understand the value that they can add to the aged care environment.

MR ROZEN: Thank you. If I can turn to the topic of governance, which is addressed on page 14 of the national submission, if I could ask you to turn to that, please. You will see the heading a third of the way down the page Leadership and Governance Practices That Have Been Used by BaptistCare Members to Respond to the Crisis. I'm interested in what the lessons more broadly are for the kind of governance arrangements that are needed to respond to crises, whether they be pandemics or bushfires or any other sort of crises that might occur. The one thing we know in this country is that something like that is around the corner. We don't necessarily know when or what but we know it's coming. So what are the lessons; there's a reference to the need for equipping leaders to be capable, agile and fast moving action in a time of crisis. Are you able – particularly you, Mr Low, from your position within the organisation, to reflect on what you and perhaps the board have learnt about these issues from the pandemic?

MR LOW: Yes. I think the great learning for us was that we were able to put very senior people into Dorothy Henderson Lodge who could immediately make decisions

that were appropriate and feed that back to the crisis management team to work through and we were very fortunate also to have the chair of our board join us right from the Tuesday evening and he stayed with us, not to necessarily manage us but to ensure that decisions that we made were appropriate. So the ability that we had right
5 across the board of having agile senior people being able to make decisions, I think, was one of the great advantages that we saw coming out of the way that we dealt with the outbreak at Dorothy Henderson Lodge.

MR ROZEN: Ms Dicks, is there anything you would like to add to that?

10

MS DICKS: I think probably just reflecting on my previous comments as well, the – that stakeholder collaborative approach where people are clear on their responsibilities from both the health services and the government agencies at the time of the commencement of the crisis is very important. What roles and
15 responsibilities, who has the capacity to make decisions and assess at that particular point what resources are available for the outbreak plan.

MR ROZEN: Thank you. Ms Dicks, I think you may have wanted to make some further general observations and I don't want to cut you off but I know you did
20 earlier make reference to a number of key lessons that emerge. Is there anything else you wanted to add at this time?

MS DICKS: No. Because it is reflective of that particular comment. What was critical to our outbreak was actually the collaborative framework we had with our
25 stakeholders, the approved provider, the health services and the government agencies. And what's very important is to be able to do a capability assessment of being able to implement the outbreak plan and what resources are needed. And making an assessment of when those resources are challenged what would happen next for them, so I wanted to raise that with the Commission.

30

MR ROZEN: I have now reminded myself that there was another matter I wanted to raise with you, and it's dealing with this management issue. I touched on it earlier and that is that you were part of a team that moved into Newmarch House on 24 April, so I think it was day 13 of their outbreak. Can you just tell the Commissioners
35 briefly how that came about, what led to that?

MS DICKS: Absolutely. So key staff from the Dorothy Henderson outbreak were seconded BaptistCare staff were seconded to Anglicare at the request of the Aged Care Quality and Safety Commission, and our role was to go in and provide some
40 experience because we had it so recently and support to the Newmarch Anglicare service whilst they were in the middle of their outbreak.

MR ROZEN: What were the particular issues that were drawn to your attention as needing your attention as part of that - - -

45

MS DICKS: So prior to going in – and there was an understanding that it was a complex situation in terms of multiple stakeholders and multiple agencies involved

and coordinating and working with those agencies to work to focus on Anglicare was one of the first ones. They had – at the time that we went in they had just implemented an external surge workforce as well and there were some challenges around infection control management, so we took some support and expertise to address those areas.

MR ROZEN: Their workforce was from a more diverse range of employers than you had to deal with. At Dorothy Henderson you had some staff that had come from other BaptistCare facilities and you had the provider Healthcare Australia and that was challenging enough, presumably, to respond to. At Dorothy Henderson it was – sorry, at Newmarch was a new level of complexity. They had staff from Mable, they had staff from Aspen. They had other existing staff that they were dealing with. What are the particular challenges for a manager, especially one coming in new, that you experienced and what are the lessons from that that you are able to share with the Commissioners?

MS DICKS: So the challenge, you're absolutely correct, to have multiple staff come on site who had come from different organisations, who had various levels of competencies and knowledge of the situation. So the first challenge is to ensure that anybody who is coming on site understands the competencies and the procedures and the operations model that was being implemented as a result of the outbreak. So that was a very clear challenge. So we had to move to a leadership model that was much more command and control to be very clear, and we needed to simplify the processes as well. So management of staff was absolutely a challenge for Newmarch because there was so – they were coming from so many areas with varying competencies.

MR ROZEN: One of the other key differences was that at Newmarch they were – that the model of response, if I can call it that, was hospital in the home which is not something you had had experience of at Dorothy Henderson. Are you able to reflect on how you saw that working and anything that you think ought to be done in future that might make hospital in the home work better in an aged care facility?

MS DICKS: One of the key things that we implemented when we went on site – and it was as a result of an experience at Dorothy Henderson Lodge – was that aged care services often run electronic care management systems which include documentation. When you start to have a number of staff coming from external agencies, those staff will not have knowledge and capacity to access those electronic management systems. So we moved to a paper-based system; that's a business continuity process that we had implemented at Dorothy Henderson. But that had a massive impact to the hospital in the home program as well.

So the lessons of implementing a care model such as hospital in the home is understanding the parameters and the resources that are required to implement the program, and two of the key challenges that we created through trying to manage the outbreak made hospital in the home difficult. So the hospital in the home couldn't see the care management documentation and we had a new staff that didn't fully understand what hospital in the home model was and we needed to continually

orientate those staff as well. So those type of programs need everybody understanding all the roles and responsibilities for both the service and the hospital in the home for them to work very effectively.

5 MR ROZEN: I don't think it's any secret that there were some challenges with communication during the Newmarch House outbreak, communication with residents, with their families in particular. Was that another area of your focus when you went in to Newmarch?

10 MS DICKS: We managed – we helped as part of that process but certainly Anglicare was focused on managing the whole communication management program. We did – we helped provide operational suggestions and implementation of some programs. So, for example, the residential manager had identified that registered nurses communicating with families would be beneficial in the situation 15 that had presented itself and as a result of support with the Commonwealth there was a registered nurse call centre implemented within the building.

MR ROZEN: Finally, Mr Low, can I just bring you in on those two points that I've been talking to Ms Dicks about. The first one being the experience with the digital 20 records and moving to the paper-based system. There's a bit of discussion about that in the submission. Are you able to reflect on what the lessons are for providers generally of that, the importance of backup to any digital record-keeping system that you have got?

25 MR LOW: Yes. Yes, I don't think we had envisaged that when you completely lose your workforce and you have agency staff come in, that they do not understand your electronic clinical system, which then in fact had to be downloaded into a paper system. All our business continuity plans up to that point would have envisaged that system going down for a technical reason for two or three days and then being able 30 to be resolved. But to have to go back to a paper system which then didn't prompt people to do things with particular residents, because that's what the electronic system does, it was a challenge to work through both the paper system and the lack of prompting that was available from it.

35 So, yes, it was a real challenge in that sense. And I think to the industry they should contemplate how they will operate if they do not have anybody that understands their system working for them at that particular point in time.

MR ROZEN: Yes. And the second issue was about communication. In your 40 submission there's a reference to the importance of openness and honesty and transparency in communication, no spin, perhaps, if I can put it that way. Can you reflect on how that worked at Dorothy Henderson, from your perspective?

MR LOW: Yes. I mean, I think one of the things that we highlighted in our 45 submission was that we believed we handled communication very well. It's something that, in a sense, took an enormous amount of time. We had about five or six people in our marketing area working nonstop on communicating both out to our

residents and their families, to our staff members, and the general public and stakeholders on a very regular basis. And I think keeping them informed, not always being able to completely, you know, pacify them on certain issues, but keeping them informed on how we are, what we're doing, I think at the end – and you saw the number of compliments that were beginning to come through, particularly as we moved to set up a connections coordinator which allowed us to have the ability to work with the individual resident and their family, to be either receiving of emails, working and talking to them on the phone, FaceTiming them on iPads.

