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TRANSCRIPT OF PROCEEDINGS

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THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

BROOME

9.20 AM, MONDAY, 17 JUNE 2019

Continued from 17.5.19

DAY 23

MR P. BOLSTER, counsel assisting, appears with MS E. BERGIN and MS E. HILL
MR McKENNA appeared for Ms Bridges and Mr Barke

COMMISSIONER TRACEY: Please open the Commission. Mr Edgar.

MR J. EDGAR: Good morning. We say in Yawuru. I'm surprised this morning to be here and feel grateful to be as well, but from the Yawuru point of view I
5 welcome you here to this nice beautiful Broome day today. We say ngaji gurrjin
I welcome you here with good feelings from the bottom of my heart and from
previous ancestors as well. We say they're the two custodians from this Broome
area. On behalf of Yawuru traditional elders, I would like to welcome everyone here
10 to the special occasion and this Royal Commission. We would like to acknowledge
everyone who have travelled from all different places, and to come to visit on special
occasion you've come to this occasion. We hope you respect our culture and
values and also you stay in which is Broome. Broome means this place
feelings I say to you we will have a good working day today.

15 My uncle always emphasised this means one good feelings from long time ago.
In Yawuru this means to agree with one's spirit, one feeling and one mind. You are
now Australian citizens and the Yawuru people welcome you to the for which we
are custodians and your feelings be strong wherever you in this Yawuru country.
Thank you very much. Good morning.

20 COMMISSIONER TRACEY: Thank you very much, Mr Edgar. As a Karajarri
man and descendant, as you've said, of Yawuru elder and for the welcome to the
country that you have given us this morning. We respectfully acknowledge the
Yawuru people, the traditional owners of the land where we gather today and pay our
25 respects to elders past, present and emerging. We also acknowledge the rich and
diverse Aboriginal cultures to which you've referred that continue in the Kimberley
region, and extend our respect to all Aboriginal and Torres Strait Islander people
here today. Thank you very much for coming and for welcoming us.

30 MR EDGAR: Thank you.

COMMISSIONER TRACEY: Mr Bolster

MR BOLSTER: Commissioners, I appear with my learned friends Ms Hill and Ms
35 Bergin at this hearing. Can I say before I commence my opening that we have a
Kimberley Kriol interpreter in the hearing room today and if anyone needs help with
language please let our staff know and the interpreter will be able to help you.
Commissioners in this fourth substantive public hearing, the focus of the evidence
will be on aged care in remote areas of Australia and the related issues of access and
40 inclusion with specific attention being directed to Aboriginal and Torres Strait
Islander people. People who identify as being Aboriginal and Torres Strait Islander
comprise 16 per cent of the remote population and 46 per cent of the very remote
population.

45 For this reason, it is important that the Royal Commission when inquiring into aged
care in remote areas, consider aged care services for people who identify as

Aboriginal and Torres Strait Islander. It would, however, be a mistake to conflate Aboriginal and Torres Strait Islander people and life with regional and remote locations, remembering that over 60 per cent of Aboriginal and Torres Strait Islander people live in major cities or inner regional areas. With that in mind, and while it will receive some attention in this hearing, the particular needs of Aboriginal and Torres Strait Islander people living in urban areas will be explored further in later hearings, including the Perth hearing next week.

What is remote aged care? We commence the answer to the question by identifying examples that frame the experience of delivering aged care in some of the most remote locations imaginable. At Docker River in the Northern Territory, close to its south-western corner, is a facility known as Tjilpi Pampaku Ngura Flexible Aged Care Service. It services a population of 394 with a median age of 31 of whom 74 per cent are Aboriginal. It is funded to provide care for 19 residential care places and 22 home care packages. Tjilpi Pampaku Ngura is in the traditional lands of the Anangu people and the predominant language is Pitjantjatjara, English being spoken at home in only 14 per cent of households.

Alice Springs is nearly 700 kilometres to the east on principally dirt roads and involves an eight to nine hour drive or a chartered plane. There are no regular airline services. Diesel is the only fuel available. The median annual income is \$15,000, just over a quarter of what it is in Darwin. We will be talking about Docker River shortly. On the other side of the border in the Anangu Pitjantjatjara Yankunytjatjara or APY Lands in remote South Australia, 217 elders receive aged care services through Aboriginal Community Services SA from whom you will hear evidence, predominantly via the Commonwealth Home Support Programme as well as a limited number of home care packages.

Balgo, or Wirrimanu in the eastern Kimberley is a 250 kilometre trip south of Halls Creek and over 10 hours from Kununurra. The drive is mainly on dirt roads that are often impassable in the wet season. A population of between 500 and 600 is serviced by a health centre run by the Aboriginal Community Controlled Health Service with visits by doctors of the Kimberley Aboriginal Medical Service. Aged care services, predominantly home care packages and CHSP, are delivered by Kimberley Aged and Community Services, an arm of the WA Country Health Service known as WACHS. That's in partnership with the local Aboriginal Corporation. At Balgo, a loaf of bread and long-life milk cost around three times the price that you will pay for them in Kununurra.

Balgo is one of a number of remote communities in the Kimberley where care is delivered through a place-based partnership model where there is a relationship with the local Aboriginal community corporation. KACS, that is Kimberley Aged and Community Services, also delivers home care packages directly at a number of other remote locations as well as undertaking client case management reviews, referrals to specialists, recruiting and training remote workers as well as quality monitoring at smaller locations.

On Thursday Island there is a 40 bed residential aged care facility known as the Star of the Sea where 80 per cent of the staff identify as Aboriginal or Torres Strait Islander. Star of the Sea is the only residential aged care facility in the Torres Strait. It contains a central meeting room known as the Ocean Room that overlooks the
5 Torres Strait, thereby providing resident with a connection to the ocean to which that unique culture is inextricably attached. As the High Court observed in *Mabo v Queensland (No 2)*, “the Meriam people of the Torres Strait retain a strong sense of affiliation with their forebears and with the society and culture of earlier times. They have a strong sense of identity with their islands.” In the case of the Torres Strait,
10 the geography is such that many of the islands are small and spread over a vast area as the map, which should be on display, identifies.

Finally, 200 kilometres south of Broome is Bidyadanga, one of the largest remote Aboriginal communities in Western Australia with a population of 700 to 1000
15 people. It is home to five language groups, Karajarri, Juwalinny, Mangala, Nyungamarta and Yulpartja. Bidyadanga has a dedicated aged care service with a CHSP-funded HACC centre, HACC being a reference to the former Western Australian Home and Community Care Program. People in Bidyadanga have high care needs; there are no residential care options available other than a move far away
20 from country to Broome. Consistent with what this Royal Commission has been told in earlier hearings, people in Bidyadanga have a strong preference for being able to stay in their own home. Just as importantly, they want to stay on country for as long as possible. Bidyadanga has a health centre, general store, and outposts of government agencies including Australia Post and Centrelink. The local fishing is
25 good. I’m told the blue nose thread fin salmon cooked on coals is a good reason to stay there.

These are just a few practical examples of the remote places where aged care is delivered; each will be the subject of evidence at this hearing. I turn now to the
30 question of what “remote” means. For the purpose of delivering services in remote Australia, the Commonwealth relies on at least two methods of classifying regions as remote or very remote. The first of these, known as the Modified Monash Model is used for service delivery purposes by the Department of Health. It has seven levels ranging from level 1 which represents major cities through to level 6 and 7 for
35 remote and very remote.

It’s best explained by a chart that is – it should be coming up on the screen now. The yellow portions are the very remote portions. They’re MMM7. And the MMM6 portions are the lilac colour slightly closer to the coast on the east coast. And in the
40 case of Tasmania, there’s another graph which we attach and the Commission will see that both in the case of King Island and the Flinders Island group, they are very remote. There is a comparable ABS remoteness classification which is largely to the same effect and the relevant charts for that purpose will be in the evidence. Any consideration though of remote aged care needs must extend beyond the States and
45 the internal Territories and address the external Territories as well.

Of the seven external Territories only three support a permanent population, Christmas Island, the Cocos (Keeling) Islands and Norfolk Island. All three are classified as very remote under the Modified Monash Model and the Commonwealth Department of Infrastructure, Regional Development and Cities has responsibility for health care on both Christmas Island and Cocos (Keeling) Island. That is delivered through a standalone Indian Ocean Territories Health Service. A recent March 2019 report by PricewaterhouseCoopers, prepared for the Commonwealth, noted that although each has a strong and easily accessible primary health care service, which is known as the Indian Ocean Territories Health Service, there is no aged care – residential aged care in either Territory. Complex procedures are delivered in Western Australia.

The PwC report is currently with government and community consultations were commenced on Christmas Island in May and there will be future consultations on Cocos (Keeling) Island in June. This is a significant issue and one that will be explored in further hearings. The Norfolk Island situation is slightly different. Norfolk is categorised as RA5 under the ABS remoteness classification. It is not classified under the Modified Monash Model. It is located within the South-East Sydney Aged Care Planning Region and the Central and Eastern Sydney Public Health Network. Norfolk Island Health and Residential Aged Care Services is an integrated multipurpose service, and I will be talking more about multipurpose services later; it provides 14 high-care residential aged care places on the island.

Can we turn now to the Kimberley. The Kimberley Aged Care Planning Region is one of 73 planning regions across Australia and you've already heard evidence about the significance of such regions for aged care planning and funding purposes. The Kimberley region provides a useful snapshot of the features of aged care in remote and very remote Australia. Although it must be acknowledged that there are many differences between regions across the country, including cultural and geographic differences. According to ABS census data from 2016 published by the Australian Institute of Health and Welfare on the generation aged care website, just over 31 and a half per cent of the region's population aged 50 or over identifies as an Aboriginal or Torres Strait Islander person. That's to be contrasted with the national or state average of about one and a half per cent. 23 – 21.3 per cent of the population over 65 was born overseas as opposed to around 36 per cent nationally. But there is a higher proportion of people over 65 for whom English is not their preferred language.

In terms of service delivery there are a number of features that stand out. Although there are more residential aged care places per 1000 people than the state and national average, the vast majority of residential care places are provided by not for profit providers. This equates to around 83 places per 1000 people over 70. At this hearing you will hear evidence from and about providers that operate in Western Australia, particularly in the Kimberley, the Northern Territory, South Australia and Far North Queensland, servicing the Torres Strait. Whilst a number of places are provided by government providers, roughly six per 1000, there are no residential aged care places provided by for profit organisations in the Kimberley, whereas on

average there are 30 places per 1000 people aged 70 or over nationally and around 22 per 1000 in Western Australia provided by for profits.

5 In the Kimberley, unlike the position nationally, slightly more males use permanent residential aged care than females. Similarly, unlike the position nationally and in the rest of the State, the majority of residents in the Kimberley are Aboriginal and/or Torres Strait Islander. There is also a markedly higher proportion of people whose preferred language is not English, even though such residents were born in Australia or another English speaking country. Perhaps the most significant comparison
10 between the Kimberley and urban Australia is to be seen in the age profiles of those that use aged care and there's a graph that should be coming up on the screen now.

Focusing for the moment on those that use residential aged care, it can be seen that as of 30 June 2017, the demand by Aboriginal and Torres Strait Islander males presents
15 at a much earlier age than is the case in the typical urban cohort. The graphs that follow provide a comparison between the demand for residential care and home care in the Kimberley, Alice Springs and inner west Sydney regions. It gives much the same impression establishing that the largest cohort of men in the city is likely to be between 80 and 90 years old, whereas in the Alice Springs and the Kimberley the
20 corresponding cohort is much young, spanning the years 65 to 79. The position is roughly comparable in the case of women, although the gap would seem to be slightly smaller given that Aboriginal women tend to enter aged care later than males.

25 I turn now to the question of culturally safe care. There are also particular important considerations that arise in relation to the provision of aged care for Aboriginal and Torres Strait Islander people which will be explored at this hearing. It's important to note the diversity of Aboriginal and Torres Strait Islander cultures and language. There are over 500 indigenous nations and over 250 different language groups across
30 Australia. An approach that works for one particular cultural group may not be appropriate in another setting. At the forefront of these challenges, whether care is delivered in the city, rural or remote Australia, it needs to be culturally safe and culturally appropriate. Whilst this encompasses many things and will hold different meanings for different cultural groups, for Aboriginal and Torres Strait Islander
35 people we will hear that at its centre is the acknowledgement of the identity of the person and their connection to community and country, their community and their country.

40 One witness will tell you that this may mean different things in different parts of the country, and in that sense it has aspects that are location based and dependent on the particular cultural practices of the region. It also has an individual element that depends upon the personal history of the person and in this respect, the perspective of people in the Stolen Generation comes to mind. The following are common themes that the evidence is likely to demonstrate. The first, as I've said, is connection to
45 country. We will hear about the importance of having connection with country and staying on country as people age. For people who are no longer living in their country, having the opportunity to return to country is important.

You will hear how in Derby and in other places, the Juniper facilities, like other facilities across the country, arrange to transfer residents to country with support staff. You will hear of the challenges for older people who may be forced with having to go off country to access health and aged care services, in particular when it comes to residential care. Secondly, there is the connection to family and community. In this respect, we will explore the unique role of the elder in traditional Aboriginal and Torres Strait Islander communities and how the important cultural responsibilities associated with that role need to be understood when attempts are made to provide care. We expect that you will hear evidence about a collectivist culture where there is a sharing of resources and the challenges in delivering home care to an older person in that setting.

Thirdly, there is language. Language plays an important role for many Aboriginal and Torres Strait Islander people in their connection to culture, kinship, land and family. And languages are the foundation upon which the capacity to learn, interact and to shape identity is built. Fourthly, there are important cultural requirements in the lead-up to and immediately following the passing of an Aboriginal person. You will hear evidence about how for some cultures a smoking ceremony is conducted in the deceased's living space for religious and cultural purposes, together with ceremonies after death that may involve keeping the body in place for a period of time before burial in country.

In some cultures it may be appropriate for attendance by kin or community members at ceremonies associated with an impending death. It would appear that there may be a need to provide notice that a person is dying so that arrangements can be made for necessary attendances for sorry time or sorry business. Singing ceremonies before and after death need to be understood and respected. You will hear of one service that has sought to have a separate palliative care residence where there is space for family and community to spend time with the older person. At the same time, it needs to be borne in mind that some Aboriginal and Torres Strait Islander people have cultural reservations about discussing these matters. We seek to approach this matter respectfully and in good faith so that these matters can ensure better delivery of culturally safe care.

Food, of course, plays an important role in culture. You will hear evidence that delivery of cultural food at least once a week in a residential facility will enhance the experience of Aboriginal and Torres Strait Islander Elders. Awareness of these relationships and a commitment to embrace them is critical to delivering culturally safe care and obtaining the trust of the resident and their community. We will also explore what is culturally safe palliative care, an issue that can be complicated by some traditional approaches to death.

On another level, the everyday delivery of care may involve attention to significant male and female roles and kinship relationships. Gender, clan and kinship can impact on whether it is appropriate for a particular person to provide care to another person. This can present challenges in terms of workforce and recruitment. Overall, the delivery of cultural safe care is based on trust on the part of the care recipient and

this is an issue that will be considered by a number of the witnesses. One witness is likely to tell you that it is best where care is provided as close as possible to home, by people who are sensitive to the history and culture and needs of that resident, and you will hear from some of those witnesses today.

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Another witness will talk about place-based models of care. You will also hear about the time that it takes to develop trusted relationships that are required to deliver care. Ruth Crawford, a nurse for 45 years, is the manager of the Kimberley Aged and Community Services and she will give evidence tomorrow about the partnership model of care that operates in places such as Balgo, Bidadanga and a number of other remote communities within the Kimberley. You will hear that where care is not culturally safe, Aboriginal and Torres Strait Islander people are not likely to access services. You will also hear about the challenges that Aboriginal and Torres Strait Islander people face in navigating My Aged Care.

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The barriers that prevent access to the aged care system or getting the types of level of assistance they need come in many forms. The aged care assessment process requires a person to talk about their intimate and personal health, their domestic situation; all of this with a complete stranger. That stranger may be of the opposite sex and may not have had any cultural awareness training. You will hear that this framework leads to Aboriginal and Torres Strait Islander people avoiding the aged care system, withdrawing from the ACAT discussion.

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You will also hear how My Aged Care assumes a level of literacy and good access to postal services as well as e-literacy and connection that is not a reality in some parts of Australia. You will hear about the services that work to get around these barriers by wrapping around the older Aboriginal or Torres Strait Islander person. They use their pre-existing relationship of trust to get the person to an ACAT assessment and support them through it. Much of this work is done without aged care funding and depends upon the goodwill and flexibility of committed services and staff and members of the local community. Language is also a barrier. When an Aboriginal or Torres Strait Islander interpreter is required, in the limited circumstances that there is a professional interpreting service available, the person can be required to pay for this out of their home care package.

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Can I turn then to funding structures. Commissioners, you have already heard evidence about how aged care is predominantly delivered through residential aged care, home care packages, as well as the Commonwealth Home Support Program. Some providers of residential and home care are also eligible for viability supplements in recognition of the additional costs of delivering care in remote settings or to people defined as special needs groups under the Aged Care Act, and that includes Aboriginal and Torres Strait Islander people. While each of these programs operate in the context of remote and very remote Australia, there are additional programs that is will be under examination in this hearing which we would like to outline briefly.

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The first and largest of those is the National Aboriginal and Torres Strait Islander Flexible Aged Care Program known as NATSIFACP or sometimes NATSIFlex which I will use because I think it's easier. The stated objects of that program are to deliver a range of services to meet the changing aged care needs of the community, to provide aged care services to Aboriginal and Torres Strait Islander people close to home and community, to improve access to aged care services for Aboriginal and Torres Strait Island people, to improve the quality of culturally appropriate aged care services for Aboriginal and Torres Strait Islander people and to develop financially viable cost effective and coordinated services outside of the existing mainstream programs.

NATSIFlex operates, as I said, outside of the Aged Care Act and providers are block funded based on an agreed allocation of aged care places and the types of places. Unlike ACFI funding, there are two levels of residential care and two levels of home care, one high and one low. The intention is to provide stability of funding and flexibility. Nationally, the program funds 453 residential aged care beds, 11 respite places and 396 home care services in 30 organisations delivered through 35 services. Currently the Commonwealth is prioritising the conversion to NATSIFlex status for which there are only limited opportunities, and this is to a very small number of services, those that are likely to struggle under mainstream funding arrangements.

Debate surrounds whether this is the right criteria or whether there should be any restriction on conversion of mainstream services to NATSIFlex status. You will hear from the provider Juniper about how their 40 bed facility at Kununurra, built with a Commonwealth grant, is precluded from NATSIFlex funding by reason of these criteria. There may, however, be reasons to prefer services that operate in the mainstream wherever possible and that they only – the conversion to NATSIFlex only be allowed if it's necessary to ensure ongoing viability.

To put the matter in perspective, the Commonwealth projects that by 2029 the use of ACFI-funded residential care in remote and very remote Australia will have increased by nearly 700 places or 63 per cent on current levels. Similarly the use of NATSIFlex-funded places will have increased by 227 or 61 per cent. Resident pathways into NATSIFlex care are broader and more flexible than the pathways under the Aged Care Act. ACAT assessment is not required and referral can be from a range of sources, including My Aged Care, CHSP assessors, GPs, social workers, etcetera. Residential care can be either permanent or short term and you will hear evidence that in some locations residents take up the care, particularly during the wet season when travel is difficult.

At least one witness is likely to criticise the program on the basis that the flexibility of the system means that admission to residential care is often premature, expressing the view that care at home, funded by other programs, including the NDIS, would suffice and that such a result may be driven by providers looking to increase occupancy rates so as to increase their funding.

Witnesses are also likely to consider whether the number of Aboriginal and Torres Strait Islander people receiving aged care at an earlier age reflects gaps, whether current or historical, in primary health care and disability services, rather than premature ageing. There is a real issue as to whether NATSIFlex funding enables
5 service providers to respond to the pressures associated with the remote delivery of care, particularly having regard to the challenges of providing culturally appropriate care. Grants only operate for periods of between two or three years and seem geared to provide the revenue associated with providing care to residents, not providing the
10 basis for any capital development or improvement. There are other avenues through which support, including for capital grants, is provided by the government, including the Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel, the SDAP. This program provides funding to enable providers to obtain
15 specialist advice and assistance in a range of areas, including service delivery, sector support and financial and project management.

Australian Regional and Remote Community Services, or ARRCs as we will refer to it, is the largest NATSIFlex provider in the country, operating the facility at Docker River, previously referred to, and facilities at Mutitjulu, Tennant Creek in the
20 Northern Territory. Its related organisation, Pinangba, which operates in Queensland, is the operator of the Star of the Sea facility on Thursday Island. ARRCs is one of the two providers through whom UnitingCare Queensland delivers aged care services to Aboriginal and Torres Strait Islanders. You will hear from the group general manager of that organisation responsible for the regional and remote
25 community services, along with the CEO of UnitingCare Queensland, the parent company.

A second relevant program is the funding of Multi-Purpose Services or MPS which are partnerships between the Commonwealth and State and Territory Governments to deliver integrated health and aged care services in very small communities,
30 particularly in regions where it is not viable to operate a standalone hospital or a standalone aged care service. Mention also needs to be made of the Aged Care Regional, Rural and Remote Infrastructure Grants funding round which provide support to regional, rural and remote aged care service providers to undertake
35 infrastructure works.

