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TRANSCRIPT OF PROCEEDINGS

O/N H-1245083

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

9.30 AM, TUESDAY, 11 AUGUST 2020

Continued from 10.8.20

DAY 84

MR P. ROZEN QC appears with MR P. BOLSTER as counsel assisting
MS M. ENGLAND appears with MS T. EPSTEIN for Anglican Community Services, Grant Millard and Erica Roy
MS N. SHARP SC appears for HammondCare, Stephen Judd, Angela Raguz Branley, Kathleen Dempsey and Dr N. Lyons
MR M. FORDHAM SC appears with MR FRASER for the State of New South Wales
MS K. MORGAN SC appears with MR J. ARNOTT for the Commonwealth of Australia
MR M. CHAMPION appears for the Health Services Union and Diana Asmar
MS J. BURNS appears for the State of Victoria

COMMISSIONER PAGONE: Mr Bolster.

MR BOLSTER: Yes, thank you, Commissioner. I call Ms Virginia Anne Clarke who I understand will take an affirmation.

<VIRGINIA ANNE CLARKE, AFFIRMED [9.30 am]

<EXAMINATION BY MR BOLSTER

MR BOLSTER: Ms Clarke, could you state for the benefit of the record your full name.

MS CLARKE: Virginia Anne Clarke.

MR BOLSTER: Have you prepared a statement in this matter – unfortunately, it doesn't have a date but you prepared it some time last week; is that correct?

MS CLARKE: That's correct.

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

MS CLARKE: I do.

MR BOLSTER: Are there any changes that you wish to make to that statement?

MS CLARKE: No.

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

MS CLARKE: Yes, they are.

MR BOLSTER: Commissioner, I tender Ms Clarke's statement which is WIT.0790.0001.0001.

COMMISSIONER PAGONE: Yes, thank you. The witness statement of Virginia Clarke will be 18-8.

EXHIBIT #18-8 WITNESS STATEMENT OF VIRGINIA CLARKE (WIT.0790.0001.0001)

MR BOLSTER: Could I ask that the two photographs of Ms Clarke's father be displayed. They are RCD.9999.0424.0001 and 0002. I tender those photographs, Commissioner.

COMMISSIONER PAGONE: Yes, the two photographs will be exhibit 18-9.

EXHIBIT #18-9 TWO PHOTOGRAPHS OF MS CLARKE'S FATHER (RCD.9999.0424.0001 & RCD.9999.0424.0002)

MR BOLSTER: Now, Ms Clarke, that is your father, isn't it?

MS CLARKE: Yes, it is.

MR BOLSTER: And we see him in about 1941 on the right?

MS CLARKE: Yes.

MR BOLSTER: Can you see that?

MS CLARKE: Yes ..... at his 90th birthday.

MR BOLSTER: That was some time ago, wasn't it?

MS CLARKE: Yes, it was; four years ago.

MR BOLSTER: And your father was a resident of Newmarch House, wasn't he?

MS CLARKE: Yes, he was.

MR BOLSTER: And, unfortunately, he passed away on 19 April this year?

MS CLARKE: That's correct.

MR BOLSTER: And he was 94 when he left you; correct?

MS CLARKE: Correct.

MR BOLSTER: Tell us a little bit about his background. How old was he when he joined the air force?

MS CLARKE: Dad was 18 when joined the air force and he worked on the Catalina flying boats. Prior to joining the air force he worked for a company doing – that dealt with wool and stock and stud. Then he joined the air force. He was in the air force for three years. Then when he left, he went back to his old company. He had

met my mum prior to joining the air force and when he returned, they got married and they ended up having seven children.

MR BOLSTER: So he was an auctioneer, a stock and station agent and from your statement it appears that you travelled around a lot?

MS CLARKE: We did. He was manager of different stores. We went from Sydney ..... to Newcastle and from Newcastle to Orange and then Orange to Forbes and then from Forbes back to Sydney where he became state manager.

MR BOLSTER: Eventually he moved into Newmarch House?

MS CLARKE: He did. He was living – my parents were living ..... out at Mulgoa. When my mum passed away, he sold and moved closer to Penrith to be closer to us and then after a couple of years, he had to have an operation and then after that, he didn't want to go back home again. He didn't like being by himself. So he wanted to go to Newmarch House.

MR BOLSTER: Now, before March of this year, how did he get on at Newmarch; did he enjoy it?

MS CLARKE: He did enjoy his time at Newmarch. He liked the people there, he loved the staff. He socialised a lot more than when he was at home. They were very good, they looked after him. He thoroughly enjoyed his time there. He called it home.

MR BOLSTER: He had a health issue in that he needed oxygen, you say in your statement. Tell us a bit about that?

MS CLARKE: Yes, when he was working through – when he was in the air force, and he was smoking because that was part of the ..... he had an issue with his lungs ..... but then he got pneumonia really badly and ended up in hospital for a couple of weeks and after the pneumonia that impacted on his lungs and he had a lot more difficulty with his breathing. So the doctor made use of oxygen to help him keep his airways opened.

MR BOLSTER: And did he have a tank that he could control himself during the course of the day?

MS CLARKE: Yes, he had a machine in the room. I can't remember what it was called. And, yes, he did that himself. He had Panadol, it was only a low dosage, he didn't have a high dosage of oxygen but it just basically helped him. He could still do different things. He could get himself up, go and shower, go to the toilet, shave. Go out and have breakfast by himself without the oxygen. So he had it there 24/7 but he could still do different activities without it, if he needed to.

MR BOLSTER: And was he a high care or a low care resident?

MS CLARKE: Low care resident. He did everything for himself. He showered himself. You know, he did most things himself.

MR BOLSTER: Right. Now, you mentioned that there had been earlier lockdowns at Newmarch in relation to flu and gastro and the like.

MS CLARKE: That's correct.

MR BOLSTER: Tell us how that was managed before COVID.

MS CLARKE: Sorry?

MR BOLSTER: How was that managed before COVID?

MS CLARKE: Before COVID if there was a gastro or a flu going around and they would go into lockdown we usually received an email to say that they were going into lockdown. Then nobody was allowed to go in and dad wasn't allowed to go out. So they didn't last very long. They usually lasted about two weeks. But Dad had a phone and we could still ring him and talk to him and he was quite happy with the lockdown provided that he had his normal routine, you know, the meals on time. Some time he got a bit bored but he understood the reasons we had – that he was in lockdown because he didn't want to get the gastro or he didn't want to get the flu so he was perfectly okay with the lockdown. Then when they go out of lockdown they would email us again and say that lockdown was now ceased and we could go and visit Dad.

MR BOLSTER: Did he ever catch anything during those lockdown periods that you are aware of?

MS CLARKE: No.

MR BOLSTER: And how would you describe the level of care that he received at Newmarch before March of this year?

MS CLARKE: Prior to COVID-19 Dad received very good care. As he was in low care, so he didn't require a lot of help with anything but he enjoyed the social aspect of it all.

MR BOLSTER: Well, everything changed in February when there was a lockdown there. Can you describe to us how that came to be implemented?

MS CLARKE: We got a notification that – well, with COVID-19 that it was recommended that we limit our visitation to Dad and not take him out at all because we used to take him out for lunches, not to let him – allow him to mix within the community. So they had restricted lockdown at that time where we could still go and see Dad because I used to do his washing and so forth, for him. So we were still allowed to see Dad. We just had to fill out a form to state that we hadn't come back

from – we hadn't travelled overseas, that we didn't have, you know, any symptoms, we didn't have a cold or cough or anything like that. We filled out the form and then we just went in and saw Dad and then but they wanted us to limit our time there, and as I said, not take him out.

MR BOLSTER: All right. And that continued through February and March, I take it?

MS CLARKE: That's correct, yes.

MR BOLSTER: And when did that change?

MS CLARKE: It changed on – we got a notification on Easter Sunday – sorry, no, it changed – they went into full lockdown in around about March, I think, where we weren't allowed to go in to see Dad at all because I think the virus had started spreading around about the end of March, 23 March that they went into full lockdown because the virus was becoming more, you know, in the – more vigilant in the community. So they decided that they didn't want anyone coming in and to keep our parents and our families safe they decided to go into full lockdown on the 23rd of March. We got an email to say that we could no longer go and see Dad. And then, so, yes, that was 23 March.

MR BOLSTER: After you got that email, how did you communicate with him?

MS CLARKE: Dad still had his phone so we could ring up and talk to him or he could ring us up and we could talk to him on the phone, and if he needed anything, he would ring and we could still take it to Newmarch House, but we had to leave it at the front door and walk away and notify them that we had left a package for Dad at the front door. And after we left, someone would come out and collect the package and take it in to Dad.

MR BOLSTER: All right. Now, everything changed about Easter, didn't it?

MS CLARKE: Easter Sunday, I received a phone call to say that a staff member had tested positive to COVID-19.

MR BOLSTER: What happened then?

MS CLARKE: I was in shock a bit. I asked how do we proceed from here now that the staff member has tested positive, what happens with the residents? What happens with Dad? They – I was told by the person that had rung me that all he was doing was notifying family that the staff member had tested positive. He couldn't answer any questions or anything. He said he will follow up with an email, which I did receive later that day. But when I tried to ask questions, they said I had to go through a special coronavirus update ..... but I didn't get any responses to any of the emails that I sent.

MR BOLSTER: Now, your statement mentions that you were told that all the residents had to be tested over the next couple of days; is that correct?

MS CLARKE: That's correct. They said that because the staff member had tested positive, they would be testing all the residents and the staff that had been on duty during the period of time that that staff member had been working.

MR BOLSTER: All right. Did anyone tell you when your father was tested?

MS CLARKE: No. No. I knew he was tested because Dad had said that they came and stuck this thing down his throat and which left him very, very hoarse.

MR BOLSTER: So when that happened, he called you to tell you that that had happened or did you call him?

MS CLARKE: I called him to see what was going on. And he just said, "Somebody has been in my room and I have to – and I had to be tested for this" – he called it "this virus thing".

MR BOLSTER: After that, did you keep in contact with the facility about the results of the test?

MS CLARKE: I kept – we rang. I rang every day to find out what was happening. Usually whoever answered the phone couldn't tell me anything. They said we'd have to get somebody to ring you back. Sometimes we would get a phone call back. Sometimes we wouldn't. The phone call back was always just to give me Dad's vitals like his temperature and his blood pressure or anything like that. There was never any – and I asked about, you know, whether his results came back. They said they'd get the results in the morning and if you haven't been contacted then they don't have Dad's results back yet.

MR BOLSTER: Now, you got a call on the 17th from the residential care manager of the facility, didn't you?

MS CLARKE: Yes, that's correct.

MR BOLSTER: Without mentioning that person's name, can you tell us what that person told you?

MS CLARKE: Well, she just rang up to see how we were. Just because Dad had been in for seven years so we knew her quite well and she – it was just a call to see how we were and just a check-up, basically, to how we were handling everything that was happening. And I said, "Look we are still waiting. We don't know what's happening with Dad. We don't know if he tested positive, we are still waiting for the results". And she said, "You don't know?" And I said no. She said, "I'm really, really sorry. He has got his results back and he has tested positive for COVID-19". And she said "On his record that I have here it said that you were notified yesterday".

And I said "No, we did not". I said I had spoken to somebody at the centre yesterday. I had been given an update on his vitals such as, you know, temperature and everything, but nobody confirmed with me that he had had a positive test result.

MR BOLSTER: What was your reaction to that?

MS CLARKE: I was in shock. I didn't know what to say. I got a bit upset and I said – and then I said – and I asked her some questions. And she said, "Look, you know" – because she was in a bit of shock as well because she thought I already had known. So, and she said "Look, I will have to go" so she went, and then that was it. We didn't have any more communication from her or from anyone else even though I sent messages to say well what happens now? What happens with Dad's – what's his prognosis? What's the treatment? How do we proceed from here?

MR BOLSTER: Was there any discussion about your father going to hospital because of the positive test at any stage?

MS CLARKE: No. There was no discussion about that. As I said, I did speak to a staff member afterwards when I was trying to find out what happened, and she said, "Look, he's only got a very mild case of COVID-19." So I took that to assume that, well ,he was okay. He only had a mild case so they probably wouldn't be sending him to hospital. And I didn't ask that, and they didn't ask if I wanted him sent to hospital or not.

MR BOLSTER: You refer to a conversation you had with another staff member the following day, that's Saturday the 18th.

MS CLARKE: That's correct.

MR BOLSTER: About advanced care planning for your father. Can you tell us how that conversation developed?

MS CLARKE: She – they rang me and said "We have to have an end-of-life form completed." I said, well, "Dad has already completed an end-of-life form and she said, "Well we have to update our records". It needed to be completed at least once every 12 months and she said it hasn't been filled out. And I said, "Well, so is there any reason we are doing this now?" and she said "No, there's not. It's just everybody is doing it". And I said, "Well, I don't want to do this without talking to my father" because he still, even though he was very hoarse and it was very difficult for him to talk, I mean, he still, you know, he still knew what was happening and so forth. So I said, "I would like to speak to my dad first before I fill out the form."

So I said "Can you please make sure the phone is near him so I can talk to him before I fill out this form" and she said yes, she will do that. And then about an hour or an hour and a half later she rang me back and said your father has got the phone next to him you can call him now. So I rang Dad and we went through the form and we filled it all out. There's a section on the form about going to hospital if required.

Dad wasn't always keen on going to hospital, and I said to him "Dad, if you needed to go, you've got to go" and he said, "Well if you're going to come, I will go." I said "I can't come with you because I'm not allowed to be there" and he said, "Well, I won't go then". And I said, "Dad, if you need to go, if they tell you have to go to hospital, you need to go" and he said "Okay, we'll see". So and that was – and then we filled out the form, scanned it in and I sent it back to Newmarch House.

MR BOLSTER: So on the Friday when you found out that he had tested positive, just going back a day, had you spoken to your father about that and talked to him about the test?

MS CLARKE: No. He – he – I did speak to Dad but he couldn't talk properly; he was very hoarse. He kept saying that the thing that they stuck down his throat had hurt his throat, and he said he couldn't talk. So I didn't keep him on the phone. We – he didn't – I don't know whether he knew he was tested positive for COVID-19. I don't even know – I think he knew that there was COVID-19 around but I think he thought he was just in a normal lockdown to protect them. And he did say "You know, maybe this virus is going to get me, I don't know." And I don't know whether he knew he had COVID-19 or not.

MR BOLSTER: Just pausing there. Did anything in your conversation with him on the Saturday, when you talked to him about the advanced care planning, did anything in the conversation suggest to you that he knew that he had COVID-19?

MS CLARKE: No. No, we just went through the form. He didn't ask anything. The only thing that we talked mainly about was if he went – if he would go to the hospital or not. But no, he didn't ask any questions and I didn't say anything to him because I didn't know what Newmarch House was telling him, and I didn't want to upset him by, you know, telling him that he was tested positive if he didn't already know that or if they didn't want him to know that. So I hadn't said anything to him about it.

MR BOLSTER: Did you raise with anyone at the facility how to resolve that impasse?

MS CLARKE: I had asked. I said, I asked the staff member one time when they – I finally got on to somebody, I said "Does Dad know that he has COVID-19? Does he know that the test result came back positive?" And they said "Look, we can't answer that". She said, "I don't know." I said, you know, "Do I tell Dad, do I not tell Dad?" And she said, "I can't answer that question, that's entirely for you" and that was the end of the conversation.

MR BOLSTER: Am I right in thinking – I just want to make sure we get this right – the reason why you didn't want to tell him is that you didn't want to upset him at the time?

MS CLARKE: I didn't want to upset him. If he didn't know – he was by himself in a room. I didn't want to tell him when he was by himself.

MR BOLSTER: If your father - - -

MS CLARKE: Sorry, I thought that somebody should have told him or if they wanted me to tell him I could have done but I wanted someone with him because I couldn't explain anything to him, if he asked "Well, what happens now?" "I don't know, Dad".

MR BOLSTER: And you mentioned that there was some discussion about some doctors were planning to come back and see him on the following Monday.

MS CLARKE: That's correct. The staff member that I spoke to when we were filling out the form, and I asked about treatment and so forth, she said, "Well, there was an infectious diseases team working out of the Nepean Hospital" and they had been to see Dad on the Friday. And I said, "Well what did they say, what was their plan going forward, treatment, what was his prognosis and everything?" She said, "Look, they're coming back in the Monday and we will update you after they have seen your father on the Monday". Unfortunately, he died on the Sunday.

MR BOLSTER: And your father died on the Sunday?

MS CLARKE: That's correct.

MR BOLSTER: Was there anything communicated to you to suggest that that was something that was going to happen relatively soon?

MS CLARKE: No, nothing whatsoever. I even – I received an email from the staff on Sunday morning at 4.11 to say that Dad was sleeping peacefully. He had rung me the night before very stressed because he didn't – he said he couldn't breathe, his oxygen was off and he was hungry, and he wanted something to eat. So I had rung the staff and they went and checked on him. They said he had taken his oxygen mask off himself. They had put that back on and they had ordered a meal for him. On the Sunday morning I got an email to say that he had eaten all his meal, and he was sleeping peacefully.

MR BOLSTER: Your father didn't suffer from any cognitive impairment, did he?

MS CLARKE: No.

MR BOLSTER: He knew what was going on, didn't he?

MS CLARKE: He knew what was going on. He always knew. And he could – yes, he had a really good memory. He knew – if we had talked to him about it and spoken to him about it, he would have understood. The reason I didn't want to tell him is because I didn't have enough information myself to tell him anything.

MR BOLSTER: Was he the sort of person that communicated to you and told you things about his health care if there was a problem, that he would let you know?

MS CLARKE: Yes.

MR BOLSTER: Or was he one of those people that sort of tried to shield you from it?

MS CLARKE: No, I think he would have told me because I was the primary contact person for him. I think he would have told me. I don't think he was concerned. I think that he – the only time, as I said, he rang Saturday night and that was the first time that he had any concerns or issues and that was mainly with his breathing because he didn't have his – he didn't have oxygen.

MR BOLSTER: There were some problems, weren't there, after he died, arranging the funeral because of certification of his death. Can you tell us briefly about how that played out?

MS CLARKE: Yes. After Dad died, they rang me up and said, you know, that he had passed away. And they said someone will be in touch with you later. I didn't know how – what to do, how to handle Dad's body or, you know, given he died of COVID-19. I was waiting for some direction from Newmarch House or Anglicare and – but in the meantime Dad had been – he was a member of the Sydney RSL subbranch and they had been in contact with him checking up on Dad. So I had rang them and told them that Dad had passed away. They had recommended a funeral director that they used for returned soldiers but I said, "No, you know, I have to wait for Anglicare to contact me" or someone to contact me because I didn't know how to proceed from there.

So finally, the funeral director actually contacted me and just told me how – what would happen and how we would proceed. Then Newmarch rang and I spoke to them but all they wanted to know who was the funeral director and when would the body be ..... and I said, "Well, I was waiting for you for some direction" and so forth. So I went with that funeral home. She picked up Dad's body and then from the Sunday morning to the Tuesday afternoon, we had tried to get someone to sign off on the death certificate because his doctor hadn't seen him for over a month. And he didn't want to go and see the body or he couldn't see the body. So the funeral director and the other doctor couldn't sign off on the death certificate because they had only seen Dad once so they didn't really know him.

So then we had to get permission from the Health Department, taking photographs, having the photos identified and then the doctor could sign off on the certificate on the Tuesday afternoon.

MR BOLSTER: You had to organise all of that yourself, did you?

MS CLARKE: Well, I was doing it but the funeral parlour – the lady from the funeral director was very good and she did a lot of it. She took a lot of it on herself and helped me out doing it and she was the one who contacted the Health Department.

MR BOLSTER: Just talking about the funeral itself, you were limited to 10 people who could attend the funeral?

MS CLARKE: Yes.

MR BOLSTER: And I take it there would have been a lot more people who would have loved to have come to see your father off?

MS CLARKE: Because I've got, there's seven children so straightaway there's seven but they all couldn't attend because two of them lived in Queensland so they couldn't come to New South Wales at that time. None of his grandchildren could attend. He had so many grandchildren, great grandchildren and great-great grandchildren so we had to be very strict on who could come. Basically, it was just – there was five children living in New South Wales. So each one of them could bring somebody, a husband or a partner. And that's how we had to do it. So it was very difficult trying to choose who could go and who couldn't go.

MR BOLSTER: The fact that your father hadn't seen a doctor for a month, was that fairly typical of his general health; was he relatively healthy?

MS CLARKE: I think he hadn't seen the doctor for over a month because I don't think the doctor had access because it was in lockdown because of COVID. But yes, basically, Dad was fairly healthy. He didn't – he didn't suffer from anything that needed constant medication or a doctor checking him all the time.

MR BOLSTER: Have you spoken to representatives of Anglicare and expressed your views to them about what happened to your father and your family?

MS CLARKE: No, not really. I did speak to one person and asking him about updates, you know, whether – even after Dad passed away, whether we could still get updates or anything because we still knew a lot of residents that were in Newmarch House. We had become friends with a lot of families. But, no, they said once Dad had passed away, we couldn't – no longer have any further contact with Newmarch House.

MR BOLSTER: How did that make you feel?

MS CLARKE: It was very hurtful. It made us feel cut off.

MR BOLSTER: I mean, I take it there would have been people that you would have come to know over the time your father was there, that you would form friendships and have conversations with rather than just hello, goodbye.

MS CLARKE: We did, we did, and I still maintain contact now after they contacted me and I still talk to them. We still ring up – so that some of the residents there I still have contact with. Yes, you know, you make friendships, Dad made a lot of friends and consequently they became our friends as well.

MR BOLSTER: What's the message that you would like to convey to the Royal Commission about how your father was treated and how we can get things right in the future?

MS CLARKE: Yes. There's one thing that happened before Dad's funeral was that I got contacted by the crematorium. They couldn't accept Dad's body because we had no time of death. I tried to contact Newmarch House. Could not get any answer to a phone call. So then I had to estimate his time of death so the crematorium would accept his body. So what I would like to see moving forward would be – sorry, I'm just going to go through my statement here.

MR BOLSTER: Please do. Take your time.

MS CLARKE: Yes. After Dad's experience I would like to see some changes. Things should be better. Technology – you know, we weren't allowed to go and see our family but technology, prearranged video calls with family would be beneficial to both the resident and the families outside. Proper paperwork, record-keeping needs to be updated. And also the staff ratios. You know, when you go into a lockdown and you have still got the same staff that are there when you are not in lockdown, Dad was in low care, so, you know, if you're pressing the buzzer and you've got quite a number of people pressing buzzers, wanting assistance or help or just to see somebody, basically, to talk to somebody basically.

I just think the staff ratios need to be increased when there's an epidemic or gastro or whatever and I think also staff need to be trained more. I think they need better training. I do not believe that having a carer without a lot of training is appropriate, especially in this situation when the New South Wales government insists on having hospital in place for the aged care facilities, then it needs to be as a hospital in place. So he needs to be able to access doctors all the time, nurses, and a fully equipped – equipment – all the equipment that is required that they would have access to if they were in a hospital.

Nobody actually told me what treatment dad was getting. I think that more communication, ringing up, giving a daily or even twice a day, ringing up in the morning and saying, you know, "Your dad slept well last night. He has had his medication" telling me what – how he went, what he – if he is eating, what will be happening to him during that day. And then at night ringing up and saying, you know, "He is okay, he is going to bed. He has eaten his meal". Just giving us more information about what was happening within the facility, because I didn't have access to any of that.

MR BOLSTER: Let me ask you a question – sorry.

MS CLARKE: Sorry.

MR BOLSTER: You mentioned hospital in the home.

MS CLARKE: Yes.

MR BOLSTER: Do you remember mentioning hospital in the home. Was that something that anyone raised with you - - -

MS CLARKE: No. I didn't know about that until – what happened was we hadn't heard anything for a number of weeks from Anglicare, and then I got on to an advocacy group and they were the ones that informed me that they were doing – they had decided to do hospital in place rather than transporting any of the residents out of Newmarch House, they wanted to confine them, keep them in there, which I could understand they didn't want to spread the virus. But when they have hospital in place, to me it's a hospital in place, like with nurses and everything that that, all the facilities that they would get if they had gone to a hospital.

MR BOLSTER: Was there anything else you wanted to tell us, Mrs Clarke?

MS CLARKE: No, I just, as I said, I just think the communication needs to be better and, you know, our elderly need to be protected. It's not fair what happened to my dad and other residents at Newmarch House.

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

COMMISSIONER PAGONE: Yes, thank you. Commissioner Briggs?

COMMISSIONER BRIGGS: No, I have no questions, but I do want to say how terribly sorry I am to hear of the situation.

COMMISSIONER PAGONE: Yes. Mrs Clarke, I echo those sentiments. It's tragic what has happened and have you relive them again today can't have been easy. And, indeed, having relived them when helping us coming up with the written statement that you have provided for us. Thank you very much for all of your assistance that you have given us. I know how difficult it is, and we really feel for you and thank you very, very much for sharing that with us and with the nation, generally. Thank you.

MS CLARKE: Thank you.

MR BOLSTER: Thank you, Commissioner.

COMMISSIONER PAGONE: I formally excuse you from further attendance.

