HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Mr AD Harper MP (Chair)
Mr MC Berkman MP
Mr MJ Crandon MP
Mr MF McArdle MP
Mr BL O'Rourke MP
Ms JE Pease MP

Member in Attendance

Mrs RA Bates MP

Counsel Assisting:

Ms Ruth O'Gorman

Staff present:

Mr R Hansen (Committee Secretary)
Mr S Finnimore (Principal Legal Advisor)

PUBLIC HEARING—INVESTIGATION OF THE CLOSURE OF THE EARLE HAVEN RESIDENTIAL AGED-CARE FACILITY AT NERANG

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 12 SEPTEMBER 2019

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The committee met at 9.40 am.

CHAIR: I now declare open this public hearing as part of the committee's investigation of the closure of the Earle Haven residential aged-care facility at Nerang. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the member for Thuringowa and chair of the committee. The other members of the committee with me today are: Mark McArdle, the member for Caloundra and deputy chair; Michael Berkman, the member for Maiwar; Barry O'Rourke, the member for Rockhampton; and Joan Pease, the member for Lytton. The remaining committee member, Marty Hunt, the member for Nicklin, is unable to be here, and I again welcome Michael Crandon, the member for Coomera, who is standing in for Mr Hunt today. Later we will be joined by Ros Bates, the member for Mudgeeraba.

The hearing is being recorded and transcribed by Hansard. Those here today should note that media may be present so you may be filmed or photographed and those images may appear on the parliament's website. I welcome Rob Molhoek, the member for Southport, who is joining us today. Please note that photography or videorecording by members of the public during public hearings or briefings held by the committee is prohibited.

The committee is a statutory committee of the Queensland parliament and as such represents the parliament. Today's proceedings are similar to the parliament and are subject to the Legislative Assembly's standing rules and orders. The guide for appearing as a witness before a committee has been provided to those appearing today. The committee will also observe schedule 3 of the standing orders. The committee is being assisted in this investigation by Ms Ruth O'Gorman as counsel. Witnesses are likely to be asked questions by both counsel assisting and committee members.

The proceedings are covered by parliamentary privilege, which means witnesses are protected from legal action in respect of the evidence they may give the committee. If witnesses give evidence today which reflects adversely on an individual or organisation, it should not be taken as proof of the allegations being made. The committee may choose to receive but not publish that evidence. Before we move to the first session, I will turn to counsel assisting and welcome Ms O'Gorman to make an opening statement perhaps outlining today and a review of yesterday.

Ms O'GORMAN: Thank you, Mr Chair. Yesterday the committee heard first from Mr Cary Strong, a member of the Queensland Ambulance Service, in particular about the scenes that were confronting him and other personnel from QAS when they arrived at the facility on the afternoon of 11 July 2019. The committee also heard from Mr Ron Calvert and Ms Karlene Willcocks from the Gold Coast HHS. The committee heard from both of those people that on the afternoon of 11 July 2019 a code brown response was declared. That was considered necessary at first instance because of the perceived possibility that a significant amount of resources from Gold Coast HHS would need to be deployed to deal with what was happening at Earle Haven.

The committee heard about the Health Emergency Operations Centre that was convened that afternoon. In particular from Mr Calvert the committee heard that his personal view, and that seemingly shared by other members who were comprising the HEOC that afternoon, was that it would be preferable if at all possible for the residents to remain at Earle Haven to cause the least amount of disruption to them. It seems, though, as the afternoon unfolded and the members of the HEOC group were having information relayed back to them from people such as Mr Strong and indeed Ms Willcocks that it became apparent to them that it was not going to be tenable or safe for the residents to remain.

The committee heard evidence that those on the ground saw significant items of furniture and basic cleaning supplies being removed from the premises and also that those attending at Earle Haven were able to confirm that medical records were not available to the emergency responders. That being the case, the committee heard that HEOC made inquiries about whether the residents could be accommodated at nearby aged-care services. The committee heard from Mr Strong in particular that the residents were in fact transported and moved to those services over the course of several hours, concluding after midnight that night.

The committee then heard from Ms Telecia Tuccori, who was the senior clinical manager at HelpStreet at the time of the closure. She gave some evidence about her knowledge of the history of regulatory compliance issues at Earle Haven. She also spoke about her observations of the way Earle Haven was being managed in the lead-up to 11 July. She also spoke about her involvement in what occurred on 11 July 2019.

The committee then heard from Ms Karen Heard, who described herself as being an independent contractor nurse administrator at Earle Haven. Over four separate periods leading up to and at the time of the closure of the facility, she was also able to express her views about what unfolded on the afternoon of 11 July 2019 at the facility. She was there for part of it. The committee heard her view that, notwithstanding the removal of significant items from the facility and evidence that this committee has heard about a lack of food and fluids being made available to the residents as well as the absence of medical records and a lack of assurance that either of the two business entities, HelpStreet or People Care, would pay staff wages, she thought it would have been more appropriate for residents to remain at the facility that afternoon. That view is something that is going to be able to be explored by some of the witnesses who are going to give evidence to committee today. The afternoon sessions yesterday comprised private sessions.

In terms of a brief overview of the evidence the committee is likely to hear today, I can start by indicating that we have two witnesses here from the Council on the Ageing. As I understand it, they are going to be able to address the committee about two significant matters, in their view: concerns about the lack of regulation around subcontracting arrangements at aged-care service facilities and also concerns held by that organisation about a lack of adequate evacuation requirements in place across the state.

Later we will hear from Mr Geoff Rowe, the Chief Executive Officer of Aged and Disability Advocacy Australia. That organisation has submitted a submission, which has been published—as has COTA's. Mr Rowe, as I understand it, will be able to speak to his review of advocate case notes from engagement with residents and family members at Earle Haven from 1 January 2016. It is anticipated that his review of those case notes might provide the committee with some longitudinal understanding of the issues leading up to 11 July 2019.

Dr Michael Wynne will also give evidence to the committee today. He is from Aged Care Crisis. It is anticipated that the sorts of information he will provide the committee relate to that organisation's concerns about the lack of regulation around subcontracting arrangements for aged-care service facilities as well.

There will be three representatives from the Queensland Nurses and Midwives' Union who will speak to their views about how the situation on 11 July 2019 was managed, an overview of the issues that have confronted the staff—the workers—since that date as well as their concerns that they held about the facility prior to 11 July 2019.

It is anticipated that this afternoon the committee will also hear from Meaghan Scanlon MP, the member for Gaven. After lunch there will be, it is planned, a final private session before the hearing adjourns to be resumed on Monday, 16 September.

That I hope provides a bit of an overview about where we are going today. Mr Chair, we have noted that we have the two witnesses here from COTA.

CHAIR: Thank you, Ms O'Gorman.

STALKER, Mr John, Policy Coordinator, Council on the Ageing Queensland

TUCKER-EVANS, Mr Mark, Chief Financial Officer, Council on the Ageing

CHAIR: Welcome, gentlemen.

Mr Tucker-Evans: Thank you for the opportunity to appear before you today to reinforce what we have said in our submission and to highlight that we are deeply concerned about the situation at Earle Haven and in particular the distress experienced by the residents, who were removed from their homes in an emergency type situation, and the health and safety risk to those residents and the increased concern and alarm for older people and their carers and families in considering residential aged care as an option for themselves and their loved ones. We are concerned that the situation at Earle Haven is the tip of the iceberg. With some of the business commitments and arrangements that have taken place with retirement villages and aged-care facilities, we are concerned that in fact this is not necessarily going to be an isolated issue.

Our interest in this area goes beyond the care arrangements and in fact goes back beyond 2013, when there were bushfires on Stradbroke Island. We had a meeting at that time with Emergency Management Queensland to talk about not only evacuation in terms of people in disaster management but also issues more broadly. Rather than talking about the Earle Haven situation, we would like to take this opportunity to talk about some of those issues of a broader nature that we think may be impacted by some of the current arrangements and some of the arrangements where there seems to be some overlap and gaps between which level of government is responsible in these circumstances. I will pass over to our policy coordinator, John Stalker, to talk more about that in detail.

Mr Stalker: I will go back to that Emergency Management Queensland meeting. When they asked us to attend that meeting they had a number of other representatives there—they had local government representation, Red Cross and a number of other organisations—who were trying to understand who had responsibility for ensuring, in this particular case an aged-care facility under threat of fire, that that organisation had appropriate measures in place so that in the event of an evacuation that could be organised and undertaken in a fairly quick and seamless manner. They expressed their frustration that they had had conversations with the Commonwealth government and neither the Commonwealth nor state government could reach agreement on who really had responsibility for what.

It has been the ongoing position—and it still is, as far as we understand—of Queensland Fire and Emergency Services that, as far as they are concerned, anything to do with aged care is a Commonwealth responsibility. The Commonwealth, while it puts out the guidelines on how aged-care facilities should be prepared and able to respond in case of an emergency, defers to state emergency arrangements. They advise providers to ensure that they liaise with the appropriate agencies both at the state and the local government level.

In 2014, as a result of the meeting at Emergency Management Queensland, we got all the key agencies together. We brought together the Inspector-General Emergency Management, QFES, Red Cross, a number of experts from interstate and a large number of organisations. We are able to table the report from that meeting for the benefit of the committee. What we wanted to get agreement on were the areas where arrangements were currently lacking. This was looking at that stage more broadly in terms of how you could better safeguard vulnerable seniors both in the community as well as in residential aged-care facilities. We produced that report. We circulated it to IGEM and other organisations to see if they disagreed with anything in that report. All organisations agreed that the report was an accurate reflection of the conversations on the day. However, there was silence after that.

Then in March 2015 COTA was invited to the third United Nations World Conference on Disaster Risk Reduction in Sendai, Japan, as part of the International Federation on Ageing delegation which was also trying to lobby for greater support of older citizens during emergency events. Our organisation, along with others, tried to ensure that the communique from that conference would give greater protection to senior citizens.

As we still had not heard anything from the agencies we had involved in our forum in 2014, we then presented a paper which highlighted the results of that forum at the Australian & New Zealand Disaster & Emergency Management Conference held on the Gold Coast in 2014. We thought that we had to continue reinforcing the need for government to take action in this space. Again, there was no response. It is someone else's problem.

In August 2016 COTA hosted the 13th International Federation on Ageing Global Conference on Ageing. Again, we made disaster and older people a key conference theme. Again, we had IGEM and a number of organisations involved in that conference. Everyone acknowledged it is a key issue, but it is someone else's problem.

Volunteering Queensland, whom we work closely with, through both the Queensland government and the Australian government, were funded to undertake a project on disaster preparedness for older people. This was largely undertaken in 2017. It was a joint initiative of Volunteering Queensland, the Australian government and the Queensland government and was funded through the National Disaster Resilience Program. COTA Queensland worked in partnership.

That project undertook forums across six local government areas both in regional Queensland and in South-East Queensland. It invited all agencies involved in disaster response and management. It involved everyone from the community with any interest. It asked a series of questions including the following. What arrangements are in place if you have to evacuate aged-care facilities in your region? What capacity exists in the local hospital, for example, to support those facilities? What capacity does the Queensland Ambulance Service have to assist with evacuations?

Based on those regional reports and other activities that occurred over that 17 months, they produced this report which was quite comprehensive and was then tabled to both the state and Commonwealth governments. One of the recommendations in that report is included in the submission. I will not read that. It basically says that there is a need to look at how we improve regulation of evacuation arrangements in Queensland.

It was basically recommending that there was a need to amend the Queensland Fire and Emergency Services Act 1990 to have a broader focus other than fire safety. Basically, if you are going to have legislation that is meant to encompass arrangements for fire and emergency events, you need to ensure that all likely events are covered, and we could not see a better piece of legislation. Currently, if you are going to operate some sort of business or organisation in Queensland you have to meet compliance requirements under that legislation. We also then did not see why, to operate an aged-care facility in Queensland, you could not also include the requirement to demonstrate that you have effective mechanisms in place to ensure safe evacuation of residents at the time of an emergency event.

Also in our submission we then question the definition of ‘emergency’. It is okay saying an emergency will cover fire, storm and flood, but we are also concerned in respect to Queenslanders whether emergency should also include any life-threatening event. The fact that you have administrative transfer of residents—and it may not be because of clinical reasons—does not mean that the lives of those older Queenslanders are not under threat through forced evacuation where there is uncertainty over where they will go and what circumstances they will be in where they end up and whether that will be better conditions than they are currently in.

We then heard that QFES was undertaking a review of their legislation. In March of this year we wrote to the appropriate contact for that review and provided, again, our views on what needed to occur in respect to amendments to that legislation. As yet we have had no reply so we are uncertain of their position, but we have been told second-hand that their view is that their responsibility is fire safety in respect to regulation and at this point in time we understand that they do not believe that it should go beyond that.

We did, after the Earle Haven situation, write to the health minister expressing our concern and we have just received a response, the day before yesterday. They explained that they are working with QFES to look at reviewing existing guidelines for aged-care providers in the event of an evacuation situation. That is probably it for the moment, thank you.

Ms O’GORMAN: Just picking up on what you have said about COTA’s view that there ought to be some expansion around the notion of what an emergency is, does COTA have a view about whether aged-care facilities ought to be required to have evacuation plans in place for the event of an administrative failure which might mean that there is no entity at the facility able to provide services to residents?

Mr Stalker: Yes, we do. Actually on the way down in the car we were saying it is nice being able to better handle evacuations and transfers in the need of that. It would be nice if there were other mitigating arrangements put in place in advance where there were some requirements, with some strong penalties attached, that where an organisation felt that it was at risk of being forced to close down that there was an appropriate time frame in which they would have to notify the relevant authorities, whoever they may be, to ensure that other organisations that may have to pick up the slack have adequate notice and that if residents do need to be transferred at some point in time it can be done in a way that has minimal impact on their health and can also ensure that those residents end up in appropriate situations where they will be well cared for.

Ms O’GORMAN: Thank you for that. I do not have further questions at this stage. Does the committee have questions?

CHAIR: Thank you for your submission and your advocacy for old people. It is ironic that we have fires all around the state right now and you are talking about disaster arrangements. Queensland is no stranger to disasters. Coming from Townsville, where we have just gone through the flooding disaster, I will put on record that our LDMG—and I know each city has its own arrangements in disaster recovery where all agencies work together—worked very well during the monsoonal events in Townsville which included moving elderly residents to evacuation centres.

Whilst you have highlighted the need for clarification of ownership, I am glad that you got a response from the health minister, working with the Minister for Fire and Emergency Services, to better strengthen those arrangements. I take on board the comments from Ms O’Gorman that not just

for fire, flood or cyclones but also for administrative failures we must have a plan. We heard yesterday in private session from family and staff the flow-on impact of the events at Earle Haven. There must be in our report going forward some kind of strengthened arrangements. We thank you for your commentary this morning.

I want to take you back to the business continuity arrangements. I know we have spoken about fire and emergency services disaster planning, recovery and response and all the rest of it, but I think we need to look a little further at business structures and what COTA's key message there might be in regard to better protecting older citizens in these facilities.

Mr Tucker-Evans: As John mentioned, we are concerned that in fact there needs to be an early warning system, that if people's business arrangements are in jeopardy then they need to advise authorities of that so there can be some alternative arrangements put in place. As I said in my introduction, we are concerned that, in fact, the Earle Haven situation is not going to be the only example of this. Certainly we are hearing from consumers—and COTA is in fact our peak consumer organisation—that this has raised a number of concerns for other people who are residents of aged-care facilities that are subcontracting their care arrangements. What we are looking for is greater support to make sure that if a business is in jeopardy there is plenty of time to make those arrangements to care for older people.

CHAIR: Does COTA have a view on probity arrangements around setting up a licence to look after older people? Should there be relevant checks of people setting up and subcontracting out?

Mr Tucker-Evans: The concern we have is that, whilst there are requirements for the actual provider, if they then subcontract there is no need to register the subcontractor. We are calling for subcontractors also to be registered.

Mr CRANDON: I take on board what you are saying about the suggestion of organisations or businesses being in some financial difficulty. On the evidence that I have heard, it appears to me that this was more about a dispute between two entities and there were some financial implications in it. It does not appear that the organisation was in financial difficulty, from the perspective that they could not pay the wages, but that there was money owed from one to the other and the argument is that there was also money owed from the other one back, so it was a dispute rather than a situation that could have been flagged to the government or to an appropriate government department. In fact, on the evidence I have seen, it looks like it was a contrived step by one or other of the parties to bring things to a head. How would you deal with that in circumstances as you suggest?

Mr Tucker-Evans: I think in all of these cases we need to make sure we have the care of the older person, the resident, at the centre—that anything that jeopardises the health and wellbeing of a resident needs to be alerted to appropriate authorities. If this is a business dispute and as a consequence of that we have 69 residents whose health and wellbeing has been compromised then what can we do in terms of legislation to prevent that happening again?

Mr CRANDON: And somehow hold those responsible.

Mr Tucker-Evans: Absolutely.

Mr CRANDON: It is a tough one.

Mr O'ROURKE: As part of this reporting of any concern about going into liquidation or the facility closing, which department do you think would be best placed to manage that notification? Do you have any opinion on that?

Mr Stalker: Clearly it is the Commonwealth department responsible for running that organisation that should be the organisation that gets the first notification. As for what then needs to be put in place, there needs to be stronger—while there are close relationships between the Commonwealth department of health and the state Department of Health—procedures/protocols in place where the relevant state agencies better work with Commonwealth agencies to ensure a faster response.

Mr O'ROURKE: From a department of housing perspective, where there was a notification of a residential facility or a caravan park closing down, there was a requirement to provide that early notification to coordinate a response. I would think it is something that should be fairly easy to put in place.

Mr Stalker: As a matter of example, we were provided last week from the Department of Housing and Public Works the draft procedures for retirement villages and how they need to respond to and liaise with residents in that situation. There are some good examples around.

CHAIR: Before I go to the next question, we heard evidence yesterday of the Commonwealth agency, the Aged Care Quality and Safety Commission, sanctioning Earle Haven on a number of occasions in the lead-up to the closure. Is it COTA's view that those sanctions should be stronger in terms of penalties applied if there are repeated sanctions placed upon residential aged-care facilities?

Mr Tucker-Evans: The care of residents is of the utmost importance. If there is a history of not meeting those needs then we certainly believe that there needs to be stronger penalties.

Mr BERKMAN: Thank you both for being here. I want to very quickly revisit the suggestion you made before that subcontractors should be required to register as providers, similar to the existing registration process. Is the scheme as it stands—if it were expanded to cover subcontractors—otherwise fit for purpose, or are there other changes that you think are required?

Mr Stalker: I suppose COTA's formal position in terms of the broad range of reforms that the Commonwealth government has introduced into aged care is that there are a lot of steps in the right direction, but unfortunately it seems to take quite a bit of time for those steps to come together and reach fruition. Obviously in terms of the new quality agency combining two helmets of pre-existing agencies, we are concerned, for example, that they have not quite verged their policy procedures, IT systems or staff and it makes it very hard to improve the regulation of the system if the organisation responsible for quality assurance is not really at a high-quality operating level itself.

