Parliamentary Committees

Investigation of the closure of the Earle Haven residential aged care facility at Nerang

(Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying)

Report No. 30, 56th Parliament

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

November 2019

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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Abbreviations

ACFI	Aged Care Funding Instrument
ADA	Aged and Disability Advocacy Australia
agency	Australian Aged Care Quality Agency
ACSAG	Aged Care Standards and Accreditation Agency Ltd
Aged Care Act	*Aged Care Act 1997* (Cth)
AACQA	Australian Aged Care Quality Agency
commission / ACQSC	Aged Care Quality and Safety Commission Australian Aged Care Quality Agency also sometimes referred to as the commission
Commissioner	Aged Care Quality and Safety Commissioner
committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
COTA	Council on the Ageing Queensland
Department / DHA	Department of Health and Ageing (Commonwealth)
Earle Haven	Earle Haven Retirement Village at Nerang
Carnell report	Australian Government, Department of Health report: *Inquiry into Events at Earle Haven*
Gold Coast HHS / HHS	Gold Coast Hospital and Health Service
HEOC	health emergency operations centre
HelpStreet	HelpStreet Villages (Qld) Pty Ltd
People Care	People Care Pty Ltd
QAS	Queensland Ambulance Service
QNMU	Queensland Nurses and Midwives' Union
Quality and Safety Commission Act	*Aged Care Quality and Safety Commission Act 2018* (Cth)
Royal Commission	Royal Commission into Aged Care Quality and Safety

References to hearings are to public hearings held by the committee, unless indicated otherwise.

References to the 'facility' are to the aged care facility at Hibiscus House and Orchid House located within the Earle Haven Retirement Village at Nerang.

Chair's foreword

Most elderly Australians will require assistance to care for themselves at some stage. Many will lose the ability to live independently and will move into a nursing home to receive full-time care. This happens at a time in their lives when they are at their most vulnerable. For these people, the care and support they receive from aged care providers and staff becomes critical to their health and wellbeing. For their loved ones who help to decide on the nursing home, they must consider "Do we trust these people to provide care?"

This report looks at what happens when nursing home providers walk away from their responsibilities.

On 11 July 2019, after a litany of problems spanning a decade, the management at the Hibiscus House and Orchid House nursing homes within the Earle Haven Retirement Village at Nerang (Earle Haven) ceased caring for the 69 residents entrusted to their care.

The management of the company running the facility at the time, HelpStreet Villages (Qld) Pty Ltd (HelpStreet), caused the removal of essential equipment from the facility, told staff they were out of a job and simply called Queensland's emergency services on '000' to do a 'bulk evacuation'. HelpStreet was not the accredited provider for the nursing home, but a sub-contractor to the provider, People Care Pty Ltd (People Care), under an unsigned commercial arrangement between the two entities that would ultimately unravel.

The catastrophe that unfolded on 11 July would trigger a Code Brown Alert, a disaster-scale response, by Queensland Health and Queensland Ambulance Service workers involving hundreds of people.

The committee heard in great detail, the decision to relocate residents was reasonable and made in best interests of the health and safety of the residents, given the information provided at the time. Those purportedly in charge of the facility were unable to outline concrete plans to ensure residents' needs would be adequately met going forward.

The events at Earle Haven were also investigated by the federal government, which reported on 11 November 2019. I find it quite perplexing that the recent federal report into the closure of Earle Haven does not agree with the QAS and Queensland Health's decision to conduct the evacuation of the residents, and suggested the residents should have remained at Earle Haven despite authorities concerns that it was not safe for residents.

Our investigation identified that HelpStreet was not the only problem at Earle Haven. Significant problems with the accredited provider, People Care, had been documented by authorities in the federal government for over a decade leading up to the home's closure in July.

Those same authorities gave People Care a string of second chances to correct problems. In the course of our investigation, the federal Aged Care Quality and Safety Commission finally acted to rescind People Care's accreditation as an aged care provider.

People Care staff employed by owner and Director, Mr Arthur Miller, also documented problems at Earle Haven and attempted to bring them to his attention, but he failed to listen or to act. Mr Miller told the committee he will not provide aged care services any longer. While this is good news, it is unfortunate it has taken him over a decade to realise he cannot provide the level of care that the residents were entitled and expected to receive.

Put bluntly, the events at Earle Haven should never have happened.

The committee calls on the federal government to take action.

The federal government is primarily responsible and accountable for deciding aged care funding arrangements, the standards of care for clients, how complaints are dealt with and which providers are permitted to operate nursing homes now and in the future.

The recommendations in our report, are our response to the problems we saw first-hand during the investigation. We will have more to say about these issues in our report to be tabled by 31 March 2020 from our wider aged care inquiry.

We are also cognisant that the Royal Commission into Aged Care Quality and Safety looked at the regulatory issues surrounding the closure of Earle Haven as part of their work, though its findings on these matters were not included in its Interim Report, and may not be published until its Final Report which is due in November 2020.

The Royal Commission recently handed down its Interim Report, titled "Neglect", in which it reflects in the most damning terms on the federal government's failures to adequately care for older Australians.

The Royal Commission's Interim Report leaves no doubt that the aged care system 'lacks transparency in communication, reporting and accountability' and must change.

Reporting arrangements for the industry need to be more transparent. When the federal government has identified significant problems (red flags) with a nursing home or provider, it needs to share the information with state counterparts and other regulatory bodies that may have to provide emergency responses should those problems escalate.

Nursing home operators are also struggling to provide quality, professional aged care services with the funding they receive.

The funding model for aged care simply must change if the underlying problems afflicting the industry are to be fixed.

We have heard consistently that funding for aged care is patently inadequate. It has not kept pace with rising costs and as a result many providers are struggling to survive in the current economic climate. In nursing homes, staffing is one of the main recurring costs, and understaffing is a common method used by providers to make ends meet. In other industries the clients would simply complain when they see staff contact hours disappearing. Nursing home residents are often unwilling, afraid or simply unable to complain.

The wages for aged care nurses, personal carers and other workers also need to increase.

Aged care workers should not be treated as the poor cousins of the health sector. Until pay rates are improved, all providers will continue to struggle to attract and retain the good staff wanting to make a career in the aged care sector who the industry desperately need.

The committee's recent work on the Queensland Government's Health Transparency Bill 2019 highlighted the critical importance of ensuring nursing homes are properly staffed to protect the welfare and quality of life of the residents as well as the staff working there. Inadequate staffing is a story we have heard all too often during our wider inquiry into aged care, end-of-life and palliative care and voluntary assisted dying.

If the federal government is serious about ensuring quality aged care services in nursing homes, it needs to enshrine in legislation minimum staffing levels and minimum staff contact hours for the care provided to residents. Sadly the Commonwealth Department of Health opposes such a move in Queensland which is articulated in their response to the Health Transparency Bill 2019.

The Earle Haven debacle has highlighted the disaster caused when a nursing home suddenly ceases providing care to its residents. Closer attention needs to be paid to operating conditions in nursing homes, and to ensure providers have proper disaster plans in place if ever they are required to evacuate residents and staff at short notice, as occurred at Earle Haven.

The committee also recommends increased penalties for significant non-compliance with quality and safety standards and that the powers of the Aged Care Quality and Safety Commission to deal with non-compliance should be reviewed.

Finally, the committee has recommended that the federal government establish an independent Aged Care Commissioner to provide oversight of the aged care system. Clearly aged care residents need a strong, truly independent voice to advocate for their needs – something the system currently lacks.

Until these issues are addressed, I fear the hard work and efforts of the vast majority of providers and staff in aged care will be overshadowed by further events such as occurred at Earle Haven, and people will not have trust in the care provided at nursing homes.

I would like to acknowledge the Queensland Health and Queensland Ambulance Service workers who assisted with the evacuation of residents from Hibiscus House and Orchid House in July, and the former staff of the facility who gave their own time unpaid to ensure the former residents were properly cared for on the day. I also thank the families of former residents and other submitters who shared their concerns with the committee. I also acknowledge the excellent assistance provided during the committee's investigation by Counsel Assisting, Ms Ruth O'Gorman.

Mr Aaron Harper MP

Chair

Commendations and acknowledgments

- The committee acknowledges all those who appeared before or provided material to it in the course of this investigation. In particular, the committee pays tribute to the former residents, family members and staff of the Earle Haven aged care facility who assisted, sometimes in circumstances that were very difficult for them emotionally.
- The committee congratulates and commends all Queensland Ambulance Service staff involved for their care of and dedication to the wellbeing of the 69 elderly Queenslanders, many of whom were frail and/or living with dementia, who they evacuated from Earle Haven on 11 July 2019.
- The committee acknowledges the care and dedication of those Earle Haven nursing and care work staff who worked diligently to assist with the evacuation of residents to alternative accommodation.
- The committee expresses appreciation for the work of all Gold Coast Hospital and Health Service and Queensland Health staff involved for their swift action to ensure all 69 elderly Queenslanders were placed into a suitable residential aged care facility on the Gold Coast and notes that their prompt response in all likelihood avoided much more serious outcomes.
- The committee notes that the Health Transparency Bill 2019 currently before the Queensland Parliament addresses several of the concerns and issues raised during the committee's investigation including around publicly available information about the care provided in private aged care settings.

Findings

1. People Care was the approved provider for Orchid House and Hibiscus House from 2006.
2. Between 2006 and 2018, People Care had a number of regulatory compliance failures. It failed to meet the expected outcomes for a number of home care standards in audits conducted by the regulator in 2007, 2015, 2016 and 2017. On each of those occasions, sanctions were imposed.
3. People Care had significant problems in providing a safe and quality level of care to its residents in those years.
4. In April 2018, People Care engaged HelpStreet to manage the facility.
5. From at least the beginning of 2019, there were numerous problems with the safety and quality of care being provided by HelpStreet to the residents.
6. From at least 20 March 2019, People Care was aware of those problems.
7. Between March and June 2019, People Care conducted three audits of HelpStreet which revealed significant problems in its management of the facility but did not seek to terminate their services.
8. In June 2019, the regulator conducted an audit of the facility which revealed that chemical restraint was being used for 71 per cent of the residents and physical restraint was being used for 50 per cent of the residents.
9. In the days leading up to 11 July 2019, People Care and HelpStreet were in conflict about financial issues.
10. On 10 July 2019, HelpStreet removed the computer servers, containing critical records, from the facility. Also on that day, Helpstreet advised People Care that if payment of money was not made by the next day, HelpStreet would place itself into administration, ultimately causing the facility to be closed.
11. The conflict between People Care and HelpStreet about the payment of money continued on 11 July 2019.
12. On the morning of 11 July 2019, HelpStreet began removing numerous items from the facility, including mattresses.
13. At about 1.30pm, Mr Bunker of HelpStreet informed HelpStreet staff members that if they continued to work that afternoon, they would not be paid and would not be covered by insurance.
14. At about 1.30pm, HelpStreet's clinical care co-ordinator telephoned 000 and advised that HelpStreet had gone into administration, that staff had gone home and that it was no longer safe for the residents to remain at the facility.
15. The Queensland Ambulance Service (QAS) and Gold Coast Hospital and Health Service (HHS) responded immediately. Medical personnel attended to providing medication to the residents.
16. An assessment of the facility revealed a lack of food, resources and necessary medical records. As a result, although the preferred option would have been to keep the residents in their homes, it was determined that they could not be properly cared for at the facility and the decision was made to relocate them to other aged care facilities.
17. In the circumstances, the decision to relocate the residents was reasonable and appropriate.
18. Numerous staff, who either had no expectation of being paid for their shift or attended on their day off, stayed to assist where they could.
19. Although the situation was distressing for many of the residents, the efforts of the QAS and Gold Coast HHS personnel and the staff members kept the situation calm and under control.
20. The residents were all removed from the facility by the early hours of 12 July 2019.

Recommendations

Recommendation 1 **32**

The committee recommends that all options be explored to allow the residents evacuated from the facility to return to their home.

Recommendation 2 **36**

The committee recommends that the state government explore options to strengthen evacuation planning measures for residential aged care facilities, in consultation with federal government agencies responsible for aged care, to ensure they adequately cover the evacuation of residents and staff from facilities due to the sudden loss of care services.

Recommendation 3 **43**

The committee calls on the federal government to immediately institute business continuity checks, including equivalent vetting processes in relation to sub-contractor relationships, to prevent any recurrence of the Earle Haven disaster in other residential aged care facilities.

Recommendation 4 **43**

The committee calls on the federal government to make sub-contractors equally accountable alongside approved providers for meeting quality and safety standards in the aspects of care they are sub contracted to deliver.

Recommendation 5 **43**

The committee calls on the federal government to better share 'red flag' information about operators of residential aged care facilities with state and territory governments and other regulatory bodies to prevent any recurrence of the Earle Haven disaster in other residential aged care facilities.

Recommendation 6 **43**

The committee calls on the federal government to improve transparency by implementing improvements in aged care sector reporting.

Recommendation 7 **43**

The committee calls on the federal government to increase penalties for significant non-compliance with quality and safety standards and review the capacity and powers of the Aged Care Quality and Safety Commission to effectively undertake this role.

Recommendation 8 **43**

The committee calls on the federal government to set up an independent Aged Care Commissioner to provide oversight of the aged care system in Australia.

Recommendation 9 **45**

The committee calls on the federal government to immediately review and redesign its aged care funding model to guarantee the ongoing financial viability of the aged care sector, ensuring the funding model reflects the actual cost of care and makes adequate provision for the increasingly complex care needs of aged care residents.

Recommendation 10 **45**

The committee calls on the federal government to ensure that a redesigned funding model includes an increase in wages for aged care employees with a long-term aim to achieve wage parity with other health care sectors.

Recommendation 11 **45**

The committee calls on the federal government to mandate the introduction of minimum nurse, care worker and support worker skill mix ratios and minimum average daily resident care hours in private aged care facilities.

Recommendation 12 **47**

The committee recommends that the federal government urgently examine and reform practices regarding physical and chemical restraints, and mandate staffing levels that will avoid these practices being used as substitutes for appropriate level of care and supervision.

1 Introduction

1.1 The committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (committee) is a portfolio committee of the Legislative Assembly.[1]

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Communities, Women, Youth and Child Safety
- Domestic and Family Violence Prevention
- Disability Services and Seniors.

The roles of a portfolio committee relevantly include dealing with any issue referred to it by the Legislative Assembly and inquiring into any matter within the committee's portfolio areas that the committee considers appropriate.[2]

1.2 Background and the committee's broader inquiry

The aged care facility forming part of the Earle Haven Retirement Village at Nerang (Earle Haven) closed without warning on 11 July 2019, leaving 69 residents with nowhere to go. All of those residents were elderly, most were frail. Many suffered from significant medical conditions including dementia. The residents were evacuated from the facility over the course of 11 July 2019.

As would be expected, this was a traumatic event for those residents, as well as their families, and staff of the facility. It was the subject of widespread media reporting. The sudden closure and the impacts on the residents caused considerable concern on the part of their families and in the broader community.

The committee resolved on 17 July 2019 to undertake an investigation into the sudden closure of the facility and into the safety and quality of care provided to the former residents in the lead up to the incident.

The aim of the investigation was to determine what could be done to prevent such an event occurring again in Queensland.

The committee's investigation was carried out as part of a broader inquiry into aged care, end-of life care, palliative care and voluntary assisted dying. That inquiry is pursuant to these terms of reference from the Legislative Assembly on 14 November 2018:

1. That the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee inquire into aged care, end-of-life and palliative care and report to the Legislative Assembly on:
    a. the delivery of aged care, end-of-life and palliative care in Queensland across the health and ageing service systems
    b. Queensland community and relevant health practitioners' views on the desirability of supporting voluntary assisted dying, including provisions for it being legislated in Queensland and any necessary safeguards to protect vulnerable persons.

[1] See section 88 of the *Parliament of Queensland Act 2001* and Standing Order 194 of the *Standing Rules and Orders of the Legislative Assembly*.

[2] Section 92(1) of the *Parliament of Queensland Act 2001*.

2. That in undertaking the inquiry, the committee should consider:
    a. in relation to aged care, the terms of reference and submissions made to the Australian Government's Royal Commission into the Quality and Safety of Aged Care and, in recognising the Commission will occur in parallel, how to proactively work with the Commission to ensure an appropriate exchange of information to inform the conduct of the inquiry
    b. outcomes of recent reviews and work including Queensland Health's Palliative Care Services Review
    c. the current legal framework, relevant reports and materials in other Australian states and territories and overseas jurisdictions, including the Victorian Government's Inquiry into end-of-life choices, the *Voluntary Assisted Dying Act 2017* (Vic) and implementation of the associated reforms.

The committee was initially to report on the inquiry by 30 November 2019. On 22 August 2019, this reporting date was extended by the Legislative Assembly to 31 March 2020.

1.3 Brief overview – the facility, the closure, and subsequent events

The approved provider for the aged care facility was People Care Pty Ltd (People Care), a company effectively controlled by Mr Arthur Miller. The Earle Haven Retirement Village also includes independent living units and serviced apartments. The retirement village land is owned, and the village operated, by Miller Investments Pty Ltd.

The availability on the one site of three levels of accommodation, catering to different levels of care needs, can be seen as attractive to potential residents and their families.

On 11 July 2019 the facility, comprising Orchid House and Hibiscus House, closed abruptly, as a result of a contractual dispute between People Care and HelpStreet Villages (Qld) Pty Ltd (HelpStreet).

For many years, the aged care facility was operated by People Care. From April 2018, People Care entered into an arrangement whereby the facility would be operated by HelpStreet. This company had its registered office in New South Wales.

The company was just one of a range of corporate entities with the word HelpStreet in their name. It was in effect run by Mr Kristofer Bunker, the global Chief Executive Officer of the HelpStreet Group, which includes HelpStreet.[3]

Mr Bunker resides in the United Kingdom. He was present at the facility on 11 July 2019.

He was the subject of a notice dated 27 June 2018 from the Australian Securities and Investment Commission disqualifying him from managing corporations for a period of three years.[4]

Mr Bunker gave a short written statement to the Royal Commission.[5] He appeared before the Royal Commission by way of video-link.