That really did help the communication and I think allayed quite a number of the concerns. We then also moved to setting up safe work – safe visiting areas and that allowed us to, again, provide that opportunity for the family to come and see their loved one within the facility.

MR ROZEN: Last topic from me before I ask the Commissioners if they have any questions. First you, Mr Low, from the CEO perspective, are you able to share with us any reflections on the impact of the pandemic on your home care, on the home care side of the business?

MR LOW: I think, yes. The immediate issue in the first place was that quite a number of our clients took the decision not to require a service until they completely understood the impact of COVID-19 on any of our operations or people in the community generally. So, therefore, immediately we had a significant reduction in the number of hours that was being planned and we had to determine how to, you know, work those through because we didn't want to lose any of our good staff. So we actually agreed to pay them an average pay rather than the actual hours that they were earning during that particular time. I think that had a positive impact on the future as it starts to come back and we've got, therefore, the same staff member being able to work with the client as we go forward.

MR ROZEN: Ms Dicks, is home care part of your responsibility at all?

MS DICKS: No, it's not.

MR ROZEN: Thank you. Commissioner Briggs, do you have any questions for Mr Low and Ms Dicks?

COMMISSIONER BRIGGS: Thank you very much for that evidence. It has been interesting to hear the comparison between your home being at the beginning of the pandemic and Newmarch right when it was going crazy in New South Wales. And that leads me to ask the question about what would you do differently if you were one of the homes in Victoria knowing full well we've got about 1000 people in residential aged care in Victoria infected with the disease?

MR LOW: I think that's not an easy one when you don't know the full circumstances of each of the facilities. But, you know, perhaps the preparation, the learnings were not picked up quite as well. I guess it would be hard for me to make

an observation sitting here. I wouldn't want to look as though we are being in any shape or form smug about where we are because I really do desperately feel sorry for the situation down in Victoria. And I think anything that we can do to help is something that we can do. But I don't think I can add much value at this particular point.

COMMISSIONER BRIGGS: I suppose I badly phrased my question, I think. I really want to follow up the issue of hospital transfers and whether, in the circumstances where you've got 1000 people in residential aged care with the disease, whether hospital transfers for everybody becomes an impossibility. And I'm assuming it is.

MS DICKS: I can make some statements in relation to that. I think when you have a need to that size, what's important is to understand the resources and the support available; that it can be about supporting a resident whether they remain in an aged care facility or go to a hospital. But it's understanding what resources are there. What is the capacity of the workforce, what are the other community health support services that are available to be part of this solution as well. And that's certainly the learning that we have from – I have from both Dorothy Henderson and Newmarch is that clear framework of collaboration with the ..... involved making frank assessments and understanding what resources are needed to make that happen.

I think that's – and that's a lesson we could learn at any point in any outbreak, to say how many people – how much have we got in terms of staffing and support, what other health care support services do we have in relation to this outbreak, and then to develop some solutions from there. So I don't think it's an absolute solution, it's a solution based on the type of resources and the capacity of the moment.

COMMISSIONER BRIGGS: Thank you. That's all from me.

MR ROZEN: Commissioner Pagone?

COMMISSIONER PAGONE: Ms Dicks, I wonder whether I might partly follow up that question by just asking – you said earlier on that one of the difficulties with transfers was that it can be very distressing to the resident. Can you just expand a little bit on the degree of the distress that we're talking about and the potential consequences?

MS DICKS: So I was referring specifically to people with a dementia diagnosis where a change of environment and a move to an environment that lacks familiarity and not having people who they are familiar with does increase that distress. And so certainly when we provide supportive care for people with a dementia diagnosis we try and maintain an environment that they're – that they understand and feel a level of comfort with.

COMMISSIONER PAGONE: Thank you. Mr Rozen, anything?

MR ROZEN: No, nothing further, thank you, other than to thank the witnesses and ask for them to be excused.

COMMISSIONER PAGONE: Yes. Thank you. Mr Low and Ms Dicks, thank you very much for the evidence that you have given today and for all of the work that has gone into the submissions in the past and in preparing for the evidence that you have given today. It has been very, very helpful. We are very grateful to you and we are very grateful to you in particular because of the circumstances in which you are participating, and I know that they have been difficult. Thank you very much.

MR LOW: Thank you.

MS DICKS: Thank you very much.

COMMISSIONER PAGONE: And I formally excuse you from further attendance.

MR LOW: Thank you.

<THE WITNESSES WITHDREW [2.43 pm]

COMMISSIONER PAGONE: Is there counsel that also needs to be - - -

MR ROZEN: Yes, there probably is counsel that needs to be excused.

MR LOCKHART: Yes, may I be excused, Commissioner.

COMMISSIONER PAGONE: Yes, I can't see you but, yes, you are. Yes, there you are, I can see you now. Thank you, and you are excused also.

MR ROZEN: Thank you. I am assuming the wonders of technology enable us to just go straight to the next witness?

COMMISSIONER PAGONE: We should do.

MR ROZEN: No one is telling me otherwise. I call Professor Gilbert Lyn Gilbert. Professor Gilbert.

< GWENDOLYN LESLEY GILBERT, AFFIRMED [2.45 pm]

<EXAMINATION BY MR ROZEN

MR ROZEN: For the transcript, can you please state your full name?

PROF GILBERT: Gwendolyn Gilbert, commonly known as Lyn.

MR ROZEN: Thank you. And Professor Gilbert, you are a physician, you have practised in relation to infectious diseases since 1991; is that right?

5

PROF GILBERT: Well, I've been in Sydney since 1991 but I practised in Melbourne for 20-odd years before that.

MR ROZEN: It did seem a bit recent, I thought. And you are an honorary professor
10 at the University of Sydney as part of the School of Medicine?

PROF GILBERT: Yes.

MR ROZEN: You are a member of the infection prevention and control advisory
15 group of the Australian Health Protection Principal Committee?

PROF GILBERT: That's correct.

MR ROZEN: And you've held that role since 2014?

20

PROF GILBERT: Yes.

MR ROZEN: I'm doing your very impressive CV a great disservice, I think, but that's an adequate summary for our purposes or is there some other qualification that
25 you would like to add to that?

PROF GILBERT: No, that was fine.

MR ROZEN: All right. You have been kind enough to provide us with your CV.
30 For the record, it's tab 9 in the witness bundle and I should probably tender that, Commissioner. It's RCD.9999.0403.0004. It's not part of any existing exhibit.

COMMISSIONER PAGONE: That will be exhibit 18-6.

35

EXHIBIT #18-6 CV OF PROFESSOR GILBERT (RCD.9999.0403.0004)

MR ROZEN: If the Commission pleases. Professor Gilbert, you have completed a
40 report in relation to the COVID-19 outbreak at Dorothy Henderson Lodge; is that right?

PROF GILBERT: That's correct.

45 MR ROZEN: I want to ask you a little bit about that, if I could. It's part of the Dorothy Henderson Lodge tender bundle behind tab 10, Commissioners. Do you have a copy of that in front of you, Professor?

PROF GILBERT: Yes, I do.

MR ROZEN: If I could ask you, firstly, how you came to prepare that report? Was that at someone's request?

5

PROF GILBERT: It was Professor Brendan Murphy who was the Chief Medical Officer at the time asked me if I would do a review of the Dorothy Henderson Lodge outbreak to try to determine what lessons could be learnt from it.

10 MR ROZEN: Right. And you had had some role in responding to the outbreak, had you not?

PROF GILBERT: Well, in the sense that I had chaired the infection control expert group from the beginning of the outbreak.

15

MR ROZEN: Yes.

PROF GILBERT: And I had had a very peripheral role in training of health care workers in preparation for that, largely as a side effect of some research I was doing
20 in infection control training with a small research group at Westmead Hospital. But mainly in the role of infection control expert group chair.