It is a bit hard to answer that question because, as I said, there are a lot of things in transition in the aged-care space. The other concern, for example, is home care, and we have always been concerned about the shortage of home care places. The Commonwealth very quickly responds and puts a lot more funding into home care, which is good. However, if home care is always already suffering from a shortage of trained professionals, the injection of funding alone is not going to solve the quality of home care currently available in Australia. There are a lot of good measures being taken by the Commonwealth, but they are just taking a while to come together. I am not sure if that really answers your question.

Mr BERKMAN: I think it does. Broadly, if I understand your answer, we might simply expand that registration process. That is not going to address all of the issues, but it is a step that could quite readily be taken within the existing framework.

Mr Stalker: Yes.

Mr McARDLE: Thank you for being here today. It is much appreciated. I want to take you back to a couple of things—first of all, a report you had there, Mr Stalker. Would you care to table that or seek leave to table that report to the committee?

Mr Stalker: That was the one from Volunteering Queensland?

Mr McARDLE: Yes, that is the one.

Mr Stalker: We have advised Volunteering Queensland that we would be possibly tabling that report today.

CHAIR: Was there further tabling with regard to reports or a response from the minister?

Mr Stalker: Yes, we can table the response from the health minister today, yes.

CHAIR: Is leave granted? Leave is granted.

Mr McARDLE: There was also a letter from an earlier minister or somebody who implied that they could not take it any further, that they thought their remit did not touch the nursing home.

Mr Stalker: That is more our interpretation of various discussions we have had. We have a letter here that we sent to the Queensland Fire and Emergency Services department. They had an email address for people to submit views on their legislative review and we did submit that in March but as yet we have had no response. We are able to table that as well if it is of assistance.

CHAIR: Is leave granted? Leave is granted.

Mr McARDLE: I want to take you back to a model. You were keen to bring it under one department—Emergency Services as I understand; that is correct?

Mr Tucker-Evans: Yes.

Mr McARDLE: Can you explain to me how that model would work? For example, would there be a static layout of individuals and organisations or would it be fluid depending upon what issue arose in relation to a nursing home?

Mr Stalker: Currently there are fairly strong fire safety regulations under the act and you need to get ticked off to meet all of those requirements. What we were simply proposing was that, for residential care facilities, apart from fire, you also have to demonstrate that you have the effective

processes in place to be able to evacuate residents at the time of need and that also there is the appropriate training regime in place to ensure that all staff are up to date on those requirements. We would see it working in partnership with the current fire safety regime and it would just be another element of it that relates to residential aged-care facilities. There may be other residential facilities in Queensland aside from aged care that might benefit from those arrangements, particularly where you have residents who are unable to basically fend for themselves and are totally dependent upon the organisation that is looking after them for their safety.

Mr McARDLE: I am more concerned about the structure. Where does it sit? Is it with local government, state government or federal government? Where does it sit?

Mr Stalker: No, it is clearly state government. The state government has a responsibility for emergency management. It clearly rests with the state government.

Mr McARDLE: So that department would be the lead agency; is that right? That was what I was trying to get at to begin with.

Mr Stalker: I suppose in Queensland, Health has a role to play in terms of—

Mr McARDLE: Let us just stay with the lead agency first and then I will talk about Health. I take your point.

Mr Stalker: Okay. The lead agency from our perspective—and I am a bit conflicted here; I have just recently been awarded a QFES medal, so I am a bit conflicted here.

Mr McARDLE: Put that feeling aside for the moment, Sir.

Mr Stalker: QFES from our perspective would have to be the lead agency. It has the responsibility for emergency management in Queensland. It currently has the responsibility for fire safety and we see that it should have an equal responsibility for ensuring there is the appropriate evacuation arrangements in place at the time of an emergency, and this is the sort of thing that needs to be in place when an organisation is being registered or is having its fire safety requirements reviewed.

Mr McARDLE: Let us go to nursing homes. Let us go to Earle Haven and what happened down there at Earle Haven. A code brown was called by the HHS, and that literally means that there is an event external to the hospital or the HHS that would have a major impact upon the HHS's capacity to provide ongoing care and services through its facilities. Would it not be logical to have Queensland Health in charge in those circumstances, because any nursing home in an evacuation is going to require the assessment, transport and treatment of patients—I just want to try and get some idea from you as to where you are going to—or would it be the case that there would be a static lead agency but that lead agency would share the power as an event unfolded and an outside agency could in fact alert the lead agency that they are taking a step in bringing them both into play?

Mr Stalker: I think it would work on that second model more. From our view, we want to ensure that before there is any event—before there is any likelihood of an event requiring evacuation—every aged-care facility or organisation in Queensland has in place a clear set of plans on how such a situation would be managed and there is regular training of staff in how to proceed. We want that in place and we believe that QFES is the appropriate agency to ensure that. In terms of what actions occur down the track on such an event, Queensland Health would probably then play a strong role in that. In terms of how that is set up, I am not in a position to answer how that could work.

Mr McARDLE: So every facility would need to be trained individually as to what would be required to happen and make contact with an appropriate body or authority in their region? Don't the local governments already—

CHAIR: The LDMG.

Mr McARDLE: Yes, they stand up in emergency situations. That coordinates police, the ambulance, the fireys, the hospitals. Is that not an ideal scenario? Why would we want to reinvent the wheel, with respect, and put another overlay in that another body exists that could really overlap an existing structure which has proven to be satisfactory?

Mr Stalker: No, but okay. A local disaster management group will ensure that there are appropriate responses in place before and during an emergency. For example, IGEM in its review of Cyclone Debbie raised the issue that there are still a lot of gaps in terms of how you respond in a situation of an aged-care facility requiring evacuation. Things do not quite hang together the way they need to and there is still confusion over who should be doing what.

When we did the forum back in 2014, I must admit that we had a conversation with a person who was then involved in the LDMG in Townsville and I was told in very strong terms that, from a local authority's perspective, their main priority is ensuring the re-establishment of infrastructure, and

with some local authorities we deal with that is still their priority. The fact that they have LDMG responsibility is good—they all try to do that as well as they can—but what we are proposing does not really impact upon how an LDMG will operate within its region. It is really just ensuring that an aged-care provider will have the appropriate processes in place and arrangements in place.

Some aged-care providers we have been advised of, particularly in other states, have partnership arrangements with other providers so that if such a situation does arise they are in a position where they know that 'we can transfer X number of residents to facility Y down the road', and that is all spelled out well in advance. There are only a minority of providers that would have that in place and we think all providers should have that arrangement in place.

Mr McARDLE: All right. We will call it a work in progress. You also referred to a subcontractor being registered as per the approved provider requiring registration. The law changed in about 1997, as I understand, to move to the current system. It seems to create the head contractor-subcontractor model. Prior to that time, as I understand it, it did not really exist in that format. Were there instances prior to 1997 where there were still failings in the aged-care system that led to dreadful outcomes? If you do not know you do not know; it is as simple as that.

Mr Tucker-Evans: There have been about 20 inquiries into aged care since 1997 and that was obviously in response to failures, but with the royal commission currently it is hoped that the lessons of the last 20-odd years and more are actually going to be resolved. We are conscious of the state inquiry into aged care, and John and I will be appearing tomorrow. I think aged care is a very complex system. It does involve the federal government. As John indicated earlier, there have been moves in recent times to bring different organisations together in response to trying to resolve some of those issues. We are still concerned that with the growing demographic of older people we have a once-in-a-lifetime chance to make this work and at the moment we are still seeing examples of where it is not working.

Mr McARDLE: The other factor of course is that we are living longer, as you said, but more importantly we now have more complex and chronic disease issues as we live longer, and the face of what was a nursing home or an aged-care facility 30 years ago no longer exists. It is a completely different model entirely—different issues, different concerns, different outcomes. Would you agree with that?

Mr Tucker-Evans: Absolutely. Most people now go into aged-care facilities for high care whereas only a decade ago there was lower need.

Mr McARDLE: Exactly. Thank you.

CHAIR: Just going back to the disaster preparations, I cannot speak for every LDMG but, certainly having worked on LDMG in my previous role in Townsville and seeing recent disaster management, I know it takes a whole-of-government approach. The stakeholders around that were certainly providers like RSL Care, which has a facility right on the coast. For me, it is what we saw at Earle Haven. We saw a whole-of-government response in terms of Queensland Health and Queensland Ambulance moving in. I am sure if there was a fire risk you would have Fire there as well. Like I said, I cannot speak to each one. Thank you for tabling that document.

Mr Tucker-Evans: We would certainly commend the response that happened in terms of Earle Haven. In speaking to the Chief Health Officer, her desire was not to move people from Earle Haven, but the circumstances meant that there was no other course. What we are advocating for is that, as John has indicated, we need to ensure there are plans in place in the eventuality that this could happen.

CHAIR: I agree. Thank you very much. Mr Stalker, just before we close, you said you received a QFES award. What was your background?

Mr Stalker: I am just a rural firefighter.

CHAIR: There is no 'just a rural firefighter'. Remember that, with the irony of it now being that we have hundreds of them out protecting Queenslanders. Thank you very much.

Mr McARDLE: And still doing so too, by the way.

CHAIR: Absolutely. Gentlemen, thank you very much for your contributions today. Ms O'Gorman, we have finished with these particular witnesses.

Ms O'GORMAN: Thank you. I do not have any further questions.

ROWE, Mr Geoff, Chief Executive Officer, Aged and Disability Advocacy Australia

Ms O'GORMAN: Mr Chair, I can indicate that Mr Rowe has prepared an opening statement and we might commence with that.

CHAIR: Welcome, Mr Rowe. I understand you have an opening statement.

Mr Rowe: I do, thank you. I thank the committee for the opportunity to present here today. I will take our submission as read. ADA Australia, as you know, is an aged-care and disability advocacy service supporting users of aged-care services and people with a disability across Queensland. You have made the comment that Australians are ageing, and that is something we very much know. We are moving from 14 per cent of the population being over the age of 65 in 2014 to an expected almost 25 per cent of people being over that age by 2050. In response to that, we are seeing a growth in the ways that aged-care providers are coming into the market, seeing that it is a significant growth area.

In respect of Earle Haven, I guess the comment that I wanted to make is that, while our submission reflects a review of case notes since 2016, we are very much aware that the problems at Earle Haven have been very long term. Our Gold Coast based advocate has been in the role for 9½ years and she describes the issues as being there ever since day one that she started. The issues at Earle Haven have been standout. They are not reflective, I think, of the broader aged-care industry. The problems at Earle Haven have been known by others in the sector and by government at both levels over many years. The fact that the closure on 11 July happened came as no surprise. My experience has been that, whenever someone has talked about there being an issue in aged care on the Gold Coast, Earle Haven has always been identified as the likely source of that concern.

This does get caught up in the complexity of the interface between Commonwealth and state governments, with aged care and the regulation of aged care being the responsibility of the Commonwealth and the regulation of retirement villages being the responsibility of the state government. We have seen an increase in the model where aged care, or residential aged care particularly, is being provided within retirement villages as part of their suite of offerings. We have seen that many people in retirement villages use Commonwealth home care support or Commonwealth home support program services to allow them to continue to live independently.

I attended the meeting that was held with residents, the Earle Haven owner and the Commonwealth department a week or two after the closure and was quite concerned at the number of families who were saying, 'We want our loved ones back here.' For me, that was something I could not reconcile with all of the history I had heard, and indeed the experience that people had just been through. Perhaps it was people wanting life to return to normal. I think that is part of it; I think none of us like change. I think one of the other issues was—in terms of their loved ones being displaced—for many people who lived in the retirement village but their family member lived in the aged-care facility, it was very easy to visit and visit on a daily basis. The concern about the interface between aged care and retirement is a matter that has to be addressed by government going forward.

I have just returned from a Churchill Fellowship, having spent seven weeks travelling around the world looking at the response to elder abuse in aged care in the community—not only the response but also prevention. While I am not aware of, I suppose, the demographics for aged care in retirement villages in Australia, I can tell you that in New Zealand 70 per cent of the retirement villages provide residential aged care. I suspect it is probably the same if not higher in Australia.

My message to the committee is that there is a role for government. There is a lack of human rights operating within the aged-care environment. I often talk about older people being required to check in their rights when they check into aged care. The state government does have a very clear role in respect of protecting the rights of older people—whether that is through the instruments that it puts in place, such as enduring powers of attorney, which do not appear to be understood by the aged-care system, or whether it is in relation to the monitoring of the use of restraint in aged care and with older people. We have seen the state government not being part of the state government's journey looking at bringing in legislation in the disability sector to protect the rights of people with a disability to reduce the use of chemical restraint, physical restraint et cetera within the disability sector. I have seen that being very effective within disability.

Indeed, I was working for a large provider at the time where we identified there were 750 clients who were subject to restrictive practices. By the time I left five years later, that number was down to 104. It was about training staff; it was about changing practices. I think there is a real role for the state government to be involved in the monitoring of that use. At the recent royal commission hearing in Brisbane it was highlighted that the review undertaken by the Commonwealth two weeks prior to the closure discovered that 71 per cent of the residents were subject to chemical restraint and 50 per cent of the residents were subject to physical restraint. I have also received anecdotal feedback from

my advocates where they have been meeting with families who have been concerned that their family member has gone into Earle Haven mobile and compos and within a four-week period they had lost the ability to walk and to talk and shortly later had passed away. There are some very, very concerning practices.

Finally, in terms of my opening comments I think we need to give consideration to whether there is a role for an ageing commissioner within Queensland. We have seen the development of that role in New South Wales—only just—and within Victoria it was about 12 months ago. As we are seeing more Queenslanders age, as we are seeing the difficulties that they are having in having their voice heard, I think it is imperative that the state government takes the lead on addressing those concerns.

Ms O'GORMAN: Mr Rowe, in your submission, you make reference to having done a review of advocate case notes that are available to you from within your organisation dating back to 1 January 2016. I would like to commence by asking you a couple of questions around what information was available to you as part of that review, if I could. Firstly, are you able to recall now exactly how many case notes you were able to review?

Mr Rowe: I had one of my staff do that review so I cannot tell you the number. We have supported many people over many, many years who have been residents at Earle Haven or who have been family members of Earle Haven. People come to us as an advocacy organisation because they have a concern or a complaint regarding their aged-care provider that they are unable to resolve: whether that is because they are fearful of retribution—and we understand that that was very real at Earle Haven, that it did not promote an environment where complaints or feedback were welcome—or whether it has been that they have raised the issue and it has been unable to be resolved. The concerns have been outlined in my report and they are many—the frequent staff changeover, being unable to have their complaints raised or resolved, and frustration that while the organisation has passed through accreditation the concerns they have raised with the Commonwealth auditors at the time do not appear to have been listened to.

I will give you an example to give you an insight into the culture. Mark certainly raised the fact that the way the Commonwealth is certifying aged-care providers changed from 1 January this year, but historically there has been an audit team coming out on a particular day or days. We have certainly seen with some aged-care providers there has been a special set of crockery and cutlery that is brought out of the cupboard for the audit days. In the case of Earle Haven, the audit crockery and cutlery was hired into the event. The culture was that it was not even worth spending enough money on that they had that there all the time. I guess I just found that was indicative of the culture and the complaints. It was many things. It was the management of people's health. It was food. It was right across the board.

Ms O'GORMAN: You have said that you are not able to say exactly how many advocacy case notes existed for that period from 1 January 2016. Are you able to provide the committee with an estimate of the frequency with which an advocate would be engaged with someone from Earle Haven?

Mr Rowe: I am happy to take on notice the provision of an analysis of how many. I am happy to go back further than 2016 if that is helpful. At the end of the day, we are a small organisation. Our focus is on supporting people through individual advocacy. Systemic advocacy is absolutely important, but we do not get a lot of time because it takes us away from that individual support. I will take that on notice.

CHAIR: Thank you for taking that on notice.

Ms O'GORMAN: Mr Rowe, do you know sitting here today, or are you able to give us an idea of, how frequently an advocate from your organisation would have been engaging with someone from Earle Haven over, say, the 9½ years that you have described having a Gold Coast based advocate?

Mr Rowe: I am sorry. We have 25 advocates located across Queensland. I do not have that knowledge on hand. Interestingly, when I talk about us having 20 advocates across the state, the Gold Coast is our busiest office and always has been. We have almost two full-time advocates based here. At the moment we have a waiting list that is out to six-plus weeks, and we do a triage to deal with the most urgent. We have staff from Brisbane who travel down to support our advocates here. Earle Haven has been part of that work but it has not been an exclusive part.

Ms O'GORMAN: Can you give us an idea of how a resident at Earle Haven would have been able to contact an advocate from your organisation—how they would have known about it, what mechanisms were in place for making that contact, that kind of thing?

Mr Rowe: I will talk about the standard process. There is an expectation that, as a funded advocacy organisation, we deliver education within aged-care services—that is, education to aged-care users about their rights and their responsibilities and to aged-care staff about residents' rights. There is a requirement from the Commonwealth's end that providers provide information about advocacy services. Probably one of the things that would set Earle Haven out from others a little bit is that, because there have been a number of sanctions over the years, whenever there is a sanction and there is a meeting with families and residents, the department of health has invited ADA to attend those so that residents are aware of our services. That is probably a level of promotion of our service that other providers do not get.

While that all sounds very cosy, one of our frustrations as a provider over the years has been that there have been many aged-care providers who will not allow us into their facilities to do that education, and they are often the ones that end up on the front page of the paper. When I first started in the role, there was a story on the front page of the *Courier-Mail*. When I asked my team, 'How long since we've been to that facility to provide an education?' their response was, 'It's been three years. We've been trying to get there but they won't let us in.' Again, that reflects on the lack of rights focus within the aged-care sector.

Ms O'GORMAN: Your submission makes it clear that, even if you are not in a position to give an exact number of the advocacy case notes that were available in that period that we have mentioned between 1 January 2016 right through to July 2019, clearly there was contact being made by your organisation with residents of Earle Haven.

Mr Rowe: There has been very regular contact.

Ms O'GORMAN: Do you have a sense from those case notes and what you were told about them about how any recommendations that were made by your advocates to management at Earle Haven were received?

Mr Rowe: I will make a general statement in response to that: probably variable. Earle Haven did not have a welcoming culture in respect of feedback or in respect of complaints. In my submission I have reported that the owner of the facility was very hostile. I am not quite sure I want this on the record, but I might as well put it there. When the post-closure meeting with families was on, my local based advocate was fearful of attending that herself and asked me to go along. Part of the reason why was that at the last meeting she attended people were throwing chairs. The communication and the trust between management and the users and their families had broken down to that extent.

Ms O'GORMAN: You have referred to 'the owner'. Are you making reference there to Arthur Miller?

Mr Rowe: Yes, I am.

Ms O'GORMAN: You have made reference to one of your advocates reporting back to you about chairs being thrown at a meeting. Did she indicate to you who was throwing the chairs?

Mr Rowe: I do not know that my memory will allow me to give a definitive answer on that. It would come down to interpretation.

Ms O'GORMAN: It seems, from what you have indicated about your review of the case notes relevant to staffing issues, that they threw up concerns around whether or not there was an appropriate number of staff on any given shift. Is that something that was reflected in your case notes?

Mr Rowe: My understanding is that it related to the number of staff, it related to the appropriate qualifications of staff and it related to the attitudes of staff. Certainly it has been reported on many occasions that the good staff do not last long. They leave. That, again, has been a recurring theme over many, many years.