Despite ongoing engagement by the committee with solicitors in Brisbane acting for HelpStreet and Mr Bunker, he did not at any stage agree to appear before the committee to give oral evidence. Through those solicitors, the committee was advised that Mr Bunker was eager to assist the committee. The committee was advised as early as 9 September 2019 that Mr Bunker was willing to

[3] Mr Bunker advised the committee that the HelpStreet Group includes HelpStreet Global Australia Pty Ltd, which owns HelpStreet Partnership (Aus) Pty Ltd, which in turn owns HelpStreet Villages (Qld) Pty Ltd. See submission EH10, p 1, paras 9-11.

[4] Under section 206F of the *Corporations Act 2001* (Cth). See submission EH10, p 1, para 7.

[5] Royal Commission, Brisbane hearing, exhibit 8-11, accessed at: https://agedcare.royalcommission.gov.au/hearings/Pages/hearings/2019/public-hearings-5-9-august-2019.aspx.

provide a statement to the committee. Ultimately, a signed statement dated 8 October 2019 was provided on 9 October 2019.

While the statement is acknowledged, the committee's view is that the flavour of the communications from Mr Bunker, through those solicitors, to the committee was one of claiming to be eager to assist the committee in its inquiry, but in reality wishing to avoid any opportunity for scrutiny by the committee.

The residents did not at any stage return to the facility. On 23 August 2019, the Aged Care Quality and Safety Commissioner revoked the accreditation of the service by People Care, effective from 24 November 2019. This decision came after an assessment conducted from 12 July to 2 August 2019 found that the facility did not meet any of the eight Aged Care Quality standards.[6]

HelpStreet went into liquidation, pursuant to a resolution of the members of the company, on 26 August 2019.

1.4 Other investigations into the closure

1.4.1 The Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018. The Commissioners were appointed to be a Commission of inquiry, and required and authorised to inquire into the following matters:

a. the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response

b. how best to deliver aged care services to:

   i. people with disabilities residing in aged care facilities, including younger people, and

   ii. the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care services

c. the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia, including:

   i. in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age

   ii. in remote, rural and regional Australia

d. what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe

e. how to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters

f. how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure

[6] Aged Cared Quality and Safety Commission, *Accreditation and Decision Report – People Care Pty Ltd*, p 1.

g. any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that [the Commissioners] believe is reasonably relevant to the inquiry.[7]

The Royal Commission has held a number of hearings around Australia. It provided an interim report on 31 October 2019[8], with a final report due by 12 November 2020. It held hearings in Brisbane from 5 to 9 August 2019, inquiring into the regulation of aged care, with a focus on:

- regulation of quality and safety in aged care and how aspects of the current regulatory system operate
- different approaches to regulation, including in other sectors
- how regulation and oversight of quality and safety in aged care could be improved.[9]

As part of these hearings the Royal Commission undertook a case study into the Earle Haven closure, in the context of examining the operation and structure of the regulatory framework:

> *The principal focus in the Earle Haven case study was on the extent to which People Care's shortcomings and related risk factors or 'red flags' were or should have been apparent to Commonwealth officials, and on the regulators' response or failure to respond.* [10]

1.4.2 Carnell inquiry into events at Earle Haven

On 19 July 2019, the federal Minister for Aged Care and Senior Australians, Senator the Hon Richard Colbeck, announced an independent inquiry into the circumstances leading to the closure. That inquiry was to:

> *… take into account the objects of the* Aged Care Act 1997 *and the* Aged Care Quality and Safety Commission Act 2018 *and in particular the protection of the health and well-being of consumers of aged care services and the accountability of the providers of the care for the funding and for the outcomes for recipients.* [11]

The inquiry was to examine the impact and consequences of the events on the safety and wellbeing of the affected residents. The inquiry was conducted by Ms Kate Carnell AO. Ms Carnell provided her report to Senator Colbeck in October 2019. [12] On 11 November 2019, Senator Colbeck released the report titled *Inquiry into Events at Earle Haven* (Carnell report), together with the federal government's response.[13]

The federal report made 23 recommendations, all of which were accepted by the federal government. Those recommendations were directed to ensuring:

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7 Royal Commission into Aged Care Quality and Safety, *Terms of Reference*, https://agedcare.royalcommission.gov.au/Pages/Terms-of-reference.aspx

8 The Royal Commission interim report can be accessed here: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx

9 Royal Commission into Aged Care Quality and Safety, *Brisbane hearing*, https://agedcare.royalcommission.gov.au/hearings/Pages/hearings/2019/brisbane-hearing.aspx.

10 Counsel Assisting the Royal Commission, Proposed findings on Earle Haven Case Study, Post-hearing submission received 26 August 2019, Brisbane hearing, p 1.

11 Australian Government, *Inquiry into Events at Earle Haven,* Appendix A, p 74.

12 See Carnell report, p 4 where the Carnell report notes some information obtained by Ms Carnell's inquiry about the impact of the closure on residents was shared with the committee. The committee acknowledges the assistance provided by Ms Carnell and her staff in this regard.

13 The Carnell report can be accessed at https://www.health.gov.au/sites/default/files/documents/2019/11/inquiry-into-events-at-earle-haven.pdf. The federal government's response can be accessed at https://www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/carnell-report-into-earle-haven-completed.

- greater regulatory capacity and coordination
- greater oversight of financial and commercial arrangements
- greater oversight of the purchasing and sub-contracting of approved provider status
- better management of the risks associated with key personnel and organisational culture.
- sanction options which better balance the need for decisive action with the desire of people to remain in their homes
- better planning and coordination of responses to emerging situations in aged care facilities.[14]

1.4.3 Other inquiries

Both the Queensland Police Service and the Australian Federal Police conducted investigations into the closure to consider whether any offences had been committed. No offences were laid as a result of those investigations.

[14] Carnell report, p 5.

2 The committee's process

2.1 Submissions

The committee called for submissions on 9 August 2019. A list of submissions is at **Appendix A**. A number of submissions remain confidential. Submissions authorised for publication are available on the committee's webpage.

2.2 Hearings

The committee held public hearings on the Gold Coast on 11 and 12 September 2019 and in Brisbane on 20 September 2019. The committee also held private hearings and meetings with stakeholders on the Gold Coast on 11 and 12 August 2019. A list of the witnesses that appear at the public hearings is at **Appendix B.**

2.3 Inquiry material

Copies of the material published in relation to the inquiry—including transcripts of the public hearings, documents tabled at the hearings, responses to questions taken on notice, and public submissions—can be found on the inquiry webpage.

2.4 Summonses

Pursuant to section 25 of the *Parliament of Queensland Act 2001*, 'an authorised committee may order a person, other than a member, to attend before the committee and also to produce to the committee any document or other thing in the person's possession'.

Section 26 of the *Parliament of Queensland Act 2001* requires that a person who is ordered to attend by an authorised committee must be given a summons issued by the Clerk of Parliament on notification by the committee's chairperson. The summons must state a reasonable time and place for the attendance and, if a document or other thing is ordered to be produced, reasonable particulars of the document or other thing.

Prior to the committee's public hearings, the committee served a summons issued by the Clerk of Parliament addressed to Mr Arthur Miller, Director, People Care Pty Ltd, requiring his attendance before the committee and the production of material including:

- documents relating to the contractual arrangements between People Care and HelpStreet for the operation of the facility
- documents relating to regulatory compliance matters involving People Care and HelpStreet
- human resources records
- correspondence and other documents relating to the contractual disputes between People Care and HelpStreet
- documents and video and photographic materials relating to the closure of the facility on 11 July 2019.

A considerable volume of material was provided by Mr Miller (through his solicitors) in response to the summons for production.[15]

The committee also had summonses issued for attendance by Ms Telecia Tuccori, Clinical Care Coordinator for HelpStreet, and Ms Karen Parsons, HelpStreet's Executive Director for home care and aged care from October 2018.

[15] Some of that material was also included in the 'tender bundle' produced to the Royal Commission on 5 August 2019 - Exhibit 8-1 - Earle Haven tender bundle, accessible at https://agedcare.royalcommission.gov.au/hearings/Pages/hearings/2019/exhibit-8-1-earle-haven-tender-bundle.aspx.

Ms Tuccori attended before the committee at the Gold Coast and gave evidence on 11 September 2019.

Attempts to locate Ms Parsons and to serve that summons proved unsuccessful. Messages for Ms Parsons to make contact though her mobile number were also unsuccessful. That summons remained unserved. Ms Parsons did not attend before the committee.[16]

2.5 Compulsory powers and jurisdiction

The committee was particularly keen to hear from representatives of People Care and HelpStreet.

As a committee of the Queensland Parliament, the committee has wide compulsory powers. However, these powers are limited to entities which have some connection with Queensland. In relation to HelpStreet, apart from the fact of its operation of the facility at Nerang, the committee did not identify any other link with Queensland, such as would support jurisdiction in the committee to exercise compulsive powers in respect of HelpStreet. On this basis, the committee could not summons the production of documents by or for HelpStreet. For similar reasons, the committee could not summons Mr Bunker to attend before it.

Mr Bunker did not make himself available to give evidence before the committee, despite invitation to do so. At a very late stage in the investigation, Mr Bunker provided a written statement to the committee which, in his words, 'sets out the evidence that I am prepared to give to the [committee] in relation to the Investigation'.[17]

[16] Ms Parsons provided a detailed written statement to the Royal Commission, and gave oral evidence at its hearing on 5 August 2019.

[17] The statement, now submission EH10, was received on 9 October 2019.

3 The regulatory framework

The legislative framework for aged care is largely governed by two pieces of federal legislation: the *Aged Care Act 1997* (Cth) (Aged Care Act) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) (Quality and Safety Commission Act).[18]

3.1 The Aged Care Act

The Aged Care Act sets out the obligations and responsibilities of approved providers with respect to quality of care, user rights and accountability. The Aged Care Act provides that the Minister can make, as legislative instruments, various principles containing detail about the operation and regulation of the aged care system.[19] Current principles include:

- Accountability Principles 2014
- Allocation Principles 2014
- Approval of Care Recipients Principles 2014
- Approved Provider Principles 2014
- Classification Principles 2014
- Committee Principles 2014
- Extra Service Principles 2014
- Fees and Payments Principles 2014 (No 2)
- Grant Principles 2014
- Information Principles 2014
- Prioritised Home Care Recipients Principles 2016
- Quality of Care Principles 2014
- Records Principles 2014
- Sanctions Principles 2014
- Subsidy Principles 2014
- User Rights Principles 2014.

3.2 The Quality and Safety Commission Act

The Quality and Safety Commission Act established the Aged Care Quality and Safety Commission (the commission).[20] The functions of the Commissioner under that Act include:

- protecting and enhancing the safety, health, wellbeing and quality of life of aged care consumers
- promoting the provision of quality care and services in aged care
- consumer engagement functions
- complaints functions
- regulatory functions

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18 See generally the Royal Commission *Background Paper 7 - Legislative framework for Aged Care Quality and Safety Regulation*, 2 August 2019: https://agedcare.royalcommission.gov.au/publications/Documents/background-paper-7.pdf.

19 Aged Care Act, ch 7 div 96-1.

20 Quality and Safety Commission Act, s 11.

- education functions.[21]

The commission commenced on 1 January 2019. Prior to that, regulatory functions were carried out by the Aged Care Standards and Accreditation Agency to 1 January 2014, and from 1 January 2014 the Australian Aged Care Quality Agency (the agency). Unless the context otherwise requires or indicates, in this report, the term 'commission' will be used to refer to both the agency and the commission.

The Aged Care Quality and Safety Commissioner has responsibility for:

- accreditation of residential care services
- quality reviews of home services
- monitoring of services for continuous improvement
- complaints handling.[22]

By letter dated 6 September 2019, the committee advised the Aged Care Quality and Safety Commissioner, Ms Janet Anderson PSM, of its investigation and its upcoming hearings and advised:

> *… the committee would welcome hearing from the commission as part of those hearings regarding the commission's interactions with the aged care facility and its operators and providers in the period leading up to the closure.*

In response, the commissioner advised that neither she nor her staff were planning to attend the committee's hearings.

[21] Quality and Safety Commission Act, s 16. The Aged Care Quality and Safety Commission Rules 2018 made under the Act make more detailed provision for the functions and operation of the commission.

[22] Quality and Safety Commission Act, s 19.

4 The history of the facility

4.1 People Care's involvement at the facility from 2006 to 2018

Mr Miller gave evidence that People Care took over the management of the Earle Haven Retirement Village in 2001.[23] At that time, he was the managing director of People Care and his wife was the only other director.[24] He gave evidence to the effect that his wife, who had a nursing background, looked after the operational side of things while he dealt with business matters.[25] Mr Miller said he has been the sole director of People Care since his wife passed away in 2012.[26]

In 2006, People Care became the approved provider for the purposes of the Commonwealth regulatory regime for the facility.

4.2 Problems with People Care's regulatory compliance

4.2.1 Mr Miller

Mr Miller accepted that, in April 2007, the agency audited Hibiscus House and found that it did not comply with several standards and outcomes, including in the areas of continuous improvement, regulatory compliance, education and staff development, and clinical care.[27]

He gave evidence that he did not accept all of the adverse findings in the agency's report and appealed them at the time. However, he accepted that the federal Department of Health and Ageing (department) did, nonetheless, impose a sanction requiring People Care to appoint a Commonwealth approved advisor for six months.[28]

He said that, following that audit, he terminated the employment of the nursing manager he had in place until that time.[29]

Mr Miller accepted that, in November 2015, the agency conducted a review which resulted in a finding that People Care complied with only six of the 18 expected outcomes of the home care standards at Orchid House and Hibiscus House. People Care did not meet the expected outcomes in areas such as regulatory compliance, risk management and care plan development and delivery.[30]

He gave evidence that he could not recall if he read that report at the time.[31] He appeared to think that he probably would have terminated the services of his nursing manager when that report came in, but his evidence on that point was unclear.[32]

Mr Miller accepted that, in May 2016, the agency conducted a review of Hibiscus House which found that People Care failed to meet the accreditation standards in nine of the expected outcomes, including in the areas of clinical care, medication management, nutrition and hydration and skin care.[33]

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23 Public hearing transcript, Brisbane, 20 September, p 4.

24 Public hearing transcript, Brisbane, 20 September, pp 4-5.

25 Public hearing transcript, Brisbane, 20 September, pp 3-4.

26 Public hearing transcript, Brisbane, 20 September, p 5.

27 Public hearing transcript, Brisbane, 20 September, pp 6-9. The agency's serious risk report on its audit can be found at the Royal Commission tender bundle, tab 4.

28 Public hearing transcript, Brisbane, 20 September, p 9.

29 Public hearing transcript, Brisbane, 20 September, pp 9-10.

30 Public hearing transcript, Brisbane, 20 September, pp 10-11. The agency's quality review report can be found at the Royal Commission tender bundle, tab 9.

31 Public hearing transcript, Brisbane, 20 September, p 12.

32 Public hearing transcript, Brisbane, 20 September, pp 12-13.

33 Public hearing transcript, Brisbane, 20 September, pp 13-14. The agency's decision and findings of a failure to comply with accreditation standards can be found at the Royal Commission tender bundle, tab 15.

He gave evidence that he was 'possibly' given that report at the time and that he would have 'designated somebody else', such as the nursing manager, to deal with it.[34]

Mr Miller accepted that, following that report, the department issued a notice of non-compliance and imposed sanctions which were in place between June and December 2016, during which period a Commonwealth approved advisor was appointed.[35]

Mr Miller was shown a document which established that the appointed nurse advisor resigned in September 2016, and which cited difficulties in dealing with People Care as the reason for doing so. However, Mr Miller said that he did not recall seeing that document at the time, or the nurse advisor leaving.[36]

Mr Miller could not recall that, in November 2016, the agency conducted a further review at which time some improvements were noted, but the agency determined that People Care did not meet the expected outcomes of the home care standards for regulatory compliance and information provision, despite being shown the report.[37]

Mr Miller accepted that he probably saw an assessment conducted by the agency in April 2017 which found that the two areas of expected outcomes in the area of regulatory compliance and information provision were still not being met and that, by that time, neither was a third such area.[38]

He gave evidence that, if he had been shown the results of the assessments conducted in November 2016 and April 2017, he would have directed other people to deal with them.[39]

4.2.2 Ms Karen Heard

Ms Karen Heard gave evidence that she was engaged by People Care as a clinical care manager in November 2016 when the facility was under sanction by the department for care issues that had occurred throughout 2016. Her contract at that time was for three months. She said the sanctions were lifted in December 2016, and she assisted in preparation for the re-accreditation process in February 2017 which was achieved before she left.[40]

Ms Heard gave evidence that she was subsequently engaged as the Commonwealth approved advisor in May 2017 after People Care was sanctioned a further time, and that she remained in that role until October 2017.[41]

She gave evidence that she assisted with the re-accreditation of the facility in October 2017 at which time People Care was re-accredited for three years.[42]

4.2.3 Aged and Disability Advocacy Australia

The committee gained further insight into the concerns and motivations of residents and their families, through evidence provided by Aged and Disability Advocacy Australia (ADA), an aged-care and disability advocacy service supporting users of aged-care services and people with a disability across

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34 Public hearing transcript, Brisbane, 20 September, p 14.

35 Public hearing transcript, Brisbane, 20 September, p 14.

36 Public hearing transcript, Brisbane, 20 September, p 15. See the letter dated 13 September 2016, Royal Commission tender bundle, tab 27.

36 Public hearing transcript, Brisbane, 20 September, p 14.

37 Public hearing transcript, Brisbane, 20 September, p 15. The agency's report can be found at the Royal Commission tender bundle, tab 32.

38 Public hearing transcript, Brisbane, 20 September, p 15. The agency's report can be found at the Royal Commission tender bundle, tab 41.