Could I then turn to the issue of home care packages in this region. Waiting times for the delivery of remote home care packages are a matter of concern and largely mirror the position in the rest of Australia. Evidence from the Commonwealth is to the effect that in remote and very remote Australia there were 1480 approvals for
40 home care packages in calendar year 2018. Of those living in remote or very remote regions who were assigned their first package, regardless of level, in that period, only 38.8 per cent, that is 608 people, received that assignment within nine months. For most people, the time between approval and assignment exceeds nine months. There were significant numbers who had not been assigned a provider after 18 months:
45 218.

At the two year and beyond period, the figure was 68 and at the three year period, there were 28 people. Evidence from the Commonwealth is that in the case of Aboriginal and Torres Strait Islander people they represent 3.1 per cent of participants, although it is not at all clear the extent to which they are required to wait for packages.

There is also a viability supplement paid to all of the providers referred to above, including NATSIFlex and MPS to recognise the higher costs of providing care due to the location, size and client mix of a service. Despite all of this, the Aged Care Financing Authority warned in September of last year that there were a number of facilities in regional and remote areas that were experiencing significant financial difficulties and were likely to be forced to merge with or sell to a larger provider.

Could I then turn to what is a good news story, and if we could go back to Bidyadanga. You will shortly hear from three people who deliver care in the Aboriginal community of Bidyadanga. The community council there comprises two members of each of the five language groups. Primary medical care is delivered by the Kimberley Aboriginal Medical Service, KAMS, through the Bidyadanga Health Centre. On Wednesday, you will hear from the general practitioner who works for both KAMS and the Broome Regional Aboriginal Medical Service. That's BRAMS, and travels to Bidyadanga for two days on a weekly basis to work at the clinic. Another doctor is also present for a number of other days during the week. The centre has four remote area nurses and one or two Aboriginal health workers. One senior Aboriginal health worker, who is a senior community member, has worked at the facility for well over 10 years.

There are also currently three Aboriginal liaison officers who work part-time for the clinic and two full-time administration staff. KAMS also trains general practice registrars who come up on six to 12 month blocks to provide primary care and emergency services to the community. Through the prism of Bidyadanga, the Commission can see firsthand the critical intersection between primary health and aged care in a location where there is no residential care in the traditional sense. You will hear from Dr Martin Laverty, the CEO of the Royal Flying Doctor Service, on the importance of that sort of primary health care as a means of avoiding admissions to hospital, often far away, and unwanted entry into residential aged care, also far away from that country.

Tomorrow, you will hear from representatives of two providers from the eastern part of the Kimberley. The first provider is Uniting Church who provide aged care services under the name of Juniper. It operates the Juniper Ngamang Bawoona and Juniper Numbala Nunga facilities in Derby. Juniper, from whom you heard evidence at the first Adelaide hearing, cross-subsidises its remote residential facilities with revenue from its more traditional aged care operations in Perth. The second provider, Southern Cross Care, operates the Germanus Kent House here in Broome, and the associated Bran Nue Dae Day Centre. We also expect that you will hear evidence from an Aboriginal enrolled nurse who has worked at Germanus Kent House, and that should occur within the next hour or so.

These are three of the six residential care services in the Kimberley ACPR. Juniper also has a NATSIFlex funded facility at Fitzroy Crossing and the larger 40-bed facility at Kununurra. Commissioners, Ruth Crawford will also give evidence about the range of direct health and aged care services across the Kimberley through
5 KACS. KACS receives State and Federal funding and no private funding. As I have mentioned, it forms partnerships with Aboriginal controlled centres out of which aged care services are provided directly to clients. Home care services are most often provided at the centre rather than at the homes, and you will hear about this at Bidyadanga, depending upon the preference of the client.

10 You will hear about the challenges in providing a Kimberley-based service that is able to be flexible and responsive. You will also hear from Mr Graham Aitken, the chief executive of Aboriginal community services which, through NATSIFlex, provides home care services in the APY Lands as well as the rest of South Australia,
15 as well as providing a residential aged care service in Adelaide.

Mr Aitken is one of the witnesses who can speak to the issues that face Aboriginal and Torres Strait Islander people who are accessing aged care in the urban areas. I foreshadow that this is an issue that we expect to return to in the future hearings,
20 including next week in Perth, where we will lead evidence about the institute or urban indigenous health in the context of considering person-centred care.

It will come as no surprise, given the evidence that you have already heard about problems associated with the aged care labour market, that there are particular
25 difficulties with finding and retaining appropriately qualified staff in remote locations. The problem operates on a number of levels. At the most remote locations like Docker River, higher qualified nursing staff have to be flown in and out at great expense. In such locations there are significant attraction and retention issues. We will explore that later today. At the other end of the spectrum, locally
30 engaged staff, often members of the same community that they serve, require training that may not even be available in the local area. We will look at how training can be delivered to remote staff, how they are all remunerated and how they can be retained. Aspects of the June 2018 Aged Care Workforce Strategy that you have previously heard evidence about, require mention here. In late 2018 the
35 Commonwealth established the Remote Accord Leadership Group with Chris Hall, the Juniper CEO, as chair. This issue will be addressed in a workforce themed hearing later in the year.

At a different level, some of the issues that the group is likely to have to confront are
40 those at the culture and care interface. For example, some Aboriginal and Torres Strait Islander staff may, by reason of traditional custom, be prevented from carrying out certain roles, or they may have to devote their time to sorry business or other cultural responsibilities. Where traditional culture is strong, certain care tasks, including the more intimate tasks, can only be performed by outsiders, so as not to
45 transgress customary rules.

When staff develop experience and obtain qualifications, you will hear that they are often drawn to higher paying jobs in the health sector and the mining sectors. Like the rest of aged care, staff remuneration is a very real issue in this region. Finally, the question of obtaining mandatory police checks for staff is often seen as an issue that takes too long to achieve and can deter potential staff from applying for work. There is a need for flexibility when it comes to addressing all of these issues.

Later today, Leon Flicker, Professor of Geriatric Medicine at the University of Western Australia, and a leader in the field of Aboriginal aged care, will give evidence about his perspective on delivering aged care in remote Australia. He will give evidence about the barriers to the delivery of care for both Aboriginal and non-Aboriginal people. He will speak about how and why Aboriginal and Torres Strait Islander people are underrepresented in residential care, about how and why they are younger than non-Aboriginal people when they present ageing-related conditions. He will explain how testing is carried out for cognitive impairment in Aboriginal communities, using what is known as the Kimberley Indigenous Cognitive Assessment tool, colloquially known as KICA.

Finally, and perhaps most importantly in this hearing we will seek to adduce evidence about the Aboriginal and Torres Strait Islander approach to the care of the older members of the community, how it differs from other approaches and philosophies within Australian society and the extent to which the rest of Australian society can learn from that approach. In consultation in advance of this hearing we have heard of perspectives of the elder in traditional Aboriginal and Torres Strait Islander culture. We propose to explore that issue to identify what the term “elder” really means, depending upon the location and context, and how it is associated with particular responsibilities in traditional culture. We will hear about the importance of elders in their community in terms of passing on stories, passing on cultural knowledge and providing benefits that only they can offer.

Finally, Commissioners, can I say, through you, to those Aboriginal and Torres Strait Islander people who may be here or who may be watching or who may be listening, we want to hear from you about your experience of aged care. This Royal Commission is not a court. This Royal Commission is not the government. We are here to hear your voice, hear your stories, and engage with you. On Wednesday, after the conclusion of the Commission’s hearing, there will be a community forum where those people can speak about their experience. We want them to come and we want to hear from them. That is my opening. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you, Mr Bolster.

MR BOLSTER: Commissioners, I call Faye Dean and Ryan Hammond.

<FAYE PHILOMENA DEAN, SWORN

[10.16 am]

MR BOLSTER: If the document WIT.1142.0001.0001 could be brought up, please.
5 Ms Dean, there's a screen in front of you and there should be a copy of your
statement on that. Can you see that?

MS DEAN: Yes, I can.

10 MR BOLSTER: All right. Okay. And you've got a copy in front of you if you
want to read it. You need your glasses? Yes, go get your glasses. You're right
now?

MS DEAN: Yes, I am, thanks.

15

MR BOLSTER: Your name is Faye Philomena Dean?

MS DEAN: Yes.

20 MR BOLSTER: And that's your statement.

MS DEAN: That's my statement.

MR BOLSTER: Are you happy with the statement? Is there anything you want to
25 change about it?

MS DEAN: Just this one. There's just something in there that says we work
together with KACS, but it was also to do the – it was also partnered with
Alzheimer's WA.

30

MR BOLSTER: Yes, we will talk about all of that - - -

MS DEAN: Okay.

35 MR BOLSTER: - - - as we go through.

MS DEAN: All right.

MR BOLSTER: Ryan, you haven't sworn a statement, but could you tell the
40 Commission briefly what your role is in helping out the Bidadanga community.

MR HAMMOND: So I've been staffed with Faye for the last three and a half years.
I've been throughout the programs with AWA and KACS, and I've come just as a
right-hand man, I guess, to Faye, pretty much.

45

MR BOLSTER: All right. Well, I will ask you some questions shortly, but I will
just start with Faye, if you don't mind. So – yes. Faye, I was going to ask you some

questions about Bidyadanga and just wanted to just confirm that your role there is as a community care supervisor. Correct?

MS DEAN: That's correct.

5

MR BOLSTER: What does that involve on a daily basis?

MS DEAN: It's making sure the staff are there and doing their job, and it's also doing the office work, you know, ticking off the tick sheets, making appointments for visitors coming in, the medical service, you know, like the – what is it? The – the – it's the - - -

MR HAMMOND: Between, let's say, taking people to hospital into Broome, sorting out with Germanus, like, who's going into respite, organising maybe some health physio – physios to come in.

15

MR BOLSTER: Let's talk about the community, can we. How many people live there?

MS DEAN: Around about 750/800.

20

MR BOLSTER: Right. And how many people get aged care help from you through the centre?

MS DEAN: Say, about 11 or 12. What was it?

25

MR BOLSTER: About 11 or 12?

MS DEAN: Mmm.

30

MR BOLSTER: Yes. They're on home care packages or CHSP?

MS DEAN: We've got about five on home care packages and the rest are on CHSP.

MR BOLSTER: And do you – are you the person that looks after and delivers the home care packages to them?

35

MS DEAN: What – what do you mean?

MR BOLSTER: Are you the one that helps them out on a daily basis?

40

MS DEAN: Yes.

MR BOLSTER: Okay. And if you could tell the Commissioners, how do you that? In the morning, I think your statement says you go and pick them up from their home.

45

MS DEAN: Yes. We then serve them some breakfast. We – if, you know, they need a shower or change, we – we do that. And then we do exercises. Usually the physio may come, you know, and we'll do the exercises with the – with the physio. We will have as many people as we have there.

5

MR BOLSTER: Yes.

MS DEAN: Usually help them with their lunches, shopping, whatever, you know, they – they – they want to do. If they have businesses they're worried about, we try and – try and help them out.

10

MR BOLSTER: Okay. So this – the centre, is it a separate building in the community that you operate out of?

15 MS DEAN: Yes.

MR BOLSTER: And you bring them there from their home in the morning.

MS DEAN: Yes.

20

MR BOLSTER: And I think you mentioned you do the washing.

MS DEAN: Yes, we - - -

25 MR BOLSTER: Do their washing.

MS DEAN: - - - do the washing. We do – also do the home cleaning.

MR BOLSTER: Yes.

30

MS DEAN: Take them on outings.

MR BOLSTER: Where do you take them?

35 MS DEAN: Usually the main thing is fishing.

MR BOLSTER: Yes.

MS DEAN: Otherwise to town, to do town trips, or we – we just finished a Crocodile Park, you know, adventure.

40

MR BOLSTER: Yes.

MS DEAN: We did go up to the – the peninsula and visit them, and, yes, for about a week.

45

MR BOLSTER: Yes. And how old are the people that you look after?

MS DEAN: What would you say?

MR BOLSTER: Just roughly.

5 MS DEAN: Well, the oldest there is 90.

MR BOLSTER: 90.

MS DEAN: Yes.

10

MR BOLSTER: And the youngest?

MS DEAN: The youngest would be about in their 40s.

15

MR BOLSTER: Yes.

MS DEAN: Mid-40s.

20

MR BOLSTER: Right. Okay. And you mentioned in your statement about a lady who didn't want to ever come out of her house.

MS DEAN: Yes.

25

MR BOLSTER: How did you manage to get her involved in what you do?

MS DEAN: We do that, Ryan.

30

MR HAMMOND: Do you mind if we can get our statement back up on the screen? Just - - -

MR BOLSTER: Yes, we will put the statement up on the screen. Yes. Have you got that?

35

MS DEAN: There you go.

40

MR HAMMOND: So some of the things we did was she would – she wouldn't really come out for, like, normal day visits. She would only come out for maybe appointments and special occasions. So sometimes we just have, like, maybe a special occasion, might be a pamper day, another special – or we'll, like – if we needed her – or you just wanted her to come out - - -

MR BOLSTER: Yes.

45

MR HAMMOND: - - - we would call it a special day, but it was just getting her out of the room. So we would – we would just put some extra paints out and – it's a little bit of lying, but - - -

MR BOLSTER: You talk - - -

MR HAMMOND: - - - it's just one of the ways to get her out.

5 MR BOLSTER: Ms Dean, your statement talks about how she likes people coming around and talking to her. Are they your staff that go around and to talk to her?

MS DEAN: That's correct.

10 MR BOLSTER: Yes.

MS DEAN: That's my staff.

MR BOLSTER: And do you go around and talk to her as well?

15

MS DEAN: Yes. Yes. I can't get away sometimes.

MR BOLSTER: Yes. Is she on a – is this lady on a home care package?

20 MS DEAN: She's on a home care package.

MR BOLSTER: And so does she require you to look after her place and clean her place for her?

25 MS DEAN: When she goes to respite, the – the thing that she really doesn't like is leaving her little dogs behind.

MR BOLSTER: Yes.

30 MS DEAN: Yes, so we promise to go there and water and feed them otherwise and – otherwise the dogs will come to us at the centre.

MR BOLSTER: Yes.

35 MS DEAN: And - - -

MR BOLSTER: Now, you mention in your statement looking after the – so the finances of people, so looking after their bank accounts and dealing with Centrelink and dealing with the government. How difficult is that for you?

40

MS DEAN: It's really, really difficult. I – I don't – you know, at times when they come to me, I will sort of pass it on to the – to the head office, the main office - - -

MR BOLSTER: Yes.

45

MS DEAN: - - - because it's just too confusing for the client.

MR BOLSTER: Yes.

MS DEAN: You know, especially when that person has got to identify themselves and, you know, we've got some with cognitive - - -

5

MR BOLSTER: Yes.

MS DEAN: - - - illnesses, so it's - and they don't remember things, you know, "Where's your Medicare card, Mavis? I need it," to, "This is an ID. This is very important for you." But the only thing - the - the card that's important to her is the bankcard.

10

MR BOLSTER: Yes.

15 MS DEAN: Yes, the key card, so - - -

MR BOLSTER: What about dealings with My Aged Care? Is that something that you have to look after for them?

20 MS DEAN: Well, yes, we - we would like to do that, but - but we can't because, yes, we haven't got a landline. We have to use our own mobiles, and it's a real waiting - waiting time too.

MR BOLSTER: So does the community care centre doesn't have a phone line that you can ring up My Aged Care with?

25

MS DEAN: Well, it has a phone line, but it doesn't have a phone.

MR BOLSTER: Doesn't have a phone?

30

MS DEAN: No, there's no phone connected.

MR HAMMOND: We're not sure if that line's still working either.

35 MR BOLSTER: All right. Now, you've previously - you worked up at Juniper - - -

MS DEAN: Numbala.

MR BOLSTER: - - - Numbala Nunga. Is that - - -

40

MS DEAN: Numbala Nunga.

MR BOLSTER: Numbala?

45 MS DEAN: Numbala Nunga.

MR BOLSTER: Thank you.

MS DEAN: That's okay.

MR BOLSTER: I'll try to get it right. Is that where you learnt how to be a carer?

5 MS DEAN: Well, that was my basic training because it was residential.

MR BOLSTER: Yes.

10 MS DEAN: It wasn't, you know, day ones, but - - -

MR BOLSTER: How long were you there for?

MS DEAN: On and off, I mean, you know, about five years but, you know, it was
15 between nursing and as a cleaner.

MR BOLSTER: As a cleaner?

MS DEAN: Mmm.

20 MR BOLSTER: What attracted you to looking after older people?

MS DEAN: I just love older people. I love – I respect my elders.

MR BOLSTER: What's important about that to you, Ms - - -
25

MS DEAN: Respect, dignity.

MR BOLSTER: Yes.

30 MS DEAN: Their wellbeing.

MR BOLSTER: Yes.

MS DEAN: I was taught never to upset your elders. You - - -
35

MR BOLSTER: Where did you learn that?

MS DEAN: I learnt it from my parents and – and the Catholic Church.

40 MR BOLSTER: Yes.

MS DEAN: Yes, the – the St John of God's nuns were very strict, but you learned
quick, you know.

45 MR BOLSTER: All right. Now, you refer to yourself – you are a Karajarri elder.

MS DEAN: I am.

MR BOLSTER: What does that mean to those of us who really don't know what that means? Can you tell us what that means.

5 MS DEAN: It basically means, you know, this area of land is where your people were, my people were, you know, situated. I've got to respect that land and – and look after it. That's basically my job.

MR BOLSTER: And Bidyadanga is in Karajarri land?

10 MS DEAN: Yes.

MR BOLSTER: And you say that you're an advocate for your clients. You use the word "advocate". What does that mean to you? What does it mean to be the advocate for these people?

15

MS DEAN: To me it means I'm – well, in a small way, responsible but, you know, do my best to get them the services that they require.

20 MR BOLSTER: Yes. All right. And how do you – what's the most important thing that you have to know to be able to do that?

MS DEAN: Respect again, and – and dignity. You go, you know, very slowly. You go at their pace.

25 MR BOLSTER: And you say in your statement that you have some staff who work for you.

MS DEAN: Yes.

30 MR BOLSTER: And do you train the staff about how to deal with your elders?

MS DEAN: Well, we – we tell them the basics when they first come in, and then we have KACS – KACS. We organise the training with KACS, who then organises extra training with TAFE.

35

MR BOLSTER: Yes.

MS DEAN: So - - -

40 MR BOLSTER: What's the most important thing for when the outsiders come in, like KACS, to help you? What's the most important thing that they need to understand?

MS DEAN: Ryan, can you - - -

45

MR HAMMOND: Most important thing to understand. For them, it's mainly not everything is going to happen on that day.

MR BOLSTER: Yes.

MR HAMMOND: A lot of the times it might happen over a span of weeks,
whereas, like, sometimes they might not be feeling like they want to come in. And
5 even though it's, like, a big drive down and they're real disappointed they won't be
able to come in, sometimes it's – they have to stay maybe four days to actually see
them.

MR BOLSTER: Yes. Is getting the staff to come to work all the time a difficulty
10 for you?

MS DEAN: Yes.

MR BOLSTER: Why is that?
15

MS DEAN: Well, because of culture.

MR BOLSTER: Yes.

MS DEAN: You know, like, if there's, like, sorry times - - -
20

MR BOLSTER: Yes.

MS DEAN: - - - they're away for a month. We can't do anything about that.
25

MR BOLSTER: Yes.

MS DEAN: We've got to respect that.

MR BOLSTER: So do you – who fills in the gap? Do you just do more?
30

MS DEAN: We – we do more.

MR BOLSTER: Yes.
35

MS DEAN: Yes.

MR BOLSTER: Yes. All right. Now, there was some reference in your statement
to some boxes that you prepare for the – for your clients to link them to their country.
40 Could you tell the Commission how important it is that you prepare a box?

MS DEAN: Yes, we did a care box for – for our clients. It's really important
because it tells them their – there's a little profile sheet. It tells – it's a little story
about them. It tells them about, "Who I am, where I came from, what language I
45 speak and the things that I like to do." We also put in special personal things like
shells and, you know, somebody might want a perfume or something. We chuck that
in there. Playlists, which is – Ryan has been in charge of, he does the – he'll put

their special little music on the – on the MP3 thing and, yes, they will listen to their music all day if they're happy.

MR HAMMOND: Yeah.

5

MR BOLSTER: If you could change anything, if you – if the decision to change things was up to you and you were the boss, how would you change things to make delivery of care to your people better?

10 MS DEAN: Well, I would go and meet with the traditional owners of the land and – because they have outside – they have family blocks outside the communities and that's not – you know, they're not being able to manage because it's self-sufficient now, but, you know, that's closer – that's one – another option for their – for respite. I mean, instead of coming into town, you've got the other option of going out on
15 country, you know, with the family groups and just spending a week out, you know, in the bush.

MR BOLSTER: And are you able to do that now?

20 MS DEAN: Well, there's a lot of family blocks in – outside of communities now that are just sitting there and it – it can be done. It would be very basic.

MR BOLSTER: What's a family block?

25 MS DEAN: Traditional owners, when they got entitlement of their land, there was a grant from the government and lease. You know, we were allowed to put family blocks outside of communities.

MR BOLSTER: Yes.