Ms O'GORMAN: One of the things you mentioned a little earlier in your opening statement was a concern that, perhaps anecdotally, there is evidence that residents would enter Earle Haven and, in some cases, within a four-week period lose the ability to walk and talk or indeed pass away. Did I understand that statement correctly?

Mr Rowe: You did understand that statement correctly. That statement related to the use or overuse of psychotropic medication. That has been and continues to be an issue that we raise more broadly.

Ms O'GORMAN: In your submission there is reference to at least one anecdotal case of a woman hearing that a family member had been given antipsychotic medication without that woman—the resident's enduring power of attorney—being advised of that in advance.

Mr Rowe: Yes.

Ms O'GORMAN: Are you aware of there being any more than one instance of that sort of thing being reported to your organisation?

Mr Rowe: That is not an uncommon report to our organisation across the board.

Ms O'GORMAN: Is that something that is particularly concerning to your organisation?

Mr Rowe: It is completely concerning. In my opening statement I referred to the lack of human rights within aged care. It refers to the lack of respect within aged care. As part of the Churchill Fellowship you are required to write a report on the fellowship and findings. That ha d to be submitted by last Friday. It is still a work in progress. One of the questions I did ask when I was overseas, because it is very much an issue within Australia, was: how often do you see issues around the use of medication to control people's behaviour? It has not been raised as an issue elsewhere. It appears to be a culture within Australia. Whether it is in response to a lack of staffing or whether it is in response to poor understanding, it is deeply concerning.

The Commonwealth government, just prior to the recent election, brought in new principles associated with the administration of chemical and physical restraint in aged care. I appeared before the Joint Parliamentary Committee on Human Rights about three weeks ago, arguing that those new principles should be repealed. They breach people's human rights. They make it easier to administer that medication than currently. You are just required to have a responsible person. A responsible person could be the gardener who signs off and gives permission.

If we go back to the disability legislation in Queensland around the use of restrictive practices, our legislation is world leading. We have invested in protecting Queenslanders with a disability but we have ignored Queenslanders who are ageing, and I do not understand that. Having come out of the disability sector, as I said, human rights is front row and central to the legislation. It is underpinned by a rights statement. In aged care you cannot find a rights statement. People have no rights. Well, that is how it would appear.

Ms O'GORMAN: Do you have any views about what mechanisms ought to be in place to ensure that people in aged-care facilities are not having their human rights abused, particularly in the area of the use of chemical restraints?

Mr Rowe: The Commonwealth government has recently reviewed a number of its rights charters and has come up with a single charter of aged-care rights. That has been rolled out from 1 July this year. I think aged care his really struggling with that and providers are really struggling with that, having been involved in some of the consultations about what that charter should look like. I saw some aged-care providers seeing it as a tool they could use to make older people do what they wanted them to do, rather than seeing it as a tool that has been put in to allow the older person to express to have a quality of life et cetera.

I am not a lawyer. Somewhere in the mix of Commonwealth-state responsibilities there is a demarcation around who ultimately is responsible for protections of older people. I do see that the state government has a role. The state government is involved in many areas of supporting and protecting older people. I have seen it done in disability. Going back 10 years, when it first came in, the murkiness about who was responsible for what between the Commonwealth and the state I think was less clear than it is now, but the state government stood up, went forward and said, 'We have to do something about this.' There is an opportunity at the moment for us to step up and say, 'We want older Queenslanders to be safe, whether they are in a disability service or whether they are in an aged-care service.'

Ms O'GORMAN: Is that something that, in your view, might fall under the purview of the ageing commissioner that you are recommending?

Mr Rowe: I probably have not thought about that enough. At the moment the monitoring of the use of chemical restraints within disability services falls within the responsibility of the Office of the Public Guardian. People are required to have what they call a positive behaviour support plan—a plan that approves the use of restrictive practices—and that is supported and signed off by QCAT through the Office of the Public Guardian. I suspect that someone far more clever than I will work out where and with whom it should sit within government.

I think the commissioner was about saying that there needs to be somewhere older people can go to have their concerns and their complaints addressed. Older people are not very good at that. My team often talks about the current cohort of users in aged care being the grateful generation. They are a generation that has grown up through the war, through the Depression. They are generally grateful for what they get. They do not complain. They are also called the silent generation.

Being slightly flippant in amongst all of the dark stuff we are talking about, we know that the generation of older people is changing. We know that the baby boomers are starting to knock on the doors of aged care. The baby boomer generation have never been described as grateful. They will be a generation that will change the system. The other day the analogy of childbirth was put to me. If you think back 30 years, husbands were excluded and it was very clinical. The mother went into the room and the husband got a phone call down at the pub. Nowadays we have birthing suites, we have everyone there and the woman is in control. We need to put the older person more in control than they are at the moment.

Ms O'GORMAN: Can I ask you some questions around another aspect that you have highlighted in your submission. It relates to the perceived disparity by some of the residents between the quality and safety of care being offered by Earle Haven and the outcomes being found by the regulatory compliance bodies at times. In your submission you refer to one of the assessments that took place in 2017, for example. You refer there to the fact that 44 out of 44 outcomes were deemed as being met as a result of that supervision but at least one resident was reporting that that was at odds with their experience of the care. To your knowledge, is there only one report about that disparity or is that something that your organisation has heard of more broadly from those in Earle Haven?

Mr Rowe: I would probably want to take that on notice to be definitive, but I would make a general statement that the issues that people from Earle Haven were raising were issues that breached the standards. How could a provider have been given 44 ticks when there were a number of areas where there were complaints that the standards were not being met? It is difficult for me to reconcile. In my mind, the only positive that comes out of what has happened at Earle Haven has been the timing. The timing has been during the course of an aged-care royal commission, so there has been interest and analysis. It has also been at a time when the state committee has been looking at aged care, amongst other things. It has been a real opportunity to shine a spotlight on what, at the end of the day, appears to have been very poor practice.

Ms O'GORMAN: Do you have any views about whether or not there should be a broadening of any requirement that regulatory assessors who are doing an assessment of an aged-care service ought to take into account the views of advocates who might be well placed to provide to them some of the complaints being held by residents who are too fearful or too grateful to speak up for themselves?

Mr Rowe: I believe there is a role for advocates to feed into the system. We have at times provided feedback to the department. I think within the current reforms that have occurred, particularly around the Aged Care Quality and Safety Commission, there is a greater appetite for dialogue with advocates and feedback. We see things that others do not. As I said, with the current cohort, people do not complain, sometimes because that is not what you do and many times for fear of retribution, whether that fear is real or not real.

Ms O'GORMAN: Finally, one of the matters that you address in your submission is a recommendation that there should be some formalisation of the role of advocates—and I am paraphrasing here—but a recommendation that there be the development of a framework that allows advocates who are well placed to make recommendations to a person's care provider without the requirement that those recommendations always be taken on face value, but certainly with the requirement that if they are not going to be followed then reasons ought to be given for that. Assuming I have correctly characterised your recommendation, is there anything that you wish to add to that recommendation?

Mr Rowe: I just really want to reaffirm that our accountability to effect change within aged care is really limited to persuasion. Some of the tools that we have had, whether it has been Commonwealth guidelines or handbooks in the interests of streamlining, have been removed. We cannot even reference those and say, 'The Commonwealth guidelines say that you must do A, B, and C,' because they no longer exist. We know that the current complaints system pre 1 January of this year was that the service provider would say, 'Yes, we'll do that,' and there was no follow-up and no check-up. Again, we often got people coming back to us and saying, 'We've gone through the formal complaints system. We've got resolution, but the service provider has done nothing.'

I had an interesting conversation in Anchorage with the woman whose title is Long Term Care Ombudsman. She sees her role as very much an advocacy role within the system around vulnerable adults—so it is across disability and aged care. She talked about how they have developed an MOU with the licensing authority and the adult protection service so that they work together. Part of her role is that she will go in three or four weeks after the resolution of an issue to check that it has actually happened and changed and she reports back. In a similar way, I am looking for a strengthening of

that advocacy role. We are not the enemy; we are there to support the older person and to ensure their rights are protected. I think it is an incredibly important role. As a spend in a Commonwealth multibillion dollar budget, there is about $8 million spent nationally on advocacy services in aged care.

Despite our best efforts, in Queensland we see less than one per cent of aged-care users. Does that mean that 99 per cent are happy? No. As I said earlier, at the moment our waiting lists are out for six weeks. Clearly, inquiries like this and like the royal commission are raising the profile and making people less fearful of raising concerns, but there needs to be an avenue available for people to raise those concerns. Agencies like us have escalation policies, depending on how serious the issue is, but there also needs to be that systemic reporting where we can say, 'This is what is happening behind those closed doors.'

Ms O'GORMAN: Thank you. Mr Rowe, my final question is really a matter of clarification of something that you said a little earlier. You made reference to Earle Haven hiring crockery for the purposes of regulatory audits. Was that said by way of a metaphor or do you have information that that actually occurred?

Mr Rowe: That is certainly the advice that we were provided by residents we were working with at the time.

Ms O'GORMAN: Can I just clarify that? It is your understanding, based on advice provided to you by residents at Earle Haven, that Earle Haven would hire crockery for the purpose of having it available at a known, upcoming audit?

Mr Rowe: Yes, noting that probably since the change to the quality and safety commission the department is now undertaking unannounced audits. They can turn up any day of the week. That practice has not been limited to Earle Haven. I fear that in these forums I just present the aged-care sector as mad and bad, and they are not all mad and bad. There are some fabulous services. There are some brilliant people, some very caring people, working in the industry. It is like everywhere: it is a couple of bad apples who are the ones who stand out. It is really important that we are balanced in our assessment of aged care. There are good providers. There are wonderful staff. There are caring staff. There is really good practice—there is world-leading practice—but there are some rogue providers out there. Whether it is the safety net or the regulatory net that should be catching them or holding them accountable, it has not been working.

Ms O'GORMAN: Thank you. Mr Chair, those are the questions that I have for Mr Rowe.

CHAIR: Thank you very much, Ms O'Gorman. The committee will move to some questions. Mr Rowe, how long have you been CEO of ADA now?

Mr Rowe: At the end of September I will have been in the role for five years.

CHAIR: As an interesting segue from Ms O'Gorman's comments, I was going to talk about the hiring of cutlery or crockery for audit purposes. The committee would very much welcome those case notes to be presented as soon as possible, if you can take that on notice. I do not mean to put a 24-hour time frame on it, but it would be very helpful if we could look at those or review those before Mr Miller appears on Monday, 16 September, which leaves tomorrow, if possible.

Mr Rowe: Yes, thank you.

CHAIR: We would deeply appreciate that. You use the words 'toxic culture' in your submission. You talked about the overuse of psychotropic drugs. In a general comment, we have heard of people who have improved since they have been moved from that facility, Earle Haven. They have become more alert and interacting with their family members.

Mr Rowe: Funny that, yes.

CHAIR: That was interesting. I would very much like to get the date of when that cutlery or crockery was brought in. I say that because we had Ms Karen Heard before us yesterday. Ms Heard herself—and I use the generalisation—had been brought in as a consultant to pass a sanction, or to improve services I think on two, three or perhaps now four occasions when a sanction was imposed on Earle Haven. Then it would be lifted. I am just interested to see the date of when those items were hired to align with dates that Ms Heard was contracted to come in.

Mr Rowe: This would have been in relation to one of the audits rather than a follow-up on the sanctions.

CHAIR: There were audits at a certain time.

Mr Rowe: The audits are effectively every three years.

CHAIR: I just find it shocking that that behaviour or practice occurs simply to pass an audit. I will move to questions from the committee.

Mr CRANDON: Thank you, Mr Rowe. Quite a bit of conversation has gone on around the subject of physical restraints and chemical restraints. You have it in your submission, we have discussed it here today with you and we discussed it with witnesses yesterday. In fact, I was only last night listening to a segment from the royal commission where the questioner was putting to one of the witnesses some of the aspects of that and specifically referring to the 71 per cent chemical restraint, or psychotropic drug use, and 50 per cent physical restraint. The questioner was putting it to the witness that it was even more alarming that the physical restraints were being used. If I recall correctly, the witness accepted and agreed with that.

This brings me to the conversation we were having yesterday with witnesses. I specifically asked about what those restraints are. They spoke about the railings on the bed and they spoke about a tray in front of a chair to ensure that someone cannot fall out of the chair. My mind went immediately to the fact that recently I was in hospital and they had railings on the side of the bed, so I fully understood what they were talking about there for obvious reasons—I had just been through an operation. I then also thought about toddlers—little ones—sitting in a high chair and being restrained. I even pushed the point and said, 'Is that it? Is there anything else—straps, that type of thing?' What do you think of when we talk about these physical restraints? Are we talking about those two things that I have just talked about or is there something else that is more concerning to you?

Mr Rowe: The definition of 'physical restraint' is very broad. It can be from locked doors and cupboards through to, as you described, bed rails and even straps in wheelchairs. When we are dealing with a population whose physical support needs and medical support needs have increased hugely over the last 20 years, we expect that there will be a use of restraints. I am not a person who would say we should never—no, no, never—but where it is done without consent, without the individual's consent or without the family member's consent, consent is one of the key things. In relation to psychotropic medication, what we know is that, of the people who have been prescribed psychotropic medication, for probably less than 10 per cent it is supplied for a medical reason. The bulk of the use of chemical restraint is around controlling people's behaviour, and that is done without their will.

I am happy to share a copy of a submission that we made to the Parliamentary Joint Committee on Human Rights. We worked with Human Rights Watch international around that. Probably, it is a statement I want to make. Certainly, we connected a number of family members who are subject to chemical restraint with Human Rights Watch, which is currently doing a research project in Australia around the use of psychotropic medication in aged care. In Queensland I think we connected it with 17 or 18 people who were willing to be research subjects. Human Rights Watch New York has also interviewed people in Sydney and Melbourne. That report, I think, is due for release in October this year and I think it will echo some of the findings in the US report after they did a similar research project in the US. In the US each day I know there are 179,000 older people who are subject to chemical restraint, generally—more often than not—against their will. It is about will, it is about agreement and it is also about appropriateness.

The other comment I make on chemical restraint is: we know that the drug companies' clinical advice is that use for longer than 12 weeks of some forms of chemical restraint is medically dangerous. That is ignored. We know that the use of chemical restraint increases an older person's risk of trips and falls and we know that that is often a lead in to their premature death. It is not just about saying 'it's not right'; we are actually pushing some buttons that place older people at significant risk, and that risk is death.

Mr CRANDON: Why are families not saying more about these chemical restraints and physical restraints? They are going in and visiting their parent. They can see that the railings are up. They can see them sitting there. Why are they not saying more? Are they accepting?

Mr Rowe: I think, again, as a society we have been taught not to challenge the medical advice. Sometimes it is nurses, but I think probably more often it is not. Certainly in terms of chemical restraint, we frequently hear the story that they were not aware it was happening until the family members got a chemist bill to pay and they have gone through and said, 'What's this drug? I have not seen that before,' and they have googled it. Again, I am making it all sound mad and bad, but frequently we as advocates see the ugly side of aged care, that families are not informed and not consulted and their agreement is not sought. The older person is not consulted.

Mr CRANDON: There is a need for education there as well to families.

Mr Rowe: Absolutely a need for education, but there is also a need for us to look at what other options are available. At the hearing in Sydney a couple of weeks ago I used the example of my parents. My dad is 91 and the primary carer for my mum, who is 88. They live in a place probably a

bit like Earle Haven, where they are in their own home in a retirement village where there is a long-term aged-care facility there. If Dad were to die tomorrow, my mother would not be able to continue to live independently. She would be fast-tracked into a residential aged-care place. She will have just lost her partner of 70 years. She will be in a new environment. She will have moved out of her home of the last 12 years. She will be in a strange place. We know that people with dementia do not deal with change. She will be a primary target. She will have a big target on her chest that says, 'I'm going to be off my tree because I'm just completely grief stricken. I am traumatised.' I think she is at huge risk that someone will come in and say, 'We can fix it. We will give you some drugs.' She actually needs to be able to grieve and she needs to talk about people.

Mr CRANDON: Often I would imagine the chemical restraint would lead to the physical restraint, because if you are subject to a chemical restraint—you talked about trips and falls—the next step would be for a provider to start putting in physical restraint as well.

Mr Rowe: I do not think there is any rule about one before the other. I think it is very individual. It is probably a clinician question.

Ms PEASE: Thank you, Mr Rowe, for coming in and thank you for the great work that your organisation does. It is really important to have you out there advocating on behalf of the people in that sector. You talked about the disturbing number of callouts and inquiries from Earle Haven. Are you able to indicate if there had been any reduction in those callouts since HelpStreet took over?

Mr Rowe: I have not done that sort of analysis. I could ask that question of the advocates.

Ms PEASE: That would be great. It would just be of interest. One of the things you also talked about was the ability to access the sites. Is it a requirement of the regulation or are there any regulations in place for a licensee to enable you to get on site to the premises?

Mr Rowe: There is an expectation, but there is no formal requirement. Mark mentioned 20 reviews into aged care. There have actually been 77 since 2012 and change has been glacial. It has been a recurring theme that we have raised that there needs to be something that formally allows access. I think under the new quality and safety commission there is an appetite: they will be asking as part of the audit process, 'How long since you have had an education?'

Ms PEASE: You believe it would be appropriate to formalise that arrangement as a requirement?

Mr Rowe: Absolutely. Even if you were to say that should happen annually, we know that there is a turnover of staff in aged care that is regular and we know that there is a turnover of residents that is regular, so we could do an education tomorrow and not see any of the same people in 12 months time.

CHAIR: That reminds me of formalising perhaps right of entry so that you can get into these places.

Mr McARDLE: How many aged-care services across Queensland do you have case notes on?

Mr Rowe: We have case notes for all clients that make contact with us. Case notes are individual case notes about the individual who has a concern or a complaint or their family member rather than the facility. We do not keep a formal record on: 'This is what we see at Earle Haven.' We are in the process of updating our data management system because our current one is not very user friendly, but we can draw down data. Part of the record that we have is what facility a person is in or who their service provider is. There is some capacity to do searches.

Mr McARDLE: There is capacity to do that. How many cases do you have on file generally across Queensland?

Mr Rowe: I suppose last year we supported about 3,000 Queenslanders. The number of those that translated into individual advocacy—I am going to get my numbers mixed up now, but I know we have gone from back in 2012 delivering about 260 incidences of individual advocacy. We also provide information and education. In 2017-18 that had grown to 660. So it was a 300 per cent increase in those times. At the moment we are getting about 100 cases a month, so that is 1,200 a year, so we have doubled in the last two years.

Mr McARDLE: Is that referrals or the matters you take on board?

Mr Rowe: That is about cases that we take on to deliver advocacy services. On an average day we get 80 to 100 calls. Sometimes they are out of scope and we will refer them elsewhere. Sometimes it is about giving people information so that they can self-advocate and resolve the issue themselves. Sometimes it is about the person needing support, and those are the ones that translate

into individual advocacy. The 3,000 number sounds big. Bring it down to 1,200, and that is actual advocacy cases. It can take anywhere from six hours to six weeks to resolve an issue, depending on the complexity.