39 Public hearing transcript, Brisbane, 20 September, p 15.

40 Public hearing transcript, Gold Coast, 11 September, p 60.

41 Public hearing transcript, Gold Coast, 11 September, p 60.

42 Public hearing transcript, Gold Coast, 11 September, p 61.

Queensland. This organisation appeared to be particularly well-placed to comment on the issues at Earle Haven, given its sanctions history of Earle Haven, as Mr Rowe explained:

> *Probably one of the things that would set Earle Haven out from others a little bit is that, because there have been a number of sanctions over the years, whenever there is a sanction and there is a meeting with families and residents, the department of health has invited ADA to attend those so that residents are aware of our services. That is probably a level of promotion of our service that other providers do not get.*[43]

The organisation provided a written submission, informed in great part by confidential information captured in advocacy by that organisation for residents and their families regarding Earle Haven, going back to the start of 2016:

> *The rationale is that rather than present just a very recent snapshot of resident concerns, this longer-term view provides useful insight into the nature of the concerns being raised by EH* [Earle Haven] *residents and their representatives prior to the appointment of an Adviser in June 2016, the subsequent imposition of sanctions in May 2017, and this most recent closure episode in July 2019.*[44]

Further, Mr Geoff Rowe, the Chief Executive Officer of ADA, told the committee:

> *… while our submission reflects a review of case notes since 2016, we are very much aware that the problems at Earle Haven have been very long term. Our Gold Coast based advocate has been in the role for 9½ years and she describes the issues as being there ever since day one that she started. The issues at Earle Haven have been standout. They are not reflective, I think, of the broader aged-care industry. The problems at Earle Haven have been known by others in the sector and by government at both levels over many years. The fact that the closure on 11 July happened came as no surprise. My experience has been that, whenever someone has talked about there being an issue in aged care on the Gold Coast, Earle Haven has always been identified as the likely source of that concern.*[45]

These long term problems at the facility included frequent staff changeover, difficulties with complaints resolution and concerns that the facility has passed accreditation processes despite residents having raised concerns with Commonwealth auditors.

4.2.4 Other evidence relating to People Care's management of the facility in that period

One staff member, who gave evidence in a private session, spoke of a number of concerning incidents that occurred while People Care had management of the facility. She said that a staff member, who was removed from Orchid House for elder abuse, was later returned to unsupervised duties there.[46]

[43] Public hearing transcript, Gold Coast, 12 September, p 10.

[44] Submission EH008, p 1.

[45] Public hearing transcript, Gold Coast, 12 September, p 9.

[46] Private hearing transcript, Gold Coast, 12 September, p 1.

5 The engagement of HelpStreet in April 2018

Mr Miller gave evidence that he recalled engaging HelpStreet to manage the facility in April 2018. He did so because, by that time, he realised that he was 'not the right person' to be running the facility.[47]

Mr Miller's explanation as to why it took him so long to come to that realisation, given the regulator's adverse findings in 2007, 2015, 2016 and 2017, was not entirely satisfactory. He said:

> *The history, what happened, I decided, I say perhaps – I cannot explain the facts. We will be just going in circles. All that time I was planning to do that, but I did not because I could not find a suitable provider for that. And that is why you do not ask that question, just ask that question there. I had been running around for a long time to try to get the right people to run the place, but I could not find them.* [48]

Mr Miller said he was approached by Mr Bunker who told him that HelpStreet had other facilities around the world and believed 'they could run the aged care very well'.[49]

Mr Bunker said he founded the HelpStreet companies in Australia in about August 2011.[50] The companies initially provided contract podiatry services to the aged care industry, then expanded to incorporate additional allied health services. He said it was a natural progression for the companies to partner with aged care service providers to manage aged care facilities.[51]

In April 2018, a Heads of Agreement between People Care and HelpStreet was drawn up pursuant to which HelpStreet was to manage the facility.[52]

Mr Miller said in his evidence that he did not personally notify the department when People Care engaged HelpStreet to manage the facility. He believed that Mr Lang, the company secretary did.[53]

47 Public hearing transcript, Brisbane, 20 September, p 16.

48 Public hearing transcript, Brisbane, 20 September, p 16.

49 Public hearing transcript, Brisbane, 20 September, p 16.

50 Submission EH010, p 1, para 14.

51 Submission EH010, pp 1-2, paras 15-16.

52 Public hearing transcript, Brisbane, 20 September, pp 18-19; Submission EH010, p2, paras 21-22.

53 Public hearing transcript, Brisbane, 20 September, p 18.

6 HelpStreet's management of the facility in 2018

Mr Miller said that he appointed Ms Heard, in May 2018, to oversee HelpStreet but he subsequently released her when she told him she was satisfied that HelpStreet could manage the place[54]. He said that he did not personally do anything to check that HelpStreet was running the facility in an appropriate manner between April and the end of 2018 and accepted that, in hindsight, it was a 'mistake' for him not to have done so.[55]

Ms Heard gave evidence that after HelpStreet was engaged to manage the facility, she reported to HelpStreet instead of People Care.[56] She said she remained in her role until Ms Karen Parsons took over from her in October 2018.[57]

Ms Telecia Tuccori gave evidence that she was employed by HelpStreet as the clinical care co-ordinator for the facility in November 2018. It was her job to ensure the safety of all the residents and staff and provide for the clinical care of the residents.

Ms Tuccori reported to Ms Karen Parsons, the executive director. She only had minimal involvement with Mr Bunker or Mr Miller.[58]

54 Public hearing transcript, Brisbane, 20 September, p 19.

55 Public hearing transcript, Brisbane, 20 September, pp 20-21.

56 Public hearing transcript, Gold Coast, 11 September, p 62.

57 Public hearing transcript, Gold Coast, 11 September, pp 62-63.

58 Public hearing transcript, Gold Coast, 11 September, pp 37-38.

7 HelpStreet's management of the facility in 2019

7.1 Evidence of Mr Miller, Ms Tuccori and Ms Heard

Mr Miller gave evidence about a meeting between himself and approximately 60 of the residents and family members which took place on 20 March 2019.

At that meeting, the residents expressed concern about the level of care being provided by HelpStreet and, in particular, the quality and number of staff.[59]

Mr Miller gave evidence that he was not aware of the residents' complaints about HelpStreet's management of the facility prior to that meeting.[60] After the meeting, he considered the level of service being offered by HelpStreet was 'very poor'.[61] He agreed that some of the complaints were alarming, but he did not advise the regulator about them.[62]

Ms Tuccori gave evidence that she also attended that meeting. During her evidence, Ms Tuccori was taken to a number of the complaints recorded as being made by residents or their family members during the meeting.

She said she did not recall a complaint about good staff having been put off but said that, if that complaint had been made, it would have been because HelpStreet had had to let some staff go due to elder abuse.[63] She gave evidence there had been three instances of elder abuse allegations, one of which involved an allegation of unreasonable force being used against a resident.[64]

She disputed some of the specific complaints recorded in the minutes and did not appear to accept the legitimacy of others. She said that HelpStreet did its best to resolve any complaints.[65]

In the committee's view, Ms Tuccori's evidence in this regard appeared to significantly downplay the extent and seriousness of the residents' concerns about the management of the facility in 2019.

Mr Miller gave evidence that he subsequently engaged Ms Heard to conduct an audit at the facility, which she did between 20 and 24 May 2019.[66] He did not do anything else in the two month period immediately following the meeting.[67]

Following her audit, Ms Heard produced a report dated 24 May 2019 which revealed many failures in the safety and quality of the service offered by HelpStreet, including in relation to staffing levels, complaints and complaint handling, volunteers and catering.[68]

On 31 May 2019, Mr Miller, having received that report, wrote to HelpStreet setting out 'some solutions [he had] to working towards an improved partnership with HelpStreet'.[69]

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59 Public hearing transcript, Brisbane, 20 September, p 21-22. The minutes of the meeting are available at the Royal Commission tender bundle, tab 76.

60 Public hearing transcript, Brisbane, 20 September, p 24.

61 Public hearing transcript, Gold Coast, 11 September, pp 24-25.

62 Public hearing transcript, Gold Coast, 11 September, p 26.

63 Public hearing transcript, Gold Coast, 11 September, pp 45-46.

64 Public hearing transcript, Gold Coast, 11 September, pp 46-47.

65 Public hearing transcript, Gold Coast, 11 September, pp 47-48.

66 Public hearing transcript, Brisbane, 20 September, pp 26-27.

67 Public hearing transcript, Brisbane, 20 September, p 27.

68 Public hearing transcript, Brisbane, 20 September, pp 27-28.

69 Public hearing transcript, Brisbane, 20 September, p 28.

He did not give responsive answers when asked why he did not terminate the contract with HelpStreet after becoming aware of the failings identified by Ms Heard in May 2019, apart from wanting to liaise with his lawyers first.[70]

The committee finds it difficult to accept that any delay in acting on the complaints Mr Miller had heard about in March 2019 and the failures he was informed about by Ms Heard in May 2019 was warranted.

Ms Heard conducted another audit between 4 and 6 June 2019 which indicated there were problems in relation to assessments and care planning; behaviour monitoring chart use; pain assessment and follow up; wound management and pressure injuries.[71] Mr Miller gave evidence that he did not read the report, which Ms Heard emailed to him on 19 June 2019, because he was overseas.[72]

In the view of the committee, given Mr Miller's knowledge of the problems occurring at the facility at that time, it is difficult to accept this as sufficient reason for not attending to Ms Heard's report.

Ms Heard conducted a third audit between 19 and 20 June 2019 in which she identified problems in relation to documentation, nutrition and hydration. At that time, a number of residents appeared to be malnourished.[73] Again, Mr Miller's evidence was that he did not read that report because he was overseas.[74]

During his evidence, Mr Miller was shown a report dated 25 June 2019 provided to People Care from the commission which included the following statements about the circumstances at the facility:

a. *Care recipients are prescribed regular and as needed psychotropic medications. The service utilises chemical and physical restraint;*
b. *There are currently 71 percent of care recipients receiving psychotropic medication; and*
c. *Fifty percent of care recipients have physical restraint.* [75]

Mr Miller gave evidence that he was not aware of that information before he received the report.[76] He also said he was not aware of the instances of elder abuse.[77]

The committee regards Mr Miller's lack of knowledge of those significant matters as demonstrating a lack of engagement and responsibility by him in that period.

Ms Tuccori gave evidence that the information about the use of physical and chemical restraints would have been provided to the commission by her.[78] At the time she gave evidence, she could not recall how many residents were receiving psychotropic medications regularly and how many were prescribed it on an 'as needed' basis.[79] At the time she gave evidence, she could not recall whether 50 percent of the residents had in fact been physically restrained but accepted that was probably correct. Physical restraint could take the form of bed rails or lap tables.[80] In her view, the use of chemical and physical

70 Public hearing transcript, Brisbane, 20 September 2019, p 29.

71 Public hearing transcript, Brisbane, 20 September 2019, pp 30-31.

72 Public hearing transcript, Brisbane, 20 September 2019, pp 31-32.

73 Public hearing transcript, Brisbane, 20 September, 2019, pp 33-34.

74 Public hearing transcript, Brisbane, 20 September, 2019, p 34.

75 Public hearing transcript, Brisbane, 20 September 2019, pp 34-35. The report is at the Royal Commission tender bundle, tab 95.

76 Public hearing transcript, Brisbane, 20 September 2019, p 35.

77 Public hearing transcript, Brisbane, 20 September 2019, p 35.

78 Public hearing transcript, Gold Coast, 11 September 2019, pp 43-44.

79 Public hearing transcript, Gold Coast, 11 September 2019, pp 43-44.

80 Public hearing transcript, Gold Coast, 11 September 2019, p 44.

restraints at the facility was appropriate and adequate, but no more than necessary, to meet the care needs of the residents.[81]

7.2 Residents' family members' views of the management of the facility

Various family members of residents either met with the committee in private session or provided submissions and other material to the committee. A number of complaints and concerns were raised in that material. Some of these mirror what was contained in some of the audit reports from the agency. The committee also notes that some material tendered to the Royal Commission contains complaints from family members.

The committee appreciates that many family members found it emotionally difficult to speak about their experiences and those of loved ones. The same can be said for members of staff of the facility. The committee pays tribute to these people and particularly acknowledges their input to the work of the committee during its investigation.

Understandably, most of those persons did not wish to be identified and most did not wish their material to be made public. Often, this was because relatives continue to reside elsewhere in the Earle Haven complex. Another reason was put forward by Mr Rowe from ADA who advised the committee that one of the reasons that people come to his advocacy organisation was:

> *… because they are fearful of retribution - and we understand that that was very real at Earle Haven, that it did not promote an environment where complaints or feedback were welcome …*[82]

And again from Mr Rowe:

> *Earle Haven did not have a welcoming culture in respect of feedback or in respect of complaints. In my submission I have reported that the owner of the facility was very hostile. I am not quite sure I want this on the record, but I might as well put it there. When the post-closure meeting with families was on, my local based advocate was fearful of attending that herself and asked me to go along. Part of the reason why was that at the last meeting she attended people were throwing chairs. The communication and the trust between management and the users and their families had broken down to that extent.* [83]

Among those individuals who spoke to the committee, there was some divergence of opinion as to the performance of People Care, though the majority were critical.

One firm theme was that, whatever the failings of People Care over the years, the quality of care deteriorated after HelpStreet took over running the facility in April 2018. There was a switch in the provider of pharmaceutical items, and cleaning, catering, and laundry operations were outsourced. Whilst some residents expressed the view that some services had improved, the majority of the evidence to the committee indicated that most considered services had decreased in quality.

One couple gave evidence, in a private session, that the husband's mother had been at the facility for 8½ years prior to being relocated on 11 July 2019. They considered that the level of service the husband's mother received after HelpStreet was engaged at the facility 'seemed to be getting better'.[84]

Another person gave evidence that his mother was at Orchid House for two years before July 2019 and that he thought the issues around catering and cleanliness were getting better in that time.[85]

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81 Public hearing transcript, Gold Coast, 11 September 2019, p 45.

82 Public hearing transcript, Gold Coast, 12 September 2019, p 10.

83 Public hearing transcript, Gold Coast, 12 September 2019, p 11. Mr Rowe went on to clarify that by 'owner', he was referring to Mr Arthur Miller.

84 Private hearing transcript, Gold Coast, 11 September 2019, pp 43-44.

85 Private hearing transcript, Gold Coast, 11 September 2019, p 6.

7.3 Staff members' views of management of the facility

A number of nursing staff formerly employed by HelpStreet and/or People Care also met with the committee in private session. Some had been long term staff at the facility, employed initially by People Care and then by HelpStreet.

The staff members who gave evidence in the private sessions were generally unhappy with the way the facility was operated under HelpStreet's management.

One staff member said:

> *… all I know is for the last two years everybody was feeling beaten up and they were not very happy with the new management.* [86]

Some stated that HelpStreet was increasingly using staff engaged through an agency and reducing shifts given to longstanding staff, or getting rid of such staff.

Some staff provided the committee with a range of documentary materials. Some of that material reinforces the inescapable conclusion that HelpStreet was readying to cease operations on 11 July 2019, with evidence of the removal of the servers as early as 10am on 10 July 2019.

Some staff explained that they had stayed on at the facility on 11 July 2019 to be of assistance to the residents, in circumstances where as far as they knew at the time they no longer had employment. Others, not rostered on that day, came to the facility to assist once they heard of the unfolding drama. Staff who stayed on or who voluntarily attended advised that they did not have expectations of being paid. Rather, they stayed or attended out of concern and regard for the residents.

Some advised that in the end they subsequently did in fact receive payment – this was made by People Care, not HelpStreet.

Another observed:

> *I felt that we could have had more nurses, more hands-on for the residents. It was too top-heavy, too much management that was unnecessary.* [87]

One staff member gave the following evidence:[88]

> *There were lots of things that happened prior to [11 July 2019], which I thought – and never working for a nursing home before – were absolutely disgusting, just as a human being, really. They made us do hand hygiene courses to keep up to date but then you would have one packet of Jenni Wipes on a trolley for the whole corridor of about 30 people. I asked if we could get a packet of Jenni Wipes in everyone's rooms, so we were not cross-contaminating. I was told no. You would go to the Jenni Wipes and there would be faeces on them, so you were cross-contaminating and they did nothing about it.*
>
> *We had one sling for the whole of the 70 residents in there for about three months, I think. We complained about it and said, 'When can we get a sling for all the residents?', because we had so many people who had to either be hoisted or stand on that machine and we had one. They said, 'They take a few months to order', whereas me and Mum got on-line, and you could order them straight away. It was just disgusting.* [89]

Another staff member was critical of the fact that HelpStreet relied heavily on staff engaged through an agency.[90]

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86 Private hearing transcript, Gold Coast, 11 September 2019, p 13.

87 Private hearing transcript, Gold Coast, 11 September 2019, p 14.

88 Private hearing transcript, Gold Coast, 11 September 2019, p 18.

89 Private hearing transcript, Gold Coast, 11 September 2019, p 14.

90 Private hearing transcript, Gold Coast, 11 September 2019, p 20.

It may be observed that many of the staff members' complaints echoed the sorts of issues the residents raised in the meeting on 20 March 2019.

8 The immediate lead up to 11 July 2019

Mr Miller gave evidence that on 8 July 2019 his lawyers sent correspondence to HelpStreet notifying HelpStreet that People Care was not satisfied with the level of care being provided by HelpStreet and required HelpStreet to hand back management of the facility to People Care by 5pm on 9 August 2019.[91]

In his statement, Mr Bunker said that HelpStreet disagreed there were any issues with the level of care being provided by HelpStreet.[92] It is the view of the committee that it is surprising that Mr Bunker would consider that there were no issues with the level of care being provided by HelpStreet.

Mr Bunker referred to a conversation he had on 10 July 2019 with Mr Gerry Epstein of Steindls Lawyers, in which he advised that he accepted the termination, by People Care and Miller Enterprises, of the licence to occupy the facility. He stated he explained that a longer period of time than until 9 August 2019 would be required to transition management of the Aged Care Facility from HelpStreet Villages to People Care.

He also stated that:

> *At no stage on 11 July 2019, was an executive decision made by HelpStreet Village to vacate the Aged Care Facility. The evacuation of residents from the Aged Care Facility was arranged by the emergency services and representatives of the Department of Health to ensure the safety of the residents.* [93]

This statement though warrants comment in two respects.

Firstly, it does not address the core issue of whether HelpStreet was vacating the facility, in the sense of leaving it.

Secondly, to the extent that it describes (accurately) the evacuation as a decision by Queensland Health, it overlooks the fact that this followed a 000 call made by HelpStreet employee Ms Tuccori apparently with his agreement. As he records in his statement:

> *The situation escalated quickly. Telecia Tuccori called '000' and emergency services as well as representatives from the Department of Health arrived at the Aged Care Facility. The Aged Care Quality Commission was also notified of the situation.*[94]

Somewhat curiously, Mr Bunker makes no reference in his statement to the removal of equipment from the facility on 11 July 2019.

