Australian Government

INQUIRY INTO EVENTS
AT EARLE HAVEN

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Executive Summary

On Thursday 11 July 2019, 69 vulnerable residents of the aged care facilities at the Earle Haven Retirement Village, known as Hibiscus House and Orchid House, were evacuated from their home without warning.

In response to this terrible event, on 19 July 2019 Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians, announced an independent inquiry to be led by Ms Kate Carnell AO. The Inquiry's terms of reference can be found at Appendix A.

The impact of these events on residents was the key driver of this Inquiry. The Inquiry heard directly from the loved ones of residents of Hibiscus House and Orchid House and the care staff responsible for them.

The Inquiry examined the circumstances leading to the collapse in aged care services and the consequences of the events. In particular, the Inquiry's attention focused on the relationship between the approved provider of aged care services, People Care Pty Ltd and Help Street Villages (Qld) Pty Ltd who had been sub-contracted to manage delivery of the aged care services. Based on the information available to it, the Inquiry's view is that senior management[1] of both companies allowed personal animosity and financial considerations to override their responsibility for the people in their care.

Contrary to media reports of a staff exodus, care staff remained on site to support the residents amid the chaos despite being told they would not be paid or covered by insurance. This compassionate act demonstrated their commitment to the wellbeing of the people in their care. This is a trait consistent with most of the dedicated and caring people who work in the aged care industry and is something we should all applaud.

This Inquiry was carried out concurrently with examinations of the events of 11 July by the Royal Commission into Aged Care Quality and Safety[2] (the Royal Commission), as well as the Queensland Parliament Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee[3] (Queensland Parliamentary Committee). Information was drawn from these sources to inform this Inquiry. Similarly, information obtained by this Inquiry about the impact of the events on residents was shared with the Queensland parliamentary committee.

The Inquiry was gratefully assisted by Mr Paul Croft, Director of BRI Ferrier who provided forensic accounting expertise to scrutinise the organisational structures and financial arrangements at play. A large amount of information was provided by People Care, although not all financial information that was requested.

In contrast, The Inquiry was disappointed with the amount of information provided by senior management of Help Street. Help Street advised they did not have anything further to add to the witness statements provided to the Royal Commission and the Queensland parliamentary committee. These statements were themselves cursory. The Inquiry is of the view that this attitude suggests a deplorable lack of accountability by Help Street for the consequences of their actions. Both the management of Help Street and the appointed liquidator refused access to any financial information.

Using all available resources, the Inquiry examined the history of the approved provider and the risks presented in the arrangement with Help Street. The *Aged Care Act 1997* as it currently stands, allows this kind of sub-contracting arrangement to occur. We found that Help Street lacked experience in aged care and used this arrangement to enter the sector without having been first assessed by aged care regulators. Additionally, the lack of controls in place to provide oversight of the contract terms and key personnel posed risks to the people living in Hibiscus House and Orchid House.

[1] References to senior management refer to the most senior individuals in the two organisations; particularly People Care's managing director and Help Street's Global CEO and CEO Australian and New Zealand.
[2] https://agedcare.royalcommission.gov.au/hearings/Pages/hearings/2019/public-hearings-5-9-august-2019.aspx
[3] https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/current-inquiries/EarleHavenClosure

The Inquiry found People Care had a history of regulatory non-compliance with its obligation under the Aged Care Act and that the aged care regulators missed a number of warning signs, including:

- the organisational culture of People Care and Help Street, including the attitude of senior management and the deteriorating relationship between the two companies
- the nature of contractual arrangements between People Care and Help Street
- People Care's financial arrangements and the way the risks inherent in them were compounded in the arrangement with Help Street
- an increase in complaints about the quality of services
- high levels of chemical and physical restraints.

The aged care regulators failed to appreciate the mounting risk primarily due to communication and capability gaps. There were also occasions when regulators failed to engage critically with information received or follow through with necessary action.

The Commonwealth is responsible for monitoring and regulating the aged care sector. Yet the way in which the events unfolded on 11 July meant the decision to immediately evacuate the facility fell to Queensland Government agencies.

Following consultation with families of the residents who were evacuated, the Inquiry is of the view this type of emergency response should only be reserved for life threatening situations such as floods and fires, as the act of sudden relocation is life threatening in itself.

To manage events such as those on 11 July aged care regulators need a greater array of tools to more effectively respond to the failure in aged care services.