<THE WITNESS WITHDREW [10.06 am]

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioner, we are a little bit early for the next witnesses. I'm not sure, they were scheduled for 10.15.

COMMISSIONER PAGONE: Let's see whether - - -

MR ROZEN: They are available. We are ready to go. I'll just wait for them to appear. I formally called Ms Erica Roy and Mr Grant Millard. They're now on the screen. Can you hear me, Mr Millard? Unfortunately, I can't hear you.

MR MILLARD: Can you hear us now?

MR ROZEN: Yes, I can, thank you very much. And Ms Roy, I'm assuming.

MS ROY: Yes, I can hear you.

MR ROZEN: Thank you. You can hear me and I can hear you. Great, thanks very much. Can I start with you, Mr Millard; could you state your full name please.

MR MILLARD: Grant William Millard.

MR ROZEN: And Mr Millard, you are the chief executive officer of Anglicare and have been since 2016.

MR MILLARD: Yes, I am.

MR ROZEN: I just realised the witnesses haven't been sworn. My apologies. Sorry, Mr Millard, Ms Roy, just some formalities we have to attend to here.

<ERICA MARY ROY, SWORN [10.08 am]

<GRANT WILLIAM MILLARD, SWORN [10.08 am]

MR ROZEN: Thank you. I'm sorry about that Mr Millard and Ms Roy. For completeness, Mr Millard, if you can confirm for us you on the chief executive officer of Anglicare Sydney and you have been since 2016.

MR MILLARD: That's correct.

MR ROZEN: And in that capacity you head up the executive team and report to the board.

MR MILLARD: I do.

MR ROZEN: You were the public face of Anglicare earlier this year during the Newmarch House response to the pandemic.

MR MILLARD: I was.

MR ROZEN: Mr Millard, for the purposes of the Royal Commission, you have made some statements; is that right?

MR MILLARD: That's correct.

MR ROZEN: The first of those is dated 24 July 2020 and it bears the code here WIT.0787.0001.0001. That statement attached a chronology of events at Newmarch House and I understand from your legal representatives that there were some minor errors in that, that you would seek to correct; is that right.

MR MILLARD: That's correct.

MR ROZEN: Those corrections, I will ask you to accept, have been made in accordance with correspondence that has passed between your solicitors and the solicitors to the Royal Commission, and without taking up any time I can indicate on the transcript that the amended chronology as provided is RCD.9999.0434.0001 and will take its place in the Newmarch tender bundle which is exhibit 18-3, Commissioner.

Accepting from me, please, Mr Millard that the chronology that I have just referred to is in accordance with the document provided by your solicitors, are the contents of your statement otherwise true and correct?

MR MILLARD: Yes, they are.

MR ROZEN: I tender the statement of Mr Millard dated 24 July 2020, Commissioner.

COMMISSIONER PAGONE: That will be exhibit 18-10.

EXHIBIT #18-10 STATEMENT OF MR MILLARD DATED 24/07/2020 (RCD.9999.0434.0001)

MR ROZEN: Is it necessary to refer formally to the amended chronology as part of the exhibits so that there is a clear link between - - -

COMMISSIONER PAGONE: That is already one of the exhibits though, isn't it?

MR ROZEN: It is now an exhibit, yes.

COMMISSIONER PAGONE: So it's in evidence and you have indicated the connections in the transcript.

MR ROZEN: As long as you're content with that. thank you. In addition more recently, Mr Millard, you provided us with a further statement dated 10 August 2020.

MR MILLARD: Yes.

MR ROZEN: And that statement responds to some matters raised by Mrs Clarke, the witness that we have just heard from; is that right?

MR MILLARD: It responds to her written statement. Unfortunately, due to technical difficulties I didn't have the opportunity to hear her testimony this morning.

MR ROZEN: Okay. All right. And you have corrected me in response to her written statement which is exhibit 18-8 in these proceedings. And are the contents of that second statement dated 10 August 2020 true and correct?

MR MILLARD: Yes.

MR ROZEN: It's WIT.0375.0001.0001, and I tender that second statement of Mr Millard dated the 10th of August 2020, Commissioner.

COMMISSIONER PAGONE: The statement of 10 August 2020 will be exhibit 18-11.

EXHIBIT #8-11 STATEMENT OF MR MILLARD DATED 10/08/2020

MR ROZEN: Ms Roy, you are a registered nurse by training?

MS ROY: Yes.

MR ROZEN: And you have worked for Anglicare since – sorry, you have worked in aged care since 2009?

MS ROY: Yes.

MR ROZEN: And you have worked for Anglicare in aged care since 2016?

MS ROY: Yes.

MR ROZEN: You're the manager of the service development and practical governance team at Anglicare?

MS ROY: Yes.

MR ROZEN: And you set out some details about that at paragraph 9 of your statement, which I won't go to now. But in summary, that team of which you are the manager, establishes systems for clinical governance at Anglicare; is that right?

MS ROY: Yes.

MR ROZEN: You are also a member of the clinical governance committee at Anglicare when that committee reports to the board?

MS ROY: Yes.

MR ROZEN: And you are a member of the crisis management team at Anglicare?

MS ROY: Yes.

MR ROZEN: You have, for the purposes of the Royal Commission, prepared a witness statement dated 7 August 2020; is that right?

MS ROY: Yes.

MR ROZEN: That's WIT.0793.0001.0001. Is there one minor error at paragraph 19 of that statement, Ms Roy?

MS ROY: Yes.

MR ROZEN: That's just an incorrect reference to a document, paragraph 19 on page 4 of the statement, and there is a reference there in the very last line of paragraph 19 to a document ANG.526.001.0001 and would you seek to correct that so it is ANG.527.001.0001?

MS ROY: Yes.

MR ROZEN: With that change being made, are the contents of your statement true and correct?

MS ROY: Yes.

MR ROZEN: I tender the statement of Erica Roy dated 7 August 2020, Commissioner.

COMMISSIONER PAGONE: That is exhibit 18-12.

EXHIBIT #18-12 STATEMENT OF ERICA ROY DATED 07/08/2020 (WIT.0793.0001.0001)

MR ROZEN: I should thank you on behalf of the Commissioners for the very helpful statements that you have provided to us, Mr Millard and Ms Roy. They very helpfully identify a number of matters arising from the experience at Newmarch House responding to the pandemic and helpfully identify some lessons which you consider can be learnt. Each statement describes a series of steps that were taken prior to 11 April 2020 which was the first day of the outbreak of Newmarch House; is that right?

MR MILLARD: Yes.

MR ROZEN: Mr Millard, I'll – well, perhaps I'll address my questions initially to you, Mr Millard. And when I want you, Ms Roy, to answer questions, I'll – I'll make it clear. The organisation was asked to self-assess its level of preparedness by the Aged Care Quality and Safety Commission; is that right, Mr Millard?

MR MILLARD: Yes. Each of our residential aged care homes was required to do that.

MR ROZEN: How many homes does Anglicare have altogether?

MR MILLARD: 22.

MR ROZEN: Are they all in New South Wales?

MR MILLARD: All in greater Sydney, Illawarra, Shoalhaven, correct.

MR ROZEN: Okay. Thank you. And in very general terms, is Newmarch House one of the bigger or smaller ones or is it about average?

MR MILLARD: It's about average. Our smallest home, I think, is about 48 beds. Our largest is 237. So it's – it's in the mid-range.

MR ROZEN: Okay. And just for the record, Newmarch House has how many beds?

MR MILLARD: It's a licence of 102, but, at the date of the outbreak, there were 97 residents.

MR ROZEN: Thank you. Now, the self-assessment survey results are part of the evidence before the Royal Commission. And I will ask that that brought up. It's in the Newmarch House tender bundle at tab 7. Sorry, tab 12 and it's CTH.4026.1002.0008. Are you in a position where you can see these documents as they are being brought up, Mr Millard and Ms Roy?

MR MILLARD: It is now on screen.

MR ROZEN: Yes. Terrific. Thank you. And, Ms Roy, I'll address these questions to you. You'll see your name on the – on the document there in the middle of the right-hand column: do you see that?

MS ROY: Yes.

MR ROZEN: And it's the case, isn't it, as I understand it from your statement, that the responses at the various homes were completed by the facility managers; is that right?

MS ROY: Yes, yes.

MR ROZEN: And you, in your role that you described for us earlier, coordinated those responses and provided them back to the regulator; is that right?

MS ROY: Yes.

MR ROZEN: And that's why we see your name appearing on the Newmarch House one. Presumably it appears on all of the others as well?

MS ROY: Yes, it does.

MR ROZEN: And did you give any instructions to the facility managers as to how they were to go about conducting the self-assessment?

MS ROY: Yes, I did. So we had already begun our preparedness before we were asked to do the self-assessments.

MR ROZEN: Yes.

MS ROY: And already had in place outbreak management plans for each of the homes. So we'd also provided a preparedness check-list – in fact, we had two different ones that each home was asked to do – and to build an outbreak management plan and to provide responses to this self-assessment through consultation with their teams and, operationally, what they knew needed to be done in their area of the business.

MR ROZEN: Self-assessments of this nature are part of the ordinary business of an approved provider; are they not?

MS ROY: Yes.

MR ROZEN: That's because, as part of the three yearly accreditation cycle, there is a requirement to do a self-assessment in advance of an accreditation audit; is that right?

MS ROY: Yes, there is. And, yes, we do. And, in fact, we have an ongoing self-assessment system as part of our program to meet the standards.

MR ROZEN: I see. That's the eight Quality Standards that all approved providers are required to meet; is that right?

MS ROY: Yes.

MR ROZEN: Now, you'll see that there's a series of questions on this you were – that Newmarch House was asked to answer. And I won't – I won't go through all of them, but I just draw your attention to the first three that appear on the screen there:

Does the service have an infection control/respiratory outbreak plan?

And the answer was "Yes":

Has the service updated its infection control/respiratory outbreak plan this year?

And the answer was "yes". And then, thirdly:

Have the relevant health care providers/organisations in the community been involved in the planning process?

Once again, the answer was "yes". Do you see that, Ms Roy?

MS ROY: Yes, I do.

MR ROZEN: In fact, all the questions on this were answered "yes" for Newmarch House; were they not?

MS ROY: Yes.

MR ROZEN: Just out of interest, was that the case for all of the – all of the homes? Are you in a position to tell us that?

MS ROY: All of the homes answered the questions according to their preparedness.

MR ROZEN: Yes.

MS ROY: And some of them did some work before we actually submitted our self-assessments to ensure we covered all of those answers.

MR ROZEN: All right. But my question is a slightly different one.

MS ROY: Yes.

MR ROZEN: Did they all have 23 yeses on them to the questions.

MS ROY: Yes, yes.

MR ROZEN: Yes. All right. And were they all rated as best practice ..... on the question.

MS ROY: They were.

MR ROZEN: All right. Now, you were asked – as part of the preparation for your statement, you were asked by the Royal Commission to reflect on those answers. And you very helpfully have done that in your statement at page 9. If that could please be brought up, paragraph 45. And you say there:

> *I am asked my opinion about whether, with the benefit of hindsight, the assessment of Newmarch House's readiness in the Aged Care Quality and Safety Commission's self-assessment questionnaire as "best practice" was accurate.*

And your response, at 46:

> *I considered the assessment to be accurate at the time, in light of the preparedness measures set out above with regard to then-current resources about preparation, including the CDNA's best practice guidelines.*

If I could just pause there for a moment. The CDNA is the – I will get the name of it right – the Communicable Diseases Network Australia; is that right?

MS ROY: Yes.

MR ROZEN: And without necessarily taking you to the document, but I'm happy to if you would like me to, that was a document that had been drawn to the attention of Anglicare by the Commonwealth Department of Health only a few days before you were asked to do this survey; is that right?

MS ROY: That is correct.

MR ROZEN: Yes. And it was drawn to your attention as guidance material to assist in preparation for COVID-19.

MS ROY: Yes, it was.

MR ROZEN: Right. For the record, the document is at tab 7 of the general tender bundle. You then go on – and returning to your statement – at paragraph 46, you say that those guidelines you:

…understood to represent the appropriate steps that should be taken to prepare for an outbreak, as well as our assessment of the current state of information on COVID-19 (including from the New South Wales and Commonwealth Departments of Health and the World Health Organisation).

And then for completeness at 47:

With the benefit of hindsight –

you say –

I acknowledge that the assessment was not accurate. In particular, I acknowledge with sadness some of the ways in which Anglicare Sydney during the outbreak (especially with keeping family members updated about their loved ones at a time of great anxiety and distress), and maintaining care standards for our residents at a time of huge challenges with staffing numbers.

Ms Roy, are you able, briefly, to summarise the ways in which, in hindsight, you consider that the best practice assessment was not accurate?

MS ROY: Yes. I think the assessment around, the CDNA guidelines drew us to treat COVID as a flu-like illness.

MR ROZEN: Yes.

MS ROY: And, I think, in hindsight, we realised that it's a lot more virulent and a lot more – has a lot more of an impact. Also, the use of, in hindsight, the contingency that the self-assessment spoke about and around staffing, definitely our strategies around preparing for a loss of staff. We could probably have had a larger number, although we had a limited number in our surge team, that would be something that, now, I would think was best practice to have a greater number of staff available.

MR ROZEN: Yes.

MS ROY: And the use of an infection prevention specialist on the ground would be something that would be best practice in my eyes now.

MR ROZEN: All right. And they're each matters that you have expanded on in your witness statement; is that right?

MS ROY: Yes.

MR ROZEN: And I will ask you about a couple of those in the time that's available. The first issue I'd like to ask you about is something you address at length in your witness statement, Mr Millard, and it concerns decision-making processes throughout the course of the response to the outbreak at Newmarch. And you make the point

that there were a number of State and Commonwealth agencies. And you also say – and no doubt it's true – that you are very grateful for the assistance that you received from many of those agencies during the course of the outbreak; is that right?

MR MILLARD: Yes, I am.

MR ROZEN: It's fair to say, isn't it, Mr Millard, that a provider such as Anglicare, even a relatively large provider such as Anglicare, is in no position to respond to an outbreak such as you experienced at Newmarch House without the assistance of Commonwealth and State agencies? Do you agree with that?

MR MILLARD: I think that's clearly the case. The resource requirement is massive.

MR ROZEN: The Royal Commission is interested in understanding how the various agencies that must necessarily be involved in responding to an outbreak of COVID-19 can work better. Do you understand that's the focus of the - - -

MR MILLARD: I do.

MR ROZEN: - - - Commissioners' interest in this issue? You have dealt with this issue in some detail in your witness statement. And I also want to draw your attention to something that you said to the board of directors of Anglicare when you were reporting to them. This – the minutes of this board meeting are found at tab 79 of the Newmarch House tender bundle, which is ANG.503.005.8254. And the page I want to ask Mr Millard about is the third page of the minutes at .8256. If that could be brought up. It's just the bottom part of that page. Now, it's the second last dot point on that page. Mr Millard, do you see that?

MR MILLARD: I can see it.

MR ROZEN: Yes. Firstly, these minutes, do they accurately record the update that you provided to the board at this meeting on the 6th of May 2020?

MR MILLARD: It is accurate, yes.

MR ROZEN: And you will see, in the second last dot point, the one that's highlighted there, that you said to the board that:

> *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 (the authorities) with an interest in management of the outbreak. 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 and how this authority intersects with Anglicare's responsibilities under the Aged Care Act to manage the home.

I want to ask you a little bit about the observations that you made to the board. Firstly, that "frustrating level of dysfunction" that you describe, was that something you experienced consistently between the commencement of the outbreak on the 11th of April and the date of providing this report on the 6th of May, or did it change during that time?

MR MILLARD: The level of dysfunction or disagreement about issues was particularly intense over the first two weeks of the outbreak, but towards when this report was being prepared – and the minute is based on a report that I gave, I guess, in advance of the board meeting date – matters were being substantially resolved.

MR ROZEN: In your statement, you identify one particular manifestation of the dysfunction which occurred in the first week of the outbreak, and that was the question of whether residents who were testing positive were to be transported from Newmarch House to hospital for treatment. Do you understand what I'm talking about?

MR MILLARD: Yes, I do.

MR ROZEN: And if I can draw your attention to paragraph 128 of your statement, please, which is on page 25. If that could please be brought up, the first statement, exhibit 18-10. At that point in your statement, you have referred to a number of meetings – and I won't go through each of them – but there were a number of meetings on the 15th, 16th and 17th of April which are detailed in your statement and a number of other statements before this Royal Commission, that indicate a level of disagreement between the Commonwealth and the State, between the Commonwealth officials and the New South Wales officials, about this issue of hospitalisation. Have I sort of fairly summarised the area of disagreement?

MR MILLARD: Yes, that was principally the issue of concern. It was about cohorting, decanting, to a certain extent about testing process as well.

MR ROZEN: Yes. And just to be accurate, the discussions, if I can use that neutral term, concerned the possibility of removing from the site residents who tested positive, so that they could get treatment off-site. That was one aspect of those discussions; is that right?

MR MILLARD: Yes, that's correct.

MR ROZEN: And there were also discussions about whether perhaps the residents that had tested negative could be removed from the site as well and perhaps taken to another facility or to a private hospital, for example; is that right?

MR MILLARD: Yes, that's correct. And the issue of decanting negative residents was more often discussed as – the longer the outbreak went on.

MR ROZEN: Yes. In your statement, in the third line there, after referring to the conferences and discussions as being very robust, you say:

> *Initially it was not at all clear who had the authority to resolve these disputes, particularly as regards issues of clinical care including testing and resident cohorting and relocation.*

I take it that, in the very novel circumstances that you were finding yourself in as the second facility in Australia to be responding to COVID-19, that you were looking to the Commonwealth and State authorities for guidance, but you were also particularly looking to the experts for their clinical judgment as to what was in the best interests of the residents; is that right?

MR MILLARD: Yes, that's exactly right. I mean, everyone was clearly exercised and passionate about how this could be dealt with quickly and for the expert opinion to be declared. But it just wasn't clear who was in a position to give that advice.

MR ROZEN: Dr James Branley is mentioned there in your statement. He was assisting Anglicare in responding to the Newmarch House outbreak in his capacity as an infectious diseases specialist working in the Local Health Network in which Newmarch was located; is that right?

MR MILLARD: Yes. Dr Branley just made an outstanding contribution. He was passionately invested in this. He was there from the very beginning. I think he first attended at site on the 13th.

MR ROZEN: Yes. You, on the 16th of April, decided to go to the Aged Care Minister, to talk to the Aged Care Minister, Minister Colbeck, to try and get some resolution; is that right?

MR MILLARD: Yes, I did.

MR ROZEN: And why did you take that step and, particularly, what was it about Dr Branley that led you to speak to the Minister?

MR MILLARD: There was one of the conference calls on the 16th of April where there was a heated interaction or robust discussion about cohorting strategies, decanting either positives or negatives, and this issue had been on the table, I think, for a couple of days. It wasn't being resolved. There was a high degree of frustration. And James Branley opposed the idea of transferring positive residents or even negative residents out of the home. His view, as I understand it, was that even those who had, at that stage, tested as positive were really incubating the virus and they would be positive. And he was concerned about spread of the virus to outside

Newmarch House. And I was greatly concerned that James Branley would walk away.

And the concern came out from a subsequent telephone discussion, which one of my regional managers had with Dr Branley. He was gravely concerned about who would make decisions here. And he was also threatening to walk, but he was – he was really saying that he couldn't operate under this environment where it wasn't clear that what would be done in the best interests of residents, in his perspective, would be followed. I was greatly concerned about that and sought to how look how could this impasse be resolved.

MR ROZEN: And so you contacted the Minister, what, personally, did you; is that right?

MR MILLARD: I reached out to Anglicare Australia, of which I'm a board member, and someone there made contact, I think, with one of his staffers. And Mr Colbeck phoned me back within a number of hours.

MR ROZEN: And are you able to summarise for us, without going through, blow-by-blow, what you said and what Senator Colbeck said. What, in summary, the conversation covered?

MR MILLARD: Certainly. My concern was about decision making authority saying that – one thing I did know even at that stage was that there needs to be clear decision making, a line of command, if you like and from my perspective, Dr Branley was the only person who was actually around – he was actually in the home – who had the expertise of being in Wuhan. He had assisted Dorothy Henderson Lodge to resolve their outbreak. He was very present, and we looked to him as an expert. I didn't want to lose him and, in my opinion, he should be making the decisions on clinical matters in the home.

MR ROZEN: Right. And what was Senator Colbeck's response?

MR MILLARD: He took my request, my advice, and he undertook that he would raise the matter and it would be resolved.

MR ROZEN: And did you have any further communication with the Minister or his department about the question?

MR MILLARD: Minister Colbeck actually phoned me a number of times during the outbreak to offer support and query some things that were going on, but he was always involved and seeking to lend support as he could. The resolution about Dr Branley's role was resolved, I think, within a matter of six hours or so. Michael Lye determined that Dr Branley would be responsible for clinical matters in Newmarch House.

MR ROZEN: And that was Michael Lye who is a Deputy Secretary working in Minister Colbeck's department; is that right?

MR MILLARD: That is correct.

MR ROZEN: Yes. And he contacted you, did he, to convey that response?

MR MILLARD: I can't recall now whether he gave me a call in isolation or whether this matter was clarified in a scheduled call that day with Michael Lye, Janet Anderson and others, but it was clear.

MR ROZEN: All right. In your statement at paragraph 129, just at the bottom of that page you say:

> *An outbreak management plan was developed for Newmarch House by the health and social policy branch, New South Wales Ministry of Health –*

and others. At the top of the next page:

> *The purpose of that plan was to document and agree roles and responsibilities and this also helped clarify the various agencies' roles and responsibilities.*

I take it that's the case, that with the plan being in place that those questions about governance arrangements, if I can use that term, for responding to the outbreak were clarified; is that right?

MR MILLARD: That was the purpose of the impasse we were seeking to reach and to my understanding that was finally resolved in this document on the 21st.

MR ROZEN: Yes. And Dr Lyons from New South Wales Health also gives some evidence about that and if I can summarise what he says – and this is at paragraph 17 of his statement – without it being brought up unless you need to see it. He expresses the opinion that such a plan ought to have been in place prior to the outbreak rather than being developed along the way. What do you say about that, Mr Millard?

MR MILLARD: Well, Anglicare did have an outbreak management plan.

MR ROZEN: Yes.

MR MILLARD: The issue was that in seeking to resolve a COVID-19 outbreak our level of preparedness and the documentation of the plan was based on what we understood based on CDNA guidelines, etcetera, and clearly this was much more complex. And we were looking for knowledge, expertise from all quarters, which I think is appropriate in the circumstances. We were learning.

MR ROZEN: Yes. I don't want you to think for one moment that I'm trying to make some cheap point about that. I'm trying to understand, from your perspective, what the lesson to be learnt is. I think you may have just conveyed it to us, that is, that – and I might bring you in here, Ms Roy, too – that answer to the first question in the self-assessment survey, "We've got an infection control plan" perhaps was based on a lack of appreciation of what such a plan looks like for a COVID response. Is that – am I summarising your evidence correctly, Ms Roy, that you gave a moment ago?

MS ROY: Yes. We deal generally with outbreaks in residential facilities seasonally and we have outbreak management plans that reflect that, and at that time it was our understanding it was a flu-like illness and what we know now is very different.

MR ROZEN: I see. As I think you told us earlier, that was in part informed by those CDNA guidelines that had been prepared?

MS ROY: Yes.

MR ROZEN: Thank you. Mr Millard, can I just draw out this question of hospitalisation in a bit more detail because it has been, obviously, the subject of a great deal of media interest and we have just heard the evidence – and I know you didn't have the opportunity to – from Mrs Clarke about questions of hospitalisation of her late father. Once again, can I start with the report that you gave to the Anglicare board, and this one appears at tab 90 of the Newmarch tender bundle. That's ANG.514.001.0012, if that could please be brought up on the screen. And there's some redacted parts of this which relate to matters that don't concern the interests of this Royal Commission; is that right, Mr Millard?

MR MILLARD: That's correct.

MR ROZEN: Some financial matters and other matters that were discussed at the board meeting. These would indicate - - -

MR MILLARD: That's correct.

MR ROZEN: I'm sorry, I didn't mean to interrupt you. If you can scroll down the screen a little bit more, the minutes indicate that both you and Ms Roy were present at this board meeting; do you see that just a little further down?

MR MILLARD: Yes.

MR ROZEN: And the meeting was on 27 May 2020. I think I'm right in saying the outbreak had not been declared over at this point in time. That came early in June, I think, didn't it, Mr Millard?

MR MILLARD: Yes, that's correct. It was substantially resolved – or under control but because of the number of case and erring on the side of caution, the outbreak was not declared over until mid-June.

MR ROZEN: So in contrast to that meeting three weeks ago that I asked you about a moment ago when, really, you were in the thick of responding and in fact on that day I think you had had the notice issued to you by the aged care regulator. By 27 May, some three weeks later you were in a better position, perhaps, to reflect on the events. Is that a fair observation?

MR MILLARD: Yes, that's correct.

MR ROZEN: And if I can ask you about something you said to the board, and it appears at page 0017, as part of what is referred to as the chief executive's update:

Issues arising from or related to the COVID-19 outbreak at Newmarch House.