30

MS DEAN: We – around our areas where our fathers all came from.

MR BOLSTER: Yes.

35 MS DEAN: So we all have little blocks, and this is throughout the Kimberley, and it's – it's – they can't maintain it. They can't maintain these blocks themselves, so I'm – I'm battling. That's why I'm working.

MR BOLSTER: Yes.

40

MS DEAN: I have a block out there.

MR BOLSTER: All right. But in terms of – if we could just focus on what your clients need, the people who you look after every day, what would you change if you
45 could to make their situation better?

MS DEAN: Well, I would give office staff permanent positions - - -

MR BOLSTER: Yes.

MS DEAN: - - - at the workplace, because right now it's just casuals.

5 MR BOLSTER: Yes, and how many hours a week do the staff get?

MS DEAN: It's usually 20 hours.

10 MR BOLSTER: Is that the most you can budget to pay them?

MS DEAN: At the moment, yes.

MR BOLSTER: Right. Okay. What else would you do? Do you have a car?

15 MS DEAN: No, I'd - I'd love a car.

MR BOLSTER: What would you use a car for if you could?

20 MS DEAN: We'd do town trips. We'd be seeing other communities, you know, because they've families. You're sort of interrelated to the peninsula.

MR BOLSTER: Yes.

25 MS DEAN: Looma.

MR BOLSTER: Yes.

MS DEAN: Yes, we'd - shopping, fishing.

30 MR BOLSTER: How do you get people around now?

MS DEAN: We use the - we use the company car. We borrow it.

35 MR BOLSTER: So that's the community's car?

MS DEAN: Yes.

MR BOLSTER: But not the - - -

40 MS DEAN: No, it's not that.

MR BOLSTER: - - - centre's car. Who's the person that makes the decisions about your service?

45 MS DEAN: You could answer that, Ryan.

MR HAMMOND: So we're under BCLG, which is Bidyadanga - - -

MS DEAN: Aboriginal Corporation Inc.

MR HAMMOND: Yeah community. So they make the decisions of how
HACC functions - - -

5

MR BOLSTER: Yes.

MR HAMMOND: - - - and works. Currently, it's – the CEO is Tanya Blaxton.

10 MR BOLSTER: All right. Now, Ms Dean, you've also mentioned about the
advocacy you've done with Dementia Australia. Could you tell the Commission
what that's about.

MS DEAN: Sorry, can you - - -

15

MR BOLSTER: Communicate – what work have you been doing with Dementia
Australia?

20 MS DEAN: Yes. We do workshops. We went to the peninsula and we presented
what is dementia to – to the HACC people over there, and that – that came out really
good.

MR BOLSTER: What was the message?

25 MS DEAN: The message was, you know, they have an illness, just like everybody
else.

MR BOLSTER: Yes.

30 MS DEAN: It's just that, you know, theirs could be – you can't see theirs.

MR BOLSTER: Yes.

35 MS DEAN: And – and as – as they grow older, you know, it's – it's not their fault
that they're being nasty or blaming you. They're – they're – they're still there inside,
you know.

MR BOLSTER: Yes.

40 MS DEAN: They're the same person inside, it's just that the brain has just
deteriorated a bit.

45 MR BOLSTER: Why do you think it is that you need to tell Aboriginal people that
message? What do they think dementia might be?

MS DEAN: Well, yeah, they – they think that dementia could be a mental health illness or people are just making it up to get attention, you know. They’re not really – you’re getting old.

5 MR BOLSTER: And do the people accept that when you tell it – when you explain it to them?

MS DEAN: Well, there was a few that came back to me and said, you know, “I really understand now why this guy – my husband is me for this other guy to come and visit.” And they were best friends, the two guys.

10

MR BOLSTER: Yes.

MS DEAN: But then once he got dementia he was – he thought the guy, his best friend, was coming over to see his wife. So, yeah, but – and she used to get really angry with him, but now she’s seen and she’s – she’ll explain to him, you know, “No, you know, he’s your friend, not mine.”

15

MR BOLSTER: Do the communities up and down the coast that you visit, are they getting to understand what dementia actually means, or do you think someone needs to help you tell them?

20

MS DEAN: Well, it would be good to get some help.

25 MR BOLSTER: Right. Okay. And the peninsula you refer to, is that north of here?

MS DEAN: Yes, that’s - - -

MR BOLSTER: What’s the name of that?

30

MS DEAN: Beagle Bay - - -

MR BOLSTER: Beagle Bay.

35 MS DEAN: - - - Lombadina and One Arm Point.

MR BOLSTER: Right. Okay. And you visit them regularly?

MS DEAN: Not as much as we’d like to because - - -

40

MR BOLSTER: Yes.

MS DEAN: Because we haven’t got a car, like I said.

45 MR BOLSTER: Yes. And do they have health centres like you operate?

MS DEAN: Yes, yes, they do.

MR BOLSTER: And are they staffed in the same way that you staff yours?

MS DEAN: Basically, yes.

5 MR BOLSTER: And do you all cooperate and talk amongst yourselves?

MS DEAN: Well, we do fishing trips at Bidyadanga. So during the salmon season, we get them - - -

10 MR BOLSTER: Yes.

MS DEAN: - - - coming over and staying for a week at the centre.

MR BOLSTER: Yes.

15

MS DEAN: And, yeah, we also had Luma come over and do fishing trips. We'd like to keep it going.

MR BOLSTER: Yes.

20

MS DEAN: And we'd like to visit their places.

MR BOLSTER: Yes. Now, attitudes. If you have a look at your statement, paragraph 45, you say there – you talk about the stigma and how elderly people are hidden from view. What do you mean by that?

25

MS DEAN: Well, they seem to be slower. Maybe not so important any more.

MR BOLSTER: Yes.

30

MS DEAN: Yeah, to – to attend these things. They're – they're – they're, you know, they're in wheelchairs, they're on - - -

MR BOLSTER: Yeah.

35

MS DEAN: - - - walkers. And, yeah, sort of a big rush. They'll go out to do these things and then it's getting back home again, and that's why - - -

MR BOLSTER: Right.

40

MS DEAN: - - - they sort of – they – they don't bother to bring them out.

MR BOLSTER: Is there enough respite care available for your people?

45 MS DEAN: Where's this? In the community or - - -

MR BOLSTER: Yes.

MS DEAN: No.

MR BOLSTER: Where do you go for respite at the moment?

5 MS DEAN: Well, they just come to the centre.

MR BOLSTER: They just come to the centre. That's the only respite, is it?

MS DEAN: That's the only - - -

10

MR BOLSTER: You pick them up and they come and stay with you.

MS DEAN: They come and stay with us at the centre, yes.

15 MR BOLSTER: Right. Is there any respite in Broome?

MS DEAN: Yes. Yes there is. Sorry, Ryan.

MR HAMMOND: Yeah, there's respite in Broome.

20

MR BOLSTER: Why do – do people like coming to Broome for respite?

MS DEAN: No.

25 MR BOLSTER: Why not?

MS DEAN: It's away from family, it's away from home.

MR BOLSTER: Yes.

30

MS DEAN: They don't seem to get the attention - - -

MR BOLSTER: Yes.

35 MS DEAN: - - - that they do back at home.

MR BOLSTER: Yes.

MS DEAN: It's not a one on one in the Germanus. It's - - -

40

MR BOLSTER: Yes. What are you proud of with the work that you do? What's the thing that makes you feel good?

MS DEAN: That I've built the place up.

45

MR BOLSTER: Yes.

MS DEAN: And that there – that I can – and I can actually have them at the centre
- - -

MR BOLSTER: Yes.

5

MS DEAN: - - - for as long as I can.

MR BOLSTER: Yes. All right. Is there anything else you wanted to tell the
Commission? Are you sure?

10

MS DEAN: Yes.

MR BOLSTER: Why have you come to tell your story? Why have you come to tell
the Commission what you do?

15

MS DEAN: Because there needs to be changes between – indigenous and – and
mainstream are – are two different types of culture.

MR BOLSTER: What's the most important thing that we need to understand?

20

MS DEAN: We need to understand that our elders are our future, our culture. And
that's who we learn off, our – our elders.

MR BOLSTER: Commissioners, I don't have any further questions.

25

COMMISSIONER TRACEY: Thank you. Ms Dean, I've read your statement and I
have listened very carefully to the evidence you have given today, and it has been
very helpful to me, and I'm sure my fellow Commissioner, in understanding the
particular problems that you've got. I would like to explore a few issues with you.
30 The first is, I'm assuming that there are clients who come to your service who are
from different tribal groups.

MS DEAN: Yes.

35

COMMISSIONER TRACEY: Do you have problems with languages in
communicating with them? And how do they communicate with other people who
come to your centre?

40

MS DEAN: Well, we do have some staff there who will – who can interpret to us,
because, you know, all I know is – is – is – like everybody else I suppose – is just all
the rude words in language. But they – they'll interpret to us what the story is. And
even the clients, you know, if there's one – they're together and they know, they'll –
they'll tell me what that person is talking about.

45

COMMISSIONER TRACEY: Right. And are there cultural problems in providing
care to individual people? Some people like to receive certain types of care and
others don't or – how do you accommodate those differences?

MS DEAN: They're basically – they – they go with the flow. You know, they – they – well, they just go with the flow, sorry. If they're upset about something, we'll just get the interpreter or something to say – you know, find out what's the problem and, yes, either talk to them, pull them aside or – but I think it's just comforting and touching, you know, the – is the main thing because I think that's how they communicate.

10 COMMISSIONER TRACEY: And does the funding you receive come straight to your centre or does it come through the corporation?

MS DEAN: It goes through the corporation.

15 COMMISSIONER TRACEY: So it would be possible, if there was enough funding, for example, for the corporation to provide you with a car or a minibus to carry out the pick-ups and visits to country and things of that kind?

MS DEAN: Well – well, I wouldn't know that because I don't see any figures. They don't come to me. I don't know how much they get for the – for the client.

20 COMMISSIONER TRACEY: Have you ever asked the corporation, "Could you provide us with a minibus or - - -"

MS DEAN: We have, haven't we?

25 MR HAMMOND: Yes, we have. I think because as far as our service is, we're kind of on the priority list, we're pretty low because they've got the marsupials – I can't say it properly.

30 MS DEAN: Municipal.

MR HAMMOND: Thank you. Services that takes mean priority. You've got the shop which is owned by the community, which takes a big priority as well, so we kind of make do with what we've got and kind of put our heads down and hope for the best.

35 MS DEAN: I think we got the centre from the Lotteries Commission. They built it.

MR HAMMOND: Lotterywest.

40 MS DEAN: Yes.

COMMISSIONER TRACEY: Yes. I'm just concerned that one of the things you say in the statement is that there are days when you have to use your own transport to go and get people because the car isn't available. Does that happen regularly?

45 MS DEAN: Well, can I just say it happens.

COMMISSIONER TRACEY: And one last thing, you have obviously had a lot of training and experience in looking after Aboriginal elders. If tomorrow you were unable to perform your duties, is there anybody in the organisation at the centre who has the qualifications and ability to take over the work you do?

5

MS DEAN: I'm looking at him.

COMMISSIONER TRACEY: I thought you might. He's a good student.

10 MS DEAN: He is. He's young and he's on the computers and everything. Whereas, you know, he will go for the computer, I will go for my dictionary.

COMMISSIONER TRACEY: Thank you.

15 MS DEAN: So, yes, he helps me out.

COMMISSIONER TRACEY: Look, thank you very, very much for coming and telling us about your work. It is so important for the elderly people in the community, and we're very grateful to learn just how you go about it, because we've
20 heard a lot of evidence about how aged care is provided in other parts of Australia, and I can tell you that it is nothing like what you do. Thank you very much and for coming in and telling us all about it.

MS DEAN: Thank you.
25

<THE WITNESSES WITHDREW

[10.46 pm]

30 MR BOLSTER: Ms Hill will deal with the next witness. Thank you, Commissioners.

COMMISSIONER TRACEY: Thank you. Yes Ms Hill.

35 MS HILL: If the Commission pleases, I call Madeleine Jadai. Ms Jadai will swear on the Bible.

40 **<MADELEINE JADAI, SWORN**

[10.47 pm]

<EXAMINATION BY MS HILL

45 COMMISSIONER TRACEY: Ms Hill, may I interrupt before you start. It's just occurred to me that I don't think Mr Bolster has tendered the statement of Ms Dean.

MR BOLSTER: No, I haven't, Commissioners. Can I rectify that situation and tender that statement?

COMMISSIONER TRACEY: Yes.

5

MR BOLSTER: Before I do that, could I perhaps tender the general tender bundle for the Broome hearing first.

COMMISSIONER TRACEY: Yes. The general tender bundle for the Broome
10 hearings will be exhibit 4-1.

EXHIBIT #4-1 GENERAL TENDER BUNDLE FOR BROOME HEARINGS

15

COMMISSIONER TRACEY: And the statement of Ms Faye Dean, which I think is dated 5 June 2019, will be exhibit 4-2.

20 **EXHIBIT #4-2 STATEMENT OF MS FAYE DEAN DATED 05/06/2019**

MR BOLSTER: Thank you, Commissioner.

25 COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: Thank you, Commissioner.

30 Ms Jadai, please feel free to sit or stand as you are comfortable. Ms Jadai, have you prepared your story to tell the Commissioners.

MS JADAI: Yes, I did.

35 MS HILL: And have you got a copy of that story in front of you.

MS JADAI: Yes.

MS HILL: Could I ask you to please read your story to the Commissioners.

40 MS JADAI:

45 *My name is Madeleine Jadai. I am an Aboriginal Mangala woman, I live in Bidyadanga Western Australia and I'm 55 years old. My sister, Betty Barney, gets aged care services, Betty is about 62. I care for Betty. I have been her carer for the last seven to eight years. After my Mum passed away, Betty got distressed. Her spirit went really down. I think losing Mum was really hurtful*

for her. Before Mum died, Betty was able to look after herself. I look after Betty now for her safety and wellbeing.

MS HILL: Would you like to keep reading your story, Ms Jadai?

5

MS JADAI: Yes:

My caring responsibilities: Being a carer takes up all my time. A few years ago my other sister died in a car accident. I now care for her children as well as my own children and grandchildren. I love my family and I'm really proud of myself looking after them. Looking after so many people means I'm really tired all the time. There are good things that I would like to do but I can't because of my caring responsibilities.

15 I talk about my sister now:

Betty has dementia. At one point she was suffering – suffering really bad and she would wander off. People in Bidiyadanga do not understand dementia very well and would try to help her in some ways. Sometimes Betty would get really angry with them. Sometimes Betty gets angry with me, my friends and my family members. Now that Betty is older she is a bit calmer. I do not know – I did not know what dementia was until I took her to the medical clinic. The doctor at the medical clinic told me that her mood were caused by her not being well. The clinic gives Betty medication which help her feel better. I think that we – we are lucky in Bidiyadanga to have access to doctors through the clinic. I am able – able to see a doctor when I need to, but I know that they have to fly in from Broome.

The HACC centre. Betty visits the HACC centre in Bidiyadanga most mornings, when she goes there she gets meals and is able to spend time with the other old people – older people in the community. When she is not well, I let the staff know and I keep her at home. The HACC centre looks after her well. Sometime they take Betty on a trip to go fishing or on country. When Betty is at the HACC centre, I am able to take a break. Betty has a home care package which is provided through the HACC centre. This help a little bit in terms of paying for Betty's care. However, paying for food for Betty comes out of her pension. It would be better if we could buy her food out of her home package instead.

Respite care. I would like my sister to be able to get better access to respite care. Sometime I have asked whether or not Betty can get respite care in Broome but I'm told that it is full. One time I had to go for a funeral out in the desert and I had to take Betty with me because I could not get her into respite care and I couldn't leave her with other family. We drove over 1000 ks to the funeral. Betty got sick and needed antibiotics. Having more access to respite care would make a difference, a big difference to me.

45

Elders cultural centre. I am working with some of our elders in Bidyadanga to establish an elders cultural centre. We want to create something that older people, especially our elders, can take with them so that they can maintain a connection to country. We also want to make something that helps younger people in our community stay attached to our history. We have not received funding for our cultural centre yet.

And that's - - -

10 MS HILL: Thank you for sharing your story with the Commission, Ms Jadai. Would you like to take a seat? Ms Jadai, what makes your people happy?

MS JADAI: Being around families and being together, especially our elders. They've given so much to us, you know, and showing us country and teach us the right way, so it's time to give – give them back something.

MS HILL: Ms Jadai, you brought some photos along with you today, didn't you.

MS JADAI: Yes, I did.

MS HILL: Could I ask Ms Maxwell to show you these photos. Are they the photos that you brought along with you today?

MS JADAI: Yes, I did.

MS HILL: Could you describe to the Commissioners what those photos show?

MS JADAI: These photo shows that we have our elder – older people, elders with us, and their carers at the football match that we have in Bidyadanga when we have home games.

MS HILL: What's important about that photo that you're holding up now, Ms Jadai?

MS JADAI: This photo shows that other elders could meet with other elders that we don't see, who might live in Bidyadanga but we don't know what goes on in their own house. And they're here to have a yarn, and they look happy and seeing their children and their grandchildren and their nieces and daughters playing football.

MS HILL: And why is that important, Ms Jadai?

MS JADAI: It is important that they be around people as well, and sitting there yarning and – and having a day out together as community should.

MS HILL: Who's in that photo, Ms Jadai?

MS JADAI: In this photo there's a mother and – and her son. So there's one carers that take care of her mother and brother as well in the same house. And in this photo they're both two sisters, one sister look after the other.

5 MS HILL: And why did you choose that photo, Ms Jadai?

MS JADAI: Being together and having fun and enjoying something. And there's laughter in this picture.

10 MS HILL: Are you happy for me to pass those photos to the Commissioners so that they may see them?

MS JADAI: Yes.

15 COMMISSIONER TRACEY: Thank you for those. Football matches are very important in bringing people together in the community?

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

20 COMMISSIONER TRACEY: How often do they occur?

MS JADAI: Sometime we would have four home games and the rest played in Broome, and it is hard for our old people to travel - - -

25 COMMISSIONER TRACEY: Yes.

MS JADAI: - - - into Broome so they have their chance to be with their people.

30 COMMISSIONER TRACEY: And how long would it take them to drive from your country into Broome for a game?

MS JADAI: Would take two hours.

35 COMMISSIONER TRACEY: Over unmade roads?

MS JADAI: Dirt roads.

COMMISSIONER TRACEY: Dirt roads.

40 MS JADAI: No.

COMMISSIONER TRACEY: Are they sealed road all the way?

MS JADAI: Yes.

45

COMMISSIONER TRACEY: Well, that's good.

MS JADAI: Mmm.

MS HILL: What role does your family have, Ms Jadai, in organising the football events?

5

MS JADAI: For this one in particular, the one with old people, my family started this one. We thought of all the old people living in our community and we don't see them day to day and we said we should do something to bring them along to the match and sit with other people and other old people and families. It's all about family event. And we started this thing up and then we – I asked the clinic if they could help with their vehicle to bring all the old people to – for an outing, and we provide morning tea, lunch and anything that they want. And it's been – we started two years ago, so it's going to be ongoing.

10

15 MS HILL: What's your role in the community at Bidyadanga, Ms Jadai?

MS JADAI: I've worked there at the school for many years, back in the '70s and after my sister had the accident, so I had to stop, it really – it broken our spirit she was gone. So we – me and my family had to take care of the five children and one grandkid. I dealt with the – with their wellbeing, physically, mentally, everything like that. And that's – I love work to care for my family and I'm just in the community and I caring for my sister. And just being everywhere around the community, if anybody needed me, and I like to help. That's home. That's why sometime – most mornings, I don't leave the house till 9, 10 o'clock. As soon as I leave at 8, I – they would call me up to do something, so I just stay home till – yes, so I've been around and I've been helping Aunty Faye as well, if she needed my help. So I'm a carer and I just stay at home so - - -

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25

MS HILL: What do you help Aunty Faye with?

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MS JADAI: Do, like, if she needed help in regarding cultural activities or things like that, I would tell her, or if there's something happening in the community, I would pass on a message.

35 MS HILL: What's it like caring for your sister, Ms Jadai?

MS JADAI: It's difficult. It's hard because sometime I don't sleep till I know for sure that if she is fast asleep. I will then go to sleep.

40 MS HILL: How often does Betty go to the HACC centre?

MS JADAI: She would go most mornings. Sometimes she wouldn't two for some reason, well, if she's sick or her mood changed, so I would keep her. Or sometimes she would go there and then come back at lunchtime. Or if I need more time I would tell Aunty Faye, keep her until half past 1 so that she – I could have time to do all my other business when she was in the HACC centre.

45

MS HILL: Does Betty speak English, Ms Jadai?

MS JADAI: Yes, bit of both. Her own traditional language as well.

5 MS HILL: Does Betty use interpreters at all?

MS JADAI: Yes. I'm always with her so I'm there to - - -

10 MS HILL: You're the interpreter?

MS JADAI: Yes.

MS HILL: If the HACC centre wasn't open for as much time, what would that mean for you and Betty?

15

MS JADAI: I've got my family. We would – that they would take her out fishing or for the day down the beach, on country, yes.

20

MS HILL: How do you care for yourself, Ms Jadai?

MS JADAI: I just, when she's well, and I have more time, I would go to the clinic and then or be with my friends, or just go down the beach. Yes, I would just do that.