In responding to the fallout of 11 July, the Inquiry found regulators did not have the right tools to strike an appropriate balance between the need to take decisive action against the people responsible for the services and the needs of the residents in that care. The sanctions imposed, coupled with People Care's apparent reluctance to resume service delivery, ultimately resulted in the worst possible outcome for some of the residents and their families: the closure of Hibiscus House and Orchid House so they could no longer return home.

The findings of the Inquiry have led to recommendations that fall into six broad categories.

To better prevent the sudden collapse in aged care service delivery, the Inquiry recommends:

- 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 managing the risks associated with key personnel and organisational culture.

To better safeguard residents in the care of approved providers that are not meeting their obligations under the Aged Care Act, the Inquiry recommends:

- sanction options which better balance the need for decisive action with the desire of people to remain in their homes.

To better manage events such as those of 11 July 2019, the Inquiry recommends:

- better planned and coordinated responses to emerging situations in aged care facilities.

The Inquiry makes these recommendations to better protect residents of aged care services. A full summary of the recommendations is provided below.

Summary of Recommendations

R1. Progress as a priority the amalgamation of aged care regulatory functions in the Aged Care Quality and Safety Commission. This should include functions relating to approved providers' compliance with prudential responsibilities.

R2. Ensure the planned delivery of an information portal which provides a single, real-time view of all information about approved providers which is available to both the Department of Health and the Quality and Safety Commission. This should include financial and prudential information as well as complaints and quality monitoring data.

R3. Further invest in staff training and other resources to support a shared culture within the newly expanded Quality and Safety Commission which emphasises information sharing and cooperative action between the Commission's various functions.

R4. The Quality and Safety Commission should appoint a Senior Responsible Officer or Case Manager for each high risk provider. This officer will have responsibility for ensuring effective information sharing and timely action.

R5. The Quality and Safety Commission should enhance its cooperation and intelligence sharing with other regulatory authorities and stakeholders.

R6. The Australian Government should finalise as a matter of priority reforms to aged care prudential arrangements, including to:

- revise metrics used for assessment of Annual Prudential Compliance Statements to incorporate measures which may indicate risk to quality of care
- introduce specific liquidity and capital requirements
- provide greater visibility of corporate structure and related-party transactions
- require updates to material changes in ownership or management arrangements
- allow regulators to request updated financial information at any time.

R7. Approved providers that do not meet the specified liquidity and capital requirements be automatically placed on a watch list and required to submit a detailed plan to rectify the situation.

R8. Approved providers should be required to report to regulators the financial information of:

- any related parties providing guarantees for the approved provider
- any organisation sub-contracted to manage the delivery of aged care services.

R9. Update the Governance Standard in the *Fees and Payments Principles 2014 (No. 2)* to require approved providers to assess on a quarterly basis their liquidity and ability to continue as a going concern. This should extend to any sub-contractor responsible for the management of care services.

R10. Clarify that the requirement in section 9-1 of the *Aged Care Act 1997* to advise aged care regulators of material changes would apply to any identified issues about an approved provider's ability to continue as a going concern.

R11. Ensure aged care regulators have the capacity to understand risks to quality of care that might arise from an approved provider's financial or contractual arrangements, including by:

- increasing the capacity of aged care regulators to effectively scrutinise financial information.
- providing the Quality and Safety Commission with the capacity to include people with expertise in contracts and accounting in the team undertaking assessment contacts where there is an indication that there are risks associated with the approved provider's financial or contractual arrangements.

R12. The Australian Government make available business or financial advisory services to providers who voluntarily disclose significant financial and/ or contractual risks which may impact on the stability of service delivery.

R13. The Australian Government amend the Aged Care Act so that management of care services can only be sub-contracted to an approved provider.

R14. The Aged Care Act be amended to require notification of sub-contracting of management of care and/or sale of a business with approved provider status before they take effect.

R15. The amended Act require the Secretary of the Department of Health to consider whether the proposed arrangement is in the best interest of care recipients and provide the power to veto the arrangements.

R16. The Australian Government revisit the requirement for approved providers to report changes in key personnel.

R17. The Australian Government introduce provisions to allow the disqualification of specific individuals from acting as key personnel of an approved provider.

R18. The risk profiling tool being developed for use by the Quality and Safety Commission should consider:

- the responsiveness of approved providers to feedback from consumers and the manner of their response to identified cases of non-compliance
- the nature of any sub-contracting arrangement in relation to management of care services
- the relationship between parties responsible for care, especially when management of care services has been sub-contracted
- intelligence from other regulators.