MR ROZEN: Yes. I just want to clarify this, if I could. It's not a huge matter but there's a reference in the BaptistCare submission that has been provided to the Royal
25 Commission to an expert panel review committee that was established in the course of the response to the outbreak at Dorothy Henderson Lodge and amongst many people on that expert review committee your name appears; is that accurate? Did you participate in a committee that was specifically responding to the Dorothy Henderson Lodge outbreak?

30

PROF GILBERT: No, no, my role was just as a single reviewer without any other review, without anyone else involved. It was a fairly quick and not very much in-depth review, just by me at that stage. I wasn't involved in any committee in relation to Dorothy Henderson Lodge.

35

MR ROZEN: I understand that there was no committee involved in preparing this report. I think we might be at cross purposes. My question is: before any question of you doing a report arose, were you involved in any way in responding to the outbreak, in assisting Dorothy Henderson Lodge to deal with the outbreak?

40

PROF GILBERT: No, I wasn't. All I knew about Dorothy Henderson Lodge when Professor Murphy asked me to do this review was what I had read in the media.

MR ROZEN: I understand. And I mean – I take it that from the role you perform in
45 advising the AHPPC on infection control matters, that given this was the first residential aged care outbreak, it was a matter of quite some significance in Australia's general response to the pandemic?

PROF GILBERT: Infection Control Expert Group had prepared some guidelines for residential aged care facilities based on the communicable disease network outbreak plan but with more detailed infection control guidelines, but really based on basic principles of infection control rather than any specific experience of COVID-19 in
5 aged care facilities.

MR ROZEN: Were you listening at all this morning when Professor McLaws was giving evidence, Prof Gilbert?

10 PROF GILBERT: Yes, I was.

MR ROZEN: Do you recall I asked her about the differences between responding to an influenza outbreak in a residential aged care facility as compared to responding to a COVID-19 outbreak? Are you able, from your position, to assist the
15 Commissioners in understanding the differences between those two?

PROF GILBERT: Look, I agreed with what Professor McLaws said largely. I mean, the difference – there has been a lot of comparison between influenza and COVID-19 and there certainly are some similarities but the main difference, I think,
20 with COVID-19 is that everybody in the world, when it started, was completely naive. None of us had been exposed to it. There was no previous infection, no immunisation and, you know, it's probably a bit comparable. I mean, there are a lot of other differences for other reasons but it's a bit comparable to the 1918 influenza pandemic, when a completely new influenza strain was circulating around the world
25 and nobody really had any past exposure or immunity to it.

With influenza, we are certainly familiar with, and I had been peripherally involved in my previous role at Westmead Hospital in giving advice and diagnosis and so on of outbreaks of influenza in aged care facilities. But as Professor McLaws indicated,
30 at least some – regrettably not all but at least some aged care facility staff were immunised. Most of them – all of them would have had previous exposure to influenza viruses which whilst they differ from year to year, which is why we need annual immunisation, nevertheless, there is some immune memory to previous influenza strains and all of us build up a certain level of resistance to severe influenza
35 infections, except for young children who haven't ever been exposed before and elderly people whose immunity begins to wane as they get older and who don't respond as well as younger people do to immunisation.

And so that's why older people are at risk from influenza and, particularly, if they
40 happen to have underlying chronic disease of one sort or another, they may develop quite severe and potentially fatal influenza infection. But they're a minority, generally.

MR ROZEN: Yes. Can I start at the end of the report, if I may, unusually perhaps,
45 and ask you about some observations you make on the very last page, which ends in .7122, page 9 in the bottom right-hand corner, if that helps you, Professor, headed Appendix: Sources of Information.

PROF GILBERT: Yes.

MR ROZEN: Do you see four lines down towards the end of the fourth line you have written:

5

This report may need to be modified after they –

that is, the people with whom you consulted in its preparation –

10 *...have had an opportunity to review it and correct any misinterpretation or errors.*

Can I ask whether the version the Royal Commission has is in fact the final version of this report?

15

PROF GILBERT: The version dated April the 14th, if that's the one - - -

MR ROZEN: It is, that's the one.

20 PROF GILBERT: Is the final one. I have to confess that I didn't check this with everybody that I had obtained information from but the two people who did help me a lot with information and who checked this final version were Melanie Dicks from BaptistCare and Kathy Dempsey from the Clinical Excellence Commission, neither of whom had any problems with this version.

25

MR ROZEN: All right. Thank you for that. I just ask you about the next line and I'm wondering if there might be a typo in the fourth word:

Unsurprisingly there was –

30

should that be "little documentation at this time to support the information in this report"? Should the word "like" be little?

PROF GILBERT: Sorry, where are we looking at here?

35

MR ROZEN: So just immediately after that sentence, the last sentence in the first paragraph starts "Unsurprisingly"; do you see that?

PROF GILBERT: Yes.

40

MR ROZEN: Yes. And should the word "like", the fourth word, should that be "little"?

PROF GILBERT: Yes, "little". Yes, I'm sorry, that's right.

45

MR ROZEN: That's absolutely fine.

PROF GILBERT: Yes.

MR ROZEN: Thank you. Can we go back, please, then to the start of your report, there's a heading Lessons Learnt at the bottom of the first page.

5

PROF GILBERT: Yes.

MR ROZEN: And you observe there, the first dot point:

10 *The response of BaptistCare management and staff to this outbreak was prompt and thorough. The outcome probably would have been worse in a less well managed facility with fewer resources and facilities.*

I just want to ask you a little bit about that. From your perspective, and you've now
15 been observing the responses to COVID not just in Dorothy Henderson but more generally in Australia and in aged care generally, what is it about that the level of managerial competence that is important here in relation to responding to COVID? What aspects of good management bear upon the thoroughness of the response of an aged care provider?

20

PROF GILBERT: Look, I think – and obviously I was coming into this after the event but my impression was that right from the start, the Dorothy Henderson Lodge senior managers were not only involved but on site at the facility directing procedures. They seemed to have clarity about whose responsibility it was to do
25 different things, to make decisions, and they got on with it. And they collaborated with New South Wales Health who made the suggestion, and to their credit, Dorothy Henderson Lodge immediately accepted the suggestion, that they would have immediate expert infection control advice, which to me was one of the most important aspects of this.

30

But I really do think that given the difficulties, and there were enormous difficulties in this and other outbreaks at the time, that when a lot of the permanent staff of Dorothy Henderson Lodge had to go on leave because they had been in contact with either the first two cases in amongst staff or the residents who were already infected
35 when they were first recognised. They lost a lot of their permanent staff and the managers were willing to not only to take control but pitch in and actually help with the care of residents. And they seconded volunteers from other parts of the organisation to help with it. So it was that decisive action very early on and the fact that they were prepared to do whatever was advised by the infection control
40 professional to implement good infection control were the major factors, I think, which were very important.

MR ROZEN: Thank you. Perhaps if I could unpack that a little bit because we have already heard from witnesses this morning about the importance of infectious control
45 expertise. I take it what you are saying to the Commissioners is one of the hallmarks of a good managerial response to a crisis like this is to know what help you need, to

be able to identify quickly what the gaps are in your skills and to take on board any offers of assistance that are made to you. Am I capturing correctly your message?

PROF GILBERT: Yes, absolutely. And I think there's a mistaken belief amongst a
5 lot of aged care facilities that because they have – their staff have done an online training program or maybe had a single session about how to put on and take off personal protective equipment that they have done enough in relation to infection control. And, unfortunately, that's not true in aged care. It's not true in hospitals, for that matter. There's a lot more to infection control than personal protective
10 equipment. And there's also context-specific aspects that really depend very much on having an infection control expert to size up the immediate situation, the physical layout, the environmental controls and so on, to determine exactly what needs to be done.

15 And I don't think that any individual – or I shouldn't say not any, but most individual aged care facilities would not have that expertise, even though they may have done all that they were required to do by the regulation in terms of having an infection control protocol and having done basic training of their staff.