25

MS HILL: Why was it important to you, Ms Jadai, to tell your story to the Commissioners today?

30

MS JADAI: Because sometime I really wanted to tell my story because we live – live out in the remote and people don't know what we go through or all this. And like, being out in a remote community and then we have to deal with our five language groups, family groups and to still have that connection around country. We have two cultural traditional owners along the coast and my family come from the desert so there's three from the east. So we have to work together to live in harmony and to make what Bidyadanga that we really want it, to make it a better place for us and our children.

35

MS HILL: How do you teach people that come to Bidyadanga about your culture?

40

MS JADAI: My aunty and myself, we started years ago, back in the '70s, sitting with old people on the ground, no building, and we listen to our people, they told us their story. And we started doing our cultural induction, cultural awareness to new staff that come into Bidye especially at the school because we both worked at the school for a long time and now it's open to all the visitors that come into Bidyadanga, and we do our cultural induction. And not only with them, but with the doctors we done one. So we keep having new doctors and nurses come through, so we do a cultural induction with them, and with the police, and with the whole staff

45

that come and work within our community.

MS HILL: Why is it important to have the cultural induction, Ms Jadai?

MS JADAI: Just letting them know they're coming to our community, our country, our home, and there's rules that they have to go by, not to go on law ground or
5 sacred places and to be aware of any things that may arise. That we there for them and they have that – they have to know that they're only visitors to our home.

MS HILL: Do you have anything that you would like to tell the Commission that you haven't already said, Ms Jadai?
10

MS JADAI: I just wanted to say I've got one last thing that I have to do and it is a very important thing. We're doing a Bidyadanga – a history of Bidyadanga, so it's going to go in like a 3D thing, movie or something like that. And in doing that, we thought of our people and especially our old people, that give back something to
15 them and to have that in place. And not only for old people, for the whole of Bidyadanga. Our young ones that are coming through, our next generation, and for the wellbeing that they should be proud of them self, their family, their connection to country, and what – their old people.

MS HILL: Thank you, Ms Jadai. Commissioners, that concludes my questions. If I could ask that the photos of Ms Jadai's be passed back? Thank you, Commissioners.
20

COMMISSIONER TRACEY: Ms Jadai, you've mentioned a number of things that you think would help you and others in similar situations. One of them is better
25 access to respite care and from what you say there are not enough places here in Broome. Would additional help in the home assist you through the home care package? Somebody coming to assist you around the home, looking after your sister?

MS JADAI: Yes. I have my family sometime and then Aunty Faye come in and Ryan and - - -
30

COMMISSIONER TRACEY: Would it be a problem if somebody from outside the family came and helped at home, perhaps doing some cleaning or maintenance or
35 things of that kind?

MS JADAI: We have workers in the community. When I need help, I go and ask at the community and they would mow the lawns and throw the rubbish, and - - -

COMMISSIONER TRACEY: So that you do have that help at the moment?
40

MS JADAI: I do, yes.

COMMISSIONER TRACEY: So are there any other things that you would find
45 helpful in looking after your sister?

MS JADAI: I would like to ask some – that if she could go for respite sometime Germanus Kent is full, and I talk a month ago and they was going to send her to Derby and I couldn't have the trust within myself – or to Broome, short stay. I was asked if she could go there but then I would trust one of my aunties to go with her and I would like her to get paid as well for taking the role – taking her to be with my sister.

COMMISSIONER TRACEY: The evidence you've given to us today in telling us your story has been very helpful, and we're very grateful to you for coming and talking to us this morning, and we will certainly do what we can, if the circumstances allow, to see what we can do about providing more respite care for people in your community that's culturally appropriate. It's obviously something of great importance to you and I'm sure to other members of the community and we're very grateful to you for coming and telling us about those needs. Thank you very much.

MS JADAI: Thank you.

MS HILL: Thank you, Commissioners. Ms Bergin will take the next witness.

COMMISSIONER TRACEY: Thank you.

<THE WITNESS WITHDREW [11.17 pm]

MS BERGIN: Commissioners, I call Yvonne Grosser.

<YVONNE GROSSER, SWORN [11.18 pm]

<EXAMINATION-IN-CHIEF BY MS BERGIN

MS BERGIN: Operator, could you please bring up document WIT.1144.0001.0001. Ms Grosser, is there a copy of your statement - - -

MS GROSSER: Yes.

MS BERGIN: - - - in front of you? That's your statement?

MS GROSSER: Yes, it is.

MS BERGIN: And do you have any amendments to make?

MS GROSSER: No.

MS BERGIN: I tender the statement of Yvonne Grosser, document WIT.1144.0001.0001.

COMMISSIONER TRACEY: What date does it bear?

5

MS BERGIN: The statement is dated 12 June 2019.

COMMISSIONER TRACEY: The 12th.

10 MS BERGIN: Thank you, Commissioner.

COMMISSIONER TRACEY: Thank you. The witness statement of Yvonne Grosser dated 12 June 2019 will be exhibit 4-3.

15

EXHIBIT #4-3 WITNESS STATEMENT OF YVONNE GROSSER DATED 12/06/2019 (WIT.1144.0001.0001)

20 MS BERGIN: Ms Grosser, where are you from?

MS GROSSER: I'm actually from Perth. I was born in so I'm actually classed as a Noongar.

25 MS BERGIN: When did you become an enrolled nurse?

MS GROSSER: 2010.

MS BERGIN: Where did you do your training, Ms Grosser?

30

MS GROSSER: At Marr Mooditj College in Manning.

MS BERGIN: Why did you decide to work in aged care?

35 MS GROSSER: I love working with old people, and especially my people, everybody is my people. Sorry.

MS BERGIN: When you say "my people", who are you talking about?

40 MS GROSSER: Aboriginal people.

MS BERGIN: How many people were in your training group?

MS GROSSER: Started off with 38, ended up with 10.

45

MS BERGIN: What happened there; why did 10 people finish the training?

MS GROSSER: Well, we all grew close network, and still today we still are very close today, keeping network ties and helping each other and pushing each other to get through. Yes, it's something that we really wanted so in the end we got it, yes.

5 MS BERGIN: Why did 28 people decide not to complete the course?

MS GROSSER: There was a lot of young people, and when it came to aged care, they got frightened by looking after old people, especially to the point of changing them, you know. You've got to show respect, it doesn't matter what age it is, you've
10 still got to show respect. And being elderly, they come in – you know, you come into the world as a baby and you go out as a baby, so you've still got to give that respect and the whole holistic care.

MS BERGIN: So what jobs have you had in the – in aged care?
15

MS GROSSER: I actually worked all sorts. I was called a multi-skilled. Yes, I'm a nurse but I enjoy cleaning and I will do anything, yes.

MS BERGIN: Where did you work in the Kimberley in aged care?
20

MS GROSSER: I worked at Germanus Kent.

MS BERGIN: And what was your role at Germanus Kent?

25 MS GROSSER: A multi-skilled, so I did cleaning, kitchen hand, whatever they needed me to do I did, and nursing.

MS BERGIN: Did you enjoy your role at Germanus Kent?

30 MS GROSSER: Yes, I loved working there, the people were good and you've got nothing to complain about as far as work. It was just not enough workers, that was the problem that we found, and tiring, getting tired. A lot of the co-workers would be burning themselves out as well, so yes.

35 MS BERGIN: So I want to ask you a bit more about that. How many residents were there at Germanus Kent?

MS GROSSER: At least 60.

40 MR BOLSTER: How many workers were there?

MS GROSSER: Two carers in each section so that's three sections of 20s and one enrolled nurse at a time.

45 MS BERGIN: Your role was as an enrolled nurse; is that right?

MS GROSSER: Yes.

MS BERGIN: How many enrolled nurses were employed by Germanus Kent when you worked there?

MS GROSSER: Shivers, I think around about 12.

5

MS BERGIN: How many enrolled nurses would there be on a particular shift?

MS GROSSER: Only one, so one nurse on one shift.

10 MS BERGIN: And that one nurse was responsible for - - -

MS GROSSER: For whole the lot, yes.

15 MS BERGIN: So what did – it sounds like you were busy. Could you tell us a bit about your typical day in Germanus Kent?

MS GROSSER: Depending on how the clients – the carers would take care of them first and get – like let us know – call us in and come down to see them if they weren't feeling the best. So we would go down and give the general care, blood
20 pressure and temperature and check them out, and then ask them questions, how they're feeling or whether they're feeling sick. Try and get that sort of frame of mind for where it's happening, and – and by that time, you would have built up a rapport with them and knowing how their body situation of what they're looking like, you would tell yourself that, you know, you know your client. So some of them
25 would have to go to hospital, yes, and some were just okay, yes.

MS BERGIN: If there was a medical crisis and you're the only enrolled nurse on staff - - -

30 MS GROSSER: Yes.

MS BERGIN: - - - how did you manage that?

35 MS GROSSER: You would just have to. Learn to have time management and learn to take things slowly because you need to make sure that you've got all the document that you're needing at that time, yes.

MS BERGIN: How many nursing staff were Aboriginal people?

40 MS GROSSER: Myself and three others.

MS BERGIN: And how many of the residents identified as Aboriginal or Torres Strait Islander people?

45 MS GROSSER: There was quite a lot, which was good to see, in one hand, yes.

MS BERGIN: Did you particularly enjoy caring for Aboriginal and Torres Strait Islander people?

5 MS GROSSER: Yes, I did. Yes. I had that, I suppose I could call it – I don't have my grandparents around so it was really lovely to have other grandparents around and listen to what they have to say at the end of the day, yes.

10 MS BERGIN: How did you – what were the main barriers to the provision of quality care?

MS GROSSER: I would have to say the language barrier was one of them. Me being from Perth I don't have any kind of language; I wasn't entitled to that. And whereas some of the clients were just language only. No English. So that was a real barrier and there was no point having a translator because you're paying those
15 translators to come in, well, at the end of the day you would need that translator on your shift all the time if that's the case of looking after them. And you're probably better off just employing a translator to be on standby if that's the case, it probably works out cheaper. Yes.

20 MS BERGIN: So you talked about getting to know the elders at Germanus Kent.

MS GROSSER: Yes.

25 MS BERGIN: How did you develop their trust when there was a language barrier, how did you communicate?

MS GROSSER: With hand signals. As kids we're taught that by our grandparents and elders, language as in hand signals or the nodding of the head or eyes, yes.

30 MS BERGIN: If there was a language barrier, did it make it harder to develop a relationship with the elders?

MS GROSSER: Yes, it can do, yes.

35 MS BERGIN: So how did you go about that?

MS GROSSER: Well, as being a nurse you do your general care of what you're going to do for that person. It doesn't matter whether it's a language barrier or not. You look at their notes and what carer plan that you're going to decide what you're doing for them and what you've got to stick to, yes.
40

MS BERGIN: You mentioned that you're employed as an enrolled nurse at Germanus Kent; how long did you work there for?

45 MS GROSSER: Probably off and on a year.

MS BERGIN: How much training did you get when you started your role at Germanus Kent?

5 MS GROSSER: I had a two-day buddy shift of each section that I went and worked in, so yes.

MS BERGIN: Do you have follow-up training after the induction?

10 MS GROSSER: Not at a time, no, but I hear that they're doing it now, so that's good.

MS BERGIN: You mentioned at the start of your evidence that you were employed as sort of someone who did everything.

15 MS GROSSER: Yes.

MS BERGIN: What tasks did other staff carry out such as the carers?

20 MS GROSSER: The carer roles, their general day would be as far as coming in the morning, dressing, showering, changing, and then organising breakfast, lunch, dinner, of course, and then working out who's prioritised first, so they would be the ones that are bedridden, and they would have their meals first and then we would come to the others that are capable to get up and move themselves, yes.

25 MS BERGIN: Okay. And while you were working at Germanus Kent was that your only job or did you have other jobs as well?

MS GROSSER: No. I was a cleaner as well. Yes.

30 MS BERGIN: So you worked two jobs?

MS GROSSER: Yes. I did the enrolled nursing then cleaning at Germanus Kent, and then I had another job as a cleaner with Footprint Cleaning.

35 MS BERGIN: Did you find Broome an expensive place to live?

MS GROSSER: Yes.

40 MS BERGIN: Is that why you had to work an extra job?

MS GROSSER: Yes, yes. The whole time that I was here for a year I didn't really see much of Broome, yes, but yes, so beautiful.

45 MR BOLSTER: So beautiful.

MS GROSSER: Yes.

MS BERGIN: So you talked a bit about communication with the Aboriginal and Torres Strait Islander residents; how important is it that residents feel connected to culture and to country?

5 MS GROSSER: Totally. It's – it's for them. That's one of their healing, to be back in country, whereas what you see in a nursing home at any nursing home of aged care, people are quite sad people. You could see that their heart is sad, and if they had it in country, they would be happy as, I think, yes.

10 MS BERGIN: So how can you as a worker, and we, think about bringing country and culture to a residential care facility; how can this be done?

MS GROSSER: I actually thought what they should have is at least a couple of nights a week their cultural food as meals which would probably make them a lot
15 happier, too, instead of eating westernised food 24/7, whereas cultural, gives them a bit of a feel of, you know, being back – sort of being back in country but not the total feel, yes, or as otherwise – I don't know, bringing more cultural sensitive into them and asking them what they want, yes, because there's not much for them to do in a nursing home.

20

MS BERGIN: So does culture play a role of activities as well as - - -

MS GROSSER: Yeah, yeah.

25 MS BERGIN: - - - food?

MS GROSSER: I mean, they might want to go and see their people dance or do the gatherings or do something with each other.

30 MS BERGIN: Yes. And how often did you observe rest debits returning to country?

MS GROSSER: I've seen once, and that was about Christmas time, and that was quite difficult and it took a whole to get it happened because of – he wasn't from
35 Broome. He was from another country area. So the plane flights and then the doctors making sure that he was okay to get on that plane flight and then connecting flight, yes. So it was a – a long journey for them just to get home, yeah, whereas I think if they had more nursing homes in those area zones, it would actually be a lot – lot more sensible and more ideal for them, yeah.

40

MS BERGIN: So is that because a resident would prefer to be in a residential care facility closer to their - - -

MS GROSSER: Yeah, knowing that they're – they're in their own country, of –
45 feeling of being home and belonging back to where they are from. Yeah.

MS BERGIN: So, Ms Grosser, why have you come to tell your story to the Royal Commission today?

5 MS GROSSER: Because I believe in somebody's got to take a stand for Aboriginal people, and I'm Aboriginal myself, and whatever we can make it better at the end of the day for aged care in any aged care home, may it be, or facility, yeah, it's got to be said. Somebody's got to tell it, yeah.

10 MS BERGIN: What would you ask the Royal Commission to think about recommending if you could change, say, three or four things about aged care services?

15 MS GROSSER: I would have to say at least have aged care back in the areas of like, say – as long as it's a bigger community – you know, have a aged care system there where they know their home, or else otherwise ask them what they want if they're still able to – you know, the cognitive is still fine. And cultural – cultural awareness for the workers and the whole setting itself. You know, a lot of people need to be taught that Aboriginal people are different. We are different.

20 MS BERGIN: So is that about training the workforce?

MS GROSSER: Yeah.

25 MS BERGIN: What's next for you, Ms Grosser? Do you hope to come back to work in Broome one day?

MS GROSSER: Yes, I do, hopefully not long away as my father is in palliative care too, so, yeah. That's one of the reasons why I went back to Perth is to deal with him and other issues at the moment. Otherwise I'm still here, doing the same.

30 MS BERGIN: Thank you, Commissioners. That concludes my examination of Ms Grosser.

35 COMMISSIONER TRACEY: Thank you. Could I just ask you a bit more about the ways that you would see as being most likely to attract fellow Aboriginal people to aged care nursing to look after the elders.

MS GROSSER: To bring more into it? To bring more into the - - -

40 COMMISSIONER TRACEY: Yes.

45 MS GROSSER: Yeah. It's – I think it all boils down to getting their trust and knowledge of the place, whether they can trust the place. If they heard good outcomes about a place, they – they'll probably have more intention or more for them to do in – in aged care as well. I mean, you've got a lot of aged people that are in there and still able to get up and move around, and when it comes to the evening, yes, you've got something to do during the day, only a little bit, but at least have

something on during the night. It doesn't have to be every night. It could be a bingo night or something that, I don't know, that gives it more of a home feel than just a hospital setting. I think that's what a lot of people get put off for, is the hospital setting instead of being a home – home setting. So if that changed as a home setting, it would be a lot better, yes.

5
COMMISSIONER TRACEY: And what about getting younger people into nursing?

10 MS GROSSER: Well, this is where we've got to start. Us nurses today are – there's a lot of Aboriginal nurses that are coming through now and should be really proud of themselves, because it is a big step and it's not easy either. But with the right support that they can get along the way through government as well, that – they can thrive.

15 COMMISSIONER TRACEY: And you say there are a lot. Where is this training being provided?

20 MS GROSSER: At Marr Mooditj in – in Perth, in Manning. They've had quite a lot of students come through now, which is awesome to have more Aboriginal nurses on board. And we've shown it ourselves, the – because we were the guinea pigs when we first started.

25 COMMISSIONER TRACEY: Yes.

MS GROSSER: And in Shenton Park, it – it showed that it works to have Aboriginal nurses, male or female, especially males. Males need to come through more too, yeah.

30 COMMISSIONER TRACEY: And what about training in-house at the facility here in Broome where you worked?

MS GROSSER: Yeah.

35 COMMISSIONER TRACEY: Was there any training provided, culturally specific, things of that kind to assist the nurses?

40 MS GROSSER: No, not at that – no, not that I'm aware of, no, not the while I've been there, there hasn't, yeah.

COMMISSIONER BRIGGS: Might I ask about attracting young men to work in the field, particularly indigenous men.

45 MS GROSSER: Yeah.

COMMISSIONER BRIGGS: But it's an issue right across - - -

MS GROSSER: Yeah.

COMMISSIONER BRIGGS: - - - the aged care sector. Have you got any ideas?

5 MS GROSSER: No. You've just put me on the spot, but no. I think they need to think that they can do it. I don't know. As far as Aboriginal men, I think they have that little bit of doubt in themselves, whereas they need to have that push and somebody to push them and say, "Yes, come on, you can do it", you know, and, yeah, just believe in them, I suppose, yeah.

10 COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Anything arising?

15 MS BERGIN: Nothing arising. Thank you, Commissioners.

COMMISSIONER TRACEY: Good. Ms Grosser, thank you very much, and I'm sure that the Broome community will be very pleased when you manage to get back here - - -

20 MS GROSSER: I miss them.

COMMISSIONER TRACEY: - - - as soon as possible.

25 MS GROSSER: Thank you.

COMMISSIONER TRACEY: Thank you very much for your evidence.

30 **<THE WITNESS WITHDREW** **[11.37 am]**

COMMISSIONER TRACEY: The Commission will adjourn until noon.

35 **ADJOURNED** **[11.37 am]**

40 **RESUMED** **[12.06 pm]**

COMMISSIONER TRACEY: Yes, Mr Bolster.

45 MR BOLSTER: Commissioners, before I call the next witnesses, I understand there's an appearance to be noted in respect of their evidence.

MR McKENNA: May it please the Commission, my name is McKenna. I'm instructed by Minter Ellison and, pursuant to your leave, I appear for the next two witnesses, Ms Bridges and Mr Barke.

5 COMMISSIONER TRACEY: You're welcome, Mr McKenna.

MR BOLSTER: Commissioners, I call Craig Robin Barke and Tamra Jade Bridges, please. Both of them will take the oath.

10

<TAMRA JADE BRIDGES, SWORN [2.07 pm]

15

<CRAIG ROBIN BARKE, SWORN [2.07 pm]

<EXAMINATION BY MR BOLSTER

20 MR BOLSTER: Please have a seat. Could document number WIT.0227.0001.0001 be brought up.

And Mr Barke, you will see in front of you on the screen there's a copy of your statement that's de-identified in terms of personal information.

25

MR BARKE: That's correct.

MR BOLSTER: Is that statement – or that is your statement?

30 MR BARKE: That is my statement.

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

35

MR BARKE: No.

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

40

MR BARKE: Yes, they are.

MR BOLSTER: Commissioners, I tender Mr Barke's statement, document number WIT.0227.0001.0001.

45

COMMISSIONER TRACEY: Yes, the witness statement of Craig Robin Barke dated 31 May 2019 will be exhibit 4-4.

EXHIBIT #4-4 WITNESS STATEMENT OF CRAIG ROBIN BARKE DATED 31/05/2019 (WIT.0227.0001.0001)

5 MR BOLSTER: Now, if we could bring up the other document, WIT.0166.0001.0001.

Ms Bridges, that's your statement?

10 MS BRIDGES: Yes, it is.

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

15 MS BRIDGES: No, I don't.

MR BOLSTER: And are you – are its contents true and correct to the best of your knowledge and belief?

20 MS BRIDGES: Yes, they are.

MR BOLSTER: Thank you.

Mr Barke, I might start with you.

25 COMMISSIONER TRACEY: Before you do, Mr Bolster - - -

MR BOLSTER: I will tender Ms Bridges' statement. Thank you, Commissioner.

