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TRANSCRIPT OF PROCEEDINGS

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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

2.00 PM, THURSDAY, 13 AUGUST 2020

Continued from 12.8.20

DAY 86A

MR P. ROZEN QC appears with MR R. KNOWLES SC and MR P. BOLSTER as counsel assisting
MR A. McKEOUGH appears for Mable
MR M. FORDHAM SC appears for the State of New South Wales

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioner Pagone. Good afternoon Commissioners. This week you have heard from three direct witnesses each of whom gave harrowing evidence about the experience of COVID-19 on their loved ones. Ms Clarke, whose father passed away of COVID-19 at Newmarch House in April; a witness who was given the pseudonym UY whose father could not cope with the anxiety and distress of the lockdown and died in a nursing home in Melbourne; and Merle Mitchell who told you of the limitations on her already limited life caused by the response to COVID-19 in her nursing home.

This evidence brought home, yet again, that the problems that bedevil of the aged care system have their most profound impact on the people who receive care and their families. You also heard from a number of highly qualified experts. Aged care providers and representatives of the aged care workforce have explained how COVID-19 is impacting on the sector more broadly. Three senior union officials told you of the day-to-day struggle of their members working in aged care with inadequate PPE and training. And yesterday you heard from the senior officials who oversee and regulate the sector.

In our submission, what emerges from the evidence are three key conclusions: (a) that COVID-19 has presented and continues to present the Australian aged care sector with an unprecedented challenge; (b) everyone involved, both in aged care homes and in government has worked and is working very diligently to respond to that challenge; and (c) none of the problems that have been associated with the response of the aged care sector to COVID-19 was unforeseeable.

On the central question of how well-prepared the sector was for COVID-19, we will be submitting that it was not well-prepared. Because the risk of an outbreak of COVID-19 in an aged care home is extremely high, even with low rates of community transmission there needed to be a planned proportionate response to protect the elderly frail residents in nursing homes from this pernicious virus. We say that level of risk demanded a level of preparedness that was very high. This may be the key to why there is a disagreement between what we were saying, and Professor Murphy's evidence yesterday that the sector was very well-prepared.

Tragically, not all that could be done was done. The sector was not properly prepared in March before the Dorothy Henderson Lodge and Newmarch House outbreaks. The lessons of those two outbreaks were not properly conveyed to the sector and, as a result, the sector was not properly prepared in June 2020 when we witnessed high levels of community transmission of the virus in Melbourne. And based on the evidence that you have heard the sector is not properly prepared now.

Commissioners, the Federal Government which has sole responsibility for aged care was firmly on notice early in 2020 about the many challenges the sector would face if there were outbreaks of COVID-19. And that notice came from a variety of

sources. First, the limitations of the aged care workforce have been well-documented in reports such as the 2018 report of the Aged Care Workforce Taskforce. The sector is understaffed, and it lacks nurses with clinical skills. Secondly, it was widely reported that in both Europe and North America residents in nursing homes were dying in large numbers as a result of COVID-19.

Thirdly, the interim report of this Royal Commission in October 2019 revealed a range of problems that beset the sector, including workforce challenges, governance problems and the challenges associated with the interface between the aged care sector and the state health systems. And finally, individuals like Professor Ibrahim and organisations such as the Australian Nursing and Midwifery Federation had raised their concerns about the sector's lack of preparedness for COVID-19 and had offered solutions. Any aged care sector plan had, at the very least, to identify each of these matters and provide a detailed and practical set of solutions to them. That is what we mean by a thorough plan. That is the benchmark we are utilising to reach the judgment we have reached.

We have decided to focus in these oral submissions on the questions of preparedness and quality of life including visitors. Many important issues have been traversed over the last three days, including staffing, hospital transfers, training and personal protective equipment use. In the time we have available today it's not possible to do justice to them all. They will, however, be addressed in the written submissions we will provide to you and the parties tomorrow afternoon. In the time we have available now we will address you only on preparedness and quality of life including visitors because they seem to us to be the issues of pressing and immediate importance to the lives of the residents in nursing homes.

Before I address you on those topics, I need to outline some important aspects of the evidence of a contextual nature. From the first panel on Monday you heard about two important public health principles, the precautionary principle and the population and focus principle; both are important in this context. Professor Spurrier, the chief public health officer in South Australia, explained that the precautionary principle requires public health decision makers to err on the side of caution even when the science is not settled and they may not have all the evidence in. The principle has a particular application in a pandemic. The principle is enshrined in the public health statutes of the States and Territories. There's no equivalent in the Commonwealth Aged Care Act1997. There should be.

The population focus principle requires decisions to be made to protect and improve the health of the community as a whole while considering the health of individuals. This can mean that individual choices may have to make way for the greater good. As we are all learning, that is the appropriate and necessary approach to a societal response to a pandemic. For example, as Professor Spurrier explained, a person who is confined to a hotel is obviously having rights they otherwise have overridden. Professor Spurrier agreed that the South Australian Department of Health's approach to hospital transfers of COVID-19 residents is a practical example of the population-focused principle. The approach is concerned as much with the clinical needs of the

positive resident as it is with what Professor McLaws described as the negative residents' right to remain negative. Advance care directives are respected in a hospital setting.