20 MR ROZEN: I wonder if I could just ask you to expand on that a little bit. The evidence before the Commission is that in response to a self-assessment survey that providers engaged in, in March of this year, the responses were generally fairly positive in terms of the perception that providers had about their, for example, infection control arrangements. Do you think, with the benefit of hindsight, no doubt
25 looking back now, that there was a degree of naiveté within the sector about what preparedness for a COVID-19 outbreak actually required?

PROF GILBERT: Yes, I do. And that's partly because nobody really knew – nobody could have quite anticipated what COVID-19 was going to be like. So in
30 their defence, I don't think they could possibly – and nor could infection control experts necessarily have predicted what was required. But I think the other problem is that the general community, the management and staff of aged care facilities and also the management and staff of many hospitals really assume that everybody more or less knows what infection control involves and it's pretty obvious it doesn't
35 require a lot of expertise. And, unfortunately, that's a misconception that I think we – that carries over and is included in hospital management priorities, if you like.

And most of the time hospitals, aged care facilities, get away with it because they don't have many outbreaks and when lapses of infection control occur, there are
40 delays and you don't necessarily recognise how that happened. But we do know that there are still a significant number of health care associated infections and transmission, just as an example, transmission of multi-resistant bacteria amongst the residents of aged care facilities, and we know that outbreaks, obviously, of diarrhoea and influenza occur as well. So, you know, the fact is that most of the time routine
45 infection control, with all its flaws, is more or less okay but in a crisis it really needs the sort of experience and expertise of an accredited infection control professional.

MR ROZEN: You mentioned that these gaps in infection control systems can be found in our hospitals as well as in our aged care facilities and it's an important reminder for us. Is that – those gaps, do you think, do they explain at least in part what seem to be large numbers of health care workers that are contracting the virus, particularly in Victoria at the moment or is it too early to gauge what the reason for that is?

PROF GILBERT: There have been lots of concern and queries about why so many health care workers are getting infected with COVID-19 and, unfortunately, we really don't have a lot of details. We do know that there's a significant proportion – and particularly in the first wave of COVID-19 in March and April, a significant proportion of the health care workers who were infected were quite clearly infected in the community or from overseas travel.

MR ROZEN: Yes.

PROF GILBERT: Some of them were certainly infected in hospital settings but there are many reports and, unfortunately, they're largely anecdotal at this stage but a lot of them, that health care workers may have been very careful with their infection control and the use of personal protective equipment when they were actually in the wards caring for patients. But when they go out to the tearoom or a meeting room, they mix with their colleagues, forget about PPE or don't really – didn't at that stage at least, need to wear PPE and were not remaining physically distanced from them. So it's very difficult to unpack exactly when and from whom they acquired infection, and I think we're still working through that at this stage.

MR ROZEN: Thank you. Focusing back on the observation under the heading Lessons Learnt, the second sentence in that first dot point reads:

> *Spread of COVID-19 is very difficult to control in a household-like residential setting with highly vulnerable residents.*

Why is that so, in your opinion? What are the difficulties associated with controlling the spread?

PROF GILBERT: Well, there has been a lot of emphasis in recent years in residential aged care facilities in making them home-like in carpet, soft furnishing, having residents bring as many of their treasures and possessions into their rooms as they want, mixing with each other, socialising, and of course, with the staff, they often need very close care, physical care, hands-on care. So, in that sort of setting, it's – physical distancing is difficult and just the sort of – in cleaning and I guess environmental cleaning and uncluttering, if you like, that we would expect in hospitals, is not possible or appropriate in an aged care setting. And people are close, physically close together. They mingle with each other and I think that's a problem which is just not – it means it's not easy if one of them happens to be infected with an infection like COVID-19 to prevent it spreading to others.

MR ROZEN: Thank you. Can I ask you about what we could do, what the aged care sector could do to improve access to the sort of high level infection control expertise that you're referring to in your report. We know, for example, that – we have heard this morning that at Dorothy Henderson Lodge, they had access to that
5 type of expertise through Kathy Dempsey on day one, whereas the experience at Newmarch House, as we understand it from Ms Dicks was that that was a very different scenario where the type of expertise wasn't available until some 13 or 14 days into the outbreak. I take it from your perspective that that is an important difference in terms of the ability of the facility to respond to COVID?
10
PROF GILBERT: Look, it's an important difference. I don't know that it's true to say that the expertise wasn't available at Newmarch. It wasn't – it wasn't sought, as far as I know. The problem is that there aren't an unlimited number of infection control professionals able to provide this advice at short notice. It's hard to know
15 how to resolve this. I think one of the ways is that there are certainly infection control professionals within hospitals in the local districts that could probably provide advice and training to staff outside of this outbreak scenario which would make everybody more prepared to respond quickly when the situation arises. But whether there are really enough infection control professionals at the moment to
20 actually do that for every aged care facility is a little bit difficult to tell.

MR ROZEN: Yes.

PROF GILBERT: It's quite possible that a large organisation like BaptistCare or
25 Anglicare could employ someone who would be in a position to take care of multiple facilities, train staff, assess preparedness and so on, on an ongoing basis. I think the real problem is that this can't be done adequately in a crisis in more than a very few settings. And Dorothy Henderson Lodge, I think, in many ways was lucky in the sense that there were no other very urgent calls on Kathy Dempsey's time. But it's
30 something that needs planning in the future, I think.

MR ROZEN: You mentioned earlier the notion of accreditation of infection control experts. Can you explain to the Commissioners how that works? Who does the accrediting and are there grades of accreditation and how many people are actually
35 out there that have this form of accreditation?

PROF GILBERT: Look, I can't tell you the details of this, but I do know that this is a relatively recent thing in Australia.

40 MR ROZEN: Yes.

PROF GILBERT: The Australian College of Infection Prevention and Control was formed only about 10 years ago – possibly less than that, I'm not quite sure exactly – and it has done an enormous amount of work in developing courses and accreditation
45 procedures for infection control professionals. Up until then, a large proportion of our hospital infection control, mostly nurses, were people who had either done courses online, done courses overseas or interstate or had learnt on the job. And

there really was very little provision for their proper training. The Australasian college now has, to a large extent, filled that gap but there are still problems with most – many hospitals not offering jobs for enough infection control professionals to, first of all, provide a large enough workforce for when these sorts of situations occur,
5 but in many people's opinion – and this is something that is hotly contested – even providing most hospitals with enough infection control professionals to do the sort of ongoing training and implementation of infection control programs within hospitals.

I think all of us involved in this field would like to see a lot more infection control
10 professionals employed in our hospitals who – and the hospitals requiring that they are accredited which means that then there would be more available for this sort of situation.

MR ROZEN: You mentioned earlier the possibility of the accredited infection
15 control practitioners not just assisting in responding to an outbreak but assisting to plan for an outbreak and to provide training. Is there scope for a type of train the trainer approach here where you would have a designated infection control officer within a residential aged care facility or a champion, I think, is sometimes the expression one sees. I'm not sure if that's you or Kathy Dempsey that uses that
20 expression in the reports. But that way we get more bang for our buck, if you like, from that scarce resource. The Kathy Dempseys of the world are able to train others who in turn can then become the infection control guru within a particular facility.

Is that an approach that you think might work, and do you have any experience
25 overseas where that does work? Hong Kong comes to mind where since SARS that is a requirement in their care homes. Are you able to assist us in relation to that?

PROF GILBERT: I don't have any experience overseas but it's a model that has been trialled and is supposed to be implemented in hospitals, for example, where
30 every ward is supposed to have a link nurse who has extra training in infection control and is the champion for infection control in their own ward. Unfortunately, it doesn't always work because sometimes the wards are so busy they just don't have time to do the additional training and so on. But I know that at Newmarch, Kathy and the team that came in later - - -
35
MR ROZEN: Yes.

