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TRANSCRIPT OF PROCEEDINGS

O/N H-1258499

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

9.31 AM, WEDNESDAY, 12 AUGUST 2020

Continued from 11.8.20

DAY 85

MR P. ROZEN QC appears with MR P. BOLSTER as counsel assisting
MS K. MORGAN SC appears with MR J. ARNOTT for the Commonwealth of Australia
MR M. FORDHAM SC appears with MR FRASER for the State of New South Wales
MR M. CHAMPION appears for the Health Services Union and Diana Asmar

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Good morning, Commissioners. The first witness today is Professor Joseph Ibrahim. I call Professor Ibrahim. Good morning, Professor, can you hear me all right?

PROF IBRAHIM: Yes, I can.

MR ROZEN: Thank you. We will just go through some formalities and then I will ask you some questions.

<JOSEPH ELIAS IBRAHIM, AFFIRMED [9.31 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Professor Ibrahim, could you please state your full name for the transcript.

PROF IBRAHIM: Joseph Elias Ibrahim.

MR ROZEN: You are the head of Health Law in the law and ageing unit. I might ask you to - - -

PROF IBRAHIM: I'm the head of the Health Law and Ageing Research Unit at the Department of Forensic Medicine, Monash University, and I'm also a visiting medical officer at Ballarat Health Service.

MR ROZEN: Thanks, Professor. You have previously, of course, given evidence in the Royal Commission the first time we were in Sydney.

PROF IBRAHIM: That's correct, back in May last year.

MR ROZEN: And you provided a detailed statement at that time which, for the record, is exhibit 3-70, and in that you set out your qualifications and experience in some detail; is that right?

PROF IBRAHIM: That's correct.

MR ROZEN: I won't ask you to repeat that at this time, but you have briefly summarised some of your qualifications and experience in a precis of evidence dated 5 August 2020, that you prepared for this hearing; is that right?

PROF IBRAHIM: Yes, that's correct.

MR ROZEN: For the record that is RCD.9999.0411.0001. It's tab 13 in the witness materials. Professor, have you had an opportunity to read through that precis of evidence before giving evidence this morning?

PROF IBRAHIM: Yes, I have.

MR ROZEN: Is there anything in it you wish to change or correct?

PROF IBRAHIM: No, there's an odd spelling mistake and grammatical error that would not cast me in a good light with my honours students.

MR ROZEN: I think we can probably all relate to that. Are there any of those that you would like to fix at this time or are they minor and perhaps if we - - -

PROF IBRAHIM: No, they are all minor.

MR ROZEN: All right. Fine. And other than those matters, are the contents of the precis true and correct?

PROF IBRAHIM: To my knowledge, yes.

MR ROZEN: Yes. I will tender the precis of evidence of Professor Ibrahim dated 5 August 2020. Commissioner Pagone, can I hear me all right?

COMMISSIONER PAGONE: Yes, I must say you, the sound was slightly muted but I did hear it eventually. That will be exhibit 18-17.

EXHIBIT #18-17 PRECIS OF EVIDENCE OF PROFESSOR IBRAHIM DATED 05/08/2020 (RCD.9999.0411.0001)

MR ROZEN: Thank you, Commissioner. Professor Ibrahim at paragraph 2 of the precis of your evidence, you explain that you are a specialist medical practitioner in geriatric medicine, and you have been in continuous clinical practice for over 30 years in Victoria; is that right.

PROF IBRAHIM: That's correct.

MR ROZEN: You also hold specialist qualifications in public health medicine which are set out in 2(b).

PROF IBRAHIM: Yes.

MR ROZEN: In paragraph (c) you set out some of the academic research and teaching work that you have done which relates to organisational and systems failures; is that right?

PROF IBRAHIM: That's correct, yes.

MR ROZEN: And has that work been predominantly in relation to aged care or partly, are you able to - - -

PROF IBRAHIM: It's partly – so it started off predominantly in health care and I've crossed over into aged care. The principles are, I believe, directly transferrable in the issues around emergency management, the public health and the patient safety. The systems of looking at care and understanding how people work and how organisations operate are fairly universal.

MR ROZEN: Thank you. Turning to paragraph 4 of your precis, which is on page 2, there's a heading What Went Wrong. Do you have a copy of the precis in front of you, Professor?

PROF IBRAHIM: Yes, I do.

MR ROZEN: I might ask you to read out paragraphs 4 to 6. They are quite brief, perhaps best conveyed in our own words, if you wouldn't mind.

PROF IBRAHIM: All right. I guess the most important thing is to maintain an objective approach to this statement.

> *However, the human misery and suffering must be acknowledged. This is the worst disaster that is still unfolding before my eyes and it's the worst in my entire career. I didn't think we would sink any lower following the Royal Commission findings from last year and yet we have. In my opinion, hundreds of residents are, and will, die prematurely because people have failed to act. There's a level of apathy, a lack of urgency. There's an attitude of futility which leads to an absence of action.*
>
> *The reliance or promotion of advanced care plans as a way to manage the pandemic and the focus on leaving residents in their setting I think is wrong and inappropriate. When I voiced my concerns, I have had comments saying that everything is under control, that I'm simply overreacting and causing panic. We have the knowledge to do better. We fail because we have treated residents as second class citizens. There's an absence of accountability. There still is and there is no consequences for failing to deliver good care in aged care.*

So they're really the, I think, the emotional side of it, or the true human cost and I think that we need to recognise that. The rest of my statement will be factually – absolutely factually based and what I wanted to stress is all of this was foreseeable. I'm not presenting anything looking back with hindsight or being smart after the fact, and the evidence I will provide will highlight that those timelines and knowledges were available back in February for us to act and act far better than we have.

MR ROZEN: Thank you, Professor. Now, we have only got an hour, a little bit less now and I want to try and get through as much of the precis as I can. You will have to bear with me, there are some parts where the written document will have to speak for itself. There were others I will seek to emphasise and ask some questions of you. Do you understand?

PROF IBRAHIM: Yes, I do.

MR ROZEN: Could we start with some references that you make to the data at paragraph 20 on page 5, if you could ask you to turn to that, please.

PROF IBRAHIM: Yes.

MR ROZEN: You refer to London School of Economics mortality report which is depicted in a table there. And you've got, we see, Australia third from the right on that bar graph, if I am reading it correctly; is that right?

PROF IBRAHIM: Yes.

MR ROZEN: And at this time, which is May of this year – is that right?

PROF IBRAHIM: That's right.

MR ROZEN: Australia was – on a measure of the total number of deaths linked to COVID-19 in the total population compared to the number of deaths among care home recipients – that's the term that is generally used in the northern hemisphere, isn't it, Professor?

PROF IBRAHIM: That's correct, yes.

MR ROZEN: We were sitting at about – what is it – 20 – very small font is it 25 per cent or - - -

PROF IBRAHIM: It's around – I think it was 29 per cent.

MR ROZEN: 29 per cent. The position as we are speaking now is much worse, isn't it? We are sitting at around about 68 per cent or just over?

PROF IBRAHIM: It's substantially worse. And I think that in my ..... then we would have a much higher rate.

MR ROZEN: Sorry, I didn't get part of what you said.

PROF IBRAHIM: The calculation in May all included the deaths associated with the cruise ships. And so if they hadn't been in the calculation then the rates on, in a sense, home soil would have been much higher in aged care as a proportion.

MR ROZEN: I understand. Looking at the current position, the graph probably speaks for itself but how does Australia rate on this measure against the comparable countries that are depicted in the graph?

PROF IBRAHIM: Well, we would probably be the second or third highest rate of death in residential aged care. Canada had the highest rate of approximately 80 per cent of deaths from residential aged care, so we're faring very badly.

MR ROZEN: Thank you. The other matter of data that I wanted to ask you about concerns paragraph 91 and 92 which are on page 19. If I could ask you to turn to those, please.

PROF IBRAHIM: Yes.

MR ROZEN: You see that? This relates to a recommendation you make about aged care remaining at high risk of catastrophic consequences and the need for it to be a national priority, and I will ask you an about that in a moment. At paragraph 91 you make the point that:

> *Residential aged care facility residents account for one per cent of the population and yet 50 per cent of all COVID-19 deaths.*

I think as you have just agreed with me, it is considerably higher than that now, is it not?

PROF IBRAHIM: Yes, that's correct.

MR ROZEN: And you then say:

> *The risk of an outbreak in an aged care home is extremely high with very low rates of community transmission.*

What's that statement based on, professor?

PROF IBRAHIM: So that statement is a back of the envelope calculation and the logic is explained there. We have 770 aged care homes in Victoria. When I looked at the data, 87 had had an outbreak. If you treat a home as a household, there are 2.4 million households in Victoria and the number at the time was 9000 cases. And so if you compare the percentages for both, you see that there is a substantial 30-fold greater risk of having an outbreak in an aged care or nursing home compared to a household. Now, this is not sophisticated modelling.

What I've been trying to do for the past five months is find a way to communicate to people that the risk is substantial and that we can't sit back and relax because the community rate of transmission is so low.

MR ROZEN: I understand. You may not be able to answer this, Professor, and it might be some homework that you are able to do for us, but I wonder if you are in a position to compare mortality rates from COVID-19 of the residential aged care cohort – so if we describe that cohort as, say, citizens who are 85 years of age and above – how that mortality rate compares to the same group of people living in the community?

PROF IBRAHIM: That data – so I won't be able to access that data readily. The answer to that question should be – take two minutes from the Department of Health to generate.

MR ROZEN: All right. Is that something we could ask you, after you complete your evidence today, to research and convey to our solicitors perhaps by email?

PROF IBRAHIM: Certainly. I will make every attempt to get the answer to that.

MR ROZEN: We appreciate that. Before I turn to your recommendations, that, as you said, back of the envelope risk assessment in paragraph 92, is your overall approach to the question of the protection of residents in aged care facilities that a proportionate response has to be based on that very high level of risk that you've identified there?

PROF IBRAHIM: Short answer, yes. You need proportionate response and a proportionate response would mean substantially more than has currently being undertaken.

MR ROZEN: Thank you. Can we go back to your recommendations, and there are 10 of them and I'm going to ask you to expand on six. As I said earlier, please don't think that the others are being ignored; it's just that the time doesn't really enable us to look at all 10 of them in the detail that they deserve. Your first recommendation is on page 11. That's at paragraph 48, if we could turn to that:

A core national unit of expert advice and management.

PROF IBRAHIM: Yes.

MR ROZEN: What is it that you have in mind there and perhaps if you are able, in giving your evidence, to compare and contrast what you have in mind, the existing bodies, the Australian Health Protection Principal Committee, and the Communicable Diseases Network Australia seem to be the two bodies that are frequently referred to as performing a role essentially similar to what you have got in mind there.

PROF IBRAHIM: So the two bodies that currently exist are dominated by, essentially, public health and infectious diseases specialists. The concept that I've provided is not anything, you know, it's not rocket science. It's really simple about having the right people in the right place at the right time who understand aged care,

that have worked in aged care, that understand older people and how they present, and building a team that's able to do that. The collection of public health specialists and the collection of infectious disease specialists does not achieve that. It's rare for public health specialists to be working in aged care, and particularly residential aged care. And the operations and understanding of managing a person with dementia, managing personal care workers, how you operate a home is not something familiar to, I believe, almost any doctor or any specialist.

So the centre or the national unit required people who understand aged care and are objective and do not have any competing interests that tie into, be it the government, the commission or the providers. I don't believe the use of peak bodies in this situation is helpful or objective and I don't believe that the commission has the relationships with the sector which they would trust the advice or trust the motives related to the commission.

MR ROZEN: This the Aged Care Quality and Safety Commission that you're talking about.

PROF IBRAHIM: Yes. So it's the Aged Care Quality and Safety Commission. As a regulator, the relationship with a regulator is – there's a huge power differential, and so you are not likely to on confess your sins or your deficits to the regulator if you expect that you will be sanctioned and have greater pressure in just your normal operations.

MR ROZEN: Perhaps if we can just put the regulator to one side for the moment if we could, because I will ask you some questions about the regulator. But focusing on the national coordinating body, you have identified the sort of range of expertise which you would see on it. Would you also want people skilled in disaster preparedness and response? Is that a - - -

PROF IBRAHIM: Yes. So the core elements, the three components would be the emergency response experts, the infectious diseases and public health experts, and then what I consider the aged care experts. And that's what's missing. I also think, given the situation, is we would need a human rights and a public advocacy group to be there to advocate for the residents because there is no one advocating for the residents. The list of people I have included would have also incorporated general practitioners, the Severe Behaviour Response Teams that are responsible for better management of persons with dementia, and palliative care experts to give a holistic approach to what we do on the ground. And the reason to have a national group is many of the problems are similar and could be solved nationally and then rolled out to each State and region for local implementation.

MR ROZEN: Professor, is the idea, if I'm understanding it correctly, that there are a number of particular features of the aged care sector, many of which of course have been documented in the proceedings of the Royal Commission and its interim report, such as the workforce challenges, the lack of clinical skills amongst the workforce, the casualised nature of the workforce, the challenges of governance and of

managerial ability in some residential aged care homes. Is your point that those particular features are generally only known to those that are working in the sector or had experience of the sector; is that where you're going?

PROF IBRAHIM: My belief is that the on-the-ground operations, those practical issues are only understood by those that work – the experts outside of aged care may have an understanding of what it means to have a workforce shortage but they don't really know what the reality is. Nor do they understand the nature of the actual work being done. Hospital specialists do not know how an aged care home operates or what a personal care worker does and what the ratio of staff is. People take their mental model of where they work and apply it to aged care and the mental model that you take from a hospital does not translate to aged care. The capabilities of staff and what you have got to do in the work-arounds that currently exists need to be addressed when you are framing an emergency response such as this pandemic.

MR ROZEN: Professor, have you been following the evidence in this week of hearings?

PROF IBRAHIM: To an extent, not fully.

MR ROZEN: To the extent that you are able to, are you able to point to examples of the phenomenon that you have just described; that is, people from coming from, say, the health sector into aged care and making certain assumptions about how things operate, the skills that the staff may have and so on?

PROF IBRAHIM: Well, I think some of the examples we have had is if I work in a hospital I assume that there will be working thermometers and there will be oximeters to measure oxygen levels and there will be nurses to take observations of the patients. In aged care, personal care workers are not trained to do vital signs or take observations. The number of nurses is very low and they don't have time to go do the observations because they're either managing the facility or dispensing the medication. They may or may not have thermometers that work or are working. They won't have the full range of equipment that you have in hospital, and you can't just duck out and ask for help from another doctor or nurse that's on another ward.

You are, in a sense, isolated by yourself and you've got to argue for everything to come in. You've got to argue with the emergency department to get help. You have got to argue, sometimes, to get doctors to come in to visit. And the doctors come and go. In a hospital, the doctors are there 24/7. The nurses are there 24/7. That's not the situation in aged care. And so the rules that we make about how we operate in a hospital do not apply in aged care.

MR ROZEN: Thanks, Professor. I draw your attention to paragraph 57 because I'm interested to explore with you how this proposed coordinating body that you're raising would interact with existing structures and, particularly, the Australian Health Protection Principal Committee which, as the Commissioners know, is made up of the chief health officers of the Commonwealth, the States and the Territories and is

often referred to, for example, by the Aged Care Minister, Senator Colbeck, as being his principal source of advice in relation to policy development in respect of aged care. How would the body you have in mind interact with that? Is it replacing that so far as aged care is concerned or does it form a complementary role?

PROF IBRAHIM: It certainly would not replace it; it would be complementary. The only way to address the issues we face in aged care is a collaborative approach drawing on all the expertise. As an aged care specialist, I'm not claiming to know how to manage a pandemic. What I do know is how to manage a situation in aged care. And you need all three groups together. I give the example is that if children were affected here, would we be simply relying on the public health specialist to be giving advice or would we be going to Westmead and the Royal Children's Hospital for their experts and their input into what's happening?

I'm surprised that the Minister is relying purely on public health specialists and infectious disease specialists to manage aged care when the department and the Minister know full well the circumstances in aged care are quite different. So they would need to work hand in hand.

MR ROZEN: I think you said earlier this is a matter that you are not raising here for the first time; is that right?

PROF IBRAHIM: That's correct.

MR ROZEN: Can you expand on that please, Professor ..... in what way?

PROF IBRAHIM: So I've raised the idea of a national taskforce specifically for aged care to provide the input. I mentioned that to Minister Colbeck. I mentioned it to Commissioner Janet Anderson. I've sent documents through to the Departments of Health, both Commonwealth and State. I have an opinion piece or – two opinion pieces published in the general media, and all of this I had proposed well before the – sorry, I proposed this by the end of April and in multiple forums.

MR ROZEN: And was your thinking informed by those early experiences at Dorothy Henderson Lodge and Newmarch House? Did they inform your thinking about this proposed structure and proposed body?

PROF IBRAHIM: No. The short answer is this was in my head the minute I started looking at the situation in early March and in terms of what is the problem to be solved, and the problem to be solved here is you have a novel virus so you need infectious diseases experts. You have a pandemic, therefore you need public health experts. You need an emergency response, you need emergency responders. And it's in an aged care setting where most people die, therefore you need people who know aged care. And so you need to put those four elements together and now you have a taskforce and a group that can do something. Having only half of that will fail.

MR ROZEN: Is an example of the sort of aged care knowledge you're talking about one of the realities of the aged care workforce being that it's quite heavily casualised and a lot of aged care workers work in different facilities? Is that an important part of the aged care knowledge that such a body would need to be aware of?

PROF IBRAHIM: Yes. Yes, and I think that the body needs to understand the sector as a whole, the nature of the built environment, the models of care being delivered, the workforce that is present, the capability and the amount of support it is able to generate or garner in times of emergency and that only through the advocacy of the aged care sector – people working in it, would it be clear that the assumptions that are being made both by – in the – in both plans that there are substantial assumptions made which would fail if they had spoken to or consulted with people that actually work in the field.

MR ROZEN: You mentioned plans and I want to ask you about that. It has been said in the media and in the last couple of days by government spokespeople including the Minister for Aged Care, that there were plans in place to prepare the aged care sector for COVID-19. Reference has been made to the health response plan and also to the CDNA guidelines, and I want to ask you about each of those, if I could. Starting with the health response plan, it's at tab 35 of the general tender bundle. Are you familiar with this?

PROF IBRAHIM: Yes, I'm very familiar with the document.

MR ROZEN: What do you say about whether this document represents a plan for responding to COVID-19 in aged care?

PROF IBRAHIM: Well, I think if you want to just go with the – so I don't believe it responds to it. I think any person reading it would see that it doesn't do that. It's Australia's health sector emergency response. It's not Australia's aged care sector response, just in the title. If you do a word search in the document, I think aged care appears 20 times, almost always in reference to high risk groups, which include disabled groups, Indigenous population. And there is no specific mention about the failures of the aged care system or what the operating environment is. And in any emergency, you must understand the operating environment that you are stepping into before you start to make decisions and not make assumptions that it's highly capable, because you will fail in your planning.

So this health sector emergency response plan does not address what needs to happen in aged care. It simply says aged care is a high-risk area.

MR ROZEN: You point out at paragraph 24 of your precis that the document which you summarise as the national COVID plan was silent on known gaps in the aged care system. Can you expand on that?

PROF IBRAHIM: Well, any reading of this document with the Royal Commission's interim report on neglect would – it simply – it doesn't even reference

the Royal Commission. It doesn't reference that there are existing failures in workforce, in infection control, in governance, in the capability of individual providers. That's nowhere to be seen. All of those factors would be essential if you're trying to coordinate a national response in the aged care sector. It's just not there.

MR ROZEN: Am I understanding you correctly that a national plan – the sort of national plan that you have in mind would need to address each of those particular features of the aged care sector and set out strategies to respond to them. Is that right?

PROF IBRAHIM: Absolutely right. I mean, the fundamentals of any emergency response plan is define the problem, define the setting. What are the resources that you have at hand to manage it and where do you need to draw in those additional resources? There is no map or groundwork about what exists that we can use, what exists that we can rely on and where are the gaps. There's fundamentally no gap analysis to prepare us. And that's the first step in, I guess, any situation around a problem. You know, what are the strengths, what are the weaknesses, where are the gaps? It's not there. This isn't complex scientific work. This is sort of plain management that you teach to undergraduates.

MR ROZEN: Is one of the matters that you would consider ought to be addressed in a plan for responding to COVID-19 in the aged care sector, the interface between the aged care sector which, of course, is Commonwealth-administered, and the State health systems. Is that something that you consider needs to be addressed in any planned response?

PROF IBRAHIM: Yes. And that was highlight – that's highlighted in a range of documents from the federal and state governments that that divide has been longstanding and we know that aged care falls in the middle of it and people simply shovel or shuffle their responsibility by claiming it's under one jurisdiction rather than the other. And that still hasn't been satisfactorily resolved despite the situation in Victoria.

MR ROZEN: I might ask you to expand on that. We had evidence earlier in the week that as a response to the Newmarch House outbreak in April and May of this year, the Commonwealth and New South Wales governments jointly produced a protocol which came into operation on 23 June 2020. I don't think I need to take you to the document unless it would help you. My question about the protocol, which I imagine you would say is a good thing, that a protocol was developed clarifying roles of the governments, but would it be better if that was done as part of the planning process that you're talking about rather than as a reaction to an outbreak?

PROF IBRAHIM: Well, that should have been done at the start. That should have been done in February. It doesn't take great insight to see that having three or four different groups in authority wanting to run something is going to create confusion. And the documents – if you go to the CDNA document around the description of

responsibilities, you already have the Aged Care Quality Commissioner, the Federal Government, the State government and the public health units all having a piece of the pie, and it's not clear who will be making the decisions about running the crisis when an outbreak occurs. Everyone has their separate role. But we don't divide up an emergency into different little bits and then say everyone has got to do their – who is in charge? Who is setting the direction? And then you coordinate the groups underneath. You don't sort of manage a disaster by consensus.

MR ROZEN: Thank you. The CDNA document is, I suggest, quite a comprehensive set of instructions, perhaps if I could call it that, guidance material for the sector, including a number of template documents and letters and the like. Is it a plan, though, for COVID-19 and the aged care sector; what do you say about that?

PROF IBRAHIM: The CDNA is not a plan for the sector. It's a plan specifically, and it's explicitly stated, it is the responsibility of the facility. That plan is designed for a single facility and one person to go through a tick sheet and answer questions that are posed that would be difficult to be resolved by a national expert group. And so some poor bugger sitting in an aged care home, a middle manager, is told tell us how you would find 20 per cent of your workforce and you are probably already short-staffed. But there's no offer of solutions. There's no offer of where information could come from or what others have done. The onus is put fairly and squarely on the individual provider and there is no sense that there's 900 providers so we're going to reproduce, duplicate, do different things.

And the visitation guidelines highlight that when you split the work into the individual provider, you get enormous variation across the country causing distress to all concerned, and you don't work out what is the best approach. So that CDNA document is helpful to guide you through the questions. What you really need is some guidance about where you find the answers. And there are some fundamental assumptions that show, I would say, naiveté around the relationship of the aged care provider with staff and the aged care sector with the acute hospital. The assumption in that CDNA document is you have GPs to call on at will, that the acute hospital will be available to help you, that there are resources there that somehow you can pull out 30 per cent of your workforce to replace those who are sick.

And if anyone developing the CDNA guideline had read the executive summary of the Royal Commission report, you would know that how do I get more workforce when I'm already short of workforce? So I - - -

MR ROZEN: Sorry, do go on, please.

PROF IBRAHIM: So I can't overemphasise that the CDNA plan is a plan for an individual facility. It is not planned for the country. It's not a plan for the region.

MR ROZEN: Do you happen to know – the CDNA has some 24 members, I think – does it have aged care expertise, to your knowledge?

PROF IBRAHIM: I honestly don't know. I think – I looked at the APHCC and found that no one there but I don't know who is on the CDNA panel.

MR ROZEN: All right. We will explore that with other witnesses, thanks. Just before leaving this topic of planning and the national coordinating body, you would be aware that the Prime Minister made an announcement, I think it was last Friday, on 7 August in which there was an announcement about some initiatives for the future in relation to planning the aged care response to COVID-19. Are you in a position to make any brief observations about whether those announcements go some or all of the way to what you have in mind as being necessary?

PROF IBRAHIM: I think I just want to go back one point is that my question I would like answered is, did the CDNA consult with the Royal Commission? Just that would be my question to them. In terms of the Prime Minister's initiative, they start to address some of the issues but they don't fully address – they don't set up a taskforce that understands aged care. They're looking very discretely at a response, not at the preparation. So it's all well and good to have a knee jerk reaction when people are dying to then say, "Let's do something." The question is what's going to happen to the other now 2500 homes in Australia; do we know how well prepared they are. And we are currently playing, you know, a kick the Victorian game.

Other states will be affected. What is the plan and the relationship with the acute hospitals? Are we going to agree nationally that people who have an infection with COVID get moved to an acute hospital because that protects the other residents and means that we get on to resolving the ..... there's so many questions that haven't been addressed. The move towards infection control training is a positive one but to what extent will that be national; who is going to be running that. And all of those announcements that the Prime Minister made could have been made back in February or March. There's nothing in them that you would say we've now learnt over the last six months and we now need to act. There's nothing novel in them. They're a start but they're not enough.

MR ROZEN: I understand all of that, Professor. Obviously, we can't change the past but I understand from the evidence you have just been giving that it's not too late from your perspective to address some of the matters and, in fact, it's important, in the sense that it's Victoria today but it could be South Australia next month or Queensland next year, realistically, in relation to this problem.

PROF IBRAHIM: Yes, absolutely, and there's still, you know, Victoria still has another 600 homes that aren't currently affected. What are we doing to address their capability and to shore up, to – shore up their resources and their capability to make sure an outbreak doesn't occur and if it does occur that it's resolved very quickly.

MR ROZEN: Thank you. You made reference earlier to the aged care regulator, the Aged Care Quality and Safety Commission and I said I would ask you about that body later in you giving your evidence. There's evidence before this Royal Commission that a self-assessment survey was done by the Aged Care Quality and

Safety Commission at around about the time that it announced there would be – that it's unannounced visiting program would cease in March of this year. Do you have any observations about the self-assessment process that the regulator went through and the regulator's performance generally in relation to the COVID response?