One of the matters that you were reporting to the board on concerned Anglicare's preparedness in the event of an outbreak of COVID-19 at another one of its homes. Is that right? Sorry, Mr Millard, you may have frozen. Can you hear me all right? I think we may be having some technical difficulties.

MR MILLARD: I'm sorry you just dropped out there, counsel.

MR ROZEN: No, that's all right. The question that I asked you, I'm not sure how much of it you caught; I will repeat it. One of the matters that you were addressing in this update to the board concerned Anglicare's preparedness for an outbreak of COVID-19 at another one of its homes. Is that right?

MR MILLARD: Yes, that's correct.

MR ROZEN: Yes, thank you, Mr Millard. Did you catch all of that question?

MR MILLARD: Yes.

MR ROZEN: Thank you.

MR MILLARD: Yes, I did.

MR ROZEN: All right. We will persevere for the moment. If it gets worse we might have to see if we can renew the connection or some other thing but for the moment please let me know if you haven't caught a question that I've asked. In the middle of that page, if we can scroll down a little bit, the second of the black dot points, it starts "In the event". The minutes recorded you as saying to the board:

In the event of infection at another 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.

What caused you, on that day, looking back at the experience you had had, to tell the board that you would be more assertive or Anglicare would be more assertive; what did you mean?

MR MILLARD: During the – the hospital in the home program - - -

MR ROZEN: Yes.

MR MILLARD: I'm sorry, can you hear me?

MR ROZEN: Yes, I can. Thank you. We're having a little bit of trouble but I can hear you fine.

MR MILLARD: Sorry. During the early stages of the outbreak, when the hospital in the home program was made available for Newmarch House, the understanding was that any COVID-positive residents who it was clearly indicated that they would benefit from being transferred to hospital, and if that was in accordance with the resident's wishes or their decision maker if they did not have cognitive ability to make a decision, it was clinically indicated then that would be possible. With the benefit of hindsight, looking to manage an outbreak – a significant outbreak like we had for 37 positive diagnosed residents in a residential aged care facility, it just presented a monumental challenge. My comments were more related to the concern about the risk of infection to other residents in the home.

MR ROZEN: Yes.

MR MILLARD: And to the risk of infection to staff and those working with those residents. And also because you had the ongoing presence of COVID-positive residents in it home, it really had another impact on the – all the residents who were still confined to their rooms. I believe that if we would have been able to transfer out COVID-positive residents earlier, we might have had an earlier liberalisation of what was, really, extremely difficult for our residents to go through being isolated in their rooms with the doors closed.

MR ROZEN: Thank you. I want to just understand that a bit more, if I can. The policy that was implemented, as you've said in your statement, and we have got this in other witness statements, was known as hospital-in-the-home. And Dr Branley was one of the key medical practitioners who were part of the implementation of that. There were also others. There was a different group which involved a geriatrician that was assisting with the implementation of that policy; is that right?

MR MILLARD: That's correct. I mean, there was an outstanding team of clinicians who were brought to bear, the Virtual Aged Care Service or VACS, from Nepean Blue Mountains Hospital, and Dr Branley, yes.

MR ROZEN: And no doubt from your perspective, and from what you saw and were told by your staff, everyone that was part of implementing hospital-in-the-home worked very hard and very conscientiously to do so; is that a fair description?

MR MILLARD: Yes. I mean, the commitment of our staff was just – just incredible. But, yes, they worked to the best of their abilities and yes, we were resource constrained with people to do that.

MR ROZEN: And not just your staff, but the hospital-in-the-home staff, the people that were coming in from VACS, Dr Branley and others, all were very conscientious and worked very hard to try and achieve the best results for the residents; is that right?

MR MILLARD: They certainly did. I mean Dr Anita Sharma from VACS, Dr Branley; they were – they were great. They were very passionate, they were available, they brought resources to bear, but they were medical practitioners. Our critical shortage was to do with registered nurses and care workers. And we were really left to your own devices there to source those people and, yes, through Commonwealth help as well.

MR ROZEN: I will come to that in a moment if I could. I will just focus for the moment on this question of hospitalisation and hospital-in-the-home. One of the documents that has been provided to the Royal Commission is a New South Wales health document entitled Adult and Paediatric Hospital in the Home Guideline. I don't know if you are at all familiar with that, but I must ask that be brought up, please. It is behind tab 1 in the general tender bundle. It's a document dated 9 August 2018. And according to the first page, as you can see there, it:

> *...provides direction and practical suggestions for the implementation of a hospital-in-the-home program –*

and then goes on. I particularly want to ask you about something which appears on page .0198 of the document. At 7.3 you will see there's a section of the document that deals with residential care facilities. Without going through all of that, I just want to draw your attention to the third paragraph, the HITH or hospital-in-the-home service:

> *...should establish a written agreement in regard to the roles and responsibilities of the residential care facility and the service. Residential care facility staff must be given training and support if they are to assist in the clinical care and management of acutely unwell patients. For example, include administering continuous intravenous antibiotics through a central venous catheter.*

Obviously, that particular example didn't apply here. But my question is this: to your knowledge, Mr Millard, was there a written agreement in place in regard to the

roles and responsibilities of the facility and the hospital-in-the-home service prior to 11 April 2020?

MR MILLARD: I'm not aware of any written agreement. I certainly have never seen one and the inquiries we have made, none was executed, no.

MR ROZEN: All right. Ms Roy, you're perhaps a bit closer to the operational detail of the organisation. That's something you would be aware of, isn't it, through your role on the clinical governance committee, if there was such an agreement?

MS ROY: Yes, I haven't seen that document until you brought it to our attention and, no, there's no written agreement that I'm aware of.

MR ROZEN: All right. Looking to the future, were there to be an attempt to implement a hospital-in-the-home program at one of Anglicare's facilities, whether in relation to a COVID-19 response or any other matter, would your suggestion, Ms Roy, be that that sort of written agreement identifying roles and responsibilities, governance arrangements and so on, would be of benefit?

MS ROY: Absolutely of benefit.

MR ROZEN: And would you also say that the sort of training and support that is anticipated in the document for your staff to get so that they can properly implement the hospital-in-the-home program would also be beneficial?

MS ROY: It would definitely be beneficial to have something like that.

MR ROZEN: All right. And reflecting on the experience at Newmarch; why is that? Why would such an agreement setting out governance arrangements and that sort of training, why would that be beneficial? How would that improve the implementation of hospital-in-the-home in one of your homes?

MS ROY: If we were to have that implemented with that support and those accountabilities, it would be definitely helpful. I mean, the outcomes for residents would certainly be impacted in a positive manner. People would have understood what their roles were and what the expectations were. The staff that are working within residential aged care facilities are not as trained to look after people who are acutely unwell, and in normal circumstances when a resident is acutely unwell, the usual practice would be to transfer them to hospital for acute care. So that would have been extremely helpful.

MR ROZEN: Thank you. You deal with this subject under the heading Support for Approved Providers in your first statement, Mr Millard. If that could perhaps be brought up; it's paragraph 179 on page .0034. Just before taking you to that, the evidence of Dr Branley in his statement – and we understand he will confirm this later this morning – is that a policy within the Local Health Network where Newmarch House falls, the policy had already been implemented that COVID-19

would be responded to by New South Wales Health pursuant to the hospital-in-the-home program. In other words, before 11 April when your outbreak had occurred that policy decision had already been taken by New South Wales Health. Were you aware of that at the time?

MR MILLARD: No, not aware of it. I certainly had never received notification of that.

MR ROZEN: All right. Mrs Clarke just gave evidence about her late father's experience. I know you didn't hear it. I will try and accurately summarise it. Her evidence was that she at no time knew that the hospital in the home, or hospital in place, as she referred to the program, was in fact being implemented at Newmarch House. Do you have any comment on that?

MR MILLARD: I'm not sure particularly why Ms Clarke may not be aware of that at the time, but certainly we had communicated that in email correspondence to all residents and families about the implementation of the hospital-in-the-home program. It didn't elaborate in great detail as to what that was but we did make reference to it certainly in that first week of the outbreak.

MR ROZEN: All right. I should know the answer to this but is that an email that has been provided to the Royal Commission, do you know?

MR MILLARD: I would need to check with our counsel but certainly these were broadcast emails of all – daily email updates. I believe they would be there, yes.

MR ROZEN: All right. Could I ask, after you have completed your evidence today, if you could please confirm that with your legal team and just ask them to communicate with the Royal Commission's legal team about identifying the particular email that you are referring to. Thank you.

MR MILLARD: Certainly.

MR ROZEN: Back to 179 of your statement, you are reflecting on one of the lessons to be learnt. You say:

> *For future outbreaks a State Government policy decision about whether the hospital-in-the-home policy should continue would also benefit approved providers. If New South Wales Health's hospital-in-the-home policy does continue in New South Wales for future outbreaks, approved providers would benefit from the State Government making experienced clinicians, such as nurses and carers, available to implement the policy in a residential care setting.*

That's really building on the evidence that you've just given in response to the question I asked you about, what needs to be in place to make hospital in the home work; is that right?

MR MILLARD: Yes, that's correct. It is really going to the point that although we were provided with Virtual Aged Care Services, Dr Branley whose work was indispensable; to run a hospital you need substantially more – a greater number of registered nurses to do that. It's just not the way a residential aged care home operates.

MR ROZEN: In addition to nurses, you need equipment, presumably, that at least gets close to the equipment that would be available in one of our public hospitals; is that right?

MR MILLARD: I think if you compare the level of equipment, the resourcing, you know, it's not reasonable to anticipate any of that level of equipment resourcing would be available in a residential aged care home. That would have to occur in a hospital.

MR ROZEN: Dr Lyons from New South Wales Health will give evidence tomorrow. One of the documents that he has drawn to our attention through the New South Wales Health legal team is a very recently produced guidance document on the implementation of hospital-in-the-home in relation to COVID-19. I won't take you to that document once again unless it would assist you. But my question of you, Mr Millard, is was Anglicare consulted in relation to the development of that policy guidance document by New South Wales Health?

MR MILLARD: No.

MR ROZEN: Do you think that you would be in a position to offer some views about how hospital-in-the-home can best be implemented in a residential aged care facility as part of a response to COVID-19?

MR MILLARD: We certainly would.

MR ROZEN: Thank you. I'm just about to go on to a new topic, Commissioner. I'm conscious of the time. It might be an appropriate time to have a break.

COMMISSIONER PAGONE: Yes, all right.

COMMISSIONER BRIGGS: Commissioner Pagone, could I just ask one question, please?

COMMISSIONER PAGONE: Of course, yes.

MR ROZEN: Sorry, Commissioner Briggs.

COMMISSIONER BRIGGS: That's all right. It's really a question about whether or not you think that New South Wales Health had made assumptions that you would be able to resource Newmarch House at the same level as a hospital, or were they

simply unfamiliar with the aged care system and didn't appreciate what would be involved in dealing with this pandemic in aged care?

MR MILLARD: Commissioner, with respect, I think that's really a question for State Health to ponder what was in their thinking and mind, but I think it's generally understood the significant resourcing difference that's provided for an average bed day in a hospital as opposed to a residential aged care setting. There could just be a misunderstanding or not an acknowledgement of that. But it does go to this point about the need for a much closer collaboration as an entire health system between State and Federal.

COMMISSIONER BRIGGS: Yes, it certainly does. Thank you very much and thank you, Commissioner Pagone. That's it from me.

COMMISSIONER PAGONE: Thank you. We will adjourn for 15 minutes and resume at 11.15.

ADJOURNED **[11.00 am]**

RESUMED **[11.16 am]**

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioner. Mr Millard, I just want to ask you about one thing arising from the answer you gave to Commissioner Briggs. You talked about the difference between resourcing of hospital beds as compared to aged care beds. Can you expand on that? What do you mean?

MR MILLARD: Well, certainly. My understanding, in terms of the – well, on an average, the funding for an aged care resident per day is something in the order of $250 to $300 if you add in accommodation supplements and the aged care funding instrument, versus someone in a hospital, certainly in acute, would be something in the order of at least $1200, $1300 a day. So it's just a substantial difference in the level of funding and resourcing. I think others have commented on that.

MR ROZEN: Yes.

MR MILLARD: And my numbers are approximate.

MR ROZEN: I understand that. And we won't hold you to the numbers. But is the point there that you get what you pay for? And to expect the hospital-like care in a residential aged care facility, need – anyone who expects that needs to understand the different resourcing; that's the point that you're making, I understand?

MR MILLARD: Yes.

MR ROZEN: Just before leaving the hospitalisation question, a question for you, Ms Roy. Mr Millard was talking about the implications for the non-positive residents of trying to treat the positive residents in the facility. And we understood the evidence that he gave about that. But from your, particularly, your clinical expertise, drawing on that, do you have any observations to make about that, about what the implications are for the general level of care that can be provided to all of the residents in a facility, of having a significant number of COVID-positive residents being treated at the same time?

MS ROY: Yes. The implication of having the COVID-positive residents along with the COVID-negative residents, the acute clinical status of those residents that were COVID-positive meant that resources were being pulled towards the focus on that acute care.

MR ROZEN: Yes.

MS ROY: So, having all of them in the home, it put a greater burden on an already stressed workforce. And when I say "stressed", a roster that was difficult to fill with capable staff, when we'd lost so many of our own, who had been sent due to isolate due to contact tracing.

MR ROZEN: Thank you. Sorry. I didn't mean to cut you off. Was there anything else you wanted to say about – on that topic?

MS ROY: No, no.

MR ROZEN: All right. Is the lesson to be learnt there that, in the future, any decision that's made about hospitalisation or non-hospitalisation of COVID-positive residents has to take – a buzz word I know – but a holistic view of all of the residents in the facility and not just a narrow view about what might be clinically indicated for one particular COVID-positive resident?

MS ROY: I would agree with that. They're a whole family in there and we need to treat each of them as important.

MR ROZEN: Indeed. Thank you. If I could turn to the topic of infection control expertise. Something you touched on very early in your evidence, Ms Roy, and something you deal with in your statement at paragraph 71. It's page 0013. Under the heading The Lack of that Expertise at an Early Stage, and that expertise is infection control expertise. Sorry. In paragraph 70, whilst that is being brought up, you say:

> *I strongly agree this is one of our key learnings from our experience at Newmarch House.*

And we heard some evidence about this yesterday in relation to Dorothy Henderson.

MS ROY: Yes.

MR ROZEN: If 72 could be highlighted, please. This goes back to the point you were making earlier, I think, Ms Roy, about what you and Anglicare, more broadly, had in mind in responding to the self-assessment survey, that is, that the planning was predicated broadly on what you needed for influenza and gastroenteritis. Once again, drawing on your clinical expertise, if we could, what are the lessons to be learnt from the infection control requirements for COVID, on the one hand, compared to what you had previously experienced by way of infectious diseases? And what is needed by way of expertise to address those differences, please?

MS ROY: So, I think, from the outset COVID is new, and we are learning about it all the time. What we would do for an influenza outbreak is not what we need to do for a COVID outbreak. And having someone on site to support the staff right at the outset, to set up the home, to manage the outbreak, right to the practical level of setting up and taping off areas in the home to be clean and dirty areas, ensuring there are no areas where there would be breaches in infection control processes, and actually guiding staff to manage that outbreak; that would be an outstanding benefit if we'd had that. And, in hindsight, it would have really helped us. And it's certainly a learning for the future and it would be really beneficial for all aged care homes in the sector to have, I guess, the benefit of someone who is an infection control professional.

MR ROZEN: How might that work in practice, Ms Roy? Would, for example, having some designation of people with appropriate infection control expertise in a given geographical area that might be available to facilities in that area, be of benefit, do you think?

MS ROY: Yes. I think, absolutely, that would be of benefit, and certainly to support residential staff, even in their preparations for an outbreak such as a COVID outbreak.

MR ROZEN: Yes. I mean, one of the, perhaps, ironies of the situations at Newmarch House is that you did have available in, you know, not very far away from Newmarch House, a great deal of expertise that could be drawn upon compared to, for example, someone in a facility in a regional centre might be quite different. Do you agree with that?

MS ROY: Yes.

MR ROZEN: Yesterday we heard from Ms Dicks from BaptistCare who came along as part of a management team to assist at Newmarch House. And she was making the point that one of the first things she considered was the need for infection control expertise from the Clinical Excellence Commission, drawing on the experience that she had had at Dorothy Henderson. Is that an example, going back to

the preparedness question that we spoke about earlier, Ms Roy, that to some extent at Newmarch you were – you didn't know what you didn't know. Or you didn't know what you needed to respond to COVID. Do you understand what I'm asking?

MS ROY: Absolutely. So, in hindsight, it would have been great to have that available and even to be flagged as part of the self-assessment, that that was something that was to be considered or even to have to be planned for in the event of a COVID outbreak. So, in hindsight, yes, absolutely and, into the future, it's certainly part of our planning.

MR ROZEN: Thank you. A related question to infection control experts is another phrase we have heard, "infection control champions". Is that an expression you're familiar with? I see you're nodding, Mr Millard. Ms Roy, is that something you've devoted some attention to? And can you describe that to the Commissioners how that's worked and how it's working?

MS ROY: Yes. So post the outbreak at Newmarch – and even, I guess, our thinking was being formed during the outbreak – was the need for us to build capacity within our own workforce around infection prevention and control. We've nominated a minimum of two staff from each home now to be trained up and to do a course specific to outbreak management, infection prevention and control in aged care, in the aged care setting. And we've also got three of our staff enrolled to become ICPs as a six-month-long course. So we're already trying to build capacity, but we also have built a relationship with Kathy Dempsey, and she's offering us support and mentoring and has giving us, I guess, advice as to where to get the training and the best places to look for that training.

MR ROZEN: So is that an option that might work in the sector, that type of train-the-trainer approach, because there aren't many Kathy Dempseys in the world, but you might – perhaps the sector might get more bang for its buck if she could train others who, in turn, could then provide training to – to care workers. Is that something you think could be explored?

MS ROY: I think it's a really good idea. I mean, we can build capacity in many ways. And also that will raise the importance of infection prevention and control in the aged care sector by doing it that way.

MR ROZEN: Before going on to the next topic, which is the workforce issue, we have just been provided with another Hospital in the Home policy document from New South Wales Health, which I should ask you about. Unfortunately, I'm not in a position to show it to you, it's literally just been provided to us. But I'll describe it. It's the Nepean Blue Mountains Local Health District policy entitled Nepean Adult Hospital in the Home (HITH). Is Newmarch in the Nepean Blue Mountains Local Health District, Mr Millard?

MR MILLARD: Yes, yes.

MR ROZEN: Okay. Were you consulted in the development of this policy, which is dated 5 August 2020?

MR MILLARD: Personally, no. I am aware, though, that a number of our residential home managers have participated in meetings concerning this policy. And there are a number of matters that have been brought to my attention. One is it would seem to be a fairly clear sort of blanket approach about not transferring COVID-positive residents to hospital. The other one is the stipulation, I think, that every home should have, I think, 30 days supply of PPE. They're two matters that come to mind. This is a very recent change.

MR ROZEN: Yes, okay. Ms Roy, are you able to assist us there? Is that a policy development process that you've been familiar with?

MS ROY: No. My – I received the final product without any knowledge around it.

MR ROZEN: Okay. Thank you. Once again, for completeness, do you think, Ms Roy, you would be in a position to offer some valuable input into the development of such a policy from the perspective of the residential aged care sector?

MS ROY: Absolutely. Myself and, certainly, other people who were operationally on the ground at Newmarch during the outbreak.

MR ROZEN: Yes. Thank you. You mentioned PPE. I'd like to just go on and deal with that topic briefly, if I can. In your statement, Mr Millard, your first statement, from paragraph 82 onwards, on page 0015, you, under the heading Experience Obtaining PPE and Implications for Managing the Outbreak. You set out in considerable detail the length that the organisation had to go to to get access to PPE, a process that you describe, in 103, as "incredibly challenging". And you say:

> *There was a lack of clarity about PPE access pathways at both state and federal level, no coordinated or centralised contact point and challenges in continuity in access and timely delivery.*

If I can just ask you about that. It's in paragraph 103 of the statement on page 19. Once again, was that right through the outbreak, from the 11th of April onwards, or was there some change during that period where things became easier or harder? Are you able to help us there?

MR MILLARD: Certainly. The – Anglicare, like many providers, was trying to shore up supplies of PPE before they might encounter an outbreak. There was a real struggle. There was a shortage of PPE internationally. We had many items on back orders. And this was a problem. So we did have a central supply of some PPE, which was on a site of ours, and that was immediately brought to bear. But it became very clear that there was not going to be enough in order to meet the needs at Newmarch House. And we reached out to the Commonwealth immediately to see

how we would access the national stockpile. We also contacted State Health. These matters are outlined in my – in my statement.

MR ROZEN: Yes.

MR MILLARD: It was a very frustrating experience early on. But I will say that once, I guess, relevant decision-makers were brought to bear, they were – did provide great assistance. But at some times it did seem that we were struggling to plead for the resources that needed to be applied.

MR ROZEN: Without taking you to the detail of it, I might just ask you about one email exchange which seems to illustrate the point. Before I do that, in that paragraph there you say that your:

> *...staff were being instructed by Dr Branley to use full PPE for all Newmarch House residents.*

That is all, whether they'd tested positive, whether they'd tested negative or whether or anyone else, for that matter. And there's an email exchange which I will ask you about, which seems to relate to that. It's at tab 47 of the Newmarch tender bundle, if that could please be brought up. If we can scroll down the page – that page, please. I can take you to the rest of it, if you need, but – sorry – if we can just scroll up a little bit, please. Michael Shehan, was he a member of the staff?

MR MILLARD: First name Shehan, last name Micheal – spelt e-a-l. Yes. He is our procurement manager.

MR ROZEN: I've got that completely wrong. His first name is Shehan is his second name is - - -

MR MILLARD: Micheal. Yes, that's right.

MR ROZEN: Micheal. Okay. Thank you. This exhibit has a series of emails. I don't think I need to take you to the detail of them, but if I can summarise them hopefully fairly. There was a request for the provision of PPE that would enable those staff members who were dealing with all the residents to be appropriately equipped with PPE, which, I take it, was as per Dr Branley's advice; is that right?

MR MILLARD: That's my understanding,. Yes.

MR ROZEN: Yes. And I think we seem to have lost that exhibit. If that could, please, be restored to the screen. It would suggest that the response that you got from New South Wales Health, we see there from Ms Barker:

> *As discussed please make sure the facility know not to use full PPE for anyone but positive and suspected cases. New South Wales Health is not in a position to provide approve what we already have.*

Is that an example of the sort of difficulty that you had, that those that you were seeking the PPE from were not in a position to provide you with what you needed to have to meet the medical advice you were getting from Dr Branley?

MR MILLARD: Yes, it is. It was deeply distressing. Based on the advice of the expert we had from Dr Branley about you really need to treat all of your residents as COVID-positive until it's proven otherwise through multiple rounds of testing over a designated period. That made sense. And I think that was our experience that many of the residents were still incubating - - -

MR ROZEN: Yes.

MR MILLARD: And, in fact, inadequate supply of PPE upfront meant that many of our staff in the initial stages were either infected or listed as close contacts, because they weren't supplied – they didn't have adequate PPE in the early stages.

MR ROZEN: All right. And is that another lesson from the experience that you've had, that one of the things that flows from the application of a policy like Hospital in the Home is that you just have to have the equipment to be able to implement it or else you end up in the worst possible world, where you are trying to implement hospital-like standards without the equipment to do so; is that right?

MR MILLARD: That is an example of it. Yes.

MR ROZEN: Thank you. You mentioned earlier about the workforce implications – and I think this is a point you were making, Ms Roy, earlier, if I understood you, that that self-assessment questionnaire asked you if you were in a position to deal with an outbreak that led to 20 to 30 per cent of your staff being unavailable. I don't think that's the word that was used but that was the gist of the question, was it not?

MS ROY: Yes.

MR ROZEN: And the experience, as I understand it from both your statements, is that that was a great underestimate of the reality that you faced. Is that right?

MR MILLARD: Yes.

MS ROY: Yes.

MR ROZEN: What was the position, Mr Millard? What proportion of your staff did you lose and over what period and in what circumstances?

MR MILLARD: Well, we had estimated in our, what we thought was conservative provisioning putting together a surge workforce of 30 to 40 people. Within a number of days we lost, we calculated, 87 per cent of our workforce.

MR ROZEN: You had actually built a bit of a buffer into your preparations, hadn't you? You had taken the 20 to 30 per cent figure and added 10. So you thought that you'd best prepare for 30 to 40. Even that obviously was inadequate; is that right?

MR MILLARD: Yes, it was inadequate, and the surge workforce which were available, and they had made personal sacrifices to put themselves into harm's way, if you like, they were themselves pretty early on ruled out as close contacts because of the PPE challenges.

MR ROZEN: At paragraph 110 of your statement, if that could be brought up on page 0020, you make reference to the assistance you received from the Commonwealth Department of Health in relation to a surge workforce, and there are two organisations that the Commonwealth put you in touch with. One was Mable and the other one was Aspen. They're not the full legal names, but you know the organisations to which I'm referring, Mr Millard?

MR MILLARD: Yes, I do.

MR ROZEN: Just sticking with Mable for the moment, am I to understand that – if we can put Aspen to one side, Mable were the only organisation that the Commonwealth were telling you they were funding for this purpose?