Computer servers were removed from the facility on 10 July 2019. Mr Bunker advised the solicitor for People Care:

> *We can confirm that the servers have been removed from the facility. This was not done to prevent patient care but to ensure that upgrades can be made and private HelpStreet information removed.* [95]

In his statement to the committee, Mr Bunker said that the removal of the servers had nothing to do with the dispute between People Care and HelpStreet.[96]

In the circumstances, it is difficult to accept that that is the case.

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91 Public hearing transcript, Brisbane, 20 September 2019, p 36.

92 Submission EH010, p 3, para 31.

93 Submission EH010, p 5, para 48.

94 Submission EH010, p 5, para 47.

95 By email dated 10 July 2019, 5.17pm. See submission EH010, pp 14-15.

96 Submission EH010, p 5, para 50.

Mr Miller said that he was not made aware that the servers were removed from the facility on 10 July 2019.[97] He said he would have been concerned if he had known.

Mr Miller gave evidence that on the afternoon of 10 July 2019 he received correspondence in which HelpStreet sought payment of the sum of approximately $3.89 million, with 50 per cent of the funds to be paid by midday the next day.[98]

Mr Miller gave evidence that his lawyers told him to take no notice of the demand, so he did not. He did 'not pay a cent to them'.[99]

He agreed that HelpStreet's letter provided that if People Care did not attend to payment in the terms demanded, HelpStreet would have 'no choice' but to place itself 'into administration with immediate effect, ultimately causing the home to be closed …'[100]

Mr Miller said he did not notify the department of the correspondence because he did not think HelpStreet would actually do that.[101]

In his statement, Mr Bunker said that the purpose of the letter was to impress upon People Care the seriousness of the situation and the need for People Care to make payment.[102]

In the committee's view, this statement significantly downplays the serious nature of the letter's contents and HelpStreet's intentions at that time.

Ms Tuccori gave evidence that she was not aware of the issues between People Care and HelpStreet until 7pm on 10 July 2019:

> *At approximately 7pm I received a phone call from Karen Parsons to say that something was happening. I could not quite ascertain as to how large and I certainly did not think it would have been as large as what it was. She basically had just said that there was some money owing and that Kris Bunker has said that if it is not paid, I believe the terms were 'we are out'. My understanding of that was that us as the management team would be taken out or that HelpStreet would be removing from the home and that Mr Miller would be taking back over. I cannot remember exactly now, but it was sort of like either going to be the next day or sometime in August. I recall 9 August, but I am not 100 per cent certain.*[103]

She was told to go into work early the next day for a 'further debriefing'.[104]

97 Public hearing transcript, Brisbane, 20 September 2019, p 37.

98 Public hearing transcript, Brisbane, 20 September 2019, p 37.

99 Public hearing transcript, Brisbane, 20 September 2019, p 38.

100 Public hearing transcript, Brisbane, 20 September 2019, p 38.

101 Public hearing transcript, Brisbane, 20 September 2019, p 38.

102 Submission EH010, p 4, para 36.

103 Public hearing transcript, Gold Coast, 11 September 2019, p 49.

104 Public hearing transcript, Gold Coast, 11 September 2019, p 49.

9 The events of 11 July 2019

Mr Bunker stated that he had a meeting with some of his staff at about 9am on 11 July 2019 at which time he advised them that if People Care did not make payment, there would be financial difficulties which could potentially affect HelpStreet's staff.[105]

Ms Tuccori's evidence was that at the meeting, Mr Bunker stated:

> *… that if we obviously were not paid that HelpStreet would be taken out of there as he would not be able to pay … us staff.* [106]

She gave evidence to the effect that this meant staff could not be paid, and it would be up to staff whether they remained.[107]

Mr Bunker stated that he and Mr Miller met at the facility sometime that morning. Mr Miller refused to negotiate with HelpStreet, and the situation became frustrated.[108]

According to Ms Tuccori, there was another meeting at 10am at which Mr Bunker asked one of the staff to organise a removal truck to remove HelpStreet items, including mattresses purchased by HelpStreet.[109]

Staff members gave evidence that they observed HelpStreet management removing items from the facility from about 11am.[110] One staff member recalled seeing Ms Tuccori removing beds at 10am.[111] Another staff member described the removal of the beds in these terms:

> *On the early morning of the 11th, one of the residents rang me and said, 'Robyn, can you tell me why Telecia just walked in here, ripped off my bedspread' – he was sitting on his chair – 'and never said a word?' I said, 'I don't know what's going on. I'll see if I can find out.' Those were the things that they were doing. They were slowly removing stuff and trying to do it not very – you know, that we could notice.*
>
> *I had made the beds and I noticed the ends of the beds were – around about 11 o'clock on the 11th I noticed that the beds were all lifted up, at the end of the beds. I thought, 'That's strange. I've just made those beds.' I went and remade them. By the time I got down the end of the PD corridor, I looked back and Telecia and Kimberley were dragging mattresses out the back door.*[112]

Mr Miller's evidence as to when he became aware that HelpStreet was leaving the facility was vague and contradictory.[113] He said removal vans were already at the facility when he arrived.[114] He described the scene as 'complete anarchy'. He said, 'paperwork, everything was a mess completely.'[115] He saw items being removed from the premises.[116]

105 Submission EH010, p 4, para 40.

106 Public hearing transcript, Gold Coast, 11 September 2019, pp 49 -50.

107 Public hearing transcript, Gold Coast, 11 September 2019, p 52.

108 Submission EH010, p 42, para 42.

109 Public hearing transcript, Gold Coast, 11 September 2019, p 52.

110 Private hearing transcript, Gold Coast, 11 September 2019, p 15.

111 Private hearing transcript, Gold Coast, 11 September 2019, p 18.

112 Private hearing transcript, Gold Coast, 11 September 2019, p 3.

113 Public hearing transcript, Brisbane, 20 September 2019, pp 38-42.

114 Public hearing transcript, Brisbane, 20 September 2019, p 41.

115 Public hearing transcript, Brisbane, 20 September 2019, p 40.

116 Public hearing transcript, Brisbane, 20 September 2019, p 41.

Mr Bunker says that he called a further meeting of his staff at about 1.30pm and told them that People Care owed HelpStreet a significant amount of money, that there were concerns about whether they would be paid and that People Care required HelpStreet to vacate by 9 August 2019.[117]

Ms Tuccori gave evidence that, in fact, Mr Bunker informed everyone at that meeting that HelpStreet had gone into administration. Another staff member gave evidence that at that meeting Mr Bunker told HelpStreet staff that Mr Miller was not going to pay HelpStreet and that if the staff members stayed on to work that day they would not be paid and would not be covered by insurance.[118]

In light of all the evidence about that meeting, the committee accepts, contrary to what Mr Bunker says about that meeting, that Mr Bunker told staff that HelpStreet was in administration and staff who continued to work beyond that time would not be paid.

Some staff who spoke to the committee in private session provided the committee with a range of documentary materials. Some of that material reinforces the inescapable conclusion that HelpStreet was readying to cease operations on 11 July, with evidence of the removal of the servers as early as 10am on 10 July 2019.

Ms Tuccori called 000 at approximately 1.30pm and told the operator:

> *We've just gone into administration and staff have gone home and it's not safe for our residents to be here anymore.*[119]

[117] Submission EH010, p 4 para 44.

[118] Private hearing transcript, Gold Coast, 11 September 2019, p 4.

[119] From the audio of the 000 call, available at Royal Commission tender bundle, tab 109.

10 The response by emergency services and Gold Coast Hospital and Health Service

The committee heard evidence about the emergency response to Ms Tuccori's telephone call from:

- Mr Ron Calvert, Chief Executive Officer, Gold Coast Health and Hospital Service (HHS), Queensland Health
- Mr Cary Strong, Senior Operations Supervisor, QAS
- Ms Karlene Willcocks, the Gold Coast HHS executive director for diagnostic and subspecialty services, Queensland Health.

10.1 QAS response

Following the 000 call, Mr Strong was tasked to attend at Earle Haven and did so immediately.[120] He was the first QAS officer on the scene. He told the committee that 'he received a paged message that Earle Haven had gone into administration and we needed to look at relocating approximately 69 residents from there.'[121]

He told the committee that upon arrival at about 2.15pm:

> *As I drove through the main entrance to Earle Haven there was a couple of removal trucks and a ute parked in front of where I parked. There was a number of pieces of furniture and boxes in the entryway to Hibiscus House. It was very uncoordinated and very confused as to what was happening and why that was happening and who the individuals were who were milling around that entrance point.*[122]

And in later evidence:

> *There were a number of residents at the main entry area. There was a verbal confrontation going on between a number of persons in that area and there were a couple of residents actually involved and getting upset during that confrontation.*[123]

Mr Strong spoke to Ms Tuccori and Mr Bunker. About those conversations, Mr Strong said:

> *I spoke to both Telecia and Kris and was advised that the place was in administration, the staff had gone, the place was closing and, basically, it was over to me to relocate 69 residents.*[124]

Mr Strong was told by Ms Tuccori that the staff had left, though it was apparent that staff were still on site.[125] She also told him the medical records were on a computer, on a server, and that server had been removed from the premises earlier the previous day. He later was given two black folders with limited information that was of assistance later in the afternoon.[126]

Mr Strong telephoned his director of operations and 'instigated a mass casualty action plan to be activated immediately for further assistance from the Queensland Ambulance Service'. He also telephoned the Queensland Hospital and Health Service to request further assistance, resulting in the Gold Coast HHS convening a health emergency operations centre (HEOC) that afternoon to assist with logistical requirements involved in moving the residents.[127]

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120 Public hearing transcript, Gold Coast, 11 September 2019, p 5.

121 Public hearing transcript, Gold Coast, 11 September 2019, p 4.

122 Public hearing transcript, Gold Coast, 11 September 2019, p 5.

123 Public hearing transcript, Gold Coast, 11 September 2019, p 6.

124 Public hearing transcript, Gold Coast, 11 September 2019, p 7.

125 Public hearing transcript, Gold Coast, 11 September 2019, p 5.

126 Public hearing transcript, Gold Coast, 11 September 2019, p 7.

127 Public hearing transcript, Gold Coast, 11 September 2019, p 7.

As a result of those telephone calls, further QAS officers were deployed to the facility. Seven patient care paramedics and three supervisors responded immediately.[128]

Mr Strong was appointed the forward commander for the incident. He was in charge of the QAS side of the response.[129]

Liaison between QAS personnel on site and the HEOC continued over the course of the afternoon as to what should be done with the residents:

> *The initial plan was to keep everyone sheltered in place for safety and then ascertain what the feasibility of that was going to be. As the afternoon unrolled, it was deemed that it was too unsafe to do that. The other plan that the HEOC came up with was what we went with - to relocate and evacuate the residents.*[130]

Some staff of the facility assisted with patient care and worked with the paramedics on site. Meanwhile, items were continuing to be removed from the facility.[131]

Mr Strong told of a conversation he had with Mr Miller, wherein Mr Miller advised him that he was the owner and 'basically we could leave and it would all be resolved' but Mr Strong could not do that—'not in that state leaving those residents vulnerable.' Mr Miller told Mr Strong he would appoint an administrator (meaning Ms Karen Heard), but when Mr Strong was asked by Counsel Assisting whether Mr Miller told him anything 'as to any concrete plans that he had to ensure the health and safety of those residents that afternoon' beyond appointing an administrator, Mr Strong replied, 'Not at any time.'[132]

Mr Strong gave evidence that Ms Karen Heard introduced herself saying that she could assist us – 'she could fix this and she had the staff to do so.' and later in the afternoon she met with him and the crisis team. However, according to Mr Strong:

> *When asked questions as to who the staff were, she could arrange them was basically the only answer. There was no concrete or definitive response in terms of food, hygiene or future safety of the residents. We elected at that time to proceed with the continuous plan to relocate.*[133]

Mr Strong stated there were various conversations between Mr Miller and Mr Bunker in the nature of confrontation or argument 'as to who owed who money and who was not paying and who was paying.'[134]

Mr Strong detailed the decision to move the residents, and the reasons for that decision:

> *Initially there were some residents who were relocated to hospital due to medical conditions. That was between about four o'clock and six o'clock. At approximately five o'clock the decision was to relocate. That plan was then implemented due to the fact that the place was already stripped or still being stripped. There were the welfare concerns. Patients had already been transported out due to the environment. It was deemed that there were no medical records, there were very few to no hygiene products, food had to be brought in and bottled water had to be brought in. It was deemed that it was too unsafe to maintain that environment. It was the unknown due to administration as to what other services were going to cease that night or through the night or early the next morning so the decision was made to relocate.*[135]

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128 Public hearing transcript, Gold Coast, 11 September 2019, p 8.

129 Public hearing transcript, Gold Coast, 11 September 2019, p 9.

130 Public hearing transcript, Gold Coast, 11 September 2019, p 7.

131 Public hearing transcript, Gold Coast, 11 September 2019, p 8.

132 Public hearing transcript, Gold Coast, 11 September 2019, p 8.

133 Public hearing transcript, Gold Coast, 11 September 2019, p 9.

134 Public hearing transcript, Gold Coast, 11 September 2019, p 9.

135 Public hearing transcript, Gold Coast, 11 September 2019, p 9.

The residents were moved to a range of other facilities on or near the Gold Coast. This operation took a number of hours, with the last resident leaving at about 12.30am on the following morning.

Mr Strong stated that as no catering could be 'ascertained' on site, it was arranged for Gold Coast University Hospital to provide water and sandwiches.

Counsel Assisting took Mr Strong to an entry in the Queensland Ambulance Service logs regarding the incident, to the effect that at 4.45pm:

> *Karen Heard reports nurses here know the patients and are familiar with their needs and care. If they are taken to other nursing homes they won't know how to care for these patients.*[136]

This exchange followed:

> *Ms O'GORMAN: … if there had been sufficient staffing resources at Earle Haven on the evening of 11 July 2019 such that you were confident that the residents would be looked after in terms of their health, would it have been preferable for those residents to be able to maintain the continuity of their care in the home that they were used to?*
>
> *Mr Strong: If the infrastructure was in place, most definitely, but, due to the fact that the infrastructure did not support that, just knowing the residents did not mean that you could care for them with hygiene, nutrition, hydration and infrastructure.*
>
> *…*
>
> [T]*here were people coming and going and we did not know who those people were - who was family, who were residents and who were carers - and also the drug chart information and patient care information was very limited to nothing.*[137]

The committee congratulates and commends all Queensland Ambulance Service staff involved for their care of and dedication to the wellbeing of the 69 elderly Queenslanders, many of whom were frail and/or living with dementia, who they evacuated from Earle Haven on 11 July 2019.

Mr Strong gave this evidence regarding the actions of Mr Miller on the day:

> *Mr Strong: He stayed until such time as I had a Queensland police officer have a discussion with him and then he left shortly after that discussion.*
>
> *…*
>
> *It was reported to me that his presence was upsetting some of the staff. I explained to the police officer that, due to the environment and patient safety, it would be advantageous if Mr Miller ceased to walk through the facility.*
>
> *Mr McARDLE: So you were concerned about his interaction with staff and patients as well that led you to that conversation?*
>
> *Mr Strong: That was what was reported to me—that it was a bit upsetting for some of the staff for him to be there.*
>
> *Mr McARDLE: Are you able to classify or describe his demeanour on the occasions that you saw and spoke with him or saw him interact with staff or residents of the facility?*
>
> *Mr Strong: He appeared to be very sombre. It just appeared that he was just walking around, not doing much to be honest—just walking around the residence.*
>
> *Mr McARDLE: The next question then is: did he participate in assisting either yourself or the relevant HHS personnel in caring for patients?*

[136] Public hearing transcript, Gold Coast, 11 September 2019, p 12.

[137] Public hearing transcript, Gold Coast, 11 September 2019, p 12.

Mr Strong: Not that I ever witnessed.

Mr McARDLE: Okay. Did he help you in understanding where the computers may have been taken that contained the medical records?

Mr Strong: No.

Mr McARDLE: Can I categorise the fact that Mr Miller virtually did nothing to assist the situation on that date, or is that too strong an observation?

Mr Strong: It would be very strong, but I do not think you would be far off.[138]

Regarding Mr Bunker, Mr Strong described him as:

Very helpful. I asked him for assistance with the patient care records, but he advised me that he could not because they were on a computer. Any other assistance or any other questions I asked him, he answered.

Mr McARDLE: And he was quite willingly open to a discussion in providing that help?

Mr Strong: Yes.[139]

10.2 Gold Coast HHS response

Mr Strong's telephone call to Gold Coast HHS triggered a code brown response, being declared by Gold Coast HHS, having been considered necessary because it was considered a significant amount of resources from Gold Coast HHS would need to be deployed to deal with what was happening at Earle Haven. Mr Ron Calvert gave evidence about that response:

- The code brown response is part of the Gold Coast HHS emergency preparedness continuity plan.
- The code brown, in turn, triggered the setting up of a HEOC to manage and resource the incident at Earle Haven.
- Mr Calvert appointed the acting chief operations officer, Patrick Turner, as the health incident controller.
- Mr Calvert's role was to support the HEOC in whatever way was necessary.[140]

The HEOC comprised 15 to 20 managers and senior clinicians.[141] In total, more than 100 staff from the Gold Coast HHS were involved in assisting with the situation at Earle Haven that day.[142]

One of the first things the HEOC did was dispatch a team to the facility. The team comprised a number of nurses, an emergency department doctor and some executive staff, including Ms Karlene Willcocks, chief executive officer, Diagnostic and Subspecialty Services.[143]

The committee expresses appreciation for the work of all Gold Coast HHS and Queensland Health staff involved for their swift action to ensure all 69 elderly Queenslanders were placed into a suitable residential aged care facility on the Gold Coast and notes that their prompt response in all likelihood avoided much more serious outcomes.