The second contextual matter is the need for a proportionate response to the very high risk posed to aged care residents by the virus, especially in times of community transmission. In the workplace safety context, everything reasonably practicable must be done to safeguard workers. We apply the same standard here but note that the standard of reasonable practicability is not fixed, and adapts to the likelihood of a risk manifesting and the likely consequences if it does.

The third matter is the witnesses have referred to COVID-19 as a novel virus about which our understanding continues to evolve. Professor Spurrier said as much in her evidence. Planning must respond to new knowledge, both scientific and practical. Plans that are found not to work must be discarded and replaced promptly. Another implication of this is it is important not to judge action that occurred in February 2020 based on what we now know about the science surrounding the virus. Having said that, as Professor Ibrahim pointed out, all of his concerns were reasonably foreseeable to the informed observer.

We examined the evidence about preparedness in three time periods. The first is February to March before the first outbreak at Dorothy Henderson Lodge. The second period is April to June before the community outbreak in Melbourne and the third period is June to August as the sector is currently responding to that outbreak and preparing for the future.
We start with the February/March period and ask did the Commonwealth Government have a COVID-19 response plan specifically for the aged care sector. Answering this important question requires an understanding of what an aged care response plan looks like. This in turn requires a careful examination of the evidence.

Professor Murphy was nothing if not clear yesterday about his position. He told you that the Commonwealth's initial planning for the aged care consisted of two documents. He said:

> *There was an overarching Australian Government coronavirus health response plan that was released and activated in February and, secondly, there was a fundamental foundational plan, the CDNA Outbreaks in Residential Aged Care Facilities plan.*

I note in passing that the word plan does not appear in the title of that document and I will return to that. Professor Murphy also referred to a number of other laudable initiatives and expenditures and detailed them in the statement that he made. We don't doubt they occurred, Commissioners, but we would characterise those as reacting, not planning. I will start with the COVID-19 emergency response plan for the Australian health sector in place in February 2020. It's a 56-page document that sets out different scenarios that require responses, governance arrangements,

decision-making and consultative arrangements and communication and coordination arrangements.

It also adapted an existing document, the Australian Health Management Plan for Pandemic Influenza to set out an operational plan which provided additional detail to support the implementation of activities under the COVID-19 health sector plan at an operational level. There are a number of references to the aged care sector in the health sector plan but there's no detail about the aged care sector. The plan did note that additional strategies may be required to support aged care. As Professor Ibrahim observed, the health sector plan was silent on known gaps in the aged care system. Put simply, as its title indicates, it is a plan; it's just not an aged care plan.

The ..... features of the aged care sector with which you are now so familiar required a bespoke plan. But while the health sector plan is not an aged care response plan, it does provide an insight into what an aged care response plan would have looked like. Any such plan needed to identify at least the following failures and shortcomings associated with the aged care sector which needed to be addressed to equip it to respond to COVID-19: (a) gaps in workforce numbers and training, including the likelihood that more staff would be necessary to deliver care during the pandemic; (b) access to PPE and training in its proper use; (c) the lack of clinical skills especially in infection control; (d) personal care workers who lack the foundational standards about infection control that are taken for granted in the health sector; (e) the challenges of achieving high-level infection control in a home-like setting; (f) efficiencies in governance and managerial ability in parts of the sector; (g) the significant operational differences between aged care facilities and hospitals; and finally, the challenges associated with the interface with the state health sector.

Another matter that could have been an addressed in a Commonwealth Government COVID-19 response plan for the aged care sector was the identification of scenarios and responses. For example, what would be the response to an increase in community transmission. What circumstances would act as triggers, and what actions would follow. Similarly, if there was an outbreak in one home without community transmission how would the response manifest.

The other document to which Professor Murphy referred is the Communicable Diseases Network Australia's Guidelines for Residential Facilities which were published on 13 March 2020, and subsequently updated on 30 April 2020 and 14 July 2020. All three versions are in the general tender bundle. The CDNA, as I will call it, is a sub-committee of the Australian Health Protection Principal Committee, the AHPPC. The CDNA has 24 members, none of whom is an aged care specialist. We note that the CDNA consulted Dr Wroth who works on a part-time basis as a chief clinical adviser to the Aged Care Quality and Safety Commission in the development of this document.

While we do attach some importance to the title of the document – it's a set of guidelines rather than a plan – it's more important, in our submission, to consider the substance. Does the document plan the governmental response for the aged care

sector in the way the health plan does that for the health sector. Does it address those various features of and gaps in aged care identified above and does it provide solutions. The first thing to note about the CDNA document is that, like the health sector plan, it is based on:

> *...previous work on influenza outbreaks in residential care facilities in Australia.*

This derivation of the document may partly explain why some aged care providers may have thought that their existing influenza plans would hold them in good stead for COVID-19, only to find that they left them woefully unprepared. The evidence of Ms Roy at Anglicare on this point was compelling. I should just interrupt myself there to point out that the evidence of Ms Roy and also Mr Millard of Anglicare is very valuable because they were quite prepared to confront problems that they had and admit errors that they had made in their planning and lessons drawn from that. When Ms Roy was asked to reflect on her team's assessment of Newmarch House's best practice, she said this:

> *I considered the assessment to be accurate at the time in light of the preparedness measures set out above and with regard to then current resources about preparation including the CDNAs best practice guidelines which we understood to represent the appropriate steps that should be taken to prepare for an outbreak.*

Any aged care response plan worth its salt needs to explain how the aged care health interface will be addressed. As Professor Ibrahim said, it doesn't take great insight to see that having three to four different groups in authority wanting to run something is going to create confusion. You have heard evidence of that confusion both in the Newmarch House response in April in Sydney and also the HammondCare response in Melbourne in mid-May.