PROF IBRAHIM: Well, I think in terms of – I still don't understand why the regulator took on the role of pandemic management. It's not within their remit. The government have said that they're now an independent body and accountable for their own actions. The use of a self-assessment survey – anyone with a child at school would know that if you ask someone to self-assess themselves they're either super confident and assess themselves as being fabulous or don't know enough about their own problems to say that they've got gaps. Self-assessment is not a productive way to assess, and self-assessment by a regulator where you would have had experiences of now being either sanctioned or investigated is not likely to promote, I believe, an honest and genuine response.

I think that the fundamental, though, is there's an assumption that people know what the pandemic was going to be like, and there wasn't sufficient information to explain to facilities this is what a pandemic looks like, these are the realities. Now can you assess against it. If you ask people "Are you doing your best?" everyone is going to say they're doing their best. But it's not about doing your best. It's understanding what you actually need to do. And the commission did not provide the information about what you need to do in a pandemic situation. The commission knew prior to the pandemic that there were problems with infection control and with clinical care. They provide this in their own quarterly reports.

They would know which facilities have a high risk of non-compliance in the past and should have been targeting that group in terms of pandemic response. They should have been actively reviewing the pandemic plans and asking for these to be submitted back to them to assess how comprehensive they are. But I believe they would have struggled because I don't know that they have anyone on staff that is capable of evaluating a pandemic plan. It's an area that then has got to go back to a national group to say and the public health and Paul Kelly and you know, what would you expect a good plan to look like and test it out, is this real? When you say you are going to get your 20 per cent of staff by calling your mates down the road to provide their staff; is that feasible? And it's not. So those type of really practical validation methods haven't been used.

MR ROZEN: Thank you. Can I ask you about paragraph 41 of your precis, please, where you identify different scenarios or different situations that, as I understand it, you're saying any planning process needed to consider. There are three scenarios that you describe at paragraph 41 in that first group of dot points. No COVID-19 in aged care home and no community transmission. So that might be – so the situation that currently prevails in Western Australia, for example, I think would be close to that.

PROF IBRAHIM: Yes.

MR ROZEN: No COVID-19 in aged care home but there is community transmission. That's what we have faced in Victoria for a while, in the middle of June before we started to see cases in aged care. And then a COVID-19 outbreak in aged care home. And that could presumably be at a time when there's little or no community, as we saw, for example at Dorothy Henderson Lodge or Newmarch House, or it could be what we are facing in Victoria, which is the worst outcome, I guess, where there is both widespread community transmission and multiple outbreak in aged care homes. Are they broadly the scenarios that need to be planned for, Professor?

PROF IBRAHIM: Yes, they're – very much so. They're the scenarios, and by looking at it this way, you get a proportionate response about what is and what isn't possible, and so you limit the adverse consequences for residents. So if – and your visitation rules change and the nature of the effort that you need to put into the aged care home differs. So no COVID, no community transmissions means a major focus on preparation, training, and the no COVID but community transmission requires, then, action to limit the entry or potential entry of COVID.

Once COVID is in the home, then you transition to a different emergency response, which is predominantly health or clinically related. And it's important to be contemplating or considering what's happening in the rest of the community because that will determine what resources you can or can't draw on. These scenarios could have been, you know, workshopped in March.

MR ROZEN: That's where I wanted to go next with this. Is your evidence that they're the sort of scenarios that ought to have been considered in a national plan and a formulated response or a range of responses that were proportionate to each of them identified early on in the pandemic?

PROF IBRAHIM: Yes. I provided what I believe is a comprehensive document in March on potential scenarios which were quite graphic. My colleagues responded to that with suggested considerations about what that might be like, and that formulated a second document. Both of those documents went to the State and Federal Health Departments and to the Federal Health and Aged Care Ministers.

MR ROZEN: Professor, looking, then, to the future, what do you say – I mean, you set this out in your precis but, in summary, what do you say we need right now by way of planning and responses to any future potential current outbreaks and future potential outbreaks that we might be facing in aged care, what would you like to see?

PROF IBRAHIM: Well, I think what we want is to use all of the experience, expertise and knowledge that we have in Australia to solve the problem ahead of us. What I see at the moment is that people have taken ownership of a problem without drawing on the expertise that's available. My colleagues and everyone that I know is willing to work and share their knowledge and insights to address the matter which is a national priority.

It's a catastrophe. Our patients, our residents, our families, our loved ones are dying and people that can help are not being drawn in to help or to have their ideas explored. We're not debating the ideas and the merits of it, and when you are in situations of uncertainty, you find solutions by considering all options and arguing your way about the strengths and limitations. You don't – do not operate in an environment where you have groupthink. And I believe that the current initiative is hampered by groupthink with people that are – know each other well and have been through a hard time together ..... each other and not drawing externally.

We need to be using everyone that has the ability to contribute, and – and, you know – and I come back to this idea of an expert group which could rapidly solve 20 to 30 separate questions by drawing in the expertise that you need from each area. And we do not – we are lacking teamwork, and we know how to do it and yet we're not doing it.

MR ROZEN: Can I turn to a topic that is of considerable interest to the Commissioners and it concerns the social isolation and reduction in visitor visitations to aged care facilities. You deal with this on page 17 of your precis in relation to recommendation 7, which is managing the impact of social isolation on people with cognitive impairment. I'd ask you to think about it a little more broadly than that, if you could, because, of course, social isolation can impact, as we heard from a witness earlier in this week's hearing, Ms Mitchell, witnesses that have no cognitive impairment but can still be very heavily affected by social isolation. Can you share with us your thinking in relation to that. Any suggestions you might have on how this can be addressed better?

PROF IBRAHIM: Well, I think the – the social – the isolation is the classic scenario where you want to limit the number of contacts to protect the person from an infection, and yet you don't want to harm them psychologically. And so arriving at a balance requires consideration from a – different points of view. The Commonwealth could have – and so having a national policy that is based in the emergency response with public health input, with input from Dementia Australia and families and residents about where is the balance to strike.

The resources that could have been put in are still possible in terms of having a coordinator or an IT expert to help ensure that families and friends and the residents remain connected. We have the technology. We've got the ability to do that. We have people that are unemployed from the pandemic that could be mobilised to do this. There are strategies that you can do to better incorporate residents into our community. The issue about whether there's heightened risk of delirium and people with dementia becoming more distressed – we have strategies that could be helpful there.

We have the severe behaviour response teams that's a national initiative that should be formulating responses to assist aged care homes to deal with this. This is sort of the – so this is the classic example of a problem that needs multiple different people

involved to solve it. We can solve it, but finding that proportionate response requires more than one person's opinion.

MR ROZEN: There is, of course, a visitation code which has been developed by the Federal Government and a number of the aged care organisations. It came into operation in May and it's been reviewed twice, I think, since then, and a most recent version of it came out in late July. Have you had an opportunity to consider the contents of the visitation code?

PROF IBRAHIM: Yes, I have.

MR ROZEN: And what do you say about the way it addresses the balance between mental health and quality of life on the one hand associated with visitation and protection of physical health from the pandemic?

PROF IBRAHIM: I think it – I think it has a – a – it's got a reasonable approach towards that. It's – well, my concern's it's a voluntary code, whereas it should have really been a national standard, and that the – that the – the code is based on existing resources rather than what we could do better. And so I think what we end up here is we have a code that's designed voluntarily by a group of well-meaning persons. What we don't have is a push from either human rights or resident advocates about what it is that should be done. What extra could be done to make it more humane? Why aren't we getting more resources in to connect residents with their family?

What we've got is we've looked at the problem and we have tried to solve it within what's possible in the sector itself instead of looking beyond, and it's the looking beyond that needs to be challenged. And I think that's why we need to be incorporating a national group, and we need greater levels of advocacy and professional advocacy to push the government to do more for the residents.

MR ROZEN: Thank you. How would you – assume you're all powerful for the moment, Professor Ibrahim. How would you address that? Is it a matter, for example, of the government identifying areas of good practice? We had an example yesterday from a provider that's instituted a number of initiatives to facilitate visits. It's involved money and extra staff. Is that where we need to be headed here, where there's an identification of good practice and an attempt to more broadly disseminate that, perhaps with some financial assistance to help?

PROF IBRAHIM: Yes. So if I'm all powerful, the first thing I'd do is ask for help because I know I don't know everything and I know other people think differently and other people come up with really good ideas and they draw on their own experience. So your example of drawing on good practice is what we need. We don't have a way of coordinating the gathering of good practice. We don't have a way of gathering information about good ideas that went bad so other people don't make the same mistakes. We're not actually gathering information. We're not gathering intelligence from the field about what works, what doesn't work, and to help the next group just progress that little bit faster.

MR ROZEN: Speaking of intelligence gathering – and this is the last topic I want to raise with you – you deal with this in recommendation 2 on page 13.

PROF IBRAHIM: Yes.

MR ROZEN: And I want to explore briefly with you this idea of advocates in aged care facilities and how – the sort of model you have in mind, which you set out in paragraphs 59 to 61, and how you see that working, and does that have implications beyond the COVID response to the sector more generally, from your point of view?

PROF IBRAHIM: Yes, it does. I think there's a number of different ways that this model could work, depending on – and there – sorry. There's a number of ways it could work. The – the simplest way is to have an ADF person in every home reporting, and so it's clear that that person is an advocate for the residents, is an advocate for the staff, is not beholden to the regulator or to the provider, and that would give families some level of comfort to know that there's reports there and information is being provided to help the national efforts.

The transparency that this provides would reassure a number of people that have contacted me who are very fearful about lockdowns because they didn't know what was going on. And so they want – they – they want a voice and they want to know that care is still being delivered. There are other ways to address this by appointing family members or junior staff to be relaying information to an external person.

You could form resident committees. There's an inordinate number of possibilities that gives you eyes and ears into a home, and that's what we're going to need now. And going forward, we absolutely need something like that to protect the residents and advocate for them because the system – the system is broken. And what we've seen with COVID is that the system is broken at a high level because it's not the aged care workers that have failed us in this. It is our – our people who are in governance roles, and I'm not going to call them leaders because they're not leading. The people in governance positions who are accountable for what happens are the – is where we have failed.

They have not – they have not provided significant planning. They have not incorporated teams or groups of people to assist them. They have not recognised the magnitude of the problem staring them in the face.

MR ROZEN: Thank you, Professor. They're the questions that I have for Professor Ibrahim. Commissioner Briggs, do you have any questions for the witness?

COMMISSIONER PAGONE: Thank you, Professor.

COMMISSIONER BRIGGS: No, I don't.

MR ROZEN: Thank you. Commissioner Pagone?

COMMISSIONER PAGONE: Thank you, Professor Ibrahim. You've been very helpful. We're very grateful to you for the time that you've put into your report and in your assistance of the work that we have in this Commission. And thank you very much, indeed.

MR ROZEN: Thank you.

PROF IBRAHIM: Thank you.

MR ROZEN: If Professor Ibrahim could be excused, please.

COMMISSIONER PAGONE: Yes. You are formally excused, Professor Ibrahim. Thank you for attending.

PROF IBRAHIM: Thank you.

<THE WITNESS WITHDREW [10.30 am]

MR ROZEN: Thank you. I call Dr Nigel Lyons. Dr Lyons, can you hear me all right?

DR LYONS: Yes, I can, thank you.

MR ROZEN: Thank you. I'll ask Ms Parmenson to affirm or swear you, please.

<NIGEL JOSEPH LYONS, SWORN [10.31 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Dr Lyons, you are – hold the position of Deputy Secretary Health Systems, Strategy and Planning within the New South Wales Ministry of Health?

DR LYONS: That's correct.

MR ROZEN: And how long have you held that position, please, Doctor?

DR LYONS: It'll be four years in October that I've held that position.

MR ROZEN: All right. And you're obviously a medical practitioner, and have you practised clinically in addition to the work that you've done with the department?

DR LYONS: I have, but not for many, many years, so after three years of clinical work, then I started to work in management and I've worked in management, executive roles and policy ever since.

MR ROZEN: Okay. And that's a period of about 30 years; is that right, with the Ministry?

DR LYONS: More than that now. Time goes by quickly.

MR ROZEN: Yes, doesn't it just. For the assistance of the Royal Commission, you've prepared a witness statement dated 4 August 2020. It's WIT.0782.0001.0003. It's at tab 10 of the witness materials. Have you had an opportunity to look through your statement before giving evidence this morning, Doctor?

DR LYONS: I have, thank you.

MR ROZEN: All right. Is there anything in it that you would want to change?

DR LYONS: No, there isn't.

MR ROZEN: Can I just draw one matter to your attention that appears to be an error, an understandable one in the circumstances. It's on page 8 in paragraph 37, if you have a copy of in front of you. In the third line, you've elevated Commissioner Anderson of the Aged Care Quality and Safety Commission to the status of Professor, which I suspect she probably wouldn't mind, but I don't think it's correct.

DR LYONS: Thank you for that correction. I note that.

MR ROZEN: All right. Would you delete the word "Professor" in that line?

DR LYONS: Certainly.

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

DR LYONS: They are.

MR ROZEN: I tender the statement of Dr Lyons, Commissioner Pagone.

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

EXHIBIT #18-18 STATEMENT OF DR LYONS DATED 04/08/2020

MR ROZEN: Thank you. Doctor, I won't go through your other aspects of your professional qualifications and experience. They are set out at paragraphs 5 through to 8; is that right?

DR LYONS: That's correct.

MR ROZEN: And you explain the circumstances in which you've come to prepare the statement, and we can obviously read it and understand those. The first question I want to ask you about is – deals with at paragraph 17 of your statement. If I could just ask you to have a look at that at the bottom of page 4, and this is in the context of the response by various agencies within New South Wales Health to the outbreak at Newmarch House. Is that what you are talking about at this point in your statement; is that right?

DR LYONS: That's correct.

MR ROZEN: I just want to understand your evidence at 16 and 17. If I'm understanding correctly, the Ministry, in conjunction with Newmarch House, prepared an outbreak management plan; is that right?

DR LYONS: That's correct, and ordinarily these would be in place of any – in – in place in advance of any outbreak. In this situation, we prepared one in conjunction with the Local Health District and with the Newmarch operator because it didn't appear that there was one in place in advance of the outbreak.

MR ROZEN: Yes, I want to ask you about that. Perhaps the best way to do it would be by reference to paragraph 99 of your statement, where you set out what you consider to be the elements of a robust outbreak management plan. Perhaps if that could be brought up on page 20 of your statement. What do you draw on here, Doctor, as the basis for what you consider to be in an outbreak management plan? Is this personal knowledge or is this – would you describe this as well-established principles of a public health response, or what is it? Where does this come from?

DR LYONS: It comes from a range of things, including our experience with the two outbreaks and more since that have occurred in New South Wales, and our discussions with people involved in providing aged care, the operators. So we've had extensive discussions now with aged care operators and also with our own services who are responsible for supporting aged care facilities when there is an outbreak. And these things are clearly important in an outbreak to respond – to be able to respond to quite quickly and I believe are critical in any outbreak management plan to have these things well organised.

MR ROZEN: It probably goes without saying, and I think you've said this just a moment or two ago, but ordinarily one would expect a plan to be in place before the outbreak rather than developing one at the same time as responding. That presumably is far from ideal, that second scenario?

DR LYONS: That's correct.

MR ROZEN: And that's, in part, because one of the things the plan should do is set out the respective roles of those who are responding; is that right?

DR LYONS: Yes, absolutely, and to start to establish relationships between key people who will be involved in responding to an outbreak and ensuring that they understand each other's roles and have established a relationship and there is documentation and also resources to support the immediate response.

MR ROZEN: Is it also preferable not only to have a plan in place in advance of an outbreak but to have – I think the expression might be "scenario tested" the plan to see that it actually is going to work?

MS ENGLAND: Michelle England for Anglicare. I object to this line of questioning, Commissioners. I would ask my learned friend to clarify whether what is meant is an interagency outbreak plan or a local management plan. There is a difference, with respect.

COMMISSIONER PAGONE: Yes, Mr Rozen, I think the objection, albeit possibly not sufficient to stop the questioning, does suggest that you might just clarify the context a bit more precisely.

MR ROZEN: Yes, I'm happy to, thank you, Commissioner Pagone. What I have in mind, Doctor, just so it's clear, is a plan along the lines of what you have set out in paragraph 99, and that, perhaps, doesn't deal in terms with roles and responsibilities, but would you say that's an additional matter that ought to be covered in an outbreak management plan? Do you understand my question?

DR LYONS: Certainly. Where – where there's a need and, of course, in an outbreak such as a pandemic response, many people need to be involved. Many agencies need to be involved.

MR ROZEN: Yes.

DR LYONS: And it's important that there is at least some discussion, awareness, planning of the roles of the respective organisations and agencies involved and clarity around making sure that they've got everything they need in place to respond swiftly.

MR ROZEN: Thank you. Just while we're on that page, I want to ask you briefly about what appears at 100(b), and here, you're describing some issues that have been highlighted by the interface between New South Wales Health and the aged care system, and one of the things you discuss there at paragraph (b) is the use of fast tracking information technology initiatives as part of a response. I wonder if you could just expand or give us some examples of the sorts of initiatives that you have been exploring in relation to residential aged care facilities.

DR LYONS: Indeed. Well, it has been, as a result of the pandemic, a very rapid uptake of technologies that allowed clinical care to be delivered through using technology rather than having a need for face-to-face interactions on every occasion. So things like telehealth, like video conferencing and Zoom and other virtual care platforms. There's been a very rapid move towards the introduction of those forms of technology to support clinical care delivery, not just in residential aged care but in the community setting more broadly. And we think it's really critical that we have much better arrangements in place in the future for the use of these virtual care technologies to support care in such situations as we've experienced.

MR ROZEN: Is there scope for such technologies, in your view, to address the issues of social isolation and loneliness experienced by many people in the aged care sector because of restrictions on visitation rights?

DR LYONS: Yes, there can be an adjunct and – and a way to address some of the issues around isolation and loneliness and allow people to have interactions, see familiar faces, talk to relatives and those loved ones that they can't actually physically see. So those things do assist. They don't completely replace, of course, because the physical interactions are just as important. But it is – it is a way to enable improved addressing issues around isolation and lack of access.

MR ROZEN: Thank you. Doctor, can I take you in your evidence to the early stages of the response to the Newmarch House outbreak. You were asked to describe, as best you were able to, some meetings which took place, particularly on 16 April, which you've already heard in evidence about, so some five days after the outbreak commenced at Newmarch House. And you deal with this – two meetings that we asked you about on page 6 of your statement, starting at paragraph 25, and I will just ask you briefly about those.

Firstly, the meeting at 9.45 on that day – these meetings have been described in other evidence, including the evidence of Mr Millard from Anglicare, as involving robust discussion about the options that were available for separating positive and negative patients – sorry, residents at Newmarch House. Is that a fair description of the meetings, as you recall them?

DR LYONS: I'm not sure what Mr Millard meant by robust. There was a difference of view about what should occur, and the conversations were always respectful and appropriate and professional. So it was more of an issue that there were views being expressed from different people about what they thought was the best course of action, and those issues were not able to be resolved through the discussions that were being had at different – at different meetings.

MR ROZEN: Yes.

DR LYONS: Which is why – which is why I escalated subsequently, as you'll see in the statement.

MR ROZEN: Yes, I understand. I want to ask about the meeting, the one at 9.45 which you described on page 6. You identified the people that were there at paragraph 26. I want to ask you about an email which has been provided to the Royal Commission, and it's in the Newmarch House tender bundle behind tab 34, which will be brought up on the screen that you can see. Are you able to see that email, Doctor?

DR LYONS: I can, thank you.

MR ROZEN: Yes. And I want to draw your attention to what appears at page 0544. And just so you understand the context, this, from its header on the previous page, is an email from Ms Amy Laffan, a representative of the Commonwealth Department of Health who you have identified as having been present at the meeting at 9.45. You were there. So you know Ms Laffan?

DR LYONS: Not personally, but I know her in a professional sense. I don't think I have actually personally met her, but we spoke on the phone, yes.

MR ROZEN: Okay. This is a telephone meeting; is that right? Is that right? The meeting was by telephone.

DR LYONS: That meeting was by telephone, yes.

MR ROZEN: Yes. And in what appears to be notes made by Ms Laffan as part of this email, and this is on the page that is in front of you, do you see that under the heading 9.45, 16 April 2020:

> *Teleconference held this morning with New South Wales Health Ministry and Doh to discuss what support Newmarch needs and also accessing hospital beds if needed.*

Then there's a heading New South Wales Health with four dashes, and I want to ask you about the third one where the following appears:

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

Firstly, are you able to tell us – you may not recall this – but who was speaking from New South Wales Health amongst the four officers that you have identified, including yourself?

DR LYONS: So there was myself and two – three other people from the ministry and James Branley who would have been, I think, considered to be New South Wales Health.

MR ROZEN: And who spoke in the meeting on behalf of New South Wales Health?

DR LYONS: There was a range of people from my recollection. My recollection is that our – the desire was to respond to the advice from people who were on the ground and actually in the facilities, so that the other participants are people who actually are not directly involved in the response at Newmarch. Dr Branley was there on the ground and was providing us very strong advice about what he thought was the appropriate response in relation to his assessment of the individual residents, the context and the care needs. And so we were looking to find solutions that reflected his advice about what he thought should be happening.

MR ROZEN: Yes, I understand that. We heard from Dr Branley yesterday. My question to you is: is the reference to a precedent that would be set if residents were decanted to hospitals an accurate - - -

DR LYONS: My recollection is that we were – we did discuss issues around decanting residents but there was real concern at that point that – so there was a lot of discussion around decanting COVID-positive residents, and there was a discussion around decanting COVID-negative residents. And the strong advice we had was that at this point in the outbreak it was very difficult to actually know who was – you knew who was COVID-positive because they had had a COVID-positive test, but you couldn't with definitive know that people were COVID-negative because it may be that they were still incubating the virus and with the extent of exposure that had occurred over a period of days, it was Dr Branley's view that there were many other residents who would ultimately become COVID-positive.

So the discussion revolved around how would it actually help, what would we do in terms of decanting, who would we choose, how could we make the choice, how did it actually improve the situation. And it was his strong view that we should actually leave people in place at this point in time until it became clearer as to the extent of the outbreak, and a number of measures should be put in place locally to cohort residents appropriately, to ensure that they – and he said at that stage I think that they all had separate rooms with ensuites. There was the ability to actually have people remain in their rooms and not mix. There was three different wings that – where there could be some cohorting occur, and there was an analysis of where the COVID-positive residents were and how we could move any COVID residents to places that tried to cohort them in the same place. So that was the discussion that occurred, in my recollection.

MR ROZEN: That description you've given of a number of residents that have tested positive and are concerned that there might be others that test positive, that's going to be the case at every residential aged care facility suffering an outbreak of COVID-19, isn't it?

DR LYONS: Potentially yes, and almost certainly yes, but it's about the extent of that. And I think what we heard was there was grave concern about the fact that the

person who was the index case had worked a number of shifts before it was detected and there was concern that there had been extensive interaction with other staff members and with residents and that this could be quite a large outbreak from the amount of time that had elapsed where infection could be spread undetected.

MR ROZEN: That's the point, though, isn't it, Doctor, if you wait until everyone who is going to test positive tests positive, you potentially lose control of the outbreak in the facility, don't you?

DR LYONS: I think it's about the fact that it's before the outbreak is discovered that that's occurred, and that as soon as you know there's an outbreak, you take immediate steps to manage and control the outbreak, which minimises those risk of future spread. So it was about what preceded and the extent of time that preceded the outbreak being known.

MR ROZEN: Going back to the email, I will just ask you one more question about it, what was the precedent that New South Wales Health was concerned about?

DR LYONS: I'm not sure that I would use the word "precedent".

MR FORDHAM: I object to this question because it's not this witness's – it's not his document.

COMMISSIONER PAGONE: Mr Rozen, I think you might just need to rephrase the question in order to – or at least get to that slightly differently.

MR FORDHAM: And I apologise, I should have said who it is; it's Fordham for the State of New South Wales.

MR ROZEN: Thank you. Does the document accurately describe that word? I'm not asking you now whether you'd use the word "precedent"; was the word "precedent" used at the meeting, Doctor?

DR LYONS: Not that I can recall but I would say we had long and involved discussions about the options that were available to us. And I think the overriding issue from our point of view was ensuring that we responded to the expert clinical advice about what should occur rather than that be something which was decided from afar, from people who weren't directly involved in providing the response.

MR ROZEN: Doctor, was the concern expressed by anyone on behalf of New South Wales Health that if there was decanting of positive residents from Newmarch House to hospital that it would then be assumed any future outbreak in New South Wales that that course would be followed; was that a matter that was raised by New South Wales Health at the meeting?

DR LYONS: I can't recall those words being used in that way, but I would say that any actions that are taken at any point in time can be then used as a basis for

assessing future actions. I think as we have seen in commentary about Dorothy Henderson Lodge, the actions that are taken there are contrasted with what we did at Newmarch, so these things are always looked at and compared.

MR ROZEN: Can you help the Commissioners with understanding why the contrasting approaches were taken.

DR LYONS: I think our experience with COVID-19 has evolved. We have learned a lot since the initial outbreak and I think even if you look at the first cases that were diagnosed in New South Wales, those four cases were admitted to hospital for the course of their condition. We don't routinely admit COVID positive people to hospital now for care. It was a very cautious and conservative approach that was initially taken, and I think it was by nature of the fact that we weren't aware of this disease and it was new. But the patterns of care and how care is now delivered are very different. So the vast majority of COVID-positive people are cared for in the community and are rarely admitted to hospital. There's about 10 per cent of all the COVID-positive patients in New South Wales have been admitted to hospital.

Around 20 per cent are admitted to hospital-in-the-home program. The vast bulk of them are actually cared for in the community setting without admission to hospital at all.

MR ROZEN: Doctor, the evidence of Ms Dicks and Mr Low on behalf of BaptistCare who are the provider at Dorothy Henderson Lodge, was that transfer of positive residents to hospital at the early stages of the outbreak at Dorothy Henderson assisted them in getting control of the outbreak, particularly when they were struggling to fulfil their staffing requirements. Have you had cause – sorry, I withdraw that. Did you hear that evidence that they gave on Monday?

DR LYONS: No, I didn't.

MR ROZEN: All right. I will ask you to accept that that is an accurate summary of the evidence that they gave. Are you in a position to reflect on that as compared to the position at Newmarch House and the policy that was followed there and whether the failure to transfer at least some of the positive residents or more of the positive residents from Newmarch House to hospital impacted on the ability of the provider and everyone else involved to manage the outbreak?

MR FORDHAM: I object to the word "failure".