138 Public hearing transcript, Gold Coast, 11 September 2019, p 16.

139 Public hearing transcript, Gold Coast, 11 September 2019, p 16.

140 Public hearing transcript, Gold Coast, 11 September 2019, pp 20-21.

141 Public hearing transcript, Gold Coast, 11 September 2019, p 21.

142 Public hearing transcript, Gold Coast, 11 September 2019, 24.

143 Public hearing transcript, Gold Coast, 11 September 2019, p 21.

10.3 The scene confronting the emergency responders

Ms Willcocks was on site from about 3.40pm to 11.00pm. She similarly told the committee of her absolute priority of keeping the residents safely on site if at all possible. She gave evidence which supported that of Mr Strong as to the chaos and confusion on site that afternoon, the removal of equipment throughout the afternoon, and of having been told of the absence of patient records.

Ms Willcocks described what she observed upon arrival:

> *The site was chaotic when we arrived. As we arrived, we walked in, a fridge walked out. The equipment was leaving past us as we arrived in the door. It was confusing. There were a lot of people milling around. It was unclear who the people were. There were people at the desk to the left that you saw in the earlier photos, but there were also a large number of people at the desk just outside the pharmacy room that you had the photos of, and then a large number of people in the lounge / dining area. There were also people in the foyer. On talking to Cary, he also was unclear. The people were entering and exiting through that door as an egress for multiple reasons.*[144]

Ms Wilcocks outlined difficulties confronting the responders in terms of identifying residents and matching them to their medicinal needs:

> *Not knowing the patients, a team of our nurses did go over to the Orchid unit and do a drug round over there, because we knew the drugs were due. They took over three hours, I think, to do that drug round, just with the complication of identifying patients and having to find medications and with medications they were not familiar with, and the potential impact on those patients if they got the wrong medication or did not get a medication. For the staff who were looking for the next-of-kin details, as I said, we found hard copy files but they did not appear to be up to date, from what was reported back to me, and you needed to go through every single file to get the list of next to kin to contact.*[145]

Ms Willcocks recalled speaking to Ms Heard. Ms Heard told Ms Willcocks that she was the administrator and a registered nurse, but Ms Willcocks was not able to confirm if that was accurate.[146] She was told by Ms Heard that staff would be arriving, but Ms Willcocks saw 'no evidence of that'.[147]

Ms Willcocks said the task of attempting to determine who could provide assistance was made more difficult because there were people everywhere: staff, residents, family members, the local state Member of Parliament and a member of her office, people from the Queensland Nurses and Midwives' Union and one or two government ministers.[148]

Mr Strong also spoke to Ms Heard. She told him she could assist but Mr Strong noted that her plan was to arrange staff to come in. He said that she had no concrete plan for the provision of food, hygiene or safety for the residents.[149]

Mr Strong recalled speaking to Mr Bunker and Mr Miller.[150] Mr Miller told him that the QAS could leave because he would appoint Ms Heard as an administrator and 'it would all be resolved'.[151] However, Mr

144 Public hearing transcript, Gold Coast, 11 September 2019, p 25.

145 Public hearing transcript, Gold Coast, 11 September 2019, p 27.

146 Public hearing transcript, Gold Coast, 11 September 2019, p 25.

147 Public hearing transcript, Gold Coast, 11 September 2019, p 26.

148 Public hearing transcript, Gold Coast, 11 September 2019, pp 33-34.

149 Public hearing transcript, Gold Coast, 11 September 2019, p 9.

150 Public hearing transcript, Gold Coast, 11 September 2019, pp 6, 8.

151 Public hearing transcript, Gold Coast, 11 September 2019, p 8.

Miller also did not indicate what plans he had in place to ensure the health and safety of the residents that afternoon.[152]

Mr Strong observed Mr Miller and Mr Bunker continued to argue about money.[153] He observed that Mr Miller's presence was upsetting some of the staff so he arranged for a Queensland police officer to request that Mr Miller leave.[154]

Many of the staff members who gave evidence at the hearing said they remained at the facility despite having no expectation that they would be paid for their shift, and others came in to assist when they heard what was occurring despite not being rostered on.[155] Mr Strong was grateful for the assistance of the staff who stayed on to help even knowing that they did not have a job.[156]

10.4 The lack of records and other resources

The emergency responders attempted to obtain the patient records but became aware that they were not available because computer servers had been removed from the site.[157] The hard copy records were not up to date.[158]

Ms Tuccori told the committee that records of the medications for the residents at the facility were not on the computers, but rather were in the medication charts located in the treatment rooms of both buildings, and were not backed up electronically. Progress notes and care plans were on computer, with no hard copies. She agreed that when 'outsiders' arrived to assist with what was occurring on 11 July 2019, they could not and did not have access to those records. Additionally, there would have been a paper-based care plan in a resident's personal file, but it would be an outdated version. Next-of-kin records were both paper and computer based. She was unsure whether the paper based next-of-kin records were up to date.[159]

As a result, Ms Willcocks said that they could not be certain that each of the residents received their required medications that evening.[160]

Ms Willcocks also gave evidence about a lack of equipment:

> *Meanwhile, in amongst all of this, the team were trying to keep people clinically safe. I was receiving sheets of paper that highlighted what supplies people needed—so a list that said we need gloves, large, extra-large, medium; rubbish bags, black and white; four alcohol foam bottles—because the area had been stripped. In all of this process, as part of our assessment when we did our first walk-through to identify whether we could keep patients in the area, we found that the medication room, which people had started to take stuff out of, probably was the most intact room. In the pan room, the pan muncher, as we call them, had the front panel off and did not look like it was electrically sound to use, but there were bed pans left in there. There was no cleaning equipment left in the cleaning room or very minimal cleaning equipment. The stores cupboard had been stripped, so there was no longer any boxes of gloves or cleaning products. There was no dressing equipment or any of those things in there.*[161]

152 Public hearing transcript, Gold Coast, 11 September 2019, p 9.

153 Public hearing transcript, Gold Coast, 11 September 2019, pp 9, 17.

154 Public hearing transcript, Gold Coast, 11 September 2019, p 16.

155 Private hearing transcript, Gold Coat, 11 September 2019, pp 16, 18, 20-22.

156 Public hearing transcript, Gold Coast, 11 September 2019, p 15.

157 Public hearing transcript, Gold Coast, 11 September 2019, pp 7, 26.

158 Public hearing transcript, Gold Coast, 11 September 2019, p 26.

159 Public hearing transcript, Gold Coast, 11 September 2019, p 49-50.

160 Public hearing transcript, Gold Coast, 11 September 2019, p 26.

161 Public hearing transcript, Gold Coast, 11 September 2019, p 26.

10.5 The decision to re-locate the residents

Mr Strong recalled that, at about 5pm, the HEOC informed those responders at the scene that the decision had been made to relocate the residents to other aged-care services.

Mr Calvert confirmed that that was the case.[162] The 'prime consideration' for the HEOC 'was always going to be the safety of the residents.'[163] The HEOC initially considered three main scenarios:

- keeping the residents at the facility, even if only for a few days
- relocating the residents to nearby aged-care facilities, or
- finding beds for the residents in hospital.[164]

The preferred option was to keep the residents at the facility to 'keep the home going in some way, even if it was only for a few days until some better arrangement could be found.'[165] The alternatives—finding up to 70 beds in other nursing homes, or else in hospitals—were 'difficult'.[166]

In light of the state of affairs at the facility, the HEOC concluded that the best option was to relocate the residents to other facilities.[167]

All but two of the residents were transferred to other aged-care services, either by Queensland Ambulance Service vehicles or Queensland Health pool cars.[168] Two residents were taken to hospital.[169] The process of moving all the residents was concluded shortly after midnight.[170]

[162] Public hearing transcript, Gold Coast, 11 September 2019, p 21.
[163] Public hearing transcript, Gold Coast, 11 September 2019, p 21.
[164] Public hearing transcript, Gold Coast, 11 September 2019, pp 21-22.
[165] Public hearing transcript, Gold Coast, 11 September 2019, p 21.
[166] Public hearing transcript, Gold Coast, 11 September 2019, pp 21-22.
[167] Public hearing transcript, Gold Coast, 11 September 2019, pp 21-22.
[168] Public hearing transcript, Gold Coast, 11 September 2019, p 10.
[169] Public hearing transcript, Gold Coast, 11 September 2019, p 11.
[170] Public hearing transcript, Gold Coast, 11 September 2019, p 13.

11 The impact on the residents and their families

Both Mr Strong and Ms Willcocks gave evidence that the incident was traumatic for the residents.[171] One of the staff members, who attended to assist despite not being rostered on, described the incident in the following terms:

> *It was very distressing. Some of the residents were crying. It is very, very hard not to cry with them, because you do not want to cry in front of them …*
>
> *Then I heard that one of the residents was pretty distressed in her room, so I went in with her and I sat in with her for quite some time. She was crying, 'I don't want to go, I don't want to go. You can't force me out of here.' I just sat there with her and held her hand and said, 'Look, it will be okay.' Anyway, with that, she was still very distressed when the ambulance people came in to take her, so I went with her then and sat with her out in the main foyer. There were more than just her that were very upset about going. It was a nightmare.*[172]

The committee did hear from some family members (in private session) that their relative's well-being had improved in some respects since being re-located on 11 July 2019.

The family members who gave evidence said that they were not informed about the incident by anyone from the facility itself. One family heard about it from Facebook and the other from a media report.[173]

With specific reference to the impact of the re-location on residents, Mr Rowe told the committee:

> *I attended the meeting that was held with residents, the Earle Haven owner and the Commonwealth department a week or two after the closure and was quite concerned at the number of families who were saying, 'We want our loved ones back here.' For me, that was something I could not reconcile with all of the history I had heard, and indeed the experience that people had just been through. Perhaps it was people wanting life to return to normal. I think that is part of it; I think none of us like change. I think one of the other issues was—in terms of their loved ones being displaced—for many people who lived in the retirement village but their family member lived in the aged-care facility, it was very easy to visit and visit on a daily basis. The concern about the interface between aged care and retirement is a matter that has to be addressed by government going forward.*[174]

One submission from a family member detailed the stress of the relocation a resident:

> *Although the staff at the … Nursing Home where* [she] *was taken to were wonderful and supportive, she continued to feel displaced and anxious due to the suddenness of the incident and ensuing uncertainty combined with the fact that all her personal belongings incl. clothes, hobby pastimes, and tv had to remain at Earle Haven. We, the family, tried to encourage her but with limited information and many questions, and with utter disbelief at the whole situation, we were not able to comfort very much. Due to the stress,* [she] *began vomiting and suffered from heartburn and nausea whilst at her new temporary dwelling…*[175]

As another family member put it:

> *Our lives really did turn upside down on 11 July. It is a very difficult and emotional experience to go through the process of putting someone that you care about into care.*
>
> *…*

171 Public hearing transcript, Gold Coast, 11 September 2019, pp 8-19 and pp 28, 34.

172 Private hearing transcript, Gold Coast, 11 September 2019, pp 16.

173 Private hearing transcript, Gold Coast, 11 September 2019, pp 6-7.

174 Public hearing transcript, Gold Coast, 12 September, p 9.

175 Confidential submission EH005, p 2.

> *I think about a week after the events there was a meeting called at Earle Haven with representatives of the federal department of health, People Care, the aged-care compliance auditors and aged-care and disability advocacy associations to give information...*
>
> *There was a lot of uncertainty about when or if Earle Haven would subsequently reopen. Mum had been taken from a private room and placed into a shared room with three other residents and was deeply distressed that things of hers were being taken by another elderly residents who obviously had some compulsions in that regard. We felt that we did need to look at getting Mum settled somewhere.*
>
> *I had a conversation with a senior representative of the department of health and said, 'I hear what you are saying that we should find somewhere, but finances are a big consideration. Mum doesn't have a lot of money.' I was assured by this person at director level that, due to the unprecedented nature of this crisis and as part of the response, the aged-care providers had agreed that they would take displaced residents under the same financial arrangements and that no resident would be financially worse off as a result of this incident.*[176]

At this time the facility remains closed, and People Care's accreditation as approved provider has been revoked. Not surprisingly, for most if not all the residents, Orchid House and Hibiscus House were, and perhaps remain 'home'. Many of the evacuated residents have partners still living in other areas of The Earle Haven Retirement Village.

The committee appreciates there are some hurdles to be overcome and some former residents might not want to return to the facility, but nonetheless those residents who wish to return should have the opportunity to do so in the future, if at all possible.

Recommendation 1

The committee recommends that all options be explored to allow the residents evacuated from the facility to return to their home.

[176] Private hearing transcript, Gold Coast, 11 September 2019, p 7.

12 Views about the response by emergency services and Gold Coast HHS

Ms Heard gave evidence that, in her view, the residents could have stayed at the facility and that she would have been able to arrange care for them in a timely and safe way.[177] She acknowledged, however, that the scene at the facility when she arrived at 3pm was 'chaotic' and, if she were in the same position as the emergency responders that day, she may have made the same decision they did to relocate the residents.[178] She also accepted that the facility could not have continued to operate while the information from the servers was missing.[179]

Mr Miller also gave evidence that he considered the residents ought to have remained at the facility that day. He gave evidence that Ms Heard told him that they were in a position to keep the residents at the facility and that, in his opinion, the emergency services did the wrong thing by removing them.[180] He acknowledged, however, that he could not personally be sure that People Care was in a position to continue to care for the residents that afternoon; he relied on what Ms Heard told him in that respect.[181]

Ms Tuccori gave evidence that 'it was very chaotic' by the time the emergency services arrived at the facility.[182] Residents were upset.[183] She said she would 'absolutely not' dispute the assessment of the emergency responders that they could not meet the care needs of the residents while they remained at the facility that afternoon.[184]

One industry worker who gave evidence in a private session was critical of the fact that the Gold Coast HHS 'sent in emergency doctors, not geriatricians' and thought the decision to relocate the residents 'was the wrong solution to the problem'.[185] However, it is not clear that she understood the full extent of the circumstances which presented themselves to the emergency responders.

Mr Dan Prentice, from the Queensland Nurses and Midwives' Union (QNMU), considered it 'surprising and concerning' that the regulators did not subject Earle Haven ownership and management to greater scrutiny in the lead up to its closure, given the history of non-compliances, but commended the response of the state authorities to what occurred on 11 July 2019.[186]

Some staff who spoke to the committee in private session expressed the view that the relocation of the residents was unnecessary, including stating that, whilst items were being removed by HelpStreet, replacement items were available elsewhere in the village complex.

Ms Bernie O'Connor, team leader of the private and aged care sector organisers, QNMU, attended the facility at approximately 3pm on 11 July 2019. She initially considered that the best approach would be to keep the residents at the facility and care for them there. However, when she arrived she observed the lack of food, resources and records. Her view was that, in the circumstances, it was more appropriate for the residents to be relocated.[187]

177 Public hearing transcript, Gold Coast, 11 September 2019, pp 67-69.

178 Public hearing transcript, Gold Coast, 11 September 2019, pp 72-73.

179 Public hearing transcript, Gold Coast, 11 September 2019, p 66.

180 Public hearing transcript, Gold Coast, 11 September 2019, pp 42, 43.

181 Public hearing transcript, Gold Coast, 11 September 2019, pp 43-44.

182 Public hearing transcript, Gold Coast, 11 September 2019, p 53.

183 Public hearing transcript, Gold Coast, 11 September 2019, p 54.

184 Public hearing transcript, Gold Coast, 11 September 2019, p 59.

185 Private hearing transcript, Gold Coast, 11 September 2019, p 3.

186 Public hearing transcript, Gold Coast, 12 September 2019, p 23.

187 Public hearing transcript, Gold Coast, 12 September 2019, pp 26-27.

Ms O'Connor considered the emergency responders did a very 'impressive' job that evening. They remained calm and treated each resident with care and individual attention.[188] She said lots of staff members remained at the scene to help.[189]

In the committee's view, Mr Miller and Ms Heard both appear to have underestimated the challenges involved were People Care to assume running the facility immediately on HelpStreet's departure on 11 July 2019, with the residents remaining in place. For example, in relation to records removed from the facility, Mr Miller himself stated at some time after the closure (in an August 2019 newsletter to residents of the village):

- 'We are in what we think are the final steps of negotiation to be given temporary access to our resident's care records we are already seeking a more permanent solution'
- (regarding other information and while some other records regarding the operation of the facility had been obtained), the 'process of recovering the remaining information from HelpStreet will be ongoing'.[190]

Certainly from the point of view of Queensland Health and QAS on the day, informed by information as to what was happening on the ground at the facility, the decision to relocate the residents was the only practical option.

188 Public hearing transcript, Gold Coast, 12 September 2019, pp 26-27.

189 Public hearing transcript, Gold Coast, 12 September 2019, p 27.

190 Article, 'Update from Mr Miller', in the *Earle Haven Chronicle*, August 2019.

13 Other issues raised during the investigation

13.1 Council on the Ageing Queensland

Council on the Ageing (COTA) Queensland made a submission which focussed on two main areas:

- the relocation of the residents
- the lack of regulation around subcontracting arrangements (arising from the engagement of HelpStreet to operate the facility on behalf of the approved provider).

13.1.1 Relocation of the residents

On the former, COTA stated it was:

> *… deeply concerned with the situation at Earle Haven—in particular the distress experienced by the residents who were removed from their 'home' in an emergency—type situation, the health and safety risks for these residents, and the increased concern and alarm for older people and their carers and families in considering Residential Aged Care as an option for themselves and their loved ones in the future.*[191]

In referring to the relocation of the residents, COTA stated:

> *Emergency evacuation arrangements for residents of Aged Care Facilities is another major area of concern which involves Commonwealth, State and Local Governments. The forced evacuation of the 69 residents for administrative rather than clinical reasons placed substantial pressure on the Queensland Ambulance Service to meet this request for assistance. It is of serious concern that the provider and the sub-contractor had no pre-existing plans in place to manage an emergency evacuation of high care residents.*
>
> *…*
>
> *Current legislation focuses on evacuation in the case of a fire, with providers required to nominate a safe place to which evacuated residents can be moved, typically a car park. Under state emergency legislation there are no specific provisions that relate to residential care facilities.*
>
> *…*
>
> *COTA now believes that the definition of emergency should be broadened to include any event that could have adverse health impacts on patients/residents in residential care.*[192]

At a hearing, Mr John Stalker, policy co-ordinator from COTA, stated:

> *It has been the ongoing position—and it still is, as far as we understand—of Queensland Fire and Emergency Services that, as far as they are concerned, anything to do with aged care is a Commonwealth responsibility. The Commonwealth, while it puts out the guidelines on how aged-care facilities should be prepared and able to respond in case of an emergency, defers to state emergency arrangements. They advise providers to ensure that they liaise with the appropriate agencies both at the state and the local government level.*
>
> *…*
>
> *It is okay saying an emergency will cover fire, storm and flood, but we are also concerned in respect to Queenslanders whether emergency should also include any life-threatening event. The fact that you have administrative transfer of residents—and it may not be because of clinical reasons—does not mean that the lives of those older Queenslanders are not under threat through forced evacuation where there is uncertainty over where they will go and what*

[191] Submission EH002, p 3.