R19. The Australian Government amend the Aged Care Act so that an additional alternative to revocation of approved provider status is an undertaking to sell the approved provider company and/ or specific services under its control.

R20. Residents of aged care facilities should only be evacuated in life-threatening situations (such as fire or flood).

R21. The Department of Health should develop a response plan for emerging situations where there is risk of an imminent collapse in the provision of aged care services (the plan).

- The plan should include provision for rapid access to resources to assist in stabilising service provision.
- The plan should be communicated to all aged care providers to encourage early notification to the Commonwealth and to state/ territory governments.

R22. Aged care regulators should have the power to appoint an independent manager to stabilise an aged care service at imminent risk of collapse.

R23. There should be agreed protocols between the Commonwealth and each state and territory for situations involving the imminent collapse of service provision at residential aged care facilities.

- The protocols should clearly allocate decision-making authority depending on the nature of the situation.
- The basic premise of these protocols should be that evacuation from a residential aged care facility should only take place in a life threatening situation because the process of evacuation can itself be life threatening.

CH .1 — What happened on 11 July 2019?

Timeline of events

8 July 2019	
A notice of termination (the notice) is prepared by People Care advising Help Street that their licence to occupy Hibiscus House and Orchid House will be revoked as of 5pm Friday 9th August 2019.	
10 July 2019	
Approximately 10am	The notice is hand delivered to Help Street at a meeting with People Care's finance manager.
Early afternoon	Help Street's Global CEO and CEO Australia and NZ remove the IT servers from the facility. These servers contain resident's care plans and progress notes. Resident's paper based medication files remain on site.
3:50pm[1]	People Care's solicitor emails Help Street's Global CEO confirming a phone conversation they had that afternoon. This record indicates Mr Bunker's acceptance of the notice and request for a longer period to manage a smooth transition out.
5:17pm	Help Street's Global CEO emails People Care's solicitor with a demand for payment of $3.9 million (plus GST) warning that without 50 per cent payment by noon on 11 July 2019 Hibiscus House and Orchid House would be closed.
11 July 2019	
08:45am	People Care's owner and managing director, Mr Arthur Miller, calls Queensland Nurses and Midwives Union officials to advise that he has not paid Help Street and that he believes Help Street's Global CEO will leave the country.
09:00am	Help Street's Clinical Care Coordinator books a removalist. Packing of items began shortly afterwards and the removal truck was seen onsite from mid-morning.
10:16am	People Care responds to Help Street's demand for payment with a conditional undertaking that People Care would pay monies owing "up to the date of departure from the premises by Help Street".
12:10pm	Photos indicate that removals had begun.
1:30pm	Care staff on site are advised by Help Street's Global CEO that the company is going into administration. Staff are told they will not be paid and if they stay they will not be insured. Staff arriving for the afternoon shift are given the same information when they get to work. Despite this advice most staff remain well into the night with additional staff arriving to lend a hand.
1:33pm	000 call made by Help Street's Clinical Care Coordinator.
2:13pm	Queensland Ambulance Service Forward Commander arrives on scene.
2:15pm	The Gold Coast Hospital and Health Service declare a Code Brown and begin an emergency response.
Between 4:00pm and 5:00pm	Decision taken by Queensland authorities that it was not safe for residents to remain at Earle Haven and that preferred option was to evacuate to other residential aged care facilities.
Approximately 5:00pm	The Lodge Restaurant in the Village delivers dinner for residents of Hibiscus House and Orchid House. CCTV footage shows service beginning at approximately 5:20pm in the Hibiscus House dining room.
Approximately 6:00pm	Evacuation commences.
12 July 2019	
Approximately 12:30am	Evacuation complete with final resident transferred away from the facility.

[1] The Inquiry was able to confirm the timing of this email exchange directly with People Care's solicitor.

'The Spark'

In simple terms, the collapse of aged care services at Earle Haven on 11 July 2019 was the consequence of a breakdown in the relationship between People Care Pty Ltd (the company that was the Approved Provider of aged care services at the facility) and Help Street Villages (Qld) Pty Ltd (the company engaged to deliver these services).

An escalating contractual dispute between the parties resulted in a notice of termination being issued by People Care. The notice was signed on 8 July and hand delivered to Help Street in a meeting on the morning of 10 July. The notice stated that the termination would take effect on 9 August 2019[4]. People Care's stated intention was to resume the delivery of aged care services at the facility within this timeframe.