COMMISSIONER PAGONE: What's the basis of that objection, Mr Fordham?

MR FORDHAM: That has within it an assumption that to do so was a failure or not to do so was a failure, and one of the problems we have here is that the two clinicians – two of the clinicians who are making decisions about these things have given their evidence – Professor Gilbert and Dr Branley – and none of them was taken up with them in this form.

COMMISSIONER PAGONE: Mr Rozen, how do you want to deal with this objection?

MR ROZEN: Well, the word "failure" has no connotations. It's just a description of what happened. Perhaps I will approach it a different way. Doctor, looking at the question more generally, perhaps, rather than in the context of Newmarch House and Dorothy Henderson Lodge, do you accept the general proposition that the transfer to hospital of COVID-positive patients in circumstances where a residential aged care facility is losing its staff and struggling to manage an outbreak can, all else being equal, be of assistance to them in responding to the outbreak?

DR LYONS: So it may be but I would say this, that it, of itself, doesn't necessarily lead to any difference. We debated this at some length in relation to the response at Newmarch. It doesn't actually take away the need for appropriate use of personal protective equipment, for infection prevention control measures. There will be measures around cohorting. All the things that need to be done to prevent the spread need to be in place and continue, because as we have indicated there could well be other residents who have not yet declared their COVID-positive status but are actually infected.

So you know, in part it may be a part of a solution but it needs to be in the context of a robust outbreak management plan because issues around PPE availability, infection prevention and control practice, workforce and surge workforce availability are all the factors that I think are being used to say, well, it actually helps us because it helps take away some challenges that we face. However, if our planning is better and we have got those other things in place, our ability to respond to the infection should be better prepared and well organised.

MR ROZEN: Thank you. You were also asked in the preparation of your statement to provide some information to the Royal Commission about the hospital-in-the-home guidelines. You deal with this on page 8 of your statement and I would like to ask you about this now. In paragraph 44, if that could please be highlighted, you make reference to a guideline, adult and paediatric hospital-in-the-home guideline, and I will ask you to have a look, please, at general tender bundle tab 1, if that could please be brought up. Is that the guideline to which you make reference in paragraph 44, Doctor?

DR LYONS: It is.

MR ROZEN: It deals specifically with the implementation of hospital-in-the-home in a residential care facility at page 0196, if that could please be – sorry, 0198, if that could be highlighted. While that is being done, it's clearly the case, isn't it, Doctor, that this guideline was developed well before the COVID-19 outbreak? It wasn't designed to relate to hospital-in-the-home for that purpose. It's a generic document, isn't it?

DR LYONS: It is.

MR ROZEN: You will see at 7.3, without going into this in detail, that there's a discussion in the first two paragraphs about the potential negative impacts that can arise where a resident from a facility is transferred to hospital, and there's reference to the literature about that and that's well understood by this Royal Commission. But it's the third paragraph I want to ask you about:

> *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.*

Why, from your perspective, is the guideline stating that there should be a written agreement between the Hospital in the Home service and the facility?

DR LYONS: So what it's indicating is that it gives an opportunity for both organisations, those providing the Hospital in the Home service and – and those receiving it, to understand how that would operate - - -

MR ROZEN: Yes.

DR LYONS: - - - what the arrangements would be, what support is required and how that would be delivered effectively. I think the – if I could just expand on that a little bit., I mean, Hospital in the Home has a range of different components, and my understanding in relation to Newmarch is that there was a virtual aged care service that was in place and was established as a component of Hospital in the Home, for instance, and there were additional Hospital in the Home services that were added as a consequence of the outbreak response.

MR ROZEN: Do you say there was a written agreement, as the guideline says there should be?

DR LYONS: My understanding is there wasn't a written agreement. However, I understand there had been ongoing contact between Newmarch and the virtual aged care service about how that service would be provided and had been provided before the pandemic. There were existing relationships in place. So that suggests that the service was operating and the parties would have had some ability to actually know their roles and responsibilities in the context of delivery of that service.

MR ROZEN: Do you say that training and support had been provided to the Newmarch House staff about how Hospital in the Home would operate there?

DR LYONS: It depends in what circumstances Hospital in the Home was being delivered. If it was around a virtual aged care service, I suspect there had been. I don't know for certain. I can take that on notice. Certainly in relation to Hospital in the Home for other components, my understanding is that Dr Branley, who was administering medical and specialist advice into the home, was providing on-the-spot support for staff as a Hospital in the Home program was delivered.

MR ROZEN: No doubt that's the case, but I suggest to you that what the guideline is envisaging is that's being done in advance of any attempt to implement Hospital in the Home, isn't it?

DR LYONS: Certainly it would be an advantage to have it in advance.

MR ROZEN: Yes, like having the plan in advance, isn't it?

DR LYONS: That's correct.

MR ROZEN: Yes. And further, the evidence we have heard is that the staff that Mr Branley was working with were, by and large, were not the staff that would have been there prior to the pandemic. Most of them had to go home in the early stages of the pandemic, didn't they, Doctor? You know that?

DR LYONS: That's correct, and so that's a challenge in any pandemic response because the staff will change and some will need to be furloughed as they've been – may have been exposed. So there is an need for ongoing education and support of staff in those circumstances.

MR ROZEN: In the discussion you told us about where it was ultimately decided the Hospital in the Home was the approach that should have been taken at Newmarch, were these matters that you and I are now discussing talked about, that is, the preparedness of Newmarch for the implementation of Hospital in the Home?

DR LYONS: Certainly were. I mean, these things were raised and discussed at – to – in some – to some extent in detail. We were – made very clear that the virtual aged care service was in place; that, in addition to that, the infectious diseases service would be added through Dr Branley being on site on a daily basis; that there was the ability to add the palliative care service, that expertise and specialist input into the program, as well, and there was, if necessary, an intensive care service that could be added to the program, as well. So there were a range of different components, and these were discussed through the meetings that we had.

MR ROZEN: I suggest, Doctor, that for Hospital in the Home to work in the residential aged care facility in response to the COVID-19 pandemic, you have to have everything in place: the agreement, the training, the facilities, to have any chance of succeeding. You've got to do all that, don't you?

DR LYONS: Well, I just make this comment about Hospital in the Home. It's not the – it's not a set and forget. So – so while we admitted people into Hospital in the Home program, it didn't preclude, based on their clinical condition, them being subsequently admitted to the hospital. In fact, many of the residents were admitted to hospital. So it's – it's an ongoing assessment. The whole purpose of the Hospital in the Home program is to try and ensure that the best possible care can be provided to residents without needing to move them to a hospital situation, which can, as

we've heard in – in other evidence, in other situations, caused distress and adverse outcomes.

So it's about looking at what the clinical condition of the patient or resident, what are their wishes and desires in relation to the care they would like to receive and where they would like to receive it, and doing everything we can to provide the support to enable that care to be delivered in a way which reflects their desires and is appropriate for their clinical condition.

MR ROZEN: Thank you, Doctor. You've provided us with a further document which has been prepared very recently. It's behind general tender bundle tab 67, if that could be brought up, and if I'm right, Doctor, this is a document – you can tell me if it's a policy or a guideline. I understand that to be an important distinction in New South Wales Health. How would you describe this?

DR LYONS: This would be a guideline - - -

MR ROZEN: Would be a guideline. Thank you.

DR LYONS: - - - produced by the ..... guideline.

MR ROZEN: And if we go to the very last page, please, which is page .0021, we see – if that box at the bottom of the page could be made a little bit larger for the older eyes amongst us. This is the first version of this document, hot off the press, 4 August, 2020; is that right?

DR LYONS: That's correct.

MR ROZEN: And you've personally endorsed it, we see in the box there?

DR LYONS: I have.

MR ROZEN: And we see above your name next to the heading Consultation a range of people that were consulted. They're all New South Wales Health people, aren't they?

DR LYONS: No, they're not. So these are communities of practice that exist that have been established in response to COVID and identify having a range of different clinical inputs and advice, including as you can see, primary care there.

MR ROZEN: Yes.

DR LYONS: So primary care is actually mostly general practitioners and people providing services outside of New South Wales Health.

MR ROZEN: Right.

DR LYONS: But there are a range of different clinicians who will be not only working in New South Wales but in a range of different settings in amongst all those groups, and there are also consumers in some of those groups, as well, so people receiving the care, so not just clinicians delivering the care.

MR ROZEN: Okay. And the reference to the aged care unit health and social policy branch – can you tell us what that is?

DR LYONS: That's a policy division within the Ministry of Health and the division that I am responsible for.

MR ROZEN: Was there consultation with the people who had the very recent experience of Hospital in the Home in response to COVID at Newmarch House? Did you consult with them?

DR LYONS: I can't answer that specifically. I'll take that on notice as to the extent of the consultations that occurred.

MR ROZEN: If you could, please. Well, not the extent of the consultation but, rather, whether Newmarch House and Anglicare were consulted is the question, Doctor. They would, you would think, have very valuable input, wouldn't they, into a document like this? Would you agree with that?

DR LYONS: They would have very recent experience, that's correct.

MR ROZEN: Yes. And it would be valuable to have the benefit of that experience in the preparation of a guideline like this; do you agree?

DR LYONS: As there were many people who have experiences and input into a – so this is a very broad document. It's not specific around aged care.

MR ROZEN: I see.

DR LYONS: So – so it's about providing how we appropriately provide and the guidance to support that.

MR ROZEN: Aged care is a very important part of the application of this guideline, isn't it, given the very high risk community that live within aged care; do you agree, doctor?

DR LYONS: Certainly.

MR ROZEN: Yes. And just before leaving it, can I ask you to have a look at page .0006. There's a discussion there on left-hand column, the second heading, Assessment Of Appropriateness For Home-Based Virtual Care And Remote Monitoring. There's a number of considerations which are required to be looked at in deciding whether or not Hospital in the Home will be applied for COVID or

whether an adult with COVID is treated under this guideline. And in the right-hand column, we see some additional factors for a residential aged care facility. Do you see that?

DR LYONS: I can see that, yes.

MR ROZEN: And the additional factors that are identified there in deciding whether a person in a residential aged care facility receives care in place are the person's advanced care directive or their known wishes, whether hospital admission will add value to the care that can be delivered particularly for palliative residents, the residential aged care facility setting and ability to separate all cohort residents with suspected or confirmed COVID-19. Do you see that?

DR LYONS: I do.

MR ROZEN: What seems to be missing from those considerations is what the impact will be on the other residents in the facility of treating a COVID positive resident pursuant to this guideline. Do you agree that that's missing from that list of considerations?

DR LYONS: So these guidelines are about delivering care to an individual. I think you're bringing in a public health or collective – you know, the implication is about the factors that would impact on others.

MR ROZEN: Yes.

DR LYONS: The guidelines here are around the delivery of the care to the individual who will be receiving that care, not taking into factors outside of that.

MR ROZEN: Why wouldn't you take into account factors outside of that? Isn't that an important consideration, that – the impact that it's going to have on other residents if one is treated in situ for COVID?

DR LYONS: I think the third dot point there reflects that. It says:

The setting and the ability to separate all cohort residents.

That's bringing into – into play the need to ensure that the care can be delivered in a way that is appropriate but also keeps others safe in that setting.

MR ROZEN: You say that is a consideration that the guideline - - -

DR LYONS: I'm just reading it again. I think it does – it does address some of the points that I think you're, you know, pointing me to.

MR ROZEN: Yes. Is another consideration that the staffing and skill mix, for example, and the relevant staffing that is available in the facility to implement the guideline? Isn't that something else you would want to take into account?

DR LYONS: Yes. So there are appropriate caregivers that are available. So remembering this guideline is broader than aged care facilities. It is actually about delivering care in any home setting.

MR ROZEN: Yes.

DR LYONS: So it does point to appropriate caregivers being available and the person and the caregivers have the capacity to recognise signs of deterioration. There are a range of factors there that I think reflect some of the things that I think you're talking about.

MR ROZEN: And, finally, what about the impact on staff safety of treatment of a resident COVID positive resident in a residential aged care facility? We've heard a great deal of evidence about number of staff who have tested positive. Aren't there implications for workplace health and safety of treating a resident who is COVID positive in a residential aged care facility?

DR LYONS: In any setting, there is a requirement to ensure there is appropriate care and safety for staff delivering that, and that's a challenge in any setting that we have at the moment with COVID. As you – as you would be aware, we've got large numbers of healthcare workers infected in Victoria as a result of a range of different settings where care's been – care is being delivered. So it's a very important factor in every setting, yes.

MR ROZEN: In your statement at paragraph 78, Doctor, if I can just briefly ask you about this, you refer in 77 to the Clinical Excellence Commission reports that were prepared and which are in evidence before the Royal Commission, and then at 78 you tell us that PHEOC, public health – can you help me - - -

DR LYONS: Emergency operation centre.

MR ROZEN: Thank you – is preparing public health reports into the outbreaks at Dorothy Henderson Lodge and Newmarch House. What's a public health report?

DR LYONS: So that's more about the public health response and how that – and some of the issues around the epidemiology of the – the outbreak and what actions were taken from a public health perspective. So that's a routine component of what our public health team do, is that they review the response because, as you know, there are a range of components in any response, public health, service delivery, the aged care provider if we're talking about a residential aged care facility, so public health have a particular role, and so they provide detailed reports subsequent to the outbreak to assess what occurred, how things worked or didn't work, what learnings can come from each of the events that occurred.

MR ROZEN: For such reports to be of benefit, their prompt production is important, isn't it, Doctor?

DR LYONS: I think that's correct. But I think, just as we outlined at the start of the statement, we are still responding to this pandemic.

MR ROZEN: Yes.

DR LYONS: And our public health teams are working extraordinarily hard in respond on a day-to-day basis with infections that are occurring, contract tracing, testing. It's a huge undertaking that they've been – their commitment, their dedication, their workload is enormous. So I think in the context of all the things that they're doing, having the time to write these reports up and provide those learnings – I think we need to look at it in the context of where we are at in relation to the pandemic.

MR ROZEN: Yes, I don't doubt that, Doctor. In fact, I have personal experience in how hard your staff are working right now. The question, though, is the balance needs to be struck between getting reports like this out as quickly as possible, as against them being thoroughly done, I – I guess you would agree with that?

DR LYONS: Well, I think they – they also need to be done to the point where it's appropriate for them to be – you know, there's got to be enough work done so that people are confident that it's something that should be published because there'll be a lot of weight put on these reports, I suspect.

MR ROZEN: Indeed. And where are we at with these reports in terms of - - -

DR LYONS: My understanding is that they were finalised yesterday and will be provided to the – if – if they haven't already been provided to the Commission, they'll be provided to the Commission very shortly.

MR ROZEN: We are very grateful for that. Thank you.

MR FORDHAM: .....

MR ROZEN: Sorry.

MR FORDHAM: ..... but we contacted the Commission staff and have asked for a notice which apparently is on its way to us.

MR ROZEN: I'm grateful for that indication. Thank you, Mr Fordham. One final matter relating to the homework which you prepared to undertake, that is, inquiries about the extent to which Anglicare and particularly those at Newmarch House were consulted in the preparation of the document which is at tab 67. Could I just ask that to be broadened a little so that you can inform us whether other parts of the aged care

sector were consulted in the preparation of that guideline, as well, beyond the aged care unit that's referred to on the last page. Is that question clear enough, Doctor?

DR LYONS: Yes, it is, thank you.

MR ROZEN: Thank you very much. Commissioner Briggs, they're the questions that I have for Dr Lyons. Do you have anything for him?

COMMISSIONER BRIGGS: Yes, I suppose I've got a bit of a tricky question because I know the answer is largely around a matter of judgment. You spoke earlier on, Dr Lyons, about what you would expect to see for Hospital in the Home to be working appropriately in a residential care facility. We appreciate that situations are evolving on the ground constantly, and it's typically a feature of human nature that you say you can manage the situation, "We'll get through it, we'll do it, we'll work in together." But there's a tipping point, isn't there, where it becomes out of control and quite dangerous to the health of people, both staff and residents, in a facility.

And so I suppose my question is do you want to give some counsel or advice to us about where that tipping point is obvious and people do need to be transferred into hospital, or who should be taking those decisions about those transfers, given the important role that New South Wales Health has played in this pandemic management arrangement?

DR LYONS: Yes, Commissioner. So I'll reflect on the experience of Newmarch, actually, because this was something which we constantly had under review. And the – the protocol we established as a result of the learnings from our experience at Newmarch identifies the need to have an ongoing review. And we did this. We were meeting twice a week during the course of – when the – the outbreak was at its – at its height and constantly receiving that advice from people who were actually involved in delivering the service.

So we had James Branley on those conversations. We had Newmarch ..... on those discussions. We had external expert advice from Lyn Gilbert and others involved in those discussions, as well as ourselves, and – and we were getting that assessment in an ongoing way. And we had a lot of discussion about, you know, we're – are we at a point where we need to, you know, decant? Do we need to take further measures? We even talked about, you know, other aged care providers taking some residents. We talked about options around private hospitals taking some of the residents.

But it always came back to the advice that the people on the ground, in particular, the clinicians caring and this – in this situation Dr Branley had a lot of advice for us about what was appropriate to do and whether or not we should take further action. But it was a constant assessment. I can – I can reassure you that it was – it was a regular discussion about are we doing enough, do we need to do more, are there further steps we need to take?

COMMISSIONER BRIGGS: Thank you. No more from me, counsel.

MR ROZEN: Thank you, and nothing arising from, Commissioner Pagone .....

COMMISSIONER PAGONE: Yes, thank you. Thank you, Dr Lyons. Thank you for your assistance and for those, no doubt, who have been in the background helping you, assembling the work and the submissions that have been made to us. So we're grateful for that. We know these are difficult times, and we are grateful for the efforts you have put in and for making yourself available this morning for these questions. I need only now formally excuse you from further attendance.

DR LYONS: Thank you.

<THE WITNESS WITHDREW [11.21 am]

MR ROZEN: And I think it's time for - - -

COMMISSIONER PAGONE: Yes, I think we now have a scheduled short break. We'll resume again at 25 to 12.

ADJOURNED [11.21 am]

RESUMED [11.38 am]

COMMISSIONER PAGONE: Mr Bolster.

MR BOLSTER: Yes, thank you, Commissioner. We now have a panel of union leaders. I call, firstly, Annie Butler. I think we have some appearances first.

MR CHAMPION: If the Commissioners please, my name is Champion. I appear for Ms Asmar who is one of the witnesses on the panel.

COMMISSIONER PAGONE: Yes, Mr Champion.

MR BOLSTER: Do you have any more appearances? I call Annie Butler. Perhaps if Ms Butler could be sworn.

<ANNIE BUTLER, AFFIRMED [11.39 am]

MR BOLSTER: And I call Diana Asmar; if she could be sworn, please.

<DIANA ASMAR, SWORN [11.39 am]

MR BOLSTER: And I call Carolyn Smith.

<CAROLYN SMITH, AFFIRMED [11.39 am]

MR BOLSTER: I might begin with you, Ms Asmar, because you have provided us with a statement. And if we could bring up please RCD.9999.0432.0001. Do you recognise that as a copy of your statement, Ms Asmar?

MS ASMAR: Yes, I do.

MR BOLSTER: Is there anything about the statement that you wish to change or correct?

MS ASMAR: No.

MR BOLSTER: Are the contents of the statement true and correct to the best of your knowledge, information and belief?

MS ASMAR: Yes, they are.

MR BOLSTER: Commissioner, I tender Ms Asmar's statement.

COMMISSIONER PAGONE: That statement will be exhibit 18-19.

EXHIBIT #18-19 STATEMENT OF DIANA ASMAR DATED 10/08/2020 (RCD.9999.0432.0001)

MR BOLSTER: Now, in the case of you, Ms Butler, the ANMF, of whom you are the federal secretary, has made a number of submissions to the Commission, and they're located in the general tender bundle. You are able to speak to the contents of those submissions, aren't you?

MS BUTLER: Yes, I am.

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

MS BUTLER: Yes, they are.

MR BOLSTER: And, Ms Smith, your organisation has also made a submission which is also in the general tender bundle, and the same applies to you; is that right?

MS SMITH: Yes, that's correct.

MR BOLSTER: All right. Let me just introduce the position of each of you. Ms Butler, we will start with you. The ANMF – how many members of the ANMF are there in aged care across Australia?

MS BUTLER: It's approximately 40,000 in aged care.

MR BOLSTER: And most of those are nurses?

MS BUTLER: It's about – just over 50 per cent of those are nurses – registered nurses and enrolled nurses. We also have personal care worker members.

MR BOLSTER: And Ms Asmar, you are the branch secretary of the Health Services Union located in Melbourne; correct?

MS ASMAR: Yes, in Victoria.

MR BOLSTER: And from your statement, I understand that you have roughly 6000 members at the moment who are working in aged care, in the State of Victoria?

MS ASMAR: Yes, that is correct.

MR BOLSTER: Can you tell us the sorts of jobs and responsibilities that they have.

MS ASMAR: We have PCWs which are the carers, so they attend to the residents. They actually feed the residents, they actually change them, they bath them, they prepare them for meals, give them medications. We have the cleaners that clean the rooms and the general facilities. We have laundry workers that wash the clothes. We have the receptionists and clerical admin workers that prepare the paperwork. We also have the kitchen staff, so the chefs and as well as the kitchen people that make the meals. And more importantly, most of our members are PCWs which are the carers in the facilities which – we have about 60 per cent of those – of the 6000 members that are actually PCWs in aged care today.

MR BOLSTER: Ms Smith, could you give us a snapshot of your aged care profile.

MS SMITH: Look, we have somewhat over 10,000 members working in aged care across a number of states: Queensland, South Australia and Western Australia and the Northern Territory, and home care workers in New South Wales. We represent care staff, predominantly, and so PCWs and domestic staff, cleaners, kitchen and laundry, and in some of the States we also represent assistants in nursing and enrolled nurses.

MR BOLSTER: Could I begin with each of you getting a brief perspective of what it's like to be delivering the sorts of services that your members are responsible for, in the current climate. And, in particular, in your case, Ms Asmar about what it's

like in Victoria and particularly Melbourne at the moment. We might start with you because your members are the closest to the action at the moment.

MS ASMAR: Unfortunately, our members right now feel like they're on the bottom of the Titanic ship. They do not have access and proper access to what we believe is PPE. A lot of our members, unfortunately, are suffering with the COVID experience of their residents that they know who have been dying. A lot of our members right now are feeling the full extent of stress and pressure with the staffing. There is no staffing ratios in aged care in private sector which is a shame, because at the moment, prior to the COVID-19 they were understaffed. And now, today, with the COVID-19 outbreak in Victoria, we're seeing more understaffing as we speak because there is a huge shortage of staffing in aged care.

Our staff at the moment and the members in the aged care facilities, whether they're a PCW or whether they are the cleaners, are feeling neglected. There has been retention bonuses given only to nurses and PCWs, but not to the cleaners, not the laundry staff, not to food, or leisure and lifestyles and to the gardeners, of course, who play an important role. But I think the most devastating news we are experiencing at this moment is that they are requesting to have protection for the residents, and they are not given it. And there is conflicting communication coming through. The communication that is actually provided to them is contradictive to the State Government and the Federal Government and, of course, the providers that are making their own policies up to what they believe is correct.

So the lack of communication, the lack of training, the lack of staffing and the lack of protection, unfortunately has caused a huge concern in the aged care sector which we believe, until today, is still not rectified and more deaths in the residents, aged care facilities happening and a lot of our members are in intensive care. A lot of our members are isolated, and a lot of our members are suffering not only for their own health and wellbeing but their loved ones. The residents themselves are their families, too.

MR BOLSTER: We will unpack that as we go through issue by issue. Just pausing there, though, amongst your members, how many people have suffered from a COVID-19-positive test in the recent times?

MS ASMAR: We believe there has been over 1000 of our members in aged care that have had positive COVID. We haven't got full figures and facts because it hasn't been available to us. But this is based on calls that we have been receiving. And this is based on calls that we have actually been doing in outbound calling. So we've actually been calling the actual staff and members from each facility that we know of outbreaks, or we have actually been receiving calls from the actual members or their family members to advise us about their actual beloved ones in hospitals.

MR BOLSTER: All right. Ms Smith, I might turn to you for a brief – if you could encapsulate the perspective of your members now, we will go through and we'll unpack a number of the issues and themes as we progress. But what's the

perspective that we need to understand about what it's like to be a carer, that you receive in terms of feedback from your members?

MS SMITH: Yes, look, thanks. And what I would say is, obviously, the experience of our members is – is very different to that of those absolutely on the frontline in Victoria, and I'm really pleased that you did ask Ms Asmar to speak first because that is really the cutting edge. But, look, we spoke to over – we had a survey of our members to prepare our submission and about 1500 workers participated in that survey across the kind of three States and the Territory. And I think you could really sum it up by saying they felt unprepared. They feel overworked, and they are suffering a significant economic impact, and that is in States where there have been isolated outbreaks but there really have been no serious outbreaks like we've seen in Victoria and New South Wales.

So in terms of being unprepared, you know, many workers are saying they haven't been briefed. So if their provider has an outbreak plan they don't know about it. I mean, I think what is really scary is four out of 10 workers said that their facility hadn't communicated their infection plan well, and three out of 10 said they had received no extra training. So I think quite unprepared, overworked. So I think we all know the system was already at breaking point and this has just really put more pressure on a system that was close to breaking already. We've seen increased workloads because of the need for infection control.

We've seen increased workloads where families have been excluded from facilities because there's just a bigger emotional load for those staff in terms of supporting residents but also in terms of helping them contact their families through, you know – by FaceTime, etcetera. And also, once families were coming back into facilities – and that's obviously happening in a number of States – the increased requirement for screening. So it's, you know, we absolutely support that people should be temperature-checked, that they should fill in paperwork, but that's one less staff member off the floor making sure those processes are done, and we are not seeing significant numbers of staff. And look, the last thing I would say is just the economic impact.

Obviously, where there have been outbreaks or potential outbreaks or fear of outbreaks – and again, nowhere near like what we have seen in Victoria but we had a situation in Queensland where recently workers were told they couldn't work in their second jobs with, again, support. That is a really important infection control, you know, really important to infection control. But there was no subsidy or support for already low-paid workers who were losing up to 50 per cent of their income. And because most providers don't provide pandemic leave and everybody, quite rightly, is being incredibly careful about when they come to work and when they don't come to work, we're finding that our members are chewing through their sick leave if they've got it, or if they're a casual or they've run out of sick leave, they're suffering significant economic hardship. So I would just say unprepared, overworked and bearing the economic brunt of this pandemic.