[192] Submission EH002, pp 3, 4.

circumstances they will be in where they end up and whether that will be better conditions than they are currently in.[193]

COTA advised the committee that after the Earle Haven closure, it had written to the state Health Minister expressing concern and had received a response on 10 September 2019, explaining that Queensland Health was working with Queensland Fire and Emergency Services (QFES) to look at reviewing existing guidelines for aged-care providers in the event of an evacuation situation.[194]

The need for the evacuation should not have arisen and was not foreseeable. The evacuation was carried out well on short notice. The committee agrees that the Earle Haven closure highlighted the need for authorities to be better prepared to meet situations where aged care facilities need to be evacuated, for whatever reason.

Recommendation 2

The committee recommends that the state government explore options to strengthen evacuation planning measures for residential aged care facilities, in consultation with federal government agencies responsible for aged care, to ensure they adequately cover the evacuation of residents and staff from facilities due to the sudden loss of care services.

13.1.2 Subcontracting arrangements

In relation to the issue of contracting out services, COTA expressed concern that:

The Earle Haven situation may have exposed a 'canary in the mine' situation, highlighting a number of risks arising through business arrangements between owners of facilities, contractors and sub-contractors.[195]

COTA highlighted the regulatory deficiency or gap here:

The aged care provider registration process places a strong onus on an organisation seeking registration to prove that it is capable of managing an aged care facility at an acceptable standard. However, if that registered provider chooses to sub-contract out its care responsibilities, the sub-contractor is not required to go through the registration process. It is presumed that the registered provider will manage the relationship under its registration. The Earle Haven situation based on the information made public shows a situation where commercial conflict existed for a reasonable period between the registered provider and the company contracted to provide residential care services on behalf of the registered provider. COTA Queensland is concerned that a sub-contractor is not also required to be a registered provider, this should be the case even where the sub-contractor does not intend to seek funding directly from the Commonwealth.

The Commonwealth Government requires that registered providers maintain resident medical and care records on-site to ensure medical records can be readily accessed to help expedite any medical assistance required by a resident. The 69 residents of Earle Haven who had to be relocated to other care facilities were reported to all have had high medical care needs, including dementia. The removal of the computer servers that held the residents' medical records on 10 July 2019 placed any resident requiring urgent medical assistance in a high risk situation if medical practitioners could not access the resident's medical history and current treatments. This situation is so serious that those responsible should face strong legal consequences for this action. The Commonwealth Government must strengthen the sanctions it currently has in place where providers and their agents breach registration requirements.

193 Public hearing transcript, Gold Coast, 12 September 2019, pp 3, 4.

194 Public hearing transcript, Gold Coast, 12 September 2019, p 4.

195 Submission EH002, p 3.

> *It is understood that Queensland Ambulance officers and Health officials would have preferred to keep all residents at Earle Haven to minimise the stress and health risks that could arise through forced relocation from their home. It was disturbing to hear that the removal from the facility of supplies and equipment necessary to maintain the residents' welfare gave health and ambulance officials little choice but to evacuate residents. This situation is another clear breach of the provider's responsibilities to the residents as well as the requirements of its registration.*[196]

Mr Stalker and Mr Mark Tucker-Evans, chief financial officer, from COTA spoke about the need for plans for the safe and orderly evacuation of older people from aged care facilities to be in place in the event of another incident like the one that occurred on 11 July 2019.[197]

In their view, there ought to be a requirement for operators of aged care facilities in Queensland to be able to demonstrate the existence of effective mechanisms to ensure safe evacuation of residents in the event of an emergency.[198]

They considered that there ought to be a requirement that, if an operator's business is in jeopardy, the operator must advise authorities of that so that alternative arrangements could be put in place.[199] They envisaged oversight of those requirements resting with state government.[200]

13.2 Aged and Disability Advocacy Australia

In evidence, Mr Rowe of ADA acknowledged what he described as 'the complexity of the interface between Commonwealth and state governments' in relation to aged care but he opined that 'the state government does have a very clear role in respect of protecting the rights of older people'.[201] He considered that the state government ought to be involved in monitoring the use of physical and chemical restraints, which he considers can be problematic if not appropriately monitored.[202]

He recommended that there should be a formalisation of the role of advocates in the protection of older people's rights in the aged care framework.[203]

Mr Rowe also proposed that there be an Ageing Commissioner for Queensland:

> *I think we need to give consideration to whether there is a role for an ageing commissioner within Queensland. We have seen the development of that role in New South Wales—only just—and within Victoria, it was about 12 months ago. As we are seeing more Queenslanders age, as we are seeing the difficulties that they are having in having their voice heard, I think it is imperative that the state government takes the lead on addressing those concerns.*[204]

Mr Rowe expanded on this proposal, particularly in the context of discussion regarding overuse of chemical and physical restraint:

> *At the moment the monitoring of the use of chemical restraints within disability services falls within the responsibility of the Office of the Public Guardian. People are required to have what they call a positive behaviour support plan—a plan that approves the use of restrictive practices—and that is supported and signed off by QCAT through the Office of the Public Guardian. I suspect that someone far more clever than I will work out where and with whom it should sit within government.*

196 Submission EH002, p 3.

197 Public hearing transcript, Gold Coast, 12 September 2019, pp 2-8.

198 Public hearing transcript, Gold Coast, 12 September 2019, p 4.

199 Public hearing transcript, Gold Coast, 12 September 2019, p 5.

200 Public hearing transcript, Gold Coast, 12 September 2019, p 7.

201 Public hearing transcript, Gold Coast, 12 September 2019, p 9.

202 Public hearing transcript, Gold Coast, 12 September 2019, pp 9, 15-16.

203 Public hearing transcript, Gold Coast, 12 September 2019, pp 10, 13.

204 Public hearing transcript, Gold Coast, 12 September 2019, p 10.

> *I think the commissioner was about saying that there needs to be somewhere older people can go to have their concerns and their complaints addressed. Older people are not very good at that. My team often talks about the current cohort of users in aged care being the grateful generation. They are a generation that has grown up through the war, through the Depression. They are generally grateful for what they get. They do not complain. They are also called the silent generation.*[205]

New South Wales established the role of Ageing and Disability Commissioner in mid-2019, with the functions to:

- investigate allegations of abuse, neglect and exploitation of adults with disability and older people in home and community settings
- provide support to vulnerable adults and their families or carers following an investigation
- report and make recommendations to government on systemic issues related to abuse, neglect and exploitation
- raise community awareness of abuse, neglect and exploitation, including how to prevent, identify and respond to matters
- administer the Official Community Visitors program, in relation to disability services and assisted boarding houses.

Victoria has a Commissioner for Senior Victorians, who advises and reports to the Victorian government on policy issues affecting senior Victorians.

The committee will consider the issue of whether there is a need for an Ageing Commissioner in Queensland as part of its broader inquiry into aged care.

13.3 Aged care crisis

Aged Care Crisis Inc. made a submission focused on the regulatory framework. It had provided the same submission to the inquiry conducted by Ms Carnell.[206]

One important focus for that organisation is the current lack of provision for input by community members in the approved provider application process. Another area addressed in the submission and in evidence from Dr Michael Wynne from Aged Care Crisis Inc., is that while the approved provider application process provides for assessment of approved providers, there is much less scope for regulation or any requirement for an assessment of any subcontractor sought to be engaged by an approved provider to provide care services on its behalf.[207]

He recommended that any changes to the regulatory regime regarding approved providers ought to provide for a mechanism whereby community members can have greater input into the application process.[208]

13.4 Queensland Nurses and Midwives' Union

Some of the staff that met with the committee were supported by the QNMU, which was advocating for staff in ongoing claims for outstanding monies. Additionally, the union made a written submission to the committee, and representatives gave evidence before the committee.

The union made these recommendations in its submission:

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[205] Public hearing transcript, Gold Coast, 12 September 2019, p 12.

[206] Submission EH009.

[207] Public hearing transcript, Gold Coast, 12 September 2019, p 20.

[208] Public hearing transcript, Gold Coast, 12 September 2019, p 20.

1. *The Queensland Government investigate its powers and/or authority under its public health mandate with a view to legislating that all Queensland residential aged care facilities must have at least one registered nurse on site 24 hours per day, 7 days a week;*
2. *The Queensland Government pursue the introduction of evidence based legislated minimum staffing and skill-mix requirements for all nursing homes (RACFs) by the Federal Government at all opportunities, e.g. Council of Australian Governments;*
3. *The Queensland Government coordinate the development of a state-wide aged care workforce plan in conjunction with the federal government, aged care providers, provider representatives, relevant unions, consumers and training and education providers to ensure that there are sufficient aged care workers to meet projected demands for care;*
4. *The Queensland Government legislate to ensure public transparency of all private nursing home nurse to resident ratios and skill mix;*
5. *The federal government amend the Aged Care Act 1997 to require evidence of compliance with benchmarks that ensure both the number and skills of staff are adequate to ensure quality care is provided by all categories of staff and abuse-by-neglect will be minimised, if not eliminated;*
6. *The federal government amend the relevant aged care regulation to include provisions mandating that aged care regulation must be read in conjunction with the Health* Practitioner Regulation National Law Act 2009 *(National Law).*[209]

The QNMU's evidence was that it had become aware of issues at Earle Haven in early July 2019, ahead of the closure. The QNMU also advised:

- *For the period January 2010 to July 2019 over 250 member contact records were reviewed*
- *Issues identified included:*
  - *Industrially related matters such as enterprise agreement enquiries, leave entitlements (various), hours of work and wage rate enquiries including underpayments, superannuation, public holidays and workloads*
  - *Disciplinary matters and requests for representation*
  - *Legal assistance requests*
  - *Membership matters*
  - *Occupational health and safety*
  - *Professional practice*
  - *Workers compensation.*
- *Issues were triaged and referred to the appropriate QNMU business unit for follow up and resolution, e.g. membership, servicing, industrial, professional.*[210]

Mr Prentice, from the QNMU, identified the following issues related to the closure at Earle Haven:

> *… the need for more robust regulatory mechanisms to identify providers at risk of failure, to prevent future uncontrolled collapses; the need for rapid response mechanisms by state and federal agencies in the event of future closures; better coordination between regulators whose responsibilities include the aged-care sector; the need for appropriate criminal sanctions against those who put the safety and welfare of older Australians at risk; the complexity of the aged-*

[209] Submission EH003, p 4.

[210] QNMU, letter to the committee, dated 4 October 2019.

care regulatory environment and the need to address gaps and clarify jurisdictional responsibilities; and the need for the state to remain engaged in the aged-care sector.[211]

He spoke of a need to improve staffing levels, and transparency about staffing levels, across the industry and identified the use of physical and chemical restraints in aged care as an ongoing issue.[212]

While these issues are thrown into relief by the events at Earle Haven, they are issues of wider concern regarding the quality and safety of aged care. The committee will consider these issues in the context of its broader inquiry into aged care. However, as set out below (at page 43), the committee makes some recommendations at this stage.

[211] Public hearing transcript, Gold Coast, 12 September 2019, p 23.

[212] Public hearing transcript, Gold Coast, 12 September 2019, pp 31-34.

14 Regulatory oversight of the facility

14.1 General issues

People Care was the approved provider for the facility from about 2006. People Care had previously operated a number of aged care facilities in New South Wales, apparently without coming to the adverse attention of regulatory agencies.

However, People Care in the context of Earle Haven had a lengthy, troubled history with regulatory compliance.

In April 2007, the agency audited Hibiscus House and found that it did not comply with several standards and outcomes, including in the areas of continuous improvement, regulatory compliance, education, staff development and clinical care.

As a result, the department imposed a sanction on People Care requiring it to appoint a Commonwealth approved provider to assist it to comply with its statutory responsibilities at Hibiscus House.

In November 2015, the agency conducted a review and found that People Care complied with only six of the 18 expected outcomes of the home care standards. People Care did not meet expected outcomes in key areas such as regulatory compliance, risk management, and care plan delivery and development. As a result of that review, the department issued People Care with a notice of non-compliance in January 2016.

In May 2016, the agency conducted a review of both Hibiscus House and Orchid House. That review concluded that People Care failed to meet several of the expected outcomes of the accreditation standards, including in the areas of continuous improvement, clinical care and catering, cleaning and laundry services.

In June 2016, a notice of non-compliance issued and sanctions were imposed from June to December 2016.

These included a requirement that People Care appoint an approved adviser to assist it in complying with its regulatory obligations.

In September 2016—only a number of months later—the appointed adviser discontinued its services at the facility because of what it described as the failure of People Care management to follow the advice that it was giving to People Care. In October 2016, the department issued a notice of non-compliance to People Care. The following month—in November 2016—the agency conducted a further review at which improvements were noted, but the agency determined that People Care did not meet the expected outcomes of the home care standards for areas that included regulatory compliance and information provision.

People Care was required to take steps to rectify its non-compliance by April 2017. In April 2017, the agency conducted a further assessment and found that those two areas of expected outcomes were still not being met and that a third area of expected outcome was not at that time being met. People Care was given a notice of non-compliance and a notice to remedy. In May 2017, the next month, the department, satisfied that People Care had not complied with its undertaking to remedy the non-compliance, imposed a sanction which required People Care to appoint an administrator to assist People Care to meet its responsibilities.

As noted earlier, in April 2018 People Care had engaged HelpStreet to undertake the day to day management and provision of aged care services at the facility. People Care remained the approved provider under the regulatory regime.

In August 2018 and January 2019, the agency then conducted further assessments and the expected outcomes were noted as being met at those times. In January 2019, however, the department issued a non-compliance notice to People Care for a failure to lodge financial documents in time.

In a post-hearing submission to the Royal Commission case study, the Commonwealth stated:

> *The Commission's and the Department's compliance functions are primarily focused on ensuring the care and well-being of care recipients and in particular, the quality of care that is provided to care recipients. They are not overly preoccupied with minimum standards and procedural steps with managing approved providers back to compliance 'at all costs'. In determining what actions are appropriate, the Commission and the Department consider not only quality and safety issues, but also the disruption to quality of care that would occur when a service's approved provider status is revoked. In particular, the Commission and the Department are aware that the closure of a residential aged care service would require moving frail elderly people and note that trauma and disruption from relocation increases the risk of adverse events.*[213]

The submission acknowledges a failure regarding Earle Haven:

> *In the context of this case study, the Commission and the Department accept that the regulatory response was shaped by deficiencies in information-sharing, follow through and assessment of identified risks. In particular, the circumstances associated with this particular outsourcing arrangement warranted closer examination at the time it was made known to the Commission and the Department. This is because:*
>
> *(a) the approved provider had outsourced its central functions to a subcontractor to such an extent that it had no role of the management of the service;*
>
> *(b) the subcontractor did not have appropriate experience in operating a residential aged care service;*
>
> *(c) the subcontractor was not itself an approved provider as was known to the Commission; and*
>
> *(d) the approved provider did not have appropriate governance structures in place.*
>
> *The Commission and the Department accept that there is a significant risk where an approved provider subcontracts substantial parts of its responsibilities to a third party (such as the management of a residential aged care facility). This is particularly where an approved provider such as People Care enters into an arrangement such as the one described in paragraph 10 above.*
>
> *…*
>
> *The Commission and the Department consider that it would be beneficial for there to be a clear obligation to require approved providers to advise the Commission of changes to sub-contracting arrangements from the time that the original application for approval was made.* [214]

The history of non-compliance by People Care set out above indicates a history of regulatory failure with respect to the facility, in turn indicative of shortcomings in the regulatory framework.

In relation to the specific issue of sub-contracting, the sub-contracting of services in aged care is expressly contemplated by the current legislation:

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[213] Submission by the Commonwealth to the Royal Commission into Aged Care Quality and Safety Brisbane Hearing: Earle Haven Case Study, p 3. https://agedcare.royalcommission.gov.au/hearings/Documents/post-hearing-submissions/brisbane/RCD.0012.0028.0024.pdf. Note: In-text references have been removed. Refer to original source.

[214] Submission by the Commonwealth to the Royal Commission into Aged Care Quality and Safety Brisbane Hearing: Earle Haven Case Study, p 4. https://agedcare.royalcommission.gov.au/hearings/Documents/post-hearing-submissions/brisbane/RCD.0012.0028.0024.pdf. Note: In-text references have been removed. Refer to original source.

Care provided on behalf of an approved provider

A reference in this Act to an approved provider providing care includes a reference to the provision of that care by another person, on the approved provider's behalf, under a contract or arrangement entered into between the approved provider and the other person.[215]

The approved provider remains responsible as the accountable entity.

Here, on the material before the committee, People Care outsourced virtually all the responsibility of operating the facility to HelpStreet. In light of the events of 11 July and the evidence of the actions of HelpStreet, the dangers in such a course are self-evident.

The committee notes the findings and recommendations of the Carnell inquiry, and awaits with interest the outcome of the Royal Commission's consideration of its Earle Haven case study. The committee will consider those outcomes in reporting on its broader inquiry into aged care.

The committee at this point wishes to stress its view that, as belatedly acknowledged by the Commonwealth in the extracts quoted at page 42 above, there must be regulatory change, including around the issue of outsourcing of the operation of aged care facilities. The committee therefore makes the following recommendations.

Recommendation 3

The committee calls on the federal government to immediately institute business continuity checks, including equivalent vetting processes in relation to sub-contractor relationships, to prevent any recurrence of the Earle Haven disaster in other residential aged care facilities.

Recommendation 4

The committee calls on the federal government to make sub-contractors equally accountable alongside approved providers for meeting quality and safety standards in the aspects of care they are sub contracted to deliver.