PROF GILBERT: - - - identified people within Newmarch who received extra training and who were – and some of them had had previous experience with
40 infection control who came in from agencies and were the champions at Newmarch which I think is absolutely right. I mean, that's the way to do it. You can't have – necessarily having an infection – a credentialled infection control professional, certainly not full-time, in every aged care facility; it would not be cost effective. But to have someone who is a consultant to an aged care facility who may be
45 someone who works in a local hospital or is a private consultant but whose job is to train a small number of relatively senior staff, one would hope, and permanent, not a

transient workforce but people who are likely to stay in the facility, and then be a resource when they need help or when they need refreshers and so on.

MR ROZEN: Yes.

PROF GILBERT: I think that's exactly the way it should be done.

MR ROZEN: Yes. And is that something you would like to see made mandatory or is it something that would be better done by way of encouragement for the sector or do you not have a view about that?

PROF GILBERT: Well, look, I have a bit of a sort of philosophical position that if you think something is really important ,and particularly if it costs money which infection control does, not a lot and it's highly cost effective but it nevertheless is an extra cost, then you almost have to make it mandatory for people to do it. It just seems to me that for many facilities, particularly as I understand it, are running very close to the line as far as their budgets are concerned, it would be very difficult to expect them to do it unless it was mandatory. And then there has to be a way to facilitate that.

MR ROZEN: Yes. Is the other side to that, that from risk control perspectives, the consequences as we are seeing on a daily basis of not having adequate infection control in the aged care facilities is the costs associated with that in terms of human life are very high. Is that another reason?

PROF GILBERT: Yes, the financial costs are very high, too, of these outbreaks.

MR ROZEN: Yes.

PROF GILBERT: Well, of course, that's true but then that's always been true of most preventive measures. We know that when they work, they don't cost anything; the consequences are not a problem. It's when they fall short that it becomes expensive but the expenditure has to be before that, and I think a lot of people hope it won't happen to them.

MR ROZEN: Yes, it's human nature I think to some extent, Professor Gilbert. Another point that you make on that same report of your report, this is page 6 that I'm looking at actually, page 19 in the coding we have, you will see page 6 in the bottom right-hand corner. Do you see that?

PROF GILBERT: Yes.

MR ROZEN: There's a heading in the middle of the page IPC and Medical Support During an Outbreak and you there refer to - - -

PROF GILBERT: We are looking at different pages somehow.

MR ROZEN: Are we? Page 6 in the bottom right-hand corner.

PROF GILBERT: ..... my copy but maybe I – any rate, I've found the heading now, yes.

5

MR ROZEN: All right. Terrific. I wanted to ask you about the section that starts with the words "medical support" in bold. Do you see that?

PROF GILBERT: Yes.

10

MR ROZEN: It's about two-thirds of the way down the page, in my copy anyway.

PROF GILBERT: Yes.

15 MR ROZEN: Medical support.

Soon after the outbreak an infectious diseases physician offered his services-

and so on. We know that's Dr James Branley that did that, and you refer to the
20 significance of his competence and his authority which helped to reassure staff, and we heard the same thing from the BaptistCare witnesses just a few minutes ago. I want to try and understand from your perspective how the skills and experience of the infection control consultant – so that's Kathy Dempsey in this example – and the infectious diseases physician, how do those skills complement each other and why
25 was that important in the response at Dorothy Henderson?

PROF GILBERT: Well, I think, particularly with COVID-19, and at that stage when there was so much unknown about it and there was so much fear in the community, James Branley's – the fact that he had been in Wuhan, he had
30 contributed to the team that brought Australians back from Wuhan and I think, you know, he's someone who has had a large experience with infection – infectious disease management was – it must have been very reassuring both to the Dorothy Henderson Lodge management and to the staff who were, I understand – and this is before I was involved, but who I understand were understandably fearful of coming
35 to work. And some of them just didn't turn up and those who did, I think, were tempted to leave.

So his sort of confidence and authority were – must have been very reassuring. But he also was able to, and willing, to actually assess the residents who became ill, to
40 make some clinical decisions about what to do about their care whether they needed to go to hospital and so on and I think that was very important in the – particularly in the earlier stages of that outbreak.

MR ROZEN: Thank you. At the top of that page, you make some reference to
45 hospitalisation of residents and the evidence we've heard today was that in the first period of the outbreak at Dorothy Henderson there was a policy of hospitalising all residents who tested positive, even those with very mild symptoms where it might

not perhaps have been clinically indicative that hospitalisation was necessarily required for looking after them and that later that changed. There was a more case-by-case analysis of whether hospitalisation was needed. The evidence of Ms Dicks was that in those very early stages where they were scrambling to staff the facility from different sources, that it was advantageous to them to have those residents hospitalised. Do you have any views on that from a general perspective or both in relation to Dorothy Henderson but also more generally?

PROF GILBERT: Look, I do and it has been something that I've been struggling with in relation to both Dorothy Henderson and Newmarch. I certainly thought that – and I still do, for Dorothy Henderson Lodge in those first few days when they were very short of staff, and it must have been really hectic trying to just care for – just the ordinary day-to-day care of residents, let alone others who were ill, even mildly ill, would have been very difficult and would almost certainly have increased the risk of breakdown of infection control. And I think – I mean, as it happened, several of those residents who developed COVID-19 early in the outbreak at Dorothy Henderson Lodge were actually quite sick anyway and needed to go to hospital for other reasons.

But I mean one of the principles of outbreak control is that you've got to not only control or prevent transmission of infection from people who are infected to those who aren't infected but if possible you need to control the source of the infection. And that usually means isolating people away from others who are not infected. And to do that in an aged care facility, even in the setting like Dorothy Henderson Lodge where they all had separate rooms and with ensuite bathrooms, they can be physically isolated but they need care, they need people coming in and out.

Putting on and taking off PPE and the sort of precautions required for people with an infection like COVID-19, it is an enormous increase in workload and when you have got a limited number of staff, that inevitably means that the care of other – or care of all residents is likely to be less than it would otherwise be with the same number of staff. And so I felt very strongly – looking at this from the outside and I still feel very strongly that if you – it's not just a matter of making an assessment about the medical needs of the resident but also about the capacity of the available staff in the facility to care for both the ones who are positive and negative for the infection, whatever it is.

MR ROZEN: Yes. I take it from that answer that you've identified at least two dimensions of the issue; that is, the consideration of what is clinically required for a particular resident but also what might be described as a broader public health consideration of your ability to look after the residents as a group, all the residents that you are responsible for as a provider.

PROF GILBERT: There is a third perspective, of course, and that's the desire of the resident and their relatives about their care. And it's true that, as I understand it, many aged care residents are very reluctant to go to hospital, at least when they're well. They – and particularly those who have any cognitive impairment or are living

with dementia, I think a move to a very alien environment like a hospital must be very distressing. On the other hand, even if they're in a familiar environment, the fact that they have carers and staff who are often, in the first phase of an outbreak, unfamiliar to them and their faces are covered and often muffled, it's an unfamiliar
5 environment even in the home where they normally live.

MR ROZEN: Yes.

PROF GILBERT: So I think it's something that can be managed and that their
10 wishes in terms of end of life care can be respected in a hospital setting as well, you know, without significant risk to them if that is better for the overall wellbeing of the other residents in the home.

MR ROZEN: Thank you. That's very helpful, Professor. Are there countervailing
15 considerations in terms of the impact on, say, a particularly frail resident or a resident suffering from dementia where the consequences of any sort of transport, especially to a hospital, could be very deleterious inform their wellbeing?

PROF GILBERT: Look, I'm sure there are.
20
MR ROZEN: Yes.

PROF GILBERT: But I mean, it's like many other things; I don't think you can make a blanket rule about these things. The whole point of good clinical care is
25 treating each individual patient, and I'm sure the same applies to aged care, each individual resident, on the merits on what they want, what is best for the community and the specifically the community in which they live, and it is a matter of judgment as to exactly what happens to any individual person in that setting. So yes, I'm sure that it's difficult to transfer someone to a hospital, or to another facility for that
30 matter.

MR ROZEN: Yes.