30 COMMISSIONER TRACEY: So the witness statement of Tanya Jade Bridges, dated 31 May 2019 will be exhibit 4-5.

EXHIBIT #4-5 WITNESS STATEMENT OF TAMRA JADE BRIDGES DATED 31/05/2019 (WIT.0166.0001.0001)

35

MR BOLSTER: Mr Barke, you're currently the CEO of UnitingCare Queensland and you've held that position for a number of years now. What is UnitingCare Queensland?

40

MR BARKE: UnitingCare Queensland is a large not-for-profit provider of community and health services based in Queensland. We run an extensive aged care network across Queensland and also into the Northern Territory under the ARCCS organisation which has been referred to earlier today. We also run four private hospitals as well as an extensive disability business, and a child and family support organisation which is part of UnitingCare Queensland. And also we are the operators of Lifeline in Queensland.

45

MR BOLSTER: If we could perhaps bring up tab 49. That's ARR.600.002.0001.

Do you have that in front of you? That's a map you've annexed to your statement of the ARCCS services in the Northern Territory. Do you have that?

5

MR BARKE: No, I don't.

COMMISSIONER TRACEY: I think it's still coming, Mr Bolster.

10 MR BOLSTER: Still coming. That's tab 48 from the general tender bundle. ARR.600.002.0001. There it is. Thank you.

15 So you can see there the map of the Northern Territory with the services. Could we perhaps just walk through the services in the Territory. Right at the start at the bottom left, we have Docker River, and we heard a bit about that today. Immediately adjacent to that is Mutitjulu, some people might refer to as Ayers Rock. What sort of facility do you have at Mutitjulu?

20 MR BARKE: Mutitjulu is a new aged care facility that was constructed under a Federal Government grant. It was built in the 2013/2014 financial year. Mutitjulu is a small community based, essentially, at the foot of Uluru. It's not more than a kilometre or so from physically the Uluru rock itself, and we have an aged care facility there of 16 beds and we also have a childcare facility which neighbours the residential aged care facility.

25

MR BOLSTER: NATSIFlex or ACFI?

MR BARKE: This is a NATSIFlex facility.

30 MR BOLSTER: All right. And to the north-east then is Hermannsburg. What is the situation there?

MR BARKE: That is a small community where we provide a school nutrition program but no other services which are based at that site.

35

MR BOLSTER: Alice Springs?

40 MR BARKE: Alice Springs, we run a range of services in Alice Springs. Predominantly there are three residential aged care facilities based in Alice Springs. So Flynn Lodge, Hetti Perkins and Old Timers are based in Alice Springs. Plus we also run a community out program throughout Alice Springs as well.

MR BOLSTER: And the funding model there, ACFI or NATSIFlex?

45 MR BARKE: They are all ACFI sites.

MR BOLSTER: Tennant Creek?

MR BARKE: Tennant Creek is a residential aged care facility. This is a NATSIFlex site and it's a site that we have been operating since about – well, the frontier services who precedes us, of course, have been operating since about 1980s.

5 MR BOLSTER: And then finally, we've got Katherine and then Darwin.

MR BARKE: That's right. So residential aged care facilities in Katherine and a number of residential aged care facilities and other services throughout Darwin.

10 MR BOLSTER: Can I ask you, what's the reason why UnitingCare Queensland does all this work in the Northern Territory? What's the background to that?

MR BARKE: The background for the organisation that we represent here today is traced back to 1912 where John Flynn, who was a Minister of the Presbyterian
15 Church, a Victorian based minister, was essentially commissioned on behalf of the Presbyterian Church to form a network of community and health services through remote Australia. That originally operated under the brand of the Australian Inland Mission, which formed up to 15 residential aged care facilities in those early years. Quite extraordinary stories are attributed to that era of the organisation, including
20 nurses travelling via camel through outback Australia to visit residents and clients on their properties. The services then transitioned in 1977 to the Uniting Church under the brand of Frontier Services, and then in 2014 were transitioned to the ARRCs business, a new entity which is now governed and operated by UnitingCare Queensland.

25 MR BOLSTER: Why the transfer in 2014?

MR BARKE: The transfer in 2014 I think recognised the fact that the aged care system was becoming increasingly complex, both clinically and financially. The
30 organisation UnitingCare Queensland is a very large-scale aged care operator. And it was felt within the context of the church that it was better for that organisation, the Frontier Services organisation, to have governance and leadership provided by a large-scale aged care provider rather than what had operated since 1977, which was when the organisation was governed under the general assembly of the Uniting
35 Church in Australia. And they – they did a fantastic job at operating those services but they weren't a specialist aged care provider.

MR BOLSTER: What was - - -

40 MR BARKE: We were.

MR BOLSTER: How well placed was Frontier Services to continue with that role, when you took it over?

45 MR BARKE: Look, I think every aged care provider in remote Australia faces extraordinary challenges, and so do we. We are working through our own complexities in these environments and Frontier Services was on that journey as

well. But it was recognised, I think, that it was appropriate for that transfer to happen between the Frontier Services body and UnitingCare Queensland, in recognition of the complexity of aged care in these environments and the increasing complexity, just generally within the aged care field.

5

MR BOLSTER: Well, if UnitingCare Queensland had not taken over the Frontier Services sites back in 2014, what would have happened?

10 MR BARKE: Well, I guess possibly some of them may have become unviable and there would have needed to have been another provider found, or those assets might have been transferred back to the Federal Government under the NATSIFlex program for operation.

15 MR BOLSTER: Yes.

15

COMMISSIONER TRACEY: Am I right in thinking that these residential facilities in the Northern Territory trace their origin to facilities on mission stations like Hermannsburg?

20 MR BARKE: The history of those sites is complicated. And we've tried to reconstruct the history of them as best we are able and we've been somewhat successful at understanding the history of some of those services, and others have been a little more elusive. But it's certainly the case that these sites were, in some cases, services based on mission statements and stations, as you've identified. In
25 other cases they have been transferred to us from local councils or the Inland Aboriginal Land Council, I think is the correct term, in the case of Docker River. That facility came to us through a transfer in the mid '80. So there is a varied history across these sites reflective of the fact that – that many of them are older sites, but some of them are newer sites.

30

MR BOLSTER: I might turn now to Ms Bridges, because you have been the general manager of Pinangba, which is the organisation that operates in Queensland. If we could bring up, please, tab 49, it's APR.600.0001.0007. We will get to that, but that's the map that you annexed to your statement showing the Queensland
35 Pinangba operations, and if we start from the south, there's a facility at Cherbourg.

MS BRIDGES: That's correct.

40 MR BOLSTER: What sort of facility is that?

MS BRIDGES: It's a residential aged care facility.

45 MR BOLSTER: What's the predominance of Aboriginal and Torres Strait Islander people in that facility?

MS BRIDGES: Currently it would be about 90 per cent.

MR BOLSTER: 90 per cent. Then there's a facility north in Townsville, similar situation?

5 MS BRIDGES: Yes Shalom Elders Village. It fluctuates between 90 to 100 per cent.

MR BOLSTER: In Cairns, what's the facility there?

10 MS BRIDGES: It's Hollingsworth Elders Village, and it would be the same.

MR BOLSTER: Cooktown.

15 MS BRIDGES: Cooktown is a different type of service, it's called Cape York Family Centre. It's a family therapy – a residential family therapy centre that does healing with the family.

MR BOLSTER: And then finally we have Thursday Island and Star of the Sea.

20 MS BRIDGES: That's a residential aged care facility.

MR BOLSTER: Now, the Pinangba facilities, are they ACFI or NATSIFlex funded facilities?

25 MS BRIDGES: They're all ACFI funded.

MR BOLSTER: All ACFI funded. Okay. If we could bring up, then, please, tab 50 which is ARR.600.001.0008. You've annexed there some photographs of the Star of the Sea facility.

30 MS BRIDGES: Yes.

MR BOLSTER: And you were the – your role there, you have an active role in that facility.

35 MS BRIDGES: Yes, I'm the general manager for Pinangba, responsible for, I guess, managerial and operational oversight.

40 MR BOLSTER: If we could just get you to move closer to your microphone, perhaps, if the associate could move the microphone slightly towards you, that would help. Thank you, Ms Bridges. And your current role?

MS BRIDGES: My current role is group general manager for aged and community services regional and remote and ARRCS.

45 MR BOLSTER: For ARRCS. So does that involve looking after the Northern Territory facilities?

MS BRIDGES: It involves oversight of both the Northern Territory facilities and also regional and remote Queensland facilities.

5 MR BOLSTER: All right. So the photos have now been brought up. That's tab 50 from the tender bundle and we see there are two photos on that page. That's the facility in the top photo; correct.

MS BRIDGES: You can see the facility and also the staff accommodation.

10 MR BOLSTER: All right. And then the second photo I think is important, isn't it. You wanted to indicate what that is a photo of?

MS BRIDGES: Well, that's a photo directly in front of the aged care facility and it's important due to the proximity to the ocean and connection.

15 MR BOLSTER: All right. In your statement you refer to the Ocean Room in that facility.

MS BRIDGES: Yes, that's right.

20 MR BOLSTER: Why is that Ocean Room important?

MS BRIDGES: The Ocean Room has significance – historically, when Star of the Sea was built, the residents' living area was towards the back of the block and there was no view to that beautiful ocean. So it was really important for us when we were doing community consultation around what the community would like to see for a residential aged care facility, the number one thing was connection with the external environment, in this case specifically the ocean, and from the Ocean Room you can see the outer islands that surround Thursday Island.

30 MR BOLSTER: And the people that live at Star of the Sea, to what extent are they Torres Strait Islanders themselves?

MS BRIDGES: 100 per cent.

35 MR BOLSTER: And what islands do they come from?

MS BRIDGES: Our residents come from a range of islands as far as Mer Island which is one of the most further away islands, more close the surrounding islands such as Prince of Wales Island, even islands as, you know, as close as 4 ks from the PNG border like Saibai or Boigu.

MR BOLSTER: And is there a range of language groups that are – that you have to deal with in looking after these people?

45

MS BRIDGES: There's different dialects in the different islands, although there is creole which is widely spoken and able to be used with people from all of the Torres Strait generally.

5 MR BOLSTER: Yes. Okay. And what about the staff at Star of the Sea; do you recruit from the Torres Strait?

MS BRIDGES: We've been working really hard over the last five or six years to ensure we have a local workforce, so we have at least 70 per cent of our staff.
10 Currently at the time of making the statement it's 80 per cent from the Torres Strait and that's in all different kind of positions from service manager to clinical roles, personal care workers.

MR BOLSTER: At the higher end clinical roles, the registered nurses, the enrolled
15 nurses, how do you get getting Torres Strait Islander staff?

MS BRIDGES: There's some advantages with Thursday Island. They have good access to education and training, so there's a university campus up there as well as TAFE campuses so we have been successful in working with the TAFEs to ensure
20 we have registered staff that are from the Torres Strait.

MR BOLSTER: So is the training carried out inside the facility?

MS BRIDGES: It's a blended model. It can be carried out at the TAFE campus and
25 then while they're employed with us they're doing the skills-based work.

MR BOLSTER: Right. And which qualification is this leading to?

MS BRIDGES: Enrolled nursing. We have also had graduates participate in a
30 postgraduate year who have completed university at a more major location and returned back to the Torres Strait to do their registered nurses graduate year.

MR BOLSTER: Right. What about personal carers?

35 MS BRIDGES: Personal carers also work with the TAFE on Thursday Island.

MR BOLSTER: What percentage of your personal carers are Torres Strait Islanders?

40 MS BRIDGES: Off the top of my head it would be close to 80 per cent.

MR BOLSTER: Yes. Right. And how do you – how do you go about instructing them or training them or guiding them in the delivery of culturally appropriate care?

45 MS BRIDGES: I think the thing about Star of the Sea is that the workforce ensures that it's driven from the community, so there isn't such a strong requirement to do cultural training, because the majority of the workforce is from that community.

MR BOLSTER: What aspects of the Torres Strait Islander culture are important at Star of the Sea in the care you deliver?

5 MS BRIDGES: Family relationships, so the way we talk about our staffing model and our service is all built on family and connection. So majority of our staff would be related to the elders that they're caring for and they see this as quite an honour and privilege to be able to provide that care for the elders, so that's the kind of cornerstone of how a staffing model is built. Access to traditional food is quite a challenge so the majority of our residents have had a diet based on fish and – and 10 ocean animals, and to provide this, it's been quite a challenge but it's something that we continuously work around to ensure there's access. Dance, song, ensuring we uphold local cultural protocols around people pass away, if we're opening new buildings, it's – it's just being tightly embedded with the local community.

15 MR BOLSTER: Do – so who is the decision-maker at the facility when it comes to making decisions that affect care but where there's a cultural interface? How do you manage that process?

20 MS BRIDGES: The service manager makes local operational decisions and she's a Torres Strait Island woman and so she would be taking advice from her elders in the community and also elders in the facility and also our staff.

25 MR BOLSTER: Right. Okay. Let's pause there and travel to the Northern Territory and the situation in Docker River. The population there is entirely Aboriginal from the local area.

MS BRIDGES: That's correct.

30 MR BOLSTER: And from what sort of catchment area do they come? Do they come from APY Lands; do they from the west and the north?

MS BRIDGES: In my experience, the residents who reside in Docker River are from the Docker River community.

35 MR BOLSTER: Right. Okay. And the staff, how do you get staff to come to Docker River? Is there training there for the locals to become carers and nurses?

40 MS BRIDGES: We do work with local people for employment, but we're not as mature in our approach in the Northern Territory as what we have been able to be in Queensland. We've been in Queensland in Aboriginal and Torres Strait Islander services a lot longer. So in Docker River we have local people employed to assist with different tasks, so I guess the communities are very different, and in Docker River the discussions we have with local community is around the appropriate roles which they might undertake and our services are quite different to the roles which 45 they might undertake somewhere like Thursday island. So our staff in Docker River that are employed and are from Docker River work alongside our qualified personal care staff to deliver things like yard maintenance, cleaning, serving of meals, social

support of residents where we find it much more challenging to recruit local people who want to undertake personal care roles.

5 MR BOLSTER: Yes. If people were prepared to take on that role, how would they get that training in a place like Docker River?

MS BRIDGES: There are some training providers that travel to remote locations, although there will be significant challenges around the language barrier.

10 MR BOLSTER: Yes. And do you have more than one language in Docker River that you have to deal with?

MS BRIDGES: There's multiple dialects in that area.

15 MR BOLSTER: And let's just pause there. The staffing structure, can you just describe, do you have a – you would have a residential manager or a care coordinator at the top of the organisation.

20 MS BRIDGES: We have a service manager in Docker River who's also a registered staff member.

MR BOLSTER: Where does that person come from?

25 MS BRIDGES: That person comes from the east coast.

MR BOLSTER: Are they there full-time?

30 MS BRIDGES: So our staff in Docker River do 10 weeks on, two weeks off, on a rotating roster. Out of context, to get to Docker River requires a flight into Alice Springs and then a flight to Yulara and then from Yulara it's what we call the bush bus where staff travel for three hours on a dirt road to get to the location.

MR BOLSTER: Right. And how many staff engage in that process?

35 MS BRIDGES: About 90 per cent of our staff.

MR BOLSTER: All of the nursing and personal care staff.

40 MS BRIDGES: That's right.

MR BOLSTER: How many nurses and how many carers do you have?

45 MS BRIDGES: So we have a range of enrolled and registered nurses and personal carers, so our total, I guess, staffing pool to deliver the 24 hour service would be around 20 staff.

MR BOLSTER: And to what extent are they Aboriginal or Torres Strait Islander?

MS BRIDGES: We have four local people employed.

MR BOLSTER: As?

5 MS BRIDGES: As activity officers assisting.

MR BOLSTER: But in terms of personal carers, so with qualifications, either personal carers with qualifications or nursing staff with qualifications, it must be hard to get anyone locally to do that?

10

MS BRIDGES: It is – it is a big challenge. The challenge is also around probity which was discussed a bit earlier as well, meeting those requirements.

15 MR BOLSTER: Tell us about the probity, the police check situation; how difficult is that if you're going to operate in these areas?

MS BRIDGES: It can be quite difficult. A lot of the community members that we work with struggle to find identification to even meet the requirements to be able to lodge something like a police check.

20

MR BOLSTER: And what impact does that have?

MS BRIDGES: We - - -

25 MR BOLSTER: On you getting staff, does it stop you getting staff?

MS BRIDGES: We do need to have police clearance for people to work at our services unsupervised.

30 MR BOLSTER: Do you think that people, when they're told they have to get a police check, simply don't proceed with the application?

35 MS BRIDGES: That's right. It can be a daunting process and the applications might cause a bit of fear if people have got minor charges, even the thought that they might be shamed.

MR BOLSTER: Yes.

40 COMMISSIONER TRACEY: How big is the community at Docker River?

MS BRIDGES: The population fluctuates between around three to 400 people.

45 COMMISSIONER TRACEY: I take it it's not a fertile field as far as recruiting staff is concerned.

MS BRIDGES: Yes, the level of education obtained in that community is quite low. English is a second language.

MR BOLSTER: Statistics would suggest that most people who live there receive nothing more than social security; is that right?

MS BRIDGES: That's right.

5

MR BOLSTER: The interface there with the professional nursing staff, or the qualified nursing and carer staff must be difficult when it comes to the culturally safe delivery of care. How have you managed to deal with that?

10 MS BRIDGES: We deal with it in a number of ways, so having the local people employed, working at the service is somebody that our staff who fly in can work with, to try and develop a broader understanding. On recruitment, we work with people to ensure that they're aware of the context in which they're coming to work, so a little bit about Docker River, about its location and what they can expect. Most
15 of our residents don't speak English so that can be quite confronting if you land there and you're not prepared for that environment. We also have buddy shifts. We've got what we call more experienced care workers that might have worked there for a year or a number of years to ensure that new staff are supported in delivering care that's culturally safe.

20

MR BOLSTER: With the language barrier how do you communicate with the residents? How do staff speak to them? Do they have the other local staff around all the time for that purpose, or do you – what do you do?

25 MS BRIDGES: Yes, so local staff can assist with that process, also staff that have worked there for a number of years have adopted some language skills, so a lot of hand – use of sign language and hand gestures for communication. And visiting family members also who might have, you know, better English skills assist as well.

30 MR BOLSTER: Right. I want to ask you about the situation when there's a death impending. What steps have you taken to make sure that that process is dealt with in a culturally appropriate way?

35 MS BRIDGES: So there's a range of things that we do, and one of them is around ensuring that the community is invited to be a part of the care planning, where discussions are able to happen. So the community will advise our staff on what the protocols are required with the death of that person, and depending on their seniority in the different clan group they come from will depend on what happens. So a couple of weeks ago I was out at Docker River and we were discussing this situation
40 and what might happen, and for the purpose of learning and the Commission, I'm happy to share it, but it is a little bit awkward because it's talking about Aboriginal people's cultural business, but when a more senior person has passed away before, the body will need to stay in the facility until a more senior person decides that it's time to do a cleansing of the area.

45

We have been a part of supporting what would be called sorry camps, where members of the community actually leave Docker River, go to another proximity,

and spend time mourning the loss of that person. And in that circumstance, we would need to transport other elders in the facility that might be required out to the sorry camp, ensure their safety, ensure there's food, and then at some time when the community determines it's the right time, it means it's time to do the next part of the ceremony which may be a more formal funeral or another cleansing.

MR BOLSTER: Yes.

MS BRIDGES: So it's different depending on - - -

MR BOLSTER: Am I right in thinking you have a separate residence for this situation when it's going to happen?

MS BRIDGES: In Mutitjulu?

MR BOLSTER: Yes. In Mutitjulu.

MS BRIDGES: We have a palliative care suite. So Mutitjulu was a more recently constructed facility. Docker River is quite old, infrastructure-wise, and in the planning of Mutitjulu, we were able to construct a separate module that allowed external access for the community because large groups of families would like to be there with their elder as they pass away. Generally speaking, it's likely that there would be singing and dance through all hours of the night, depending on the wishes of that person while they passed. So it's really important to have it separate from the residential aged care facility so that can take place.

MR BOLSTER: Just correct me if I'm wrong, but is this about getting trust of the community, all of these processes?

MS BRIDGES: Yes, it starts before the whole palliative care, you know, takes place, it's in listening to the community when we design services and service models and that's a request of the community and that's what establishes trust, a listening.

MR BOLSTER: And in terms of the experience inside the facility, the staff experience; how long have your more experienced staff been involved with places like Docker River and Mutitjulu?

MS BRIDGES: Yes. So we have a service manager out there that has been out there for at least six years. Another senior enrolled nurse has been out there for four years. So we do have people that build really strong respect and relationships in the community and work very closely with the community and stay out there.

MR BOLSTER: Yes. All right. Other staff, how easy is it to retain the staff that you can attract to work for you?

MS BRIDGES: It's one of our biggest challenges, retaining staff in these locations. The environment is harsh, you know, temperatures of, you know, 47 degrees or this

time of year when I was out there it was one degree, so from freezing to boiling hot. It's a challenging, harsh and dry environment outside of delivering care. The town of Docker River doesn't have a lot of social interaction for our staff. They would drive three hours, when they have access to a vehicle, to Yulara to perhaps have a meal out or something like that if that was their preference, but in Docker River our staff live in close proximity to the aged care facility. All their meals are provided to them from the aged care facility, so it's a tightknit little community.

MR BOLSTER: What about the wet season; how does things change in the wet season?