Recommendation 5

The committee calls on the federal government to better share 'red flag' information about operators of residential aged care facilities with state and territory governments and other regulatory bodies to prevent any recurrence of the Earle Haven disaster in other residential aged care facilities.

Recommendation 6

The committee calls on the federal government to improve transparency by implementing improvements in aged care sector reporting.

Recommendation 7

The committee calls on the federal government to increase penalties for significant non-compliance with quality and safety standards and review the capacity and powers of the Aged Care Quality and Safety Commission to effectively undertake this role.

Recommendation 8

The committee calls on the federal government to set up an independent Aged Care Commissioner to provide oversight of the aged care system in Australia.

[215] Aged Care Act, ch 7 div 96-4.

15 Quality of care issues - staffing

This report has noted the various staffing issues that were raised in the course of the committee's investigation, including claims of inadequate numbers and inadequate training. It is clear to the committee that staffing was an ongoing problem at Earl Haven—with inadequate numbers—and the committee heard evidence that HelpStreet was replacing experienced staff with inexperienced staff.

Ms Heard addressed some complaints about staffing:

> *I had investigated some complaints of that time, and then just a week prior, around 1 July, there were three different complaints and I investigated those... I took them all to [Mr Miller] and explained about those complaints, in particular that there was not enough staff caring. I do think they were justified, those complaints.*[216]

In a written submission and in evidence before the committee, Mr Rowe expanded on the issues raised in complaints. On matters regarding staffing, it was submitted:

> *The unusually high turnover of staff, from the most senior managerial and clinical staff to the personal care workers who delivered the hands-on care, was a recurring comment made by care recipients. One resident lived through 6 different managers over her 13-year residency. Residents reported the transient workforce impacted in respect to continuity of care, quality of the care, and relationships, from a social and clinical perspective. For some residents whom have no family nearby, their engagement with care staff may be their only interactions, creating an additional level of vulnerability*.[217]

Mr Rowe expanded on the nature of the concerns raised regarding staffing:

> *My understanding is that it related to the number of staff, it related to the appropriate qualifications of staff and it related to the attitudes of staff. Certainly it has been reported on many occasions that the good staff do not last long. They leave. That, again, has been a recurring theme over many, many years.*[218]

Earle Haven is but one example of a broader problem in the provision of aged care, as the submission from the QNMU and other material has made clear.

Understaffing, the over-reliance on casual staff and the low levels of pay for nurses and other care staff in the aged care sector can be explained in part by the underfunding of aged care in Australia. Again these issues will be addressed in more detail by the committee in its report on its broader inquiry into aged care. However, having regard to evidence before the committee to date, in the context both of the Earle Haven investigation and the broader aged care inquiry, the committee has concluded that it should make some recommendations at this point.

[216] Public hearing transcript, Gold Coast, 11 September 2019, p 65.

[217] Submission EH8, p 2.

[218] Public hearing transcript, Gold Coast, 12 September 2019, p 11.

Recommendation 9

The committee calls on the federal government to immediately review and redesign its aged care funding model to guarantee the ongoing financial viability of the aged care sector, ensuring the funding model reflects the actual cost of care and makes adequate provision for the increasingly complex care needs of aged care residents.

Recommendation 10

The committee calls on the federal government to ensure that a redesigned funding model includes an increase in wages for aged care employees with a long-term aim to achieve wage parity with other health care sectors.

Recommendation 11

The committee calls on the federal government to mandate the introduction of minimum nurse, care worker and support worker skill mix ratios and minimum average daily resident care hours in private aged care facilities.

16 Quality of care issues - use of chemical and physical restraints

Some evidence before the committee raised concerns of excessive use of chemical and physical restraint, including the use or overuse of psychotropic medication.

The QNMU expressed the view that issues regarding restraint in aged care have been well documented in the Royal Commission hearings to date. Regarding physical restraint, the union stated its view:

> *… that physical restraint should be used only as a last resort when there is an imminent risk of serious harm to the resident or others after all other strategies have been tried and failed.*[219]

With regard to chemical restraint, the union stated:

> *… [M]edication should be prescribed for residents only when there is a clinical need. Whilst the behavioural and psychological symptoms of dementia can create disruption and risk within an aged care facility, the use of medication should never be a substitute for appropriate surveillance by a sufficient number of registered and enrolled nurses.*
>
> *It is our view that the prevalence of the use of restraint in aged care, whether physical or chemical, is a symptom of the chronic understaffing of residential aged care services, as illustrated above. Appropriate staffing and skill mix, along with training in minimising the impact of the behavioural and psychological symptoms of dementia, would go a long way to reducing restraint in aged care.*[220]

In commenting on regulation of these practices, the union observed:

> *The federal government lacks effective policy and practice guidelines for the use of restraint in aged care. Queensland however has quite prescriptive policies and practice guidelines regarding restraint, relevant to mental health services, published by the Chief Psychiatrist. They focus on the safety and dignity of the patient, including reduction and elimination plans and, significantly, mandate the immediate reporting of the use of restraint.*
>
> *We note here that physical restraint in aged care is the equivalent of mechanical restraint described by the Chief Psychiatrist. The federal government would do well to adapt these policies and guidelines for use in aged care.*[221]

Again on the question of regulation in this sphere, Mr Rowe submitted:

> *The Commonwealth government, just prior to the recent election, brought in new principles associated with the administration of chemical and physical restraint in aged care. I appeared before the Joint Parliamentary Committee on Human Rights about three weeks ago, arguing that those new principles should be repealed. They breach people's human rights. They make it easier to administer that medication than currently. You are just required to have a responsible person. A responsible person could be the gardener who signs off and gives permission.*
>
> *If we go back to the disability legislation in Queensland around the use of restrictive practices, our legislation is world leading. We have invested in protecting Queenslanders with a disability but we have ignored Queenslanders who are ageing, and I do not understand that. Having come out of the disability sector, as I said, human rights is front row and central to the legislation. It is underpinned by a rights statement. In aged care you cannot find a rights statement. People have no rights. Well, that is how it would appear.*[222]

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219 Submission EH003, p 9.

220 Submission EH003, p 10.

221 Submission EH003, p 10.

222 Public hearing transcript, Gold Coast, 12 September 2019, p 12.

Ms Tuccori gave evidence that, as of June 2019, 71 per cent of care recipients were receiving (or being able to receive as needed) psychotropic medication, and 50 per cent of the facility's care recipients had some form of physical restraint. Regarding physical restraint, she advised that:

> *Predominantly it would have been bed rails, whether it be for their safety or their personal choice—some residents do use them to mobilise in the bed; it helps to promote their independence—or it would have been lap tables. When they are in the chair, it is a table that locks in which keeps them safe and stops them from falling out of the chair, essentially. They were the two that were used.*[223]

She expressed her view that the use of chemical and physical restraints was appropriate and adequate, and no more than necessary, to meet the needs of the care recipients in the facility.[224]

[It might be noted here that Ms Tuccori told the committee she had received reports from staff of cases alleging elder abuse by staff (separately involving three members of staff) directed to care recipients at the facility in her time there. The staff members were immediately stood down with pay, and matters reported to the Queensland Police Service.[225]

Ms Heard said this:

> *I feel it is very important to clarify ... If we were to talk about chemical restraint, it is the use of antipsychotic medication. Taking into consideration that a lot of those residents at People Care had diagnoses of dementia, some with aggressive behaviours, after they are medically assessed a general practitioner may decide to put them on some certain drugs. Then there is the alternative that they may have, as required, medication along with other provisions of behaviour management that is not just chemical restraint. The up to 70 per cent—and I am actually reviewing those statistics at the moment, because I have been asked to by the commission. I am seeing that there were up to 70 per cent—60 to 70 per cent—that were written up for antipsychotic medication, quite a considerable amount with PRN* [pro re nata – that is as needed] *usage as required. I have current medication charts that would indicate there was not a great deal of use of PRN medication.*[226]

The complaints of the excessive use of restraint as practised at Earle Haven are of great concern to the committee. Equally, they serve as just an example of what is clearly a broader issue in aged care. The committee will consider the evidence provided and submissions made in the context of its broader inquiry into aged care.

Recommendation 12

The committee recommends that the federal government urgently examine and reform practices regarding physical and chemical restraints, and mandate staffing levels that will avoid these practices being used as substitutes for appropriate level of care and supervision.

[223] Public hearing transcript, Gold Coast, 11 September 2019, pp 43, 44.

[224] Public hearing transcript, Gold Coast, 11 September 2019, p 45.

[225] Public hearing transcript, Gold Coast, 11 September, p 46.

[226] Public hearing transcript, Gold Coast, 11 September 2019, p 64.

17 Conclusion - Earle Haven and the broader aged care sphere

The precise nature of the contractual arrangements between People Care and HelpStreet, and the details of the financial dispute between them that led to the closure, are ultimately of no great moment. What matters is that the dispute led to the abandonment of many elderly and often unwell residents, who were uprooted from their homes as a result.

Both parties must share the blame for this. Mr Miller's evidence to the committee disclosed an inability to adequately meet the regulatory requirements let alone adequately respond to sanctions and recommendations.

His suggestion that his difficulties with regulators were at least in part due to anti-Semitism on the part of some public servants who had 'tried to crucify [his] business there completely based on that' was unsubstantiated, if not bizarre.[227] It was one example of various statements by Mr Miller in evidence that indicated an unwillingness or inability to fully grasp the failings of his operation.

What can be said in favour of Mr Miller is that, when he concluded that the relationship between People Care and HelpStreet had become terminal, he at least showed an awareness of the needs of the residents, giving notice of termination of HelpStreet's engagement with some weeks' notice.

It appears to be also to Mr Miller's credit that it seems he made payments to staff of some monies that were properly due by HelpStreet.[228]

It is clear from evidence from Ms Tuccori and others that the computer servers were removed on 10 July. It is also clear that HelpStreet had determined on 10 July to vacate the premises and cease operating the facility the following day. No notice was given.

As noted, Mr Miller gave notice to HelpStreet to vacate the premises. The response by Mr Bunker for HelpStreet was cynical and showed complete disregard for the residents. The prior removal of the servers with the critical medical and drug information, on the pretext of an 'upgrade',[229] the demand for the payment of almost $3.9 million dollars (and for half of it to be paid almost immediately, with the rest in two equal instalments on 30 July and 9 August 2019), the failure to even attempt to put into place any alternative arrangements for the residents, and the issuance of statements to the media placing the blame for the closure on People Care, all were indicative of a high and unforgiveable level of disregard for the welfare and needs of the residents.

Nonetheless, no matter how effectively the relocation process was put into place, it is clearly undesirable that it happened. Residents were displaced from their home. In some instances, their partners remained living elsewhere in the village, and so became separated by distance. The committee heard of a resident going from private room accommodation to a setting of four persons in the room, which raised both privacy and security concerns.

It can be envisaged that for families with an ongoing investment in a unit in the village, the lack of an on-site aged care facility makes the unit less attractive and so of less market value. In private meetings, the committee heard that financial arrangements involved in securing alternative aged care accommodation on a long term basis (even in places to which a resident had been relocated), were causing stress and uncertainty.

It is clear that many of the issues arising from this investigation apply more broadly in the aged care sphere. The events at Earle Haven on 11 July 2019 served to throw those issues into stark relief. As one witness succinctly noted:

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227 Public hearing transcript, Brisbane, 20 September 2019, p 32.

228 Public hearing transcript, Gold Coast, 11 September 2019, pp 59, 69. This evidence was also supported by evidence provided in private session.

229 Public hearing transcript, Brisbane, 20 September 2019, p 37.

... the situation at Earle Haven is the tip of the iceberg.[230]

The committee will consider those broader issues in more detail as part of this committee's report on its wider inquiry into aged care.

[230] Mr Mark Tucker-Evans, COTA, Public hearing transcript, Gold Coast, 12 September 2019, p 2.

Appendix A – Submitters

Number	Submitter
EH001	Name withheld
EH002	Council on the Ageing (COTA) Queensland
EH003	Queensland Nurses & Midwives' Union
EH004	Confidential
EH005	Name withheld
EH006	Confidential
EH007	Confidential
EH008	Aged and Disability Advocacy Australia
EH009	Aged Care Crisis Inc
EH010	Mr Kristofer Bunker

Appendix B – Witnesses at public hearings

Public hearing on Wednesday 11 September 2019

Queensland Ambulance Service

- Mr Cary Strong, Senior Operations Supervisor

Gold Coast Hospital and Health Service – Queensland Health

- Mr Ron Calvert, Chief Executive Officer
- Ms Karlene Willcocks, Executive Director, Diagnostic and Subspecialty Services

HelpStreet Villages (Qld) Pty Ltd

- Ms Telecia Tuccori, former Clinical Manager

People Care Pty Ltd

- Ms Karen Heard, Nurse Administrator

Public hearing on Thursday 12 September 2019

Council on the Ageing Queensland

- Mr Mark Tucker-Evans, Chief Executive Officer
- Mr John Stalker, Policy Coordinator

Aged and Disability Advocacy Australia

- Mr Geoff Rowe, Chief Executive Officer

Aged Care Crisis

- Dr Michael Wynne

Queensland Nurses and Midwives' Union

- Ms Bernie O'Connor, Team Leader, Private and Aged Care Sector Organisers
- Mr Chris Murray, Industrial Officer
- Mr Dan Prentice, Professional Research Officer

Private capacity

- Ms Meaghan Scanlon MP, Member for Gaven

Public hearing on Friday 20 September 2019

People Care Pty Ltd

- Mr Arthur Miller, Managing Director

Appendix C – Chronology of significant events on the closure of the Earle Haven Retirement Village Residential Aged Care Facility

Date	Event
2006	
10 Feb	Letter from Department of Health and Ageing (DHA) to People Care advising People Care has been granted Approved Provider Status for aged care services (residential care, community care and flexible care), effective 10 February 2006.
2007	
29 April	Aged Care Standards and Accreditation Agency Ltd (ACSAG) 'Serious risk to residents report' issued to People Care re services at Hibiscus House for an audit review visit on 29 April 2007. It finds evidence of non-compliance with Accreditation Standards and recommends sanctions.
30 April	DHA 'Notice Of Decision To Impose Sanctions under Section 67-5 of the *Aged Care Act 1997*' issued to People Care regarding services at Hibiscus House. It requires People Care to appoint a Commonwealth approved assister for six months, effective 30 April 2007.
2015	
27 Nov	Australian Aged Care Quality Agency (AACQA) 'Final Quality Review Report' issued to People Care regarding services at Hibiscus and Orchid Houses. It finds: • service meets 6 out of 18 expected outcomes of the Home Care Standards • revised plan for continuous improvement must be received by 11 Dec 2015.
2016	
10 April	DHA 'Notice To Give Information under Section 9-2 of the *Aged Care Act 1997*' issued to People Care. It requests certain information to be provided as evidence of suitability to be a provider of aged care.
27 May	AACQA 'Failure to comply with Accreditation Standards Decision' issued to People Care regarding services at Orchid House for an audit review visit conducted from 4 to 11 May 2016.
31 May	AACQA 'Failure to comply with Accreditation Standards Decision' issued to People Care regarding services at Hibiscus House for an audit review visit conducted from 16 to 23 May 2016.
3 June	ACSAG 'Serious risk to residents report' issued to People Care regarding services at Hibiscus House for an audit review visit conducted from 16 to 23 May 2016 and from 24 to 29 May 2016. It finds evidence of non-compliance with Accreditation Standards and recommends sanctions.
3 June	DHA 'Notice Of Decision To Impose Sanctions under Section 67-5 of *The Aged Care Act 1997*' issued to People Care regarding services at Hibiscus House and Orchid House. It requires People Care to appoint a Commonwealth approved assister for six months, effective 3 June 2016.
13 Sept	Letter to Mr Miller from the Commonwealth nurse advisor appointed for the sanction period from June to Dec 2016. It advises notice to discontinue services on 26 September 2016 and a statement of reasons.
6 Oct	AACQA 'Re-accreditation Decision for 12 months from 9 Dec 2016' issued to People Care regarding services at Hibiscus House for a re-accreditation audit conducted from 31 August to 1 September 2016. It finds the service meets all 44 expected outcomes of the home care standards.

Date	Event
Nov	Ms Karen Heard starts employment with People Care as a clinical nurse manager (three month contract).
30 Nov	AACQA 'Final Quality Review Report' issued to People Care regarding services at Hibiscus and Orchid houses. It finds: • service meets 16 out of 18 expected outcomes of the Home Care Standards • revised plan for continuous improvement must be received by 14 Dec 2016.
2017	
3 April	Department of Health 'Notice of Non-compliance – Home care standards, Section 67-2 of the *Aged Care Act 1997*' issued to People Care. It finds People Care failed to meet the expected outcomes for regulatory compliance and information provision.
3 April	AACQA 'Re-accreditation Decision for 31 May 2017 to 31 May 2018' issued to People Care regarding Orchid House for a re-accreditation audit conducted 21 to 22 February 2017. It finds the service meets all 44 expected outcomes for the home care standards.
19 April	AACQA 'Home Care – Assessment Contact Report' issued to People Care for an assessment contact visit on 19 April 2017. It finds People Care failed to meet the expected outcomes for regulatory compliance and information provision.
11 May	DHA 'Notice Of Decision To Impose Sanctions under Section 67-5 of *The Aged Care Act 1997*' issued to People Care. It requires People Care to appoint a Commonwealth approved assister for six months, effective 11 May 2017.
May	Ms Karen Heard appointed as Commonwealth approved nurse administrator (home care) for People Care until October 2017.
May	Ms Karen Heard starts employment as acting manager with People Care until October 2018.
20 Oct	AACQA 'Re-accreditation Decision for three years to 9 December 2020' issued to People Care for a re-accreditation audit conducted 12 to 13 September 2017. It identified one non-compliance, which was rectified. This was the last accreditation of the Earle Haven facility.
2018	
22 Mar	Unannounced AACQA 'Assessment Contact Report' issued to People Care for an assessment contact visit on 22 March 2018.
23 Mar	Advice that People Care engaged HelpStreet to manage services on its behalf at Hibiscus House and Orchid House from 1 April 2018, and that People Care will continue to hold the bed licences and Approved Provider Status, emailed to AACQA from Mr Bruce Lang.
April	Mr Miller confirms that People Care engaged HelpStreet to manage services on its behalf at Hibiscus House and Orchid House, effective April 2018 (COMMITTEE Earle Haven Investigation public hearing, Brisbane, 20 Sept 2019).
11 April	'Basic Heads of Agreement' for People Care to HelpStreet interim licence agreement for full management, emailed to Mr Lang from Mr Kris Bunker.
12 April	'Draft Heads of Agreement', emailed to Bunker from Mr Miller.