PROF GILBERT: But it may still be the lesser of a variety of difficult choices or
35 the best of a variety of difficult choices.

MR ROZEN: Yes. Thank you. That's very helpful, professor. Finally, can I just ask you about – you've mentioned Newmarch House and you're aware of the circumstances there. The evidence before this Royal Commission from Mr Lye of
40 the Commonwealth Department of Health is that you were part of the senior case management meetings in the Newmarch House response. Is that right?

PROF GILBERT: That's correct, yes.

45 MR ROZEN: Yes, and I won't ask you about your experience; we have got other evidence which we are going to hear tomorrow about Newmarch House, but just as you were asked by the Commonwealth Government to produce a report in relation to

Dorothy Henderson Lodge, you have also been asked to produce one in relation to Newmarch, have you not?

PROF GILBERT: Correct.

5

MR ROZEN: And it was due to be provided to the Commonwealth last Friday, 7 August but no doubt because of many competing demands on your time, it's going to be a little bit later than that; is that right?

10 PROF GILBERT: Well, we provided a preliminary report last Friday. So the Commonwealth does have what will be pretty close to our final report but we've undertaken to provide the final final report, if you like, next Friday.

MR ROZEN: All right. Thank you very much, Professor. They are all the
15 questions I have for Professor Gilbert. Commissioner Briggs, do you have any questions? I think you might be on mute.

COMMISSIONER BRIGGS: I'm on central mute.

20 MR ROZEN: We can hear you now.

COMMISSIONER BRIGGS: You can hear me now, okay. I said I had no questions. Thank you.

25 MR ROZEN: Thank you. Commissioner Pagone.

COMMISSIONER PAGONE: Professor Gilbert, thank you very much for your assistance throughout all of this. It has been very helpful, indeed, and we have learnt a great deal from your evidence today and the assistance that you have given up until
30 today. So thank you very much indeed. And I think I should formally excuse you from further attendance.

PROF GILBERT: Thank you.

35

<THE WITNESS WITHDREW [3.31 pm]

MR ROZEN: Thank you, Commissioner. Mr Bolster will take the last witness
40 today.

COMMISSIONER PAGONE: Yes, Mr Bolster.

MR BOLSTER: Thank you, Commissioner. The next witness is to be identified by
45 a pseudonym and the pseudonym is UY, and I therefore call Ms UY. Perhaps if the witness could be sworn.

<UY, AFFIRMED **[3.32 pm]**

<EXAMINATION BY MR BOLSTER

5

MR BOLSTER: Ms UY, you have prepared a statement dated 5 August this year; correct?

10 MS UY: Yes.

MR BOLSTER: Do you have a copy of that in front of you now?

MS UY: Yes, I do.

15

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

MS UY: No.

20 MR BOLSTER: And to the best of your knowledge, are the contents of the document true and correct?

MS UY: Yes, true.

25 MR BOLSTER: Commissioner, I tender Ms UY's statement, which is WIT.0971.0001.0001.

COMMISSIONER PAGONE: Yes, the statement of the witness identified for anonymity as witness UY is exhibit 18-7.

30

EXHIBIT #18-7 STATEMENT OF WITNESS IDENTIFIED AS WITNESS UY DATED 05/08/2020 (WIT.0971.0001.0001)

35

MR BOLSTER: Now, Ms UY, you made a submission to the Royal Commission about the experiences of your late father in residential aged care during the current pandemic in Melbourne; correct?

40 MS UY: Correct.

MR BOLSTER: And your father was living in an aged care facility near where you live?

45 MS UY: That's right. That's right.

MR BOLSTER: And he died in June of this year; is that correct?

MS UY: Yes.

MR BOLSTER: But he did not test positive at any stage for COVID-19, did he?

5 MS UY: No. Not at all. Not at all.

MR BOLSTER: Tell us about your father; how old was he when he died?

MS UY: 82. And yes, he was 82 and, yes, he had motor neurone disease.

10

MR BOLSTER: He had been a farmer?

MS UY: Well, yes, back in Italy. Almost everybody was a farmer who came from the south of Italy. But yes, he was a farmer, an outdoor man.

15

MR BOLSTER: He was an active man, wasn't he?

MS UY: Yes, very active, digging, always in the garden.

20 MR BOLSTER: And the diagnosis of motor neurone disease, when did that happen?

MS UY: About 2016.

25 MR BOLSTER: And what was the effects of that on him?

MS UY: It was a gradual process. He began slurring and then eventually lost his ability to speak altogether. So his ability to have conversations became very minimal, and it started to affect him, I think, even from a point of view of his
30 mindset and his dementia started to kick in a little bit more. And, yes, it was sad but he was happy because we could still communicate, you know thumbs up and handshake, hugs, go for walks and we made life as normal as possible.

MR BOLSTER: Before he went into care how often were you in contact with him
35 in caring for him?

MS UY: Always. Always. And even while he was in care, I was with him. I was with him almost every day, like as much as I could because I knew he needed that physical contact. He couldn't speak. He was always also giving a lot of people
40 thumbs ups and handshakes all over the centre. It was his way of communicating. He was kind of happy like that. He was still going on and surviving, doing well.

MR BOLSTER: He moved into aged care in May of last year.

45 MS UY: Yes, it sort of ended up being the beginning of June because in May he went into hospital and that's what after the hospital he went into the nursing home after that.

MR BOLSTER: And I think in your statement you mention that he had a PEG tube.

MS UY: Yes. It got complicated for my mum, because his voice went but his whole swallowing system started to be affected.

5

MR BOLSTER: So he was living with your mum but close to you?

MS UY: Well, no, they were living in – 25 minutes away from me, and I was going to see them but then I decided to put him closer to me because I would be his
10 primary carer.

MR BOLSTER: All right. Now, how was the facility able to look after him before COVID came along?

15 MS UY: Very well. They – everything was smooth, and it was like an extended home. You know, as far as looking after him, feeding him, making sure that, you know, all the medical stuff was taken care of, that was done very well. Even his room, everything, clothing, everything was fine until the whole COVID crisis hit.

20 MR BOLSTER: And how did that play out in terms of lockdown for your father?

MS UY: Yes, well, it was a whole different picture. It wasn't what we had signed up to, although we needed them. We needed them because he was being looked after, feeding and making sure he was physically well. I'm just not sure about the
25 emotional side of it. They did their best but there was aspects that only I could do.

MR BOLSTER: Let's talk about an incident that you relate in your statement in paragraph 9. And that's the 17 March when you - - -

30 MS UY: Yes.

MR BOLSTER: You say it was the last time you had a physical visit with your dad.

MS UY: Yes.

35

MR BOLSTER: In the ordinary sense.

MS UY: In the ordinary sense, exactly. So I would go into his room, "Come on, Dad. Up out of your chair, let's go for a walk" and, you know, I'd sort get him to
40 walk with me, put on his cap, put on his jacket and we'd go for a walk. And hour and a half, an hour. We would go around the whole block. We would go to the park. This time he wanted to go – I took him around the whole block so it was a long walk.

MR BOLSTER: Did you measure how long the two of you walked.

45

MS UY: Probably an hour, and we stopped and walked and stopped and walked. And it was just beautiful. And he'd stop and look at the trees and just wander and

then he'd just keep going, but he was actually pulling me along that day, I will never forget it.

MR BOLSTER: All right. After that, describe the contact that you had with your father.

MS UY: Windows. Windows, windows, windows and it was sudden, and it was a big sudden change. And I think it was everybody had a sudden change including those that were working in there with him. And it wasn't like they be were happy about it. I'm not saying they were happy about it. They were just, you know, "This is all we can do right now". And it was like commonsense, "This is all we can do. This is what we are all doing" and you just went along with it, not realising how long it was dragging on for and the impact of what that would mean.

MR BOLSTER: So you couldn't ring him up and tell him you loved him.