MR MILLARD: That's the only thing that was made available to us within the first week. The primary surge workforce capacity offered by the Commonwealth was through – through Mable, yes.

MR ROZEN: Okay. As you say there in the third sentence in that paragraph:

> *It quickly became apparent the staff that Mable could provide did not have the skills and qualifications that were needed in the particular circumstances.*

Can you expand on that; what skills and qualifications were they lacking?

MR MILLARD: Well, I want to be fair to Mable in this context, that this was – I think we were probably the first organisation, I imagine, to actually call on this resource which had only just been put in place. But the types of people who were being provided, I think there were very few people who had any residential aged care experience, some had home care experience. None of them had any practical experience in the use of PPE. Now, this was changed over a number of weeks and we were supplied by very capable people but early on they just weren't up to the task. It was dangerous for them.

MR ROZEN: You provided that feedback to the Commonwealth, didn't you, at the time?

MR MILLARD: Yes, I did.

MR ROZEN: And I think, as I'm understanding your evidence, things did improve. Is that because Mable found other people or because additional training was provided to the ones who were provided to you or some other way?

MR MILLARD: I think, to be fair, the requirements and specifications for the particularly challenging environment were better understood by Mable.

MR ROZEN: Yes.

MR MILLARD: And we, like Mable, were really fishing in the same pool for aged care workers.

MR ROZEN: Yes.

MR MILLARD: It wasn't as if they had a magic quarantine number of workers. We were all scratching around and people were scared. They were terrified of COVID and it was difficult to get people.

MR ROZEN: A final topic I want to ask you about, Mr Millard and Ms Roy, concerns the role of the regulator, the Aged Care Quality and Safety Commission headed up by Commissioner Anderson. The commission was quite active in two ways in relation to the response at Newmarch House. They were playing a role of assisting the response; do you agree with that? Providing advice to you and input to your response to the outbreak?

MR MILLARD: If assistance includes – Melanie Wroth, Ann Wunsch and others, they did provide advice, yes.

MR ROZEN: Yes. So Melanie Wroth, of course, is the chief clinical adviser to the Aged Care Quality and Safety Commission; is that right?

MR MILLARD: That's correct.

MR ROZEN: Ms Wunsch, you've referred to as well, who is a senior officer with the commission; they were involved in some of those early meetings that we were talking about before morning tea, the robust discussion meetings about cohorting and decanting of residents and so on; is that right?

MR MILLARD: That's correct, and Ann Wunsch, in particular, continued to be present at the ongoing meetings.

MR ROZEN: Yes. And we know from evidence that has been provided to the Commission that Commissioner Anderson herself participated in a webinar which was broadcast to residents' families on 23 April in which you were also a participant. Do you recall that?

MR MILLARD: That was our first webinar, yes.

MR ROZEN: Yes. The other participants were Mr Lye from the Commonwealth Department of Health; is that right?

MR MILLARD: Yes.

MR ROZEN: Dr Branley.

MR MILLARD: Correct.

MR ROZEN: And Mr Gear from OPAN, an advocacy service.

MR MILLARD: Yes, the Older Persons Advocacy Network, yes.

MR ROZEN: Indeed. How did Ms Anderson come to be involved in that; was that at your invitation?

MR MILLARD: Yes, it was. There was a webinar that was put together by Anglicare and the commissioner made herself available ,as did Michael Lye and James Branley who was very much involved. The involvement of Craig Gear from OPAN, that was at the instigation of the Aged Care Quality and Safety Commission, I believe, and that proved to be very useful over time.

MR ROZEN: Is it fair to summarise the contribution that Commissioner Anderson made to that webinar as being certainly not critical of the response that Anglicare was engaged in, in response to the outbreak; do you agree with that?

MR MILLARD: It was certainly not critical. I do acknowledge that at the time that webinar went to air on the 23rd, I think, we had received – or I had certainly had a discussion with the commissioner concerning the use of the BaptistCare personnel which was to take place on, I think the 24th or the 25th.

MR ROZEN: Yes, the BaptistCare management team, including Ms Dicks, came in the following day on the 24th, in response to a requirement that was imposed on you by the Aged Care Quality and Safety Commission; is that right?

MR MILLARD: That's correct. There had been a discussion with – I guess, Anglicare looking for support, but the Commission stipulating that we were to take them – to give them management responsibility.

MR ROZEN: Subsequently, of course, we know that the commission took far more serious regulatory action against you on 6 May, didn't they?

MR MILLARD: Yes, they did.

MR ROZEN: And in which you were required to agree to certain conditions, including the appointment of an adviser and not taking in any more residents and providing regular reporting to the commission, and if you didn't comply with those

conditions, you would potentially have your provider status – approved provider status revoked; is that right?

MR MILLARD: Correct. I believe the commission described it as the ICBM of notices.

MR ROZEN: Indeed. What I'm trying to understand is, from a provider's point of view, whether there is any potential for confusion on your part about the role of the regulator when they're essentially providing this sort of role assisting in response but then at the same time taking regulatory action imposing obligations on you. Was there any real confusion on your part about their role or was there from your perspective any potential for confusion; could you comment on that?

MR MILLARD: I think potentially there's an inherent conflict the one who gives advice and the one who audits their own advice the way it's applied. But to be fair, the commission's role, from our perspective, I think is clearly understood. They're the regulator, they have a strong hand in making the rules and their advice, to the extent it was given, was well received. But it was ultimately our responsibility as the approved provider to do what we had to do under the Aged Care Act.

MR ROZEN: A final matter about the regulator, since taking that action on 6 May, you appointed Mr Kinkade as an adviser. His time with Anglicare has now concluded; is that right?

MR MILLARD: That's right. That's ended.

MR ROZEN: He provided a report to both the regulator and to you which included his observations about his time and made some recommendations, particularly about governance arrangements; is that right?

MR MILLARD: Yes, that's correct.

MR ROZEN: And there's an ongoing process, is there not, of reviewing governance arrangements within Anglicare and that's something that's being done in consultation with the regulator, which the Aged Care Quality and Safety Commission; is that right, Mr Millard?

MR MILLARD: Well, certainly, Anglicare's board has itself undertaken an external review of its governance and practices and that has been done. The commissioner herself has graciously agreed to appear at two board meetings that the board has held so far; the last one I think was under two weeks ago now.

MR ROZEN: And has that been of benefit to the organisation from your perspective, the commissioner's input?

MR MILLARD: Yes, I believe it has, yes. Her advice was frank and fearless, and the board had done a substantial amount of work and, as I mentioned, had been

meeting many, many times during the outbreak of their own volition. They had undertaken a review of various matters and in fact they developed – I think it's about 48 action points to be completed before June next year. So there's a lot of change.

MR ROZEN: Thank you. For completeness and just so that you don't think we are neglecting it, we are aware that you've documented some of the further lessons, Mr Millard, that you think are there to be learnt from the Newmarch experience. You have done that both in your witness statement and also in some contemporaneous records that you made during the course of the outbreak, which are part of the tender bundle. I think you know the lists that I'm referring to.

MR MILLARD: Yes.

MR ROZEN: And time doesn't permit us to go to those, but it is important for you to know that we are aware of them and they're valuable and of assistance to the work that the Royal Commission is doing. In conclusion, I will ask each of you in turn, firstly you, Mr Millard, is there anything additional that you would like to say to the Commissioners from the perspective of lessons to be learnt from this very challenging experience that you had?

MR MILLARD: I would like to pay testament to the incredible sacrifice and hard work of so many people who never relented from their love and compassion for the residents in Newmarch House. It was an extremely difficult time. And those residents who tragically died in Newmarch House, they did not die alone. They knew that they were loved and cared for. And it has been traumatic for everyone involved in this situation. And I just need to pay testament to their sacrifice and love, and express my regret that organisationally we were challenged in communicating with families. We were absolutely overwhelmed with the challenges of dealing with COVID-19.

And we have had some learnings from that, particularly about communication from within the home to families because families missed their loved ones. They are stressed and they want to know how their mum is, how their dad is. And it's a struggle to do that with a completely foreign workforce in a home, wearing a face mask, who just don't know their mum and dad. It's very, very difficult. My heart goes out to all those Victorian homes at the moment.

MR ROZEN: Thank you, Mr Millard. Ms Roy, is there anything you would like to add to that from your perspective?

MS ROY: No. What Grant said is – I think he said what I was wanting to say.

MR ROZEN: Thank you. Commissioner Briggs, do you have any questions for these witnesses? Thank you. Commissioner Pagone.

COMMISSIONER PAGONE: Thank you, Mr Rozen. Thank you, Mr Millard and Ms Roy for the work that you have – the assistance you have given us. We are very

conscious of the efforts that you have had to undergo to provide the information. These are very difficult times. We are still living through them. And we are very conscious of the fact that you have put in time and resources and are helping us significantly in the work that we're doing. So thank you to each of you.

MR ROZEN: Before you excuse the witnesses, Commissioner Pagone, there's a request from Ms England who represents Anglicare for us to have a short break. The note I've been given - - -

COMMISSIONER PAGONE: Apparently not.

MR ROZEN: No? Sorry, Commissioner. Sorry, Mr Millard and Ms Roy. I'm reminded that a matter has arisen in relation to the Communicable Diseases Network Australia guidelines. Ms Roy, you will recall giving some evidence about this earlier and how they guided your response to the self-assessment survey; do you recall that?

MS ROY: Yes, I do.

MR ROZEN: Yes. It has been drawn to our attention that the version of the guidelines that is in the tender bundle that I was asking you about is the version 2 of those guidelines which post-dated the self-assessment survey. The Commonwealth has been good enough to provide us with version 1 which is dated 13 March 2020. The difficulty is that I'm not in a position to ask you to look at it because I don't think it has been uploaded to the system. But will you accept from me that there was the first version dated 13 March 2020 and that would seem to accord with the evidence you gave earlier about how you went about completing the survey on 24 March, that it was that version that you had in mind.

MS ROY: Yes, absolutely. I'm familiar with the number of updates.

MR ROZEN: Yes. Thank you. Commissioner, can I just clarify one other matter? All right. I'm instructed the witnesses can be excused, please.

COMMISSIONER PAGONE: Yes, thank you. I do formally excuse you and thank you for attendance and your help.

<THE WITNESSES WITHDREW [11.52 am]

COMMISSIONER PAGONE: Are there lawyers that need to be excused as well?

MR ROZEN: No such application has been made, so no. I think we can go straight into the next panel. I formally call Dr James Branley and Ms Kathy Dempsey. Dr Branley, can you hear us all right?

DR BRANLEY: I can, thank you, counsel.

MR ROZEN: Thank you. And Ms Dempsey?

MS DEMPSEY: Yes, I can. Thank you.

MR ROZEN: Good morning.

<JAMES BRANLEY, AFFIRMED [11.53 am]

<KATHLEEN MARGARET DEMPSEY, AFFIRMED [11.53 am]

MR ROZEN: Thank you. If I can start with you, Ms Dempsey. Can you state for the transcript your full name, please.

MS DEMPSEY: Kathleen Margaret Dempsey.

MR ROZEN: And Ms Dempsey, you are in the first place a registered nurse by training; is that right?

MS DEMPSEY: That's correct.

MR ROZEN: And you hold a number of other qualifications which are listed in your CV, which we don't need to go to.

MS DEMPSEY: I do, yes.

MR ROZEN: In terms of position, you are the senior manager of the Healthcare Associated Infections of the Clinical Excellence Commission in New South Wales; is that right?

MS DEMPSEY: That's correct.

MR ROZEN: And you a credentialled infection control practitioner?

MS DEMPSEY: Yes, I am.

MR ROZEN: Can you tell the Commissioners a little bit about what that means; who does the credentialing and are there different sorts of credentials that one can have as an infection control practitioner?

MS DEMPSEY: Yes, there is. So credentialing is done by the Australasian College of Infection Prevention and Control, the credentialing and professional standards committee of which I have been a member for a number of years and currently chair

for the college. There are a number of different levels for credentialing. You can be credentialled at a primary level, an advanced level or an expert level. So recognising your level of practice experience, expertise and qualifications. So I'm currently credentialled at an expert level. We currently have around 66 credentialled ICPs across Australia currently: around 47 at an expert level, and then the remainder in primary and advanced level.

MR ROZEN: For reasons that will become apparent, are you able to tell the Commissioners a little bit about where the 66 are located; are they to be found mainly in our larger cities, for example?

MS DEMPSEY: Predominantly sort of spread out but they're usually more senior ICPs and they're usually allocated in sort of major facilities or major programs.

MR ROZEN: When you say major facilities, do you mean hospitals primarily, is that where we find them working?

MS DEMPSEY: Yes, hospital, health care settings, hospitals, yes.

MR ROZEN: All right. Thank you. And you haven't provided a witness statement to us – and that's not meant as a criticism, we haven't asked you to, but you've been good enough to provide us with a CV which I do need to tender, Commissioner. It's RCD.9999.0396.0001. It's at tab 8 of the witness materials but does need to be given an exhibit number, please, sir.

COMMISSIONER PAGONE: All right. That will be 18-13.

EXHIBIT #18-13 CV OF KATHY DEMPSEY (RCD.9999.0396.0001)

MR ROZEN: Thank you. You have – before asking Dr Branley some introductory questions, Ms Dempsey, you are the author or the co-author of several reports that have been completed which have examined infection control processes both at Newmarch House and at Dorothy Henderson Lodge; is that right?

MS DEMPSEY: That's correct.

MR ROZEN: I will ask you about some of the details of that in a moment. Dr Branley, if I can come to you. You're an infectious diseases physician and a clinical microbiologist; is that right?

DR BRANLEY: That's correct, counsel.

MR ROZEN: Amongst many positions that you hold, you are the head of the department of infectious diseases and microbiology at Nepean Hospital in Penrith in Sydney; is that right?

DR BRANLEY: That's correct also.

MR ROZEN: In your witness statement, you have been good enough to provide us with a summary of your background experience and qualifications at paragraphs 8 to 18, have you not?

DR BRANLEY: I have.

MR ROZEN: Yes. And you've made a witness statement for us, which is WIT.0769.0001.0001. That's a witness statement dated 24 July 2020; is that the case?

DR BRANLEY: That's correct.

MR ROZEN: And have you had an opportunity to read through that statement before giving evidence this morning, Doctor?

DR BRANLEY: I have, counsel.

MR ROZEN: Anything in it that you would like to change?

DR BRANLEY: No, I'm happy with the statement, counsel.

MR ROZEN: All right. I tender the statement of Dr Branley dated 24 July 2020, Commissioner.

COMMISSIONER PAGONE: That is exhibit 18-14.

EXHIBIT #18-14 STATEMENT OF DR BRANLEY DATED 24/07/2020 (WIT.0769.0001.0001)

MR ROZEN: Thank you. As with so many other witnesses, Dr Branley and Ms Dempsey, the statement that you have made, Dr Branley, and the reports that you've completed, Ms Dempsey, have been very valuable to us, particularly because, firstly, Dr Branley, you had experience in responding not only to the Dorothy Henderson Lodge outbreak but also the one at Newmarch House; is that right?

DR BRANLEY: That's correct.

MR ROZEN: And Ms Dempsey, similarly, you had that same experience, both outbreaks, you were involved in, albeit Dorothy Henderson, your involvement was greater; is that right?

MS DEMPSEY: That's correct, although, sorry, I missed the last statement?

MR ROZEN: Yes. Your involvement at Dorothy Henderson – perhaps I incorrectly described it. You were involved at Dorothy Henderson earlier in the outbreak than was the case at Newmarch House; is that right?

MS DEMPSEY: That's correct.

MR ROZEN: All right. So I will ask you about that in a moment. If I can start with you, please, Dr Branley. Your involvement at Dorothy Henderson Lodge was, in a sense, in a voluntary capacity; is that right? You weren't actually deployed there by New South Wales Health. Have I understood that correctly?

DR BRANLEY: That is – that is correct. It was a voluntary act to go there.

MR ROZEN: Yes. And what motivated you to do that?

DR BRANLEY: I heard the Chief Medical Officer on the radio. And I sent her an email offering my services if she needed help. My understanding at the time was that there was some deficiency of medical staff because of furloughing of staff.

MR ROZEN: You had, of course, had some COVID-19 experience, both in Australia and as part of assisting with the evacuation of some Australians from Wuhan in China; is that right?

DR BRANLEY: Yes, that's correct.

MR ROZEN: Can you tell us briefly about what that involved, the Wuhan experience?

DR BRANLEY: Yes. Thank you, counsel. I am part of an Australian group called AUSMAT, which is the Australian Medical Assistance Teams, and we perform a range of tasks on request, often from the Federal Government. And I was asked and agreed to take part in the evacuation of Australians from the city of Wuhan. And we returned those Australians to 14 days quarantine on Christmas Island.

MR ROZEN: Thank you. And I take it that was a valuable experience in assisting with the outbreaks both at Dorothy Henderson Lodge and at Newmarch House?

DR BRANLEY: I think it was very valuable experience for me. And I would highlight one of my publications, counsel, where we have written up the testing experience on Christmas Island in terms of testing patients for COVID-19 or SARS-CoV-2.

MR ROZEN: Thank you. The first topic I'd like to ask the two of you about concerns the topic of infection control in residential aged care facilities. And a little bit of context here might be helpful. Firstly, in relation to Dorothy Henderson Lodge, you were both involved very early on in the response; is that right, Dr

Branley? You were there, I think, on – or you tell us. The first day of the outbreak was the 3rd of March.

DR BRANLEY: The 3rd of March. My first day at Dorothy Henderson was the 6th of March.

MR ROZEN: Yes.

DR BRANLEY: And, yes, you are correct. I did meet and discuss infection control with Ms Dempsey.

MR ROZEN: Yes, she was already there, I think - - -

DR BRANLEY: That's correct.

MR ROZEN: - - - at that point; is that right? Ms Dempsey, I neglected to ask you a little about the Clinical Excellence Commission, which I should do now. And then I'll ask you how you came to be at Dorothy Henderson. What is the Clinical Excellence Commission in New South Wales Health?

MS DEMPSEY: So the Clinical Excellence Commission is one of the five pillars of New South Wales Health. And it's tasked to support the system in quality and safety in patient care, and have a number of quality safety programs and initiatives and leadership training to help support the system in that. The Healthcare-Acquired Infection Program and infection control is one of those safety programs. So managing and implementing healthcare-acquired infection, strategies to reduce risk to patients and, I guess, the other arm of that is ensuring protection of our staff as well.

MR ROZEN: And how did you come to be involved at the first residential aged care facility that was dealing with a COVID-19 outbreak; Dorothy Henderson?

MS DEMPSEY: So I actually got a phone call from the Chief Health Officer on the 4th of March, at about 8 o'clock at night, asking if I would attend Dorothy Henderson; that they'd had some additional cases. So I wasn't the first infection control on site. The northern Sydney LHD infection control practitioner was on site with the first notification on the 3rd.

MR ROZEN: Yes.

MS DEMPSEY: And she'd spent most of that night into the early hours of the morning. And then because Ryde had had some other issues with cases, I had been asked to go in on the 4th to provide assistance.

MR ROZEN: We heard some evidence yesterday, Ms Dempsey, from Professor Lyn Gilbert, who I am sure you are familiar with, and Professor Mary-Louise McLaws, who I imagine you are also familiar with. Their evidence about the

challenges of the implementation of infection control principles in a residential aged care setting is of interest to the Commissioners. Did you happen to catch any of that evidence yesterday?

MS DEMPSEY: I did. Thank you, counsel.

MR ROZEN: Okay. I assume that the basic principles of infection control, which I think are set out in the reports that you prepared, I assume that the basic principles remain applicable regardless of setting. Is that a useful place to start?

MS DEMPSEY: It is. So the principles remain the same.

MR ROZEN: Yes.

MS DEMPSEY: And you can often transfer or translate the requirements to different settings.

MR ROZEN: Yes.

MS DEMPSEY: The challenges will be in the detail of those detail of those settings and the application and the understanding and the knowledge.

MR ROZEN: All right. Before your experience add Dorothy Henderson, had you had any experience of applying infection control principles in a residential aged care setting yourself? Is that something you'd had any personal experience of?

MS DEMPSEY: So in my role previously to the CEC - - -

MR ROZEN: Yes.

MS DEMPSEY: - - - running the infection control program at Western Sydney LHD and Westmead, we would often work with the aged care facilities and provide education and training for some of those facilities.

MR ROZEN: Yes. And that would be to, at that time, assist them in responding, what, to influenza outbreaks, for example?

MS DEMPSEY: So – yes. So responding to other communicable diseases, so influenza, gastro - - -

MR ROZEN: Yes.

MS DEMPSEY: - - - any of the multiple-resistant organisms, some of the novel multiple resistant organisms. So setting up some strategies and programs to manage those patients.

MR ROZEN: Are you able to reflect on your experience and help us with understanding the difference between the application of infection control principles responding, say, to an influenza outbreak on the one hand, with responding to a COVID-19 outbreak, on the other?

MS DEMPSEY: I think the principles, essentially, are very similar. The differences are the enormity. And, certainly, I think with any novel virus, there is also a lot of degree of anxiety. And you need to also combat the anxiety and fear from staff and other clinicians as much as trying to apply the principles themselves. I think, you know, the other issues are, you know, health care is very regimented and, I guess, very sort of strategic with infection control. Aged care, it's a balance between infection control and providing a homely and inviting environment and often the two don't match when things are going wrong.

MR ROZEN: Can you expand on that? What are the particular challenges, from the point of view of an infection control practitioner, to implementation of the principles in a residential aged care facility, taking the examples you've had this year to illustrate, if you like?

MS DEMPSEY: I think when you look at the methodologies for aged care, it focuses on a community spirit, community environment.

MR ROZEN: Yes.

MS DEMPSEY: So based on communal living, communal practices, you know, gatherings in the community way. Whereas, a lot of those things, in a health care setting, would be some of the first things that we would stop on a day-to-day basis. So, some of those – some of the design, some of the structure, some of the soft furnishings, you know, the carpet, all provide challenges for cleaning and decontamination. The fact that I think, as well, a lot of aged care residents have a lot of their own personal belongings and that, you know, from an infection control perspective, all adds to the microbial footprint when you are trying to manage and reduce the spread of infections.

MR ROZEN: Is another dimension to this the human beings involved? That is, that good infection control necessarily requires the people that are implementing it to follow certain rules on a consistent basis, such as the wearing of personal protective equipment and handwashing, and so on. Is that another dimension to the difficulty associated with doing it in a residential aged care facility compared, say, to a hospital, where such practices might be more part of the routine of the staff?

MS DEMPSEY: Well, the basic principles for any infection control, including standard precautions, should be equally applied regardless of the setting.

MR ROZEN: Yes.

MS DEMPSEY: And whilst COVID-19 or SARS-CoV-2 is novel, the principles for infection control are, in fact, not and the application of infection control, you know, is consistent, standard and transmission-based precautions. So contact droplet airborne precautions should all be very familiar with any discipline that's administering health care and should be, I guess a very good baseline for that. It's really just the enormity. And when you're faced with an outbreak like COVID in such an environment, you really need the experience and expertise to kind of interrogate all the nuances and the difficulties as they arise, when they arise.

MR ROZEN: You said that those principles ought to be familiar to anyone delivering health care, I think, was the expression that you used. You're aware, of course, that the majority of care workers – if I can use the general term – in residential aged care settings are not medically trained. They're personal care workers, some of whom don't even have a Certificate III, for example. You are certainly aware of that; are you not?

MS DEMPSEY: I am aware of that. When we talk about "health workers" - - -

MR ROZEN: Yes.

MS DEMPSEY: - - - I guess the reason we try not to refer to them as "health care workers" is that health workers in the system should incorporate all those levels. So even in the health care setting, that includes, you know, environmental services, cleaning staff, maintenance.

MR ROZEN: Yes.

MS DEMPSEY: And so a health worker in that environment should be provided with the same, you know, education and training.

MR ROZEN: That's your expectation, I think, is what you're saying; that's what you would like to see?

MS DEMPSEY: Yes.

MR ROZEN: All right. Thank you. Dr Branley, if I can bring you in on - - -

COMMISSIONER BRIGGS: Excuse me. Excuse me, counsel.

MR ROZEN: Sorry, Commissioner. Sorry.

COMMISSIONER BRIGGS: That's fine, counsel. Might I just ask, is it your experience that it is common practice that personal care workers should be trained in infection disease control and, in fact, are?

MS DEMPSEY: So anyone that's performing care with residents should have an understanding of infection prevention and control. So standard precautions as they

apply to each and every resident. You know, implementing hand hygiene, good environmental cleaning and also a level of transmission-based precautions, albeit directed or coordinated from a registered nurse or a more senior nurse.

COMMISSIONER BRIGGS: Thank you. Thank you, counsel.

MR ROZEN: Thank you, Commissioner. Dr Branley, if I can bring you in on this topic and draw your attention to paragraph 211 of your statement, which is on page 24 of the document. You will see the numbers in the top right-hand corner. The page I'm referring you to ends in 0024. Do you have that, Doctor?

DR BRANLEY: This paragraph starts with:

Early (first 48 hours).

MR ROZEN: Indeed, it does, under the heading Infection Control.