Mr McARDLE: Can I summarise it: back in 2012 the case numbers you took on were about 270?

Mr Rowe: Yes.

Mr McARDLE: That has grown now in 2017-18 to about 600?

Mr Rowe: 660, yes.

Mr McARDLE: You think this financial year—

Mr Rowe: At the moment, in the current financial year, we are taking on 100 new advocacy cases every month. We are getting squeezed.

Mr McARDLE: You anticipate that in 2019-20 you will take on board 1,200 cases?

Mr Rowe: Yes.

Mr McARDLE: You mentioned that you escalate the cases in certain circumstances. What would be the highest level you go to in relation to a matter?

Mr Rowe: My reference to escalation was that it falls more appropriately in the scope of the aged-care and quality system or it is a police matter. If we are talking about a sexual assault, we are not going to go in and investigate that; we will support the person to raise that with the police. If it is a criminal matter, again it will be the police. If it is around a serious clinical matter, we will support the person to raise that with the aged-care quality system.

Mr McARDLE: With a clinical matter, whether it be a practitioner—a nurse, AIN, EN or doctor—do you deal with the Health Ombudsman at all here in Queensland?

Mr Rowe: I understand the responsibility of OHO. Being the CEO, I am not involved in the day-to-day cases. I would think that where that is appropriate we do.

Mr McARDLE: Could you take that on notice?

Mr Rowe: I can ask, yes. It will depend on how our system goes but, yes, referrals to OHO.

Mr McARDLE: Early in your statement you said that there were a number of people in relation to Earle Haven who claimed that they 'want our loved ones back here', which is a most unusual statement, and you made reference to that. You also commented that it may well be that they want life to return to normal and that is why they made that statement. The statement is curious, because the image that we have been given about Earle Haven is that it is not a good place to be in, but that statement does not coincide with that. In fact, it paints a picture that the staff at Earle Haven—and I am talking here about RNs, ENs and AINs—were well respected by the residents. It was something else that impacted upon them—that is, the management style, which can be quite distinct from the love, care and attention given by the medical staff.

Mr Rowe: The feedback I have received from my team is that—and it sounds awful—good staff struggled to stay there a long time. I am not saying that all of the staff there were bad. I really struggled with hearing what families were saying about wanting their loved ones back there, given the history that I was aware of, the trauma that they had been through and the complete disregard that they had seen. I have used the term elsewhere that the older people were commodified. They were treated like they were plants in a nursery: we could walk out and we could just leave them there and there would be no consequence. If we are talking about putting your family member back in that environment, I really struggled. The staff was a complex mix of employees of HelpStreet, as I understand it, rather than Earle Haven. There is no guarantee. There would be some staff, clearly, who would happily be back tomorrow, because people also lost their jobs in this whole process. But I did struggle with that.

Some of my team raised the issue that, where there is a couple where one of the family members had moved into the aged-care facility, easy access now is very difficult and they are not able to see their spouse as frequently. That has to be a huge concern. I would hate to be in that environment. That is where I am saying that I think people want to see things return to normal. I would not want to see Earle Haven returned to normal because 'normal', in my view, was poor quality service.

CHAIR: Would you conclude that perhaps the residents at Earle Haven are now better off in alternative accommodation?

Mr Rowe: As a general statement I would think that is the case, although I also acknowledge that the way this all happened was extraordinarily traumatic and disturbing. Certainly anecdotal feedback I have had is that quite a number of people have found permanent accommodation elsewhere. I did a radio interview recently where the announcer talked about one of the Earle Haven residents sharing their room with her mother in another aged-care facility and the person said they had never been happier with the move. Again, it is very much an individual lens that people look through.

CHAIR: Do you have a view as to the increase in people contacting you? You have noted an increase over the last few years because of the spotlight that is occurring with the royal commission and our committee, which has been running since last year.

Mr Rowe: Certainly the spotlight that has been placed on aged care by the royal commission, by this committee and I think by the media. I think some of the work that Anne Connolly from ABC has done and continues to do has been remarkable in terms of getting it out there and giving the public a very unsanitised view of what is happening in some parts of aged care.

CHAIR: Thank you. Ms O'Gorman, we have finished with Mr Rowe. We do not have any other questions.

Ms O'GORMAN: Thank you, Mr Chair. I do not have any further questions either, so might Mr Rowe be excused?

CHAIR: Yes. Thank you very much for your contribution here today.

WYNNE, Dr Michael, Aged Care Crisis

Ms O'GORMAN: Dr Wynne is here with Aged Care Crisis. As I understand it, he is ready to proceed. Dr Wynne has prepared an opening statement which he wishes to make.

Dr Wynne: Thank you very much for the opportunity to appear before the committee. I would like to make a short statement. Aged Care Crisis is an advocacy group. We have been collecting information about aged care, analysing it and advocating for change. We have made submissions to most of the multiple inquiries over the last 15 years.

I have had a long interest in social systems that do not work, and particularly the impact that has had on the medical profession. Some of that is personal experience and some of it is just what I have examined. It is important to realise that the people behind these systems usually believe very fervently in what they are doing and they often devote most of their lives to implementing their ideas. The problem sometimes is that the ideas they are implementing are not suited to the sector. That is why these situations can be so very difficult to deal with. I think that is relevant for aged care.

I collected a lot of information about the US health companies that attempted to come into Australia in the 1990s and supplied that to the Foreign Investment Review Board and to state probity regulators. I had some experience of what was happening in the USA in both aged care and health care.

We are going to talk about regulation, presumably. To understand that, it is good to look at the way government is thinking. I would like to briefly comment on the appointment of Professor Shergold as chairman of the Aged Care Sector Committee in 2014. It was tasked to build a working partnership between the federal government and the aged-care sector and to set out the way in which government and the aged-care sector would work together to progress reform.

I want to move on to when Professor Shergold resigned in March 2015 and left his position as chairman and moved to become chairman of one of our largest aged-care corporations, Opal Aged Care. He immediately departed with Opal's managing director as guest speaker at an Institute of Policy Studies workshop in Singapore. Accompanying them were representatives from major investors AMP and GK Goh Holdings. I am sure you are aware that the banks and the big financial institutions have just recently been the subject of a royal commission. As happened in the USA, they are major investors and role models for business in aged care and they exert a considerable influence.

I want to go on to what Professor Shergold said at that meeting because it is of interest. He was talking about Australian government policy. I will bring up a couple of his comments. The first was that it was an immature sector, it is dominated by non-profit providers and there was little market competition. In the future, government would play a more facilitatory role, with the private sector delivering a greater degree of the services. They were going to be facilitating and helping the industry. The next statement was that aged care in Australia is over-regulated. Shergold came in behind that and said that regulation in the aged-care sector is misplaced. He also suggested that a good aged-care sector should resemble the hotel industry.

The most revealing remark I think he made was that government is concerned about a public backlash from people who believe that aged care should be a community service and not motivated by profit. The fear that the public would not support the present model of care, if they really understood what was happening, has played a major role in policy, management and the way government regulation was formulated in 1997. I would be happy to comment on the pressures on the government in 1997 when they introduced the regulation.

One of the first of the 2014 reforms that Shergold implemented was the red-tape-reduction program. That stripped $6 billion out of Australian regulation over the next 3½ years. That is $1.7 billion a year. Aged care was one of the first to be targeted. Over the next few years—and I can let you have the tables later on—the number of visits made by the quality agency fell by a third, from 6,400 in 2012 to under 400 in 2016. The number of visits by the complaints commission to investigate complaints fell from just over 200 in 2010 to fewer than 100 in 2016. That is a very big drop. Nobody was going out to see what the complaints were about. They were being resolved on the telephone. The number of reviews of funding claims made by the aged-care funding instrument fell from 20,000 in 2013 to 3,800 by 2018.

At the same time that was happening, facilitators were not getting fully accredited. In terms of the number of facilities that were not being accredited, the results fell from 7.2 per cent to below three per cent. Far more facilities were being accredited. The number being sanctioned fell from just below one in 200 to below two in a thousand. There was a very marked reduction in the detection of problems. I do not believe that was due to any change in the service being provided.

To understand why we have the sort of regulation we have, we need to understand some of the things Professor Shergold said in that presentation. I have a copy of that for the committee if you would like it. That is all I really need to say to start with. The rest of it is in the submission.

Ms O'GORMAN: Dr Wynne, I have some brief questions for you related to the contents of your submissions. I understand that the thrust of your submission is that you are critical of the system that has been in place since 1997 which provides for the application process that must be undertaken by a would-be approved provider. Have I characterised that correctly?

Dr Wynne: We had quite a lot to do with that. I personally and Aged Care Crisis have taken up that issue with government, with ministers and with the department on multiple occasions. As I say, I did collect information and we have information about companies that are coming in. We did try to get some sort of review of these companies before they bought into Australian aged care, because we did not think they were suitable. There were several of those.

Ms O'GORMAN: As I understand it, one of the concerns that you have about the process is the lack of ability of community members, and in particular those who might be most affected by the quality and safety of aged-care services provided to their family members, to have input into those applications being made by approved providers. Is that one of your concerns?

Dr Wynne: Yes, it is very much so. In the healthcare sector, it was not then only government investigations that detected the problems; it was outsiders who realised what was happening and collected information. They were interested and I was interested. That is why we collected that information and supplied it. This is behind closed doors. It is a confidential process. It does not cover the owners at all, as I made the point there.

Ms O'GORMAN: It seems as well from your submission that one of your concerns around the approved provider application process, particularly in the context of the Earle Haven situation that we are looking at here, is that, whilst the application process allows for an assessment of an approved provider, it did not allow for an assessment of any subcontractor that that approved provider might then want to engage to provide care services on its behalf. Has that been a concern of yours?

Dr Wynne: That has been a fairly major concern. Our primary concern is really with owners. That has come up with Bupa at the moment, which has problems and which you would have probably seen if you saw the news this morning. It is both that and related party transactions when you have a number of different groups forming companies and also subcontractors, yes.

Ms O'GORMAN: Finally, in your submission it becomes clear, I think, that it is your view that any changes to the regulatory regime around the provision of aged-care services needs to include a mechanism moving forward whereby members of the community can have greater input into application processes. Is that correct?

Dr Wynne: That is correct, yes. I would make comment that I think it is almost an ideological thing that the community was excluded in 1997 in the way the system was set up. Basically, aged care is all about responsibility—responsibility to communities. Basically, we are not able to hold our agents to account because whoever provides this is providing it on our behalf. We have been pushed aside as a community.

Ms O'GORMAN: Thank you very much, Dr Wynne. Those are the questions that I have for Dr Wynne, Mr Chair.

CHAIR: Thank you, Ms O'Gorman. Thank you for your submission. You raise the issue of probity. We have heard that this morning in relation to the checks and balances around people setting up companies and subcontracting. Do you see the role of an ageing commissioner, as brought up by ADA Australia, having some further input into the reviewing of—

Dr Wynne: I think so. I think that may well be useful. I cannot say I have really looked at it. I cannot comment too much. I very much am a supporter of what Geoff Rowe was saying. I am also very supportive of what the Public Advocate and the Public Guardian in Queensland are pushing for—a visitors scheme. We would like Geoff to go further, because we feel that those visitors schemes should really be from the community, should be part of the community and should be reporting to the community as well as to government. If you look at aged care, it is all centrally managed and all centrally controlled. As Geoff said, it is a very complicated and local process. It just is not flexible enough to be able to regulate it and oversee it from the sort of distance in the system we have.

I can tell you that accreditation may be a very good process but it has never been an effective regulator. It was an ineffective regulator in the USA. Ronald Reagan wanted to bring it in when he was president and the public rejected it and the government rejected it. It was brought in in Australia. It was intended to assist the providers of care and make them approved there.

Throughout its period until 2014 it insisted it was not a regulator. It insisted it should not be incorporated into a common body with the rest of the regulators because it was there to assist the providers. In fact, the minister said as much in 1997 when it was introduced—that it was not a policeman; it was there to support the providers. When you have a system where there are so many perverse incentives as we have in aged care, that sort of regulation is not going to work.

I agree very much with what Braithwaite said. Braithwaite was very critical when he looked at the system and wrote his book in 2017. He was very critical of the accreditation process as well. As he found, it is the interaction between people that determines the way they think. If somebody has to communicate with the community and be responsible to them, they have to justify what they do.

You can see that this happened in aged care and in health care when the medical profession put its foot down and refused to be pushed aside in 1997. If you remember, there was a very big battle between the minister for health and the medical association. Following that, Mayne Health attempted to bring in the sorts of business practices they had in the USA, and the medical profession just walked away.

They have imposed that sort of authority that they are able to check the things that big business want to do. We do not have that in aged care. There is nothing to check the way they think or to challenge it. That needs to be brought in on the ground, not up in the boardroom, so that a lot of what has happened is controlled more at the coalface rather than at the top. What we are pushing for is more community control of what is happening.

CHAIR: On the recommendations page of your submission you talk about a neoliberal belief system and say that neoliberalism has pushed the community aside. What do you mean by that?

Dr Wynne: I think if you go back to the beginning—and neoliberal really started in the 1930s. It is a belief in personal freedom. It was expressed through markets. It originated from the economists in the Austrian School of Economy. They saw the community, society, as the core of the collective that would inevitably result in totalitarianism and that limited the freedom of individuals. They were very against that; the market needed to be free. We saw that coming in with particularly Friedrich Hayek and the Mont Pelerin Society. We saw that with Milton Friedman, who had a great influence and was brought in in the 1980s. That had a very major impact on society as we know it today.

There are a lot of us who have been critical of that because it has resulted in the loss of social capital, a sardonios society. We cannot prove it, but obviously, if you look around, almost every vulnerable sector that we have had in this country has been exploited in one way or another, whether it is the franchising and employees, the job searches or the vocational education. People have been misused. I do not think it is necessarily always done by people who do not believe—I think they believe in what they are doing—but it is the patterns of thinking within which it established.

While a lot of people were trying to do very good things in aged care, the system was not designed to provide that sort of aged-care service. It was designed to be a business and not to provide care. I think the patterns of thinking of those two are very different. The way the nurses and the medical profession are taught to think is very different to the way the business community thinks, and those clash. The business community patterns of thinking are now so powerful and so all pervasive, so it creates a confronting situation for the people who are working.

When you have this difference in culture, you get people disillusioned, you get toxic cultures and you get the sort of thing that Geoff has spoken about. From a theoretical point of view, looking at it from the sociology of it, because I am interested in the sociology of it, it is a case of trying to return the community caring focus to be the primary means of delivering care and making the money follow the care—

CHAIR: Not the other way around.

Dr Wynne: Currently, the care follows the money and that distorts it. Even in advocacy, as John Braithwaite said, he described advocacy as 'small A' because they were worried about their funding. I think that still applies. A lot of the advocate groups have been feeling very threatened lately because their funding is threatened and the government very much selects the advocates it wants. I think advocacy needs to be part of the community. The funding should come through the community and there should be community advocates and visitors in the community working with the community.

If you look at what happened in South Australia with the big nursing home that failed there, the advocates had been attending and visiting that place regularly but they had obviously never been in contact with the community. They went through for about three years, I think, and did not detect anything until somebody went and spoke to them about it and then they acted.

CHAIR: Thank you. That was very well articulated. Are there any further questions?

Mr McARDLE: Dr Wynne, you say on page 3 that you want any organisation seeking to provide aged-care services to be 'assessed by the communities'. I know what the words mean. How does it look on the ground?

Dr Wynne: I think they need an opportunity to decide. I think the community should have a fairly big say. There are local organisations. We have local government, which actually have been very active, particularly in the disability sector. They could be working with community groups to decide who should be welcomed into their communities, in a sense. If you want to set up a business in that community, you really need to get the approval from that community.

Mr McARDLE: So you would have some sort of community forum—

Dr Wynne: It is suggesting a voluntary community group formed around visitors and advocates working together. Those are people, families, people who have past experience, doctors and nurses.

Mr McARDLE: And they would approve or disapprove?

Dr Wynne: Yes, they would have some say over it. There is another thing which we might think about. If you look at the case of Bupa, it has 72 nursing homes. This has been a major problem in the UK, where they have had these enormous bankruptcies which have created havoc with their health system, particularly with private equity. They have a successful body to track the financial performance of them because they are so worried about the fact that they can collapse. I am losing track of my thoughts now. What was your question again?

Mr McARDLE: What I was asking is: if you are going to have an assessment by a community, I want to understand exactly how—

Dr Wynne: Sorry, that is exactly what I was saying. I am back again.

Mr McARDLE: I am from Caloundra. If we have an application for an aged-care facility in Caloundra, who assesses it in Caloundra under your model?

Dr Wynne: In my model, the community would have a chance. People who were interested would have an opportunity to look around, make inquiries and decide whether they want that group to be. I was going to suggest that the ownership of the nursing homes be separate from the operator—in other words, they lease the thing to an operator. That enables you to get rid of an operator that you do not like, that is unsuitable, and replace that without interfering with the staffing or with the residents. I think that would make it very much easier for regulators to do it and also for the community to exert pressure and say, 'We don't want you,' and negotiate for somebody else to come in and take over.

Mr McARDLE: They could change halfway through who runs—

Dr Wynne: That could change when people were fed up, yes, if they had enough. If you think of Earle Haven, if the community did not like those guys, they would get somebody else. I think there was a good reason for doing that.

Mr McARDLE: Thank you very much. You have made your point clearly.

CHAIR: There are no further questions, Ms O'Gorman, from the committee so we will conclude this session.

Ms O'GORMAN: Thank you, Mr Chair. I do not have any further questions for Dr Wynne. He can be excused.

CHAIR: We will take a break now.

Proceedings suspended from 11.52 am to 12.09 pm.

MURRAY, Mr Chris, Industrial Officer, Queensland Nurses and Midwives' Union

O'CONNOR, Ms Bernie, Team Leader, Private and Aged Care Sector Organisers, Queensland Nurses and Midwives' Union

PRENTICE, Mr Dan, Professional Research Officer, Queensland Nurses and Midwives' Union

CHAIR: Ms O'Gorman?

Ms O'GORMAN: Thank you, Mr Chair. We have now three witnesses from the Queensland Nurses and Midwives' Union. Mr Dan Prentice, on behalf of those three, has prepared a brief opening statement, which he will commence with.

Mr Prentice: Thank you very much. My name is Dan Prentice and I am here today with my colleagues Bernie O'Connor, the team leader for private and aged-care organisers, and Chris Murray, industrial officer, appearing on behalf of the Queensland Nurses and Midwives' Union. We thank the committee for the opportunity to speak with you regarding the events surrounding the unexpected closure of Earle Haven nursing home on 11 July and what might be done to prevent further similar occurrences, as well as resolve the significant systemic aged-care issues this event highlights.

The QNMU has over 60,000 members across the public, private and aged-care sectors and, as you would be aware, has been campaigning for some time, in conjunction with other state nursing and midwifery unions and the Australian Nursing and Midwifery Federation at the national level, for a wide range of improvements in aged care. These areas include appropriate staffing and skill mix in aged-care service delivery; high standards of safety and quality of care; funding that reflects the actual cost of care; better regulation and governance of the sector; and transparency of reporting around financial workforce and care related activities.