MS UY: Not really because he couldn't speak back so a phone call in his case wouldn't really work and you know technology wasn't my dad's thing, he doesn't get that. Even if we did the iPad and, you know, hands up, thumbs up, he would do it but it wasn't the same as grabbing him by the hand or the arm and walking him.

MR BOLSTER: So the window access, how did that develop?

MS UY: We made it fun. You know, we did – we kept talking, hands, we did a lot of hands. He used to find my hands on the window and he would follow my hand; as I moved my hand he would follow the hand. So he was matching my hand, standing up, sitting down, fingers, thumbs, all that – that kind of thing. We just tried to turn it into some sort of fun thing to do.

MR BOLSTER: Was that outside his bedroom?

MS UY: No, because he was upstairs. So we had to go downstairs. So I would pick times when he was on his way down just before dinner or just before lunch because they would go get him. Because he wasn't – unless you go and get him, he wasn't always just willing to walk around. He lacked a little bit of that motivation, I think.

MR BOLSTER: Was the facility cooperative - - -

MS UY: Yes.

MR BOLSTER: - - - with your attempts to communicate?

MS UY: In the beginning, they were. I think then I tried to come, like, every day. Like I thought "You know what, I've got to find half an hour to go see my dad". I've got to go find that. And because it wasn't far from my home, I would go there and I'd go to the window and they would bring the chair down. They would bring the

chair down. Sometimes my dad would even pick up the chair and put it away and we'd say "Don't touch the chair". But they would have it ready, like, I'd go down. They'd bring the chair down. They were willing. It's just that it was complicated because there was only one window. There was only one door. So if I was taking up
5 that whole time, I knew that perhaps others wouldn't be able to do it.

MR BOLSTER: Were there other people queueing to see their loved ones?

MS UY: Sometimes there was. There was – I wasn't there when that happened but
10 there was one time that I couldn't see him because it was just too busy.

MR BOLSTER: Now, you say in your statement in paragraph 10 that when the nursing home went into lockdown, that:

15 *It seemed to me that there was panic almost immediately.*

What do you mean by that; what was the panic that you observed?

MS UY: That's my interpretation. I call it panic because I think intelligence wasn't
20 really as good as it could have been, and I think what's happening there, there's not a lot of power, I felt, in this situation, an unknown – you know, it's a situation that everybody has just been thrown into. It was like I say panic because that's how it looked like to me in the sense of not well thought out and not well thought – not planned. So I called it panic because it's like reactive.
25
MR BOLSTER: And how did they communicate the lockdown to you; was it explained to you?

MS UY: It took a while.
30
MR BOLSTER: Were the questions that you had answered?

MS UY: It took a long time before we actually had the visiting system set up. So I feel it was like a three week to four week period between the moment I came back
35 from that quick holiday that I mentioned; I had to come back because we were on a bit of a – after the 17th. We had gone away, we had to be back in Melbourne because we went into lockdown. That was about like, for me, a four-week gap before we could actually book in your half an hour visit, so I was just at the window for a long time and they were just doing their best. They were doing their best but there was a
40 lot of gaps, I believe.

MR BOLSTER: What did you see in your father's condition change over time?

MS UY: The confusion, just a massive confusion. I mean, how to stand - - -
45
MR BOLSTER: How did that demonstrate itself?

MS UY: Just looking at me like in a way that he was confused. He was trying to press the buttons to try to get out of the room. He was trying to open the door and we would go "Sorry, dad, there's a virus" – in Italian, I would say it. We were just trying to make him understand that it was – it's funny, my mum was even, you know,
5 referring to the Bible end days, it was the end days. The end days have come, you know, stuff like this going on. And just to try to help him understand that we were in the end days, you know. And I think, you know, it doesn't matter what he believed but he kind of accepted it. He would then accept it and he would sit down, but it was just sad.
10

MR BOLSTER: What about your mother, how did this affect her?

MS UY: Well, she didn't come and visit him for about a month so I was the only one going to the window because at that point, I wasn't going to get my mum – not
15 until we could actually enter in for visiting that she was then coming in. So for a long time, between the lockdown and the implementation of the visit, I was the only one going to the window, and my husband would come. But, you know, we didn't get my mum to come down. She wasn't going to stand at the window and talk to him at the window, I felt that would be too, too difficult for him, emotionally.
20

MR BOLSTER: When did a system of visitation get established?

MS UY: I believe it was about three – three to four weeks after that, from the, whatever the lockdown would have started, I believe it may have been 26 March
25 whenever Victoria hit lockdown, because I had just come back from my short holiday and, yes, so that first visit, which I got wrong, I ended up booking in another venue, I've said that in the statement, and I had to wait another week. So I just continued doing – I was grateful for the window visits. I mean, you know, I felt like I'm a beggar now, and like I'm glad to see my dad. At least I get to see my dad at
30 the window, and that's how it felt.

MR BOLSTER: What was the process for seeing your father?

MS UY: At the window?
35

MR BOLSTER: No, I'm talking about the visits when you were in the - - -

MS UY: Eventually.

40 MR BOLSTER: - - - old hairdressing salon.

MS UY: Well, that was the thing. Okay, so they converted the hairdressing salon into a visiting room which was quite small. So that first visit was terrible, and I wrote an email about it. It was – it smelt of Domestos. There was the perspex in
45 between that my dad couldn't shake our hands. We were wearing masks. He could shake the nurse's hand, but he couldn't shake our hand. He walked out very confused and I remember his eyes – I can still see it now, and as he walked out he

was like, "What's this; a visit. Is this a visit?" So it was not visit and I was really, really upset that day so that's when I ended up speaking to Banksia Care and then OPAN.

5 MR BOLSTER: So the result of that was you were able to have some visits with him in the garden; correct.

MS UY: So then I spoke to OPAN and they arranged a conversation with management and we then said, "I'm not ever going in that room again; I will stay at
10 the window, thanks". But I wasn't angry, I was just – I felt helpless. Like I didn't know what to do and I knew my dad; to leave him like that was terrible at that moment. I don't know how he coped with that. I still don't know how he coped with that.

15 MR BOLSTER: Okay, so 14 May, you are able to have a visit in the garden with your father.

MS UY: That was lovely, yes.

20 MR BOLSTER: First time you have been able to get close to him since March.

MS UY: Yes.

MR BOLSTER: How was he coping at that stage?

25

MS UY: Yes. So at that point I'd bring my mum for the first time. Okay, so from March – so from March, probably the 17th also until 14 May my mum hadn't been there because there was no system for her other than that room we had been in. Okay, so we go to the garden, and it was lovely. You know, at that point I was
30 holding his hand, but we weren't allowed to do any of that. You couldn't really hold his hand. I couldn't hug him. He walked out the door, he would go to hug me and I'm like holding back, and it was unexplainable. Like, how do you explain that?

MR BOLSTER: And then how many times did you see him in the garden?

35

MS UY: Probably four to five times until he – so the last visit in the garden would have been – because he went to sleep on that Saturday night, I think it's the 6th. So work three days back from that, it would have been the Wednesday was the last time we saw my dad, 3 June, roughly, in the garden. He was out of it by then. By then he
40 was – he did give my mum a very, very big hug. As he walked out the door, I didn't hug him because everybody was there, the nurses were there and we weren't really supposed to. I said to my mum "Wait". Then we went to the back where nobody could see us, and we were sitting in the garden and he just hugged my mum very, very tightly and my mum couldn't – I actually videoed it and it was such a tight hug.

45

He understood but he was just cognitively, he was losing it, you know. He was just vague and, yes, we showed him a beautiful song that we played at the funeral called

Bocelli's, you know, Fall on Me. And we were showing him because he looked a little bit like Andrea Bocelli with his glasses and his cap. And we were showing him this song and then we did play it at his funeral.

5 MR BOLSTER: Just describe for us the change in your father from the five kilometre walk in March to this last visit in the garden in May? Just over two months.