MS BRIDGES: Yes. The wet season is interesting and a couple of years ago the staff tell me there was a really big wet season which resulted in Docker River being cut off for up to six weeks. So supplies would have to be flown in. Usually Docker River is serviced by a truck that drives in weekly and delivers food supplies, but in this case I think it was two months before a truck could, you know, access Docker River so supplies were flown in. Also we would, you know, see an increase in residents requiring support and services during the wet season. It's quite a transient community and if there's people out on the home lands, they would come into Docker River and potentially come into our services for more support because food is limited and transport is really difficult.

MR BOLSTER: Yes. In terms of delivering home care in Docker River, how many home care people do you look after?

MS BRIDGES: We deliver home care services to around 20 old people in Docker River.

MR BOLSTER: What's the typical need for those people?

MS BRIDGES: Generally, it's meals. So we would attend, provide meals, provide assistance with medication. We also provide personal care, and the way it seems to work in Docker River, at the request of the community, is that the older people would like to come to the facility, have assistance at the facility for showering, we – we take their linen, we wash their clothes, take them back home, provide a lunchtime meal, provide – and enrolled nurses usually coordinating the home care support that's given. So we do things like routine observations and monitoring of ADLs and then in some cases we also provide an evening meal, just depending on the request of the elder.

MR BOLSTER: All right. Now, a while ago we were talking about the Torres Strait, you were talking about the approach of the Torres Strait Islander people to their elders and the way they viewed caring for them. Could you please expand on that; what is the special attitude that they have? Is it unique to the Torres Strait Islands or do you see it elsewhere?

MS BRIDGES: No, I've seen it elsewhere. It's just extremely strong in the Torres Strait. So one thing that I hear often up there is from our staff and our community members is what a privilege it is to care for their elders because they're the national treasure of this country, and I just wish more Australians would see older people as
5 the national treasures of our country.

MR BOLSTER: All right. Mr Barke, I want to ask you about NATSIFlex and NATSIFlex funding. How well does NATSIFlex service the sorts of operations that we've been talking about today?
10

MR BARKE: We run three NATSIFlex facilities as we've identified and we are in discussions with the federal Department of Health to construct a fourth facility and, look, my assessment is that the NATSIFlex program provides an adequate standard of care, but I think it is a qualified support. There are issues with the NATSIFlex
15 model, at least in my view, that make, you know, it not necessarily ideal and somewhat difficult to navigate.

MR BOLSTER: Well, could you expand on what they are?

MR BARKE: So firstly the NATSIFlex programs that we're contracted to the Federal Government to supply are two and a half year agreements. So they roll every two and a half years and are subject to renegotiation. So they're short term in nature. The second component of this is that there's an extensive reporting process required against them, a quarterly reporting process and then there's an annual
25 acquittal process which happens at the end of every year. The acquittal process essentially weighs up the funding received for running of that particular site against the costs incurred and if you underspend the grant you essentially refund the moneys to the department.

30 What that essentially leads to is a very complicated financial arrangement, but essentially you're largely prevented from generating any form of surplus to reinvest in capital investment for a particular site.

MR BOLSTER: Pausing there, Docker River is an old facility - - -
35

MR BARKE: It is.

MR BOLSTER: - - - we've heard.

40 MR BARKE: It is.

MR BOLSTER: Could it do with capital improvement?

MR BARKE: It certainly could.
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MR BOLSTER: But if you have a remittal after acquittal at the end of a year, you can't use those funds for that improvement; is that right?

MR BARKE: That's correct. So what is in place to support providers like ours in that scenario is – is a grant application process. And there are a range of federal grant processes which have been referred to. There's the aged care regional, rural and remote infrastructure fund. The NATSIFlex program have its own or has its own
5 grant, capital grant application scheme. And then there's also one-off grants which we've been able to access, for example, in the case of the construction at Mutitjulu. But the point I'm making is that you are essentially reliant on securing those grants in order to be viable and, you know, in our case we have had reasonable success in
10 applied for, and we still have a number of old sites and those sites are subject to our capital planning and we're reliant, essentially, on securing grants to continue to operate sustainably.

MR BOLSTER: Another provider in the west will give evidence later this week to the effect that the facilities that they operate in Perth effectively are used to subsidise capital losses of their other facilities in the more remote areas. Is that an experience that is common to your organisation?

MR BARKE: If you deconstruct the ARRCs financial, so if you do that, for
20 example, for the '17/18 year and you remove the capital grants that we receive, the ARRCs organisation ran at a loss last year and it ran at a loss of just over two per cent of its turnover. So there is cross-subsidy within each of those sites but fundamentally we are at the edge of viability on these sites and our experience is that as you get more remote, the costs to provide services increase. So, for example, a
25 common indicator of the cost of operation of an aged care facility is the operating cost per resident per day. Now, in Brisbane – and we operate many aged care facilities in Brisbane – that number is about \$200 per resident per day. In Darwin it's about 220, in Docker River that number is about \$380. So the costs escalate as the remoteness increases and that's what you would expect. And so our experience is
30 that fundamentally remote aged care is very, very difficult to be viable and you have to constantly be fine-tuning the operation of those sites and trying to squeeze every last dollar to make these sites work.

MR BOLSTER: \$230 a day in Docker River.
35

MR BARKE: Three, no Docker River is \$380.

MR BOLSTER: \$380?

MR BARKE: Correct.
40

MR BOLSTER: I do apologise. How much of that – what does NATSIFlex work out as per day?

MR BARKE: So when you talk about NATSIFlex, you're talking about a combination of funding streams because there is a residential component to NATSIFlex and then there is also a home care component. So the – the combination
45

of those funding streams essentially go close to breaking that site even. That site clearly receives a very high viability supplement as does all of our sites, but as one gets more and more remote, the viability supplement increases. So our experience is that in order to be viable, you need to effectively trim your costs to meet the revenue budget that is provided to you. So in order to make Docker River viable, we are, you know, we are doing maintenance, you know, at, you know, at the latest stage possible and we are doing that as economically as we can, but it's very complicated to achieve that, of course, because - - -

10 MR BOLSTER: If you need an electrician?

MR BARKE: If you need an electrician, you would need to source them, possibly out of Yulara, which is three to four hours' drive. I'm not aware whether any tradespeople exist locally, but the vast majority of trades are supplied either out of Alice Springs or out of Yulara.

MR BOLSTER: Does food cost obviously more?

MR BARKE: Correct.

MR BOLSTER: How do you calculate the extra cost for food to Docker River?

MR BARKE: Again, we measure the cost of food. For example, the cost of providing sustenance in Darwin is roughly about two-thirds of the price of doing it in Docker River, so it's - we measure it on a dollar per resident per day ratio.

MR BOLSTER: The cost of staff?

MR BARKE: I think Tamra would be better to speak to the staffing model than me, but the complexity of staff, of course, is that these people are coming to us from right across Australia. Many of them are based around the coastal parts of Australia and fly in, or fly in and then drive into Docker River, as Tamra has identified. And we operate, you know, essentially a longer shift per day in order to effectively recognise that there needs to be some loading paid. So that's how we - - -

MR BOLSTER: What proportion - for example, of the \$380 a day, what proportion of that would be attributable to a staff cost?

MR BARKE: I would think it's in the order of 50 to 60 per cent of the - - -

MR BOLSTER: And the costs?

MR BARKE: Yes.

MR BOLSTER: Does that include the staff travel costs?

MR BARKE: Staff travel costs are included in the overall costs of running the site, that's correct.

5 MR BOLSTER: Yes. How does the pay packet of a nurse or a carer who's flown in from Sydney or Brisbane or Melbourne compare to your competitors in the market?

10 MR BARKE: In Docker River we have no competitors, I guess, in the sense that this is the only site for many hundreds of kilometres, but the reality is, and I think this has been identified through the Royal Commission's processes, is that salaries and wages in aged care are low, by comparison to other clinical professions, including the public hospital system, which is a major competitor for the staff that we would employ. So we face challenges because of that, of course, and whilst we would love to be able to pay our staff more, the funding model is simply not sustainable above the current level.

15 MR BOLSTER: All right. Was there anything that either of you wished to add to your statements, or that you think that the Commission needs to be aware of that you would like to raise at this stage?

20 MR BARKE: No. Look, I think that we would agree that the services we run, we're quite privileged to have the opportunity to run. These are in some ways iconic parts of Australia's history really. They're very, very challenging and we are there because we're motivated to provide care for these people, not because there's a financial incentive to do that, and I note your comments, counsel, earlier in the day which essentially was that most or, in fact, all of the providers in these locations are not-for-profits and, you know, I think that demonstrates that you need to have a motivation other than a financial motivation to – to operate in these very remote communities.

30 MR BOLSTER: All right. What about you, Ms Bridges, what would you like to say to the Commission?

35 MS BRIDGES: Comments earlier around attracting people to the workforce is something particularly pertinent in these areas and the message that I would like to get out there is around the amazing experience and challenge that people have in working in these locations. The calibre of the staff that we get out there, we have very committed people that are out there, but it is few and far between, that people want to come to these locations. So if people could, I guess, experience and see the benefits in working in places like Docker River, in Mutitjulu, as far as their experience of the sophisticated culture, working with Aboriginal and Torres Strait Islander people, the multi skills that you develop in working in very remote locations, and I guess it's – it is clinically challenging which makes it attractive to nurses to go to these locations, although we don't seem to get that message out there when we talk about aged care. It's not – you know, the general kind of stigma.

45

MR BOLSTER: I wanted to ask you a couple more questions about food, and I think in Thursday Island, there's an issue about getting the fresh fish that the residents like onto their plate. Could you explain what the problem there is?

5 MS BRIDGES: Yes. So there's a lot of regulation around food safety and then also regulations in the aged care environment which prevent us from catching and preparing local fish in our kitchens. It doesn't follow the basic food safety standards and there's, I think, three different levels of regulatory compliance around that local council, and then State, and then also the aged care regulatory compliance. So we
10 have to do work-arounds to ensure that fish is an affordable and regular item on our menu. We have to buy imported frozen fish, you know, and have it delivered to Thursday Island, or we do work-arounds with family and we're relying on the goodwill of family when we do that which is not really fair on them because it's at a cost that they're going hunting and providing these – providing fish, so they need to
15 prepare it at home or in their kitchens and then bring it into the service to share with elders.

MR BOLSTER: Have you had discussions with the local council about this? I presume it's a local government regulation.

20

MS BRIDGES: We've had discussions at lots of levels around this, so local council do our food safety inspections. We've also sort of raised it on the national advisory groups that I'm a part of for Aboriginal and Torres Strait Islander aged care so there's definitely more work to be done in that space to enable that to happen.

25

MR BOLSTER: In Docker River, how do you – what's the food that the people like there?

MS BRIDGES: A very popular item is kangaroo tails.

30

MR BOLSTER: Do you supply that?

MS BRIDGES: We do. You can buy kangaroo tails in the shop and local people that have the ability to go hunting can also bring them in for their residents and the same kind of regulations would apply if it was brought in but if it's purchased from the shop it can be cooked in the facility and is cooked on a fire.

35

MR BOLSTER: Commissioners, they were my questions.

40 COMMISSIONER TRACEY: Would a creative way of getting round the fish problem at the Torres Strait Islands be to get some relatives to bring in some food already prepared?

MS BRIDGES: Yes, that's what we do.

45

COMMISSIONER TRACEY: Yes. Two other matters arising out of your evidence in relation to the Torres Strait. How far away do your carers have to go to get their basic qualifications? Do they have to go into Cairns or - - -

5 MS BRIDGES: No, there are training organisations on Thursday Island such as TAFE that deliver the training for personal care workers.

COMMISSIONER TRACEY: Yes. We've heard a lot of evidence about the potential need to register carers nationally because people move around and they
10 may be found unsuitable, for whatever reason, in one State, and just move on to the next State and nobody knows that they've been found to be unsuitable. If such a regime were to be put in place, would that create problems for you in recruiting carer staff?

15 MS BRIDGES: As long as there was a way that we could assist our care staff to register. The difficulties we have with paperwork is more around identification. But if there was a way to work around that, having a register I think is a positive thing.

COMMISSIONER TRACEY: Well, look, thank you both. We have not had any
20 detailed evidence about the problems that necessarily arise in conducting care facilities in very remote areas, and it's been very helpful to us today to hear your evidence, and to get some insight into just what those problems are and how they might be overcome. But the country, I think, is very much in the debt of your organisation for providing facilities that realistically would not be provided if you
25 weren't providing them in many areas, and thank you very much.

MR BARKE: Thank you.

MS BRIDGES: Thank you.
30

<THE WITNESSES WITHDREW [12.59 pm]

35 COMMISSIONER TRACEY: Mr Bolster, I notice we're well ahead of schedule. 2 o'clock.

MR BOLSTER: 2 o'clock. Thank you, Commissioners.

40 COMMISSIONER TRACEY: Please adjourn.

ADJOURNED [12.59 pm]

45 **RESUMED [2.04 pm]**

COMMISSIONER TRACEY: Yes.

MS BERGIN: May it please the Commission, I call Professor Leon Flicker.
Professor Flicker will take an affirmation.

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COMMISSIONER TRACEY: Thank you, Ms Bergin.

<LEON FLICKER, AFFIRMED

[2.04 pm]

10

<EXAMINATION BY MS BERGIN

15 MS BERGIN: Please have a seat or stand as you prefer, Professor Flicker.

PROF FLICKER: Thanks, counsel.

20 MS BERGIN: There should be a hard copy of your statement there on the table in
front of you. Is that your - - -

PROF FLICKER: That is.

25 MS BERGIN: And do you wish to make any amendments to your statement?

PROF FLICKER: No, I don't.

30 MS BERGIN: Are its contents true and correct to the best of your knowledge and
belief?

PROF FLICKER: They are.

MS BERGIN: I tender the statement of Professor Flicker.

35 COMMISSIONER TRACEY: Yes. The witness statement of Professor Leon
Flicker, dated 27 May 2019, will be exhibit 4-6.

40 **EXHIBIT #4-6 WITNESS STATEMENT OF PROFESSOR LEON FLICKER
DATED 27/05/2019**

MS BERGIN: Thank you, Commissioner.

45 Professor Flicker, I just want to start with your expertise, and it is extensive. Could
you describe your recent relevant roles.

PROF FLICKER: I'm the Professor of Geriatric Medicine at the University of Western Australia, and have been in position since 1998. I'm also the director of the West Australian centre for Health and Ageing since 2005. I am a consultant geriatrician at Royal Perth Hospital since 1998.

5

MS BERGIN: And you've written extensively, and I won't read out each of the articles, but each of the articles referred to in your witness statement has been included in the general tender bundle, if you wish to refer to them during the course of this afternoon.

10

PROF FLICKER: Thank you.

MS BERGIN: The statistics show that Aboriginal and Torres Strait Islander people are underrepresented in residential care, and you note in your statement that the target group of Aboriginal and Torres Strait Islander people are approximately three per cent of the population but occupy only one per cent of residential care beds. Why are Aboriginal and Torres Strait Islander people underrepresented in residential aged care?

PROF FLICKER: There's probably several reasons. One reason is the fact that Aboriginal and Torres Strait Islander peoples are more likely to develop age-related syndromes at a younger age and therefore don't find residential care that suitable. The other thing is that Aboriginal and Torres Strait Islander people are much more likely to live in regional and remote areas, and therefore access to appropriate residential care is less. And thirdly – and I don't list these in any order of priority, but thirdly, Aboriginal and Torres Strait Islander people often do not believe that residential care is culturally safe for them, and therefore they shun it and do not use the service as much as they could.

MS BERGIN: Would you say that Aboriginal and Torres Strait Islander people have a preference for community care?

PROF FLICKER: Virtually every Australian prefers community care to residential aged care. Aboriginal and Torres Strait Islander people have that preference more than non-Aboriginal and Torres Strait Islander people. And that's for a number of reasons, which partly is why you're less likely to go residential care, but culturally safe and appropriate services is one of the major reasons why they don't. They prefer community care as opposed to residential care.

MS BERGIN: I might just pause you there, Professor Flicker, and ask if there's a problem with the audio. Are we dropping in and out? I'm not sure if that's because – it's all good. Okay. Thank you.

So you mentioned that Aboriginal and Torres Strait Islander people may consider that residential care is not culturally sensitive, or not culturally appropriate to their needs. Could you tell us a bit more about that and a bit more about the delivery of residential care to Aboriginal and Torres Strait Islander people.

45

PROF FLICKER: So, firstly, it has to be there nearby, so people who live in rural and remote conditions may not have a nearby service. So if somebody doesn't have a nearby service it means that they're going to move from their family and friends, which happens for non-Aboriginal people as well. But the other thing that
5 complicates the matter for Aboriginal and Torres Strait Islander people is that they are moving from country. So a lot of Aboriginal and Torres Strait Islander people have an innate attachment to the land that they're living in, and this is more than you would expect in a non-Aboriginal and Torres Strait Islander situation. So because of that, moving off country is a big deal for them, and so they view that.

10 MS BERGIN: Professor Flicker, I just ask you to move. We're going to move your mike back a bit.

PROF FLICKER: Is this better that way?

15 MS BERGIN: Yes.

PROF FLICKER: Better?

20 MS BERGIN: Thank you. So you're talking about the delivery of culturally appropriate care to Aboriginal and Torres Strait Islander people.

PROF FLICKER: That's right. So the next point – so firstly it may not be available and they have to move a long way. The other thing is that the care has to be
25 culturally safe and this means that the staff have to be trained in how to manage and how to assess and treat older Aboriginal people and this is something that does not necessarily come intuitively. So there is a need for cultural safety training. Now, the staff in many residential care services and community services come from a wide range of backgrounds, often not Australian-born, and they make have very little
30 understanding of the history and perspective of the – of the Aboriginal and Torres Strait Islander people in Australia. So they have very little understanding of what they're dealing with, and then they don't necessarily have a respect for some of the practices that are innate to that group of people.

35 And even – and even for Australian-born people there's often little understanding of – of the recent history and perspectives of Aboriginal people. So for those reasons, cultural safety may not be apparent in the residential care place and that will mean that there will be tension between both the Aboriginal people and Torres Strait Islander people in that residential care facility and also the family members who
40 come to visit.

MS BERGIN: Thank you, Professor Flicker. So turning to another point of difference, why is – for aged care planning purposes, why is 50 the relevant age for
45 Aboriginal and Torres Strait Islander people and for others it's 70 or 75?

PROF FLICKER: This has got a long history. So the 70 figure was always plucked from the air for non-Aboriginal people. So let me state that at the beginning, that the

70 figure was just – was just notional, even at the beginning. So we know that the – for non-Aboriginal and Torres Strait Islander people, the average age of people in residential care is people in the mid-80s, so most of the needs are in the 75 plus age group. By far the majority of people in residential care fall into that age group, but we use a 70 plus division and it was because it was a simple measure trying to determine the needs of a population. And it has been used for planning purposes to derive some sort of population estimates, for individual areas around Australia so that we could then derive some idea of how many places, both community care and residential care, could be allocated to those areas.

We know that the disability rates for Aboriginal and Torres Strait Islander people are much greater and they occur at an earlier age, and a notional age of 50 was used in the planning, again with virtually no access to the data. It was again plucked from the air. Whether that's equivalent to the population over the age of 70, non-Aboriginal, the needs basis for those two groups is really unknown. As far as I'm aware, nobody has ever done that study. Nobody has ever actually worked out whether there are better population estimates for non-Aboriginal people, let alone for Aboriginal people. My guess is it's not too bad. I think it's probably pretty comparable, but it's a guess. And as has been tabled now by the Commission, the figures over – from 2011 would suggest that the disability rates for people over the age of 50 would mirror the disability rates over the age of 70 for non-Aboriginal people. But there would be a need to be a lot more work on that.

MS BERGIN: I want to come to that point about the choice of care mode a little bit later. But on the topic of ageing and Aboriginal and Torres Strait Islander people, what is the normal onset of ageing, in your view?

PROF FLICKER: We have evidence that the onset of the ageing related syndromes occur at a much younger age than in non-Aboriginal people. At least 10 years earlier and possibly longer. So we – we would hesitate to use words that they age – that Aboriginal and Torres Strait Islander people age earlier, but what happens is they exhibit disability rates and syndromes associated with ageing up to 20 years earlier than non-Aboriginal and Torres Strait Islander people. So we're seeing rates in the 50 plus age group that normally we would see in the 70s and beyond in non-Aboriginal people.

MS BERGIN: Thank you, Professor, and I should acknowledge that using words like "normal" is a bit fraught but we're talking in terms of general propositions and I appreciate you responding to that. Is there any evidence that the gap is closing between the ageing Aboriginal population and the ageing general population in terms of the data?

PROF FLICKER: Probably the answer is no. The – there's – tabled by Commission is the 2016 report but that notices that there are more people now who have identified themselves as Aboriginal and Torres Strait Islander people which is probably appropriate but it means that there are some of those people who are less likely to be disabled. If you allow for the changes in the denominated people in the

total group, probably there is no evidence that disability is changing. One of the things that we really don't know in non-Aboriginal Torres Strait Islander people is whether disability rates are changing dramatically either. There's some evidence that Australians are living a little bit healthier and a little bit less disabled with time, but that evidence is, again, slightly biased because when we have done the serial – we, as a country has done those serial measurements we've changed the question slightly which may change some of the answers.