Date	Event
18 July	Unannounced AACQA 'Assessment Contact Report' issued to People Care for an assessment contact visit on 18 July 2018.
8 Oct	Establishment of a Royal Commission into Aged Care Quality and Safety by Governor-General of the Commonwealth of Australia.
20 Oct	Ms Karen Parsons starts employment as executive director with HelpStreet.
Nov	Ms Telecia Tuccori starts employment as clinical care co-ordinator with HelpStreet.
7 Nov	'HelpStreet: Internal Report: Nerang Village', Auditor - Karen Heard RN, Aged Care Consultant.
2019	
11 Jan	Unannounced AACQA 'Assessment contact visit report' issued to People Care for an assessment contact visit on 11 January 2019.
22 Jan	Department of Health 'Notice of Non-compliance – Home care standards, Section 67-2 of the *Aged Care Act 1997*'. It finds People Care failed to lodge financial documents in time.
1 Feb	Email to HelpStreet from QNMU regarding failure to pay employees. It requests confirmation that all employees have been paid.
6 Feb	Email to Mr Arthur Miller from Mr David Lamb (HelpStreet) apologising for putting him into 'current financial predicament', stating facility under almost constant review by 'the commission', grateful for Miller committing to continuing payments to HelpStreet, their idea of a penalty declined by Miller.
20 Mar	Earle Haven residents meeting. HelpStreet staff were invited but did not attend. The minutes recorded residents' concerns raised regarding quality and quantity of staffing, and Mr Miller's statement to residents that he did not have the right to say anything to HelpStreet re any problems with their level of services provided to Hibiscus and Orchid Houses.
14-21 Mar	Email thread Mr Bunker and Mr Lang regarding agreement for contras for various payments, including a contra of $125,924 leave entitlements owing to HelpStreet against the Refurb Accommodation Supplement for same amount of $125,924 and the balance of $54,275.61 to be paid or contracted against outstanding invoice, Adjustment for Refurb accommodation Supplement each month to be deducted from government subsidies commencing next month, to deduct laundry and meals invoice each month from monthly subsidies commencing next month, continue pay to Miller $30,000 each Friday until caught up to 30 day outstanding.
23-24 April	Email thread Mr Bunker and Mr Lang r regarding outstanding payments. Lang states total amount still outstanding is $249,922.27 after contra to invoices were done. Bunker responded offering $75,000 per month.
24 April / 3 May	Email thread Mr Bunker and Mr Lang regarding outstanding payments. Bunker states regarding insurances: 'we have two brokers working on options, both are struggling with options, the 1st issue has been around the number of sanctions People Care have had as bed license holders over the last 10 years, it is currently deemed too much of a risk by the insurance companies, HelpStreet is easily able to obtain the insurance required, but not with People Care as beneficiaries'.
30 April	A complaint about underpayment is made to the Fair Work Commission (later reported statement by QNMU spokesperson).

Date	Event
28 May	'People Care - Independent Audit - Hibiscus and Orchid House, May 20-24, 2019', Auditor: Karen Heard RN, Aged Care Consultant.
30 May	Meeting, attended by 10 staff and about 20 residents/family, as well as Mr Miller and Bruce Lang from People Care, and Ms Parsons and Ms Tuccori from HelpStreet, as an education session by Commission officers on complaints resolution for residents and staff.
June	'People Care - Clinical Audit Report - Hibiscus and Orchid Houses - 4 to 6 June 2019', Auditor – Karen Heard RN, Aged Care Consultant.
June	'People Care - Clinical Audit Follow-up Report - Hibiscus and Orchid Houses - 19 to 20 June 2019', Auditor: Karen Heard RN, Aged Care Consultant.
25 June	Unannounced 'AACQA Assessment contact visit report', issued to People Care for an assessment contact visit on 25 June 2019.
27 June	Email to David Lamb from Mr Miller, expresses concern he is not being told accurate figures People Care is being blamed for everything. Concerns regarding catering and laundry being taken outside and use of agency staff and extra staff have increased HelpStreet's costs astronomically. Miller believes there have been 15 to 24 empty beds for the last 4 months, meaning there is reduced income and missing out on huge income from subsidies of average $169 per day per bed it is not good management practice. Miller writes: *I am very scared that you cannot have enough revenue to run your business and naturally you blame People Care you want more revenue. The other thing that concerns me is that ACFI is being increased and if overstated Government dept. monitoring team make the assessment and realise that those figures were incorrect the government will claim back all the funds supplied which could be thousands and thousands of dollars.* Bunker's response is to reject the concerns, maintains they are able to pay staff, and seeks payment of monies due by People Care.
5 July	QNMU holds case conference on site regarding concerns raised in relation to the level of care and staffing issues at Earle Haven.
8 July	People Care notifies HelpStreet that its agreement with People Care is terminated, effective 5:00pm 9 August 2019, letter to HelpStreet (cc Mr Lamb and Mr Bunker) from People Care (represented by Mr Epstein, Steindls Lawyers & Notary).
10 July	HelpStreet notifies the DHA it no longer has management status for People Care, effective 30 August 2019, emailed (14:04pm) to Department of Health from Mr Lang.
10 July	Mr Bunker (HelpStreet) notifies Mr Epstein (Steindls Lawyers & Notary) of the removal of computer servers from the facility and the outstanding monies owed to HelpStreet, non-payment by the deadline advised would place HelpStreet into administration, ultimately causing the home to be closed, emailed (5:17pm) to Epstein from Mr Bunker.
11 July	Mr Epstein (Steindls Lawyers & Notary) responds to Bunker's email (10 July at 5:17pm), advising People Care will attend to payments owing to HelpStreet to the 20 June 2019 and up to the date of departure from the facility provided certain requests are met, including any monies owed to it are paid, emailed (10:16am) to Mr Bunker from Mr Epstein (Steindls Lawyers & Notary).
11 July 2019 – the closure	
11 July	The closure of Earle Haven facility was widely reported in the media from 11 July 2019. The media reported that following a reported financial dispute between 'People Care' and 'HelpStreet', (and

Date	Event
	possibly also staff) the facility closed suddenly on 11 July 2019. Medical equipment, fridges and computers were removed. It was reported that after a staff member dialled 000, about 70 patients were moved as a matter of urgency to various other premises. A Queensland Health spokesperson stated they were notified at 3:00pm. Staff and residents had no notice. A video obtained by Nine News 'showed staff confronting management'.
11 July	Key events on the day of the closure, and approximate times: • 9:00am: Mr Bunker meets with HelpStreet staff regarding financial issues • 10:00am: Mr Bunker meets again with HelpStreet staff and asks a staff member to organise a removal truck to remove HelpStreet items • 11:00am to 4:00pm: Removal of HelpStreet items from the facility • 1:30pm: Mr Bunker informs HelpStreet staff if they continue to work that afternoon, they would not be paid and would not be covered by insurance • 1:30pm: Triple 000 call from Earle Haven to emergency services • 2:15pm: Mr Cary Strong, QAS, arrives at Earle Haven • 2:15pm: Gold Coast HHS declares 'code brown', establishes a health emergency operations centre onsite, and thereafter meeting hourly from 2:30pm to approx. midnight • 4:00pm – 5:00pm: Relocation of some residents to Gold Coast Hospital and Health Service hospitals due to medical conditions • 5:00pm: Decision made to relocate remaining residents • 6:00pm: First patient transported to alternate residential aged care facility • 1:10am (12 July): Final resident transported to alternate residential aged care facility
The aftermath	
12 July	Queensland Minister for Health and Minister for Ambulance Services releases a media statement**:** • praised ambulance service and Gold Coast health staff as heroes after they rescued more than 70 aged care residents overnight. • rescue operation was completed just after 1:00am this morning. • transferred around 70 residents to other accommodation, including three to hospitals in a stable condition. • that this happened, over what appears to be a contract dispute, is disgraceful. • 'The federal government must launch a full investigation into how this could have possibly happened and I have written to the federal Aged Care Minister.' • QAS allocated 32 paramedics to the operation; Gold Coast HHS deployed about 12 staff to site.
12 July	Federal Minister for Aged Care and Senior Australians, Senator Richard Colbeck announced that he had: *directed my department to work closely with the Aged Care Quality and Safety Commission and Queensland Health to examine the circumstances that led to this terrible situation. It appears that this incident arose from a contractual dispute between the approved aged care provider and a sub-contractor who was providing administrative, nursing, catering and other support services. It appears that the sub-contractor, without notice, withdrew all services and proceeded to remove equipment from site, leaving the facility unsuitable for residents to occupy.*
12 July	Aged Care Quality and Safety Commission issued a statement: • Ensuring the safety and wellbeing of residents is of the utmost priority. • The Commission is taking immediate action, working in collaboration with the Department of Health and Queensland Health, to ensure all residents are safe and families are kept informed of the situation.

Date	Event
	• An assessment team from the Commission, together with the Department of Health, is at the facility this morning to fully assess the situation. The team is ensuring all residents who have been moved to other residential aged care facilities are safe, have access to their appropriate medication and are given the support they need. The Commission is undertaking a welfare check on all residents that have been moved to other services and will be visiting each of these services to ensure they are safe and receiving appropriate care. • The Commission is also undertaking a review audit of People Care's regulatory compliance and will notify the Department of Health as soon as possible about the outcome. • The Commission will continue to closely monitor the situation until it is fully resolved. The health, safety and wellbeing of older people who reside in aged care services is of paramount importance to the Commission.
13 July	Department of Health 'Sanctions Decision under Section 65-1 of the *Aged Care Act 1997*' issued to People Care. It imposes the following sanctions on People Care for a period of six months, effective 13 July: • ineligibility to receive subsidy for new care recipients • requirement to appoint a Commonwealth approved assister, by 17 July 2019 • immediate suspension of allocated places that are vacant • revocation of vacant places if the service is closed.
13 July	Ms Karen Heard appointed as Commonwealth approved nurse administrator for People Care.
14 July	The *Sunday Mail* reported staff at a Gold Coast nursing home that was shut down last week amid a contract dispute had not been paid superannuation for eight months.
16 July	*Brisbane Times* reported that People Care called a meeting with the retirement village's permanent residents on Tuesday morning to address concerns, but it was held behind closed doors and media were excluded. It is reported that People Care told residents the issue would be referred to the Royal Commission.
16 July	QNMU states that only one registered nurse was rostered on to look after 69 residents at Earle Haven on the day of their evacuation last week after its sudden closure.
17 July	The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (committee) resolves to investigate the sudden closure of the Earle Haven residential aged care facility, as part of its broader inquiry into aged care, end-of-life and palliative care and voluntary assisted dying.
17 July	QNMU annual conference passes motion to 'pursue criminal investigation of Earle Haven'. 'More than 350 Queensland nurses and midwives have today voted to pass an urgent and extraordinary motion to pursue the criminal investigation of Earle Haven management.'
19 July	Federal Minister for Aged Care and Senior Australians, Hon Richard Colbeck announces the establishment of an inquiry to be headed by Ms Kate Carnell AO, to report by October 2019. The inquiry will examine the events leading to a collapse in the provision of aged care services for the residents of the Earle Haven Retirement Village and the events that occurred on 11 July 2019 and their aftermath.
19 July	The *Courier Mail* reported that the Queensland Police Service on this date announced it had finished an investigation with no evidence of criminal offences being found, saying a thorough investigation had 'determined there was no evidence of any criminal offences being committed'.
19 July	The Courier Mail reported on an announcement by the Premier and Beth Mohle, QNMU, at the QNMU conference: • Premier announces legislating for staffing ratios.

Date	Event
	• Ms Mohle says one registered nurse for 70 patients is the norm. 'Staffing hours at that facility are about the average for aged care.' • Ms Mohle says staff pay was due yesterday but had not been paid.
Aug	Miller issues statement in the *Earle Haven Chronicle*, apologising to residents of Hibiscus House and Orchid House who were displaced from their homes on 11 July 2019. Miller said it should 'never have happened' and blamed HelpStreet Villages, which was brought on by People Care last year to operate Earle Haven's nursing home wing. Miller states People Care have: • made payments owing to former employees on 23 July • petitioned to be given temporary access to residents' care record • sought the recovery of remaining records and other information related to Hibiscus and Orchid homes from HelpStreet.
5-9 Aug	Royal Commission public hearings held in Brisbane on aspects of the regulation of aged care, in particular, the closure of the Earle Haven residential aged care facility.
23 Aug	ACQSC 'Accreditation Decision and Report' issued to People Care for a review audit conducted from 12 July to 2 August 2019. It finds the service met none of the 8 aged care quality standards. ACQSC revokes the accreditation of the service, effective 24 Nov 2019.
11-12 Sept	Committee holds public and private hearings for the Earle Haven investigation on the Gold Coast.
20 Sept	Committee holds a public hearing for the Earle Haven investigation at Parliament House, Brisbane.
10 Oct	*ABC News* reported Mr Miller as stating the federal government has revoked his accreditation to operate a high-care facility and that the Earle Haven residential aged care facility will not reopen.

Statement of Reservation

Statement of Reservations

By the LNP Members

Into the Investigation of the closure of the

Earle Haven Residential Aged Care Facility at Nerang

The situation at Earle Haven leading up to the events on the 11th of July 2019 are both tragic and disgusting. No right thinking person could be anything but horrified and condemn what occurred. Rightly the Committee praises the actions of Queensland Health, the Queensland Ambulance Service and staff who stayed and assisted residents on the 11th of July 2019. We would add, praise for the Queensland Police Service, and the families and friends of residents who comforted their loved ones.

We would like, however, to single out the residents for special mention. Many were frail, elderly, suffering and from many medical conditions including dementia. As a society, when you needed protection and support we let you down. We apologise and this must never happen again!

One of the matters not drawn from the hearing held by the Committee is:-

What are the rights of Aged Care Residents and, importantly, were those rights violated at Earle Haven? This maybe a question for a different venue or perhaps the Royal Commission.

THE COMMITTEE'S INQUIRY AND THE ROYAL COMMISSION

Queenslanders want to see a world-class aged care service that provides care and protection for residents. These are Queenslanders who have worked hard all their lives and deserve to be treated with dignity and respect. Critically, given the revelations of the Royal Commission, Queenslanders will not tolerate political grandstanding on the question of aged care. It is our hope that all levels of Government will work together in the interest of all residents and those yet to be residents, in a bipartisan approach.

There have been many inquiries into the Aged Care system over the years, too numerous to list, and multiple agencies have a role in the operation, funding, accreditation and oversight of them.

The Royal Commission into Aged Care and Quality has been operating since October 2018 and has held 14 hearings with approximately 386 witnesses in Adelaide, Sydney, Broome, Perth, Darwin, Cairns, Mildura, Brisbane, Melbourne, Mudgee and Hobart. In addition, there have been 6,139 submissions by various methods.

An Interim Report by the Royal Commission was delivered on the 31st of October 2019 with a final report by the 12th of November 2020. The Interim Report referred to "A Shocking Tale of Neglect".

Critically, it is important to understand the role of the Royal Commission and how best it, the Queensland State Health Committee Inquiry into Earle Haven, the wider Committee's hearing into Aged Care and the Carnell Inquiry into Earle Haven intersect, to provide one source of recommendations to the Federal Government.

The L.N.P. members acknowledge the Recommendations contained in the Committee's Report and feel the Royal Commission, holding hearings across the nation and gathering evidence across all sectors, is the appropriate body to both assess all Reports and formalise Recommendations. The L.N.P. members are concerned about some recommendations as there appears a paucity of evidence to support them.

It is important to remember that the Aged Care sector is one governed overwhelmingly by the Federal Government. Clearly, we need a comprehensive approach that covers all facets of the system wherever it operates. We see the Recommendations of the Committee as very important and the evidence gathered during its inquiry as invaluable. At the end of the day, we do not dispute hard action needs to be taken and see the Committee Recommendations and evidence as vital to better inform the Royal Commission.

We also refer to a letter from the Minister for Communities, Minister for Disability Services and Seniors dated 20th of September 2019 concerning the larger inquiry being held by the Committee. The letter deals with Elder Abuse and though it does not refer to Earle Haven, there is no clearer evidence of such abuse. The Minister at page 4 states:

> "The Royal Commission into Aged Care Quality and Safety is actively considering quality and safeguarding arrangements and will likely make recommendations about aged care quality and safeguards in line with the Terms of Reference for the Royal Commission. The Royal Commission has published a suite of background papers, including: providing an outline of the legislative framework in place, with a particular focus on quality and safety regulation[8]; and on the use of restrictive practices in residential aged care[9]. The findings of the Royal Commission will be critical in determining if further reform is necessary to strengthen safeguards in the aged care system in Queensland."

Again, we stress the letter does not touch on Earle Haven and focuses on Elder Abuse – yet we agree with the Minister's sentiment as to the role of the Royal Commission.

IMMEDIATE STEPS

On reading the Committee's Report and understanding the unique and regrettable nature of the events that took place on the 11th of July 2019, there are steps that can now be taken –

(a) Queensland Health should review the actions they took that day and assess criteria for action and improvements;
(b) Queensland Ambulance Service should undertake a similar review;
(c) A joint review should assess the co-ordinated approach and assess criteria for action and improvements; (The L.N.P. members acknowledge Recommendation Number 23 of the Carnell Inquiry into Earle Haven and the two dot points that follow)
(d) The reviews be made public;
(e) Both Commonwealth and State Agencies have contact with former residents to assess their physical and mental wellbeing;
(f) The Committee forward, to the Royal Commission, the transcript of the hearings and its Report to better inform the Commission;
(g) That Members of the Committee meet with the Royal Commissioners to discuss the Report;
(h) The Committee's Report and transcript of the hearings be forwarded to the relevant Federal Ministers; and
(i) That Members of the Committee meet with the relevant Federal Minister to discuss the Report.

Marty Hunt
State Member for Nicklin

Mark McArdle
State Member for Caloundra

26 November 2019