DR BRANLEY: Yes.

MR ROZEN: This is part – the part of your statement where you very helpfully identify a number of lessons for the future that you think are there to be learnt by the aged care sector. And the lesson here, as you describe it, is:

Early (first 48 hours) review by high level infection control practitioners is essential.

Are you able to draw on your experience, firstly, at Dorothy Henderson Lodge, where that was available through Ms Dempsey and her colleague, the day before she arrived? Are you able to refer the Commissioners to your experience of the difference it made when it wasn't available in those first 48 hours at Newmarch House? What were the consequences?

DR BRANLEY: Yes, sure. So, Dorothy Henderson, I – I had the great advantage of arriving after Kathy had – Ms Dempsey had already laid the ground rules for infection control. The beauty of that is those rules had then been entrenched within the nursing hierarchy of the facility, and there was no dispute about infection control. It was one source of truth and that truth was being applied consistently and the rules were well understood and well applied. Would you like me to contrast that with Newmarch?

MR ROZEN: Yes, please.

DR BRANLEY: At Newmarch, there were some very good efforts at infection control. And I think, in reality, the infection control that was implemented early at Newmarch was clearly effective at cutting transmission between residents. It was a source of some degree of angst and a lot of discussion amongst staff about variability in infection control practice. And I think the beauty of having somebody very senior,

like Kathy, arrive at a facility in the first couple of days of a large outbreak, can't be understated for establishing those rules, establishing one source of truth, and providing particularly the nursing and care staff with a sense of confidence and a sense of discipline about the application of infection control. That's not to say that the infection control failed at Newmarch, because, clearly, I don't think it did.

MR ROZEN: If I can just come back to you on this topic, Ms Dempsey, please. I think your observations about this are very valuable to the work of the Commissioners. Can I draw your attention to the report that you authored on the 1st of 2020 in relation to Newmarch House. It's at tab 105 of the Newmarch House tender bundle. It's ANG507.006.7856. Having said all that, is that something you can now see on a screen that you're looking at, Ms Dempsey?

MS DEMPSEY: Yes, it is. Thank you, counsel.

MR ROZEN: Okay. I'm very grateful to hear that. Firstly, can you confirm for us, please, that this is the report that you prepared, I think, in fairness, with the assistance of a number of others, including Dr Branley?

MS DEMPSEY: That's correct.

MR ROZEN: And are these standard practice at the Clinical Excellence Commission? Is this part of your – your way of learning lessons and continuous improvement? Is that – is that how we are to understand this report?

MS DEMPSEY: So I guess there's a couple of things to understand.

MR ROZEN: Yes.

MS DEMPSEY: Going out to an aged care facility in this manner wouldn't normally sit under my remit - - -

MR ROZEN: Yes.

MS DEMPSEY: - - - providing support for New South Wales public health systems. But, certainly, any time that we would go out and assist any of our facilities with either interrogating an issue or providing some external assistance, then, yes, the way that I would follow that up would be with a kind of summary report that goes through some of the issues and highlights some of the opportunities for improvement.

MR ROZEN: And do these reports follow a particular sort of – "template" might be overstating it – but is there a particular structure to the way these reports are prepared at the Clinical Excellence Commission by .....

MS DEMPSEY: Not with these specific reports, because they really just followed the specific issue and how we unpacked those during the visits.

MR ROZEN: Right. And without going through the detail, given the limitations of time, you go through each of the seven principles of COVID-19 infection prevention and control and assess compliance with those seven principles in the report. Is that a fair summary?

MS DEMPSEY: Yes. So based on the existing guidelines and advice - - -

MR ROZEN: Yes.

MS DEMPSEY: - - - that we had from the CEC for infection prevention and control and advice to health workers, we tried to mimic, if you like, those guidelines and conduct the reports and the review in a similar way.

MR ROZEN: Yes. And, for completeness, the seven principles, I will just ask you to confirm, are: (1) early recognition of patients with confirmed, probable or suspected COVID-19; (2) physical distancing; (3) respiratory hygiene and cough etiquette; (4) application of standard precautions for all patients; (5) implement transmission based precautions; (6) hand hygiene; and (7) cleaning the environment and shared patient care equipment. Is that a summary of the seven principles that we see in the report that you have assessed against?

MS DEMPSEY: That's correct.

MR ROZEN: And there's obviously a degree to which they are COVID-19 specific. Have you adapted some set of principles that are of general application in infection control for this particular purpose? Is that how we are to understand - - -

MS DEMPSEY: Yes. So they're usually general principles that you can extrapolate that you can apply to any sort of usual outbreak management process.

MR ROZEN: Yes. So hand hygiene is an obviously example. You'll always want to see people cleaning their hands?

MS DEMPSEY: That's correct.

MR ROZEN: That much, I think, we've all learned from the medical advice about COVID. Can I draw your attention to the last page of the report, please, which is .7863, headed Summary. Do you see that?

MS DEMPSEY: Yes.

MR ROZEN: And you say in the first paragraph that:

> *Newmarch House is an innovative and modern building design that is very welcoming on entry.*

That it looks:

...well cared for and clean.

And I just want to pause there for a moment. The Commissioners are interested in building design. In fact, we have a hearing devoted to that topic later in the week. But from the point of view of infection control, are there features of Newmarch House and Dorothy Henderson Lodge that you can point to to say were either beneficial from an infection control point of view or, on the contrary, made it more difficult? Can you help us there?

MS DEMPSEY: Sure. Thanks, counsel. So, I think, for Newmarch, in actual fact, the design of Newmarch was almost better from an infection control perspective than Dorothy Henderson. It had very distinct contained areas that we could close off. It had very distinct different sort of sides or wings that we could cohort a little bit better. There was much more defined areas that we could, in fact, zone off to create sort of clinical zones versus non-clinical zones versus some grey zones. So, I think, all of those things actually sat Newmarch in a much better position from an infection control perspective. But, notwithstanding, you know, there's still a lot of soft furnishings, a lot of personal belongings. You know, a lot of books, a lot of flowers, a lot of nice things that don't do usually very well for an infection prevention and control aspect.

MR ROZEN: I understand. The report's dated the 1st of May and it actually reports on a visit that you did to the site on that day; is that right?

MS DEMPSEY: That's correct.

MR ROZEN: So where you say, in that paragraph that's highlighted, that:

There is a visible presence of facility and operational management, however, a lack of infection prevention and control expertise.

That – that's a description of the operational management that was in place on the 1st of May, presumably?

MS DEMPSEY: That's correct.

MR ROZEN: Was that your first day at Newmarch House or had you had some previous experience there?

MS DEMPSEY: So that was my first day on site.

MR ROZEN: Yes.

MS DEMPSEY: And I dictated, I guess, I a lot of the review to a support person at the CEC.

MR ROZEN: Yes.

MS DEMPSEY: And that report was written later that night - - -

MR ROZEN: I see.

MS DEMPSEY: - - - given, I think, the importance around the findings.

MR ROZEN: And getting that back to Newmarch House to improve on the areas - - -

MS DEMPSEY: That's correct.

MR ROZEN: - - - that are identified to be improved.

MS DEMPSEY: That's correct.

MR ROZEN: Dr Branley, can I bring you in here, because the evidence we heard yesterday from Ms Dicks from BaptistCare was that she came in as part of a management team into Newmarch House on the 24th of April, so about a week before the date that Ms Dempsey is reporting on. You were there, of course, both before and after the BaptistCare management team came in, having been involved from 12 April onwards; is that right?

DR BRANLEY: Yes, that's correct.

MR ROZEN: Are you able to reflect, both from the point of infection control specifically, but, more generally, management of the response to the outbreak on the difference that the BaptistCare team made coming in on the 24th of April?

DR BRANLEY: Once again, it's a similar perspective to the infection control. I think that the Anglicare staff initially, and the BaptistCare staff on the ground, were dealing with a large and difficult problem. And I was in great admiration for the efforts that were made on the ground from both the Anglicare and the Baptist staff. I think the Baptist staff were more familiar, having gone through a difficult situation at Dorothy Henderson Lodge.

MR ROZEN: Yes.

DR BRANLEY: And had a degree more confidence in approaching the management. And that's understandable given the staff at Newmarch were encountering this for the first time. Having said that, right from the get-go there was implementation of lockdown in single rooms with ensuites. There was wearing of masks. There was wearing of contact plus droplet precautions when dealing with COVID-positive patients throughout the episode. So I think the core elements of infection control were there all along. The degree of confidence and familiarity with this rather frightening viral situation that the BaptistCare staff brought to the management role, I think was really, really valuable.

MR ROZEN: Thank you. Just before leaving the report, Ms Dempsey, the final paragraph there, if that could please be highlighted, that starts with the words "This summary is not a reflection". You are making a few points there, as I am reading it. Firstly, you weren't seeking to question how hard people were working and how dedicated they were in their response; is that right?

MS DEMPSEY: That's correct.

MR ROZEN: The second point you make is that in any situation where a facility is responding to a COVID-19 outbreak and is bringing in staff from different sources who may be unfamiliar with the facility, who may have varying degrees of training in relation to infection control principles, that the governance of that arrangement becomes particularly important and the execution of any plans is also equally important to make it work. Is that right?

MS DEMPSEY: Yes, correct. So I think it's important to understand that with a lot of infection prevention and control, whilst it's very easy for people to roll infection control off their tongue, it's very much principle-based. There are key strategies and principles that you need to apply but you also need to understand how to apply those, and when you are faced with a difficult environment that's where the challenges actually arise. When you've got a lot of different agencies and there were a lot of resources from what I could tell, that were applied to Newmarch, but it seemed to kind of lack, you know, almost sort of like, you know, a policing, you know – and my ICP colleagues will not like this – but, you know, it's like a policing and command post that, you know, if there's any issues then you go to one source. If there's differences in opinions, you go back to one source to sort those out and I think that was lacking.

They had a lot of resources. They had certainly a lot of PPE. And were practising a lot of infection control but it was just trying to streamline that and bring that into a degree of, I guess, organised system.

MR ROZEN: Just on that question of PPE, probably a question for you, Dr Branley. We just heard from Mr Millard, the CEO of Anglicare. He told us that your advice was that all care workers dealing with all residents, whether they had been tested as COVID-19 positive or not, should be wearing PPE. Is that a correct summary of the advice that you were giving?

DR BRANLEY: I'm not exactly sure of where that advice is being referenced. However, if I can express my recollection of that issue in my own words, I - - -

MR ROZEN: Please.

DR BRANLEY: Yes. So from my point of view, the separation of positive COVID patients and negative patients, particularly in the early phase of the outbreak, is problematic. Within the COVID-negative patients there are likely to be, if you like, hidden COVID-positive patients due to the fallible nature of testing and the need for

repeat testing. So one of the principles of infection control is to take a cautious approach and where there's uncertainty about the infectious status of patients, to have a broad approach to keeping patients within their rooms and wearing appropriate PPE in both those two cohorts. And, yes, that would have been consistent with advice I would have given along those lines.

MR ROZEN: Mr Millard told us, and the contemporary emails seemed to bear this out, that they had difficulty obtaining the PPE requirements to meet that advice. Were you familiar or did you see examples of that, Dr Branley?

DR BRANLEY: I was not involved in the supply or the supply chain of PPE and I didn't have visibility of the supply chain. I was aware of an issue, a fairly brief issue as far as I could tell, where there weren't enough gowns and I suggested, I think, that aprons could be used instead of gowns for the negative patients in that setting. And I was also aware of an issue with gloves. We had vinyl gloves being used in the early part of the outbreak and I was not happy with that and requested nitrile or proper gloves to be used in this setting.

MR ROZEN: Thank you. Can I change the topics and ask you some questions about hospitalisation. Firstly, as I understand your statement, Dr Branley, there was a – the policy that was implemented at Newmarch House was a policy known as hospital-in-the-home. Is that right?

DR BRANLEY: Hospital-in-the-home is the umbrella term for – for what we did at Newmarch. I think what we did at Newmarch was a little bit more bespoke than a standard hospital-in-the-home approach. I'm happy to elaborate if you would like me to.

MR ROZEN: I will ask you to in a moment. Just before you do that, though, can I draw your attention to paragraph 56 of your statement, which appears on page 7, at the bottom of the page.

DR BRANLEY: Yes.

MR ROZEN: Do you see that? You have written there:

> *By the time of the first case at Newmarch –*

which we know was 11 April, do you agree, Doctor?

DR BRANLEY: Yes.

MR ROZEN: You go on:

> *The policy that had been established at Nepean Hospital was to admit all COVID-19-positive residents to hospital-in-the-home, HITH, and manage them in their own home unless they required hospitalisation.*

If I could just pause there in the reading. Am I correct to understand you to be saying that there was a policy in your health district that had been developed which was that all COVID-19 positive cases, whether they be in a private house or a residential aged care facility, were to be managed under hospital-in-the-home? Is that what you are conveying there?

DR BRANLEY: Let's separate – if I can separate those into two, please, counsel.

MR ROZEN: Sure.

DR BRANLEY: Prior to Newmarch, we hadn't managed COVID-positive patients in an aged care facility. So this was our first – the first time that this had occurred in the Nepean Blue Mountains. Obviously, I had been involved at Dorothy Henderson prior to that and had thought about it. The policy – the working document – and I think policy is perhaps a little too elaborate a title, but the working arrangement for the management of COVID-positive patients in Nepean Blue Mountains had been to admit them all to hospital-in-the-home, to provide some monitoring equipment to those patients, and to remain in contact with them largely by phone and admit them to hospital if and when required.

MR ROZEN: Thank you. We have been provided by New South Wales Health with a document entitled Adult and Paediatric Hospital in the Home Guideline. Is that a document you're familiar with, Dr Branley?

DR BRANLEY: Yes, it is, counsel.

MR ROZEN: I'll ask that it be brought up. It's tab 1 in the general tender bundle, RCD.9999.0366.0181. Are you able to tell us, was this – this policy is dated August 2018. Was it extant as at April of this year, the events that we're talking about?

DR BRANLEY: So in April this year, this document was in draft form and it was being reviewed.

MR ROZEN: I see.

DR BRANLEY: We did have an existing paediatric document which effectively has the same elements contained within it and was our working document at that time.

MR ROZEN: All right. Could I ask you to have a look at page .0188 at the top of the page. If that could be brought up please; it's page 5 of 54 looking at the bottom, if that helps. Do you see the eligibility criteria that are identified at the top of the page:

> *To be eligible for hospital-in-the-home care in New South Wales, a patient must meet the criteria for hospital admission under the New South Wales Health admission policy, be an admitted patient under the care of a designated*

admitting clinician and receive daily clinical care or clinical review from a member of a multidisciplinary team.

My question for you, Dr Branley is: is your evidence that all of the patients that were treated at Newmarch House under this policy satisfied the first of those criteria, that they met the criteria for hospital admission under the New South Wales Health admission policy?

DR BRANLEY: They met the criteria for admission for our COVID rules at the time in that all of our COVID patients were being admitted into hospital-in-the-home. So, in that sense, yes.

MR ROZEN: I'm not sure that I have understood that answer, Doctor. As I understand this policy, correct me if I am wrong, it's essentially saying that if you meet the criteria for admission to a hospital in New South Wales, then you can be treated under this policy in your home. Is that essentially the central principle that underlies the hospital-in-the-home policy?

DR BRANLEY: If that's appropriate, counsel, and for COVID we had decided that that was our appropriate strategy.

MR ROZEN: See, what I'm trying to understand, Doctor, I will come directly to the point, is whether each individual resident at Newmarch House had this policy applied to them on a case-by-case basis or whether the policy was just applied in some generic sense to the residential aged care facility so that all of the residents fell under the policy. Can you help us with understanding that? Do you understand the distinction I'm making?

MR FORDHAM: I object to that - - -

DR BRANLEY: I think so, counsel, but - - -

MR ROZEN: Sorry, Dr Branley, I think there's an objection which I heard.

MR FORDHAM: Sorry, it's Michael Fordham, counsel for the State of New South Wales. That document is a guideline.

MR ROZEN: Not a policy; is that the point, Mr Fordham?

MR FORDHAM: Correct.

MR ROZEN: I withdraw to the reference to it as a policy. I will refer to it as a guideline and I will adopt your language, Dr Branley, that it was a draft as at April of this year. Have I understood that correctly?

DR BRANLEY: Yes, that's correct. I guess, counsel, could I highlight that the Easter weekend, what turned out to be a large outbreak in an aged care facility, we

needed to apply our existing models, and our existing models was to admit COVID-positive patients to hospital-in-the-home. We never admitted all of the patients at Newmarch to hospital-in-the-home.

MR ROZEN: Just all of the positive patients?

DR BRANLEY: Just the positive patients.

MR ROZEN: I just want to try and understand that. As each resident was tested positive, is your evidence that the principles in this guideline were applied to them on an individual case-by-case basis. Is that your evidence to the Commissioners?

DR BRANLEY: That's correct. The way that worked is that we had the flow charts that are attached to my statement whereby when patients tested positive, there was a flow chart application of their pathway forward into hospital-in-the-home and I would highlight that it was more than hospital-in-the-home, in that it was a combined infectious diseases geriatric hospital-in-the-home and virtual aged care service, both of which were existing models of care which we merged into a problem-solving solution for a very difficult problem.

MR ROZEN: One of the principles in the policy is this, isn't it, that any decision about treating someone, an individual patient under the policy requires discussion with them about the options available, including transfer to hospital. Do you agree with that?

DR BRANLEY: I agree that in a perfect world it might have been good to have had individualised patient discussions with every single patient. I think our degree of organisation wasn't up to that level in the first part of the outbreak. But we did need to solve problems and we did need to have a mechanism for doing it and so we chose to, as much as possible, stick to the existing methods we had in place.

MR ROZEN: I understand. Just before leaving this particular question, did you hear the evidence of the last – sorry, of the first witness today, Mrs Clarke; did you hear any of that evidence, Dr Branley?

DR BRANLEY: Counsel, I haven't heard any evidence.

MR ROZEN: Okay. Mrs Clarke's father passed away at Newmarch House from COVID, and her evidence was that at no time was she told that the hospital-in-the-home, or hospital-in-place she described it as, was the policy that was many implemented. Does that surprise you? If that's the case - - -

DR BRANLEY: Firstly, counsel, I would like to express my sympathy to the family of Mr Farrell. I do feel for their pain and I would acknowledge that their father's death occurred early in this outbreak and I am sure we could have communicated better with the family in hindsight. Can you remind me of the question beyond that, please?

MR ROZEN: Yes. Well, it's really about the way the policy, the guideline I'm sorry, was implemented. I'm trying to understand the processes that you followed. I think what you are saying is that the communication aspects of its implementation were less than optimal. Is that a fair way to describe your evidence?

DR BRANLEY: I think that's a fair way of describing it and my – the other thing I would like to highlight is the difficulty in communicating, particularly critical issues around end of life or severe viral infection issues with families when society was in social distancing lockdown. In ordinary circumstances we would – in non-COVID circumstances we would have the ability to have a face-to-face discussion, and to be able to discuss individual issues much more time efficiently and in a much more controlled fashion. In retrospect, I wish we had had the ability to do that on every single patient and to commit the amount of time to that situation. And I regret that we weren't able to do that in a better fashion.

However, and without checking my notes, I would assume that my hospital-in-the-home team and the VACS team have made contact with Anglicare and been responsive to the needs of the patient in that setting.

MR ROZEN: Before leaving this guideline, can I ask you to have a look at page 0198. It's page 15 of 54 in the document. If that could be brought up, please. With a heading Residential Care Facilities, 7.3; do you see that?

DR BRANLEY: Sorry, counsel, which document is this?

MR ROZEN: This is the hospital-in-the-home guideline, the one that you referred to as having been in draft.

DR BRANLEY: Right.

MR ROZEN: Are you sure about that draft question, Dr Branley? It does bear the date August 2018. Are you saying it was still in draft in April of this year; have I understood you correctly?

DR BRANLEY: Is that the paediatric document or the - - -

MR ROZEN: Yes.

DR BRANLEY: The paediatric document wasn't in draft. The adult version of the paediatric document was in draft.

MR ROZEN: This one is headed Adult and Paediatric Hospital in the Home Guideline; is that the one you're referring to? Was this the one that was in draft? It bears the date 9 August 2018, if that helps.

MR FORDHAM: Look, it's Michael Fordham again. It is not an objection as such, but I think you might be at cross-purposes between State guidelines and local policy but if you want to talk to me over the lunch, I might be able to help you with that.

MR ROZEN: Let's not worry about the draft question for the moment, Dr Branley, and if I could just ask you to look at 7.3 Residential Care Facilities. If we can summarise, this would appear to be a set of preconditions that need to be satisfied before hospital-in-the-home can be implemented in a residential aged care facility; do you agree that's what this part of the document is? It refers to a written agreement being in place. It refers to training having been provided to staff of the facility. It refers to support being provided to them, the development of business rules for communication and so on. That's what it is, isn't it, a set of preconditions before you can implement the policy in a residential aged care facility?

DR BRANLEY: Well, I agree that might be what that says, but I would highlight that we look after a lot of patients in their own homes that don't have the resources of a residential aged care facility. I also highlight that as well as HITH, we were implementing VACS which is a parallel model. So we were in fact implementing two models simultaneously and I don't think any policy document or guideline covers that situation.

MR ROZEN: I understand that, but these preconditions are there for a reason, aren't they, Doctor, that is, to facilitate the implementation of the policy in a residential aged care facility? Presumably that's why they're included in the guideline. Do you agree with that?

DR BRANLEY: I agree with that and many guidelines are not focusing on a major COVID outbreak when they're being constructed.

MR ROZEN: I understand that. I think that was the last thing from the author's mind when this document was being prepared. But my question is a different one; that is, none of these steps were implemented at Newmarch House, were they?

DR BRANLEY: The volume of patients at Newmarch House - - -

MR ROZEN: Dr Branley, it's a very simple question. None of these conditions were satisfied at Newmarch House, were they?

DR BRANLEY: There were family discussions with the residents about the model of care and about the advanced care directives and about transfer to hospital, so I think those conditions were – were applied as best we could.

MR ROZEN: Doctor, was there a written agreement in regard to the roles and responsibilities of the facility and the hospital-in-the-home service?

DR BRANLEY: No, not as far as I am aware.

MR ROZEN: Were staff of the residential aged care facility given training and support for them to assist in the clinical care and management of acutely unwell patients?

DR BRANLEY: Yes, I think we did assist in training and support of staff.

MR ROZEN: You were doing that in the process of implementing the policy; it hadn't been done in advance, had it?

DR BRANLEY: We hadn't done training and support in advance, except to say that our VACS team had been involved in that facility, managing patients, training and supporting them in the lead-up to this outbreak and, in fact, the VACS team knew many of the residents individually.

MR ROZEN: Where I'm going with this, Doctor, is that hospital-in-the-home has now been confirmed as the approach to managing COVID-19 in residential aged care facilities in New South Wales, has it not? We have been given very recent policy documents which state that. Is that the case, as far as you understand it?

DR BRANLEY: I – I wouldn't like to comment without looking at the document directly.

MR ROZEN: Would you agree, looking back on the experience at Newmarch House – and I accept as we all do that it was a very difficult position you found yourself in, but if we are now in the future to implement a hospital-in-the-home approach to residential aged care facilities for COVID-19, that ideally these preconditions would be satisfied in advance of any outbreak occurring; would you agree with that?

DR BRANLEY: I agree with that, counsel.

MR ROZEN: It might be an appropriate time, Commissioner.

COMMISSIONER PAGONE: Well - - -

MR ROZEN: I think we said quarter to one, had we not?

COMMISSIONER PAGONE: Not quite, no. We have a change of guards, I think, at quarter to 1, a different set of people.

MR ROZEN: I'm sorry.

COMMISSIONER PAGONE: What would you like to do?

MR ROZEN: I have completed my examination of these witnesses subject, of course, to any questions that you may have Commissioners. Sorry, I misread the sheet.

COMMISSIONER PAGONE: Commissioner Briggs, have you got some questions you would like to ask?

COMMISSIONER BRIGGS: It's an unformed question, if I may, Dr Branley. I very much appreciate how new and overwhelming this situation was and I suppose I would like to ask you a Dorothy Dixer-type question, and that is my assumption from hearing your evidence and reading your witness statements is that everyone was doing the best they could in the circumstances with the guidance and the policies that were available to them. Is that correct?

DR BRANLEY: That's correct, Commissioner.

COMMISSIONER BRIGGS: And on reflection, do you have any views about what you might have done differently in hindsight as a result of the experience and bearing in mind we're looking at lessons to be learnt that other States such as Victoria or other aged care facilities and health care systems might pursue in future. Do you want to make any commentary on that, please?

DR BRANLEY: Commissioner, thank you very much. I want to make two major points here. The first is the really essential value of testing cannot be overstated. And that includes repeat testing of residents and finding the positives in amongst the negative cohort. Because testing in elderly residents is problematic and needs to be done repeatedly in order to reveal all of the positives. And I think until you have clearly identified the positive and negative cohorts, discussions about moving patients represents a real risk of spreading this virus to health care facilities, and health care facilities act as amplifiers of this virus in society in general.