MR BOLSTER: And is there a perspective of your workers being infected by COVID-19 that you can relate to us?

MS SMITH: Look we haven't – we've had, obviously, one worker in Queensland that we know of. So no, we haven't had the sort of experience that the Victorians have. But I think our members also talk about the incredible emotional burden. They are watching every day what's going on in Victoria. Their hearts are going out to those residents and to those workers. And so whilst they're in no sort of situation like the Victorians, every day they wonder whether they will be. Every day when they go into a facility, they worry that they're taking the virus into a facility, and when they go home they're worrying that they're taking it home.

MR BOLSTER: Ms Butler, your perspective.

MS BUTLER: Thanks very much. I would just reiterate what both of my union colleagues have said talking about – there are a number of issues I think we'll have to come back to: paid pandemic leave, the retention bonus, how these various supports have worked. I hope that we get to introduce another – a number of other factors as well. But just with regard to how members are coping; so our members are dealing with this situation in every State and Territory at all levels, registered nurse, enrolled nurse and personal care worker, assistants in nursing. Not just in the aged care sector but there's an enormous load being picked up by public health sector. With what's just happening general in the community, from the moment this started, the COVID-19 outbreak started, in Australia, to the crisis that's happening in the Victorian situation right now.

In supporting what my colleagues have said, to add to that, I think we must address the unspeakable grief that many people are going to have to be dealing with and that's the residents themselves, most incredibly their families but the workers, and that grief extends beyond the loss and the immediate loss. It extends to – I would call it trauma. And some of our nurses are reporting – registered nurses who are coming from the public health sector to support staffing in residential aged care facilities and some of the things that they're finding, that can only be described as abject neglect, which already identified by the Royal Commission previously. There has not been enough attention – not enough immediate urgent action from the moment we knew this outbreak was happening.

And so there's going to be – our members are going to have to deal with the emotional difficulties as described by Carolyn, the guilt for some. There are some where workers have been infected and with not proper processes in place and a whole lot of conditions around the way they have to work, the insecure nature of the work, their low incomes, the pressure on them to work, etcetera. They're going to have to deal with that. Then as I'm saying, what nurses are facing, who come from a well-prepared sector, being asked to go and do their best in a sector that is now in crisis, without preparation, support and then having to deal with some of the horrific circumstances, the situations they're finding the residents in.

All those things are going to continue for – for many, many months, if not longer. How we address that now is going to be – I mean, we have supports available to members in Victoria. There is a nursing midwife support across the country. There needs to be urgent support of an emotional, psychological nature provided to personal care workers and others, the cleaners, the laundry staff, all the others in the system, not to mention the relatives and the residents. I mean, the fallout will be ongoing.

MR BOLSTER: Let's deal with that issue firstly. The Victorian Government announced last week some enhanced mental health support programs directly targeted towards nurses.
What's your position about that, and I might ask you about that, as well, Ms Asmar. But Ms Butler, what's the ANMFs perspective on the adequacy of that response?

MS BUTLER: Well, that response is extremely welcome, and our branch in Victoria also already offers supports to our members. But I know that our branch has welcomed those announcements from Victoria and has certainly communicated that as widely as they can to our members, and I presume that HWU has done similarly for their members. But it is a welcome measure.

It's something that we could look at not waiting, not waiting until the crisis occurs, but trying to implement better mental health supports, and there has been a fair focus on the need for mental health support across the country, but targeted specifically towards those on the frontline, from, you know, doctors, nurses, midwives, to care workers, cleaners, laundry staff, etcetera, would be very welcome if we had a national coordinated response.

MR BOLSTER: Your counsellors – are they reporting an upsurge in people contacting them for help?

MS BUTLER: Was that a question to me?

MR BOLSTER: Yes, to you, Ms Butler, sorry.

MS BUTLER: Yes. Counsellors?

MR BOLSTER: Yes, the people who – the people – you have staff to assist with counselling in relation to these sorts of matters, don't you?

MS BUTLER: Yes. Yes, they are. The – what we try and do is have very frequent communication, and we've actually been – so we have the Victorian situation, of course, and then we have what's happened across the country. And most of our branches have been tracking members' queries and the sorts of concerns and things that are being raised. Of course, we have seen an upsurge in that over the last month in Victoria, but that is starting to settle a little now, and I know that our Victorian branch contacted 330 aged care facilities who were in the Melbourne and Mitchell

Shire lockdown areas on the weekend of 19 and 20 July, to contact as many members as possible and find – try and find out the key issues that were occurring.

Still, I suppose, we're talking about at the height of the crisis, and what they have reported – ongoing concerns has been articulated in terms of particularly wanting better education and training and staffing situations, but again, I go back to the – the increase in reporting back from particularly registered nurses going into the sector, an increase in concerns from them about the trauma they're experiencing from what they're seeing.

MR BOLSTER: Ms Asmar, how do your members cope with the trauma? Are there services available for them when they are finding it a bit hard to deal with all of this?

MS ASMAR: They're finding it extremely hard. The announcement that was made by the government was not in consultation with the Health Workers Union. We welcome it, we think it's fantastic, but also, it's missed out a lot of other people that, again, are in the bottom of the ship in the Titanic. Unfortunately, it did not outline how cleaners get hold of this. The cleaners work in aged care facilities. They actually communicate with the residents and they see them every single day. It's unfortunate that this actually isn't spread out to every single health worker. Every single health worker is affected by COVID-19. As we know, this virus does not discriminate. So why are we discriminated against every single health worker?

We think this is a great initiative and it should be done. Everyone needs it, but we need to make sure that everyone actually can be assisted by this. Because our members right now, as we have heard from my colleagues, are traumatised. They are traumatised because they were shocked with what had just happened overnight. They were shocked that they didn't get any precautions about what's happening, any communications. They weren't even told how to deal with these situations. There is no counselling or briefing in the aged care facilities right now in Victoria with the COVID outbreak to the members as we speak right this moment.

There is a lot of people grieving because the aged care residents are their families. They treat them like their own families. So they're in grief and in sadness, but unfortunately, there is nothing right now to assist health workers.

MR BOLSTER: Let's move on, shall we, because we've got a number of things to get through. The first thing I wanted to talk about is the actual ability to deliver care and the amount of time that is required to deliver care. Can we perhaps start with tab 37 on page 8, please. And this is a portion of your submission, Ms Smith, about the increased care needs that your membership has reported to you. If we could go to page 8, please. While we are doing that, this is a survey across the country or is this a survey in particular States?

MS SMITH: This survey, in the main, was in Queensland, Western Australia, Northern Territory and South Australia. I think some other – some other workers

were forwarded the link and we – we had, you know, a handful from other States. But it was – it was those States and it was prior to the outbreak in Victoria.

MR BOLSTER: So this is 1000 aged care staffers that are members of your union, and if we go halfway down the paragraph, you see that three-quarters of respondents in residential care reported not having enough staff to provide quality care during the pandemic; correct?

MS SMITH: Yes. That's right, yes.

MR BOLSTER: 43 reporting that understaffing has become more of a problem since the pandemic.

MS SMITH: Yes.

MR BOLSTER: Correct?

MS SMITH: Yes.

MR BOLSTER: And if we go down to the beginning of the second paragraph, and again, this is in moderately impaired COVID States:

> *Over 90 per cent of our residential care workers reported not having enough time to complete tasks at some time during the pandemic.*

What's your perspective on what that means in practice for your members?

MS SMITH: Well this is the second year that we have done this survey, and, you know, as you would expect, what it says is that things are bad, things were bad before the outbreak, and things are now worse. And every time that – and, I mean, I think you were right to kind of point out the numbers. I think one of the most worrying numbers is just under that, that 39 per cent saying they always are unable to complete tasks.

And every uncompleted task is an older Australian who is not receiving the care that they deserve, and I think, you know, that is a terrible indictment on the system. I know that it has a huge impact, obviously, on those residents, but also on the care workers. They talk about the emotional toll of not being able to provide the care that they want to, and I would just reinforce what Ms Asmar said – is because so many residents don't have family visiting, and at this time, many residents weren't having family visiting. The care workers feel a heavy burden to be their family and provide that care. So they – you know, it's – it's a terrible situation for the residents and the care workers.

MR BOLSTER: That was the point that I was leading to here. The change in visitation arrangements, as varied as they may be across the country – what have they meant in terms of actual care delivery, and what sort of care tasks were being

performed by visitors that are now not being performed by them and having to be performed by your members?

MS SMITH: Yes, look, I think this is really significant. I will say, a really significant number of residential aged care residents don't have any visits at all or have very, very low levels of visits, and that's a bit of an indictment on us as a country, I think. But certainly many families do visit and visit daily. They provide a lot of support, both emotional and often they will do some of the sort of support with activities of daily living while they're there. So I think that has increased the workload. You know, if a family member can help one of their family members in care, that's a task that someone doesn't have to do. I think the other – apart from that, there's also, as I said, connecting to families electronically, using FaceTime or iPads, etcetera, etcetera.

I think there's also just the emotional impact on residents of not having their family that – you know, where we are connected – we are connected animals, human beings, and aged care residents value that connection. And when they don't have that connection with their loved ones, what we are seeing in facilities is more difficult behaviours, more stress, more difficult behaviours, and actually residents who need extra time spent with them, who need that moment where you can sit and hold a hand, sing a song, brush someone's hair, talk to them. And care workers are saying again and again, "Actually people need a bit of extra time and we haven't got that time for them".

MR BOLSTER: Ms Butler, how does a restrictive approach to visitation affect the ability of nurses and carers that you represent to deliver care?

MS BUTLER: Well, to add to what Ms Smith has just said, I mean in our very first submission to the Royal Commission, we identified, you know, already about an hour and a half gap in the care that was needed for residents across the country prior to anything like COVID happening. So I would only just add to everything that Carolyn has said. Our members have certainly reported increased workloads, increased stress. If you couple that with where there might be an outbreak, then there are all the requirements around infection control that the sector has proved itself to be ill-equipped to grasp quickly and implement quickly. Doing – applying that process properly takes time.

So that's additional time on top of an already stressed situation, increased workloads and then you lose the visitors and, as Carolyn said, you lose the emotional support, you lose the connection that many elderly people so desperately need. I know some of our members have told us that they have stayed after a shift or they've gone in on their days off so they can spend time with residents just to sing to them, to try and help, because they – as my two colleagues have said, they have an enormous commitment to their residents. But then, with an outbreak and people put in isolation, new staff brought in – brought in because they have to be, and without visitors, then the residents just have no connection to familiarity and the usual sort of

support mechanisms that they rely on. So it is an incredibly stressful situation for everybody right now.

MR BOLSTER: Could we turn, perhaps, to your survey which is at tab 15 and if we could go to the graph on page 29. And this was a question asked of your members:

> *Has your employer increased nursing and care staff at your workplace in preparation for dealing with COVID-19?*

And the vast majority, 76 per cent, said "No". But a small minority said "Yes" and there were eight per cent who weren't sure. How is the dialogue – how do you, as a union, represent that need for the extra time to care to individual employers? How do you do that in a time of COVID with emergency with they're run off their feet? How do you do that? How do we engage with the employer about these sorts of things?

MS BUTLER: We have tried to engage and our first – we thought the first reasonable point of that engagement when we are facing a global pandemic requiring a national response was to go to the federal Aged Care Minister. Our first call to alert the Minister and, therefore, the sector to the need for urgent attention to increased staffing and increased skills was on 4 March. This was actually prior to us conducting this survey, which we did in the last two weeks of April and the 1st of May. That was because we looked to overseas and saw that there could be a critical, critical concern for those living in residential care but especially residential aged care.

And so we had – we tried to advocate for the urgent need to that increase in staffing. We have tried to make applications to the peak organisations through our State connections, through public – publicising – making public announcements about staffing, through the media when not getting a response from the government. But I have to say that – I understood – we requested a meeting with the Minister from the 4th of March. We didn't get a meeting until the 4th of April despite insistence and despite raising our concerns. I had to go through Minister Hunt's office to try and increase our concerns and to use the media – unfortunately, to use the media to try and get proper attention put on this issue.

I would contend as well that it remains unresolved and, in fact, rather – and the Federal Government also has put quite a bit of additional funding into the sector, allocated as laid out in our submission against where it was supposed to go. There was supposed to be money dedicated specifically for increasing staffing and skills but there's no accountability. There's no checking of where that money has gone. There is no requirement of providers by the government to say tell us exactly how and where you have increased the skills, and to show that you are prepared.

And so consequently we continue to see this situation and what, to us, is most astonishing of all, even in Victoria right now but in Queensland, South Australia, Tasmania, Victoria and some parts of New South Wales, aged care providers are

actually cutting staff. So we were told at the time we did our survey that some providers had cut staff from 1 March but over the last month or two, the feedback from members and even from employers directly, that they're cutting staff has increased.

MR BOLSTER: If we could go, please, to the table on page 31, your members said that when there was an increase in staffing it was generally sufficient to meet the needs of the residents. So in those organisations, where there was a provider who did increase staff, it seems to have made some sort of difference. Do you agree with that?

MS SMITH: Yes. So you can see that the N equals 233 there. So that's the number we are talking about, as compared to the 1500 who completed the survey, so you know – but of course, where they did increase staffing in response to, you know, anticipating the needs – particularly those who were cognisant of the consequences of imposing restrictions in facilities. Those who understood that necessarily a lot more was going to have to fall on the staff that we had present. So, of course, it naturally follows that increasing the staff is going to make the situation better.

MR BOLSTER: Ms Asmar, what's your perspective on how do you engage with employers to improve this particular situation during the pandemic?

MS ASMAR: Well, unfortunately, I think this needs to start with a new legislation that should be implemented to mandate the ratios in Victoria which we don't have. If we had the ratios implemented then we could have enforced this on to the providers and ensuring that we have the quality of care that is required. The unfortunate thing, too, is that we did raise this so many times to both State and Federal Government in relation to the concerns that we had for our members. In both incidents, the lack of support that we've had for our members, the unfortunate situation where we had a lot of calls from our members with concerns that we had to ring the providers and ask the providers to support them. We have a lot of casualisation in the workforce as well which does not help in aged care sector.

So the things that we are really looking at is that there needs to be a mandatory regulation in place to enforce ratios for PCWs which actually would fix a lot of these issues. By actually enforcing permanent full-time employment or part-time employment would also address this situation. The pressures that we've seen has increased dramatically in reduction of the available workers caused by many combinations such as the self-isolation, infections, the requirements of going to one facility rather than the other. This – these extreme precious on the workers have caused a lot of lack of staffing.

I agree with what my colleague just said, Ms Butler, that more staffing on, the better the efficiency of work can be done, the better the tasks could be done, and the work is completed. But right now – prior to COVID-19 we already had short-staffed. During COVID-19, we've got a lot less and, unfortunately, we won't be able to get the workers to complete any tasks they can do when they're already understaffed.

And if you don't have both governments, whether State or Federal, listening to this and ensuring that this is mandatory, it won't work. You need the extra staff in urgently and permanent staff in urgently.

MR BOLSTER: Let's turn to another issue, shall we, the planning of the providers for the COVID outbreak, and the nurses dealt with this in their June survey. If we could go, please, to page 17 of the nurses' survey and the graph there, figure 6. A majority of employers had provided your members, Ms Butler, with a reviewed or updated plan regarding COVID-19, but a significant minority did not. What – this all occurred in – this survey occurred in June, didn't it? And I take it you haven't had any opportunity to explore the issues as events have deteriorated in Victoria in July and August?

MS BUTLER: The survey report was actually produced in June, but the survey itself was conducted in the last two weeks of April and the first week of May. So it was around the sort of – as the Newmarch situation was unfolding. We haven't conducted a survey of our aged care members in Victoria, but there's a constant communication with those members rather than an official survey.

MR BOLSTER: If we could turn over, then, to page 19, there was a question asked about the adequacy of the supplies of PPE. If we could bring up page 19, please, and the graph there. It should be figure 8. So only 29 per cent of your members were reporting adequacy of PPE in April of this year; correct?

MS BUTLER: That's right. And just – before we just go into detail on the PPE, can I just say with that box before, with the plan, there's a difference between just having an outbreak plan, words on a piece of paper, and – there's a big gap between that and everybody actually knowing what to do and how to implement it. And I think that's revealed itself particularly in the current crisis and second wave outbreak in Victoria. Yes, from the very outset of the outbreak of the pandemic across Australia, one of our very big concerns from members across the country was about PPE, obviously. A never-seen-before global pandemic, entire world competing for the same resources – understood that there were problems.

We raised repeatedly the two important pieces of the pie for our members is around certainty around supply and then consistency around guidance for use. Now, we had particular struggles in the aged care sector that didn't come out of State stockpiles. It was coming out of a national stockpile. It was being distributed through the PHNs. There was concern about it getting to the place in time. There was – also from other areas, Aboriginal medical services, etcetera – had a lot of trouble negotiating initially through the PHNs. Supplies weren't getting through. The wrong supplies. There were gaps in the sorts of things that were required.

And then at facility levels, we heard a range of different situations where people would stockpile them within an actual facility, so hoard them because, "We'll keep them for later," or, "You don't need to use that now." We had members tell us they could only use one glove rather than two. We had members who told they had to

reuse equipment, put it in collective plastic bags. A whole range of incredible breaches in infection control. So issues of supply, issues of use, issues of understanding what to use, when to use it and how to use it. It was a key concern.

MR BOLSTER: Let me ask the three of you this broad question. The degree to which your members are, pre-COVID, aware of the correct procedure for the donning and doffing of PPE, when it needs to be used and other infection control mechanisms – how adequate? I mean, we're looking back on it now in August, having had the pandemic, but how adequate has the training of your members been in those skills previously? Ms Asmar, why don't you start with that question?

MS ASMAR: I can assure you there's been no training whatsoever for our members. If there has been any training, there has been some discussions in relation to gastro outbreaks, but in relation to gastro, those precautions that take place should have been for COVID-19, as well. But there was no proper training or cautions or health and safety guidelines for them. Nothing. They – if anything, they've been informed they do not require PPE because they are not in contact with the patients. And if they had anything, the only thing they probably did use was gloves, but we came to a situation where there actually was no soap, no sanitisers for them, and the actual masks were locked up in the medication cupboards where they couldn't access and they were told, as I've heard also from my colleague, "You're only entitled to one mask per shift," if they got it.

But in relation to training, how do you wear the gown, if you got one, how do you put on a mask, how do you take it off, if you got one, when to wear a glove, when to take it off, when to wash your hands – now, washing of hands, normal hygiene – we all know that because it's normally next to the sink, so that's normally always there for everybody to see, but I'm talking about serious contagious viruses. There was no communication whatsoever. Until today, in the aged care sector, our members still cannot get masks, gloves, gowns for today with the huge outbreak in Victoria with these death tolls.

Our members are struggling to get a mask. They have to go to the nurse manager in charge to request one, if they can get one. And they're locked up. And yes, we have heard the same stories as Ms Butler said. "Oh, we've got the stockpile. That's for later on." Well, later on has come and gone, and they still can't get it.

MR BOLSTER: Let me ask you this: your members, when they start as a carer, having completed their training, have they received any formal training in the use of PPE when they graduate or they obtain their certification?

MS ASMAR: No. Definitely not. Any training they have to do should be in their own time. And if you're lucky enough, maybe you can do it during working hours, but it's actually online, but there's nothing in relation to PPE training for any of the members of the Health Workers Union. None of the health workers .....

MR BOLSTER: Ms Smith, what's your perspective on this issue?

MS SMITH: Look, I mean, I would just echo what my colleagues have said. I think the training has been completely inadequate and, I think, you know, neglectful, to be honest. In our survey, we had our members say that three out of 10 had received no extra training at all, and that's really concerning, and probably the question we didn't ask and probably should have was, "How adequate was the training that you did receive?" And I think – I think the answer to that would be pretty horrifying. I think there's been a huge amount of confusion for staff. Masks was one of the issues: when should I wear it, when shouldn't I? There was just a complete lack of – so as well as the training, just a complete lack of information. As a union, we took on that role of kind of providing that sort of information when they couldn't get it from the provider and they certainly couldn't get it from any sort of central source. There was a lot of information floating around. Most of it wasn't aged care-specific, and none of it recognised the particular needs of the care workforce and the particular kind of information that they would want. They would have to kind of wade through pages and pages of very clinical kind of information.

MR BOLSTER: Ms Butler, the graduate nurse, will they have come through university with a knowledge – a working knowledge of PPE?

MS BUTLER: A graduate nurse definitely will have. They will definitely understand universal precautions, basic infection control – prevention and control principles, most definitely. But I would agree with my colleagues that the care workers would have incredibly varied knowledge and I imagine in too many instances way too little.

MR BOLSTER: We saw yesterday some evidence of what might be described as a best practice action plan. Going back to 2009 in relation to an earlier pandemic where there would be a stocktake of the PPE equipment. There would be establishment of a response plan for an outbreak. How common is that degree of preparation amongst the providers that your members work for?

MS SMITH: Can I start?

MR BOLSTER: Yes, please.

MS SMITH: Yes, I happened to see that. That was with reference to the H1N1 outbreak, I think. I can't remember which provider but, yes, I would say they're close to unique in terms of that preparedness – level of preparedness. And having – having learnt from that kind of outbreak – and COVID-19 is far beyond what we saw with those earlier swine flu, bird flus, etcetera, it's of an infectious nature that no one had really ever anticipated, I think is fair to say. One of the things that we have done – or that we know, is that we have good connections with our international colleagues, in particular the Hong Kong nurses, the south Korean nurses and the Taiwanese nurses; those countries have all managed their outbreaks extremely well and very well in aged care.

And what they have told us, that they definitely learnt from SARS and they definitely learnt from MERS. Let's take the example of South Korea: from 2016 they had instituted in all residential aged care drills – infection control drills. So there's a quarterly drill – you know, I mean every three months, of preparing for a pandemic and making sure that there's infection control expertise located in the facility, that there are plans in place and that, most importantly, people know how to implement the plans, what to do, what to actually do in the event of an outbreak. And so but I would say that that – we are nowhere – absolutely nowhere near that sort of preparedness in this country. We're not even terribly well-equipped for infection control in residential aged care to deal with influenza outbreaks and gastroenteritis outbreaks, as I think Mrs Asmar said earlier.

MR BOLSTER: We might move on, given the time that we have left. Could I turn to your views about the Commonwealth's plan for the pandemic in aged care, and you will have seen some discussion about that in the media over the last 24 hours. What is the perspective of the three unions about the broad level of preparedness in the aged care sector, if we could be really specific about that. Was there a plan in place that your organisations regard as having been sufficient? Ms Butler, perhaps you go first.

MS BUTLER: Yes. I will say no. I understand why there is a document – there's a document that allows the Federal Government to say "We have a plan", but when you ask the question "Is the plan sufficient?", I would say no. So those guidelines – so the first ones that we saw in April didn't even have the Federal Government as one of the bodies with responsibility – roles and responsibility. The Federal Government wasn't even included. Which is absolutely astonishing. And I will be as quick as I can. Nowhere in the document or in the subsequent updated document from 14 July where they did at least recognise that they had to include the Federal Government as one of the bodies responsible. There is no mention of ensuring the need for adequate staffing and skill mix as a baseline.

There is no – it's very much an approach of what you do, closing the door after the horse has bolted. So there's nothing that says you must maintain staff or you must increase staff until you have got a baseline and then what you need to do once you have an outbreak and then you need to respond. So, in terms of preparedness, I would say that there are very big gaps in these plans which actually call themselves a set of guidelines. The other thing I would just say is that, again, it's words on paper. It doesn't mean that where it's going out to, the people who are receiving these guidelines, fully understand. There's a lot of medical terminology. There's words like hemoptysis, etcetera. I'm not sure how many of the residential care providers out there understand some of the language. There's some of it that needs a lot of translation by a health professional and I'm not sure how – and those supports weren't put in place.

MR BOLSTER: Ms Smith, do you have a perspective on the state of the Commonwealth's preparedness for aged care?

MS SMITH: Yes, look, I would absolutely agree with Ms Butler, that really you could almost characterise it as no plan. There were words on a piece of paper, but I don't think there was anyone taking responsibility for it, ensuring that it was – you know, that even the plan that they had was being put in place and no one taking action where it wasn't happening. We knew this was coming. You look around the world, you know that, you know, older – older people are really vulnerable to this and residential aged care is an absolute flashpoint, and probably the most dangerous place to be in a COVID-19 pandemic. And it feels like we wrote something on a – you know, there was a plan written on a piece of paper and then we have ticked the box and that's it. And that is disgraceful – I think that's absolutely disgraceful.

One thing I would say particularly with the perspective of care staff is that there was – you know, even if a provider had a plan and it was an adequate plan, it was very – it wasn't adequate because it was very, very rarely communicated well to the care staff who are the majority of staff. They do deal with infection control. People have mentioned flu, gastro. This is something completely different and out of that situation, and the absolute lack of involvement and communication with care staff who are doing the majority of work in the facilities, I think is negligent to the extreme.

MR BOLSTER: Ms Asmar, is there anything you want to add to those perspectives?

MS ASMAR: I just want to say you can do as much guidelines as you want but you actually need to consult and communicate guidelines, but also how you are implementing these. Who is regulating them? Is WorkSafe checking these? Are they actually mandatory? The problem is you can put as much guidelines as you want that really meaning nothing unless they are enforced and actually monitored. Because we all know that guidelines are put from Federal and State Government, but they're not implemented. We also know that providers are making also their interpretation of what these guidelines mean. So, no, I believe we are not prepared. We never have been, and until today we are still not prepared. Until today we still don't have efficient guidelines and we don't have sufficient protection to the aged care workers, unfortunately.

MR BOLSTER: Let's turn then to the issue of leave. There was a decision of the Fair Work Commission about two weeks ago which gave some pandemic leave to a limited range of workers in this area. How limited was that decision and what needs to be done? What is the problem now, despite that decision, with the pandemic leave situation? Ms Butler?

MS BUTLER: So for our members, the decision by Fair Work affects about 10 per cent of those, and we have a variation in an enterprise agreement coverage across the country, very high enterprise agreement coverage in Victoria, about 96 per cent, down to about 78 per cent in Queensland. So that's leaving a lot of members still without access to paid pandemic leave. There was an announcement of support from the Victorian Government and then the recent announcement of the disaster

pandemic payment from the Prime Minister. The problem with those payments – yes, they're a good step but, again, they are acting – closing the door after the horse has bolted.