How did the CDNA guidelines address the vital planning question. In the first two iterations they didn't address it at all. Remarkably, the first two versions made no mention of the Federal Government having a role in the aged care system, that it funds and oversees to the total exclusion of the states. After trying to explain that it was unnecessary to make any reference to the role of the Federal Government in the document because the document was a Commonwealth document, Mr Lye yesterday ultimately accepted that the Commonwealth's role probably needed to be made explicit. It wasn't until the third version of the document in July that the Commonwealth's role was set out and only then at a very high level.

While the advisory role of State and Territory governments is summarised, the guidelines make no attempt to address how the various levels of government will interact and who is responsible for questions such as the circumstances in which a resident who tests positive to COVID-19 will be transferred to hospital. We submit that this is what an aged care sector plan has to do. As the health sector plan noted:

A clear understanding of the roles and responsibilities between parties responding to a novel coronavirus outbreak will support quick decision-making and efficient coordinated use of resources.

As important as this is in the health sector, which is largely a State responsibility, it is acutely important in aged care as was very well known to those in the sector and government earlier this year. The lack of such a clear understanding was apparent in the Newmarch House response in April. As Mr Millard told the Anglicare board:

Over the course of the outbreak there has been a frustrating level of dysfunction in the collaboration between Newmarch House, Anglicare management and the numerous government departments, agencies and hospital employees at both Federal and State level with an interest in management of the outbreak.

And he went on:

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

Commissioners, the respective roles of aged care providers, the Commonwealth and New South Wales government, were clarified in the course of the Newmarch House response in this April of this year. These arrangements were not formalised until on or about 23 June 2020 when they were reflected in a joint protocol. The purpose of this protocol is to formalise the coordination of government support to an aged care provider in their management of COVID-19 outbreak in a Commonwealth-funded residential aged care in New South Wales. It's not a complex document but it sets out the roles and responsibilities of the Commonwealth government, aged care providers and the various New South Wales government agencies.

While it could no doubt be more comprehensive and detailed it does also include governance arrangements and it identifies trigger events. Such a document could easily have been prepared in February before any outbreak of COVID-19, a residential aged care facility in New South Wales. Instead, the protocol was formalised in June and was developed as a response to the two outbreaks in New South Wales earlier in 2020. According to Dr Lyons of New South Wales Health, who gave evidence yesterday, the New South Wales protocol has been shared with the Australian Health Ministers' Advisory Council as what he described as good practice in how to facilitate fast mobilisation of required government support to a residential aged care facility in the event of a COVID-19 outbreak.

It is clearly desirable that state-specific protocols be in place. Mr Lye's unwillingness to acknowledge this in his evidence yesterday is difficult to understand. Despite the reference of the New South Wales protocol to that

ministerial council it's not apparent that similar protocols are in place even now in other states and territories. Professor Spurrier told you on Monday that she was not sure if there was a framework document that governed the relationship between the Commonwealth and the South Australian governments. She subsequently confirmed there is no protocol between South Australia and the Commonwealth.

Other than New South Wales, it would appear there are no other protocols that set out coordination arrangements. This is what we mean when we say the aged care sector is still not properly prepared for COVID-19. It is unacceptable that such arrangements were not in place in February. It's unforgiveable that they are not in place in August. The virus is not a fair fighter, Commissioners. It doesn't wait until the bell rings.

Professor Spurrier explained that South Australia's approach had been influenced by a number of factors including the state's geography, the set-up of the state health system, advice from the World Health Organisation, including making a decision to transfer all infected residents to a dedicated hospital, and the availability of negative pressure rooms and intensive care facilities. She acknowledged that not all state health systems are set up the same way and suggested that how hospitals are set up, networked and the associated governance for that system would influence the decision about whether to transfer infected residents to hospital in other states.

In light of this evidence, we readily accept that any national plan clearly needs to be supplemented by state-specific plans to take into account such matters. But where is the sense of urgency to get this done? Professor Ibrahim said yesterday that the CDNA plan is not a plan for the sector. He said.

> *I can't over-emphasise that the CDNA plan is a plan for an individual facility. It is not a plan for the country.*

We submit that's correct. To the extent that the CDNA document can be described as a plan, it was a plan for individual facilities and not for the sector as a whole. As its name indicates, it was guiding their approach. It didn't contain sector-wide initiatives such as a surge workforce and Commonwealth/State protocols. Those matters, which could and should have been in place in February, were addressed in a reactive way and then only partially in April and June, respectively. Commissioners, there's no reason why our government should be scrambling now to be putting such arrangements in place. This should have all been done back in February when the health plan was being prepared and disseminated.