While the QNMU has provided a comprehensive written submission to the committee regarding the closure of Earle Haven, as well as to the national Carnell inquiry and the aged-care royal commission, I would like to highlight the following issues, which we believe must be addressed as a matter of urgency: the need for more robust regulatory mechanisms to identify providers at risk of failure, to prevent future uncontrolled collapses; the need for rapid response mechanisms by state and federal agencies in the event of future closures; better coordination between regulators whose responsibilities include the aged-care sector; the need for appropriate criminal sanctions against those who put the safety and welfare of older Australians at risk; the complexity of the aged-care regulatory environment and the need to address gaps and clarify jurisdictional responsibilities; and the need for the state to remain engaged in the aged-care sector.

Just as significant failures of governance were revealed by the recently concluded financial services royal commission, recent inquiries into aspects of the aged-care sector, including the ongoing Royal Commission Into Aged Care Quality and Safety, have identified the need for regulators to actually regulate and to act proactively to protect the interests of older Australians. In terms of the Earle Haven situation, this regulatory responsibility includes ensuring that service providers are able to actually deliver safe, high-quality services and for regulators to have mechanisms in place to respond in the event of service delivery failures, however sudden.

The QNMU commends state authorities for the rapid and comprehensive response to the Earle Haven closure but is concerned that those federal regulatory bodies responsible for aged care seemed to be largely absent as this disaster unfolded. From a regulatory perspective, the Earle Haven closure also calls into question the capacity of regulators, the federal department of health and the Aged Care Quality and Safety Commission to effectively identify, manage and if necessary remove those providers at risk of failure, and calls into question the probity checks process for aged-care providers, particularly when third parties are providing services in contractual arrangements with approved aged-care providers.

Given the history of accreditation concerns and sanctions imposed on Earle Haven, it is surprising and concerning that the regulators did not subject Earle Haven ownership and management to greater scrutiny in the lead-up to its closure. From the QNMU's perspective, the issues leading up to and following the Earle Haven closure have involved a number of regulators, such as the Fair Work Commission and the Australian Taxation Office, as the QNMU has supported members in relation to payment of wages and superannuation issues as well as concerns around the quality of care and professional standards.

This case demonstrates the need for greater coordination between regulators for identification of risks and red flags to better identify providers and services at risk of failure. It would be reasonable to expect that this is a lesson learned from this experience that can be applied to the aged-care sector and others such as disability services where the ongoing health and welfare of vulnerable groups is highly dependent on reliable service provision.

We would urge the Australian Aged Care Quality and Safety Commission and the Australian government department of health to undertake work to improve inter-regulator coordination to better identify at-risk aged-care provider organisations. This review would include entities such as Fair Work Commission, Australian Taxation Office and state regulators such as the Office of the Health Ombudsman Queensland.

In addition to better coordination between regulators, the QNMU also urges that jurisdictional issues between state and federal authorities be reviewed with the underlying aim of strengthening, clarifying and streamlining the regulatory environment. The current landscape is a patchwork of state and national legislation, regulations and standards, and we urge this to be reviewed to identify where better coordination and reduced complexity can be achieved. Within such a review, we would also urge that the potential for changes to state and federal criminal codes be considered to explicitly protect older Australians from situations that put them at risk of harm from the actions or inactions of entities such as aged-care providers.

Finally, we would urge the current and future state government to remain engaged in the aged-care space from a range of perspectives including policy, workforce planning and regulation, particularly in relation to oversight mechanisms such as the role of the Health Ombudsman and potential co-regulatory mechanisms, advocacy and provision of services in regional, rural and remote areas where the private sector is unwilling or unable to operate.

Again, the QNMU would like to thank the committee for the opportunity to speak with you today and we look forward to any questions that you may have. Thank you very much.

Ms O'GORMAN: Mr Prentice, I will commence by asking you some questions about the knowledge that the QNMU had, if any, from its members in the days or weeks leading up to 11 July 2019 about any concerns that were being reported at Earle Haven. Are you able to tell us whether the union was aware of any concerns?

Mr Prentice: Yes. Earle Haven came to our attention because of issues around wages and superannuation—certainly my colleague Chris Murray can speak in more detail around that—and that was being managed by our industrial officers on behalf of our members at Earle Haven.

Ms O'GORMAN: Did those issues come to light prior to 11 July 2019?

Mr Prentice: Yes, they initially came to us on 1 February 2019. That is when we started looking at those particular issues, yes.

Ms O'GORMAN: Was there, at a time closer to 11 July 2019, a time when you were hearing reports about the level of care services being provided to residents there?

Mr Prentice: That is correct. In the course of the industrial officers assisting members in relation to wages and superannuation issues, we were alerted by our industrial officer team that members were also concerned about levels of care and staffing at Earle Haven and, that being a professional practice issue, consulted with the professional officer team, myself included. We held a case conference regarding those issues at Earle Haven on 5 July, I believe, to discuss the broad suite of concerns that we had at that time. I think our general consensus was that this was probably an organisation under some pressure and in some degree of distress, yes.

Ms O'GORMAN: Did you form any view at that time—that is, at that meeting on 5 July—about any risks being posed to either staff at the facility or residents?

Mr Prentice: Certainly whenever we have concerns about the level and quality of care, that raises our concerns about things like workloads and the capacity of staff to deliver appropriate care. Certainly that was high on our list of concerns, to the point that out of that meeting we resolved to write to the clinical management team at Earle Haven and request a meeting to discuss those particular care issues, yes.

Ms O'GORMAN: Did you in fact then write to the—

Mr Prentice: Yes, a letter was drafted and I believe, if memory serves me, it was due to be signed by the secretary of the QNMU on the day, and sent on the day, that Earle Haven unexpectedly closed, on the 11th. So we were not able to—events intervened, but that was our intention.

Ms O'GORMAN: There is some irony perhaps in the timing of that?

Mr Prentice: Yes.

Ms O'GORMAN: Do you have any views about, given the fact that your organisation was aware of the risks that were apparent as of at least early July 2019, whether the regulatory bodies tasked with overseeing this facility ought also to have been aware of those risks?

Mr Prentice: I think there is a very reasonable expectation. Certainly there was never any thought, when we case-conferenced on that—and that involved industrial officers, professional officers and organisers who were dealing with the staff there—that there would be a catastrophic collapse of the organisation and closure. That certainly was not a consideration, but I think it is fair to say that, if we as an organisation acting on behalf of our members could form a view that this was an organisation that might have been struggling, it would be reasonable to expect that the regulator would, too.

Ms O'GORMAN: Thank you, Mr Prentice. I will turn now to some questions for you, Ms O'Connor. As I understand it, you personally attended at Earle Haven on 11 July 2019; is that correct?

Ms O'Connor: Yes, it is.

Ms O'GORMAN: Was it approximately 3 pm that you arrived that day?

Ms O'Connor: Yes, it was.

Ms O'GORMAN: And can you tell us why it is that you attended at Earle Haven that day?

Ms O'Connor: Certainly. Our call centre received a distressed member call and they put it straight through to my mobile. That was at 2.24. I very quickly could ascertain that I would need to get down there to get my head around it, because the member could only give me so much information and she was in her own level of distress. Whilst I was talking to the member, I hopped in the car. I teed up with other organisers who live closer to the facility to meet me there. They actually arrived earlier than I did, so within half an hour of that first phone call we had somebody there on the ground. There were only three of us. Our brief was to go there and provide assistance in whatever way we could under these incredible circumstances that none of us had any experience with.

Ms O'GORMAN: I will ask you some questions about your observations of what took place that afternoon after you arrived, but to put some context around your views I think it would be worthwhile if you could explain to the committee the depth and breadth of your experience as a clinician.

Ms O'Connor: Certainly. I am a nurse of 41 years standing, 38 years of that in the clinical role. More often, like a lot of nurses, I have had two jobs; hence, I could work for the Queensland Nurses and Midwives' Union and still have a clinical role. I am one of the old-school ones that is a jack-of-all-trades and, as far as the union is concerned, for the nearly 13 years I have worked for the organisation I have been involved in the private sector—aged-care private hospitals and diverse—everything except public sector. From that time, our organisation certainly, as part of the national body, has been trying to deal with the status of aged care and in that time the worsening has been very obvious to all of us that have had that constant involvement.

Ms O'GORMAN: Ms O'Connor, is it the case that throughout the course of your career you have worked both here and abroad?

Ms O'Connor: Yes.

Ms O'GORMAN: And also within different states in Australia?

Ms O'Connor: Yes.

Ms O'GORMAN: Is it the case that for the last 12 years at least you worked predominantly in aged care, both as an organiser and also as a registered nurse?

Ms O'Connor: No, as a registered nurse in a clinical role. I was doing general nursing certainly in aged care for the nurses union.

Ms O'GORMAN: In an organising capacity have you been engaged with aged care for about that period of time—that is, about 12 years?

Ms O'Connor: The whole entirety, 13 years.

Ms O'GORMAN: Can I ask you whether or not you formed any preliminary views on your way to Earle Haven—so this is before you arrived and saw what was happening—about what would be preferable as a solution to what you had been told was unfolding?

Ms O'Connor: Yes. As I said, I was on the phone to the member as I hopped in the car. From there on, the union secretary and I were the ones having the conversations and she was giving me updates as I was driving down to the facility. With each phone call it changed a little bit and I knew to expect that emergency services would be there when I got there. At that stage our discussion was that, yes, we thought the idea of moving them all seemed impossible. We thought we would more likely be bringing services in to care for them there. But once I arrived and Beth asked me to check on a few things in regards to food being taken away and medications not being available, I was then made aware by HelpStreet management that the computers had been taken the day before and that all the information of the care was on that. So that made it a very different situation. I can see the reasoning then, and I changed my original view, that it would have been easier to have the 67 or so people moved to multiple places where you only had a core group that they had no information about, rather than a facility with no information with all of them in there.

Ms O'GORMAN: If when you had arrived at Earle Haven there was the breakdown that existed that day—that is, the inability of any organisation to continue to provide services—but there was adequate food and adequate fluids, adequate medications and a complete set of care records, plus all of the necessary equipment and infrastructure that was needed to care for the patients, would it have been your view that it would then have been preferable that the residents stay and external assistance be brought in to care for them there?

Ms O'Connor: I personally would have thought so, yes.

Ms O'GORMAN: Is it the case that, upon arrival and becoming informed of the fact that there were problems with adequate food, fluids, medications, care records and even things like mops and mattresses being available, it was those features that caused you to change your view and consider that the residents were in fact better off being sent elsewhere?

Ms O'Connor: Yes.

Ms O'GORMAN: You said that your remit there was to arrive and be of assistance in any way that you could.

Ms O'Connor: Yes.

Ms O'GORMAN: Were you able to offer assistance to any of the emergency staff there or anyone else?

Ms O'Connor: What we first did was the three of us met. We stationed ourselves in an area that was not in the way but people could see who we were and could approach us, and we kept still so people could approach us. We introduced ourselves to the team that was there from Queensland Health and just said, 'We're here to assist, certainly not to get in the way,' and they really just got on with doing their role.

From that point there I started walking around. I went around to Orchid House. The bulk of the activity was happening in Hibiscus behind closed doors. You had to have a swipe card to get in there. That is where most of the arrangement was happening. I went around there and my colleagues and I were approached by multiple family members and residents as we went through Orchid House and so forth as well as the staff. Our brief was to talk to everybody. It was not just our members; it was anybody. For weeks later we were talking to cleaners and so forth because there was a void of support and knowledge if you did not have somebody to attach yourself to as far as union services and so forth.

Ms O'GORMAN: What time were you there till that night?

Ms O'Connor: I was there until about eight. My colleagues left at about seven. I was on the phone to West End for that hour in-between.

Ms O'GORMAN: Did you arrive shortly after 3 pm?

Ms O'Connor: Yes. My colleagues were there at 2.30.

Ms O'GORMAN: I take it from that, then, that you were there on the ground in a capacity to observe what was occurring around you for a period of something like five hours?

Ms O'Connor: Yes.

Ms O'GORMAN: Can you please describe to the committee your observations of the quality of the response by Queensland Health and the Queensland Ambulance Service?

Ms O'Connor: Initially, the three of us all had the same opinion. You arrived to the chaos that was there—people everywhere, emergency services and everything—and it took a while to get your head around and very quickly it became just very impressive in terms of the professionalism and the calmness with which they went about their duty in and out of people trying to feed people and look after the residents, most of whom were in communal areas so that they could look after them together.

There was lots of traffic. The setting itself is on a bigger site that has 800 people living there in a retirement setting where they own their own units and so forth, so there was lots of traffic and you would have had at any time three ambulances and police cars. Earlier in the afternoon was the furniture van. There was a very systemic, in-control approach. The fact that the triple 0 call was at 1.30 and the last resident left at 2 am, they found places for all those people and moved them in just over 12 hours. That was incredible. Certainly on the way down there I did not think it was possible, so I could not say enough about how impressive it was.

Ms O'GORMAN: I was just going to ask whether or not you could provide some comments about the manner in which those from Queensland Health and the Queensland Ambulance Service conducted themselves, bearing in mind they were dealing with elderly and confused, traumatised residents.

Ms O'Connor: Yes. When I saw people moved on stretchers and so forth, it was as if they were the only person that they had dealt with—like it was a single event. That is what it looked like from my observation. They did not have the luxury to talk to family members and to staff. We tried to fill that void, but there was no rush and there was no hecticness in those interactions that I viewed.

Ms O'GORMAN: Do you mean by that that you observed those personnel dealing with each of the residents? That is, when you said 'as if they were the only person there', you mean they were focused on them?

Ms O'Connor: Yes, instead of it being No. 32 out of 67.

Ms O'GORMAN: I see.

Ms O'Connor: Yes. It was as if it would be a standalone interaction.

Ms O'GORMAN: Did you consider that there was anything that those who attended from Queensland Health or from the Queensland Ambulance Service ought to have done but did not?

Ms O'Connor: No, not that I could see at all. The Queensland Health personnel—again, I was very conscious of not getting in the way and you could stand back and be in the privileged position to look around you and see where you may need to go or talk to or whatever, so you left them to it. They seemed to have been there for a long time, but I knew they had only been there for a couple of hours.

Ms O'GORMAN: This committee has heard a view expressed by at least one witness that it would have been preferable for those at Earle Haven—that is, the residents—to remain there at the facility throughout the afternoon and the night rather than be taken elsewhere. What would be your comment on that sort of a view?

Ms O'Connor: I do not know how you could with the lack of information that would have been there.

Ms O'GORMAN: When you say 'the lack of information', are you referring to—

Ms O'Connor: Lack of information, lack of food, lack of lots of resources. There was paperwork taken and it was just not functioning. I did not go down there with that view. I thought the idea of moving all those people would have to be the worst case scenario, but I do not think they had a lot of choice and they did not have a lot of time to deliberate on that. They looked at what they had to work with. It was not tenable. For instance, the medications were there. When we were at Orchid House the enrolled nurses were saying, 'We need to give people medication,' but the keys had been taken somewhere and so forth. I think when you had a few more of those stories lined up about what could not be done, that is how the decision was made. We had nothing to do with that. Beth called me and said that that was what was happening.

Ms O'GORMAN: I turn to a slightly different aspect of that day. There were some reports very early on—that is, close in time to the closure of the facility—that there had been something of a mass walkout by staff members. Have you had an opportunity to make any inquiries amongst your membership as to whether or not those reports are accurate? That is, did the actual staff on the ground—the nurses—walk out en masse?

Ms O'Connor: Absolutely not. To say that that is a fallacy is too soft a word. It is an actual misrepresentation of the dedication that happened, because not only did they not walk out but they came in. I contacted six people, because I had a copy of the roster. I knew who was on duty that day. I contacted six people to ascertain who they knew was around and what the actions were. I have a few copies here, if it is any good to you, rather than me reading it, but it covers all three shifts and it includes people coming in early for night shifts and staying beyond when the last resident left, just in case those facilities needed extra information they had somewhere to call. They had people coming in who did not work there. They had people coming in who worked in a GP clinic who were then told

by their colleagues, 'It's chaotic,' so they knocked off their shift on a GP clinic and grabbed their mates and came in. I have all their names. I know who did what. I have taken them out for this, but I have that documentation there and I welcome the opportunity to actually tell that story because not only did they not go; they all came in and they did not need to, and they knew they were not going to get paid.

Ms O'GORMAN: Ms O'Connor, I think the committee would be very much assisted by having reference to that document.

Ms O'Connor: Sure.

CHAIR: Certainly. Is leave granted to table that? Leave is granted. Thank you very much.

Ms O'GORMAN: I might turn now to some questions that I have for you, Mr Murray. As I understand it, you are involved in the industrial relations side of the work that the union does; is that correct?

Mr Murray: Yes, that is correct, Ms O'Gorman.

Ms O'GORMAN: You have had some involvement in attempts by the union to secure outstanding wages and superannuation entitlements since the closure of the facility on 11 July 2019; is that right?

Mr Murray: That is correct, Ms O'Gorman.

Ms O'GORMAN: Who have you dealt with?

Mr Murray: HelpStreet engaged a law firm called HW Litigation.

Ms O'GORMAN: That is the organisation that you have dealt with in terms of trying to recover those entitlements?

Mr Murray: That is correct, where they initially contacted us and said, 'We are acting for HelpStreet. Please direct your correspondence to us.'

Ms O'GORMAN: As I understand it, the first thing that you did was make an attempt to obtain the employee records from HelpStreet so that you could ascertain exactly who was owed what. How cooperative were HelpStreet in responding to your requests that they provide you with employee records?

Mr Murray: I would use the word recalcitrant. It took a number of attempts and it got to the stage where I basically had to threaten them with what is called civil remedy penalties, which off the top of my head is about $12,600 for each breach. Considering the refusal, I think off the top of my head, of about 38 records, I threatened them with that amount of money and said, 'If you do not give this to us within seven days, we will take proceedings against your client.' It was by the sixth day that they finally provided those records and it was also after I put it to them that they actually did not have possession of those records when they are legally obliged to have those records.

Ms O'GORMAN: Did you just say that they had told you that they did not have possession of the records?

Mr Murray: I put that to them. They never answered that question. It was something that I observed that day. I put it to them, off the top of my head, either two or three times and that was something that was never answered. The other difficulty is: the way the Fair Work Act is structured, I have the power to enter a premise, once putting the relevant notice in, to inspect and make copies of the record. In the situation like Earle Haven, where I was aware that they had taken the computers which may have had the records and the facility had essentially shut down, if I was to go to the premise physically I could not get to the records. I knew they were stored on a cloud, but the act does not actually contemplate those electronic systems.

Ms O'GORMAN: Is it the case that on that sixth day that you have mentioned you were in fact provided with those records?

Mr Murray: That is correct.

Ms O'GORMAN: Once in possession of those records, did you form the view that there were a number of workers who were entitled to various payments from HelpStreet?

Mr Murray: That is correct. That was when I sent what is termed a letter of demand, essentially setting out what we viewed, given the information that we had, that they were entitled to, because at that stage it appeared to be, given what the employees were verbally told, that their employment was terminated. So it was a redundancy situation, so they would be entitled to the payment of wages, notice in lieu of actually being provided it and any sort of redundancy payments.