More particularly, it was the manner in which the senior management of Help Street and People Care conducted themselves which led to the collapse of service provision rather than a transition to new arrangements.

Based on the information available to the Inquiry, the Inquiry is of the view that senior management of both Help Street and People Care allowed commercial considerations and personal animosity to override their responsibility to the people in their care. A different group of people taking a more constructive approach to resolving their conflict and with greater compassion for those in their care would almost certainly have been able to achieve a smooth transition of service delivery.

This chapter will look specifically at the actions in the days between the notice of termination on 8 July and the collapse of aged care services on 11 July. Chapter 2 will explain the impact this collapse had on residents, their families and representatives. Chapter 3 will explore the relationship between People Care and Help Street in greater detail.

Questions of payment

While People Care's stated intent was for an orderly transition of services back to its control, it directly undermined the ability of Help Street to continue to operate by withholding a payment that was due on or around 10 July. This payment was to pass on subsidies from the Australian Government for the care of residents during the first part of July. The decision to withhold payment was made because People Care feared that, having received the termination notice, Help Street 's Global CEO, Mr Kristofer Bunker would take the money and then leave the country without paying staff. This justification, however, is in direct contradiction to claims that People Care was surprised that Help Street ceased the delivery of services on 11 July and that People Care had not made contingency plans to resume service delivery before 9 August because it was not considered necessary.

At around 8:45am on 11 July, People Care's owner and managing director, Mr Arthur Miller, called several officials of the Queensland Nurses and Midwives' Union to let them know he had not paid Help Street money it was owed. During the conversation, Mr Miller repeated the accusation that Mr Bunker intended to leave the country. The implication of the call is that Mr Miller understood the potential consequence of not making payment for the first part of July was that Help Street may not have been able to pay its staff.

Moreover, the timing of Mr Miller's call to the union suggests his intention may have been to create further difficulty for Help Street.

In an interview with the Commonwealth Department of Health (the Department) in the aftermath of 11 July, Mr Miller was explicitly asked if he had considered the potential impact on residents of his decision to not make the 10 July payment. Mr Miller's response was: "Not in general, I looked at the financial side."

[4] The original letter of termination included both 9 August and 30 August as dates of effect. Subsequent email correspondence indicates that the correct date was 9 August 2019.

In response to the notice of termination, on the evening of 10 July, Mr Bunker made a demand for a payment of $3.8 million (plus GST). Mr Bunker indicated that unless People Care agreed to this payment by 11:59pm 10 July and remitted 50 per cent of the amount by noon on 11 July then Help Street would not be able to continue to operate. Specifically, Mr Bunker wrote:

> *"Due to lack of confirmation of payment from People Care in any form, at the time of writing this email, should the deadlines set out in this email pass, we will have no choice but to place Help Street Villages (QLD) Pty Ltd into administration with immediate effect, ultimately causing the home to be closed."*

Had Help Street's request for payment been limited to the period in July during which its staff had already worked, this would have been reasonable. However, Mr Bunker's demand included a number of other expenses related to the winding up of the agreement with People Care including $2.7 million (plus GST) in compensation for loss of earnings relating to the anticipated 10-year timeframe of the agreement.

The total amount claimed is as follows:

Item	Amount (GST exclusive)
Australian Government Aged Care Subsidies for July – Full month (estimated)	$430,000
Australian Government Aged Care Subsidies for 1-9 August 2019	$124,838
Reimbursement for capital investments made by Help Street including new computer systems and servers, patient management software, firewall security, golf buggies, cars, mobile phones and iPads	$250,000
Staff liability	$275,000
Early settlement compensation	$2,700,000
Rental Bond	$109,636.86
Total (GST exclusive)	**$3,889,474.86**

To demand this large amount at short notice as a precondition for continuing operations was unreasonable and arguably impractical.

The range of items included in the demand for payment also supports the finding that Help Street was more interested in financial concerns than the wellbeing of residents.

The monthly government subsidy payments were Help Street's core operational funding and so it is reasonable to expect this funding would have continued to flow. The remaining items, accounting for close to 90 per cent of the amount demanded, were not related to ongoing operational funding. Making these parts of the demand a condition of ongoing service delivery essentially made the residents of Hibiscus House and Orchid House commodities in the dispute between Help Street and People Care.