So I think testing strategy needs to be very strong and aggressive and I think we did testing very well at Newmarch, but I think in retrospect, I underestimated the extent of the staff component of positive COVID patients amongst the – or people amongst the staff. And I think any future situation really needs to focus on eliminating positive staff from that workplace and, hopefully with really sophisticated testing models, leaving staff in place who have the knowledge and the experience with elderly patients. Because the most valuable staff members are not people with backgrounds outside of the facility. The most valuable staff members in this equation are the people that know the elderly residents and have a pre-existing relationship with those elderly residents, where they know their views, they know how to communicate with those residents.

And those staff are invaluable and, unfortunately, with our public health rules, we have wiped out whole cohorts of staff that, with a more aggressive testing strategy, we could leave in place and we could still use their expertise and their knowledge of the residents to really guide the individual person-centred care that we want to deliver in this setting. I think in summary, it's really balancing that person-centred care of the elderly resident with society's public health need to not spread this. We know that, internationally, residential aged care facilities and hospitals have acted as the big amplifier and spreader of the virus throughout society.

If we move elderly residents to a hospital and they have cognitive issues and they are walking out of a four-bed bay at Nepean Hospital into the corridor and needing to be physically restrained within the COVID space that's not as ideal as an aged care facility that has individual rooms, doors on those rooms and residents can be contained, from an infection control point of view, much better than a hospital. In New South Wales, we have, to my knowledge, no hospitals with 100 per cent single rooms. There are a couple in Australia but there are very few hospitals where you can move patients to completely single room profile to actually maintain that infection control. So you do put your health care workers at risk by major movements of large cohorts of positive or negative patients that may still be positive.

So, Commissioner, I'm sorry that's a bit of a grab-bag of ideas but I think – I really appreciate the Commission's efforts to try and work with this problem because we really need to do it better. It's not going to be the last time we are going to face this – we're going to have this problem.

COMMISSIONER BRIGGS: Yes. And I very much appreciate that clarification, Dr Branley. I'm not surprised by what you are saying. I suppose my follow-up question to that, either to you, Doctor or to Ms Dempsey, is it does appear to be clear, at least from the evidence that we have had to date, that to make hospital-in-the-home work in this kind of circumstance, we do need to bring in people, I think, with expertise from the hospital system itself with expertise in infectious disease control if it is to work properly. Am I right or am I overstating it, bearing in mind that in circumstances like the one we're in now, we know that the staff who work in aged care mightn't have the same degree of expertise that people within the hospital system do. Can you take that?

MS DEMPSEY: I think, Commissioner, if I perhaps start with that. And I think, you know, to extrapolate just the hospital-in-the-home that we need to bring in infection control expertise really undervalues the entire system if we just leave it to hospital-in-the-home. Aged care facilities and organisations need to have a commitment to infection control before we get to hospital-in-the-home so that they can prevent an outbreak to getting to that point. Whilst there has been a lot of work historically around trying to upskill some of the aged care – and there has been a greater commitment to infection control, we are not quite there, and I think that's evidenced by the fact that they don't have ICPs on the ground, trying to link in to some of the senior ICPs and how we can better do that at perhaps a State level and use the expertise within the local health districts and better align those.

But certainly, I think waiting until we get to a hospital-in-the-home situation and just saying that you need that hospital-in-the-home is a mistake. They need to upskill and have those expertise on site and, you know, keeping things at bay until we get to that point.

DR BRANLEY: Commissioner, if I could add to that – thanks Kathy. I think if we look at the way Newmarch functioned for the second half of the outbreak, it was functioning really, really well. And it's a real model and it's a challenge to get what

happened in the second half of the outbreak at Newmarch happening from day one. I think we had a lag time in establishing a whole lot of practice because of the novel nature of that. And look, the other thing I think is really important for the Commission to take on board is the importance of honest and open discussions in advance about advance care directives and a discussion with families and residents about their intention and their views prior to COVID arriving in their facility.

COMMISSIONER BRIGGS: One final question, I'm sorry, if I may, because I'm finding this very helpful in helping me to understand the complexity of the interactions between the aged care system and the health system. Where somebody's condition is clearly very, very serious, those policy guidelines that Mr Rozen referred to did talk about hospitalisations. So there's a question in my mind around where those decisions about hospitalisation should be taken. Can you help us with that?

DR BRANLEY: Thanks Commissioner. Yes, and I think the other component we haven't touched on is palliative care because, clearly, some patients, some residents – you know, many of our residents – I think 65 per cent of our COVID patients were over the age of 85 years. The mortality in that group is really significant. And there needs to be a discussion, and we did this with palliative care specialists about end of life issues and how that occurs. I think if people – residents and family express a desire to go to intensive care and be intubated, that is entirely their right and it should be respected.

For many people – and I have one resident of Newmarch in mind, in particular, she – a woman in her 90s was able to die peacefully in her room, listening to the music she loved, and that was her written express desire prior to getting COVID. I think it's really important that there be a discussion about the appropriateness of intubation and ventilation and intensive care, and that should be a parallel discussion with an end of life discussion about how death occurs. Do you want to be surrounded by photos of your family and your familiar things in your room with your music playing when you come to the end of your life.

COMMISSIONER BRIGGS: Thank you both very much. I'm finished my questions, Commissioner Pagone.

COMMISSIONER PAGONE: Thank you, Commissioner Briggs. Can I just ask what I hope is going to be a short question; Dr Branley, did I understand that part of your answer to an earlier question was that hospital-in-the-home was at least in part, and if so, how significant a part, directed to the risk that might otherwise be posed to admission into the hospitals?

DR BRANLEY: Commissioner, thank you for the question. I think the movement of patients represents a risk, and the mass movement of elderly patients in the literature is – is not beneficial to those – to those residents in the studies that I've looked at. And I think I've quoted those in my statement. Movement of patients does pose a risk of transmission, and I will be very interested to look at Victoria when the Victorian situation has been fully analysed. But I think the number of

health care workers that are potentially exposed and the number of other patients in health care facilities that are exposed by mass movement of positive patients or of negative patients that are falsely negative and not yet positive poses a really significant health issue and it's a public health issue. And it needs discussion.

COMMISSIONER PAGONE: Thank you. Is there anything arising?

MR ROZEN: Nothing arising, thank you, Commissioner.

COMMISSIONER PAGONE: The last thing to do is to thank you both for the time and effort you have put into this. These are very, very difficult times. You've really both begun on the frontline of all of this, and as you will have gathered by the questions from counsel and from us, we have been very indebted to you in learning from that experience. So I thank you both very much indeed.

DR BRANLEY: Thank you, Commissioner.

MS DEMPSEY: Thank you, Commissioner.

<THE WITNESSES WITHDREW [1.04 pm]

COMMISSIONER PAGONE: I think the idea is now to adjourn at this stage, correct.

MR ROZEN: Yes, rather than splitting the next panel.

COMMISSIONER PAGONE: All right. We might resume again at 2 o'clock.

MR ROZEN: Thank you.

COMMISSIONER PAGONE: Adjourn until 2 o'clock.

ADJOURNED [1.04 pm]

RESUMED [2.03 pm]

HIS HONOUR: Mr Bolster.

MR BOLSTER: Thank you, Commissioner. We have now a panel of four witnesses. From the Opal Aged Care Group, I call Jonathan Anderson and Lucy Thompson. I apologise, we do have an appearance first. At least one appearance to be announced. I believe.

MS N. SHARP SC: My name is Sharp. I appear for Dr Stephen Judd and for Ms Angela Raguz.

COMMISSIONER PAGONE: Yes, thank you, Ms Sharp.

MR S. LLOYD SC: I appear for Opal Specialist Aged Care and Ms Thompson and Mr Anderson.

COMMISSIONER PAGONE: Yes. Thank you, Mr Lloyd.

MR BOLSTER: Commissioner, firstly, I call Jonathan Anderson and Lucy Thompson.

<JONATHAN ANDERSON, SWORN [2.04 pm]

<LUCY THOMPSON, SWORN [2.04 pm]

MR BOLSTER: And I call Stephen Judd and Angela Raguz.

<STEPHEN EDWIN IRETON JUDD, SWORN [2.05 pm]

<ANGELA RAGUZ, SWORN [2.05 pm]

MR BOLSTER: I might begin with you, Ms Raguz; have we got the pronunciation of your name correct?

MS RAGUZ: It's close enough. It's fine, thank you.

MR BOLSTER: Thank you. All right. Then the next question is to you, Dr Judd. You have prepared a statement in this matter. Do you have a copy of that in front of you?

DR JUDD: Yes, I do.

MR BOLSTER: And is there anything in that statement that you wish to change?

DR JUDD: No.

MR BOLSTER: And is the statement true to the best of your knowledge, information and belief?

DR JUDD: Yes, it is, counsel.

MR BOLSTER: Commissioner, I tender Dr Judd's statement which is WIT.1367.0001.0001.

COMMISSIONER PAGONE: Dr Judd's statement will be exhibit 18-15.

EXHIBIT #18-15 STATEMENT OF DR STEPHEN JUDD DATED 31/07/2020 (WIT.1367.0001.0001)

MR BOLSTER: In the case of the witnesses from Opal Care, there is a bundle. It's the Opal Care tender bundle, and I formally tender that bundle.

COMMISSIONER PAGONE: Yes, the tender bundle will be exhibit 18-16.

EXHIBIT #18-16 OPAL CARE TENDER BUNDLE

MR BOLSTER: Now, Mr Anderson and Ms Thompson, located within the tender bundle at tab 15, is effectively the statement or submission of the Opal Group in relation to these matters, isn't it?

MS THOMPSON: Yes, it is.

MR ANDERSON: That's correct, yes.

MR BOLSTER: And each of you can speak to the propositions that are put forward there and the narrative of facts that are recorded in that document?

MR ANDERSON: Yes.

MS THOMPSON: Yes, we can.

MR BOLSTER: All right. Let me just start with identifying your positions and expertise. Ms Thompson, you are the person in charge of all care matters for Opal Aged Care across Australia; correct?

MS THOMPSON: I'm the director of clinical services for Opal Aged Care, that's correct.

MR BOLSTER: And that involves oversight for the clinical dimension of delivering aged care in how many facilities?

MS THOMPSON: Currently 78 facilities across four States.

MR BOLSTER: And you have facilities at the moment that are under extreme stress in Victoria?

MS THOMPSON: That is correct, yes.

MR BOLSTER: And in that respect we thank you for the time that you've given to give us your evidence. Mr Anderson, you have a different role within Opal Care. Could you describe that, please?

MR ANDERSON: Yes, so my role is regional general manager for Opal which has responsibility for 12 care homes in a region of New South Wales, so southern New South Wales, one of which is Opal Bankstown which was the subject of an outbreak in – a COVID-19 outbreak in March and April.

MR BOLSTER: All right. We will come back to the details of that shortly. Could I turn then to Dr Judd and Ms Raguz. Dr Judd you are the CEO of HammondCare and we have heard from you on a number of occasions during the course of the Royal Commission; correct?

DR JUDD: That's correct.

MR BOLSTER: And the position of you, Ms Raguz; you are a registered nurse?

MS RAGUZ: That's correct.

MR BOLSTER: And how long have you been a registered nurse?

MS RAGUZ: I've been a registered nurse since 1994.

MR BOLSTER: And you are the general manager of residential for the Hammond group; correct?

MS RAGUZ: Correct.

MR BOLSTER: And I think since the COVID pandemic established itself, you have been in charge of HammondCare's clinical governance team; is that correct?

MS RAGUZ: That is correct.

MR BOLSTER: I thought we might start the panel discussion with the pandemic preparation that took place before 2020, and I thought we might do that by reference to some documents that have been produced by Dr Judd. If we could bring up please, tab 63 of the general tender bundle. You can see there, Ms Raguz, the aged care pandemic management plan of HammondCare going back to 2009. Are you familiar with that document?

MS RAGUZ: I am familiar with that document, yes.

MR BOLSTER: And what were the essential features of pandemic planning for an organisation like HammondCare prior to anyone knowing anything about COVID-19?

MS RAGUZ: Well, we – this initial document was developed in 2009 when there was a threat of a global pandemic, and so that preparation went to really focusing on all of the checklists, I guess, for each phase of a pandemic that we may go through. And at the time it was based on the phases that the Australian Government had, which have changed a little bit but not a great deal in the last 11 years, focusing on our stock of equipment, whether we have adequate personal protective equipment. Focus on identification of infection or responding to a novel virus which is generally what a pandemic would come from; focusing on the training and preparedness at each local level with outbreak coordinators, with planning and preparing at that local level.

MR BOLSTER: If we could just turn over to the second page of that, and you will see there a table which lists a number of elements. It contemplated a novel virus with pandemic potential at that time?

MS RAGUZ: Yes, that's correct.

MR BOLSTER: And this followed, was it the swine flu or the SARS epidemic?

MS RAGUZ: It was the H1N1. It was the 2009 H1N1 virus.

MR BOLSTER: And the elements of that summary there on page 2, are the essential elements the same today when it comes to COVID-19?

MS RAGUZ: Well, this was our starting point and I would say that the phases themselves, they may be slightly different language used but essentially the process, I think, is very much similar.

MR BOLSTER: All right. I might turn, then, to you, Ms Thompson. You have been with Opal for around 18 months; is that correct?

MS THOMPSON: That's correct; I joined Opal in February 2019.

MR BOLSTER: And correct me if I am wrong but during the second half of last year, Opal committed itself to a review of its infection control mechanisms and procedures?

MS THOMPSON: Yes, that is correct. Our policies and procedures are all reviewed on a regular cyclical basis, and the review of infection control formed part of that approach.

MR BOLSTER: And the sort of language that you are seeing in front of you in that plan from 2009 would come as no great surprise to you, I take it?

MS THOMPSON: No, it does not.

MR BOLSTER: Could you outline the steps you took to develop your infection control at the end of last year?

MS THOMPSON: Certainly. So we were in the process of preparing for the new Aged Care Quality Standards and as a part of that, we were reviewing every single policy and procedure within the organisation. As we stepped through that process, we identified that we needed to review infection control. We sought then to implement a new infection control policy and procedure, and beyond implementing that procedure to commence education and training across all – across the organisation in the form of infection control workshops.

MR BOLSTER: All right. And how did you set about doing that? Do you bring in outside expertise in infection control?

MS THOMPSON: Yes, we did. We engaged with a private consulting company and delivered eight infection control workshops to identified staff within Opal and those workshops were run by an infection control clinical nurse consultant.

MR BOLSTER: And do I take it that the intention there was that the participants would go back to their own facilities and become, effectively, infection champions, I think is the term that is sometimes used?

MS THOMPSON: Yes, that's correct. Following the delivery of the eight infection control workshops we ended up with over 100 infection control champions who had a basic knowledge of infection control practice.

MR BOLSTER: And so for a place like Opal Bankstown, how many champions did you have on deck in March when the first positive test came in?

MS THOMPSON: So every home had a minimum of two champions in place, and in addition to that each home received support from regional quality advisers who provide the service to a number of homes. They were also trained in infection control and prevention.

MR BOLSTER: All right. I might turn then to you, Ms Raguz. Is the HammondCare experience different or similar; how did you go about it?

MS RAGUZ: I think it differs – yes, it differs slightly in that we didn't call people identified infection control champions, but what we did do was create small teams within each of the services who were tasked with preparing the service for – I mean prior to it being declared a pandemic, it's an annual event where we prepare for the winter flu season and the – what generally occurs during winter which is – it's more likely that there can be gastroenteritis outbreaks. And so those teams are in place annually to prepare for those, what I will now call normal outbreak events. But we didn't – we did not necessarily have infection control champions using that language.

MR BOLSTER: If we could go, please, to tab 65, you will see there your aged care pandemic management plan that I believe, based on Dr Judd's evidence, was developed as the COVID-19 pandemic got off the ground in January and February. Is that right?

MS RAGUZ: That is correct.

MR BOLSTER: So what did that process entail, and could you tell us what did you do about things like PPE and training and overall infection control with your staff?

MS RAGUZ: What we did was, first of all, we revised our pandemic plan, taking into consideration all the new information that we were receiving based on what was known about coronavirus. And we put in place those local planning teams in order to develop those local plans in the first space. We trained all of our staff – and we continue to, through a process that we've developed which is a toolbox talk which is basically at the start of every shift. We are providing staff with the training around what are the common symptoms of coronavirus. We are screening staff in order to ensure that they are indeed well. We are conducting that as a daily event for all staff in terms of the use of PPE and how that should be used.

In the early days, we made a decision that we would – we did a stocktake of our PPE and we ensured we had stock for a certain level, but we didn't make the decision to stockpile. Since that time there was a couple of months where PPE was difficult to come by and not just within the aged care industry, but I think that was a global event. Since then we have got a little bit more in our stockpile in order to ensure that we are prepared for those first few days until we're able to get government – government stock. The training that we provide was – sorry.

MR BOLSTER: Sorry. Let me just ask you a question on PPE while we are there. The original plan that you implemented back in 2009, it involved some sort of audit. And I take it, it was an annual audit of the PPE stock within the organisation?

MS RAGUZ: That's correct. And that occurred, again, in January and early February of this year as well.

MR BOLSTER: And was it the case that, because of the COVID-19 situation, that you thought there was a need for further PPE or did you regard your reserves as being sufficient?

MS RAGUZ: At that stage, when we did that stocktake, we – we believed that we had sufficient stock without knowing that there would be – that globally, basically, that the supply chain would grind to a halt come, I think that was probably in March and April. So at the time that we did the audit, we did not think that we would not have enough PPE; that's correct.

MR BOLSTER: Let me ask, bring in Dr Judd and Mr Anderson. What was the – what was the problem in March and April when it came to accessing PPE in this country? Perhaps, Dr Judd, if you would like to go first.

DR JUDD: Well, I'd say that our procurement people did a wonderful job, but we were promised that a delivery would occur on a particular day, and then it didn't happen. And then you actually look to actually get it another day and it didn't happen. So there were challenges in the distribution of PPE, not just for HammondCare or, indeed, I don't know about Opal, but for the whole of the sector.

MR BOLSTER: Have those challenges resolved themselves?

DR JUDD: Yes; that's correct. So by the time – by the time the Caulfield May '19 outbreak occurred, we got strong support from the Commonwealth Department of Health in support of getting additional PPE into Caulfield.

MR BOLSTER: But before you had that outbreak, which, ultimately, was, arguably, a false outbreak, what were your chances of getting PPE as late as May 2020?

DR JUDD: We got – we actually got some deliveries of PPE, but we had to husband it really, really carefully, so that, in the event of an outbreak, we actually had – that we thought it was great that we had 4000 masks, for example, at one stage. And so we actually had to make sure that we actually distributed it appropriately. And that, obviously, meant that some people who felt that they needed it right now, but, in our judgment, didn't need it right now within the organisation, we actually had to decline. And that's obviously disappointed some of our services.

MR BOLSTER: Give us an example, please, of how that would have impacted on a resident's quality of care?

DR JUDD: I don't believe it actually impacted on quality of care of residents at that time. It was more anxiety in our home care space, where clients were perhaps insisting that everyone come into their home with full PPE. And there was fear of – of our care workers going into their home. And we just could not provide that to our – to our care – to our care staff in home care.

MR BOLSTER: Mr Anderson, how did Opal access PPE before it had its first positive test?

MR ANDERSON: So most homes had a supply of PPE in preparation for the normal outbreak season. So there was emergency and, more than that, supply available just generally within our homes. We were aware that we were seeking to ensure supply through our procurement team. And so they were actively consulting with our various suppliers to see the extent of supply available across the variety of PPE. The other initiative that Opal commenced at that time was to have a register of all stock availability across every one of Opal's homes that was reported on a daily

basis and visible across our organisation. So, at any time, we could see where homes may have more than sufficient supply, compared to a home that might be running a little low. And that provided the opportunity for, then, redistribution to make sure that there was always going to be sufficient supply in the event of an outbreak.

MR BOLSTER: Did that end up being necessary?

MR ANDERSON: Yes, it did, because what you have is patterns of increased usage, whereby we'd identified that a resident or a group of residents were showing symptoms, which then required isolation and the utilisation of PPE. So, in those cases, you'd see a draw-down on supplies and then the system would automatically demonstrate, on a daily basis, where that supply was running low through, you know, various coordination mechanisms. Then we would redistribute, as necessary, pending the stock-up more broadly across Opal.

MR BOLSTER: All right. If we could perhaps turn now to tab 63 of the general tender bundle, and – sorry, 64. Tab 64, please. Ms Raguz and Dr Judd, you'll recognise that as one of the toolbox talks that you mentioned previously. This was number 5 in a course from May of 2020. How important, in communicating and educating your staff, were these sorts of processes?

MS RAGUZ: Look, I think this was one of the – and continues to be – one of the critical ways of ensuring that we are bringing to the front of mind for each staff member, at the beginning of each shift, the areas of focus and attention and, particularly, around PPE, the usage of PPE and, importantly, identifying those symptoms and ensuring that we are responding swiftly if anybody does have any symptoms, staff or residents.

MR BOLSTER: There's a lot of detail in a document like this. Is this something that's spoken to by an infection control leader at the beginning of a shift or during the course of the working day?

MS RAGUZ: It's run with the registered nurse. Yes. The registered nurse, at the beginning of each shift, as part of – it's the small group discussion. And then, along with the toolbox talks, there are a series of questions, and so the care workers and the registered nurses discuss. They go through that – the questions. And a record is kept of all attendance. And that is then centrally assessed to ensure that we have all staff captured across all shifts.

MR BOLSTER: I imagine there must have been a degree of apprehension and fear on the part of some of your staff about the way things were developing in March, as there was an outbreak at Dorothy Henderson Lodge and then at Newmarch. Dr Judd, how did HammondCare approach that issue of staff fear?

DR JUDD: Well, we were very concerned about our staff, particularly – and you're quite right to say that, once we saw the experience of Dorothy Henderson Lodge, there was clearly concern amongst the Dorothy Henderson Lodge staff about going

into that service. It was important for us, therefore, to ensure that proper information was actually getting to our staff. I mean, because there was a cacophony, if I can put it that way, of external and internal sources of information, notably Facebook. And – and so we actually sought to give them a single source of truth and do it continuously. And we did that in a number of ways.

So on about the 23rd of March, Professor Andrew Cole, who is our Chief Medical Officer for HammondCare, did a video, and that went to every staff member. He actually just explained it, what it was, he even referred to his mother. And said, "Look, this is what my mother said to do: wash your hands." He actually did it in a very approachable way to reduce the anxiety of our staff. And it was very effective. And then, from about the 23rd of March through to – well it's ongoing, but certainly to the end of July, we've delivered a series of videos – short video clips – to staff centrally, so direct from me – I did about three; Andrew Cole did a couple; Angela Raguz did one, as well – just giving people information.

And the other thing we did – well, I did – probably in late March probably, was actually telling staff stories about what they themselves were doing, because there were some quite exceptional things that people were doing, like a home care staff worker in the north of Sydney whose car broke down, knew the shift was – the roster was really, really tight. Knew that she had a palliative client, so she walked seven or eight kilometres to actually care for that particular client. So we told those stories. And I have to say, at that stage, the – I mean, I have to say, at that stage, staff were incredibly emboldened, if I can put it that way, by what they were doing. They really were feeling quite proud about what they were doing. So we kept up that messaging, if you like, and delivering through the pandemic inbox. We established a pandemic inbox, so that all their questions could go into one inbox and be answered within a few hours. I think the number of questions that have come in to date is like twelve and a half thousand. But we just made sure that we were getting that information out to everyone from this channel. And all those questions were going into that channel. Certain things like that.

MR BOLSTER: It seems to me, from the documentation, particularly, the toolbox talk-style documentation, that there was a conscious decision about communicating one particular message to staff.

DR JUDD: That's correct. And if I, say, talk about the toolbox talk, because you indicated that it was quite detailed. At each – at each shift – and I hope this is the case – at each shift it's jazzed up a little bit as a mini quiz. So you actually ask people. So it's not as boring, if I can put it that way, and you can actually change over, "We're going to talk about toolbox 4 today, which is about the use of PPE." "We're going to talk about what COVID?" Again, "How do we prevent it?" And you keep on doing that, because we recognised that the greatest risk to our residents was transmission from our staff, not – primarily because they're the ones who are providing personal care. They're the ones who are in close – one-on-one, close with our residents. So they were the people who we had to look after in order that we could look after our residents.

MR BOLSTER: Ms Thompson, do you want to comment on that, on the perspective of Opal about how you dealt with your staff?

MS THOMPSON: Certainly. So, by early March, we had established a central emergency command team that was meeting every day, that constituted most of the executive. We had streamlined a communications plan that went out to every single home. So we were providing regular updates to the homes, in forms – in the form of email and fact sheets. We were also providing information directly into staff team rooms, through team screens. So they were key components of our education approach. We also implemented regular teleconferences with all general managers across homes, and have since implemented a weekly teleconference with all care managers. And we were communicating that way. We were meeting every week with the board. And we had, certainly, through our communication plan, informed chairs of our clinical governance committee and audit and risk committee. So we had a tiered approach that went out across the organisation and then also directly into homes.

In addition to that, we had, as of the 23rd of March when the Commonwealth Department of Health e-learning modules became available; uploaded those into our organisational learning and development system and had gotten that education and training underway. Communication also occurred at handover and huddles. We had instituted, by that time, preventative screening for any person entering the home. And we were closely monitoring advice from the Commonwealth and State deposits to continue to analyse and update the information that we provided to the team on the ground and to the team who were working regionally and across home office.