Ms O'GORMAN: Would that include things like payouts for leave and other entitlements?

Mr Murray: That is correct, Ms O'Gorman.

Ms O'GORMAN: Having sent that letter of demand to HelpStreet, did they cooperate?

Mr Murray: That is when they responded with basically saying, 'We haven't terminated their employment.' They relied upon a section of the Fair Work Act—section 526(1) (c)—basically stating that they had stood the employees down without pay, stating that that section of the act provided them the authority to do so because what had occurred was a circumstance outside of their control which they cannot be reasonably held responsible for. In receiving that response, there is a mechanism within the Fair Work Commission to initiate a dispute to state that we do not agree with that.

Ms O'GORMAN: Firstly, was that a response which you found either helpful or fair?

Mr Murray: Neither, Ms O'Gorman.

Ms O'GORMAN: That being the case, did you take any steps through the Fair Work Commission to rectify the situation?

Mr Murray: That is correct. We obtained a recommendation from the commission. I can table that recommendation if the committee desires.

CHAIR: Is leave granted? Leave is granted.

Ms O'GORMAN: Whilst that is being provided, Mr Murray, can I ask you please to briefly identify what the recommendation was that you managed to obtain from the Fair Work Commission?

Mr Murray: Essentially stating that the stand-down was invalid under the sections of the act that they were relying upon. The difficulty that I had, at the forefront of my mind and in terms of my role, was getting members their money, what they were entitled to and owed. We had people contacting us stating that they were defaulting on their mortgages; they did not have enough money to put petrol in their cars to go to job interviews. That was, I suppose, the major thing for me. When it came down to trying to seek that in the commission, there is a well-established body of case law basically stating that the commission cannot make any orders in relation to the enforcement of payment. That is something that we would either have to go to the Federal Circuit Court or the Federal Court to enforce.

Ms O'GORMAN: Having received that recommendation, did you in fact send a further letter of demand to the lawyers for HelpStreet?

Mr Murray: That is correct, Ms O'Gorman.

Ms O'GORMAN: Is it the case that you understand that HelpStreet is now disputing the factual circumstances and continuing to refuse to recognise that they have terminated their staff?

Mr Murray: That is correct. The circumstances have slightly changed now. I will say that one of their entities, which the majority of employees were paid from, has now gone into receivership. I can table the relevant correspondence in terms of what we sent and what we received from HelpStreet. What happened was that I received correspondence where they said, 'Well, the commission made a recommendation on these circumstances. That's now changed.' It was something in my mind where I could see things and trying to think two steps ahead. I knew we were always going to have to take it to the Federal Court, because from their previous behaviour there was no way they were going to comply with what I would call a fundamental obligation: if you do a day's work, you are entitled to a day's pay.

Ms O'GORMAN: Is that in fact the situation? Are your members still in a position where HelpStreet, however comprised, has not paid those outstanding entitlements?

Mr Murray: After some vigorous pushing from our behalf, they paid a period of 1 July to 11 July. I went through and did the calculations, and people were short-paid anywhere from about $80 to about $500 of what they should have been paid for the full pay period of 1 July to 14 July. People would have to go through what is called fair entitlements guarantee to get the outstanding payment of their wages, their leave and long service leave if they are entitled to it, but the one issue that has popped up—we initially took this to the Fair Work Commission, and I apologise for going back in time, but I feel it is pertinent. We took this to the Fair Work Commission in April about the non-payment of superannuation. Unfortunately, that is something that is in the remit of the ATO to follow up. From the information we have, superannuation has not been paid since then. I have been in contact with the Australian Taxation Office. They have what they call a phoenixing department in relation to that superannuation, but I think there is a big question mark on what will happen with that.

Ms O'GORMAN: On your assessment, is it the case that some of your members may well be entitled to payments in the several thousands?

Mr Murray: Yes.

Ms O'GORMAN: You were present yesterday afternoon, I believe, at the commencement of one of the private sessions, when there were here a number of staff who gave some evidence to the committee.

Mr Murray: That is correct, Ms O'Gorman.

Ms O'GORMAN: It is important that we do not identify those people, because, as I said, that was a private session. Was the cohort of people who were here yesterday afternoon, in your view, consistent with the general demographic of the staff at Earle Haven?

Mr Murray: Definitely. At Earle Haven and in the wider aged-care industry, you have predominantly assistant in nursing, personal carers, mainly female and within that cohort you also have single-income families. I remember one of the members even stating, 'I've got to go now; my daughter is at home.' I think the other thing to consider is: in a situation where someone has not been paid and they are a single-income family, they have no-one else to rely upon.

Ms O'GORMAN: In those circumstances, do you have a view about the complaints or concerns that you have heard from some of your members about things like the inability to pay their mortgage because of the non-payment to them, about the veracity of those sorts of claims?

Mr Murray: Very valid. Off the top of my head, was it six—as a union, we have given members what we call hardship payments, just for the dire straits that they have been in due to this situation.

Ms O'GORMAN: Mr Chair, those are the questions that I have for these witnesses at this time.

CHAIR: Thank you very much, Ms O'Gorman.

Ms O'GORMAN: I am sorry, Mr Chair: I think Mr Murray might have wished to say something else. I might have cut you off.

Mr Murray: I just wanted to say something, if you would permit me, in closing.

Ms O'GORMAN: Please.

Mr Murray: The one thing to consider in all of this is that the residents are a vulnerable class of people in society; the workers are vulnerable and they continue to be vulnerable. I think we need to ask ourselves: what happens when we let those mechanisms that protect the vulnerable in society fail?

Ms O'GORMAN: Mr Murray, I am sure members of the committee are going to have questions for potentially all three of you. When that is concluded, if there are some further things that any of you wish to add beyond what you have been asked about, please just let me know.

Ms O'Connor: Great, thank you.

CHAIR: Thank you, Ms O'Gorman. Again, I welcome each of you. It is disturbing to hear that people are owed moneys going back to April. As the industrial body representing them, you should be commended. I note the hardship payments. People still have to live and pay their bills and mortgages and things like that. Again, the fallout of this complexity in the arrangements between HelpStreet and People Care, Arthur Miller; it is a complex arrangement, but at the end of the day there are people—residents, families and staff—who are affected. Mr Murray, you did say that you had some information that was shared between People Care or HelpStreet that you might want to table, in the lead-up to the recommendation made by the Fair Work Commission.

Mr Murray: Yes, that is correct, Mr Harper.

CHAIR: Did you want to table that?

Mr Murray: Sure.

CHAIR: That might be helpful for the committee. Is leave granted? Leave is granted. In terms of quality and safety in the aged-care arena, is it the view of the QNMU that the aged-care system is currently not transparent enough so that older Queenslanders know what level of care they will receive when they enter a residential aged-care facility?

Mr Prentice: Yes, I think that would be a fair summary. In my experience as a nurse, prior to 2017 I worked for about 20 years as a clinical nurse consultant in patient safety and quality at the Royal Brisbane and Women's Hospital, so I am very familiar with all the safety and quality initiatives

that have happened over the past 20 years, particularly in Queensland since the Bundaberg commission of inquiry and the issues there. Until late last year, I also worked for about 11 years as a registered nurse in an aged-care facility, pretty much every Sunday. I have been in a position to compare and contrast the kind of safety and quality and standards that we routinely expect if we have contact with the acute healthcare system, compared to the aged-care sector generally, and more recently in my work as a professional research officer at the QNMU.

I think there is quite a significant difference. It would be fair to say that, as far as the broad safety and quality and other aspects of care that we would expect if we go to a hospital, the aged-care sector has some way to go to come up to the kind of standards that we expect. As a general rule, I think it would be our view that, no matter where you are receiving care in the healthcare system, you should expect the same kind of standards of care irrespective of where you are, whether it is in a hospital, whether it is receiving primary care or whether it is receiving aged care. I think it is now well established that there is a significant component to health care in aged care, whether that be in a community setting or in a residential setting. Yes, I think there is a difference and there is some way to go.

Certainly, our major campaign efforts are around improving the level of staffing and the skill mix in aged care generally. We believe that there is more that needs to be done in that space, as well as a range of other issues that also need attention. I think the issue with aged care is that there is no one, magic figure to this. There is a range of, I guess, systemic issues that are interconnected and they all have to be dealt with essentially at the same time to achieve what we would all agree would be that older Australians are entitled to a high standard of aged-care services irrespective of where they are, whether they are in a retirement village, whether they are in their own home or whether they are in a residential aged-care facility of some kind.

CHAIR: Thank you very much, Mr Prentice. As you would be aware, the government passed legislation a couple of years ago in regard to ratios in acute care. This committee has now been tasked with the Health Transparency Bill, which will look to increase contact hours in our state-run aged-care facilities, the 16 that we have. Do you see that as a good thing going forward, and also the reporting publicly of staff-to-patient ratios in the private sector, which the bill aims to do?

Mr Prentice: Most definitely. We certainly applaud the government in the initiative of implementing staffing and skill-mix ratios in those 16 residential aged-care facilities run by Health services. From a reporting point of view, I think it is fair to say that it is well established that, if you can provide the general public with information that helps them make their choices about their care and, in the case of aged care, about the level of care and the quality of care that they might expect when they, for example, have to enter an aged-care facility, then enhancing consumer choice about where that should be and what that might be can only be a good thing. Yes, we certainly are very supportive of reporting.

That goes back to what I said before about the kind of differences between, say, the acute sector and aged care, which is that the reporting of performance data in the hospital sector is accepted as the norm. There is considerable reporting around a whole range of areas in the acute sector, whether that be safety, quality, financial performance, clinical outcomes or process outcomes. You name it, the hospital sector is data rich. However, at the moment I believe that there are only, for example, two quality outcome indicators that have been mandated in the aged-care sector. For years we have been reporting on a wide range of quality data in the hospital sector, yet we are only starting to do that now in a mandatory way in 2019 for the aged-care sector. Again, I think information drives choice and choice drives an increase in quality, wherever we are in society—absolutely.

CHAIR: Thank you for that. I have one further question before opening up the questioning to other members. The committee is concerned very much about what happened at Earle Haven. We do not want to see it happen again, so that will be part of our recommendations going forward. In terms of quality and safety and staffing ratios, is the QNMU aware of any other residential aged-care facilities—and I gather you have members right throughout the 459 other providers besides those 16—in Queensland that do not provide perhaps a registered nurse 24 hours a day, seven days a week? If you do, would you be able to share that with the committee?

Ms O'Connor: Yes, there are lots of employer groups that do not provide an RN 24 hours a day. Dan, you can add to this. What is a common occurrence is a thing called indirect supervision. Somebody can be asleep at home and be supervising an EN or something—an enrolled nurse—at a facility who is the most senior person. Blue Care, the biggest provider we have in Queensland, has lots of facilities that do not have 24-hour RN coverage. That is just one example, but there are many.

CHAIR: Perhaps it is best taken on notice if you have concerns about other potential residential aged-care facilities that are at risk of not providing quality and safety with a lack of nursing. The committee would very much welcome that information. I will leave that one to take on notice. I will open up to questions from any other members. I welcome the member for from Mudgeeraba, who has joined us at the table today.

Ms BATES: I thank the QNMU for appearing today. I would like to put on record, too, that I am also a registered nurse of 39 years and have been in charge of aged-care facilities in the past. I want to explore further with Mr Prentice comments made by counsel assisting about the time line of the knowledge of what was happening at Earle Haven. You mentioned that the QNMU was aware from 1 February 2019 and you then had a meeting with staff on 5 July 2019. In that five-month period where, obviously, the QNMU was aware that there were issues, you mentioned that you wrote to Earle Haven. Did the QNMU notify any other authorities, such as Queensland Health, the Minister for Health or any relevant federal authorities?

Mr Prentice: My involvement in Earle Haven began at our case conference—just prior to our case conference meeting. Certainly, from details of our assistance with members, I would refer to Mr Murray in relation to the details around that. At our case conference, as I indicated before, where we resolved to follow up with Earle Haven from a clinical side of things—the professional side of things—that was where my involvement began from the professional team. I think our view would have been that, as our concerns moved from the industrial to issues around quality of care and professional practice issues, our first step would have been to speak with the appropriate clinical staff at Earle Haven and then go from there. We had that meeting on the fifth, if my memory serves me. Earle Haven ceased operation on the 11th. No, there was no contacting of any other authorities at that time. Our usual practice would be that, had Earle Haven continued in operation and our concerns continued, that would certainly have been part of our case conferencing about that.

Ms BATES: Can I ask how many complaints you have received? Was it a lot of complaints from nurses or the AINs? Did it ramp up, basically, is what I am asking you? From when you were first made aware in February to the lead-up to the collapse, how many complaints would you have received?

Mr Prentice: Again, I would have to—

Mr Murray: If you would allow me, I would like to clarify.

Ms BATES: Yes, absolutely.

Mr Murray: It was not me who initially had carriage of this matter. I was not at the QNMU at that time. It was another one of my co-workers. However, there was a handover process. Essentially, when this first came through, the issues that came to us that were at the forefront were about, 'I'm not getting paid.' They were not paying an extra week of annual leave. They were not paying superannuation.

Through that period, from the time line I have, we took that to the Fair Work Commission. It was those things that were at the forefront and emanating. Then a couple of months down the track is when it started to get raised anecdotally. It would happen from time to time where I would be dealing with a member and at the forefront was, 'I'm not getting paid,' or, 'This is happening.' Unfortunately, from what I have experienced, if there are not enough wipes or there are not enough gloves, members just bring them in and they try to do the best with what they have in that situation. From my perspective, I am not from a clinical background, so when those things start to be raised by members, that is when we will then raise it with the professional officers.

Ms BATES: It is fair to say that there were clinical concerns raised—

Ms O'Connor: Down the track in the conversations. Initially, it was the industrial payment ones and those arguments and then when they had member meetings in person those conversations came up, which is when the case conference happened.

Ms BATES: Can I ask how many nursing staff are at Earle Haven? Are you aware?

Ms O'Connor: I cannot remember, honestly.

Mr Murray: It would be in the roster.

Ms O'Connor: It would be on the roster. The roster actually has every staff member down there.

Ms BATES: How many staff did the QNMU represent at Earle Haven?

CHAIR: You can take it on notice.

Ms BATES: You can take it on notice, if you like.

Ms O'Connor: No, we currently have about 42 people. Some were casuals and did not need assistance, but on our books and the people we are still dealing with is 42.

Ms BATES: Ms O'Connor, you mentioned that you got the roster when the turmoil was occurring. Can I ask who gave you the roster and who asked you to call staff to come in?

Ms O'Connor: We did not call staff to come in.

Ms BATES: I thought you said that you did.

Ms O'Connor: No, I called staff. I looked at the roster. I saw who was on duty, who were witnesses. I called them and said, 'Who was there at that time?' They gave me the descriptions of what staff came in, what staff finished their shift. I said, 'Did you know of anybody who actually left?' and they said no. I spoke to five members, all of whom were rostered on. That is where the stories came out about night duty coming on earlier, morning shift coming on and that sort of stuff.

Ms BATES: Again, my question was: who gave you the roster?

Ms O'Connor: A staff member gave us a roster when they saw an eight-foot IT tower removed on the Wednesday at lunchtime.

Ms BATES: Do you know if they gave the roster to the Queensland Health staff who were evacuating Earle Haven? What I am asking is: did QH have the same information that you had?

Ms O'Connor: I do not know.

Ms BATES: My final question is in relation to the comments that were made about nurse-patient ratios. Anyone can answer this one. It was Mr Prentice who made the comment. You mentioned that you had concerns about privately-run facilities in Queensland. Do you have similar concerns about the 16 state-run aged-care facilities?

Mr Prentice: Certainly, on average the level of care hours at the state-run facilities is higher than the average that we have looked at in terms of that audit that we did last year—in 2018—around the average care hours across the state in private facilities. I think it would be fair to say that, generally speaking, the level of care is—

Ms BATES: Are you aware of any complaints similar to abuse of elderly residents out of state-run facilities?

Mr Prentice: No, not that I am aware of—me personally, no.

Ms BATES: Thank you.

Mr O'ROURKE: Through your visits to various residential aged-care facilities, do you think some of the private ones put dollars before the care of the residents?

Ms O'Connor: Absolutely. I have had 13 years and it has got worse. I do not think it is a few bad apples; it is a business model. When cuts are made it is usually to staffing, or more and more now we are seeing resources, whether it is wipes, equipment or whatever. Yes, it is worsening—undoubtedly.

Mr O'ROURKE: Do you think the Commonwealth should implement staff ratios to ensure quality care for our elderly?

Mr Prentice: Yes, absolutely. I think there is now, particularly with the latest evidence that has been released by staffing and skill-mix levels in the hospital sector—the Aiken research that has been recently released through the work that they have done in conjunction with the state government—the evidence is that the level and quality of staffing is linked to the outcomes of care. I think that is pretty indisputable these days. If we have the argument in child care that there is a minimum level of care that is required to keep you as a child safe, then other vulnerable populations, such as those in residential aged care in particular—I think it is a fair and reasonable expectation that the same philosophical approach as to how we deliver care and how we respect those vulnerable groups should be adhered to. Certainly, having a minimum level of care, in terms of both quality and quantity, is probably an essential part of that. As the federal government is the primary regulator in aged care, I think that is certainly something that really needs to be at the forefront of the agenda to fix some of those broad, systemic issues that we are seeing at the moment.

Just as a follow-on from what Bernie indicated before, clinical governance, for example, which is an awareness around how we deliver health services in a particular setting and how the whole organisation works in relation to that, has been a core attribute of how we deliver services in the acute sector for many, many years, but it is only now being considered as a core aspect of standards in the aged-care sector. I think aged-care providers see aged care as a business. I hate to be broadbrush,

but I think there is a general view that it is a business. I think some of the evidence for that is simply that probably on a number of boards for organisations there is not one person who has any healthcare experience. When you have organisations where the governing board, for example, has no-one there who is not an accountant or a lawyer—and I have nothing against accountants and lawyers—it probably reflects the kind of priorities that organisation has. While those organisations may well have clinicians further down the leadership chain, I think it probably is important that, on governance bodies, those views are represented and taken into account during decision-making processes.

Mr CRANDON: Mr Prentice, what is your take on the discussion that we have had right throughout the last day and a half about the 71 per cent chemical restraint and 50 per cent physical restraint, specifically about Earle Haven? What is your take on that?

Mr Prentice: As we did indicate in our submission, and certainly more generally, we believe that restraint is an ultimate last resort. I think, again, if we take the acute sector—let us say mental health services, for example—there are longstanding and lots of evidence based application of policies and procedures around how restraint, both chemical and physical, is used there. We have lots of evidence to call on. I think, generally speaking, the evidence would suggest that this really is a last-resort thing to do.

In terms of physical restraint, as you would know there are a range of risks associated with that—and certainly from a chemical restraint perspective. A primary risk with chemical restraint is one that is used in the first place on a group of people who are vulnerable, frail, elderly or cognitively impaired, and we are using drugs that are probably actually not meant for elderly people and all the attendant risks that go with that: the increased risk of not mobilising, the increased risk of falls, the increased risk of pressure injuries and nutritional deficits and that sort of thing. Most recently we have had input into the federal department of health and the work they have been doing around developing processes around physical restraint in residential aged care.