This is about once somebody has been identified, has been directed by a public health official to isolate, etcetera. If we really want to prevent and contain this outbreak, we need full paid pandemic leave for everybody so that people are stopped from going to work when they have even the slightest of symptoms, that they're supported and that they don't have to make a choice between food on the table and the – you know, and the loss of – and the loss of money and the risk of taking something into an aged care facility or heading – furthering the spread. So – and we – I think the three of us and the union movement, we've been making those calls since the beginning of March.

MR BOLSTER: Perhaps, Ms Asmar, you could explain why it's a problem for some of your members who might be working one, two, three or even four jobs. How is it practically a problem for them at the moment?

MS ASMAR: It's a huge problem. I also agree with Ms Butler that most of our aged care facilities or most of our aged care members do have an enterprise bargaining agreement. So the pandemic leave does not apply to most of my members, if any. The – the biggest problem is that our members are working, some of them, four jobs, three jobs, and it's common because of the casualisation that we have. 60 per cent of our members are either casual workers or part-timers, too.

So the biggest problem you've got is they've been told they have to use their annual leave, all of their annual leave, long service leave, sick leave before you get anything else. So the problem we have today is I've used up all my annual leave or don't have annual leave at one provider. Second provider, yes, I've got a bit of leave but it finish next week. I have to work at only one facility, and I'm actually casual at another facility which I've got nothing, anyhow. So there's loss of income generated. So people at the end of hopefully this COVID-19 won't have any leave to actually relax and take it easy, won't have any income coming through at all if they're lucky because right now, they're lucky to get meals on the table because they are struggling to work just in one job which doesn't bring them income because they are casual workers. They are lucky to work four hours a week now, if that, because they have to stick to one facility.

Now, the biggest problem is the casualisation and the permanent staffing because it's all about profits. It's not about genuine care of the residents. If we had permanent – and ratios is the biggest way to do this. If you have patient ratios one to six, which is actually a standard in the public sector, which is a legislation there, and implemented in the private sector, which the Commonwealth should be doing and seriously taken serious, we wouldn't have this problem. If we had people working in one facility, we wouldn't have had a COVID outbreak, and it's not their fault. It's not the workers' fault. There was no precautions. There was no PPE. There was no training, and the biggest and the worst impact of all this – the actual

recommendations from the State Government and Federal Government conflicted it. So DHHS said to people, "Until you get your results, keep working," because they knew it was short of – there was a huge shortage of staff. So working in various unfortunate different facilities is a common practice in aged care today.

MR BOLSTER: Ms Smith, is there anything you want to add to those perspectives?

MS SMITH: Look, only to say that pandemic leave, as well as being important to workers, is a key infection control measure and if you don't have – you know, again, we knew it was coming. It was raised again and again and again by the workforce and by the unions. Even if we weren't advocating on behalf of workers, which we obviously are, we would advocate for paid pandemic leave as a key infection control measure.

MR BOLSTER: Could I change direction slightly. We talked earlier about the gap that your members have to fill when visitors aren't allowed into a facility. What's the view of your members about the visitation code and the way it's structured at the moment? Have we achieved the right balance? If it's to be changed, how should we – how should it be changed? Ms Smith?

MS BUTLER: .....

MR BOLSTER: Sorry, Ms Butler. I thought Ms Smith was nodding and I went to her first. Ms Smith.

MS SMITH: Look, I think the whole issue of visitation – you know, it's a very difficult issue for our members and there's – but one of the things I would say is there was absolutely no consultation with the workforce with this issue. There was some chats between providers, the Government, I think the Council of the Ageing was – was advocating, but no one thought to talk to the workforce. And I think that's just a huge miss in thinking about this issue.

As many of our members were concerned about – members were concerned about visitors not being allowed, but members were also concerned about visits being opened back up again and what that would mean. So ..... I think it's – it's contentious. There are many different views, but my concern is no one thought to ask any workers or any workers' representatives about what the visitation rights meant, what sort of support and extra staffing could be required.

MR BOLSTER: Ms Butler, if they'd ask you, what would you have told them?

MS BUTLER: Very much what Carolyn has just said. We objected strongly to the exclusion of unions in the development of the code. Consequently, we developed our own, the ANMF did, which we call our Principles For Safe And Compassionate Entry Into Nursing Homes, which goes to what Ms Smith is talking about – is the need for increased staff because you do have to balance containing and protecting any spread or what we can by limiting access at certain points, and certainly we've

always said that we would advise our members to comply with the best health advice and specifically public health advice.

But because they haven't consulted with us, the unions and the workers, there's really zero acknowledgement in the staffing that's required to make that – the visitation work properly and the restrictions on visitation when required work properly. So we had advocated for you've got to ensure safe staffing. We have a list of points under these – each – each of these things:

Implement safe screening procedures and protections for visitors.

Now, I think Ms Smith alluded earlier that that staff just comes off the floor, increasing the workload and the burden, etcetera, for the existing staff. There needs to be additional staff with the right skills to make sure that that happens properly. You need safe screenings and protections for staff, as well. And then we – another key element, which is touched upon in the – in the code itself but it doesn't recognise the staffing requirements sufficiently need for it, is about the communication between residents and their families and maintaining that connection.

MR BOLSTER: Ms Asmar, is there anything you want to add to that or do you have a different perspective?

MS ASMAR: No, I agree in relation to staffing. Increased staffing should have been done, but I think, also, the downfall of what happened without communication is a lot of the residents missed out on families for their birthdays. So unfortunately, a lot of the health workers had to provide that extra small space for family missing in relation to birthdays. And that is actually one downfall because there was no plan in place. How do we communicate to their families? They want to wish them happy birthday. Do we stand outside? And we know that that's been happening. So the saddest thing is the – the wellbeing of the health workers because they were sitting there, caring for, obviously, the residents, but there was no – no care given to all the workers in this particular incidence that occurred .....

MR BOLSTER: I wanted to – thank you for that. I wanted to finish with some research that has come to our attention overnight. It was – Kathy Eagar tweeted the result of a US study that has just come out about staffing – the connection between staffing and the susceptibility of nursing homes in the US to COVID. If we could bring up tab 80 please, in the tender bundle. If we could go to the heading Discussion, it should be towards the end of the – yes, please. Ms Butler, have you come across this study in your preparation to give evidence?

MS BUTLER: I have come across this study because I also saw Kathy Eagar's tweet and I – my attention was drawn to it. And my reply to Kathy, as she tweeted herself was, "Well this is no surprise to us". We had also seen an earlier piece of research done by Charlene Harrington who has done a lot in the US and California, done a lot of work on the – looking at staffing and care outcomes in nursing home settings. And she had an earlier paper – only a couple of weeks earlier than this

paper showing the relationship between – particularly increased nurse staffing and prevention of COVID and better outcomes from COVID.

MR BOLSTER: Let's just distil what the message is – and this is early days from some data from a number of States in the US, California, Connecticut, Florida, Illinois, Maryland, Massachusetts, New Jersey and Pennsylvania. And there's a correlation, as the discussion indicates in the first and second sentences:

> *High-performing nursing homes for nurse staffing had a better result for COVID-19 positive testing than low-performing nursing homes.*

The staffing seemed to have been the issue. Where there was health inspection or quality measure ratings didn't seem to correlate to any benefit in terms of COVID overall. So the message – and look, it's early days but it would seem to suggest that the more nursing staff you have on duty to deal with COVID, the better the outcome in residential aged care context and I take it there's no surprise to you.

MS BUTLER: There's absolutely zero surprise to me and, in fact, that is what we have been claiming – and as I said, our first request was made on the 4th of March about the urgent need – on the back of already all the information that we have provided to the Commission and the years we've been trying to secure better staffing, increased staffing across the board and increased skill – a better skill mix. So it's not a surprise. It's of no surprise to us.

MR BOLSTER: And for the record, the report or the research letter is in the Journal of The American Medical Association and it was published on Monday of this week. Is there - - -

MS BUTLER: Can I just add – sorry. One of the things – one of the issues with this is that it was immediately apparent to us, and my colleagues as well, and to many others, that COVID-19 is an urgent health crisis. The persistent view from much of the residential aged care sector that it is only a home, they are not, you know, not to provide – they're not – not health settings, etcetera, even though there is a standard that requires personal – appropriate personal and clinical care – obviously, the standards are insufficient – and that there is supposed to be infection control, it is a health crisis. It requires a health response. It therefore required the commensurate increase in appropriate staffing both in numbers and skills.

MR BOLSTER: Is there anything that you want to say in closing, Ms Smith or Ms Asmar before we finish?

MS SMITH: Just referring to this study – and I haven't seen it, but I think you might say it's as obvious as your nose on your face, really. And I would say, you know, the staffing mix, you know, if – the decision to keep people and treat them in situ in residential aged care, you know, people in residential aged care are frail, they have many comorbidities but once you have people who are kind of very sick, seriously unwell, you do need a really different level of staffing, and you do need

those clinical skills and that ability to kind of – yes, so I think it's good to see that result. It's a pretty obvious result.

MR BOLSTER: Ms Asmar, do you have a final perspective?

MS ASMAR: Yes, I would just like to say I entirely agree with the results that we see in front of us, and we're not surprised with that. But I would also like to mention the retention of staffing which most recently we know that was announced only for PCWs and nurses and that's a problem because we need to retain staff, and HWU members are missing out. So all I want to say is cleaners, laundry workers, kitchen, food workers, admin staff, leisure and lifestyle workers are all essential frontline workers, too. And what happens if cleaners don't arrive to work today; we've got huge problems with COVID. What happens if the residents aren't fed; we have huge problems. What happens if the workers don't receive these payments, can't get meals on the table? All I say that we need to be all treated equally and valued equally in the fight against this pandemic.

And the second problem that we have also got is that the operators and the actual facility providers have to get on board. In one in four of the actual facilities did not even apply for getting the retention bonus for the workers, and why not because it's not good enough for them because they get zero dollars for it, whereas it was actually going just for the workers, and that's a huge problem. And I think we need to come down to reality that this pandemic is an eye-opener and we need to value every single health worker and we need to take extra precautions and communications for every single health worker, and it's quite sad what has happened today.

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

COMMISSIONER PAGONE: Thank you. Commissioner Briggs.

COMMISSIONER BRIGGS: Thank you, Commissioner Pagone. I have to say I'm shocked and deeply disturbed by some of the evidence we have had this morning; in particular, the high numbers of personal care workers who have contracted the virus, and the shortfalls in the provision of PPE and associated training, and comments on the effectiveness of communication. If you were in our shoes, thinking about what needs to change immediately, I would like to ask you, Ms Asmar and you, Ms Smith, for some counsel and guidance to governments in Victoria, in particular, but across other States.

MS ASMAR: Thank you, Commissioner. I would say immediately there are three solutions. And one is the health and safety perspective in relation to the workers. And to address that you must have the ratios mandated for one carer to six residents built on the example of the Safe Patient Care, which is the Nurse to Patient and Midwife to Patient Ratio Act 2014. This needs to be implemented and it will improve not only the employees' working lives but also the residents' ..... in the private sector. The other thing, yes, I would also suggest that PPE, as you

mentioned, is a huge crisis, and there should be no restriction to the limit of PPE provided to the health care workers. Today there is a ..... two masks per shift and that is an appalling guideline.

COMMISSIONER BRIGGS: Oh God.

MS ASMAR: Yes, Commissioner, it's appalling that our members are doing the best care possible to actually take care of the residents, and they actually have them all locked up ..... we also need to provide not only masks but you need to provide ..... equipment, gloves, the simple soaps and water. I mean water is available, but soap is not there, nor is the sanitisers. These are very, very important perspectives that have to take place to address these. And casualisation, of course, is the biggest issue in the sector. Unfortunately, the health workers are known to be one of the lowest paid workers and they're on minimum wages 22 to 23 hours. So by providing more permanent stability in the workforce would address a lot of these issues and making people more full-time in their jobs. That would go a long way, Commissioner, in my view.

COMMISSIONER BRIGGS: Ms Smith.

MS SMITH: Yes, thanks for the question, Commissioner. I think the absolute key to this is someone has to take responsibility for ensuring this sector is properly regulated. And I think that's the job of the Commonwealth. But right now, we just, you know, Commonwealth/State, someone has to take responsibility. In terms of the COVID-19 crisis, really, we have to make sure that providers not only have plans, that they are adequate, someone is assessing whether they're adequate, and thirdly, assessing whether they're rolling it out and whether they are rolling it out adequately. A really key issue is staffing and, again, going back to COVID, ensuring that there is adequate staff, that there is more staff before there's an outbreak and even more staff after there's an outbreak, that those staff are properly trained, are properly consulted and have the right skill mix for the outbreak.

And I think the last thing I would say is just to remember that this isn't just specifically a COVID-19 scenario. COVID-19 has exacerbated what is already a broken system and we have 44 per cent of people who filled in a survey said they didn't see themselves being in the sector in five years time. That's a terrible situation in terms of skill, knowledgeability. But last year 37 per cent of people said they wouldn't be in the sector, they didn't see themselves so – and that's before the pandemic. So, really, someone – the buck has to stop with someone. The buck has to stop with someone and someone has to say aged care matters. Older Australians matter. And the workers who support those older Australians matter as well.

COMMISSIONER BRIGGS: Thank you. Thank you, Commissioner Pagone.

COMMISSIONER PAGONE: Yes, thank you Commissioner Briggs. And thank you to each of the three panellists. I think you can reasonably sure that a great deal of what you had to say today will have come as a surprise to many, and many would

respond as Commissioner Briggs has expressed, as one of being shocked by what we've heard. We thank you for having taken the time to make the submissions and to give us the information you have and being available for the questions, particularly for the very sound, practical and reasonable suggestions that you have made about how the quality and care of older Australians at this very moment can be improved. So thank you very much. We now formally excuse you from further attendance. Thank you.

MS SMITH: Thanks, Commissioner.

<THE WITNESSES WITHDREW [12.57 pm]

COMMISSIONER PAGONE: Mr Bolster.

MR BOLSTER: We were due to finish - - -

COMMISSIONER PAGONE: A little earlier. So if we resume at 2 o'clock, is that likely to be problematic?

MR BOLSTER: That's really a question for Mr Rozen. I think - - -

COMMISSIONER PAGONE: I think his instructor is giving me an indication that that is acceptable.

MR BOLSTER: If it's acceptable to him, it's acceptable to me.

MR ROZEN: It is.

COMMISSIONER PAGONE: All right. Well, 2 o'clock.

MR BOLSTER: Thank you.

ADJOURNED [12.58 pm]

RESUMED [2.00 pm]

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioner. The last witnesses that we will call as part of this three-day hearing are four Commonwealth Government witnesses. I call Mr Michael Lye, Ms Janet Anderson, Dr Melanie Wroth and Professor Brendan Murphy.

<MICHAEL PATRICK LYE, SWORN [2.00 pm]

<JANET MARY ANDERSON, AFFIRMED

<BRENDAN FRANCIS MURPHY, AFFIRMED

<MELANIE WROTH, AFFIRMED

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Ms Amundsen. If I can start with you, Mr Lye, please, you're the - - -

PROF MURPHY: Commissioners, could I – could I crave your indulgence, Commissioner, and ask if it's possible if I could make a very, very brief opening statement to respond to some of the statements made by the counsel assisting in his opening address on Monday, where it was alleged that the Australian Government has not planned or prepared for the impact of COVID-19 and, as a result, we have had a high death rate. Neither of those statements is accurate, and none of the witnesses today have been asked to respond to those issues, and I think it would be reasonable if I could make the very briefest of two-minute opening comments on that, if the Commissioners would give me that indulgence.

COMMISSIONER PAGONE: Professor, I think this comes a little bit out of left field for us and it may be difficult to accommodate with the timeframe that counsel has in mind. Certainly this is the first I have heard of the request. Mr Rozen, I don't know whether that causes you difficulty at this stage or whether you have known about this request before, having heard it just then. It may be, Professor, that it might be best to deal with it at the end, subject to timing. Mr Rozen, do you have a view about this?

MR ROZEN: Yes, if I could respond, please, Commissioner Pagone. I have not heard of this request until now, and it's not an indulgence that any other witness has been granted and, in my submission, it would be inappropriate for Professor Murphy to be granted that indulgence. Having said that, I propose to ask a number of witnesses, including Professor Murphy, questions which will give him the opportunity to address the matters in the usual way in response to questions from counsel assisting.

COMMISSIONER PAGONE: Yes. I think - - -

PROF MURPHY: Commissioners, could I then request, if that's not allowed, that, if time permitting, I could be able to give this statement at the end because making

this statement, which would only take three minutes, I think more accurately would address our serious concerns about those statements than simply answering questions. So if your indulgence at the time allows it at the end, I would greatly appreciate that opportunity because some of the statements, as you've seen reported in the media, have caused grave concern and we do feel that there should be an opportunity to redress those statements.

COMMISSIONER PAGONE: Professor, I don't want to cause any further difficulties, but perhaps what we might do is adjourn momentarily so that I can consult with Commissioner Briggs and then resume in a moment. If we could possibly adjourn momentarily.

ADJOURNED **[2.04 pm]**

RESUMED **[2.04 pm]**

MS ENGLAND: Ms Briggs, it's Michelle England for Anglicare. I feel I should tell you that it's being broadcast at the moment.

COMMISSIONER BRIGGS: Thank you. Thank you. I might take a call from Commissioner Pagone. Clearly, we're in separate cities, so this is a bit difficult.

MS ENGLAND: Thank you.

COMMISSIONER BRIGGS: Thank you for letting me know.

MS ENGLAND: You're welcome.

ADJOURNED **[2.05 pm]**

RESUMED **[2.07 pm]**

COMMISSIONER BRIGGS: Excuse me, Commissioner Pagone. I don't have sound at my end. I'm not sure whether others do.

MR ROZEN: I can't hear you either, Commissioner Pagone.

COMMISSIONER PAGONE: Commissioner Briggs, are you now back on?

COMMISSIONER BRIGGS: Yes, I am, thank you.

COMMISSIONER PAGONE: Okay. So I started addressing the request that came from Professor Murphy, and I began really by saying that I hope that what I am about to say doesn't become itself one of the stories rather than just a procedural matter. So I hope people understand that all I am trying to do, really, is to proceed in a disciplined and proper way. It's not usual for any of the parties that have appeared before us to be given an opportunity to make a statement about what has appeared in the media, and, indeed, when I say it's not usual, it's never been done in the course of this Commission and I really don't propose for that to occur today.

That's not to say that I endorse everything that appears in the media, nor is it to say that we don't think that there may be something that needs to be responded to in the media, nor is it to deny anybody the opportunity to make submissions to us in the usual way, but we are really in control of the procedure that we have and we just need to continue with that. We're mindful of the significance of the issues and the sensitivities of the issues, but I think that just highlights the importance to maintain the processes as rigorously as we are doing, and, Professor, I do hope that such concerns as you have may be capable of being resolved during the course of the questions. But, really, the focus of today is not in order for different positions to be put in response to what appears in the media but, rather, for our inquiries to continue in the way they have. So I hope - - -

PROF MURPHY: Commissioner, could I say it's not so much the media we were responding to; it was the – what we believe the inaccurate statements by senior counsel assisting which were reported in the media, but it was those statements by senior counsel assisting that I wish to respond to, not what was reported in the media. But I accept your ruling, and could we then at least enable us to make a submission of – of a statement pertaining to those inaccurate statements to the Commission? Would you accept such a submission from us?

COMMISSIONER PAGONE: We will certainly accept submissions, Professor. We've now got – there we go. I hope you can still hear me. There seems to be one or two technical difficulties. But, Professor, the Commonwealth is certainly able to put in submissions. Indeed, we welcome submissions, and I'm sure that I sure I speak for counsel, as well as Commissioner Briggs and me, that if there's anything that's been said that is wrong, we want to know about it. So we positively encourage submissions to clear up any mistake that may have occurred. So Mr Rozen.

MR ROZEN: Thank you, Commissioner Pagone. I should just place on record that Professor Murphy became part of this panel at the request of the solicitors acting for the Commonwealth, a request that was received by the Royal Commission's solicitors late on Monday. We acceded to that request, or I did, rather, and on Tuesday morning, the solicitors for the Royal Commission wrote to the Commonwealth solicitors inviting Professor Murphy to provide the Royal Commission with a precis of his evidence, given the short timeframe, and a precis of Professor Murphy's evidence has not been forthcoming. There has been some correspondence about it. I make no criticism of the professor but that is the position.

Now, back to where I was with you, Mr Lye. Sorry for that interruption. You are the Deputy Secretary for Ageing and Aged Care within the Commonwealth Department of Health; is that right?

MR LYE: That's right.

MR ROZEN: It's a position you have held since December 2019?

MR LYE: That's correct.

MR ROZEN: And, in summary, in that position, you oversee the department's aged care policy division; is that right?

MR LYE: That's correct.

MR ROZEN: And are you the senior most official within the Commonwealth Department of Health with responsibility solely for aged care?

MR LYE: That's correct.

MR ROZEN: Thank you. You have very helpfully provided the Royal Commission with a statement of 17 July 2020; is that correct?

MR LYE: Yes, counsel.

MR ROZEN: Yes. And the code the WIT.0773.0001.0001. It is behind tab 1 in the witness folder. Mr Lye, have you had an opportunity to read through your statement before coming along to give evidence this afternoon?

MR LYE: I have.

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

MR LYE: No.

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

MR LYE: Yes.

MR ROZEN: I tender the statement of Michael Lye dated 17 July 2020.

COMMISSIONER PAGONE: That will be exhibit 18-20.

EXHIBIT #18-20 STATEMENT OF MICHAEL LYE DATED 17/07/2020 (WIT.0773.0001.0001)

MR ROZEN: Thank you, Commissioner Pagone. Ms Anderson, you're the Inaugural Aged Care Quality and Safety Commissioner, a position you have held since 1 January 2019; is that right?

MS ANDERSON: Yes, that's right.

MR ROZEN: You provided an earlier statement to the Royal Commission dated 4 February 2019. You've set out your full qualifications, background and experience in that statement; is that right?

MS ANDERSON: Yes.

MR ROZEN: We don't need to repeat that in detail; that is before the Commission, but for the purposes of this hearing, you've made a statement dated 3 August 2020; is that right?

MS ANDERSON: Yes.

MR ROZEN: Yes, and that's WIT.0772.0001.0001. And is there anything in your statement you would like to change?

MS ANDERSON: No.

MR ROZEN: Are its contents true and correct?

MS ANDERSON: Yes.

MR ROZEN: I tender the statement of Janet Anderson dated 3 August 2020.

COMMISSIONER PAGONE: That's exhibit 18-21.

EXHIBIT #18-21 STATEMENT OF JANET ANDERSON DATED 03/08/2020 (WIT.0772.0001.0001)

MR ROZEN: Thank you, Commissioner Pagone. Dr Wroth, is that the correct pronunciation of your surname?

DR WROTH: No, it's not, actually. It's Wroth, but it's usually - - -

MR ROZEN: I do apologise. I'm glad I asked.

DR WROTH: It's all right.

MR ROZEN: You're the Chief Clinical Advisor to the Aged Care Quality and Safety Commissioner; is that right?

DR WROTH: Yes. Correct, yes.

MR ROZEN: And that's a position you have held since May 2019?

DR WROTH: Yes.

MR ROZEN: It's a statutory office under the Aged Care Quality and Safety Commission Act 2018?

COMMISSIONER BRIGGS: No.

DR WROTH: No.

MR ROZEN: It's not.

COMMISSIONER BRIGGS: No, it's not.

DR WROTH: The Commissioner's correcting me. It's an – it's an office that is described in the Act.

MR ROZEN: I see. All right. It's a – I accept the fine distinction. And you're a senior staff specialist in geriatric medicine at the Royal Prince Alfred Hospital?

MS ANDERSON: Yes.

MR ROZEN: And you've held that position since 2005?

DR WROTH: Correct.

MR ROZEN: And the role you perform with the Commission – the clinical adviser role – is that a full-time position?

DR WROTH: It's four days a week. It's a point 8 position.

MR ROZEN: Right. Thank you.

DR WROTH: I still do one day a week in clinical geriatrics.

COMMISSIONER PAGONE: Mr Rozen, a note has been given to me. I understand that counsel for the Commonwealth wants to make a submission of some kind.

MR ROZEN: Can we – well, of course.

COMMISSIONER PAGONE: Do we have a counsel for the Commonwealth?

MR ROZEN: Ms Morgan, I think.

COMMISSIONER PAGONE: All right. Perhaps in view of the difficulties surrounding the – yes, there we are, Ms Morgan. We can't hear you, though.

MS MORGAN: Commissioner, it's Ms Morgan. I'm very sorry; there have been difficulties here. I wanted to interrupt earlier when you were discussing with Professor Murphy in relation to the Commonwealth providing a submission. Professor Murphy has managed in the limited time available to put together a signed statement that we can send through to the Commission now, if that may assist. I understand, obviously, Mr Rozen will not have had access to that document. It will address at a factual level, not a submission level, the matters raised on Monday which were not sought from our witnesses. And that is what Professor Murphy was seeking to address earlier.

COMMISSIONER PAGONE: Ms Morgan, I think that is probably something that you really could have taken offline rather than occupy space of the Commission time. But anyway, it has been done now and I will leave you and your instructors to deal with the Commission instructors and counsel.

MS MORGAN: Thank you.

COMMISSIONER PAGONE: Back to you, Mr Rozen.

MR ROZEN: Thank you, Commissioner Pagone. I think we're up to you, Professor Murphy. Professor, you are the secretary of the Department of Health?

PROF MURPHY: Correct.

MR ROZEN: And you're the former chief health officer of the Commonwealth.

PROF MURPHY: Chief Medical Officer of the Commonwealth, yes.

MR ROZEN: I do apologise. For how long were you the Chief Medical Officer of the Commonwealth?

PROF MURPHY: For approximately three and a half years, up until the end of June this year.

MR ROZEN: In that capacity, you were the chair of the AHPPC. You might have to help me with the acronym; the Australian Health - - -

PROF MURPHY: Protection Principal Committee.

MR ROZEN: Yes, thank you. And you were the chair during the time that you were the Chief Medical Officer?

PROF MURPHY: Correct.

MR ROZEN: That committee's members are the chief health officers or chief medical officers from the Commonwealth, the States and the Territories; is that right?