Individual states had COVID-19 plans for their aged care sectors. At least one individual provider made provision for developing increased preparedness before the virus arrived and Australia and was stockpiling PPE. There are no doubt other examples; that's just the one we heard about. Commissioners, none of this is intended to be a criticism of the CDNA guidelines. For what it's worth, we consider that it's a helpful document; it's just not an aged care sector preparedness plan. What about the Aged Care Regulator? The Aged Care Quality and Safety

Commission was asked in a notice dated 26 June 2020 under the Royal Commissions Act issued by you, Commissioners, to produce a copy of any pandemic plan or risk-based framework prepared by or for the Aged Care Quality and Safety Commission for the aged care sector on a variety of dates.

In response to this demand, the Aged Care Quality and Safety Commission produced the documents which are found at tabs 21 and 22 of the general tender bundle. The first is a document entitled The Commission's Regulatory Response. The second is entitled Aged Care Quality and Safety Commission: Proportionate Risk-based Regulatory Response to COVID-19. It is an adaption of the well-known regulatory pyramid developed by Professor John Braithwaite. Appearing on the screen on the left is the first document; on the right is the second. Whatever else may be said about the documents, they are not the comprehensive plan of a regulator facing the COVID-19 pandemic needed.

Such a plan, in our submission, would have included, for example, a thorough profile of all aged care facilities along the lines of that suggested by Professor Ibrahim in his precis of evidence. It out reasonably have referred to deficits in infection control that had emerged from recent regulatory action. It might also have provided a template for a range of the best practice tasks and preparation that providers ought to be carrying out. Appropriate monitoring arrangements would also have been identified. Such arrangements would have addressed the lack of visibility of events in nursing homes identified in the South Australian Health Department's submission to you.

As that submission observed, the cessation in March 2020 by the regulator of unannounced visits to homes at a time when on-site visits by families were severely limited:

> *...reduced the level of regulation and oversight of the quality of care being delivered within residential aged care facilities.*

It was incumbent on the regulator to have strategies in place to fill that gap. Another matter that should have been part of the regulator's planning was a system that passed on any vital information it obtained in its routine monitoring work. For example, if in carrying out that work an employee of the Commission found out about a COVID-19 outbreak, that information should be routinely conveyed to the Department of Health immediately in case the provider had not met its responsibilities to report under the first 24 hours document that you heard about yesterday.

Ms Anderson was unable to explain to you why such information was not conveyed when it came to the attention of one of her employees in a particular case in Melbourne in July. She informed you that she has now put in place an arrangement to ensure that happens routinely. Yet again, Commissioners, that is reacting, not planning. The second period we examine is May to June 2020. We ask whether the lessons of Dorothy Henderson Lodge and Newmarch House learnt. The time between the two Sydney outbreaks and the increase in community transmission in

Melbourne in June was an important period for the state of planning to be assessed and if necessary augmented. What did the Commonwealth do to ensure that the lessons of the first two aged care outbreaks in Sydney in March and April were conveyed to the aged care sector. We say it's not enough.

We accept that the third version of the CDNA guidelines incorporate some of the learnings, for example, provision is now made for the allocation of a case manager to connect a facility to Commonwealth support, and there is access to a surge workforce which is not limited any more to just Mable and Aspen. The Commonwealth is to be congratulated on these initiatives but much more was and is needed. For example, if one thing was clear from the report by Professor Gilbert dated 14 April into the Dorothy Henderson Lodge outbreak, it was that even a well-managed provider such as BaptistCare needed the help of high-level infection control expertise. This was needed to assist, first, with the preparation of an outbreak management plan; secondly, to provide training to staff and, thirdly, to provide help on the ground on day one of an outbreak if one occurred.

You may conclude from the evidence that nothing could be more important to help a provider prepare for and respond to a COVID-19 outbreak. You will recall that the highly experienced aged care nurse, Ms Roy, at Newmarch House was unaware of the need for this level of infection control expertise. If she didn't know until Ms Dicks from BaptistCare arrived on the 24th of April to assist the response at Newmarch House, how many other are providers without access to clinical skills, such as those possessed by Ms Roy, were and are similarly ignorant of what is needed to respond to COVID-19?

This, Commissioners, is the pointy end of preparedness: it's equipping the providers with the knowledge and help they need. You heard from Ms Dempsey of the Clinical Excellence Commission about the process by which experts are accredited. She told you they are credentialed by the Australian College of Infection Prevention and Control. She chairs the professional standards committee of that college and told you that there are three levels of accreditation: primary, advanced and expert.

And there are currently 66 credentialed infection control practitioner experts across Australia. They are mainly in our major hospitals and are spread around the country. Most of them work for state governments. In light of what was learned in those early outbreaks, why hasn't the Commonwealth put in place arrangements for easy access by providers to these accredited experts? Several witnesses thought such an approach could work. To be blunt, what could be more important to the nation right now than to deploy these experts to help our floundering aged care sector respond to this pandemic?