Mr CRANDON: In a facility like this one, who makes the call on the chemical restraint and the physical restraint? Is that a doctor making the call every time?

Mr Prentice: At the end of the day, it is the prescriber who has to take responsibility for the prescribing of chemical restraint. I would suggest that one of the issues in aged care, which is not an issue, say, in the acute sector, is that we do not have a multidisciplinary team as you would expect that you would have in a hospital. I will give you an example. If you were in a hospital as a subacute, non-acute patient, you would have a whole multidisciplinary team around you to help you progress through your treatment. If you get discharged from that hospital and then 15 minutes down the road you end up in an aged-care facility, that level of team is not there. Oftentimes GPs in particular are highly dependent on the feedback they get from the staff who are caring for people in a facility.

Mr CRANDON: Thank you for that. Mr Murray, you were in the room yesterday I believe?

Mr Murray: That is correct, yes.

Mr CRANDON: Some of the witnesses did indicate that Mr Miller had paid them some of their entitlements.

Mr Murray: That is correct, as I have previously indicated to Ms O'Gorman.

Mr CRANDON: Some of the individuals indicated that they had been around for a long time. Would Mr Miller be liable for any of the long service leave entitlements or anything of that nature in that regard?

Mr Murray: Because effectively what happened was that the contract of employment transferred from People Care to HelpStreet, essentially it is HelpStreet who are liable for those bills.

Mr CRANDON: There would have been mechanisms in place to transfer that liability on?

Mr Murray: Yes, what is called a transfer of business. It was raised during my toing and froing with HW Litigation whether a transfer of business did indeed occur and there was some again toing and froing of what those actual leave entitlements may consist of. So there could quite possibly be people who are being short-changed for their long service leave.

Mr CRANDON: Ms O'Connor, Mr Strong yesterday talked about there not being sufficient staff on site. The decision-making process that they went through—the ambos and the Gold Coast hospital board—included a lack of sufficient staffing on the premises. I think you may have supported that, but then there was a sort of a conflict in what you were saying because I thought you were saying that they all stayed, but that is not what he said. That is where perhaps the member for Mudgeeraba got it wrong as well. I thought you said that you had made calls to other people and they had come in to support—

Ms O'Connor: No. The calls I made were about a week later, because we kept hearing about abandonment so I wanted to get the facts.

Mr CRANDON: Going back to the day?

Ms O'Connor: On the day, yes.

Mr CRANDON: Did you make any calls getting people to come in?

Ms O'Connor: No, no. What I was reporting in the conversations was that they all received a memo from HelpStreet, which was around 2.30, and then they talked to each other and that is when people came in. What I have handed you was the result of those conversations.

Mr CRANDON: Can you provide to the committee the number of staff of Earle Haven that you noted from the roster were there for the duration in each category?

Ms O'Connor: There would be probably staff I do not know of that would have been there too. There were people who had not worked there for three months who actually turned up as well. From a person coming in from an ambulance point of view, I would find that they probably do not realise that aged-care facilities have minimal staffing anyway so there would have been one RN between the two areas, which is 60 or 70 residents. That would seem like naturally light on, but that is constant. I can only capture—and that is what I have provided there—names and examples of people coming in and extending their shifts—just the opposite of everybody going home.

Mr CRANDON: The reason I was asking that is because Mr Strong was of the view that there were not a lot of people.

Ms O'Connor: But I think for a layperson going in—if you knew there was one RN for 67 residents you would think that, but that is normal.

Mr CRANDON: When did you get the roster?

Ms O'Connor: I got the roster probably the day or the day after.

Mr CRANDON: On the day?

Ms O'Connor: No, the day or the day after.

Mr CRANDON: It was a day or two later?

Ms O'Connor: Yes.

Mr CRANDON: It was not before or on the day?

Ms O'Connor: I only referred to that roster because I needed it to see who was working to find out what was the situation—who came in, who stayed and that sort of thing.

Mr CRANDON: You do have some idea about who was there and who was not there?

Ms O'Connor: Yes, represented there, but that would not capture it all. As I said, there were people who did not work there who came.

Ms O'GORMAN: Mr Chair, might I interject just very briefly? I think some of the confusion might have arisen because perhaps I was not clear in my questions. It might help if I just clarify a couple of things with Ms O'Connor.

CHAIR: Yes.

Ms O'GORMAN: Ms O'Connor, is it the case that on 11 July 2019 you attended at Earle Haven with two other people from the union?

Ms O'Connor: Yes.

Ms O'GORMAN: And the telephone calls that you made to anyone else to attend to Earle Haven on that day were simply to those two other people who attended with you?

Ms O'Connor: Yes. My phone calls were mostly with our secretary. The three of us were there on the spot.

Ms O'GORMAN: Thank you. It was not the case that you made any telephone calls to any staff of Earle Haven?

Ms O'Connor: No. That is what I was trying to say. They did this of their own volition. I followed up a week later.

Ms O'GORMAN: I understand. For the sake of clarity, the document that you produced and that has been tabled this afternoon is a result of your subsequent inquiries about who had been there, not knowledge that you had actually on 11 July?

Ms O'Connor: No.

Ms O'GORMAN: Thank you. I think that may have clarified it.

CHAIR: Thank you, Ms O'Gorman. I think just to clarify as well, Mr Strong's information, member for Coomera, was not just around the staffing but certainly the infrastructure, medications and records and things that had been taken out.

Mr CRANDON: That is absolutely right.

CHAIR: It was a whole assessment.

Mr CRANDON: That is exactly right.

Mr McARDLE: Thank you for being here. Ms O'Connor, you mentioned in response to counsel's question that it was mostly the secretary of the union you telephoned on the way to Earle Haven on the day. Who else did you phone?

Ms O'Connor: The two colleagues who were meeting me there—and I asked my colleague who got there first to get David Lamb to call me, because I really wanted to speak to him to find out what was going on.

Mr McARDLE: You phoned nobody else outside those three people or did not ask them to phone somebody else on your behalf?

Ms O'Connor: When David Lamb had not called, I asked our director back at West End to keep trying to call him to get the information.

Mr McARDLE: I want to look at a couple of points. Mr Prentice, you made the comment that the first contact the union had had with Earle Haven was 1 February.

Mr Prentice: I believe so, yes.

Mr McARDLE: That led to a conversation or conversations with staff members that triggered the meeting on 5 July.

Mr Prentice: That is right.

Mr McARDLE: Can I take it, then, that no member of the union made contact with the union prior to 1 February 2019 on any issue?

Ms O'Connor: Oh, no.

Mr Prentice: I have no personal knowledge of that, but I would not think that would be the case. We have members there.

Ms O'Connor: We have constant contact.

Mr Prentice: I do not have those records available, I am sorry.

Mr McARDLE: Could you take that on notice? Can you check as to when the first contact was from Earle Haven, because I did take the date that you gave us as the first contact re Earle Haven?

Ms O'Connor: Could I answer that?

Mr Prentice: Yes.

Ms O'Connor: I think it is 2007. We have been having contact and visits and so forth since that time.

Mr Prentice: I think we take that date as where we have gone back to to look at the series of events that we feel—

Mr McARDLE: Could we get some history from the union as to what that contact was? I do not want chapter and verse. There is no need for that. Just give us some sort of flavour, time line, number and issues so that the committee is informed, from the union's perspective, as to what had taken place. The other thing is that you mentioned there was a letter that was drafted post a meeting of 5 July and I missed who was that to be addressed to.

Mr Prentice: That was addressed to the clinical manager, I believe, of Earle Haven but never sent.

Mr McARDLE: Would you care to seek leave to table that draft letter?

Mr Prentice: I could certainly talk to the secretary about that.

CHAIR: Take it on notice.

Mr McARDLE: On the issue of the roster, Ms O'Connor, you have given us a document but that is not quite the roster.

Ms O'Connor: No, it is not.

Mr McARDLE: It was a second document, and you have agreed to take it on notice to deliver it to the committee.

Ms O'Connor: Yes.

Mr McARDLE: We are hearing again next Monday. Is it possible to have that document by close of business tomorrow, because it may become relevant in relation to a witness on Monday.

Ms O'Connor: Yes. If it is all right with our secretary, that is all. I have to get the okay.

CHAIR: I think we have tried to attain copies of rosters from the operator as well and clinical staff but we have not seen that at this time, so any rosters would be beneficial.

Mr McARDLE: By tomorrow afternoon, if you possibly could.

Ms O'Connor: The only thing stopping it is that I have to get our secretary's approval.

Mr McARDLE: Who is a wonderful human being.

Ms O'Connor: Absolutely, yes. I am sure she will have no trouble.

Mr McARDLE: I want to take you to your submission. I am not quite certain who put it together so I am going to ask any of you to make comment. Mr Prentice, you have just been allocated the task, shall we say.

Mr Prentice: I will be happy to elaborate on that.

Mr McARDLE: You start on page 7. You refer to the May 2018 audit of facilities in Queensland and you then say that residents received 2.61 hours of care per day average. I take it that 2.61 hours of care per day is broken up into RNs, ENs and PCWs.

Mr Prentice: Yes, that is right.

Mr McARDLE: You then say that the average is 4.3 hours in relation to the Willis study of 2016.

Mr Prentice: That is correct.

Mr McARDLE: Can you indicate to me: of the 2.61 hours, if I translated the figures at the base of that dot point—RNs, ENs and I call them PCWs. if I divided those figures into 2.61, would that be an accurate translation?

Mr Prentice: The percentage figures there relate to the information received around the hours of RNs, ENs—

Mr McARDLE: So I can divide that into the 2.61 and get my relevant figures?

Mr Prentice: That would very roughly give you a bit of an idea of the kind of output, yes.

Mr McARDLE: Why do you not include the government-run nursing home figures? They are not mentioned here. As I understand it, these are private-run aged-care facilities. Did you audit the government?

Mr Prentice: No, we did not.

Mr McARDLE: Why did you not audit the state government?

Mr Prentice: The majority of aged-care facilities in Queensland are privately run. In the public sector, of course, our close working relationship with Queensland Health gives us a much better understanding of the staffing and skill mix.

CHAIR: I think he answered it before, with respect, Deputy Chair, about complaints in the 16 residential facilities.

Mr Prentice: That is right.

Mr McARDLE: We will come to that in a moment.

Mr Prentice: It is simply that—

Mr McARDLE: Why not pop one into the equation? Why not try to at least look at one?

CHAIR: We are looking at private.

Mr McARDLE: With all due respect, this has been opened by you, Chair. Mr Prentice, in his document, refers to private facilities. I am asking what I think is a legitimate question. Why were any public facilities run by Queensland Health not included in this state, or were you advised there was no need to?

Mr Prentice: No, it was not that there was no need to. Because the public sector aged-care facilities are covered under the enterprise agreement that we have with Queensland Health, we have a much closer working relationship through, for example, our nursing and midwifery consultative forums at the facility level and health district level. We are also given information from those districts around, for example, the business planning framework information for facilities, including residential aged-care facilities in those relevant HHSs. We had a much greater understanding of the staffing and skill mix that was out there in those public facilities but little understanding of the majority of aged-care facilities in Queensland which are privately run. I think that was our effort to try and understand better the staffing and skill mix in those privately run facilities.

Mr McARDLE: Can I perhaps precis the situation? Because you have a close working relationship with Queensland Health and because you have, you say, a better understanding of what happens inside the Queensland Health facilities, you did not think it worthwhile reporting on them?

CHAIR: I probably asked that. We are just going to rule that one out.

Mr McARDLE: With respect, Chair, you opened the question of nurse-patient ratio.

CHAIR: We are here examining—

Mr McARDLE: Well, you opened the question, Mr Chair; I did not. I will let that matter go and ask the question: did you not feel it relevant?

Mr Prentice: Just to make a comment, in the public sector the business planning framework is the mandated workforce planning tool within the public sector. Each of those 16 residential aged-care facilities comes under that purview, so to speak. So our concerns do not lie with the public sector, I guess—

Mr McARDLE: It should have been uniform.

Mr Prentice: Which was essentially our reason to look at the private aged-care facilities.

CHAIR: Thank you. The committee has visited some of our public-run facilities. In fact, we were at Redlands only the other day and we are looking at Parklands in Townsville. That is not the intent of this inquiry. It is looking at Earle Haven and the private-run facilities. I bring the member back to that.

Mr McARDLE: If it stayed at that, Mr Chair, I would be happy. I want to take you to page 6. In the study by Phillips 2017, it was noted that the requirement for high care had jumped from 13 per cent in 2009 to 61 per cent in 2016.

Mr Prentice: That is correct.

Mr McARDLE: That is a dramatic leap in high care some years ago.

Mr Prentice: It is.

Mr McARDLE: Go back 30 years, it was almost unheard of.

Mr Prentice: Yes.

Mr McARDLE: Seventy-five was about, generally speaking, the age that we move on from the normal. That presents very important questions for nursing homes going forward.

Mr Prentice: I think that is a very relevant observation, yes.

Mr McARDLE: And the model we have now will not continue to exist in time to come with a cut?

Mr Prentice: I think you have touched on a very important issue there. Generally speaking, the level of care required, particularly the components of high care which are often health care related, has increased significantly for those in residential aged care. The old days of having high-care and low-care models simply do not exist anymore. For a lot of people receiving residential aged care, there are only two places you can be if you need that level of care. That is either as a subacute or non-acute patient in a hospital or as a resident in a residential aged care. People are living longer. They have more co-morbidities, they have more diagnoses, they have increasing polypharmacy and the complexity of their care is getting greater over time.

Perversely, what we have seen, though, is a restructuring of the workforce at the very time the care requirements, particularly the complex care requirements, of those in residential aged care in particular is that the unregulated component of the aged-care workforce is increasing, and our audit figures from 2018 closely follow the workforce data that is produced in Australia around that particular workforce. So you are absolutely right: it is pretty unsustainable to have a cohort of people in

residential aged care who have increasing care needs at a time when the workforce seems to be increasingly incapable or increasingly less able—perhaps that is a better phrase—to deliver the complexity of the care.

Mr McARDLE: The training level is not up to standard.

Mr Prentice: Well, there is a range of issues there. Just to give you an example, if you are in hospital and an acute event happens to you, like a cardiac arrest, the person who will save your life is a nurse. If the same thing happened in residential aged care—and remember that being in residential aged care does not mean that all emergency procedures or resuscitation attempts are not appropriate—the person who might first respond to you is an unregulated carer who may not even have first-aid training.

Mr McARDLE: Can I take this point further? You then say during the same period that the proportion of qualified nurses fell dramatically 'with the registered nurse cohort reducing by 33 per cent'. First of all, with that phrase 'registered nurse cohort reducing by 33 per cent', are you talking about the number of RNs that are trained or the number who are working in aged care?

Mr Prentice: This was written while I was on leave, but it used a lot of the material that I prepared earlier. No, it is essentially the percentage of registered nurses coming into the aged-care workforce.

Mr McARDLE: Numbers coming out of the universities?

Mr Prentice: No, not even that. I believe it simply goes to the fact that globally within aged care, in the private side of things, we have seen a progressive reduction in the number of registered and enrolled nurses and at the same time a corresponding increase in the number of—

Mr McARDLE: In PCWs?

Mr Prentice: Yes, who may have a cert III or a cert IV or may have no qualification.

Mr McARDLE: Yes. That then raises the point, of course, that, unless we develop a better system to train more RNs and ENs, a ratio will be almost impossible to achieve if it is set at a level that cannot be met by staff coming out of universities. It is an observation; I am not asking you to make a comment.

Mr Prentice: No.

Mr McARDLE: That will be an issue as part of any ongoing discussion about how to achieve a ratio when you settle on—if we settle on—what that break-up of components is going to be. It is a long-term strategy that I see.

Mr Prentice: Oh, absolutely. No, I agree, and I think that really highlights the work that was initiated through the aged-care workforce taskforce and the report where those very issues are identified. I think one of the things that is exceptionally important to do in aged care is to have a long-term workforce planning strategy, and we would certainly like to see the state involved in that process. I think that is exceptionally important.

Mr McARDLE: Mr Prentice, you made the comment that you had not heard of complaints about public aged-care health services in the state. Did the ABC not release an RTI recently that raised concerns in relation to 16 complaints in 2018?

Mr Prentice: Perhaps I should answer it to say that I worked for nearly 40 years in the public hospital system. In 2005 I was one of the change managers who were seconded to the Patient Safety Centre—that was its name at the time—and one of my roles was to roll out a single online, internet management system across all public facilities in Queensland. It was groundbreaking at the time. That had not happened. That was really leading-edge stuff at the time. It was again in response to the issues that had come out of the Bundaberg inquiry. It was a very exciting time to be working in that patient safety space.

Mr McARDLE: It was a concerning time, put it that way.

Mr Prentice: Very, yes, but it was exciting in the sense that there was a whole range of initiatives that were very proactively being implemented to meet the concerns that had come out of that inquiry. Certainly when I answer that question, I guess I am talking that I personally have knowledge of because my role as a professional research officer does not encompass that frontline role of hearing complaints. I would imagine that the other thing is that in the public sector in Queensland, in the health sector, there is a rich patient safety culture that is very much focused around reporting clinical incidents, and I would say that any one of those 16 aged-care facilities would be contributing to the clinical incidents of quite a range or variety of issues almost every day.

Mr McARDLE: So you do not know?

Mr Prentice: I am just not privy to the number, but I know that when I worked at the Royal Brisbane, thousands of clinical incidents were reported every year, thoroughly investigated and resolved. It is about having a reporting culture. That is probably the most important thing.

Mr McARDLE: Thank you, Mr Prentice. Well said, Sir.

CHAIR: Before we conclude, Mr Prentice, the federal government has ownership of aged care.

Mr Prentice: That is right.

CHAIR: As in the main ownership. The *Courier-Mail* and, in fact, this committee received documentation from the federal minister, Greg Hunt, not supporting the introduction of increasing nurse-to-patient ratios. What is the view of the QNMU on that?

Mr McARDLE: Mr Chair, sorry, I thought you just ruled me out of order.

CHAIR: No, nurse-patient ratio.

Mr McARDLE: Is this a change of tack?

CHAIR: No, I am interested in the answer.

Mr Prentice: Our position is that evidence based staffing and skill mix is a core aspect of aged care, and we have based our ask on 4.3 hours per resident per day and a skill mix of 30 per cent RNs, 20 per cent enrolled nurses and 50 per cent AINs/PCWs, however named. That is an evidence based ask, just as the information that has been recently provided through the Atkin work in the acute sector again is evidence based. I think the whole issue is that it is exceptionally important that, wherever you receive care, that care has an evidence base. It is not a number that we have come at any other way. It is evidence based. Certainly we would be very supportive of ongoing studies in that, I think, which is the other thing: you cannot rely on just one. I think the greater the evidence base, the better the outcome.

CHAIR: Thank you, Mr Prentice.

Mr McARDLE: That question prompts another question, Mr Chair.

CHAIR: We might adjourn now.

Mr McARDLE: It is only one question. It flows from a direct question.

CHAIR: I am going to pull it up. We will adjourn for 30 minutes. We have well and truly gone over time.

Mr Prentice: Can I make just one last comment, if you would not mind?