PROF MURPHY: They are the core composition but we – there are a range of other experts on the committee including emergency management, defence force and public health laboratory and we co-opted some – a series of expert academics on to the HPPC for the duration of the pandemic, so it's much larger – it's about twice the size of that chief health officer core contingent but it has got a broad expertise.

MR ROZEN: I see. Just in relation to that, of the core group, none of them is a geriatrician or has any particular aged care experience; is that right?

PROF MURPHY: No, not of that core group, because this was an overarching public health response committee but clearly we have sought much input from geriatricians and aged care specialists over the course of our deliberation.

MR ROZEN: Can you perhaps provide us with a little more detail about that, because it is of interest.

PROF MURPHY: Well, for example, in our foundational coronavirus outbreak plan for residential aged care facilities that was launched in March this year, which is a very comprehensive plan of preparedness, preparation and response, that was produced by a subcommittee of HPPC but there was significant advice from Dr Wroth who provided input into it and we sought at every stage sector, when we've had aged care advice, sector engagement with geriatricians, aged care peaks and we have – not all of the aged care academics in the country have felt that they have been given an opportunity to contribute but we have sought the experts that we believe were the best available at the time. And Dr Wroth can talk about her involvement in this foundational and comprehensive plan that we launched in early March.

MR ROZEN: Thank you. Professor Murphy, I will have to ask you in your answers to just answer the questions that I ask. We have got a lot to get through in not very much time with four witnesses.

PROF MURPHY: Understood, counsel.

MR ROZEN: Thank you, Professor Murphy. Your instructors have provided us with a CV for you. It's RCD.9999.0443.0042. Have you seen that document before coming along this afternoon; I assume you have.

PROF MURPHY: Yes, I have.

MR ROZEN: It's not part of the tender bundle presently, Commissioners, so I think it will be appropriate to tender Professor Murphy's CV.

COMMISSIONER PAGONE: Yes, exhibit 18-23.

EXHIBIT #18-23 CV OF PROFESSOR MURPHY (RCD.9999.0443.0042)

MR ROZEN: The first question for you, Mr Lye; did you hear the evidence of Professor Ibrahim this morning?

MR LYE: Some of it; not all of it.

MR ROZEN: You may have heard the interchange between the professor and myself about how Australia fared compared to other like countries in relation to the proportion of COVID-19 deaths that are made up of residential aged care residents. And I will just read to you from the transcript of the professor's evidence comparing Australia to countries like France, Germany, Belgium, Canada, Ireland and Denmark. He said:

> *We would probably be the second or third highest rate of death in residential aged care. Canada had the highest rate of approximately 80 per cent from residential aged care and we are faring very badly.*

The evidence before the Commission is that the proportion presently is somewhere in the vicinity of 70 per cent. It is increasing on a daily basis with the news coming out of Victoria. I will ask you, Mr Lye, holding the position that you do, why is Australia faring so badly compared to other countries?

MR LYE: Counsel, if it's acceptable, I would like to defer that question to Professor Murphy who actually is expert in this area, and I believe can assist with those – with that.

MR ROZEN: No, I don't want Professor Murphy to answer the question, Mr Lye. I'm asking you. You told us you were the senior most official with aged care responsibility within the Commonwealth Department of Health, and I would like you to answer the question, please.

MR LYE: So it will be essentially the – that the problem with the formulation that I understand Professor Ibrahim has given is that in looking at a percentage across countries without looking at the actual incidence of COVID-19 in those countries and, in fact, the mortality rate from those countries, that it unfairly makes Australia look as though there is a larger problem than there is. I will give you an example. New Zealand is a country where there has been extremely low mortality in relation – and recognised in relation to COVID-19, and yet around 73 per cent of the deaths in New Zealand have occurred in aged care.

Now, every death – you must understand this, that we believe every death that has occurred in aged care is an absolute tragedy and we are – spend every day trying to make sure that we – that we prevent deaths. But nonetheless, given the nature of the COVID and its preponderance with – its preponderance to affect the frail aged population that where – where it takes hold, then we necessarily see that result. So

Australia has a very, very low death rate in relation to COVID. But the percentage of that very low rate is – is – has been found in the aged population including in aged care. Our death rate in – in aged care is 1.5 per cent of the – of the aged care population – sorry, 0.1 per cent of the death rate in the aged care population.

And you could compare that to the United Kingdom where it is five per cent and there have been nearly 20,000 deaths. And in the case of the UK, unlike Australia, there has been not particularly good recording of deaths in aged care facilities. So we would strongly reject that the – that the kind of comparison that Professor Ibrahim has made, that should not be taken as a – in any way that we are not acutely concerned about every – every death in aged care and that we do not have very advanced plans to try and combat that.

MR ROZEN: Thank you, Mr Lye. I don't understand the unfairness of the comparison. Surely, comparing on a proportionate basis rather than an absolute number basis is the only fair comparison between these countries?

MR LYE: Well, I mean, I don't – I mean, I think the New Zealand example is a good one in the sense that New Zealand and Australia are very, very, very low down the order in terms of the impact of COVID in their total populations. And – and yet we're getting that very low number, there's a large percentage of – of the deaths that are attributable to the older population. We do know in relation to COVID that the average age of – of the population who succumb to COVID are – are the older population. And so the – the – given the level of community transmission in – in Victoria at the present time, it then follows that the large proposition of deaths within that very small number are occurring amongst our aged population including in the aged care sector.

MR ROZEN: You don't take issue with the figure of 68 per cent, do you?

MR LYE: Well, look, I haven't seen Professor Ibrahim's figures but I don't take issue that the percentage of the small number of deaths is – is high.

MR ROZEN: Okay. Thank you. If I can turn, then, to the question of the planning arrangements that were in place towards the start of the year. We know that the pandemic declaration was made by the World Health Organisation on 30 January 2020. And there have been media reports – as Professor Murphy has said – in which both the Aged Care Minister, Senator Colbeck, and the Chief Medical Officer, Dr Kelly, have referred to a document prepared by the Communicable Diseases Network Australia as part of – or perhaps the main part of the planning that was done by the Commonwealth Government in relation to aged care. I want to ask you, Mr Lye, firstly, some questions about that document, and Professor Murphy, you will have the opportunity to address that as well.

Firstly, if I could ask for the document to be brought up on the screen so that you can see what I'm talking about. We have three versions of the document. The first is at tab 7 of the general tender bundle. And I would ask that that be brought up. If I

could just clarify to make sure – sorry, that's the second version, I think. The first version is at tab 71, my apologies. No, I'm sorry.

PROF MURPHY: Counsel, if it assists, I have the plan here.

MR ROZEN: It would be helpful to have it on the screen. There seems to have been some mix up. Could we try tab 72 and cross our fingers. Thank you. Can you confirm for us, Mr Lye, that this is the national Guidelines for Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia to which reference has been made in the media by Senator Colbeck and Dr Kelly?

MR LYE: I'm sorry, counsel, we don't have it on the screen.

MR ROZEN: My apologies. I'm not sure why; it's on the screen I am looking at. Did you say you have a hard copy of this in front of you, Mr Lye?

MR LYE: I do, yes.

MR ROZEN: You have this version do you, version number 1?

MR LYE: My version is the current version.

MR ROZEN: Version 3, is it?

MR LYE: I believe so.

MR ROZEN: All right. Okay. I think, for present purposes, the questions I need to ask you can be asked in relation to version 3. Just for clarification, this document, the first version, was produced on 13 March 2020; you agree with that? I think you can see the date, can't you, on the front of the one you are looking at?

MR LYE: Yes, I think that was the point it was released. Yes.

MR ROZEN: Yes, first released then, and then there was a version 2 which was published on 30 April 2020.

MR LYE: Correct.

MR ROZEN: And the current version, the one you are looking at, is 14 July 2020.

MR LYE: Yes.

MR ROZEN: And I think, to assist everyone, I'll ask the current version be brought up, which is tab 79 in the general tender bundle, and apologies to the operator. Thank you. Firstly, can I ask you about the Communicable Diseases Network Australia, or CDNA. It has 24 members; is that right, do you know, Mr Lye?

MR LYE: I do – I do have a list here of the membership of the CDNA.

MR ROZEN: Okay.

MR LYE: And - - -

MR ROZEN: Not – sorry.

MR LYE: That looks about right.

MR ROZEN: All right. Well, that was my counting. All of them Commonwealth department officers from the Health Protection Officer; is that right?

MR LYE: That's correct.

MR ROZEN: It has representatives of the States, Territories, New Zealand, a number of other organisations, Food Standards, it has an Aboriginal and Torres Strait Islanders expert and other members; is that right?

MR LYE: That's correct.

MR ROZEN: It doesn't seem to have anyone who is an aged care representative or a geriatrician, for example; do you agree with that?

MR LYE: I do, but I would just reiterate what Professor Murphy said, and that is in the formulation of the work that the CDNA does, that they draw on expertise for that, and in relation to aged care, that did include geriatrician advice.

MR ROZEN: Are you able to tell us who was consulted?

MR LYE: Well, I would point to one of the witnesses here, Dr Melanie Wroth, from the Aged Care Commission.

MR ROZEN: One of the features of this document that I imagine that you would point to as being part of the planning that was done by the Commonwealth Government in relation to COVID in aged care was the identification of roles and responsibilities of key levels of government. Would you agree with that, that's an important part of the planning process?

MR LYE: Yes.

MR ROZEN: Just in relation to the title of this, it's not actually entitled a plan, is it? It's entitled Guidelines. Do you see that on the front page?

MR LYE: It's – yes. Yes.

MR ROZEN: In relation to the identification of roles and responsibilities, if we look at page 2 of the document, we'll see that – that is a different version to the one I am looking at, unfortunately. My apologies. You'll see the identification of the responsibilities of a residential care facility. Do you see that, just down from the top of the page?

MR LYE: Yes.

MR ROZEN: And then if we scroll down the page, we can see the State/Territory Department of Health is identified.

MR LYE: Correct.

MR ROZEN: Under that, the Aged Care Quality and Safety Commission. Do you see that?

MR LYE: Yes. Yes.

MR ROZEN: And then at the bottom, the Australian Government Department of Health. It's the case, isn't it, Mr Lye, that in the first two versions of this document, of this key Commonwealth Government document, the Australian Government Department of Health was not identified as having a role in relation to responding to COVID-19 in residential aged care facilities. Do you agree with that?

MR LYE: Well, I haven't – I haven't got that version with me, counsel. I haven't got those previous versions with me.

MR ROZEN: Right. So you don't know - - -

MR LYE: Yes.

MR ROZEN: - - - whether the Australian Government Department of Health was - - -

MR LYE: Well, I know that – I know that – I can tell you most assuredly that from early January – that the Department of Health had a leading role. I can't – I can't – I haven't got the older versions of the document, but I can tell you the role we've played.

MR ROZEN: No, that's not the question I'm asking you. The question I'm asking you is - - -

MR LYE: I understand. I understand.

MR ROZEN: ..... document. And you're telling me you don't know the answer to that?

MR LYE: Well I'm just saying to you that I haven't got the earlier versions with me, so - - -

MR ROZEN: ..... you're telling me, though, that you don't know. I know you don't have them in front of you, but you don't know whether the Australian Department of Health was mentioned - - -

MR LYE: What I'm – what I'm saying to you is that I am most assuredly sure about our role and the role we played in this formulation of this – these set of guidelines, this plan, that's – that's nested within the broader pandemic response that has been developed through AHPPC for the Department of Health. We've been very clear about our role and we've exercised that role - - -

MR ROZEN: Mr Lye - - -

MR LYE: - - - since early January. So I – I – look, counsel, I don't want to argue that – whether the Australian Government role was in the first version of the document or not, but it is in there – it is in this version that I have in front of me, and I can tell you that we have exercised that role.

MR ROZEN: Mr Lye, you're going to have to just try and confine yourself to answering my questions, if you could, please. I don't want to be rude, but it'll – we have a lot to get through, and it will be difficult enough to do it in the time. I'll ask you to accept from me that there is no reference at all to the Australian Government's role in relation to aged care in either of the first version of this document or the second. Does that surprise you?

MR LYE: Well, it's a – yes, look, it's our document, counsel, so it's – it's – it's an Australian Government document that deals with aged care. So it's possible that the first version that that was implicit and then it has been made explicit in – in future versions.

MR ROZEN: Did Professor Murphy just whisper to you the answer he suggest you give, Mr Lye?

PROF MURPHY: I just – I just said it was an Australian Government document, which – which it is. I was just - - -

MR ROZEN: Mr Lye, was this document checked – the first version of this document checked by the department before it was released?

MR LYE: Well, it would have been, but I think that the answer that it's – it's a – it's obviously - - -

MR ROZEN: ..... you've answered the question. So you think it would have been checked and, what, you're telling me no one noticed that there was no reference to the Federal Government's role?

MR LYE: Well, I said to you that the – because it's a Commonwealth document, a document emanating from the Department of Health, that the – it might have been implicit, our role, and that that has been made explicit. I know that – I can say to you that in relation to over the course of the pandemic, that we've had an awful lot of feedback from the people who are the end users of this document in the aged care sector, and - - -

MR ROZEN: Mr Lye, can you please confine yourself to answering my questions.

MR LYE: Well, I'm trying to answer the substance of it, counsel. I - - -

MR ROZEN: .....

MR LYE: I'm honestly trying to answer the substance of it.

MR ROZEN: It's a very simple question. You think this document would have been checked by the department without anyone noticing that it failed to refer to the Australian Government's role. Is that a fair summary of your evidence?

MR LYE: I think the document would have been checked.

MR ROZEN: Yes.

MR LYE: And that the Commonwealth role would have been implicit in the document and probably needed to be made explicit.

MR ROZEN: Yes. And not only was it not mentioned in the first version, but the second version, which came out after the Dorothy Henderson Lodge and Newmarch House incidents, was no doubt intended to be an update of the document taking into account new knowledge and the experience of those early outbreaks; is that right?

MR LYE: I can't say to you that it directly followed those outbreaks, but certainly – what I would say is that the – those – the lessons learnt from those outbreaks have been incorporated in all our materials - - -

MR ROZEN: Yes.

MR LYE: - - - and all our communications with the sector.

MR ROZEN: Let's just stick with this document, but that was the idea of putting out a second version. It was an update for the sector. As the science was developing and as you were learning about the effect of the virus in the aged care facilities, an update was put out on 30 April; is that right?

MR LYE: I think that's a fair assessment, yes.

MR ROZEN: Right. And, yet again, it did not contain a reference to the Federal Government's role. Once again, was the second version checked by your department before it went out?

MR LYE: Yes, it would have been, yes.

MR ROZEN: And your explanation is that it was implicit, because it was produced by the Federal Government, that the Federal Government had a role .....

MR LYE: That's right, and – yes. Yes.

MR ROZEN: Are you still unable to see the screen, Mr Lye?

MR LYE: No, counsel, I can see it now.

MR ROZEN: Okay. Perhaps we can go back, then, to tab 7, which is the version 2, 30 April 2020. And if we can just highlight the bottom paragraph, please, on that first page. You can see there that it says:

> *The membership of CDNA and AHPPC and the Commonwealth of Australia, as represented by the Department of Health, the Department, do not warrant or represent that the information contained in the guideline is accurate, current or complete.*

What sort of message are you sending to the sector that's looking to this document to assist it in responding to this novel virus by telling them that they shouldn't assume that the document, the guideline, is accurate, current or complete?

MR LYE: Counsel, I – I – that – I would – I would need to confer with the AHPPC as to the – as to why they would put commentary of that regard into it. I could say to you that - - -

MR ROZEN: It's said to be on behalf of your department, Mr Lye.

MR LYE: Sorry?

MR ROZEN: It's said to be on behalf of your department as well as the AHPPC. So why is your department including a statement like that in a document which is intended to provide guidance for the sector?

MR LYE: Look, the – the – the only reason I can give you for that is that the, – you know, the – the way in which the aged care sector is – is funded by government, it's obviously a – it's not a government service. It's a, in large part, not-for-profit and for-profit service delivery system, and that, as the document makes clear, residential aged care facilities have primary responsibility for the management of their – their service. And so they need to exercise judgment within their own legal

responsibilities. And so as a distributed service, we – we can't assume that responsibility from them.

PROF MURPHY: Counsel, I could assist if you wish.

MR ROZEN: No, I'm happy to hear Mr Lye's answer, Professor Murphy, and then I'll ask you to assist. Mr Lye, it's not a question of responsibility; it's a question of accuracy, isn't it? This says that, "We're not warranting what is in here is accurate, current or complete." Why would you have felt the need to put that rider on a document intended to be a guiding response by the sector to COVID-19? Mr Lye?

MR LYE: Counsel, I would have to – I would have to confer with someone from the AHPPC and – and the CDNA.

MR ROZEN: Professor Murphy, are you able to help us?

PROF MURPHY: I can, certainly, counsel. This is a standard disclaimer. Unfortunately, we do what our lawyers advise. CDNA guidelines have – are always living documents that change from time to time, and legal advice that the Commonwealth has had over many years on many such guidelines say that this sort of disclaimer should be put in just to avoid them being used in – they're meant for clinicians and to guide health care. They're not meant to provide the basis for legal action in the future. So it's just simply our advice, standard advice, from our – our solicitors. It's on all of the CDNA similar documents. It doesn't reflect any lack of – of conviction or accuracy in these documents. Just a standard disclaimer.

MR ROZEN: Thank you, Professor Murphy. One other matter of detail before we leave this document. If I can go to the – and I'm sorry to jump you around the versions. If we can go back to tab 72, please ..... version. And if we can go to page 11, please. Sorry. The pagination is a bit different to the one in front of me. I do apologise. Section 3.1.3. Do you have this physically in front of you, Mr Lye? I don't think you do, do you?

MR LYE: No.

MR ROZEN: Let's go to the one at tab 7, version 2, please, and to page .0033. Workforce management is obviously a very important part of the advice that needed to be conveyed to the sector in relation to responding to COVID-19. Do you agree with that, Professor Murphy?

PROF MURPHY: Yes, indeed.

MR ROZEN: And when the first version of this document was produced back in March, there was an estimate included in it that a workforce management plan prepared by the sector should be able to cover a 20 to 30 per cent staff absentee rate. Are you familiar with that, Professor?

PROF MURPHY: Well, I wasn't – I haven't read that document for some time but I accept that statement, yes.

MR ROZEN: All right. You will see it there in the second paragraph highlighted - - -

PROF MURPHY: Correct.

MR ROZEN: ..... workforce management plan should be able to cover a 20 to 30 per cent staff absentee rate. Are you able to assist us with where that estimate came from, that 20 to 30 per cent absentee rate; why that figure was chosen as guidance?

PROF MURPHY: No, I can't, counsel. I would have to take advice on that. Presumably, it was the best available advice they had from the time from international experience which was – which was evolving. Clearly, we have seen examples where further absentee rates – much bigger absentee rates than that have been seen since then.

MR LYE: I might be able to help, counsel.

MR ROZEN: Thank you, Mr Lye.

MR LYE: I think it's the way you read this, but I think that our expectation of our providers would be that they had contemplated an absentee rate of between 20 and 30 per cent. As you would be aware, that in the COVID response that we devised we – we believed that it – it wasn't necessarily reasonable for an organisation to contemplate higher rates of absenteeism and we – as a result of COVID, and that we have used our rapid response – our workforce support surge program to come in and assist. Now, it is the case that in some instances we have helped organisations who might have had an absentee rate of between 20 and 30 per cent but we certainly think that, you know, it's – it's not necessarily reasonable for a service within our outbreak management plan to contemplate higher than that amount. Certainly, they can think about how they draw on extra resources but there's limits – we recognise there's limits to that.

MR ROZEN: Mr Lye, I'm going to have to ask you again to just try and answer my question. Do you know where those figures of 20 po 30 per cent came from; is that from some international standard or is it taken from previous experience, for example, with the influenza outbreaks; are you able to help us?

MR LYE: Yes, look, it will be – it will be – it will be both those things that it has come from, both domestic and international experience that we could draw together.

MR ROZEN: Yes. Perhaps I will bring you in here, Ms Anderson. That was a figure that was used in the self-assessment survey that you released on the 17th of March to the sector, was it not?

MS ANDERSON: Yes, that's correct, counsel.

MR ROZEN: Yes. And are you able to tell us where it came from, or did you just take it from that CDNA guideline?

MS ANDERSON: We based those questions largely on the CDNA guidelines, counsel.

MR ROZEN: Thank you. If I can go back to you, Professor Murphy, we've heard evidence earlier in the week from Mr Millard at Anglicare. His evidence was that in their planning for Newmarch House they thought 20 to 30 per cent was a bit light on; they thought it was likely that they might lose 30 to 40 per cent and they did their planning on that basis. And he said that in reality once the outbreak started on 11 April, that estimate – the 30 to 40 per cent estimate was totally unrealistic. They were the words that he used to describe that. He told us that he lost more than 80 per cent of his staff. You were aware of that, weren't you, Professor Murphy, at around about the time of the Newmarch House outbreak, that that was the experience of the provider?

PROF MURPHY: Absolutely, counsel, that there had been a number of instances where very large no-show rates and quarantining in isolation have led to significant workforce loss in excess of that. Whether it's reasonable for the facility to meet that rather than the extra surge we put in place is another question.

MR ROZEN: Yes, that was also the experience of Dorothy Henderson Lodge, wasn't it; they lost a good deal more than 20 to 30 per cent of their staff in the outbreak in March, Professor Murphy?

PROF MURPHY: Correct.

MR ROZEN: Yes. And in fact, it was their experience that led the Commonwealth to develop – to prepare the surge workforce, wasn't it?

PROF MURPHY: No, counsel, it was not. It was early engagement with the sector in very early planning shared by Minister Colbeck that I attended where we all recognised that there would be circumstances where workforce shortages would eventuate and we set up at that stage to pre-emptively plan a surge workforce and first responder workforce prior to any significant outbreaks.

MR ROZEN: But that's not right, is it, Professor Murphy? Mr Lye's statement tells us that contracts with Mable and Aspen to provide the surge workforce were entered into after the Dorothy Henderson Lodge experience. Is he wrong about that?

PROF MURPHY: Well, the planning took place well before that, counsel. The contracts were – there was a big process to engage and contract people. The contracts were entered into after that, but that process started before the Dorothy Henderson Lodge outbreak.

MR LYE: And counsel, in relation to Dorothy Henderson, the – the grant program which took some time to set up within Commonwealth rules. We had an arrangement with BaptistCare that they were noting the cost of their – of the surge workforce response and then they put an application in after the outbreak through that program.

MR ROZEN: It's right, isn't it, Mr Lye, the contracts for Mable and Aspen were entered into after the Dorothy Henderson Lodge outbreak?

MR LYE: That's correct. That's correct.

MR ROZEN: All right. If I could just move to the third version, and before it's brought up, I think you – Professor Murphy, you agreed earlier – or it may have been Mr Lye – that the intention of producing iterations of this document was to update as new information came to hand about the virus and about the experience of providers in responding to it. Is that right?

PROF MURPHY: Correct.

MR ROZEN: And one of the new bits of information that clearly emerged from both Dorothy Henderson Lodge and Newmarch House was that as Mr Millard put it in his evidence earlier in the week, the estimate of 20 to 30 per cent was totally unrealistic. That was your understanding of how things were panning out, wasn't it, Professor Murphy?

PROF MURPHY: I think the estimate of that as a workforce shortage was unrealistic. Whether it's unrealistic for a provider to make provision for any more than a 20 or 30 per cent internally is another matter.

MR ROZEN: Providers needed to know, didn't they, that in the event that they faced an outbreak that they were likely to lose considerably more than 20 to 30 per cent of their staff. It was an important learning from the Sydney outbreaks in March and April, was it not, Professor?

PROF MURPHY: Correct.

MR ROZEN: That's exactly the sort of thing one would expect to see updated in the third version of this guideline, isn't it?

PROF MURPHY: Well, I think the guideline – as I think Mr Lye has said, that was a workforce plan for the facility to – to be able to compensate for – we have recognised. That's why the surge capacity has been substantially increased over time since then because we have recognised that much more than that can be lost. So – so whether – but the provider is not really – it's not within their capability to provide for a surge greater than 20 to 30 per cent.

MR ROZEN: It's not a question of whether it's within their capability; it's a question of what information is being provided by the Commonwealth to the sector as to what they need to plan for ..... plan, isn't that - - -

MR LYE: Well, counsel, the nature of the outbreak and the impact on workforce has varied across all sites and Newmarch and Dorothy Henderson are notable for their high impact because of the nature of the way the virus took hold in those two facilities, but – and so, you know, if we looked across all of the outbreak sites, 20 to 30 per cent might end up still looking like a fair figure. But I think that we cannot ask a service – Newmarch is a great example. Anglicare has a national network where other services don't. We expect those organisations to draw on available workforce and help have a plan to bring available workforce in to assist alongside us.

But it is not reasonable to suggest that they should have a plan that could account for, say, 60 or 70 per cent of their workforce, even the biggest and most proficient providers would struggle at that level. And so we wanted them to have a plan to deal with that. We stood up a whole series of interventions to work alongside them because we knew this was a novel pandemic.

MR ROZEN: Mr Lye, this is not an opportunity for you to make speeches. I'm sorry, but you have to confine yourself to answering my question, please. My question is a simple one. Wasn't the purpose of putting out a third version of these guidelines to provide updated accurate information to the sector to assist providers to prepare for an outbreak of COVID. Is that right?

MR LYE: Yes. Yes

MR ROZEN: And one of the things that you had learnt from the experience of Dorothy Henderson Lodge and Newmarch House was that the estimate of 20 to 30 per cent, to use the words of Mr Millard, was totally unrealistic; correct?

MR LYE: In that instance.

MR ROZEN: In both those instances.

MR LYE: In those two instances, amongst many outbreaks.

MR ROZEN: Yes. But the planning needs to plan for the worst, doesn't it? Isn't that the idea of planning for an outbreak?

MR LYE: As I said before, the planning needs to plan for what the service is capable of managing alone and it should not – they should not be asked to plan for something that is not within their capability.

MR ROZEN: If we go to page 8 of this document, please.

COMMISSIONER PAGONE: Mr Rozen, just before you go there, Mr Rozen. I have had a message from our technicians. It appears that – and this is not meant in any way critical of anybody so please don't see it as such – but there's a bit of paper shuffling that is understandably taking place in Canberra – I don't mean that in any way other than physical movement of paper on the desk – which is making it difficult for the technicians to pick up the sound. I know it's difficult. I know you are doing your best but if you could just bear in mind when you are moving bits of paper that it gets magnified, amplified and is causing difficulties for the operators. Sorry, Mr Rozen.