We submit it's not enough to tell providers that if they request help, they will be provided with a first nurse responder as the CDNA guidelines do. As competent as such a nurse may be, unless he or she has the level of expertise that Professor Gilbert spoke of in her report, there's a real risk that they will not provide the necessary assistance. For reasons that remain unclear, the Commonwealth did not publish

Professor Gilbert's important report. It's full of valuable lessons, and was written by a person with serious high-level relevant expertise. It can only help – ..... excuse me.

Another lesson that does not appear to be learnt is that providers should plan to lose close to their entire workforce in the first few days of an outbreak. The figure of 20 to 30 per cent, which appears in the regulator's survey and all three iterations of the CDNA guidelines, is plainly wrong, as experience told us. None of the senior Commonwealth officials, from whom you heard yesterday could tell you its genesis. Be that as it may, it should now be confined to the dustbin of history as part of the iterative planning process to which we earlier referred. It should certainly not be part of the current advice of the Commonwealth, because, in our submission, it has the potential to lull providers into a false sense of security. Despite Mr Lye's curious efforts to suggest otherwise, it is flatly contradicted by the accurate figure of 80 to 100 per cent in the first 24 hours document. Contradictory advice on important questions is not unusually a hallmark of good planning.

The third period is June to August 2020, the response in community transmission of COVID-19 in Melbourne. Commissioners, daily new infection rates in Melbourne rose from 20 on the 16th of June to 76 on the 30th of June 2020. However, masks were not made compulsory for aged care workers until 13 July 2020. That was two days after the first recorded death of an aged care resident in Victoria from COVID-19. By the 13th of July 2020, when masks were made compulsory, the number of new infections in Victoria had reached 250. There was a lag between the community infection rates and those in aged care. Until 7 July, there were still no active cases in residential aged care, but, by 13 July, there were already 28. That number skyrocketed to over a thousand by the 9th of August. Death rates are steadily climbing. In the four days of this hearing, there many further aged care deaths in Victoria.

In circumstances that are not entirely clear because of its status as a subcommittee of the National Cabinet, the AHPPC recommended to masks be made compulsory for aged care workers. That was four weeks after the steady increase in Victorian community transmissions which, as I've said, commenced on 16 June. The legal instrument by which this important measure concerning masks was effected is unclear. Our researchers have not revealed any instrument imposing the requirement. Professor Murphy was not sure and thought it might have been a Victorian public health order. He said he would have to check. We await the outcome of that checking. Mr Lye was not necessarily sure it was such an order. This level of confusion by senior officers in the Department of Health is far from reassuring, it appears to have been law by press release. This is not the hallmark of a considered approach, but, rather, decision-making on the run reacting to circumstances.

Professor Spurrier, who is a member of the AHPPC, told you that she couldn't divulge the reasoning of the committee, because it is a subcommittee of National Cabinet. We make no criticism of her. Professor Murphy, on the other hand, apparently had no such concerns. He told you the trigger for the advice was

prompted by the understanding that the public health response in Victoria was overwhelmed by the growing number of outbreaks in aged care facilities. Professor Murphy and Mr Lye were unable to clarify if there'd been discussions within the AHPPC regarding making mask-wearing compulsory any time between 16 June and 13 July.

Commissioners, one is left with the sense that it was the death of an aged care resident on 11 July, the first in the current outbreak, that prompted the advice. Would earlier action have limited the spread of COVID-19 into Victoria's nursing homes? Should a requirement for aged care workers to masks have been imposed earlier? Professor McLaws had no doubt that the answer to those questions was "yes". Even Professor Murphy agreed that:

In hindsight, you could have implemented that earlier. Absolutely.

He told us yesterday. We question, though, whether it's a matter of hindsight. Masks are a very cheap and effective method of slowing the spread of COVID-19. Further, she said that one or two cases, as they started to increase in June, should have been an alert that this is potentially a problem. We asked who was watching the figures and thinking about what they meant for the aged care sector. There was no guidance provided by the AHPPC to aged care providers in this crucial period between 19 June 2020 and 3 August 2020. During that time, the number of new daily infections in Victoria grew from 25 to 413 and the number of active cases in residential aged care grew from zero to over 500. Did the authorities miss an opportunity?

Applying the precautionary principle and acting in a pre-emptive rather than a reactionary way, we submit the evidence of Professor McLaws ought to be accepted by you. The masks order should have been made earlier. Commissioners, we will never know whether the earlier imposition of this requirement would reduce the number of infections and save lives. Professor Murphy, when asked yesterday, thought it was possible that it may have.

The important point to make here, Commissioners, is that the piecemeal and reactive way that the AHPPC and the Federal Government responded to the threat posed by community transmission in Victoria in June and July emphasises the lack of proper planning earlier in the year. It also lends support to Professor Ibrahim's view that what is needed is a dedicated aged care-specific national coordinating body to advise government. It seems to us correct that, as he says, coordinated national expertise for aged care has been missing from the planning process since February of this year, and we continue to suffer from its absence. This could be addressed if a core national unit is established.