CHAIR: Yes.

Mr Prentice: When I worked at the Royal, I was involved in the Cairns hospital evacuation—remember, with the cyclone? That took considerable logistic effort. I was manning the emergency centre at the Royal and we were taking patients. The fact that the Queensland services were able to relocate 70 people from Earle Haven in a short period is an absolute testament to the expertise, I believe, of the state response. I think that really does need to be highlighted.

CHAIR: Thank you. A closing remark?

Mr McARDLE: A closing question.

Ms BATES: It is a yes-or-no question. It is pretty quick.

CHAIR: I want to move to Ms O'Gorman in a minute. Do you have something to say, Ms O'Connor?

Ms O'Connor: Yes, please. Just to finalise, today I have heard people say that because of the royal commission a spotlight is being shone on aged care. The fact that we have a royal commission is in response to all the complaints. What we have now, as Dan has said, is the care needs going up and the skill mix and the staffing going down. The system itself is drawing attention to itself. That is what we are seeing. Yes, it is hard to fix it and most of the responses we have seen over the past 13 years have led to minimising—that it is a few bad apples. It is not. It is more systemic than that and the fact that you blame somebody else. Somewhere along the line we have the intelligence and the people who can fix this system. We just need the will of our decision-makers.

CHAIR: Thank you. Ms O'Gorman?

Ms O'GORMAN: Chair, I do not have any further questions. Noting that we are adjourning now, I would ask that the witnesses be excused.

CHAIR: Thank you very much.

Mr McARDLE: That is not quite right. I have indicated that there is a question.

Ms O'GORMAN: I am sorry.

CHAIR: I am sorry, we have one final question and then we will adjourn.

Ms BATES: Mr Prentice, the government plans to name and shame private facilities in the upcoming legislation. Do you think failed state-run facilities with serious allegations made against them should also be named and shamed?

Mr Prentice: I would believe that all quality-of-care issues must be appropriately reported and investigated and remediated, irrespective of where they occur in any part of the healthcare system.

CHAIR: Thank you, Mr Prentice.

Proceedings suspended from 1.48 pm to 2.20 pm.

SCANLON, Ms Meaghan, Member for Gaven, Parliament of Queensland

CHAIR: Ms O'Gorman?

Ms O'GORMAN: Thank you, Mr Chair. I understand that Ms Scanlon has an opening address she wishes to make.

CHAIR: The committee welcomes the member for Gaven, Meaghan Scanlon.

Ms Scanlon: Thank you very much. I thank the committee for coming to the Gold Coast to conduct this important hearing into the horrible incident that happened in our community. On 11 July I received a phone call I never want to receive again. It was from Minister Steven Miles's office telling me that triple 0 had been called to attend to 70 elderly residents from Orchid House and Hibiscus House at Earle Haven nursing home, whose care had been compromised. I drove to the facility as soon as I could, where I remained until the late hours of the night.

What I witnessed when I arrived was akin to what you would see during a disaster, although it was not caused by a fire, flood or cyclone. It was caused because the providers or companies who were supposed to be caring for those residents put money before people. I remained outside Hibiscus House for some time, speaking with police, HHS representatives, families who were rushing to make sure their loved ones were okay, and residents in the independent living section of the retirement village, who were understandably distressed at the sight of police and ambulances littered throughout the entry. I watched elderly frail residents being transported on stretchers into ambulances without any loved ones around them to support them.

I went into the facility to see if there was anything I could do, knowing that my assistance would be limited to providing coffees and listening to people. I have no medical or health qualifications. I was incredibly impressed with the professionalism, focus and compassion shown by all emergency services and HHS staff who were coordinating the relocation, making sure that residents had food and liquids, and trying to determine who needed what medication. I was shown a room that had what looked like medical records scattered on the floor, so I support yesterday's witness evidence describing the scene as chaotic.

Amongst the chaos, I saw two elderly women sitting in silence, staring at a table. I sat down with them to keep them company and check on how they were doing. After speaking with one of the women for a little while, Mike, her son, came over. Mike informed me that his father had died only a couple of weeks ago and how angry and upset he was that this was now happening to his mother. I want the committee to consider how you would feel as a grieving son or daughter to find out through a phone call or some through the media that your only living parent, who was not capable of living independently, was no longer safe in their own home.

Mike told me that Velma, I believe her name was, the other woman sitting at the table with us, had worked in the legal profession. That was evident when a nurse came to take Velma to another facility in the evening. Velma responded, 'I'm not going anywhere until you can convince me as to why that is appropriate,' or words to that effect. Velma took quite a lot of convincing that it was not safe for her to remain at Earle Haven. She had no family by her side and was being ripped out of her home. She was understandably apprehensive.

After the two women left, I watched extremely frail residents being hoisted onto stretchers. It still makes me incredibly sick to think of some of the most vulnerable people in our community who were effectively abandoned. Some of those residents could not walk or could barely move.

While the company heads were doing media, arguing with each other and not providing any real support, aged-care staff had come in voluntarily to provide assistance for the people they cared for and loved. Some of those people earn a wage of around $50,000 or less a year. Aged-care staff are the unsung heroes in our community. They are overworked, underpaid and the overwhelming majority of the staff I have met will always go above and beyond, cutting their lunchbreaks short, doing unpaid overtime, paying for items for residents out of their own pockets and, in this case, walking in when others were walking out. They have shown up during this committee process while Arthur Miller and the HelpStreet CFO or CEO have not.

Chair, I will leave with you one last story from that evening. On 11 July 2019, late at night at Orchid House, I saw a man who, for the purpose of this committee, I will call Peter. Peter looks after my brother Callum, who has Down syndrome, providing much-needed respite for my mum. Peter's dad was one of the 71 residents who had to be moved that night. He had an expectation, like my family does when Callum goes under someone else's care, that his father would be looked after and at the very least not abandoned.

CHAIR: Take your time, Meaghan.

Ms Scanlon: The system let his family down and 70 other families. I am angry that this happened to our community. I am angry that it happened to our most vulnerable. I am angry that there were so many red flags raised to the federal government in the lead-up to this incident occurring. My apologies. I do not usually get emotional, but it is speaking about this incident.

We are not just talking about one sanction. There were multiple sanctions imposed before this chaotic event occurred, notices of noncompliance and numerous complaints. People in my community are now terrified of what is going to happen to their mums, their dads, their grandparents or themselves when they need to access aged care. My own mum has expressly told me that she refuses to go into an aged-care facility when that time comes.

Unfortunately, that is not an option for some families. My extended family had to make the difficult decision to put my own grandmother into a nursing home as she had dementia and everyone was working hard to earn money to keep a roof over our heads and food on the table. I would be furious if this had happened to my grandmother and I am furious on behalf of the families who deserved better. We cannot let what happened at Earle Haven ever happen again. It was disgraceful and we need to hold these facilities accountable. Care for our elderly Queenslanders must be the highest priority and it is time that we all show courage and leadership and confront an issue that has been avoided for too long. Thank you.

CHAIR: Ms O'Gorman?

Ms O'GORMAN: Thank you, Mr Chair. I do not have any questions for Ms Scanlon.

CHAIR: Ms Scanlon, thank you. I do not care which side of politics you come from. Your emotion showed that you care about your patch. As members, we would all feel the same. We do not want to see this occur. Thank you for being there. Thank you for getting the coffees and keeping them going. What time did you leave the site?

Ms Scanlon: Approximately 11.30, I think it was, that both the Minister for Health and I had left.

CHAIR: Did you see Mr Miller or Mr Bunker doing media?

Ms Scanlon: I understand that Mr Bunker, I believe, was doing media. I do not recall personally seeing him do that, but I understand that occurred before I had arrived. Again, I did not witness that. I saw it on the news and it looked as though it was obviously during the time at which people were being relocated. I did see Mr Miller. I did not have any personal interaction with him, but I did see him pacing up and down the facility. At that time, I did not see him interacting with residents.

CHAIR: Thank you very much. I will open up to questions from members.

Ms BATES: Thanks, Meaghan, for your evidence. Earle Haven was actually in my electorate for many years, so I am very familiar with that facility. How many times have you visited the high-care facility in the past 18 months?

Ms Scanlon: I had not visited the high-care section of the facility prior to this event. I had tried numerous times to get on site, asking the management to meet with the independent residents. My electorate office staff would have the exact correspondence. We were not permitted to for some time, until there was an incident in regards to conversations about bus services during the Commonwealth Games. We were then permitted to come on and clarify some information for residents.

Ms BATES: Do you have documentation where they refused, basically?

Ms Scanlon: I do not know if they expressly refused or did not get back to us, but I know there were several conversations whereby we had requested and that did not eventuate.

Ms BATES: When were you first aware of any issue at Earle Haven? We have listened to the QNMU this morning and I know you were sitting there listening, as well. Their evidence was that there were issues from five months before this occurred. When were you aware? Did it come from families of residents there directly to you as the local member or did it come from nurses who were concerned and came to you because you are in government?

Ms Scanlon: I was aware from one particular family member that complaints had been raised, I understand, through the appropriate means and I suspect that was one of the 22 complaints that was lodged in the lead-up to January. I believe we now know those numbers. I was aware that there were industrial issues that the QNMU was managing. I did not know the full detail or extent of those issues. I did not have any information that the federal government agencies, presumably, would have had.

Ms BATES: Did the QNMU notify you of the concerns that were happening at Earle Haven or was it from nurses who had approached you?

Ms Scanlon: I received information from the QNMU that they were having issues in relation to the underpayment of superannuation.

Ms BATES: Did you raise any of these concerns with the Minister for Health at the time?

Ms Scanlon: The federal Minister for Health?

Ms BATES: No, the state Minister for Health.

Ms Scanlon: It is the jurisdiction of the federal government.

Ms BATES: I understand that, but the question was did you alert Minister Miles at any time?

Ms Scanlon: No, but I was aware that we were obviously—I had been talking about the issues within aged care prior to this event occurring. This was really one of many aged-care facilities where I was hearing issues about the treatment of staff, so, no.

Ms BATES: That speech that you made to parliament in October, was that in reference to concerns that you had about Earle Haven?

Ms Scanlon: I would need to look back at my speech in October, but the issues that I was articulating then were based on the many stories that I had been told by aged-care staff from across the Gold Coast in Queensland in private and not-for-profit facilities that had raised concerns in relation to a lack of support and understaffing.

Ms BATES: The concerns that were raised with your office, whether with you personally or with your staff, were they then referred to the relevant federal authorities?

Ms Scanlon: Any information that I received was never specific enough in nature to warrant anything being raised with an authority as such. They were in relation to understaffing, which we have been very vocal in saying needs to be changed. That was on the public record in parliament, in the media—in a variety of realms—that any federal government agency, or minister, or member of parliament, I assume, would have seen.

Ms BATES: Sure. As the state member, did you raise any complaints that you may or may not have been privy to personally, or that your staff had received with your federal member for Moncrieff?

Ms Scanlon: Sorry, can you clarify? What complaints?

Ms BATES: Any complaints that you received, or your staff had received, did you raise any of those issues with the federal member for Moncrieff, given that it is a federal issue?

Ms Scanlon: Prior to Earle Haven? At Earle Haven, or just generally?

Ms BATES: Earle Haven in general.

Ms Scanlon: The only complaint that I had received from an individual was from a woman, Lorraine Cook, who is a family member who had said that she had already made complaints, so I did not feel it appropriate to then make another complaint when she had very clearly already raised that herself. As I said, the others were just in relation to understaffing—very generic issues.

Ms BATES: Were any of the QNMU concerns raised with the federal government at any stage? Obviously, nurses are paid under a Commonwealth award in aged-care facilities. You did not share that with any federal authority?

Ms Scanlon: The QNMU, I think, has already raised evidence in relation to that. I do not work for the QNMU. I naturally assumed that they had raised those issues in the way they would ordinarily raise industrial relations issues.

Ms BATES: Have you, since Earle Haven has occurred, visited the Nerang Nursing Centre where 50 of those patients were evacuated to?

Ms Scanlon: I have not been to the Nerang Nursing Centre as yet. I had every intention of visiting that facility on the thank you aged care day, but I was not able to, but I have a hamper in the back of my car for them so I will be visiting there soon. But I have received information back from some of the family members who have been to that facility.

Ms BATES: I have visited that facility with the federal minister for ageing and the member for Moncrieff. Might I suggest that you do go and visit—

CHAIR: Let us keep this above politics, member.

Ms BATES: No, what I wanted to say—

CHAIR: Or I will make a ruling.

Ms BATES: The nursing home that took the 50 patients did a fantastic job that night, as you well know.

Ms Scanlon: Absolutely.

Ms BATES: I think as the local member it would be worth listening to the managers about the concerns they had of the way they were treated by the media and by some relatives, even though they did the right thing and opened their doors to have all of those 50 residents, which is a lot of people. It might be an opportunity for you to go and have a chat to them.

Ms Scanlon: I will always chat to any aged-care staff member who wants to talk about the issues within aged care. I have been cautious, though, that this is the jurisdiction of the federal government, which is the regulator and which funds these agencies. Ultimately, I need to be given permission to enter these sites as well. I absolutely will always speak to aged-care staff and have continued to since this incident.

Ms BATES: Thank you very much.

CHAIR: Any other questions?

Mr McARDLE: Yes. Ms Scanlon, thank you for being here today. I applaud your actions on that day. Congratulations.

CHAIR: Hear, hear!

Mr McARDLE: You made the comment in your opening address that, as you were walking in, others were walking out. Who were the others?

Ms Scanlon: I did not—I think you have misheard me. I will just reread what I had said.

Mr McARDLE: Yes, sure.

CHAIR: Whilst you are finding that, to contextualise it we have heard about lots of movements of people.

Ms Scanlon: Yes. What I was referring to—and I think I had said that staff were walking in to volunteer—

Mr McARDLE: Could you just read it out?

Ms Scanlon: Yes—

Aged-care staff are the unsung heroes in our community. They are overworked, underpaid and the overwhelming majority of the staff I have met will always go above and beyond, cutting their lunchbreaks short, doing unpaid overtime, paying for items for residents out of their own pockets and, in this case, walking in when others were walking out.

Mr McARDLE: Who were the others?

Ms Scanlon: There were, as I said, a number of people walking in and out during that time. In fact, we heard evidence yesterday, I think, of people who had left the facility who were working there during that day. The point I was making was that people who clearly were not rostered on, who were not even sure whether they were getting paid, had walked in just to care for these elderly people.

Mr McARDLE: Who was walking out? Others were walking out, you said.

Ms Scanlon: As I said, there were numerous people walking in and out throughout the day.

Mr McARDLE: I am trying to clarify, were there staff or RNs, EN, AINs walking out? Can you clarify who you are talking about, or the type of employee you are talking about or was it a general statement that you were trying to make?

Ms Scanlon: It is a general statement that I was making—that there were multiple people walking in and out during the day. As I said, the providers, or the people responsible, were not providing the care that the staff who had volunteered their time were.

Mr McARDLE: Right. The staff were walking out—that is the management staff?

Ms Scanlon: No, I was referring specifically to Arthur Miller and I believe—I cannot remember what his first name is now—Bunker.

Mr McARDLE: They were walking out?

Ms Scanlon: They were walking all throughout the facility and they were outside. At one stage, Mr Bunker was outside the facility while there were staff who had voluntarily come in to look after these elderly people.

Mr McARDLE: I want to take you inside the facility. Can you describe what you saw as you walked inside the front door of the facility?

Ms Scanlon: When you walk in the front door of the facility, there is a door that you need a pin code, I think, to get into.

Mr McARDLE: A pass code; correct.

Ms Scanlon: I had looked through that door very early on when I had first arrived and there were medical professionals there. I think there were some family members there at the time and I had made the decision at that point to stay out of the way, because there was quite a lot of movement and I thought the last thing they needed was a politician in the middle of all of that. I stayed outside and spoke to the police who were out there, residents from the independent section and later on in the evening I walked into the facility itself and there were a number of health staff in the entry. There was an administration block to your right. There were two halls with beds—

Mr McARDLE: Were there tables and chairs and trolleys all over the place, or fridges being moved? Was there a chaotic movement of furniture and items, put it that way?

Ms Scanlon: At the point that I had arrived, I believe that that had stopped. My electorate officer was there before me and she had seen a number of items being removed.

Mr McARDLE: You had made contact with her to get her to go down there before you arrived.

Ms Scanlon: Yes.

Mr McARDLE: I think you said that the minister made a telephone call to you to advise you—

Ms Scanlon: The minister did not, but someone from the minister's office—a staff member from the minister's office advised me that triple 0 had been called.

Mr McARDLE: Did you contemplate not going down there? You are like me: I have no qualifications of a medical nature. Did you think that maybe it was not appropriate to go at that stage?

Ms Scanlon: I considered whether it would be appropriate.

Mr McARDLE: At that point?

Ms Scanlon: At the point of that first phone call?

Mr McARDLE: Yes.

Ms Scanlon: I did consider whether it would be appropriate or not and I was in Brisbane at the time for a meeting, so I knew that it would take some time to get to the Gold Coast. After considering what the best thing to do was, I thought that the best thing to do was to get there and find out what was going on and provide any support I could but also not to get in the way.

Mr McARDLE: Did you do media that might?

Ms Scanlon: I did speak to the ABC, I believe, just to explain what I knew and said that, obviously, questions needed to be answered, because, frankly, it was appalling that this had been allowed to happen and that all of these health resources had to be pulled in because a private provider had effectively shut up shop, in terms of what we were being told, anyway.

Mr McARDLE: There would have been media all over the place—the radio early in the afternoon, the TV from four o'clock onwards. You said that Mr Miller was talking to the media at one stage.

Ms Scanlon: No, Mr Bunker.

Mr McARDLE: My apologies—Mr Bunker. Did you hear the interview?

Ms Scanlon: I did not hear the interview myself, no.

Mr McARDLE: I take it the media was tracking anyone they could to talk to at that point in time?

Ms Scanlon: Sorry, can you repeat that?

Mr McARDLE: They were keen to talk to anybody they could at that point in time to get a perspective.

Ms Scanlon: I suspect so. They were outside of the facility, yes.

Mr McARDLE: Thank you.

Ms PEASE: I have a question. Thank you, Ms Scanlon for coming in and for sharing and for going in and attending. I know how important it is to show your community that you support them in good times and in bad. I would just like to elaborate on the conversation and the line of questioning that the member for Caloundra was having with you around the phrase in your opening statement. May I suggest that 'The staff were walking in while others were walking out' was more of a metaphoric statement in that the contractor and the licensee had walked out. Both of them had abandoned that facility.

Ms Scanlon: Yes.

Ms PEASE: Would I be correct in that assumption?

Ms Scanlon: Absolutely, yes.

Ms PEASE: What we have heard is that it is a situation where they were playing chicken with each other as to who was or who was not going to pay up the money and, 'If you don't pay, we're are gone.'

Ms Scanlon: Yes.

Ms PEASE: Thank you.

CHAIR: There no further questions?

Ms O'GORMAN: No questions arising from me either. Thank you, Mr Chair.

CHAIR: Thank you very much, Ms Scanlon. We will now move to a private session, I believe. Thank you very much for being here today.

The committee adjourned at 2.42 pm.