10 MS BERGIN: When you talk about changing the question slightly, is that with reference to the census data?

PROF FLICKER: And the disability and handicap data and other data sources that are used to construct those data.

15 MS BERGIN: Thank you, Professor. Operator, could you bring up tab 70 in the general tender bundle, and I would like to go to figure 5 which is at native page 7.

20 COMMISSIONER TRACEY: While that's being done, Professor, is there a distinction between rural-based Aboriginal people and city-based Aboriginal people, taking into account those statistics you were looking at earlier?

25 PROF FLICKER: Firstly, the overall statistics would suggest that rural-based are a little bit worse – rural and remote in general, in the community, and that's for both Aboriginal and non-Aboriginal people. Living in a rural situation, it's not a good thing in Australia, for a number of reasons. When we've looked at the overall – when we've looked in-depth in both our study and a study done in New South Wales in Sydney and in rural New South Wales there seems to be relatively little difference in the rates of dementia and ageing syndromes. So that work is being led by Kylie Bradford at the University of New South Wales, and she and her group have found pretty similar results to the data that we found in – in remote Aboriginal people in the Kimberley.

30 COMMISSIONER TRACEY: One would assume that city-based Aboriginal people would have greater access to medical facilities than their country equivalents, but that doesn't seem to make any great difference?

35 PROF FLICKER: There's quite a literature about this, that merely having availability doesn't mean that people access the services. So Aboriginal people in urban centres often access services poorly for a number of reasons and it – it may not be much better in urban centres than it is in rural and remote areas. And locality and culturally safe services can vary from place to place, so once again, it's, you know, can be quite good in some areas and in the nearby area it can be, you know, terrible.

45 COMMISSIONER TRACEY: Yes, Ms Bergin.

MS BERGIN: The figure on the screen is taken from paper 14 population projections prepared by the Centre for Aboriginal Economic Policy Research at the

ANU and is part of a paper produced by Dr Nicholas Biddle. Now, this figure has been referred – we’ve been referred to this figure and even there has been a more recent census, there’s not a comparable figure in the more recent analysis done by the ANU. I just wanted to present that to you and ask you if you would agree – and it sounds from what you’ve said as though you would – that as a general proposition, age-specific disability rates are higher among Aboriginal and Torres Strait Islander people than non-Aboriginal and Torres Strait Islander people at all ages. Is that a fair comment?

10 PROF FLICKER: That is a – that is a fair comment.

MS BERGIN: Referring to that report, it seems clear that there are large numbers of Aboriginal and Torres Strait Islander people over the age of 50 in need of support as a general proposition.

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PROF FLICKER: That’s also true, yes.

MS BERGIN: And my question is whether that support would be better delivered through the aged care system or through the NDIS or through another avenue of support. What’s your view about that?

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PROF FLICKER: The most important criteria that you need is that you need access to culturally appropriate services. Whether that’s provided by the NDIS, National Disability Insurance Scheme, or whether it’s provided by aged care services is relatively a secondary consideration. One of the things that we – we know is that ageing syndromes are more apparent in younger Aboriginal people but mostly those syndromes still occur in the 60s, 70s and 80. So if you looked at Aboriginal people in residential care they’re mostly in that age group, rather than in under 65. But there’s no doubt there’s huge unmet needs, disability in people over the age of 50 in Aboriginal and Torres Strait Islander people.

25

30

Until – we also know that until the NDIS appeared that it was very difficult for adults from anybody to access the disability schemes after the age of 50. It was just very unusual but it was hard to penetrate that system for adults, whether they were Aboriginal or non-Aboriginal. So the ability for Aboriginal people to access the NDIS is a good one. To make sure that those services are culturally appropriate would be fantastic and the flexibility of those services for people who may have disabling conditions that are relatively poorly associated with ageing. For example, if somebody has acquired brain injury due to a head trauma, it would be most appropriate for them to access the NDIS and those services would be tailored for them. But it depends whether what service is available, and the appropriateness of that service.

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MS BERGIN: So when you talk about the appropriateness of that service, is that a reference to cultural safety?

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PROF FLICKER: It's a reference to cultural safety and availability. So in rural and remote, often do not have specialised services for individuals anyway, whether Aboriginal or non-Aboriginal. But the cultural safety is of paramount importance. Aboriginal and Torres Strait Islander people will not access culturally unsafe services. They just won't take them on.

MS BERGIN: So in a remote area there may be only one service, and is it your view that some care is better than no care; how far should that be pushed?

10 PROF FLICKER: So one of the things that we – I've tried to indicate in my evidence is the Lungurra Ngoora model of care. Can I just explain to the Commission a bit about that?

MS BERGIN: Yes.

15 PROF FLICKER: So after we completed our initial studies of people with dementia in remote areas in the Kimberley, we tried to work out how services could be remodelled to provide care, because at the time there were very little services provided to remote communities, and the reason is because of the economies of scale. So that the then HACC services, home care packages, wouldn't have enough services to operate in a community. We were fortunate that we had – were able to form a partnership with the Looma community to trial a new model, and that was the Lungurra Ngoora model of care. And what we did – and we were also fortunate that we were able to convince the relative partners from the service providers to participate in the model.

25 So we were able to get the then HACC services, the home care package people, the mental health people and the disability services people to pool their funds to provide a single point of care for that community. So – and at the time, and Looma is a community of around 350 people, and at the time that we started this, there were eight people who were in the community receiving predominantly meal services and that was it. There was no personal care offered at that time because it was unable to be provided. Within – within a few months, 28 people were identified and some of them had severe and profound disability. They had not identified themselves as requiring assistance because there was no assistance that was available.

30 And that was the first lesson for me, that if the service isn't there, people will not identify themselves as disabled or needing assistance. And then over the next 12 months, we went from just a few under, around 100 services per month to 1800 services a month. So it was a dramatic difference trying to provide personal care services. The important thing was to have an independent broker for the various services because otherwise the divisions between each of those services, the mental health versus disability versus aged care can become overwhelming. So an independent broker and strong community support and community ownership was really important. The reason why we chose Looma at the time was that the council wanted it; the council were very upset at older people going off country and going to Derby for residential care. So the council was a great supporter for the new model.

MS BERGIN: Which council was that, Professor?

PROF FLICKER: The Looma Community Council.

5 MS BERGIN: Was it the Looma Community Council?

PROF FLICKER: Yes, Aboriginal council.

10 MS BERGIN: It was an Aboriginal council.

PROF FLICKER: Yes.

15 MR BOLSTER: And to what extent did you do relationship building in commencing that pilot project with the local people.

PROF FLICKER: We – we had – we'd been very fortunate. Looma was one of the communities that we had been involved in, in identifying the Kimberley Indigenous Cognitive Assessment tool, so that was one of the communities we had worked with there. We had been involved with them in their initial prevalence study. They were – they were – as a community, they were very interested in the problems of their
20 – older people and they wanted to help – to help keep their older people on land. So they were – throughout our studies, they had been involved in previously, they had been incredibly obliging and – and flexible with us. I mean - - -

25 MS BERGIN: So in demographic terms, why was Looma appropriate?

PROF FLICKER: In demographic terms, it's a medium-sized community. It's – it's probably, you know, a fairly average community in other terms. It's – it has all the problems of small communities in Aboriginal communities. It has the
30 remoteness, it has – but it also had – but I must say it had advantages. It was just – it was a community that really wanted to change, it wanted some action. So that was by far the biggest advantage it had.

35 MS BERGIN: So how did you – you quoted some statistics earlier about the rapid increase in the delivery of services during the time of your pilot project. How did you collect data and evaluate that data?

PROF FLICKER: Well, you heard this morning actually that the care coordinator from Bidyadanga was talking about her tick boxes, the tick sheets. So each time a
40 service is provided they have a tick to work out the number of services which is important for funding and other mechanisms and that's how we – that's one of the major things we looked at, was the tick services, the services provided to individuals.

45 MS BERGIN: What were the key outcomes of the project?

PROF FLICKER: The outcomes were, well, some – we both had anecdotal outcomes and also qualitative outcomes and we also had quantitative outcomes. The

quantitative outcomes were that we provided more services and that a service model which allowed pooling of resources and community ownership worked. And it seemed that we were able to provide more services to more people. We identified far more people, almost – more than three times the number of people that were at the beginning. Anecdotally, we had a number of people who were providing services, both mental health, aged care, disability, who talked about the fact that their clients had been dramatically altered by the service, that they were happier, more engaged, they were more mobile, that the service actually delivered something tangible to those people in a very real way.

And qualitatively, the services were well regarded by the community as a whole. So on a number of fronts we were able to show that the model worked.

MS BERGIN: So with reference to the increase, the significant increase in services, was trust of significance?

PROF FLICKER: Trust and ownership and respect. I mean, part of the issue was that the – the community had been listened to and there was a sense that this was a service that they wanted, and you can hear it already in some of the people today. There's very little interest in community members on where the money is coming from to provide the service. They just want the service provided and the trouble is there are arcane and numerous pathways for the sources of funds and these mechanisms are of no interest in people receiving the funds and the resources. They really just want a service which is available to everybody in Australia, mostly, but they just want that service as well.

MS BERGIN: Professor, you wrote an article about this pilot model called 'Lungurra Ngoora, a Pilot Model of Care for Aged and Disabled in a Remote Community. Can it work?' I've included that in the tender bundle and I would just like to quote sort of a practical example of the effectiveness of the program which was described by an allied health professional who visited the Looma community monthly:

One particular client had a severe condition that limited his ability to walk or manage his personal hygiene. He had not walked for many months and was unable to access his toilet or shower. And his mental state was very low. However, the project has enabled him to receive regular personal care services, improving his personal hygiene, that enabled him to partake in valued activities such as fishing.

Are there other examples you would like to share with the Commission to illustrate the effectiveness of the program?

PROF FLICKER: I probably just would refer the Commission to the documents and the fact that there are a number of anecdotal reports that we had from the time. It was actually a major problem when the service discontinued and we were – the service was reduced in somewhat in scope, still present but not to the same degree as

it was, and one of the things that we noticed was it wasn't the same intensity of that service afterwards.

5 MS BERGIN: So the pilot had a steering committee, as you mentioned, consisting of representatives from the community council, government and NGOs. Could you talk a bit more about the importance of the influence of the steering committee on decisions and in the outcomes.

10 PROF FLICKER: It's really important that the community be part of the engagement of its service. The – we did this model of care in an Aboriginal community, but it's actually of relevance not just to Aboriginal communities. It's of relevance to small communities generally in Australia. Because what happens is that small communities generally don't have the infrastructure or the capacity to provide all the services for each of the alcohol services, disability, whatever. There's just not 15 the economy of scale that's required. So it's really important to gather both the community's wishes, aspirations, and also the service providers to come to some sort of agreement to what is the priority in that community, and how it's going to be funded. One of the problems we have is, for example, in both the NDIS and the home care packages, is that they are funded for individuals. But if there's no service 20 there, those individual packages can't be provided. So somehow there has to be a pooling of funds to allow for those services to be provided.

MS BERGIN: How many other communities want these sorts of changes?

25 PROF FLICKER: I think – I have no idea. We would have no idea. But there – if you just looked at rural Australia generally, the ability for people to stay in their own homes, even in quite reasonable sized towns, often requires the availability of personal care supports in their own home. And that's the sort of thing that can be best done by pooling resources, if there's no service available.

30 MS BERGIN: Professor Flicker, what were the challenges in this pilot project?

35 PROF FLICKER: There's always challenges when you're getting service providers who have different views about matters, trying them to work together to come up with common priorities. There's challenges with risk taking. Some – and we've heard before about in Aboriginal communities there's often some degree of risk associated with providing services and that's got to be balanced in some way. We very much struggled to get an NGO to take on this service, to auspice this service, when the university left – left it as the broker, because it's very hard for an NGO to 40 manage that risk in small communities as well. And that's – that's both financial risk, occupational health and there's lots of risks associated with remote communities.

45 MS BERGIN: There are lots of risks. Professor Flicker, we heard this morning about delivery of services on Thursday Island. And one of the risks mentioned by Ms Tamra Bridges, who works for ARRCs, was in relation to food preparation and,

in particular, ensuring that residents have access to culturally appropriate food. Did you hear that evidence?

5 PROF FLICKER: No, I didn't but I – I heard what it was about, the idea that preparing recently caught fish but not necessarily certified by any manufacturer became an issue. Again, this is the sort of – the risk taking that people have all the time, that Aboriginal people in remote communities often eat some traditional foods. It's not necessarily going to be – the goanna that they hunt isn't necessarily going to be certified as safe for human consumption but again, that's such a traditional part of
10 life of some of these small communities that it seems churlish by people interfering with it, frankly.

MS BERGIN: In terms of the long-term outcomes, was ongoing funding made
15 available for the Looma pilot project to continue?

PROF FLICKER: We were – well, the community was able to obtain resources to provide a sort of a slightly stepped down service, but it continued on in Looma, and personal care is now being offered. So it was – perhaps it wasn't the full services we had envisaged but it was certainly better than what had had – what was there before
20 we started, so it was an outcome worth going through.

MS BERGIN: Thank you, professor. I just want to take you back to the topic that we were on before we started talking about the Looma pilot project and ask you a bit more about the mode of care, and the mode of care that's most appropriate to be
25 delivered to people falling within the gap, if you like, between 50 and an older age in the Aboriginal and Torres Strait Islander population. So in Western Australia, for example, we've heard that the NDIS is still being rolled out. Does that affect the level of unmet need in Western Australia?

30 PROF FLICKER: The – the disability services has always been a difficult problem for people over the age of 50. So, previously, people over the age of 50 with a new adult acquired disability were relatively low priority for the disability services. And so they often fell through the gaps then, and aged care services would be provided if disability services weren't able to be offered. With the NDIS, that has allowed some
35 of those people to be picked up by the disability services, the NDIS, and is something that's worthwhile often for people. For Aboriginal people, again, it may be a very worthwhile service, depending on what the service availability is in that local area.

MS BERGIN: And then in terms of the causes of disability, you mentioned head
40 trauma and the example of someone with a disability in the Aboriginal and Torres Strait Islander community who then may most appropriately be assisted by the NDIS. How common is head trauma in this community?

PROF FLICKER: Head trauma is incredibly common in Aboriginal communities
45 generally. It's – I think in our studies, it was close on 50 per cent of Aboriginal people answered the question:

Have you ever been hit on the head so as to lose consciousness?

So that's – it's much, much more common than in non-Aboriginal and Torres Strait Islander communities.

5

MS BERGIN: Thank you, professor. Now, before I move away from that topic, was there anything else you wanted to add?

PROF FLICKER: No, I think - - -

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MS BERGIN: Nothing?

PROF FLICKER: Nothing.

15 MS BERGIN: All right. Well, let's turn to the topic of assessment and navigation into aged care. I want to ask you a bit more about dementia and the causes and diagnosis of cognitive decline in Aboriginal people. So what are the causes of cognitive decline in Aboriginal people as they age?

20 PROF FLICKER: We don't have a full picture. So one of the things that we should talk about generally is that in non-Aboriginal and Torres Strait Islander people, we assume that the commonest cause of dementia is what's called the dementia of Alzheimer's type or Alzheimer's disease dementia, which is a condition where there's an insidious onset, slowly progressive, associated with age, affecting people's
25 memory first. That's what – the sort of thing. If you look at Aboriginal and Torres Strait Islander communities, the commonest form of dementia is an Alzheimer's-type dementia that fulfils those criteria. And in non-Aboriginal communities, non-Aboriginal people, we would say that that syndrome is something we don't fully understand. We know that family history is important, we know that mid-life blood
30 pressure and obesity might increase the risk, diabetes might increase the risk, education decreases the risk.

On the whole, the risk factors are very similar in Aboriginal and Torres Strait Islander. Head injury would – because it's more commonplace, seems to be a bigger
35 risk factor but, again, we're finding things like high blood pressure, the presence of strokes, those sort of things that – diabetes. Those sort of things that we think increase the risk in non-Aboriginal and Torres Strait Islander people work the same in Aboriginal and Torres Strait Islander people. Poor education again increases the risk. So the sort of – it's the risk factors are remarkably similar, but one of the things
40 that happens in Aboriginal and Torres Strait Islander people is that their risks are much greater, the risk factors on the whole are much greater and the dementia is much earlier.

So looking at this, there's – my colleagues from the University of New South Wales
45 and, in particular, Professor Tony Broe, have described a life course approach to dementia, where Aboriginal and Torres Strait Islander seem to exhibit the fact that a life course approach where poor – relatively poor education, risk factors in

childhood, are manifest throughout life, with later risk factors culminating in dementia in late life. So it's a life course problem associated with risk factors.

5 MS BERGIN: Thank you, professor. So in terms of this life course approach, you mention that education decreases the risk of cognitive decline. To what extent are these causes influenced by socio-economic factors?

10 PROF FLICKER: The socio-economic factors and, in particular poverty, magnify these risk factors. So we know that all these risk factors are actually much more common in people who are poor, and that's around the world. The sort of rates that we found in people with dementia in the Kimberley are only found in communities like, for example, an Arab population in Israel, other communities that are relatively deprived and have life course factors associated, risk factors associated with cognitive impairment.

15 MS BERGIN: And turning to barriers, we've heard about the barriers for the general population entering aged care. Specifically, we've heard about problems with My Aged Care and we heard – you might have been present for some of the evidence this morning on that question. I want to ask you something important, 20 although all the questions are important, of course, what additional barriers do Aboriginal people in remote locations face accessing aged care?

25 PROF FLICKER: It's tortuous for a literate middle class Melburnian. It's impossible for a remote Aboriginal Kimberley person who may not be literate, may not own a computer, may not even own a landline or a mobile phone, that can wait 35 minutes. The idea that this is a system that is navigable by the average client is basically absurd. So they're – the people who use My Aged Care in remote – Aboriginal people have largely been assisted by family members, if available, or sometimes service providers. There – it's very, very difficult for people in remote 30 communities to navigate this system.

35 MS BERGIN: Just on that, and the problems of access, what assumptions are built into a system that may prevent an Aboriginal and Torres Strait Islander person from accessing aged care?

40 PROF FLICKER: Literacy – there's the literacy assumptions, there's computer literacy assumptions, there's assumptions about what's available in the surrounding environment for you. There's so many assumptions around. And – even getting proper assessments can be even difficult as well.

MS BERGIN: So then also in terms of access why is diagnosis of cognitive impairment more difficult, if you agree it is more difficult?

45 PROF FLICKER: Cognitive impairment has been more difficult traditionally and, in fact, that's one of the reasons why we developed the Kimberley Indigenous Cognitive Assessment. In the early 2000s, there was no tool, there was no simple instrument to detect whether somebody, an Aboriginal or Torres Strait Islander

person had cognitive impairment or not. So, for example, often say if a mini mental state examination was applied to somebody, they would score a low score, even if an interpreter had been used, so it was not just a problem of language. And when you actually talked to that person you realised that they didn't have cognitive impairment.

5

So the problem was that we had no simple way of measuring cognitive impairment and that's why, well, my colleagues, Dina LoGiudice and Kate Smith and I set about trying to develop the Kimberley Indigenous Cognitive Assessment Tool.

10 MS BERGIN: What is the KICA tool?

PROF FLICKER: It's a fairly simple tool which was just used to see if we could measure the memory and some of the other cognitive functioning of people who were in remote situations who didn't necessarily have any formal education. The –
15 in our initial group that we studied in the Kimberley, only 40 per cent of them had completed a year of schooling. So it's quite different from non-Aboriginal and Torres Strait Islander people and even different from people from culturally and linguistically diverse groups who usually have had some form of formal education in a place overseas. So we had to devise a tool that was fair to the – to the cognitive
20 abilities of people that didn't rely on those sort of cultural norms that we assumed.

MS BERGIN: So when you talk about cultural norms, can the KICA tool be translated into local Aboriginal languages and not lose its effectiveness?

25 PROF FLICKER: So that was one of the things that we did right at the beginning was that we translated it to Walmajarri and then back-translated it to make sure it was still the same instrument. We applied it in different languages. We were fortunate. We got a lot of assistance for no money at the beginning, where the linguistic groups in the Kimberley assisted us with trying to work out what the terms
30 meant and how we could apply them. So it was, as far as we could tell at the beginning and probably is, that it's a fair instrument to use through any of the language groups.

35 MS BERGIN: How tailored are the questions in the tool to an Aboriginal or Torres Strait Islander audience?

PROF FLICKER: They're reasonably tailored. They're respectful. We have used it – not we, with colleagues we've used it in the Northern Territory and also in Far North Queensland. My colleagues Eddie Strivens has used it up in Far North
40 Queensland and the Torres Strait. And there's been some minor modifications I required on some of the pictures for example. We've lost the pension week question, because that doesn't occur every two weeks now. We've had some minor alterations over the years but it's been reasonably appropriate for most of those communities.

45 MS BERGIN: You mentioned that Professor Strivens has been involved in validating the tool in Far North Queensland.

PROF FLICKER: Yes.

MS BERGIN: He was a witness in this Royal Commission in Adelaide Hearing 1. To what extent has it been validated elsewhere, either in Australia or overseas?