MR BOLSTER: If we could go to tab 3, please, of the Opal tender bundle.

MS THOMPSON: Yes.

MR BOLSTER: You have that?

MS THOMPSON: We have that, yes.

MR BOLSTER: We will just wait for that to come up on the screen. Yes, that's it. I take it this is part of that communication process and messaging going out from head office to regional general managers, general managers and care managers?

MS THOMPSON: Yes, that is correct.

MR BOLSTER: All right. And that was a daily occurrence?

MS THOMPSON: It was as required. It often occurred daily, certainly in the beginning. And as outbreaks have occurred, it certainly continued that way.

MR BOLSTER: Now, each organisation had a fairly high-powered clinical governance team, may I say respectfully, in advance of any outbreaks that you

suffered. How difficult is it for an ordinary provider to put together a pandemic response team that doesn't have the sort of expertise that you had? I suppose the point that I'm trying to make is that in the case of HammondCare, you had a number of professors on your clinical governance team for COVID. At HammondCare, what was the level of expertise that you had?

MR ANDERSON: The level of expertise at the – on the clinical governance team was – Angela Raguz was the chair of that and Professor Chris Poulos who is head of research but also our aged care clinical services, and Professor Andrew Cole who is our chief medical officer were, if you like, the major three of that particular team. And operational portfolio general managers were there as needed or as required. I think in answer – I think something like that is necessary. I think probably what your – I think that was a very important decision-making body because this – a pandemic is not the time for consensus decision-making. And so you actually need to have, in my view, you need to have clinicians are who are making the call.

You notice that I wasn't actually on that clinical governance team because I know to take the advice of our doctors and our nurses. And so it's actually people who are well-informed about these issues who can guide the advice that we actually put out to our services.

MR BOLSTER: Ms Thompson, from your perspective, how did your clinical governance team get established?

MS THOMPSON: So the clinical governance team – clinical governance committee at Opal was in existence when I joined in 2019. As a part of our review of all things clinical and quality we have reviewed the terms of reference of that clinical governance committee and have added to that committee more representation from regional general managers. That committee is chaired by Dr Victoria Atkinson and so we are quite fortunate to have quite senior clinicians on that committee as well. And you know, we've done a lot of work in terms of working with that committee to establish very sound mechanisms for that committee to be informed around all things clinical and quality related within the organisation.

MR BOLSTER: I believe Commissioner - - -

COMMISSIONER BRIGGS: If I could – thank you, Mr Bolster. If I could just follow up Mr Bolster's earlier question. Do you think smaller providers could produce similar preparations or do you think, for want of a better word, they might be all at sea because they don't have the same resources as organisations as large as yours?

MS THOMPSON: I'm happy to provide an answer there. So certainly, at Opal we have been fortunate with the resources that we have available to us. I think that's a key component of being able to respond in a very agile manner when something such as this occurs. Having not worked in a smaller aged care provider prior, it's probably a little difficult for me to make a general statement around a smaller provider's

ability to, you know, to prepare for something like this. But I could see there would be challenges, yes, in place for a smaller provider.

MR BOLSTER: Can I – developing that question, what should clinical governance post-COVID-19 look like for every provider across the sector? Do you need to have some form of expertise referable to these sorts of issues on your clinical governance team?

MS RAGUZ: Could I just – just in adding to the last – just the last question because I think it adds into the next part of that. There is – the role of the public health units in a smaller outbreak can play that role of supporting smaller providers in that clinical governance and preparedness and response to an infectious disease. If there's an influenza outbreak, or a gastro outbreak, the PHU is a very useful resource and mostly understood and used within the sector. I think the challenge with the pandemic is that the PHU is stretched and providing that resource to the broader community and thinking about hotel quarantine and travel in and out of the country as well as trying to support those smaller providers. So in this context small providers would absolutely struggle.

The future, my view would be that clinical governance is already and always will be a very important part of the care, the care delivery, the processes, the systems, the monitoring and the measuring that is occurring in aged care. But I think what we did that which was separate to that normal process which does exist was separate it out. It was almost like this was an emergency team that sat above that even, just to give the focus for COVID. The future should be that those things are wrapped up into the existing systems, if possible, and expertise is developed as a result of some of these things. But I think, you know, this is extraordinary, and I think everybody agrees that what we're going through as a world is extraordinary. Clinical governance is something we should be doing but I don't think we should be creating – pandemic governance, governance structures for non-pandemic times.

MR BOLSTER: All right. We might turn, then, to some of the specific aspects of the COVID-19 experience as each facility or each organisation experienced it. Let's start with Opal, shall we; so the Opal story, in brief, if I can just summarise it – people will tell me if I am wrong – is that you had your first resident go ill on 23 March and they were taken to hospital. A second resident fell ill on 25 March and they tested positive and they too were taken to hospital. A third resident was tested positive some time later on 8 April and they were taken to hospital. It's a very different scenario to what happened at Newmarch. The decision about taking residents who had tested positive to hospital, how did that play out, Ms Thompson, at Opal Bankstown?

MS THOMPSON: Certainly. So it's probably beneficial for both of us to jump in because Jonathan was on the ground running the outbreak in the local command centre, and I was a part of the central emergency command centre that was assisting with the outbreak. I think the first clarifying point here is that resident 1 who tested positive for COVID was already an inpatient in hospital, and was actually due to

return to the home. As a part of our COVID planning, we had instructed our general managers in homes to seek advice from hospitals as to the current COVID status of a resident before they came back into our care. So that COVID status was in fact that they were either – they had tested COVID-positive, that they did not require testing and so their status was effectively unknown, or they had had a test and had tested COVID negative.

So resident 1, on further inquiry, had actually been tested and had returned a positive COVID test whilst in hospital. Residents 2 and 3 during the outbreak tested positive in the home and there was a collaborative discussion with the hospital – with the hospital around the clinical care requirements related not just to that positive result but also the clinical care requirements of each of those residents and following that, they were each separately transferred to hospital.

MR BOLSTER: Was the prospect of hospital-in-the-home discussed in relation to any one of those three residents?

MR ANDERSON: I might answer that question; no, it was not specifically raised as an option to be considered in relation to those residents.

MR BOLSTER: You were operating in a different area health district to Newmarch, they're in the Nepean or Blue Mountains and you were in the south-west Sydney.

MR ANDERSON: That's correct, yes.

MR BOLSTER: All right. Let's then turn to what happens on the ground at Opal after the two positive tests inside the facility. I mean, it's remarkable, given what we know about this disease from other experiences, that no one else tested positive at any stage at Opal Bankstown. That's correct, isn't it?

MR ANDERSON: That is – that is correct, yes.

MR BOLSTER: What did you do to achieve that result?

MR ANDERSON: I think there were a variety of things that certainly came to play that I think had an impact on the final outcome at Bankstown. I think many of the things we discussed previously in terms of the preparation work that had been done, did come into play in that particular instance. I think the other thing for us was that we had also established some important emergency disaster response arrangements out of our learnings from the bushfire situation affecting New South Wales and other States at that particular time which really heightened our focus on ensuring that we had the right command and control structures in – and Lucy spoke about those previously, about a high level overarching command responsibility group and then a local on the ground group.

I think that was an important initiative at Bankstown so that both the connection with key stakeholders was happening at an Opal level, and at a home level we were also

making sure that there was communication coming into the team so they understood exactly what was required of them at any given time, because one of the things that I think is definitely our learning is that responsive and agility to the changing situation is a key and, therefore, for that messaging to be very rapidly communicated is very important. So I think - - -

MR BOLSTER: Can I just pause there. There is a couple of things I wanted to clarify about all of that. In terms of decision-making though, who was making the decisions; was it the facility, was it New South Wales Health, was it the Commonwealth Government? Who was in charge?

MR ANDERSON: Yes, I think we would say Opal, as an organisation, was in charge because we carry, obviously, the fiduciary responsibility for the final outcome. So we believed that it was absolutely important that we had active discussion through our structures to set a position that we believed was the right one. But, obviously, that's important to then get the expert advice coming in from other agencies, whether it's the public health unit, the Department of Health or even external consultants, to take their advice and then obviously part of that, the consideration process, is to consider those but then reach the final conclusion around what Opal believed was the best – the best option.

MR BOLSTER: Were there any decisions about which there was a tension or a disagreement that had to be resolved by Opal saying, "This is what we're going to do"?

MR ANDERSON: So in our situation at Bankstown I don't think we ever reached that. There was certainly some fairly robust discussions and some, you know, strongly expressed views, as you would expect there to be and important that there were those inputs and those discussions because you really want to make the best outcome here, because, obviously, we all understand the consequence of making a wrong decision. And there are passionate players and people with particular opinions that need to be considered. And I think, through those robust discussions, we were able, with the stakeholders groups, the other agencies, able to come up with, I think, what proved to be the right decisions with respect to Opal Bankstown's situation.

MR BOLSTER: Dr Judd, I might ask for your perspective on that now, because HammondCare's situation in Caulfield in Melbourne in May was such that you had a couple of people testing positive. They were in different units. They subsequently tested negative. But what was the – what was the HammondCare response? And how did HammondCare see its role in making decisions about implementing the plans that you'd developed over time?

DR JUDD: Yes. So on the 18th of May, we had a resident who returned a positive case. That particular resident, resident A, lived in – and had dementia. She lived in a small cottage with 11 other residents. We immediately isolated her in her room but that was quite a challenge, because it's a dementia-specific service. She was

physically very well. And we actually had to have one-on-one support for her for that duration. The following week, we had a second positive case on the twenty – I think it was about the 25th of May in another cottage. By that stage, we had the opportunity – in the intervening week, we had recommissioned a service that we had decommissioned on site. And so we relocated resident B, and she was supported one-on-one. I think this raises the issue of supporting someone who is COVID-positive – who has returned a positive COVID test in situ and trying to isolate them, which is jolly, jolly hard, particularly, if they have dementia – as opposed to having hospitalisation. And I don't think it's actually binary. I think there is a possibility for having isolation units. And that's what we're looking to do where we can. So on that Caulfield site, we actually did that. We actually had resident B in that recommissioned service with very special care.

MR BOLSTER: Thank you. And the question, though, that I was really trying to get an answer from you was about the decision-making. How important was HammondCare being in control when it came to making these decisions at that time?

DR JUDD: We made a decision very early on, similar to what Mr Anderson has said that, we wouldn't going to cede control, if you like, to other – other agencies. We would certainly call on their support. And I have to say that, for example, in the experience – my experience, when I was in Melbourne, on the – on the 19th of May, there were a lot of different agencies there. So there is the Public Health Unit of Victoria. There was the Department of Health and Human Services. There was the Commonwealth Department of Health. There was the Quality and Safety Commission, Aspen Medical and also the Alfred, because we were in that – in that location.

So sometimes it was hard to understand what people wanted – information. Sometimes they wanted the same information in different templates. We probably gave them the same information and told them to put it in their own template. And – but I do want to actually make note that Michael Lye, the Deputy Secretary of the Commonwealth Department of Health, was very helpful, because I indicated to him, "Look, there's a lot of voices out there. We're not ceding control, but we welcome the support in various ways." So the Commonwealth Department of Health, for example, Mr Lye said, "That's great. Just tell me who's actually providing the road blocks." So from a point of view of recommendation, it's great to have a single point to go to for those external agencies.

MR BOLSTER: What were the road blocks?

DR JUDD: Angela might have a couple of examples of those road blocks. One of the road blocks that comes to mind might be there was a differing view from the Public Health Unit to what the Quality and Safety Commission had or there – there was different perspectives. And so you actually had or – I'm struggling to think of an exact example.

MS RAGUZ: But I think an example was the question around whether or not resident B should or should not be moved - - -

DR JUDD: That's right.

MS RAGUZ: - - - into the recommissioned service. And this was where our clinical governance committee was invaluable, because that small group of three was where those decisions were made. And we decided that was what we would do. And we did that, even though that was not – that was not necessarily the view held by DHHS or the Public Health Unit at the time.

DR JUDD: That's right.

MR BOLSTER: So that was Professor Poulos, Associate Professor Cole. And Professor Cole - - -

MS RAGUZ: And myself. And me.

MR BOLSTER: You made the decisions. And you were the ones with the medical expertise, I take it?

MS RAGUZ: And nursing expertise. Yes; that's correct.

MR BOLSTER: And what was the countervailing view that was coming across your bow from others.

MS RAGUZ: Well, the view was that the person should be isolated in the unit itself, the dementia-specific unit. And our view was that that was not going to be achievable, even though, yes, resident B only lived with five other residents at the time, our view was we still did not know. We say now that, you know, this may have been false positives, but, at the time, this was treated as an outbreak. And it was our view – and the doctors definitely were instrumental in us forming this view – that if we had one person who had returned a positive result, it was likely that other people could already be incubating or positive, and we needed to turn on our isolation unit quickly rather than wait, so we didn't do that.

MR BOLSTER: Well, what's the message, then, for the future? What does the interface between provider, between state, federal, government, the regulator, look like in a pandemic situation in the future?

MS RAGUZ: Well, from a personal perspective and, I guess, from a HammondCare perspective – and I'm sure this will be a different perspective if the people sitting here were from the State or the Commonwealth – I believe that decision-making occurring within the organisation that holds that responsibility and has to make those decisions not just for the people who are COVID-positive, which I think is where the health system can make decisions for people who are COVID-positive, because, at that point, they are – they become a patient with COVID. We still have other people,

who are residents within aged care, who may be negative and they are not – they're part – part of the health system. So the decision-making should sit with the provider in order to look at our overall cohort of people that we provide care for, not just the people who are returning a positive result.

MR BOLSTER: Ms Thompson, what's your perspective on how this ought to be done?

MS THOMPSON: Yes. I think these are very complex questions and they're complex situations. I think what would be beneficial, going forward, is mechanisms by which to ensure that the advice and direction provided by the Commonwealth Department of Health, Aged Care Quality and Safety Commission and state departments of health are tested prior to them being applied within the aged care setting. That was certainly what we landed on as we worked with the Public Health Unit and others at the – during the outbreak at Bankstown. Advice would be provided. And we had communication mechanisms set up where we could discuss that advice and the application of that advice in a practical way within the aged care environment. And, I guess, just to note there that every aged care home is slightly different. And so, again, the testing and application of that advice in a practical sense, I believe, is key.

MR BOLSTER: The differences being the design, for one, the size?

MS THOMPSON: Yes.

MR BOLSTER: Whether the people have dementia?

MS THOMPSON: Yes.

MR BOLSTER: All of those dimensions come into play, don't they?

MS THOMPSON: Correct. Yes.

MR BOLSTER: So, for example, at Opal Bankstown, which is a large, new, modern facility; correct?

MS THOMPSON: Correct. Yes.

MR BOLSTER: How many residents?

MR ANDERSON: 155 is its total capacity. At the time of the outbreak, we were running around 140.

MR BOLSTER: And if you compare that to the – a HammondCare small dementia unit, where there's maybe a house of, what, eight to 15 people, Dr Judd?

DR JUDD: That's correct.

MR BOLSTER: So – and people live in a completely different communal atmosphere don't they, to Opal Bankstown?

DR JUDD: That's correct. Yes.

MR BOLSTER: So the – all right. I think – I think the point's been made. Can I turn to the issue of visitation. Dr Judd, what's the perspective of HammondCare, which seems to be quite different from the standard response to visitation that we've seen in the evidence so far this week?

DR JUDD: Counsel, I think, actually, the issue of visitation is actually quite a vexed one. It's not as, perhaps, simple as people think, because, as Ms Johnson just said, different providers have different physical and social environments, different staffing environments, and so on. We made a decision in early March to screen all visitors, but then the question comes along: who's going to do the screening? And if you've got a workforce that's focused upon care, are you going to take them off caring in order to do the screening?

We made the decision not to what is called "lockdown". Think I think that's actually a slight misnomer. But we made a decision to continue to have visitors to residents. And we made that decision, because it was – we thought it was going to be a marathon, not a sprint. I wish it had been a sprint. But that the pandemic was a marathon. We really didn't know how long it was going to continue. And we thought that actually saying "no" to people visiting our services would have a very bad impact upon our residents. And so we made that decision. And then we actually had to work out how we were going to do it.

So within two weeks in mid-March, we introduced what we call a concierge service, which was quite separate from our care workers, who are working in our residential services, which is basically a group of people. It's people who are from our back office – you know, our corporate office and our property people, our planning, and so on, and also volunteers – and they actually screened visitors and have continued to do so. So we actually have about, at any one week, we have about 250 shifts in our services with about two and a-half thousand staff. And we're going to continue to do that, unless we are directed by State order, being a directions order or a public health order, not to do that.

MR BOLSTER: So what about in Victoria, though, where you have homes now.

DR JUDD: Yes.

MR BOLSTER: Do they operate under the same - - -

DR JUDD: Yes.

MR BOLSTER: - - - procedure?

DR JUDD: Yes, they do.

MS RAGUZ: We continue to have the concierge operating. And we continue to facilitate visits for people who are providing those essential care and services. The complexity in Victoria at the moment is that the state – Melbourne is in a stage 4 lockdown, which means the visitors themselves are not allowed to leave their home except under certain circumstances. So we do continue to have those people who are – we've done an assessment on each person and their visits. And we ensure that those people who are receiving care and support from family members continue to do so.

MR BOLSTER: And what about in Sydney, where things are slightly better? Is it the same philosophy - - -

MS RAGUZ: It is.

MR BOLSTER: - - - and system in play?

MS RAGUZ: It is. And the daily – the daily lists that New South Wales Health and the Chief Health Officer, Dr Kerri Chant, in New South Wales, are releasing does – does mean that every day we do need to observe for where there are considered hotspots. It's not an either/or. It's balancing and managing the risk. So we do have visits occurring in New South Wales facilities. However, in the case of, for example, our service in south-west Sydney, when the Crossroads Hotel cluster became an issue for New South Wales, the advice was that we should not have visitors in that service for that time. And we complied with that direction, but continued with those people who were deemed essential visitors.

MR BOLSTER: All right.

MS RAGUZ: And the palliative care visits has continued.

MR BOLSTER: Ms Thompson – yes. How different is the Opal position when it comes to visitation at the moment? Is it geographically specific?

MS THOMPSON: So, certainly, from the beginning of March onwards, we had implemented a range of mechanisms around restrictive access. But I do want to stress that, during that restricted access, that's not lockdown. We'd already had in place preventative screening for all visitors coming on site, and a series of questions which we updated regularly that were informed by the State and Commonwealth Departments of Health. Restricted access allowed for restricted visitation and a set number of visitors on site. And, certainly, when a home had gone into lockdown as a result of an outbreak, we continued to maintain access for visitors, particularly as it related to palliative and end-of-life care. And we were assessing visitation, really, on a one-by-one risk basis to ensure that we were doing the best we could possibly do to meet the needs of our residents and our families. But we did abide with the visitation code. And I think Jonathan probably - - -

MR ANDERSON: Yes. I was just going to add, too, one of the other things that we did is that we were very concerned to ensure we were getting feedback from residents and residents' families about what they felt about our approach to restricted access and, overwhelmingly, the response we were getting back was, "We want to keep our loved ones safe, so the steps you are taking, we fully support."

MR BOLSTER: Do you – does anyone have any view about the code of conduct as it now stands? Is it the right balance? Or does it need further fine-tuning?

MS THOMPSON: I think that given that we are in the throes of the pandemic, and that we are continuing to learn. You know, all things, such as a code like this, should be reviewed on a regular basis. And that we should, you know, very carefully make sure that we have processes in place to receive feedback from our residents and from families and, certainly, from the other stakeholders that we're working with.

So I think it's hard to lock in something as a final solution, when we're in the throes of a pandemic. But I do believe that carefully risk assessing visitors on site to ensure that you're not bringing infection into the home is key. And that needs to be very carefully balanced with the needs of the residents that we're providing care for, because their emotional and – emotional wellbeing and their mental health is as important as their physical health when you're working in a situation that we are at the moment.

MR ANDERSON: If I could just add quickly, too. I think it was an important step to take. I think it was a step in which, you know, peak bodies, providers, representative of the resident community, came together with government to agree a basic code that I think we would accept was a nicely appropriate articulation of what was an appropriate response to visitation. As Lucy said, I think there's opportunity for continuing to refine that document as circumstances change.

MR BOLSTER: As a code, though, its primary focus is to guarantee a degree of access for relatives and friends and carers of people. You would agree with that, wouldn't you?

MR ANDERSON: I think it certainly does that, but it also provides a basis for providers to establish a degree of restricted access and to have an agreement with government and other representatives that that is an appropriate step with the right balance of giving access to those that should still, even under restricted access requirements, be able to still visit their loved ones in that time. And, you know, because it also goes to important points of the sector working very hard to ensure that other mechanisms are available, either through technology, communication devices, other means, for which people can come to site without actually having to go into rooms.

MR BOLSTER: Dr Judd, what's your perspective of the code? Do you offer the family member, the visitor, the carer, more than the code? Or do you follow the code?

DR JUDD: We offer, we comply with the code and we exceed the code. But can I – at the risk of – can I actually say that I remain convinced that the biggest – the biggest risk for our residents of transmission of COVID-19 to our residents is – is through staff. And so we've actually got to be incredibly vigilant, as Ms Thompson has said, in actually looking at that. I can almost say it's the back door. It's not the problem at the front door. It's the back door. And that's why we're very focused on your toolbox talks, for example. Can I also say with all of the planning that we have spoken about, with all of the procedures of toolbox talks and concierges and everything else, we could still have another outbreak. I mean, this is an amazingly insidious and virulent virus. So all of this planning, and we can have another outbreak tomorrow.

MS RAGUZ: Can I just – just in terms of visitation, sorry, but the idea – one of the things that we are proposing to put in place which goes to the heart of the idea that, yes, people who do not see their loved ones are at higher risk of not just mental wellbeing suffering but also physical. I think underestimating the physical impact on people of not seeing people who they love is – that's a mistake. We are introducing a program where we will provide training for family members in infection control and the use of personal protective equipment, and to understand our protocols in order to be able to continue those visits that people – that we believe people must have, even in the event of those local community increases of transmission, because as Stephen said, this is a marathon, not a sprint.

And so even the idea of locking down, opening up, locking down, opening up is quite distressing for people. So that training will hopefully provide people with the mechanisms to safely visit even as the pandemic progresses.

MR BOLSTER: Ms Thompson, you referred to the mental health challenge a few moments ago for residents. Have you seen an uptake in the need for specialist dementia support programs like the program that Dr Judd's organisation runs to come in and handle the isolation and issues that arise for people living with dementia?

MS THOMPSON: During our lived experience of outbreaks at Opal we have been fortunate to seek that advice through expert geriatricians that we have worked with through a range of local health districts. I do believe that the inreach programs into aged care to provide that additional support and advice down to a resident level, down to the individual needs of what a resident requires at a particular point in time are highly valuable and we're very grateful to our health partners who have provided that to us in each occasion where we've sought it.

MR BOLSTER: But is there more of it as people feel isolated, feel under stress?

MS THOMPSON: I think we can always do more in terms of understanding the impacts of isolation on someone who is living with dementia and the specific behaviours that they have as a part of their condition.

MR BOLSTER: How would you describe, generally, the need for mental health support, psychological support; has that need grown over the last three to four months across the Opal Care set of facilities?

MS THOMPSON: Yes, I believe that it has grown. One of the things that I would mention there is that we have just on-boarded a head of dementia who has joined the organisation to be, you know, in-house and provide additional expertise and advice for all things dementia but obviously specifically as they arise within situations such as an outbreak.

MR BOLSTER: Dr Judd, are your dementia advisory hotlines and specialist teams, are they getting called out more or less under COVID?

DR JUDD: Counsel, I should say first up that Dementia Support Australia is a federally funded program, and it's a partnership that we lead so there are many partners in it. Dementia Support Australia visits to January to June of this year increased about 17 per cent, went up 17 per cent. During the pandemic – so into late March and through to April, Dementia Support Australia introduced a proactive engagement plan. So they actually did over 1000 -what might one call cold calls – to providers and they recognised that providers were stretched. And they actually went to more than 600 care homes. So, yes, that's occurred but there's no evidence to date that there has been increases in the symptoms – the behavioural and psychological symptoms of dementia which Dementia Support Australia is focused on.

MR BOLSTER: And what about access – and I open this to both pairs – access to physiotherapy services, dealing with mobility issues that can develop as people are isolated and unable to get outside, unable to move around the facility. Are you seeing a greater incidence of problems in that area and how are you dealing with that under the current situation?

MR ANDERSON: If I can just start on that. It was certainly something that was recognised as we began to lift restrictions in terms of isolation at Bankstown. The sort of chronology of an outbreak is that in the first week or so, where you're really in the middle of a crisis dealing with everything that is coming at you, it's a very challenging time, making sure your rosters are right. Very quickly after that it was quickly realised that there was a need to ensure that we had some input from the perspective of ensuring people's mobility and that they weren't deconditioning in that period of time. And so we designed a number of specific programs to assist residents maintain a degree of strength and balance and there was a program designed to give, if you like, little gentle exercises in-room conducted by team members.