MS UY: He was just vague, but he was also picking some stuff on my mum's face.
10 He was leaning over and – but he was just not there. Like, I think he had already – I reckon he had given up. He was definitely losing it a lot. I think he lost about 30 per cent. It was already pretty bad as it was but because you know, the walk, but I couldn't walk with him like that - - -

15 MR BOLSTER: Had he lost weight in that period?

MS UY: No, it wasn't lost weight, no. It was more cognitively, he wasn't – I couldn't go for a walk like that with him, and neither could we get out of the premises anyway but he wasn't capable of doing what he had done. So he lost a lot,
20 yes.

MR BOLSTER: I was wondering if you could please read to us please paragraph 26 of your statement just so that we can hear the way you have expressed yourself there.

25 MS UY: Okay.

I believe that I could have taken Dad by the hand and walked him around. Even if I was wearing a glove, we could have still had a relationship. I felt as though I was no longer trusted to care for him even though I had been only
30 *weeks and months before. I lost this connection with my father and I felt as though he had become the nursing home's property. I felt like my family were no longer considered to be important and instead the nursing staff and management were the best people to look after Dad. This feeling was really enforced, like my family were outsiders and my dad was an insider. I believe*
35 *that during this time, love was not the biggest priority but enforcing the system was.*

I felt that all that had been promised when Dad entered the nursing home had changed. All the wonderful leisure and freedom aspects such as coming on
40 *visits to my home and being able to take Dad shopping and for walks had all gone suddenly overnight because of the virus.*

MR BOLSTER: Thank you for that. Now, in paragraph 28 you talk about the importance of his "blood support" from a cultural perspective.
45

MS UY: Yes.

MR BOLSTER: Could you elaborate on that, explain to us what you mean there.

MS UY: Yes, I mean, he loved the people at the nursing home and he was so thankful, and so we were. We were absolutely thankful for the wonderful help they gave him and they did their best. But nothing matches family and family is the rooting systems, particularly for Italian people, you know. We promised him that we would be there for him. And suddenly because of a huge system change, because of, you know, a crisis, we had to get back to bare minimal which is structured focused, rather than family focused. And I think nursing homes are all about families and people. And it had to – and in its urgency it had to resolve itself to having systems and processes because there was deep fear of the place becoming contaminated and I don't know to this day if it's happened there or not.

But there was a real fear "We don't want to become like some of those other nursing homes around and we have got to protect everybody". And I kind of get it. It's not like I don't get it. But how do we intelligently do this and maintain family in a situation like that and I have made some recommendations.

MR BOLSTER: We will come to that in a minute. If you could please explain how your father passed away. He was asleep, as you say in the statement for nearly a week.

MS UY: Yes.

MR BOLSTER: And you saw him in a wheelchair which was the first time he had been in a wheelchair.

MS UY: First time ever. He used to hate wheelchairs. So even if I put him in a wheelchair to take him to the shopping centre so we would go quickly, he would not take a wheelchair. He would refuse it, so I had to put it back. But that last day, so you know, we had done the garden visit maybe the Wednesday, I think it was, and then by the Saturday or Friday night I was at the window – sorry, Saturday night I was at the window doing one finger only. He could barely – he was wheeled out in a wheelchair. He was very lethargic, run down. I believe he was switching off. It had nothing to do with his food. He may have had an infection, I'm not sure, but at the end of the day he couldn't really respond to me.

So he so he was just doing one finger at a time if that, and then he would wander off, and I knew he didn't look right; he looked very unwell. But you know, those things – I couldn't tell the nurses what to do there, really, because, you know, they're the medical staff. So I could only see it from my emotional point of view but our hands were tied. There wasn't much we could do, really.

MR BOLSTER: And the facility gave the family an opportunity to be with him because it was clear what was going to happen?

MS UY: No, no, no, no. So what happened from that point is they took him to dinner from that window and said "Let's see if he will have some dinner". And I don't know if he had dinner but then he was taken to his room and he went to sleep. And that was it; we didn't see him any more after that window visit. He went to
5 sleep and he just slept and he peacefully passed away which is the most beautiful way of passing away and gave us enough time to come in and visit him but he didn't wake up again from that Saturday night that I know of and he was tested for COVID that night – or either Sunday he was tested for COVID on the Sunday.

10 MR BOLSTER: But when he was asleep the facility let you come into the room?

MS UY: Yes. After he was – so that Saturday night he went to bed. Sunday, they did the COVID test and they made sure because he did have a temperature, so he was okay. We got the information Monday, and then by Monday we were in there
15 visiting, hoping he would wake up, of course. But he never did.

MR BOLSTER: Now, you include a number of reflections and recommendations in your statement which are set out there at some length. Was there anything in particular that you wanted to communicate to the Commissioners in addition to
20 what's there?

MS UY: Just overall the nursing home did everything well, you know, looking after my dad. Prior to the COVID virus, the environment was good. It wasn't perfect but it was good enough and it was great. We were happy with it and I had flexibility to
25 go and take my dad and be with my dad and fill the gap. So what I was doing was filling the gaps, playing the games, taking him for walks, and all the stuff that I could do that he wasn't getting and needed, and he needed it from a family member. But when the virus kicked in, I say it was a panic because there was this tremendous shift with not necessarily a focus on what was already existing and how to maintain that.
30 What we needed to do there is to maintain at least the key visitors for each person and so I would have liked to maybe have been treated a bit differently in the sense of, you know, we know you've been here all the time, can we allocate one family member to continue visiting their loved ones, if they want. Not everybody gets the visitors like I was giving my dad.
35
MR BOLSTER: Two more questions; one is about the fact that your father was on a level 4 home care package before he went into care.

MS UY: Yes.
40
MR BOLSTER: And one of the reasons why he went into care was problems with the delivery of that package.

MS UY: 100 per cent, yes.
45
MR BOLSTER: What were they?

MS UY: Well, different people. Different people walking in all the time. Even though you have a particular care company, their staff aren't always reliable; they're not in, they're sick. So you bring in another person, so every time a new person walks in, you start again getting to know them. And it wasn't me. It was my mum
5 having to get to know them, trust them, start again and explain how she wants things done. So she was having to repeat herself all the time, and the more she repeated herself, she was getting exhausted, you know. And so too many people walking in and out, too many different people; I think that's the main thing. We didn't have two people rotating; it was different people coming in all the time and then
10 cancelling at the last minute, too; that kind of thing. So it wasn't reliable.

MR BOLSTER: My last question. I would like you to please, if you could, read paragraph 38, the second last paragraph in your statement.

15 MS UY: Yes. Okay.

A nursing home can never be what a family is to someone. It will never fill the gap. But it is a tool to help families and their loved ones. It will never replace the loving connection a family can give to loved ones and it should not assume
20 *that it has the right and authority to do that. Even though most of the carers are beautiful people, genuinely doing their best, the nursing home didn't give my dad more days. It gave him less days. After what happened to Dad, I wouldn't put my mum in there now with the restrictions.*

25 MR BOLSTER: Thank you very much. I have no further questions, Commissioners.

COMMISSIONER PAGONE: Yes, thank you, Mr Bolster. Commissioner Briggs?

30 COMMISSIONER BRIGGS: No, I have no questions, thank you.

COMMISSIONER PAGONE: Yes, thank you. I am sorry to be referring to you by the pseudonym but that's unfortunately what it has to be. Thank you for giving us this evidence. It has been important to hear what people like you have had to say and
35 the experience that you have had. It's important for the entire nation to hear of these kinds of events and it will help inform us in the conclusions that we reach, so I thank you very much for coming out.

MS UY: Thank you very much. Thank you.
40

MR ROZEN: That concludes today's evidence. It's a 9.30 start tomorrow.

COMMISSIONER PAGONE: Yes, I think I should formally excuse the last witness. I always seem to forget to do that, so I do formally excuse her from further
45 attendance.

<THE WITNESS WITHDREW [4.00 pm]

COMMISSIONER PAGONE: We will adjourn until 9.30 tomorrow morning.

5

MATTER ADJOURNED at 4.00 pm UNTIL TUESDAY, 11 AUGUST 2020

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