A national aged care plan: A national aged care plan for COVID-19 could still be put in place with the type of national coordinating body Professor Ibrahim says we need, and that he called for in March. Such a body could bring together the expertise about the aged care sector, infection control and emergency preparedness and

response is readily available in Australia. Professor Ibrahim also said that the body would need a human rights and a public advocacy group to be there to advocate for the residents, because there's no one advocating for the residents. The Victorian Aged Care Response Centre that was established in July is a welcome development, but it is an operational response body, not a forward-looking planning body.

A national COVID-19 aged care plan needs to consider the workforce challenges that the aged care sector continues to face. It must anticipate the effect of the lack of clinical skills. It must consider what additional training in infection control and PPE use is needed, how it can best be provided, and whether it should be made compulsory. It must recognise the need for high-level infection control expertise, early in an outbreak response, and it must make appropriate arrangements with organisations such as the Clinical Excellence Commission in New South Wales, so that it's not left to chance whether someone like Ms Dempsey is available to assist a provider.

A thorough national plan needs to respond to the challenges associated with the casualised aged care workforce. Such a plan must anticipate that in the face of a risk of infection to the workforce, the difficulties associated with delivering care under COVID-19 conditions will require more care staff and it must anticipate the costs of operating an aged care service for an extended period are likely to be significant and place great financial strain on all providers. It might be said against us, Commissioners, that this is a judgment made with the benefit of hindsight. Of course, it is; all judgments are. But none of these matters was unknown in February of this year. Many of them were documented in this Royal Commission's interim report provided to the Commonwealth last October. What use was made of that document in the COVID-19 planning, you may ask. There is still more time for it to be put to good use.

Turning, Commissioners, to maintaining quality of life. Just as important as preparing for and responding to outbreaks when they occur is maintaining the quality of life of those people living in residential aged care throughout the pandemic. All residents are legally entitled to quality care at all times. That doesn't change in emergency. If anything, it becomes more important. Thankfully, many residents have, to date, not experienced an outbreak in their facility. They have, however, been subject to restrictions for most of this year which go beyond those endured by the rest of us in the community. Many of these restrictions may, unfortunately, be necessary. We have seen the devastating consequence of COVID-19 outbreaks in residential aged care. However, it's important to acknowledge that for many, if not all residents, these restrictions have had and will continue to have serious consequences.

As we heard this week, the impact of these restrictions has sometimes been tragic. As I noted earlier, Ms Merle Mitchell AM gave evidence this week about her experience. There have not been any cases of COVID-19 amongst staff or the residents at her facility. However, it's been in lockdown since early February. Ms Mitchell said about the lockdown:

From the time I wake up to the time I go to sleep, I am sitting in my own room in my one chair.

With her only view being that of a brick wall. She's seen her daughter twice during lockdown: once in a room with a glass partition; and, more recently, for Ms Mitchell's birthday, through a window opened a crack to speak through. Commissioners, as you would have seen, Ms Mitchell is an active self-described people person. She told you how the lockdown has meant she can no longer visit friends or receive the massages which make up part of her care plan. Ms Mitchell described the decline she has witnessed in residents living with dementia, who she believed did not understand why their families are no longer visiting them. She acknowledged the success of her facility in keeping the virus out, but she asks at what cost.

Commissioners you have, in previous hearings, heard evidence about the important role played by those who are often called "informal carers". These are often family members who supplement the care provided in residential aged care facilities. Their role is particularly critical in the many facilities with inadequate staffing levels and they often play a critical role as the eyes and ears monitoring the quality of care. A witness given the pseudonym "UY" described the impact that visitation restrictions had on her father, who died during the lockdown. UY was an informal carer for her father. Her father was non-verbal due to motor neurone disease and he had dementia. An Italian man, for whom family connection was everything, he relied on physical touch to communicate.

Before lockdown, she visited almost every day to take him outside for the walks he loved and she would play games with him to keep his brain active. The restrictions imposed at his facility from the end of March allowed for window visits, where family members had to wear masks and, eventually, visits in a converted hairdressing salon where family would be separated by a glass partition. With the ability to hug and shake hands with his family taken away, UYs father would look very confused during their visits in the converted hair salon. She told you that she didn't want him living like that. UY petitioned to be able to take her father outside for socially distanced walks and was eventually granted permission to do this from mid-May. By this time, UY said she could see how much her father had deteriorated. On 6 June, went to sleep. He didn't wake up. He died six days later. She told us she believed:

Dad gave up wanting to live, because his family support and connection was disconnected.

UY has called for aged care facilities to allow key family members to continue to visit and care for their loved ones during the lockdown. She told us that an aged care facility will never replace the love and connection a family can give. Julie Kelly, a psychologist providing services in residential aged care facilities in Victoria, gave evidence that, because of COVID-19, she'd seen a large increase in depression, anxiety and confusion. She told you that suicide risk had increased. Ms Kelly explained that the significant changes to residents day-to-day lives within a facility,

as well as not being able to see family and friends, have caused a lot of anxiety. She said that loneliness has had a real impact on residents' mood and especially on depression.

Ms Kelly told you that, for a lot of the residents, there's a real, real strong sense of hopelessness of not knowing when this is going to end or being able to see any changes for them. Since COVID-19 cases first occurred in Australia early this year, visitation has been a contested issue. It was ultimately addressed through an industry visitation code, which was published on 11 May 2020. That code has been the subject of three reviews. It is not binding. We note that version 3 of the CDNA guidelines also notes the importance of visitors for the personal welfare and mental health of residents.