We also, on a broader issue, going back to, I guess, the previous point about mental health, we were also concerned to make sure that there was ongoing mental activity going on. And so for example we were doing things like corridor bingo in which we were able to run bingo down a corridor of a particular wing of our units so that people were still mentally active during that time as well. But it was – in terms of

the physical needs, we were fortunate in that we had physiotherapists who were able to come in and support some programs and wherever possible we would, for example, allow residents to mobilise, move around the wing so that they were actually getting exercise. But a really important point that, you know, we quickly realised we needed to do something about this because without some intervention falls risk would go up substantially.

MR BOLSTER: I have no further questions. Was there anything that either pair wanted to indicate to the Commission that is of significance to them to raise at this last moment?

MR ANDERSON: I think only a couple of things I would like to say is, you know, obviously, the sad reality is for the situation at Bankstown is that there are three families who prematurely lost loved ones, and I think it's important to acknowledge that. I think the other point to be made is just how inspirational our teams have continued to be in the middle of crisis. In Opal's case, team members willing to attend in the middle of a fire crisis but also continuing to provide compassion and dedicated care to situations in which we've got an outbreak. They're an extraordinary group and we are very grateful to them all.

MS THOMPSON: If I could just add something small on to that. As a large operator that operates across multiple States, I think one of the things that would be beneficial going forward is a nationally supported cohorting approach that occurs externally off-site. One of the changes we have is varying advice and guidance from different States in their approaches and when you're operating services across multiple sites that can prove challenging. So that, in addition to – certainly, we are grateful for the ready access we have had particularly again most recently to the national stockpile, and very grateful for the assistance we have had from the Commonwealth and State departments of health and the Aged Care Quality and Safety Commission.

MR BOLSTER: Dr Judd, was there anything?

DR JUDD: Look, as I said earlier, all the preparation in the world, all the plans everything that we've got won't prevent an outbreak. It can mitigate it. Can I say and endorse what Mr Anderson said. At the height of – when we had the second positive case in Caulfield, no one called in sick. I mean, I'm in awe of that.

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

COMMISSIONER PAGONE: Thank you, Mr Bolster. Commissioner Briggs?

COMMISSIONER BRIGGS: No, thank you.

COMMISSIONER PAGONE: Thank you to each of the panel members. We are very, very grateful for the time that you have given us, both in preparing the written materials that we've seen and making time available today and in preparation for

today. We are conscious of the fact that you are on the frontline of all of this and dealing with a lot of people with different directions, or being pulled in different directions. On the other hand, we have got a task to do and we are very grateful, indeed, that you have assisted us in that task. So thank you very much and I am delighted to formally excuse you from further attendance. Thank you.

MR ANDERSON: Thank you, Commissioners.

MS RAGUZ: Thank you, Commissioners.

<THE WITNESSES WITHDREW [3.21 pm]

COMMISSIONER PAGONE: Yes, there are a couple of counsel to be excused. Who have we got to be excused; Mr Dawson, no, not Mr Dawson.

MR BOLSTER: Mr Dawson is the next witness.

COMMISSIONER PAGONE: Mr Dawson is the next witness, yes. Ms Sharp is one, I think.

MS SHARP: Yes. Thank you, Commissioner.

COMMISSIONER PAGONE: You're excused. And there's somebody else, I think.

MR LLOYD: Yes, Stephen Lloyd, Commissioner.

COMMISSIONER PAGONE: Mr Lloyd, of course. Yes. Thank you.

MR BOLSTER: The next panel is Mr Rik Dawson and Ms Julie Kelly.

COMMISSIONER PAGONE: I think we better check, first of all, that Mr Dawson is there and, secondly, that he can hear us and we can hear him. Mr Dawson, can you hear us?

MR DAWSON: Yes, I can.

COMMISSIONER PAGONE: We can now hear you.

<RIK DAWSON, AFFIRMED [3.22 pm]

COMMISSIONER PAGONE: Ms Kelly, shall we just check you can hear us and we can hear you.

MS KELLY: I can hear you, thank you.

<JULIE KELLY, SWORN [3.22 pm]

COMMISSIONER PAGONE: Yes, Mr Bolster.

MR BOLSTER: Mr Dawson, could you state your full name please.

MR DAWSON: My name is Rik Dawson.

MR BOLSTER: And you are a gerontological physiotherapist, and you are a member of the Australian Physiotherapy Association; correct?

MR DAWSON: That's correct. I'm one of the directors of the Australian Physio Association.

MR BOLSTER: Do you practise as a registered physiotherapist in New South Wales?

MR DAWSON: That's right.

MR BOLSTER: And you – the organisation which you represent, has made two submissions to the Royal Commission, which are in the general tender bundle, for your information.

MR DAWSON: Yes.

MR BOLSTER: You are familiar with those and can speak to those.

MR DAWSON: I can. I was one of the subject matter experts at creating the submissions.

MR BOLSTER: Just broadly, your experience in physiotherapy with older Australians?

MR DAWSON: So graduated in '93 as a physio and started working in aged care in 1998 in my own business, and for 22 years ran a business and employed over 100 physios working in residential, community and NDIS, and now I've just started my higher degree research program at Sydney Uni in aged care.

MR BOLSTER: All right. Ms Kelly, you are a registered psychologist working in Melbourne right now, correct.

MS KELLY: Correct, yes.

MR BOLSTER: And you currently work part-time, I understand?

MS KELLY: Correct, three days a week.

MR BOLSTER: How long have you been a registered psychologist?

MS KELLY: I received my registration in 2005.

MR BOLSTER: And predominantly do you work with people in the aged care setting?

MS KELLY: So my practice has led me to work predominantly with the older adults in aged care settings in the last four years. My practice before then - - -

MR BOLSTER: It was going so good for two days.

COMMISSIONER PAGONE: Yes.

MR BOLSTER: Perhaps if we temporarily adjourn, Commissioner.

COMMISSIONER PAGONE: Let's just see whether we need to. We have got them both back.

MR BOLSTER: Can you hear me, Mr Dawson?

MR DAWSON: Yes, I can.

MR BOLSTER: And can you hear me, Ms Kelly?

MS KELLY: Yes, I can.

MR BOLSTER: Good. So you were just telling us that you had been working for four years with older Australians.

MS KELLY: Correct, in residential aged care facilities. Before then, I had had experience working in an acute inpatient psychiatric unit for older adults and my previous beforehand has been predominantly with adults between 18 and 65 years of age.

MR BOLSTER: Could you just describe very briefly for us what your practice is like now in Melbourne under COVID-19, and the sorts of people that you see and the sorts of problems that you come across.

MS KELLY: Could I please clarify whether you would also like me to explain the nature of my work or just in general or just specifically what - - -

MR BOLSTER: Yes, please.

MS KELLY: Okay. All right. So I'm a senior psychologist that works for an organisation called Star Health who has received government funding through a primary health network to deliver psychological services into residential aged care facilities in the south-east Melbourne area. So I work three days a week where I am responsible for delivering and implementing psychology services to four facilities. I also have students – postgraduate psychology students who I supervise who have also been on site and also have been doing telehealth in the last seven months.

MR BOLSTER: How has your practice changed as the COVID pandemic has developed over the last month or so?

MS KELLY: Okay. So our practice has changed a lot in regards to how we have been able to deliver our service to start with. Initially, my team and my students, we were on site at facilities. However, with the first COVID lockdown we received different responses. We had facilities that asked us to return when lockdown or restrictions were lifted. We had other facilities who asked us to stay and saw us as essential workers. Our practice also had to change because we no longer could go across a number of different sites. We were already aware quite early on about not getting caught in cross-contamination. So we ended up staying on site at one facility and having to set up telehealth at a number of other facilities.

Now, with the second, I guess, COVID scenario with stage 4 restrictions here in Melbourne, we have definitely only been at the one site, trying to continue with telehealth at other sites, and more recently as of last week, we're looking, within my team of all clinicians moving to telehealth but we are negotiating whether we can still continue one day a week on site to meet the needs of those residents who really are at clinically high risk.

MR BOLSTER: Let's talk about the people that you are physically seeing at the moment. What are you observing about the deterioration in their presentation because of COVID-19?

MS KELLY: Thank you. I certainly have seen a large increase in depression and anxiety as well as confusion. Suicidal risk has gone higher as well. My experiences have shown me, too, that those that generally were coping relatively well during the first lot of COVID earlier on in March, they're presenting now with a lot more generalised distress as well, and worry. A lot of this I think has occurred because there are significant changes to their day-to-day life. It's not just about not seeing family and friends, but what's going on inside a facility as well has dramatically changed for them, which has caused a lot of anxiety in regards to the structure of their day, what is possible for them to do. They also are very worried about family in their community. I have residents who are very anxious about attending any medical appointments because there's a concern that, by attending the medical appointment in the community, there's the COVID risk, of course, but they're also concerned about having to further isolate within their own room for a period of time.

MR BOLSTER: People with cognitive deficits and people without, are you noticing any difference?

MS KELLY: I can only talk about my own experiences. I guess, my work has led me to work more with those who have less cognitive impairment. There are a couple of residents who have moderate cognitive impairment and having seen myself even in my PPE gear can be confusing for them and can be distressing for them, and we have had to work through that. I do have residents with more – who present with more severe cognitive impairments. And I find that COVID has impacted the residents that I am familiar with, in the sense that they're confused about family, how they present with their PPE gear – not so much as to why they're not coming, because they don't retain that information – but just the confusion of why things look different or why they have to talk to family across a glass screen rather than in their room.

MR BOLSTER: What's the greatest source of anxiety for the people that see you? Is it fear of the virus? Is it confusion? Is it the fact that they can't leave their room? Is it visitation? What's their – what are their priorities that are causing their concerns?

MS KELLY: I think that's a really – a really interesting question. And everybody that I'm familiar with would have a different priority. So I don't think there is just the one – the one key issue. I have, for a number of residents, where not being able to see family and friends has definitely been one of the most challenging things for them. Whereas, I have another resident where his anxiety has reached high levels because he's not able to access the medical appointments he would like to due to his own fear of getting COVID, but also the worry of having to, then, be further isolated once he's back at the facility after having been in the community. I think a lot of confusion in my residents is due to the fact that the – the structure of their day is so different. They're not attending groups as they were. They're not sitting, even, in the same structure or format in the dining area due to social distancing. And I think for a lot of - - -

MR BOLSTER: Please continue.

MS KELLY: I was going to say, just for a lot of the residents, there's a real, real strong sense of hopelessness, of not knowing when this is going to end or being able to see any changes for them.

MR BOLSTER: What about loneliness: not being able to talk to the other people that they would play their bingo with or watch their television with. How does that play out?

MS KELLY: Absolutely. I think loneliness is huge because it's not just about not being able to see family and friends in the community. Things are very different within a facility environment as well. They're not interacting with their co-residents as they normally would. As you mentioned, they are not meeting out to play those

scrabble games. And I think that loneliness has had a real impact on their mood and, especially, on depression.

MR BOLSTER: All right. I might turn now to Mr Dawson, and ask you, Mr Dawson, some questions about – along a similar vein.

MR DAWSON: Yes.

MR BOLSTER: Although you're in – you're in Sydney, what's the Physiotherapy Association's perspective on the way in which residents in aged care are being impacted by the pandemic?

MR DAWSON: So we have been in contact with a lot of members in Melbourne, Victoria, New South Wales, and across the country. So if we look at residential, as a workforce, we move really quickly to the primary place of work recommendation. So we adapted to reduce the risk of infection from community transmission and got our workforce one physio to one site. And so we were able to pretty – adapt to deliver the normal pain management programs that we do and also the assessment and care planning. But the difficulty that we had was that many residents received contracted physios, who weren't able to access the facility in wave 1 and even now. So there's been a reduced frequency of contact. We have a limited scope of practice within residential aged care. And a lot of physios have really wanted to deliver the therapies that the residents want – that consumers want – but are limited by the tool that we have to exist in.

But what we're seeing is that people are, in Victoria and Melbourne, in particular, they're very much in their rooms, on their chairs, not doing their normal physical activity that they would normally do, which is walk to the dining room for meals, walk to recreation activities for group activities. They're spending a lot of time in their chairs. A lot of them watching TV and becoming anxious about all the COVID news they are seeing. So we're seeing an increase in falls. We're seeing a reduction in their ability to be independent with their walking and, like Julie was saying, we're seeing a lot of anxious behaviours and expressions of loneliness and, yes, it's a difficult time for them. In the community, similar. Similar.

MR BOLSTER: Yes. Now, the body of these older people, how does it degenerate when they don't get the sort of exercise that they ordinarily would expect to have?

MR DAWSON: So in anybody's normal day-to-day, we have a certain amount of physical activity, just to shower ourselves, dress ourselves, do our ADLs. And there's certainly an element of that that's required within a facility. We really encourage our residents to be as independently mobile as possible; so many benefits. But once you take that physical activity away because of the – we want to reduce the risk of transmission even within facilities, they will rapidly reduce their muscle strength. They will rapidly lose their balance and their fitness. So – and when you have a – when you're an older person and you're very frail, you don't have a lot of

spare capacity, before pain increases, before you use your balance and your ability to be independent with your walking and ADL. So they deteriorate very quickly.

MR BOLSTER: You give an example in your supplementary submission, which is behind tab 17A, I believe. Yes. Tab 17A. If we could go to that on page 24, which is the RCD.9999.0416.0024. These case studies, they're based on actual people, are they?

MR DAWSON: They are, yes.

MR BOLSTER: So give us – if you could outline for us the sort of experience of Mr X in that case.

MR DAWSON: This is a couple that lived in their own home. And the husband was the carer for his wife, who had a progressive neurological condition and minor cognitive impairment. In March, they went on a bit of a holiday and, unfortunately, contracted COVID. He became very sick and required to go into an acute setting. And his wife also contracted COVID, but she didn't develop the severity of symptoms, but because she had no care at home, she ended up being admitted to hospital as well. The hospital were pretty motivated to get her home, but there were no home services that they could get quickly to support her. So they had to then look at respite into a facility, but even that, trying to get an ACAT assessment really quickly, trying to find a bed in a nursing home that would take somebody that had recently had COVID was a challenge. And so she did eventually get into a facility. And the husband recovered from his acute respiratory problems that he had with COVID and needed some rehabilitation, but everybody was really keen to get home.

And so, soon as the husband was able to agree to care for his wife, they both went home, but because they had both had a recent case of COVID, they had to wait a couple of weeks before any outpatient services or any in-home services. So they were essentially left to their own devices at home at high risk of falls, any possible things that could have gone wrong. Luckily, no problems. And, then, after a couple of weeks at home, both the husband and wife were able to get access to an outpatient rehabilitation service and they began their rehab, because what you're seeing now with these older people contracting COVID – even younger people – they're left with, you know, a lot of them develop a post-viral fatigue syndrome. They're all very unfit. And if they had any chronic illness before, often that's been exacerbated. But – so this couple are doing well, because they've been able to get some rehab in their home, but there were a lot of barriers in the way. And it just reflects the lack of flexibility our health system has in really adapting to something – such a – like what an acute pandemic throws at the health system.

MR BOLSTER: So let me understand this: are there facilities – aged care facilities – at the moment for which there are no physiotherapy services being provided to elderly Australians?

MR DAWSON: Look, I would say that physio services that were contracted before COVID, they're all there now. There was a lot of – there were problems when COVID first came out. Some facilities stopped all physio altogether; they felt that it was a risk. The access code that was developed in May went a long way to ensuring that residents would get the access. But there are still a number of residents whom, perhaps, were contracting private physio, private allied health, that aren't getting the access at the moment, because of the risk – perceived risk – of infection. And there's still a number of residents, who don't have the means to provide their own private therapy, that aren't able to access physio through the current funding instrument, that have nothing. There's probably 25 to 35 per cent of residents in nursing homes that have no access, or very limited access, to physio.

MR BOLSTER: So the physios that go in, is the emphasis on funding related care, such as the pain management?

MR DAWSON: Yes, that's the primary motivation for the physios at the moment is the ACFI fund related pain management. And that's the - - -

MR BOLSTER: What's the actual – what's the primary need, though, of the people who've perhaps been in lockdown, kept in their rooms, can't go outside for a walk, can't move up and down the corridors, what do they need?

MR DAWSON: They need a much more comprehensive exercise program that's really, you know, about what their own goals are, and it can be varied. But, essentially, they need you know, sit, stand practice. They need standing practice. They need walking practice. They need strength and balance work. And they need fitness work, walking work.

MR BOLSTER: And if they don't get that – if they were a walker - - -

MR DAWSON: And with no - - -

MR BOLSTER: - - - and they've stopped walking for two or three weeks, what's going to happen to them?

MR DAWSON: Highly likely they won't walk again, because older people don't have the bounce back that a lot of us younger people have.

MR BOLSTER: Could we bring up, please, tab 70 in the general tender bundle. And this is a document you provided us overnight – when that comes up. You are familiar with that?

MR DAWSON: Yes. So this is the falls rate for Fiona Stanley hospital in WA. And - - -

MR BOLSTER: So it's very early. And we're not seeing stats coming through. But this is the two months before July - - -

MR DAWSON: Yes.

MR BOLSTER: - - - in one hospital in Perth, which is in the State with the least exposure to COVID, perhaps arguably. And tell us what that graph tells us.

MR DAWSON: So if you look at June, from June this year to June last year, they almost doubled their falls rate. And so, often physical problems are – need a few weeks to develop the consequence. And what we're seeing in June is probably a consequence of the physical inactivity and social isolation necessary to reduce infection and, hence, an increased spike in their falls admissions from people that - - -

MR BOLSTER: So is that – so what age are we talking about here?

MR DAWSON: You would, generally speaking, we talk older people at 65-plus, but, generally speaking, in our presentation, is 75-plus.

MR BOLSTER: Yes. So what – explain to me the way this happens to someone who is 75, who has been in aged care, and has not been as mobile as they ought to be. They get up - - -

MR DAWSON: So 50 per cent of people in a nursing home need physical assistance, staff assistance, to get out of bed, to get out of a chair and walk. And what we are seeing is the response to managing infection in facilities that have had outbreaks. It's just the care staff don't have the time to devote to help these people move and walk. And unfortunately, we as physios are not there generally to help them do that; we're there to deliver massage, essentially. So it's a missed opportunity in some ways that we're a workforce there that could be enabling people to reduce the harm of this physical inactivity that's a response to COVID. But, yes, we were talking about it, it's like a catch-22. We need to reduce people's contact with the infection, but as a result of that people aren't moving and if older people don't move who are frail it's almost impossible to start them up again later, when it's safe.

MR BOLSTER: What's the message to government and how urgent is it about mobility for people in aged care right now?

MR DAWSON: Right now the easiest thing to do is that we have got – essentially 75 per cent of residents have contact with a physio. If we would be allowed to develop our full scope of practice and deliver the treatments that the patient – the consumers want, the residents want, which is primarily mobility and balance focus – fitness focused, we would be able to reduce the harm. And a lot of older people, as Julie was saying, are a little bit wary of the touch, and to do the massage we've got to dress up in PPE and, you know, we could deliver physically distanced appropriate treatments that really helps their ability to maintain the things that they want to do, which is to essentially walk and to be independent.

MR BOLSTER: What do you say to the proposition, well, you can do this via telehealth? Can you?

MR DAWSON: You can. What's going to be the basis of my PhD is telehealth for older frail people, but the challenge that we have at the moment in this – in residential aged care, we need somebody with the older person to access the technology. A lot of the facilities don't actually have the technology. A lot of the care staff don't have the time or not the experience in using the technology. So it's available but it's very, very, I would say even a one per cent take up for what we do in residential, and probably only about a five per cent take up of telehealth in the community. It's a missed opportunity because we weren't really ready to embrace telehealth when COVID hit.

MR BOLSTER: Ms Kelly, I might turn back to you, I noticed you nodding a couple of times.

MS KELLY: Yes.

MR BOLSTER: I expect that the physical side is related to the mental side and the two have to operate together to have the healthy person in aged care. Is that a fair proposition?

MS KELLY: Correct. I think so. I can talk about some of my own residents who have recently had a fall or are unable to mobilise as they normally would, and that's certainly had an impact on their mental health, their feelings of reduced autonomy and independence and a sense of, I guess, overarching uselessness; "I can't do this any more" and how that certainly impacts the way they view themselves.

MR BOLSTER: Finally, can I turn to the practitioners, so the psychologists and the physios themselves. How difficult is it for you to be engaged in providing this care at the moment? How do you deal with the infection risk? Are you given PPE? Has your training been sufficient? Perhaps Mr Dawson, you might start off with that.

MR DAWSON: Originally, PPE was a problem getting access, especially for physios and other allied health working community. There was even a large percentage of physios working in residential that were having difficulty getting the PPE. That seems to be resolved now. And you know, as a workforce we are adapting to wearing the PPE, changing the PPE. We are adapting to what we can and can't do. And we are also adapting in actually trying to help the facilities where we can when often the care staff, they've got reduced care staff numbers so we are jumping in where we can and helping the care staff to mobilise where we can, but we have a limited scope even there.

MR BOLSTER: Ms Kelly, how hard is it for you at the moment?

MS KELLY: Just going back to your original question, receiving PPE was – was not an issue at all for myself. The facilities were very much on top of that providing

that for the allied health that were coming in, and being supported by my own organisation. I think the challenge in the current stage 4 restrictions that we have here in Melbourne is being able to deliver effective telehealth. We work very much systemically when we are in an aged care facility in regards to providing treatment for a resident but also when it comes to delivering telehealth. And the staff at the moment are very much stretched in already what they have to do. They don't have the capacity to go from one resident to another with an iPad or a telephone to set up these appointments, and it's not just a matter of delivering the technology to the room, but it is about spending that time setting it up, making sure someone is comfortable, that they can see the screen, whether they can hold the phone or whether a different prop needs to be used to set up the telehealth appointment in itself.

So that's one of the main barriers at the moment. Another obvious one is the fact that not all residents are able to engage in telehealth. They may be presenting with cognitive impairment, or working with telehealth may lead them to feel more confused. That's certainly not the case for everybody but we're very mindful as to how the telehealth, I guess, delivery can be tailored to individual residents, how we can assist them to access it. And in some cases, as I mentioned earlier, it might mean having to provide onsite support instead.

MR BOLSTER: Going back, though, to the question about how you deal with it yourself, having to don the PPE and the stress and the pressure on yourself. How do you deal with that?

MS KELLY: I think, personally, walking in with the PPE gear, I feel reassured in a sense that, you know, there's a level of protection there that I'm not bringing something in to the residents being such a vulnerable cohort. There's certainly been challenges in psychology therapy sessions wearing the mask, especially if you have a resident who has a hearing impairment or generally has been using lip reading in their communications. Also sitting in a resident's room, making sure there's the adequate distance between myself and the resident, that can also be very challenging in regards to, again, being heard and being able, in some regards to communicate effectively.

I think it's very challenging time for all staff in residential aged care. I think myself there's certainly a lot more pressures during the current stage 4 restrictions as to the concerns of constantly changing the PPE gear and thinking about, really, the level of risk of should I even be here on site at all any more, versus needing to meet the psychological and emotional needs of residents because they're not being met in any other way. Yes.

MR BOLSTER: All right. That's the end of my list of questions. Was there anything that either of you wanted to say by way of closing or to finish off the evidence? Mr Dawson.

MR DAWSON: I've just got one point. The stage 4 in Melbourne, one thing we have noticed is a lot of our new referrals to all allied health – physio, dietetics, speech – it's the new patients who are too scared to take up the service because they are concerned about the infection. What's really nice is that people who already have access with a health professional, they want to keep it going because they can see the benefit. So we are really seeing a difference in those who understand and see the benefit and those, whether it's a new, that they are too fearful to take it on and that the health consequences of not taking on the allied health now, we are going to have to pay for it later.

MR BOLSTER: Ms Kelly?

MS KELLY: I think just to add on what Rik said, there are a whole number of facilities that are very open to having psychological services implemented. There's very much a shortage of psychologists being able to go in and do that, and currently in the stage 4 restrictions the staff, I feel, require the extra support in order to be able to – for us to go ahead with telehealth in the sense that they would like our services but they're so stretched at the moment to help us implement it. And I think that's a real – a real barrier and sticking point.

MR BOLSTER: Thank you, Commissioners.

COMMISSIONER PAGONE: Thank you, Mr Bolster. Commissioner Briggs.

COMMISSIONER BRIGGS: No questions, thank you.

COMMISSIONER PAGONE: Thank you, Commissioner. Well, Mr Dawson and Ms Kelly, thank you very much for the assistance that you have given us. We have benefitted greatly from your experience and expertise, and I thank you very much for giving up time and for helping us in working through these issues. And I formally excuse you from further attendance.

MR DAWSON: Thank you.

MR DAWSON: Thank you.

<THE WITNESSES WITHDREW [3.55 pm]

COMMISSIONER PAGONE: Mr Bolster, anything else this evening?

MR BOLSTER: Nothing, Commissioner. 9.30 tomorrow.

COMMISSIONER PAGONE: 9.30 tomorrow. Yes. We will adjourn until 9.30 tomorrow.

MR BOLSTER: Thank you.

MATTER ADJOURNED at 3.55 pm UNTIL WEDNESDAY, 12 AUGUST 2020

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