MR ROZEN: Thank you. Sorry, it's native page 8; it's page 12 of the exhibit, please. Do you see the heading Workforce, Professor Murphy, in the middle of the page there?

PROF MURPHY: Yes. Yes.

MR ROZEN: The second paragraph is in the same terms as appeared in version 2:

> *The workforce management plan should be able to cover a 20 to 30 per cent staff absentee rate.*

Do you see that?

PROF MURPHY: Yes, counsel.

MR ROZEN: The sector should have been advised, shouldn't it, of the experience that you had gleaned from Dorothy Henderson Lodge and Newmarch House that planning for a 20 to 30 per cent staff absentee rate could well leave them far short of available workers; do you agree?

PROF MURPHY: The sector should have been advised that that is what they should plan for, but they were advised that we had ample capability of surge workforce should that be exceeded. So they were all aware that – and were made very aware in the early stages of an outbreak that if their workforce was not able to be managed within their local plan we would support them, as we have done.

MR ROZEN: Professor Murphy, I suggest to you that maintaining the 20 to 30 per cent figure when you knew, as you have told us, that the experience was far worse than that, was not providing accurate and helpful information to the sector. What do you say?

PROF MURPHY: I disagree with that, counsel, because as Mr Lye said we could not expect a provider to have a plan that – that enabled them to surge up more than 20 to 30 per cent. That was what we expected them to do. We advised them that in the unlikely event, as in a big outbreak, that if it was worse than that we would provide the extra surge report.

MR ROZEN: Another document that you would no doubt point the Commissioners to as part of the planning by the Commonwealth for the sector and responding to COVID is the first 24 hours document, which was released on 29 June. Are you familiar with that, Professor Murphy?

PROF MURPHY: I am, counsel.

MR ROZEN: Yes. It's at tab 31 of the general tender bundle. Perhaps if that could be brought up, please. This also contained information to assist the sector in workforce planning, did it not? Or it also does, I should say, include such information. It's not meant to be a trick question. Perhaps if we can go to page 5, please, 0005. Do you see the bottom section, number 14:

Bolster your staff and plan your roster.

Do you see that, Professor? Professor Murphy? Can you hear me, Professor Murphy?

COMMISSIONER PAGONE: The screen looks as though it has frozen, Mr Rozen.

MR ROZEN: Mr Lye, can you hear me? Should we perhaps stand down for a minute?

COMMISSIONER BRIGGS: Yes. Commissioner Pagone, the Commonwealth officials are in a room not far from me. I can go and see if we can get technical support, if needs be.

COMMISSIONER PAGONE: I think we do have technical support nearby, so that won't be necessary, but it's certainly not a bad idea to adjourn momentarily so that the technical people from here can talk to the technical people there and see whether the Commonwealth can be resuscitated.

COMMISSIONER BRIGGS: .....

MR ROZEN: Can we clarify quickly if they're back, by any chance. Professor Murphy, can you hear me? Back to plan A, I think, Commissioner Pagone.

COMMISSIONER PAGONE: All right. We'll momentarily adjourn and seek to resuscitate.

ADJOURNED **[3.02 pm]**

RESUMED **[3.06 pm]**

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: My apologies. Professor Murphy, can you hear me okay?

PROF MURPHY: I can, counsel.

MR ROZEN: Yes. Apologies for the technical difficulties. I got to a point where I was asking you about section 14 of this First 24 Hours document, which you'll see highlighted on the screen in front of you. Do you see that Professor?

PROF MURPHY: I do, counsel.

MR ROZEN: The advice that was being provided to the sector in this document, which was produced on 29 June, so some two weeks before the CDNA document – in the advice is:

> *Keep in mind up to 80 to 100 per cent of the workforce may need to isolate in a major outbreak.*

Which was the advice the sector is meant to rely upon, the 20 to 30 per cent or the 80 to 100 per cent?

PROF MURPHY: Both. Both, counsel. They're both separate pieces of information. 20 to 30 per cent is what we would expect the facility to be able to meet in their workforce plan. The 80 to 100 per cent is a worst case scenario that – it's information to give them that that has happened on a couple of occasions and that that may be an issue, but there was no expectation that they should meet that 80 to 100 per cent. So the two pieces of information are not inconsistent.

MR ROZEN: That's your evidence, is it, Professor Murphy? You don't see any - - -

PROF MURPHY: Yes, counsel.

MR ROZEN: I see.

PROF MURPHY: No, I don't, no, counsel.

MR ROZEN: Mr Lye, you don't see any conflict between the 20 to 30 per cent figure in the one document, the 80 to 100 in the other?

MR LYE: No. No, counsel. I think it – because when you read on, it kind of makes clear that – where the Commonwealth steps in to assist, where people can't fill a roster.

MR ROZEN: Thank you. While we've got this document open, can we please go back to page .0002, and I'd like to address some questions to you, Ms Anderson,

about this reporting question in section 3. Do you see the heading Contact The Commonwealth Department Of Health, Ms Anderson?

MS ANDERSON: Yes.

MR ROZEN: Yes. In relation to the requirement to report, as is apparent from this document, it was no mere administrative requirement; it was the trigger for the appointment by the Commonwealth, or it is the trigger for the appointment by the Commonwealth, of a case manager. Do you see that?

MS ANDERSON: Yes.

MR ROZEN: And the case manager's role is to connect providers with resources to manage the outbreak, including PPE, surge workforce, supplementary testing and access to primary and allied health care. Do you see that?

MS ANDERSON: Yes.

MR ROZEN: It's the report to the Commonwealth that triggers those various matters; is that how the process is intended to operate?

MS ANDERSON: That's the way it reads.

MR ROZEN: Yes. And as you are well aware, there have been reports recently in the media that in relation to a particular facility in Melbourne, which I won't name, but which – I think you are familiar with the one I'm talking about, that a report was made to an officer in your Commission of an outbreak at that provider, but I understand some four days passed before that information was conveyed to the Commonwealth Department of Health; is that right?

MS ANDERSON: The information was provided by the Department of Health and Human Services to the Commonwealth.

MR ROZEN: It wasn't provided by your agency?

MS ANDERSON: No. If you read the section above this one, counsel, you will note that there are two agencies who must be notified immediately on outbreak. I believe it's in the first 30 minutes, and one is the State public health unit and the second is the Commonwealth Department of Health. The provider reported in this instance that they had notified the public health unit.

MR ROZEN: Yes. I just want to understand, though, the role of your agency, putting the public health unit to one side. As I understand it, an officer in your agency was making a sort of routine assessment call to this provider, asking them a predetermined series of questions as part of your monitoring role. Is that right, Ms Anderson?

MS ANDERSON: This was a – a specific purpose exercise we mounted deliberately in line with the outbreak of the COVID-19 in Victoria.

MR ROZEN: Yes. The officer asked a series of questions, one of which was had the provider heard of or was the provider aware of this document. Is that right?

MS ANDERSON: Yes.

MR ROZEN: And another question was have they experienced an outbreak of COVID-19; is that right?

MS ANDERSON: Yes.

MR ROZEN: And in the event, the officer was – received an affirmative answer to each of those questions, that is, the provider had heard of the document and was experiencing an outbreak.

MS ANDERSON: And supplemented the second answer by indicating that they had advised the PHU.

MR ROZEN: But in any event, they hadn't complied with the second part of the reporting in 3, had they?

MS ANDERSON: No. Well, at least not on the report that they provided. I can't say they were complete in the response they offered to my regulatory official.

MR ROZEN: Yes. The important question as you well know, is that – why didn't your office convey that very important information to the Commonwealth Department of Health? Are you able to assist us in understanding why that didn't happen?

MS ANDERSON: Yes. I would be pleased to. The Commission is – the Aged Care Quality and Safety Commission is not a first responder. We do not appear in this document as the first responder. The first responders are the State public health unit and the Commonwealth Department of Health. So in undertaking an assessment contact by phone, when we were advised by the provider that they had an outbreak and they had notified the PHU, we moved on to the next question.

MR ROZEN: Well, that's - - -

MS ANDERSON: We are not - - -

MR ROZEN: I'm sorry. Do finish.

MS ANDERSON: No, I'm fine.

MR ROZEN: All right. That's really – that's the question that I want to try and understand. How is it that your officers don't join the dots on such vital information? Isn't the obvious next question – you know about the document and you've got an outbreak –"Have you alerted the Commonwealth Department of Health?" given how important that alert is. Why didn't your officer ask that, do you know?

MS ANDERSON: So I can't – I can't answer for the officer, counsel. I wasn't on the phone call.

MR ROZEN: No.

MS ANDERSON: I – in hindsight, that would appear to be something that we should have done, and we have now put into place an arrangement to ensure that happens routinely, notwithstanding that that is not our principal role.

MR ROZEN: Yes. If you just – the reason I'm pursuing this – it raises a broader question about whether there is, as my colleague Mr Gray described it back in the Brisbane hearing – whether there's a sufficient agree of curiosity on the part of the regulator to pursue issues like this beyond just ticking boxes on a list of questions that they have to ask the provider. Are you able to offer us any observations about that from your position as the head of the regulator?

MS ANDERSON: We don't tick boxes, counsel. The – we undertook thousands of telephone calls. We certainly have undertaken thousands of telephone calls over the last five months. I have deployed – redeployed staff from across the Commission to undertake this important activity. They have spoken to every single approved provider in the country twice. And we have also administered online surveys to every single service in the country. We are in the process of completing the second one of those. We - - -

MR ROZEN: Ms Anderson – sorry, do finish.

MS ANDERSON: Thank you. Where we find information which identifies a high level of risk of non-compliance with the quality standards, we act. We escalate that concern and we take – we – we consider it alongside other evidence that's available to us and we may even move to take a further regulatory response, as, indeed, we did from early March. We have undertaken 451 on-site visits between March and July - - -

MR ROZEN: Ms Anderson - - -

MS ANDERSON: - - - because we have been concerned – those are risk-based figures, counsel.

MR ROZEN: I'd ask you, please, once again, to try and answer my questions and we'll get through this much more quickly and cover the material that we need to. If I

can ask you about the self-assessment survey, which you've mentioned, that was sent out by you on 17 March at about the time that you ceased making unannounced visits to aged care facilities.

MS ANDERSON: In fact, the – when I look at the data more closely, the only months in which we haven't taken – undertaken unannounced visits was April. In every other month from March we have undertaken unannounced visits on a risk basis.

MR ROZEN: I'll just ask you to answer my question. That was – the two were coincidental, weren't they, sending out the self-assessment survey and the announcement that you would cease unannounced visits, albeit as you say, only for a limited period of time? Is that right?

MS ANDERSON: I don't have in front of me, counsel, the date on which we made that announcement.

MR ROZEN: Okay. Well, I will accept you accept from me that the survey was sent out on 17 March, and we have in the materials before the Commission the consolidated results of that survey. If they could please be brought up, it's general tender bundle tab 9. You'd be familiar with the survey results. This is the residential aged care survey, Ms Anderson. Are you familiar with these results?

MS ANDERSON: Yes.

MR ROZEN: Were you aware of the results before the date of this report, 20 May of this year? Were you given advance notice of the results that were coming back?

MS ANDERSON: I believe I was advised on a rolling basis as the surveys were returned.

MR ROZEN: You see the first question there:

Does the service have an infection control respiratory outbreak plan?

The evidence before the Commission in relation to Newmarch House is that the New South Wales Department of Health developed an outbreak management plan for Newmarch House because there wasn't one in place. Why wasn't that the question that was asked in the survey, "Do you have an outbreak management plan for COVID-19?"

MS ENGLAND: Michelle England for Anglicare. I object to the question.

COMMISSIONER PAGONE: Yes, and what's the basis, Ms England, of your objection?

MR ROZEN: I'll reword it, Commissioner Pagone.

MS ENGLAND: Simply that it needs to be made clear, Commissioner, whether it's an intergovernmental management plan or a local management plan, of which there are clear evidence that there were at least two in place for Anglicare.

MR ROZEN: I think I can meet the objection, Commissioner Pagone, in this way. Leaving aside the experience of Newmarch House, Ms Anderson, why wasn't the question,
"Do you have an outbreak management plan for COVID-19?"

MS ANDERSON: I don't know, counsel.

MR ROZEN: Did you – well, who compiled the questions for the survey?

MS ANDERSON: A number of my staff.

MR ROZEN: Okay. As you're aware, the results that came back indicated a very high level of preparedness, or at least an assessment by the sector that there was a very high level of preparedness for the pandemic. Do you agree with that general observation?

MS ANDERSON: There was some variability in the results. Overall, there did seem to be a degree of confidence, a large degree of confidence, that providers were ready in the event of a pandemic.

MR ROZEN: And were you surprised at that, given what you know of the sector and the many difficulties that a number of providers faced in relation to compliance with standards? Were you surprised at those assessments?

MS ANDERSON: We never took it as the only piece of evidence available to us, counsel. We're not a one-note regulator. We had many more inputs that we considered as we understood risk across the sector.

MR ROZEN: Well, that's not my question, though, Ms Anderson. Were you surprised at the results?

MS ANDERSON: The nuancing was not a surprise. There were numbers who identified that they could answer "yes" categorically and a further proportion who identified that they could answer "developing". But if you disaggregate those two sections, there was a far more nuanced picture across the sector, which I think is relevant.

MR ROZEN: Well, we know that over 40 per cent assessed themselves as best practice, didn't they? Is that right, Ms Anderson?

MS ANDERSON: Yes. Well, depending on the question, yes, the final question, yes.

MR ROZEN: The final question. In relation to everything, over 40 per cent assessed themselves as best practice, and we know one of those was Newmarch House, wasn't it?

MS ANDERSON: Yes.

MR ROZEN: Yes. And you had cause, ultimately, in relation to Newmarch House to issue them with a notice on 6 May in which you were critical of their infection, protection and control strategies and their general response to the outbreak in a way that Mr Millard, I think, said that you told him was the ICBM of regulatory action. I don't know if that is what you actually said but that's the case, though, isn't it, you issued them with a notice on 6 May? Ms Anderson.

MS ANDERSON: Yes, that notice was issued, correct.

MR ROZEN: Yes. The question then is what lessons did you learn from that as the regulator of the sector in relation to the sector's perception of its readiness for COVID-19? On the one hand, you've got Newmarch House saying we are best practice and then, when you actually investigated their circumstances, they were found to be anything but best practice. So what do you learn from that as a regulator, for example, about how much you can trust the sector in its self-assessments?

MS ANDERSON: Counsel, I met with the board. I have met with the board twice and we have had this very discussion. And the board was very candid with me in reflecting on their earlier assessment of their own performance and understanding that they had overestimated their readiness, and I think that would be a generally applicable view for those services who had experienced an outbreak. It is – it is a massively impactful event which has not been understood well in Australia until it has impacted aged care services, specifically.

MR ROZEN: So how did you use that information to guide the regulatory initiatives that you have engaged in since 20 May? Has it altered your regulatory approach to the sector?

MS ANDERSON: We have become more questioning, and we have deployed a number of additional regulatory activities in order to both prompt activity or action by providers. The self-assessment survey had two purposes. One was to provide – or give providers an opportunity of going through a checklist process for themselves. It also gave us some regulatory intelligence about their own view of their readiness. I mentioned earlier we are repeating a self-assessment survey with a different and larger set of questions, which is more deeply informed by the experiences of the sector to this point. As you can imagine, it is longer and it is multi-layered. It runs for a number of pages and we have been accused by some providers of regulatory burden, and we are determined that this is an important next step in making sure that providers have available to them the most detailed opportunity to assess their own level of readiness and then to report back to the regulator on it.

Counsel, if I may, and I know – I will be concise, but we have also managed over 4000 complaints since March, and they are also a very rich source of regulatory intelligence of the sector and the way in which they are performing and the way in which others perceive the safety and quality of care in a particular service.

MR ROZEN: Thank you. Can I ask you to have a look at a letter you wrote to the sector on – a statement, rather, that you made on 9 July. It's behind tab 49 of the general tender bundle:

> *Statement by Janet Anderson on response to COVID-19 situation in Victoria.*

Are you familiar with that statement, Ms Anderson?

MS ANDERSON: Yes.

MR ROZEN: It sets out a number of steps that you were taking at that time, some three weeks into the increase in community transmission in Victoria, and I just want to draw your attention to the fourth last paragraph on that page that starts "The regulatory officials"; that is your regulatory officials. Do you see that?

MS ANDERSON: Yes.

MR ROZEN: "will be seeking assurances" – it follows on from the description of telephoning providers:

> *... seeking assurances from providers that COVID response plans have been developed and are ready for immediate activation.*

If I can stop there; that telephone conversation where your officer learnt of the outbreak at that provider, that was part of this process, wasn't it, this seeking assurances?

MS ANDERSON: I would have to position this in time. What was – I'm sorry, counsel, what was the date of this communication?

MR ROZEN: The 9th of July was the date of the communication.

MS ANDERSON: Right. That would be among the issues that we were drawing on, yes.

MR BOLSTER: Yes.

MS ANDERSON: Recalling, though, that telephone calls had been undertaken on several occasions.

MR ROZEN: Yes, I understand that. My question is this, Ms Anderson, in light of the experience of that you recognise to be less trusting, I think was how you put it, of

the sector or more questioning, rather, was I think what you said; aren't you falling back into the same trap where you just – where your officers ring providers and seek assurances from them about preparedness. Isn't there a limit to how much can be achieved by that approach to regulation?

MS ANDERSON: Yes, there is a limit, and that's why we don't rely on it exclusively.

MR ROZEN: So what sort of auditing did you do as a follow-up of these assurances?

MS ANDERSON: Where we rated an individual service as high or very high risk, we would either make a remote position contact, we would make a phone call but it would be a rigorously structured interaction with the provider where we asked them the usual questions. We may on occasion – or we did on occasion ask for submission of particular information to us. And on other occasions where we had a heightened level of concern about what may have been an unmitigated risk, we undertook a site visit.

MR ROZEN: If I can bring you in here, please, Dr Wroth; I know you have been sitting there patiently. I want to ask you a question about the response at Newmarch House and perhaps if I could do it by asking you to look at an email which is in the Newmarch House tender bundle at tab 98. While that is being brought up, Dr Wroth, you were involved in some discussions around about 15, 16 and 17 April in which questions of whether either COVID-positive or COVID-negative residents should be removed from Newmarch House as part of the response. Do you recall that?

DR WROTH: Yes.

MR ROZEN: And the email I want to ask you about is towards – it's at the beginning of this email chain, it's on page .0732. And just to familiarise yourself with this but you're are not actually part of this email chain, Dr Wroth; it's an email from Lisa Peterson who is – she is a Commonwealth Department of Health officer based in Sydney, is she not, in the New South Wales office, is that right?

DR WROTH: That's what I'm reading, yes, from Lisa Peterson sent on the 15th of April.

MR ROZEN: To a number of officials, including Mr Lye. It's what appears next to the number 249 that I want to ask you about. Ms Peterson is alerting the officials to discussions that evening that she had had with representatives of the provider and yourself and another officer, Ms Wunsch, of the Aged Care Quality and Safety Commission. And do you see that she refers to you as strongly recommending that infected residents be removed from the site, and going on;

...and it appears unlikely that the service can manage this itself at speed. Can the department offer a separate location, for example, through private hospital funding initiative.

I won't read out the rest of it. Is that right? Were you strongly recommending that infected residents be removed from Newmarch House?

DR WROTH: I was strongly recommending that infected residents be separated from residents who were as yet testing negative as a – in my opinion, the best way of protecting people who were not yet exposed or were not yet – had not yet contracted the illness from contracting it. I have set out my reasons for that in detail in my statement but, yes, that was my recommendation. It wasn't specifically removing positive people from Newmarch House but that was absolutely one of the – one of the options that I put forward.

MR ROZEN: Ms Peterson got that wrong, has she, when she said you were advocating removal from the site. That's not what - - -

DR WROTH: I was advocating that as one of the – as one of the potential options to – to protect people, basically, yes.

MR ROZEN: From your perspective, what's the benefit of that from the point of view of protecting the negative residents? Why would removal from the site be a good idea, in your perspective?

DR WROTH: Well, in my – in my view, having a substantial outbreak that was – that was the case in Newmarch House, where it was clear that there were both staff and residents infected and there was a high likelihood that the service was reasonably well-contaminated in terms of surfaces as well, and that having spoken to the staff at Newmarch House and understanding the difficulties that they were experiencing in caring for residents in circumstances that were very stressful at the beginning of an outbreak, that the best way to protect people, as happens in the general community, is that you completely limit the exposure of people who may still be negative from having any contact with people who are known to be positive.

MR ROZEN: Mr Lye, you also deal with this topic in your statement and you refer to the discussions and the disagreement between the New South Wales Health officers including the doctor who was assisting on the site, Dr Branley, and the Commonwealth officials. You don't say, though, in your statement that that dispute was ultimately only resolved by the intervention of Senator Colbeck, do you?

MR LYE: Counsel, I think that Senator Colbeck was involved in the process. I can only speak for my part of that, what I did. I can go through what I did but I know that Senator Colbeck at all times was involved.

MR ROZEN: It's a simple question, Mr Lye. You don't mention that in your statement, do you, Senator Colbeck's involvement? That's right, isn't it?

MR LYE: Well, I can't – I can't speak for Senator Colbeck's involvement. I think it – I think it's Mr Millard – Mr Millard made in his statement, he set out the involvement of Senator Colbeck and his facilitation.

MR ROZEN: He did.

MR LYE: I didn't.

MR ROZEN: And he told us that he spoke to you subsequently to the conversation with Senator Colbeck and that as a result the New South Wales position held sway, if I can put it that way. Do you say otherwise?

MR LYE: Well, I mean, I think my recollection of this is that, certainly, Senator Colbeck was involved and concerned that there be no – that we work through any disagreements and there were – there was a disagreement between Commonwealth officials in the working group meeting, the operational level interaction with Newmarch House, there was a difference of view, and that was expressed strongly by the Commonwealth officials, by Dr Wroth and our own case manager. And while we characterised it, that they exhorted, people as part of that case management meeting, to consider off-site cohorting and cohorting itself. And – and what happened when that occurred - - -

MR ROZEN: Mr Lye, please just answer my question.

MR LYE: I'm trying to help.

MR ROZEN: I'm not at the moment asking you about the detail of the dispute but rather the process by which it was resolved; do you understand? That what I'm focusing on.

MR LYE: Yes.

MR ROZEN: Whose responsibility ultimately was it to make the call and you - - -

MR LYE: The roles and responsibilities, it was New South Wales' responsibility to make the call, but that we established a process whereby a respectful engagement could occur and the Commonwealth's learnings from Dorothy Henderson could be applied in a forum with clinicians to ensure that all issues were properly considered by New South Wales in making decisions around Newmarch House. That would be the best way I can characterise it.

MR ROZEN: Thank you. You subsequently, together with New South Wales department, developed a protocol to guide the respective roles of the two governments in the event of further outbreaks, didn't you?

MR LYE: We did.

MR ROZEN: Yes. And it appears in the general tender bundle at tab 26, I don't think it needs to be brought up, unless it would assist you. It's dated 23 June 2020. Dr Lyons from New South Wales Health tells us that the document was provided to the Australian Health Ministers' Advisory Council as an example of good practice. Is that right?

MR LYE: Well, it was certainly provided to AHMAC and it certainly reflected, for other people's assistance, the way in which we had engaged with New South Wales.

MR ROZEN: And it now guides any future outbreaks and no doubt it's a very helpful document to have, to clarify the roles and responsibilities of the respective governments; is that right?

MR LYE: Look, I would say that we – we absolutely recognise the different jurisdictions see this differently. It was meant to - - -

MR ROZEN: Mr Lye, I just want you to answer my question, please.

MR LYE: No, I don't think it – I don't it was meant to – I don't think it was meant to be a document that was slavishly followed by all jurisdictions. Not all jurisdictions have the same view.

MR ROZEN: That's not my question, Mr Lye. My question is, is it helpful in guiding the respective roles of the Commonwealth and New South Wales in relation to any future outbreaks, having that protocol in place?

MR LYE: Yes.

MR ROZEN: Is there a similar protocol in place in Victoria that guides the relationship between Victoria and the Commonwealth in relation to outbreaks of COVID in residential aged care facilities?

MR LYE: There's a similar process but the operating rhythm with Victoria is slightly different.

MR ROZEN: Can you point us to the document that sets out the relationships – a protocol; is there such a thing?

MR LYE: Well, they're set out – I mean, we are guided by our CDNA document, which was at the start of the pandemic, which sets out people's roles and responsibility and that is the core.

MR ROZEN: My question is a different one. Having developed the protocol in New South Wales, would you agree with me that it would be useful to have protocols in other jurisdictions in advance of outbreaks rather than waiting to do it after an outbreak. Do you agree with that?

MR LYE: The roles and responsibilities are defined in the CDNA document which is the pandemic document, the plan. The protocol that we developed with New South Wales was more or less endorsed by all jurisdictions as the basis for operating with us during the pandemic. There was general agreement to it with some notable exceptions, South Australia being one.

MR ROZEN: Is there a documented protocol to guide the relationship between Victoria and the Commonwealth in relation to an outbreak of COVID in a residential aged care facility that you can provide to the Royal Commission?

MR LYE: The CDNA document. It sets out the roles and responsibilities.

MR ROZEN: And what about other jurisdictions; is the answer the same, there is no protocol specifically, for example, for Queensland?

MR LYE: It's the CDNA document, counsel, because it sets out the roles and responsibilities.

MR ROZEN: At a very high level, doesn't it?

MR LYE: Well, I mean, that's our guiding principle. So whether it's Newmarch House or another facility, we – that's our touchstone.

MR ROZEN: Can I ask you – change the topic please, and ask you some questions about the visitor protocol and perhaps, Mr Lye, you are the appropriate person to start with on this. Without going through each of the various documents, can I summarise the position that as a result of some disagreement between the sector and the Commonwealth Government, a code of practice was ultimately developed jointly between the sector and the Commonwealth in relation to visitor rights; is that right?

MR LYE: It was developed by the sector and noted by government.

MR ROZEN: Okay. We heard earlier today that there was no consultation with any of the unions that represent workers in the aged care sector in the development of that code. Is that right?

MR LYE: I can't speak to that counsel. It's a sector code, not a government code.

MR ROZEN: You don't know whether there was consultation with unions?