Approved providers are understandably fearful of experiencing an outbreak of COVID-19. It's a natural reaction in these circumstances to take whatever action is available to limit the risk of such an outbreak. It was clear from the evidence that there are no easy answers to the questions of how to strike the right balance. Jonathan Anderson of Opal Aged Care described the overwhelming feedback from residents and their families to the effect that all they wanted was to keep their loved ones safe. But, on the other hand, Dr Stephen Judd reported that a HammondCare survey of residents and families confirmed that most preferred to stay open to visitation even if it presented a risk. It's not just the mental health of residents that is affected. As Ms Angela Raguz from HammondCare said:

> *Underestimating the physical impact on people of not seeing people who they love, that's a mistake.*

She spoke of the need to balance and manage the risk. Michael Lye from the Department of Health yesterday spoke of what he called the delicate balance that needs to be achieved and noted that he was not aware of any cases where visitation has resulted in a case of COVID-19 within a facility. You have heard evidence this week from providers about the measures they have implemented to strike the balance. Dr Judd said that HammondCare made the decision to continue allowing visitors into their facilities to see residents, because we thought the pandemic was going to be a marathon not a sprint, and that HammondCare believed restricting visitation would have a very bad impact on its residents. We have heard evidence that HammondCare set up a concierge service early on to coordinate and screen visitors. Other initiatives we heard about this week include walking programs and active and passive in-room programs, connection coordinators or dedicated communication teams, and a training program for family members in infection control and PPE use.

Clearly, such an issue use required resources and are dependent on adequate staffing. However, Ms Butler of the ANMF and Ms Smith of the United Workers Union both told you that the visitor code was developed without any consultation with the workforce and their representative organisations. They pointed to a lack of acknowledgement of the increased staffing numbers required to support the

requirements in the code. Ms Butler told you that, as a result, the staff needs necessary to support the code's approach just come off the floor increasing the workload burden for the existing staff. Commissioners, the sector needs to appreciate the contribution that its workers and their representatives can make to work processes.

You also heard evidence that with many residents missing out on regular visits, care workers feel a heavy burden to be their family and provide that care. It's axiomatic, Commissioners, that visits from family and friends are critical to the physical, mental and emotional health and wellbeing of people living in residential aged care. While technology is important and should be leveraged wherever possible, it cannot replace face-to-face contact. Does the existing code and other relevant guidance strike the right balance between safety, narrowly understood, and quality? To borrow the words of Professor Ibrahim, what else can be done to make the approach to visitation more humane? The position on visitation must be continually reviewed and revised and must be adapted to the particular circumstances of each facility. Innovative solutions must be celebrated and shared. Every effort should be made by providers and the department to encourage and facilitate safe visitation even during periods of community transmission. We submit that a blanket ban on visitation is, however, unacceptable in all but extreme cases.

Allied health. Commissioners, only a matter of weeks ago you held a hearing which looked at mental and allied health in aged care. You heard significant evidence about the important role these services play. You heard evidence from a Mr Rik Dawson and Ms Julie Kelly – allied health professionals – about the negative impact on the health and wellbeing of COVID-19 restrictions on all residents in nursing homes, not just those managing a COVID-19 outbreak. Ms Kelly is a psychologist delivering services in residential aged care facilities. Mr Dawson is a gerontological physiotherapist. He is a director of the Australian Physiotherapy Association.

Each of the witnesses spoke of the increasing levels of depression, anxiety, confusion, loneliness and suicide risk and also reduced mobility and the long-term consequences of this. Mr Dawson explained that reduced activity means older frail people deteriorate very quickly. As you heard time and again during the Royal Commission, falls can be the beginning of decline and death in for people in aged care. There's a real risk that reduced levels of physical and mental health will have long-term ramifications for residents. As Mr Dawson said, once fail older people lose their mobility it may never return.

Both Mr Dawson and Ms Kelly said restrictions have had an impact on their ability to provide services. While the visitation code and changes to the public health directives have provided more clarity and, despite allied health professionals being recognised as essential workers, we heard that some residential aged care residents have reduced access to allied health professionals at a time when there is an increased need. Ms Kelly said that with the stage 4 restrictions, her business is considering the use of telehealth and only providing services on site to those who are clinically high risk. Mr Dawson said that while the visitation code had helped there

were still a number of residents who are not getting the access at the moment because of the perceived risk of infection.

In addition ..... are often paid by providers through their aged care funding instrument funding to provide a limited range of pain relief services and not the mobility work that is urgently needed as you will from the allied health hearing. We submit the Australian Government should consider immediate action on this front. We've seen the government respond quickly to establish MBS items to increase mental health services for those living in the community. We should urgently take similar messages to support our ..... mental health professionals to provide services to people in aged care during the pandemic to prevent deterioration in physical and mental health. Telehealth should also be included in options for service provision. Any barriers, be they real or perceived, to allied health professional being able to enter aged care facilities should be removed.