5

PROF FLICKER: It's been validated quite a lot. It's also been used by the New South Wales group in urban and rural New South Wales. It tends to be most applicable to northern Australia, so the Brisbane line maybe, anything north of Brisbane, I don't know. So – but certainly northern Australia and Aboriginal people, it seems to be the most applicable. But – and remote Aboriginal and Torres Strait Islander people. It's been adapted for use in Canada. So the First Nation people in Canada, it's been tried and seems to be going reasonably well. We are using it – well, we're not using it, but there's a group adapting it for American Indians.

15 They've looked – they've looked at it in New Zealand but they're probably going down a different route. They're not necessarily using the KICA but something that's sort of been inspired by the KICA with Maori. It's been used a bit. There's somebody in Brazil trying it out. We've had somebody in Iran trying it as well. So it's being used in lots of different places in the world.

20

MS BERGIN: Professor, you've already touched upon this a little bit already but I want – it's important so I want to ask you, when you talk about a culturally fair tool, what are you talking about for our purposes?

25 PROF FLICKER: We're talking about a tool that's culturally safe, that's been developed with the target group, Aboriginal people, it's been developed with them, not for them but with them. The questions have been tailored from the beginning to be relevant. They are not seen to be judgmental. Respectful and appropriate. I mean, that's probably the main things. And still has the qualities that we require to assess cognition. Which I might add, Aboriginal people require, they've – Aboriginal people – Aboriginal and Torres Strait Islander people have worked out that they need it as well.

30

MS BERGIN: So obviously there's trust then from the Aboriginal and Torres Strait Islander people in this tool. What are the consequences of not providing culturally safe testing and culturally safe care?

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PROF FLICKER: We – what happens is we don't know which people have cognitive impairment and not. And for non-Aboriginal people, when we don't know that, there's a lot of consequences for – because we expect people to behave in certain ways, and when they don't do so and we think that they're not cognitively impaired, non-Aboriginal people apply blame and repercussions to those people. For Aboriginal people there's a lot of things that people with cognitive impairment and dementia do in a situation which is not culturally appropriate and would – would produce stigma within the community. So they need to know as – they need to know very much so whether somebody has dementia and that's why they're behaving in a culturally inappropriate fashion.

45

MS BERGIN: Professor, it's a difficult topic but in your statement you say at paragraph 16:

Unfortunately, frank racism is commonplace.

5

Why – why is that?

PROF FLICKER: This is in, I think I referred to that in residential care and community care.

10

MS BERGIN: Yes.

PROF FLICKER: I think racism is reasonably common everywhere in, not just in those services but it is common enough. And when it does occur people become immediately distrustful of the entire service. It's something that's – produces such a negative reaction, particularly with the history of Aboriginal and Torres Strait Islander people, the history is so recent and often quite raw, that this sort of just provokes immediate reaction.

15

MS BERGIN: So what would the consequences be of entering residential care for someone from the Stolen Generation?

20

PROF FLICKER: That just puts another layer of distrust on. The Stolen Generation, the word that probably describes it most is the trauma of that early upbringing and uprooting. The – the distrust of institutions and services that that has resulted in may produce a particular problem for when people are going into residential care. So we – we knew that – that people who had experienced – during the Second World War, who had experienced institutional disasters, holocaust survivors, people who have been tortured or imprisoned falsely on political beliefs, those people are very difficult to manage in residential care once they have cognitive impairment because often the situation produces vivid reminders of previous trauma. So this will – this again, and at this stage we're at the beginning of this process, but again it's going to be very likely going to have the trouble where the trauma will be relived.

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MS BERGIN: Thank you, Professor. So then before I move off the topic of the KICA tool, you mentioned that it has been validated in Australia and offshore, what's the plan for the tool moving forward?

PROF FLICKER: Just continue to use – I think it's actually just a part of the normal systems now. It's used in the aged care assessment teams when appropriate. It's just another useful thing that we can have around us to make diagnoses of cognitive impairment. It's actually only a screen. One of the things that we've tried to emphasise most importantly is it defined a group of people who need further looking at to see whether they have a problem, how severe their problem, how it's impacting them and their family and that's the important part of any cognitive screen.

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45

COMMISSIONER BRIGGS: Professor, might I ask, for the benefit of we Commissioners, could you tell us some of the sorts of questions you might ask as part of the KICA tool so we can understand what the differences might be.

5 PROF FLICKER: I would have to table the tool, Commissioner. I think that's probably the easiest thing to do.

COMMISSIONER BRIGGS: Okay.

10 PROF FLICKER: Rather than get the words wrong, table the tool.

COMMISSIONER BRIGGS: Okay. Right. Thanks

15 MS BERGIN: We talked a bit about the many and varied reasons for a distrust of aged care services provided under the Commonwealth system. What are the consequences of mistrust generally?

20 PROF FLICKER: The mistrust produces aggression and anxiety from people, often behavioural disturbance for people with cognitive impairment who are struggling with the system anyway, and often aggression from family members who are – everywhere, family members are the person's advocate and if they see – if they're mistrustful, they think they need to advocate more.

25 MS BERGIN: Thank you, Professor. Now, we've talked a little bit about access. I want to ask you about your practice in provision of geriatric services. How accessible are geriatric services in remote Australia?

30 PROF FLICKER: So I know the Western Australian situation the best. So we – outside the large rural centres, there's no resident geriatrician. There are aged care assessment teams based in every region in Western Australia. They do visit; there's a very good team based here in Broome who we've had a lot to do with over the years, and so these services often consist of allied health professionals. They don't have an in-house geriatrician, so there's a visiting geriatrician to this service and there's often – and there's often telehealth augmenting that service. One of the things that we feel reasonably strongly is that there needs to be in-person visiting service and telehealth should be augmenting it, rather than replacing it, because there's quite a lot more that the visiting geriatrician does besides just assessments.

40 They do actually quite a lot in providing in-house training and education of allied health staff and nursing staff and generally of the people they see as well. So it's one of the models of visiting services, trying to augment the often reasonable allied health services in communities. The service here, for example, travels a lot. It has to go to a lot of quite small communities. It tries to cover them all. It has a big, you know, the Kimberley is the size of Victoria so it has a big area to go round with not
45 that many people.

MS BERGIN: Is telehealth part of your practice?

PROF FLICKER: It has been. We've evaluated telehealth. It is an effective model of care. We've evaluated it in the assessment of people with dementia not in Aboriginal people with dementia but we've validated it in non-Aboriginal people with dementia. It seems to work reasonably. The service is good if – it's best done if you have in the distant place staff who are pretty competent at doing cognitive assessments and also other bits and pieces of general assessments and then the telehealth is the most valuable in that situation, where it just provides the final medical augmentation of the service. It's less useful when there's not that remote capability in the service.

10

MS BERGIN: You talked just then about the delivery of services to the whole population. In cities like Melbourne and Sydney, staff can call the DBMAS service. Is there a substitute in remote areas?

15 PROF FLICKER: It's very difficult to substitute that here. So the mental health services are sometimes called, the geriatric services are sometimes called, sometimes the internal medicine service. It's very difficult to provide that support for people with challenging behaviours, both in residential care and community care. So there's less options available.

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MS BERGIN: Turning to NATSIFlex which is also known as NATSIFACP, to what extent – so NATSIFlex operates outside the Aged Care Act and providers are block funded based on an agreed allocation of aged care places and the type of places, whereas for ACFI there are two levels of residential care and home care, high and low. Do you have any view about the effectiveness of NATSIFlex, measured as against ACFI in the provision of services to Aboriginal and Torres Strait Islander people?

30 PROF FLICKER: It sounds like a great idea but I've got no direct experience, I'm afraid.

MS BERGIN: Thank you, professor. Now, turning to a couple of brief topics. Do you need to take a break or - - -

35 PROF FLICKER: I'm good if you are.

MS BERGIN: Okay. Very good. In relation to the palliative care situation, in more remote communities where culture is strong, we've heard about need for a special room. We heard this morning about the room provided by ARRCS where family members can stay when a resident is palliating and ceremonies can be conducted. Could you please explain how this works in your perspective, or in your experience?

45 PROF FLICKER: The – I'm by no means an expert in this, but for Aboriginal people approaching death there's a lot of cultural taboos associated with that and there are a lot of concerns, which are more so than non-Aboriginal people. So they're – there is certain taboos about mentioning death, about dying, about explaining that to Aboriginal people, which is important, and requires considerable

time and training. So the physical infrastructure is important because if you're providing a resource and somebody dies and the whole place has to be – have a smoking ceremony, that's obviously an issue for other people who might use that facility in the future. But there's also a lot of support and counselling for both the
5 people who are providing that palliative care service and also the community who are using it, so there's a lot of bridges to cover. It requires a lot of Aboriginal liaison officer involvement, people who can have a bridge between the two cultures involved, so that they can understand the concerns and communicate it in a sensitive way.

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MS BERGIN: You were present for the evidence of Faye Dean and Madeleine Jadai earlier today, I think - - -

PROF FLICKER: Yes.

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MS BERGIN: - - - if I'm not mistaken. How typical are their experiences as at the communities you've worked in?

20

PROF FLICKER: Pretty – well, they're actually pretty good, actually. I was very impressed with both of them. I mean, they're obviously doing a good job and obviously have worked out how to use some of the systems that have been offered to them for the maximum benefit of the community. I think they obviously worked out a lot of things, and in a smart way too. I mean, I don't know if I would have been smart enough to do it that way, so they've obviously worked hard.

25

MS BERGIN: Thank you, professor. Indeed they have. So if you had a wish list for a reform to be proposed by this Royal Commission, I gave you advance notice of this question so you could prepare your wish list.

30

PROF FLICKER: Yes.

MS BERGIN: Tell us what's on it.

35

PROF FLICKER: My five wishes. My first wish is for navigators, so these are funded key workers and advocates employed by Aboriginal controlled organisations, so these are people to help navigate My Aged Care and the National Disability Insurance Scheme. Because those are both almost impenetrable system for Aboriginal people, not only in rural and remote, but also urban centres. So somebody who's employed help navigate the system with people would be really
40 useful. The next – next thing would be maybe we should be looking at Aboriginal controlled organisations auspicing age and community care services, age and community aged care services. It's relative – it's happening in Brisbane, but I think that's about the only place that I know at this moment, and maybe that's a model that needs further expansion.

45

I would hope that maybe after this period of time we could look at maybe using the Lungurra Ngoora model of pooling resources from different services together in rural

and remote Australia. Because I think that that has widespread applicability not just to Aboriginal communities but to rural communities of small numbers, who don't really have enough people to provide service to their community using the traditional pillars that we have at this moment. I've got two more which are more sort of – are
5 sort of less tangible. I think we probably should be looking at a cultural strengths framework that maybe we've been looking at what actually is the outcomes that we're really wanting in the services, and maybe we're looking at an Aboriginal quality of life.

10 My colleague, Kate Smith, is just about finished developing a quality of life tool for Aboriginal people called the Good Spirit, Good Life tool, which is a lot more based around the spiritual aspects, the attachment to country and culture, which I think may have a place in trying to evaluate services. And lastly, my last wish, my fifth wish, is supporting the traditional roles of the elders, which is part of the Uluru Statement.

15 MS BERGIN: Thank you, Professor Flicker. Commissioners, that concludes my examination.

20 COMMISSIONER TRACEY: Thank you. Professor, I want to take you off on a different tangent if I may. And it relates to the education of undergraduates and trainee specialists in geriatrics. To what extent does the undergraduate medical training, sort of within your own university and, if you are familiar with it, in other Australian medical schools, equip budding doctors to be alert to the sort of cultural problems that they will face in treating Aboriginal patients and, in particular, dealing
25 with matters of dementia?

PROF FLICKER: Yes, I – look, I can speak most from my own university. We have an Aboriginal component, an Aboriginal awareness component within our university which is one of the streams. It's an important part. Probably is not a huge
30 part of the course but it's an important part. We're actually a graduate program but it's still part of the stream of the graduate program. The – my impression is generally, of universities around Australia, that this has become more a part of the traditional mainstream medical courses that we are – that Newcastle, for example, started with an Aboriginal component, I think, 20 years ago of their course and
35 actually had specific Aboriginal people who were brought into the course as part of the trainees in medicine. So it's variable around Australia. I think in general it's getting a bit better. The principles of cultural safety are probably approached. We do try – in my university we do try to make sure that at least some patients have been clerked and some reflection has taken place. It's not huge by any means. It's
40 entering into the curriculum, which is a start.

COMMISSIONER TRACEY: What about postgraduate training?

45 PROF FLICKER: Postgraduate training is more iffy. Depends on where people – in which postgraduate training they're doing and where they're doing it. So the cultural training – the cultural awareness training is often not taught very much and, if it is, it's usually just one introductory program, often online. In – the number of

Aboriginal patients that people see is very much dependent on which hospital they're in. The ability for people to gain much experience of Aboriginal liaison officers and culturally appropriate ways of dealing with patients is piecemeal, probably, at best. I think we're making inroads. As a – as a group of medical educators, I think we're
5 making inroads. I think it's pretty slow but - - -

COMMISSIONER TRACEY: The demographics of ageing in this country suggest that we are in the not too distant future going to have many more times elderly people requiring care than presently is the case. Within your own specialty, are there
10 enough training positions for future specialist – geriatric specialists?

PROF FLICKER: We're not doing badly. I mean, is what I would say. So there are currently around 300 trainees across Australia and New Zealand. It's a three year program, so we're training 100 geriatricians across Australia and New Zealand,
15 which is not a bad number. I know that in Western Australia we train 20 geriatricians, and about six or seven finish each year in specialist geriatrics, and we're going from a community of around 72 geriatricians in Western Australia to about 120 to 140 over the next 10 years. I don't think – I don't think we're doing too
20 badly in specialist geriatric medicine. I think what we can probably be doing better is we haven't worked out how the geriatric workforce is utilised the best in residential care and community care.

I think we've – we've come across – we've come backwards from our model of the aged care assessment team which was very much part of the typical geriatrician's
25 workload and now it's becoming uncommon. And I think, in so many ways, geriatricians are becoming much more involved in acute medical care. Which I think is appropriate but I don't think leaving community care is appropriate at all. So I think that that has been an issue which has worried me in recent times.

30 COMMISSIONER TRACEY: I was going to ask you about that because you mentioned earlier that part of the answer to, as a general rule, don't attend at aged care centres, they deal with people referred to them and do so in hospitals?

PROF FLICKER: You're right and not quite right. That is a big part of the geriatric
35 practice but it is also an ambulatory care practice which is run through clinics and through the aged care assessment team. The assessment team – aged care assessment teams have less and less geriatric input, but still have some. There's also clinics, ambulatory care, which is provided by public hospitals and also by private geriatricians. That is, the Aboriginal people use that less than they should for a
40 number of reasons. We as a group haven't worked hard enough, including myself for that matter, but we haven't worked hard enough trying to make ambulatory care Aboriginal friendly. And one of the things that we need to do, I think, is establish more Aboriginal liaison officers and people, Aboriginal and direct links to Aboriginal controlled medical services, so that we can provide that service better, but
45 that's - - -

COMMISSIONER TRACEY: And is it part of your own practice to attend at Aboriginal accommodation facilities?

5 PROF FLICKER: No, not at this moment. I'm just in the process of organising that, actually. So we're trying to organise a clinic at Derbarl Yerrigan which is an Aboriginal controlled practice up the road from us, so that we're in midst of trying to
10 organise that. Yes. It has been – and I think one of the issues hasn't – it has not just been our blindness. It has also been that when you're an Aboriginal controlled medical service there's a lot of competing priorities, including women's and
15 children's health, mental health, drug and alcohol services. There's a lot of priorities there and ageing has not been necessarily a priority for those services either. We're recognising that has been a problem we need to address and we need to somehow – and the funding streams do not support it. That's the other thing. So we have to somehow work around that a bit and - - -

20 COMMISSIONER TRACEY: One of our terms of reference emphasises the need for the quality of care that is being provided, both at home care services and in institutions. I'm just wondering whether you have a view as to whether the assurance of good quality care would be advanced if geriatricians on a more regular basis actually attended at these centres and conducted clinics?

25 PROF FLICKER: Yes. I think that would be helpful but one of the things that I notice in my own practice is that I'm not very helpful by myself. What I do – well, I spend most of my time when I'm seeing patients by myself is I'm just crossing off medications, just stopping medications, and diagnosis and maybe looking at other
30 issues. The things that value-add to my practice are the use of allied health staff members and the multidisciplinary team. That's one of the things that I think is really important for geriatric medicine, and one of the things, if we're going into residential care facilities or community services, we have to establish that
35 multidisciplinary team network. So I think that my – whatever I do is so much better if I have access to a – a physiotherapist who does their own assessments as well as provides input, an occupational therapist, a social worker. These people are paramount to my – my practice and if I don't having access to the team, just going to a residential care facility by myself is not that helpful. It - - -

40 COMMISSIONER TRACEY: No. I did have in mind that, not so much independent operation but we've heard a lot of evidence, for example, about over-medication of patients and I assume that applies to Aboriginal patients and the way that it does to the broader residential care community. Now, if there's somebody with the specialist qualifications that you and your colleagues have, then there would be the opportunity for a cautionary approach as part of a team.

45 PROF FLICKER: I couldn't agree more. So we're currently involved in some of the – I'm involved in a couple of projects trying to look at decreasing medication use in residential care. The natural allies for us there are the pharmacists because they're, again, looking at the quality of medication use within residential care. But we need a team approach because one of the issues that we have with over-

medication use or too much psychotropic medication use in particular is that you can't just withdraw the medications and say that that's it. The – part of the problem that we have in residential care is that people's behaviour is – is – is complex. It's because not only of their cognitive impairment, but their nature and their history;
5 there are triggers that are involved in challenging behaviours. We have to work through what they are. We need nurse – trained nurses who can understand this and can initiate non-pharmacological strategies to help. So we don't just want to take medications – though that would be a good thing, taking medications off people which is causing them harm, but we also want to put something in its place that
10 would be better for people.

COMMISSIONER TRACEY: Yes. Thank you. That's been very helpful.

COMMISSIONER BRIGGS: I want to ask about something completely different,
15 Professor Flicker. Throughout this morning's or today' evidence we've heard a lot about trust, and it seems to me that the issue of trust seems to be way more important in the Aboriginal and Torres Strait Islander community than it does in the community per se. I could be wrong about that. Maybe it is that the community per se is more trusting and has better outcomes from the services provided more generally, I don't
20 know. But tell us a little more about trust and how it relates to Aboriginal and Torres Strait Islander people and why it is as it is.

PROF FLICKER: Trust is earned. That's one of the things. We've all learnt to trust
25 people and the people we trust have largely earned it. A – a historical perspective of Aboriginal people in this – in this land would not – would say that maybe Aboriginal people should not trust us very much – non-Aboriginal people. And that would be to look at it in sort of the most objective terms. Some of the things that have happened in relatively recent times have – have not earned the trust of Aboriginal and Torres Strait Islander people. And, you know, there's no – it's – no way do I want to
30 apportion blame on every non-Aboriginal person but I just think that we all bear some of that historical sort of affront.

And so there's not an immediate acceptance that the person from authority is here to
35 do them some good. The Stolen Generation were people from authority who came to take away people's children, and those people now are in their 50s and 60s, so this is relatively recent for a lot of people. So there's stark reminders of why Aboriginal and Torres Strait Islander people won't necessarily trust non-Aboriginal and Torres Strait Islander people. The other thing is there's quite a lot of – there's often quite a
40 lot of cultural gap between Aboriginal and Torres Strait Islander people and non-Aboriginal and Torres Strait Islander people. And when there's a difference, there's sort of the other, there's always a little bit of suspicion of the other, I think, in every community and we see that with people from different lands, culturally and linguistically diverse people, we see the same sort of, you know, uncertainty about
45 trust in that situation as well. So I think there is that sense that trust has to be earned a bit, which may not occur in routine non-Aboriginal and Torres Strait Islander sort of interactions.

COMMISSIONER BRIGGS: Going on your five points then, do you think Aboriginal and aged care services should be almost entirely Aboriginal and Torres Strait Islander controlled?

5 PROF FLICKER: Yes. Yes, and no, it should be, but it needs obviously monitoring, it needs efficiencies, it needs to be made sure that the quality is there, that the people are trained, all those things that we would expect in any service. That in any government's auspice service with Australian taxpayer dollars, I personally would like to make sure that they're effective and evidence-based, as well as
10 culturally appropriate and all those other things.

COMMISSIONER BRIGGS: Anything arising out of that, Ms Bergin?

15 MS BERGIN: Thank you, Commissioners, nothing arising.

COMMISSIONER TRACEY: Very well.

MS BERGIN: If the witness may be excused.

20 COMMISSIONER TRACEY: Yes. Certainly. Professor, thank you very much, and we've learned a great deal and we're very grateful to you for giving us the benefit of your considerable expertise in this area. Thank you.

25 PROF FLICKER: Thank you very much, Commissioners.

<THE WITNESS WITHDREW

[3.22 pm]

30 COMMISSIONER TRACEY: Any other matter this evening?

MS BERGIN: The only other matter, Commissioner, is the question of starting time for tomorrow.

35 COMMISSIONER TRACEY: 9.30.

MS BERGIN: 9.30.

40 COMMISSIONER TRACEY: Very well.

MS BERGIN: Thank you.

45 COMMISSIONER TRACEY: The Commission will now adjourn until 9.30 tomorrow morning.

MATTER ADJOURNED at 3.23 pm UNTIL TUESDAY, 18 JUNE 2019

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