MR LYE: It's not my code, counsel. I – I – I believe that the – this is the visitation code, I believe that the – that the – that the organisations involved in drafting that, I – I would have thought that they would have consulted. I would have expected that they would have. I wouldn't – but I am – I – I do not know.

MR ROZEN: It has significant impacts on the workforce, doesn't it, the visitor code, potentially, for it to work well? You really need buy-in, don't you, from the workforce within aged care providers. Do you agree with that?

MR LYE: Look – look, I feel uncomfortable commenting on the code that the objective from the Commonwealth point of view was that they got together and devised a code to work – that Cabinet then noted, National Cabinet noted.

MR ROZEN: Yes.

MR LYE: I wasn't involved in the mechanics of the development of that code.

MR ROZEN: Right. I understand that. I'll ask a different question, then. From your perspective within the Department of Health, with the tweaking that's occurred to the code – there have been two reviews now, haven't there, one in June and one more recently in July; is that right?

MR LYE: This is in regard to the industry code?

MR ROZEN: Yes.

MR LYE: Yes.

MR ROZEN: Yes.

MR LYE: I believe that's the case.

MR ROZEN: Yes. Do you think, from your perspective, that we have got the balance right; that is, the balance between protection of residents' physical health from the virus and protecting the mental health associated with isolation and the quality of life considerations? Do you think we've got it right or do you think there's further work to be done? What do you think?

MR LYE: Counsel, I just want to be clear. Are you are referring to the industry-developed code or the AHPPC advice around visitation?

MR ROZEN: No, no, the industry-developed code.

MR LYE: Industry code. Look, there – I am aware that, in talking with the consumer peaks, and I speak to them regularly, that there remains complaints from individuals, from families, about access to their loved ones and – and on the other side, there are concerns expressed by the peaks and aged care providers that some of their families and residents are concerned about their security. So there – there's two – there remains some noise in the system about that. It's a difficult balance to achieve in COVID. So I know when we're monitoring – well, certainly I know that the Commission is monitoring this and the industry is monitoring it, too.

MR ROZEN: Okay. So beyond that, you're not able to assist us - - -

MR LYE: Well, I would say that we are – as – as a department, we are concerned that – that people have access to – to family. We are concerned about their mental health. We are – we believe that the provisions in place around protecting against COVID are robust. We have had very, very – I don't – I'm not sure that we've had any cases where visitation has resulted in a COVID positive case within a facility. So, you know, I think – and there's a delicate balance there to be achieved. So I think that, you know – but – but we are conscious of the difficulty environment in which providers find themselves and State Governments with different situations happening. Obviously in Victoria, we've got to be very alive to the rate of community transmission that exists there, and visitation is one of the ways in which COVID could get into a facility, and so we have to be extremely cautious about that.

MR ROZEN: Mr Lye, can I ask you a question, another question, about Newmarch House which I neglected to ask you earlier. It relates to the surge workforce that the Commonwealth developed. You've explained in your statement that contracts were entered into between the Commonwealth and Mable and Aspen, and at paragraph 34 you say:

> *The Mable staff were pre-screened.*

That's the expression you used. What do you mean they were pre-screened?

MR LYE: Well, that there was an expectation that Mable had done a level of checking with those staff around qualifications and competence in – you know, in core areas, and I'm aware that – well, it was the case that there was a complaint from Anglicare about the pre-screened applicants who came to service - - -

MR ROZEN: .....

MR LYE: - - - and we – we addressed the issue with Mable.

MR ROZEN: Well, I'll ask you about that in a moment. But Mr Millard, in the evidence that he gave to the Royal Commission earlier in the week, said this, and this is transcript 8502 at line 36. He said:

> *The types of people who were being provided by Mable – 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 earlier on they just weren't up to the task. It was dangerous for them.*

He's referring there to the provider that the Commonwealth had identified as being – the labour source that the Commonwealth had identified as being appropriate to assist in the pandemic. What had you done when you entered into the contract with

Mable to ensure that the workers they were providing would be such that could provide a quality response in such an important role?

MR LYE: Well, look, the – our intention with that was – and we certainly made clear our intention to Mable through the contracting processes – that we wanted people to be part of the surge workforce capability for residential aged care. And – and on the basis of Anglicare conveying to us that they did not believe that they were being given people who were suitable to the task - - -

MR ROZEN: Yes.

MR LYE: - - - we immediately took that issue up with Mable, and we said, "This isn't in line with our expectations," and Mable sought to address that.

MR ROZEN: I see. And - - -

MR LYE: And that – yes.

MR ROZEN: Yes, all right. Because the Commonwealth spent considerable money on Mable in response to Newmarch House, didn't it? I think your estimate is $640,000; is that right?

MR LYE: I – I have them – I have them in my papers. I'll – I'll take you at your word, counsel, in the interests of time.

MR ROZEN: Yes.

MR LYE: Yes, but a substantial investment.

MR ROZEN: Is the taxpayer getting value for money if the quality of the workers was as described by Mr Millard?

MS ENGLAND: I object. Michelle England for Anglicare.

COMMISSIONER PAGONE: What's the basis of the objection, Ms England?

MS ENGLAND: Commissioner, Mr Millard said the challenge was in the first immediate period in the first day or two, but he did go on to say that there was an effective working relationship for a number of months afterwards, during which Mable's contribution was valued by Anglicare. The question is put as a global statement, not just confined to a very limited period of time.

COMMISSIONER PAGONE: Yes, I see. Mr Rozen, I think probably you – you're certainly entitled to ask a question about whether the conclusion drawn by Mr Millard was one that would be accepted. Perhaps if you can just reformulate the question by identifying precisely what it is that Mr Millard had said.

MR ROZEN: And that's why I read the transcript. He said that:

It changed over a number of weeks and were supplied by very capable people.

And I'm not sure if that's ..... the objection or not. Just to make it clear, Mr Lye, if necessary, Mr Millard did make it clear that the position improved with Mable. The question is, at those very early stages – I mean, it's a key time, isn't it, in responding to the outbreak? Those first few days, it's vital that a provider has high quality staff that can be relied upon and not ones for whom it is dangerous for them to be working. That was the word he used. And so I repeat my question. Is the taxpayer getting value for money for the money that Commonwealth's spending on Mable as its surge workforce in relation to - - -

MR LYE: Well – so, counsel, I would say to you that absolutely we would take Mr Millard at his word that the initial provision of people wasn't matching the requirements. We addressed that. We believe that it is working as – it is working well now. We believe we are getting the money – value for money from Mable.

MR ROZEN: Yes.

MR LYE: But we have also contracted another – a range of providers and we pay on the basis that they provide surge workforce for us. So we have greatly expanded our – our reach in terms of agency staff. But – but I have to say to you that there was an issue, absolutely, and we took it up with Mable and they, to my best understanding – they addressed that.

MR ROZEN: Thank you. And so there's a – you're not just stipulating Mable now; is that your evidence, Mr Lye? Providers are being given a choice.

MR LYE: We are, counsel, absolutely. And so we have broadened the base on which we can draw surge workforce to a range of agencies, and in Victoria, we are doing that plus we are also assisting people from interstate to – who work in the industry to – to come to Victoria, such is the type workforce because, you know, there's very, very many people in the health sector and the aged care sector who have been furloughed because of COVID, so yes.

MR ROZEN: Mr Lye, can I ask you a broader question about the infection control expertise. We've heard a lot of evidence this week about the crucial role that highly experienced and accredited infection control practitioners can play in the early stages of a response to COVID-19, and the evidence is that such expertise were available at Dorothy Henderson Lodge from the get-go, whereas at Newmarch House it wasn't, and we've heard witnesses reflecting on the differences between the responses, including the presence or absence of such expertise.

My question for you, looking more broadly at the sector, is do you think that it's the place for the Commonwealth, in its role oversighting the system, the aged care system, to be identifying accredited infection control experts in particular

geographical locations and facilitating arrangements between providers and those infection control experts to provide, perhaps, training and also responses to outbreaks .....

MR LYE: Well, yes. So, look – but prior to the pandemic, we – there is an expectation, obviously, that people are competent in infection control, and I think – I think my reflection about the pandemic is that it is entirely possible that an organisation would feel competent in this regard and then, when an outbreak comes and staff are lost, key staff, in terms of – including clinical leadership are lost, that they can lose their ability to do that in a competent way. I think that – that probably is the most kind of regular thing we've seen where we've had major outbreaks. And so, yes, you're right. There is a role for organisations to get very practical benefit from clinical excellence-type people who are, you know, for the most part, in the State and Territory health systems - - -

MR ROZEN: Yes.

MR LYE: - - - to assist in those situations, and, in fact, that's – that's what the States and Territories have agreed, through National Cabinet, to do with providers and starting with those where we're obviously most concerned. And, look, that is – the – the Commonwealth, from the start, with the use of Aspen first nurse responders, was to put someone in place who could make some judgments around how – how was the organisation going at the start of a crisis? Do they need extra guidance around infection control? Do they need PPE? They're our eyes and ears to help us manage that. And in - - -

MR ROZEN: Well - - -

MR LYE: In most of these outbreak sites, we've benefitted from the State and Territory infection control experts coming in in tandem with Aspen. And so I do think, going forward, we need to look at that as an issue because the sort of shock to the system, shock to these organisations, with the pandemic is such that even – even the very best aged care facilities have struggled.

MR ROZEN: Yes. I'm not sure – I think you largely answered my question and I will just clarify it, if I could. Of course, providers can make arrangements with the State health departments and the Clinical Excellence Commission and so on. My question was a slightly different one. That is, do you see a role for the Commonwealth facilitating those arrangements, for example, reaching agreement - - -

MR LYE: Yes.

MR ROZEN: - - - with the States about designated expertise. I mean, first nurse responders are one thing, but these are accredited experts that we are talking about in infection control.

MR LYE: Yes. No, I agree with you. I – I agree, and – and National Cabinet has agreed the same thing.

MR ROZEN: That was the agreement last Friday, was it? Is that - - -

MR LYE: That's right.

MR ROZEN: Yes .....

MR LYE: Precisely.

MR ROZEN: Thank you.

MR LYE: Yes.

MR ROZEN: The last matter I want to raise with you concerns the response to the community transmission increase in Melbourne starting in June of 2020. So I think it's well known that from 16 June we started to see increases in infection numbers in Victoria which were over 20 and ultimately, as we know, reached into the hundreds more recently. Despite those increasing numbers of community transmissions, we have no active cases in aged care homes in Victoria up to 7 July. Do you agree with that, Mr Lye? Is that your understanding of the data?

MR LYE: I – look, I would have to check back, but I'll take you at your word on that.

MR ROZEN: Based on your department's figures, I'd ask you to accept - - -

MR LYE: Yes. Yes.

MR ROZEN: So that was 7 July. By 11 July, there were four active cases. On the 12th, 15, on the 13th, 28, and then, as we all know, the numbers skyrocketed from there so that by 9 August it was over 1000 and has remained at that level, has it not, Mr Lye, in Victoria?

MR LYE: That's right.

MR ROZEN: And the decision to make masks compulsory for care providers in aged care homes in Victoria was made on 13 July; is that right?

MR LYE: I believe that's right.

MR ROZEN: Yes. Are you able to assist us on the legal instrument that was used to do that? It was mentioned in a press release from the Health Minister, Mr Hunt. Are you or anyone else on the panel able to point the Royal Commission to what legal instrument effected that requirement, if there is one? Do you know, Professor Murphy?

PROF MURPHY: I'm – I'm not sure, counsel. It may have been effected – all of those measures are generally effected by public health orders in the States and Territories. I'm not sure whether that was effected in a public health order. I'd have to check.

MR LYE: I'm not – I'm not necessarily sure it was, counsel. I know that, obviously, the advice around masks has been, you know, debated and – and updated through AHPPC. I know that at the point of which that advice evolved, that – that we immediately provided that to – provided that through the stockpile to – to our aged care providers. And, in fact, I think there's been another – there has been another piece of advice around the use of N95 masks versus surgical masks and we have – on – on the basis of that , we have immediately started despatching N95 masks to services where there's an outbreak.

MR ROZEN: Professor McLaws on Monday gave evidence that she considered that the decision was too late, the decision on 13 July; that given the numbers of community transmission, given that asymptomatic workers can be positive, given that aged care workers move from site to site, that the application of the precautionary principle would have led to an earlier decision to make masks compulsory. I'm trying to understand from you, Mr Lye or Professor Murphy, what was the trigger? What happened on 13 July that caused the AHPPC to give the advice that masks should be made compulsory? Was it the death that occurred on 11 July, the first death in aged care?

PROF MURPHY: I believe, counsel, it was – what has happened in Victoria – and, as you say, early in the outbreak when the public health response in Victoria was very strong and prompt, single cases in aged care facilities were isolated quickly and controlled. What was happening in July was that it was pretty clear that the public health response in Victoria was overwhelmed with – and there was not prompt contact tracing response and follow-up, and because, as you say, that risk then is you've got people who may be infected that may not be isolated and quarantined, that there was a much greater risk of workers coming in, that that decision, whilst there had been – masks had been made available and certainly were being worn in all outbreak sites and were available in other sites, the decision was made to make it compulsory. The situation in Victoria changed dramatically with the – when the public health became substantially overwhelmed in July.

MR ROZEN: I wonder if you can try and answer my question. Maybe you don't know the answer, Professor Murphy, but what was the trigger? Why 13 July?

PROF MURPHY: The – the trigger was further – further outbreaks, the – the growing number of outbreaks in aged care facilities, as I said, following on the broad community transmission.

MR ROZEN: Is Professor McLaws right? Was it too late?

PROF MURPHY: I think – I think in – in hindsight, you could have implemented that earlier, absolutely. The – the situation changed very, very rapidly in Victoria in July.

MR ROZEN: The implementation of it earlier may well have reduced the number of infections entering homes, mightn't it? We know it - - -

PROF MURPHY: That's speculation, counsel, but it's possible, yes.

MR ROZEN: Yes. And does it bring us back to the initial point that what we needed and what we perhaps still need, Professor Murphy, is a plan for the aged care sector that identifies just this sort of thing, just these kind of triggers that will activate an increase in response. So it might be after seven days of community transmission that are over 20 we are going to move to response A or B, or whatever it happens to be, rather than waiting for the AHPPC to give the advice. It seems a very reactive way rather than a proactive planned way; do you understand my point?

PROF MURPHY: I understand your point, counsel, but AHPPC has met almost every day during this pandemic. There is no rule book for this pandemic. There is no rule for this virus. We are learning more about it all the time. Nobody expected – when the National Cabinet reduced restrictions in May, the expectation was that every Public Health Unit would be able to cope with outbreaks and we would never see community transmission on the scale we have seen in Victoria. That has been a very unfortunate occurrence following the quarantine breaches and the overwhelming of the Public Health Unit. AHPPC, because it meets daily, has reacted almost daily to circumstances. You cannot write a plan for this virus which covers all eventualities when we are still learning about it. The CDNA plan is a very good solid fundamental plan, and we stick by it.

MR ROZEN: Finally, Professor Murphy, can I ask you about the letter that Minister Colbeck wrote to the sector on 7 July. It's tab 48 of the general tender bundle. Now, this is three weeks into that period of increasing community transmission that I spoke to you about that you are well aware of in Victoria. Do you think in hindsight it might have been appropriate in the Minister's letter to have at least recommended that masks be worn by aged care workers? If not - - -

PROF MURPHY: I was not involved in the crafting of that letter. I don't know what it – the context. It's obviously an update from the Minister. It's not really the Minister's role to make a recommendation around public health measures; that's the AHPPC role. And as I said, they have been doing it on a daily basis throughout the pandemic.

MR ROZEN: Well, that may be the case but there was a period of about six weeks in the lead-up to the 3rd of August where the AHPPC did not issue any advice in relation to aged care; that's the case, isn't it?

PROF MURPHY: Again, I would have to go back and check the dates, but I accept your word. That doesn't mean that – published advice does not mean that there wasn't active discussion at HPCC and local policy changes in each jurisdiction. HPPC advice statements are fairly generally of a higher order and approved by National Cabinet but that doesn't – certainly a lot of public health responses have changed from AHPPC meetings without an advice statement being published.

MR LYE: Counsel, if it assists, I think – I can't remember the last time I didn't – wasn't attending AHPPC on a daily basis to provide an update on aged care and to interact with that committee around the response to aged care. So I think aged care has been on their agenda during that whole period. So it's not – certainly all the intelligence from what we're doing involved with the Victorian Government in Victoria is being fed into AHPPC.

MR ROZEN: Can I just try and understand that, Mr Lye because it's a very important for this Royal Commission. We know that the advice was given by the AHPPC on 13 July. That was four weeks after 16 June when the community transmission numbers started to go up. I'm just trying to understand the process we have got in place where if they are meeting daily and you're attending those meetings, presumably you're looking at the figures of community transmission in Victoria and thinking about the implications for aged care homes. Is that right?

MR LYE: That's correct.

MR ROZEN: That would have been the number one issue for you to be concerned about at this time, wouldn't it?

MR LYE: I mean, look, we have done an enormous number of things in the last six weeks in aged care.

MR ROZEN: I understand that, but just if you wouldn't mind, if you can focus on this period of four weeks between 16 June and 13 July. Was there a discussion of making masks compulsory or at least recommending them earlier than 13 July? Can you help us?

MR LYE: Well, I think that as Professor Murphy said, that there was interaction with the community transmission and the – to the extent to which our ability to limit outbreaks in aged care which was dependent, in many respects, on early – early identification through PHUs that that – that became overwhelmed. And I think AHPPC, you know, have – have from that point looked at all aspects of how to control community transmission including masks, and hence the decision they've taken.

PROF MURPHY: Counsel, masks are not a substitute for a strong public health response. They – in fact, they are partially beneficial but they – and in that context they have added some value, but they are no panacea.

MR ROZEN: I understand that, Professor, but when we are dealing with the specific problem which seems to have arisen in Victoria of asymptomatic yet COVID-positive aged care workers, masks are one of the few tools you have got to address that risk, aren't they?

PROF MURPHY: No. The most important tool is adequate contact tracing and isolation of all contact so that people who might be contacts that might be asymptomatic do not go to work. and that that is the most important response. And that's what has happened in New South Wales with their current outbreak. That's why they've brought their outbreak under control.

MR ROZEN: But screening is not going to pick them up, is it; they're not going to respond to temperature testing, for example or - - -

PROF MURPHY: No. But if they are a contact – if they're a contact of someone who is infected, which most of them are, and they're contacted immediately they will isolate and quarantine – or quarantine.

MR ROZEN: Yes. As you say, masks are a supplementary means of control; is that right?

PROF MURPHY: Correct. They add some value, and as you are probably aware there has been a lot of debate about masks; masks – poorly worn masks, poorly fitted can be more dangerous if people touch them so they've got to be worn properly and they've got to be trained in their wearing. So it's a complex area but they do add some value.

MR ROZEN: And a final matter for you, Mr Lye, PPE training; was it a mistake not to make it compulsory for aged care workers?

MR LYE: Well, there was an expectation that people had a proficiency in PPE which we supplemented with training which was refresher training in our eyes, refresher training which 155,000 aged care workers took up. Some people in the sector met that proficiency via other means, other training modules. Again, in response to feedback – because we've maintained a regular dialogue with the aged care sector over the course of the pandemic. I think we have had 61 separate meetings with them, we – we then developed tools like doffing and donning videos to demonstrate how to use PPE. Again, I will just make the point that there's a level of preparedness and proficiency which is important, but in instances where we have had outbreaks, I think the Aspen first responder nurses and combined with the public health officials from the State governments have been very, very important in really making sure in an environment where you need to have very strict doffing and donning and PPE adherence that we have tried to achieve that. And that has been essentially, you know, bespoke around outbreak sites.

So I think – you know, look, I would say that going forward we would certainly think that, you know, if you look at the severity of the outbreak of the COVID

outbreak and, in fact, if you look at the number of people we lose each year to influenza in aged care facilities that we can do more and insist on more and greater proficiency and greater refresher training for staff in aged care facilities to better manage that. I do think that when you are faced with an outbreak on site you need – that's not enough. You need to then have very, very specific tutelage and – and that you not allow agency staff on site without making sure that they're proficient, that you take them through their paces and that – you know, you really help familiarise people with the physical layout of the facility and you – and you require that discipline. I think that is a learning.

MR ROZEN: So what's the answer to my question, Mr Lye: was it a mistake not to make it compulsory given what you have must have known about the lack of clinical skills within the aged care sector?

MR LYE: Well, I mean, I suppose I regard it as a mandatory requirement already. So – but I think I'm saying – and I, you know, accede to what you are saying, that – that not only should it be mandatory but that we could insist on a much higher standard going forward.

MR BOLSTER: In the planning process, what sort of assessment was made, do you know, of whether or not it should be made compulsory? What was the reasoning behind making it voluntary? Are you able to tell me - - -

MR LYE: Well, I mean, all of our – all of our messaging was that people needed to be proficient around PPE, that they needed to have competence in that regard. I don't think we ever said, look, this is voluntary. I think we've always said you need to have these skills. We put a lot of attention to making training available. In part, the making platform training available ,which 155,000 staff have done, was to give them confidence that that – if they – that they would have that basic training and it was a refresher, to give them confidence to come to work. And so, you know, I think that – I don't think in any communication we have said to anybody, "Look, this is a nice to do, not a must do". But – but, look, having said that, I think that when you look at the havoc that COVID has wrought on – you know, in those areas where there's huge community transmission – large community transmission, there's no doubt that we can – we could do more to make sure our workforce is prepared for such an eventuality. I think that is a learning.

MR ROZEN: Thank you, Mr Lye. Professor Murphy, I'm not sure whether you still wish to pursue the option of making what I would hope would be a brief statement, but if you do, subject to hearing from the Commissioners, now would be an appropriate time to do it.

PROF MURPHY: I would like to, counsel, if the Commissioners are agreeable. I can be very brief.

COMMISSIONER PAGONE: Yes, Professor Murphy.

PROF MURPHY: Thank you, Commissioners. So obviously, every death in aged care is a tragedy and no country in the world has avoided substantial outbreaks and, unfortunately and tragically, substantial deaths when they have had community transmission of the scale that we are currently seeing in Victoria. We reject categorically that the Australian Government failed to adequately plan and prepare. We have well-established emergency coordination response arrangements which were initiated and operated right from the beginning of the pandemic with a strong focus on the protection of our most vulnerable people, the elderly, who we know are the most susceptible to severe COVID disease.

I'll just highlight just a few elements of our planning framework. As you all know, we have had an overarching Australian Government coronavirus health response plan that was released and activated in February, the same time as Mr Lye established a COVID response taskforce in his department in the Department of Health which worked with the national incident room. Based on this overall health sector response plan, there have been subsequently progressive staged advances in our planning and preparedness in aged care specifically, under the specific guidance of the AHPPC and the CDNA.

We have already mentioned at length the fundamental foundational plan, the CDNA Outbreaks in Residential Aged Care Facilities plan. But on top of that, there have been a huge number of other staged, careful, preparation preparedness and response activities with investment of over $850 million from the Commonwealth in these activities. Just to mention a tiny fraction: we've had huge funding for surge workforce, first responders, dedicated testing teams to go to aged care facilities. Huge engagement with the sector as Mr Lye has talked about with multiple meeting. Deployment of tens of millions of items of PPE early and rapidly across the whole sector.

The infection prevention and control training and response plans, and the requirement for every facility to have an outbreak response plan. The agreement with the private hospital sector was funded by the Commonwealth to make private hospital beds available for aged care residents. We now have over 400 Victorian aged care residents in hospital not necessarily to receive hospital treatment but to manage the outbreak in those aged care facilities. Some of them are indeed COVID-negative.

Finally, I just would like to strongly reject the assertion that somehow the proportion of an extraordinarily low death rate in Australia that is high in aged care has any pejorative interpretation. I would say the contrary is true. As Mr Lye said, our mortality rate from COVID, tragic though every death is, is only 1.5 per cent compared to 15 per cent in the UK, 5 per cent in the USA. Across our aged care facilities .1 per cent of our aged care residents have unfortunately succumbed to this terrible disease whereas in the UK it's five per cent with nearly 20,000 deaths and many, many more not detected. We have detected, identified and transparently reported every single aged care case of COVID. Many countries – many high-

income countries didn't even bother to report aged care deaths. We have had a high priority on this issue.

As Mr Lye said, the fact that our – there's a high proportion of two-thirds of our approximately 350 tragic deaths are due to aged care is really a reflection of the extraordinarily low community death rate. We have an 11 per cent death rate in ICU with COVID, one of the lowest in the world. The Victorian outbreak would have expected in any other country to have more deaths in the community. The fact they we have tragically seen some in aged care and that they make up a high proportion of our very, very low death rate by international comparison is a completely meaningless statistic and I reject absolutely that that has any pejorative context to it.

Obviously – and I will just iterate again that we have from the beginning, from late January when we first put advice out to aged care providers we have been extraordinarily focused on protecting the vulnerable. Otherwise – this virus does not cause great damage to most fit young people; it causes its damage in the elderly. That's why our whole response has been about protecting the elderly, but the most important protection is to control community transmission. Without that, no amount of preparation and planning can stop outbreaks in aged care. Every country in the world has seen that. So we strongly congratulate the Victorian Government for introducing their stronger lockdown measures to bring community transmission under control. That will stop this outbreak in Victoria which has kept us all awake at night for many, many weeks. Thank you, Commissioners.

COMMISSIONER PAGONE: Thank you, Professor Murphy. Just before I ask counsel whether he has anything arising from that, Commissioner Briggs, are there any questions that you want to raise? I know we have exceeded the time but if there is something you want to raise you should do so.

COMMISSIONER BRIGGS: No, thank you, Commissioner Pagone; I'm fine.

COMMISSIONER PAGONE: Yes, thank you. Mr Rozen, is there anything arising from the remarks made by Professor Murphy that you would like to take up at this stage?

MR ROZEN: No, there is not. Thank you Commissioner Pagone.

COMMISSIONER PAGONE: Yes, thank you. Well, thank you to all four of the panellists for making yourselves available. These are difficult matters for us and we are grateful for the time and effort that you and your officers and staff have put into the process to assist us in these matters. I think I can formally excuse you from further attendance and we adjourn now until 2 o'clock tomorrow.

<THE WITNESSES WITHDREW [4.19 pm]

MATTER ADJOURNED at 4.19 pm UNTIL THURSDAY, 13 AUGUST 2020

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