Conclusion: into an uncertain future. Commissioners, there have been 220 deaths of residents in residential aged care due to COVID-19. This represents 70 per cent of all the country's COVID-19 deaths. On this measure, we're one of the worst-performing countries in the world. Our elderly citizens and their families deserve better. We don't go so far as Professor Ibrahim and conclude that hundreds of residents will die prematurely because people have failed to act. The evidence before you does not enable that causal link to be made, but we do submit that it's open to you to conclude that the sector has been hinder in its response by a lack of coordinated planning by all levels of government.

We also submit that it is open to conclude, based on the evidence of Professor McLaws and Professor Murphy, that masks should have been made compulsory earlier in aged care homes in Victoria, and that this may have reduced the spread of the virus and saved lives as a result. Commissioners, there is reason to think that in the crucial months between the Newmarch House outbreak in April and mid-June a degree of self-congratulation and even hubris was displayed by the Commonwealth Government. Perhaps they were reflecting the general mood in the country that we were through it. It seemed that Australia may have weathered the COVID-19 storm in a way that avoided the large-scale deaths in other countries.

As late as 9 July 2020, the Aged Care Minister wrote to aged care providers telling them they had:

> *...responded incredibly well to the unprecedented challenges of COVID-19.*

Although the Minister did urge continued vigilance in the letter, and he warned that the battle was not yet over, there's no real sense of urgency in reading the letter. There was no suggestion, for example, that providers should consider asking their employees to wear masks. Finally, Commissioners, you will recall that Professor Murphy was yesterday keen to compare Australia's performance with that of New Zealand. As you may be aware, New Zealand has very recently experienced a handful of COVID-19 cases after being virus-free for over 100 days. New Zealand

immediately moved to a level 4 alert, locking down its nursing homes and barring all family visits. Simon Wallace, New Zealand's Aged Care Association chief executive has been quoted in the media as saying:

> *We have seen what's happened in Melbourne where aged care has been affected. More than 100 rest homes in Melbourne have had COVID-19 outbreaks and they didn't move quickly enough. We can't afford to take any risks at all.*

Perhaps, Commissioners, that's the ultimate lesson. When it comes to the health and safety of the residents in our nursing homes we can't afford to take any risks at all.

COMMISSIONER PAGONE: Yes, thank you, Mr Rozen, for your submissions. In a moment, we will have a short adjournment before we start a separate hearing on a different topic occurring on the same day but in fact a separate matter. But we wanted to thank you, Mr Rozen, and those who have been assisting you in the preparation of the hearing and of the submissions that you have made to us today. We need also to thank the very many whose submissions to us, since we called for submissions, have helped inform the work that we have seen over the last few days, leading ultimately to the submissions – well, leading at the moment to the submissions that you have made to us, and we will thank, in anticipation, those who will make submissions pursuant to the order that we make today for the receipt of submissions.

This has been an especially challenging hearing for all of us and for that reason we do need to express our thanks to a large group of people right across the country who have enabled the hearing to take place at all and to have taken place with very few hitches. There are a number of technical people, some of whom I can physically, some, one or two, who Commissioner Briggs may be able to see at the moment but many of whom are simply not visible to anybody but without whose work the hearing could not have taken place. And we do want to thank all of you for that hard work behind the scenes, being as I am able to see, constantly alert, making sure that things are being monitored, looked after.

It is a matter of great thanks to you that it has gone as smoothly as it has. Not only have we had to work under these great difficulties, some of which have been created by the restrictions imposed as governments deal with the virus, but we have also had to work in the context of trying to gain an understanding of the impact of the virus on the aged care sector whilst it is still playing out and developing around us. That has been very difficult, indeed, and in part reflected by the submissions that you have made, Mr Rozen, that indicate that there is a lot of thought still to be done.

Plainly, we are not in a position to make recommendations but you made a number of very many helpful suggestions, Mr Rozen, in your submissions, and we've heard of a number of very helpful suggestions in the course of the hearing by people who have had direct experience and a great deal of personal expertise. We can only urge government to listen to that carefully. Such matters as you raised today, Mr Rozen,

such as a dedicated aged care-specific national coordinating body to advise government, such things as additional staff so as to enable greater visitation in aged care homes so that the informal care that is missing can take place. These are all practical things that should perhaps not wait. As we often heard, the virus doesn't wait and nor should the measures that need to be implemented to deal with the virus wait either.

However, thank you for those submissions, Mr Rozen. I understand you wanted to say something before we formally adjourn?

MR ROZEN: I do. Thank you very much, Commissioner Pagone. I would also like to endorse your thanks to the staff that have supported the running of the hearing this week, which as you have observed, has taken place in particularly difficult circumstances. I would like to mention by name, Ms Amundsen, Ms Hagger and their team who have done a remarkable job supporting the work of the counsel assisting team, and I echo the observations you have made about the remarkable technical team that we have supporting the work and enabling it to proceed as can be seen on the screen, in somewhat unusual circumstances. Thank you.

COMMISSIONER PAGONE: Thank you. We will now formally conclude this hearing but resume another hearing at 3.10. Thank you. Formally adjourn, please.

MATTER ADJOURNED at 2.55 pm ACCORDINGLY