Several witnesses have reported hearing Mr Bunker say to Mr Miller words to the effect of "this can all stop if you just pay the money". In a phone call on the morning of 11 July 2019, Mr Bunker also told People Care's solicitor that "this is going to cost Arthur Miller one way or the other". Assuming these statements were in fact made by Mr Bunker, they support a view that Help Street was seeking to leverage the risk of an imminent collapse in service delivery to extract payment from People Care.

People Care responded to Mr Bunker's demand at 10.16am on 11 July with a conditional undertaking to pay "any monies owing to the 30 June 2019 and up to the date of departure from the premises by Help Street".

The list of conditions included:

- that People Care was satisfied all staff would be paid all their entitlements
- all monies owing to People Care were paid
- all patient records and other documentation required to allow People Care to properly manage the aged care facility were handed over
- all plant and equipment that were the property of People Care were returned in good condition
- that an audit of the management did not reveal any breaches of the Accreditation Standards which would put People Care's Approved Provider status at risk.

These conditions were not necessarily unreasonable but they were also not designed to resolve the immediate situation and could certainly not have been met prior to the noon deadline given by Help Street. Other than indicating that Mr Miller was on location at Earle Haven and willing to meet Mr Bunker, the formal response to Help Street does not convey a sense of urgency about the need to maintain service continuity for the residents of Hibiscus House and Orchid House.

In an interview with the Department, Help Street senior management claimed they had attempted to engage Mr Miller in discussion about a smooth exit plan but that they were hamstrung by an unwillingness from Mr Miller to guarantee further payments. Help Street senior management also indicated that even amidst the seriousness of the events of 11 July, Mr Miller would consistently return the conversation to Help Street's decision to stop using People Care's catering and laundry service. As we will see in Chapter 3, this decision was a major irritant in the relationship between the two parties.

Scorched Earth

In addition to the debate about payment, Help Street senior management appears to have resolved to do as much damage as possible on its way out; both to People Care and to Mr Miller personally. Some families reported Mr Bunker saying words to the effect of "we'll ruin you" to Mr Miller and several of Help Street's actions after receiving the notice of termination appear to have had this motivation.

There was already significant animosity and lack of trust between the two organisations before the notice of termination. We have already noted that Mr Miller did not trust Help Street to use the July subsidy payment to pay staff and continue to provide care. In a similar vein, Help Street did not trust People Care. Ms Karen Parsons, Help Street's Executive Director for Aged Care services at Hibiscus House and Orchid House, reported that Mr Bunker asked her to arrive early on 11 July with words to the effects of:

> *"There is a risk, knowing Arthur [Miller], that he may change the key pads to prevent us access now that he's given us the letter."* [5]

Ms Parsons described Mr Miller as overbearing and quite "intimidating" [6]. The Inquiry heard that Mr Miller refused to meet with Ms Parsons because she was not a registered nurse and would address her only as "madam".

Numerous hostile confrontations occurred between employees of Help Street and People Care during the course of the day. In the most disgraceful of these confrontations, the residents of Hibiscus House were caught physically in the middle of heated arguments.

The actions of Help Street on 10 and 11 July need to be understood in the context of this hostile relationship reaching final stages.

[5] Royal Commission into Aged Care Quality and Safety, Exhibit 8-3 – WIT.0327.0001.0001 – Statement of Karen Parsons
[6] Royal Commission into Aged Care Quality and Safety, Brisbane Hearing 5 August 2019 – Transcript, testimony of Ms Karen Parsons

Perhaps the clearest indicator of an intention to cause as much harm as possible to People Care, and a disregard for the wellbeing of residents on the part of Help Street, was the removal of computer servers holding client records on the afternoon of 10 July. The removal was originally justified on the basis it was to allow the servers to be upgraded and private Help Street information removed. After the events of 11 July, Help Street also justified the removal as necessary to preserve the equipment from damage.

Neither of these explanations seems plausible. The equipment was less than a year old, having been purchased by Help Street, and if data was to be moved to a new location it would be more likely that the data be transferred to the new location first before the physical servers were removed. The Inquiry has also seen no evidence to support a reasonable fear the servers would be physically damaged in any way.

The circumstances of the removal are also suspicious. The task was undertaken personally by Mr Bunker and Help Street's CEO Australia and New Zealand, Mr David Lamb, immediately after receiving the notice of termination. In normal circumstances, it would be unusual for the people holding these roles to personally undertake removal or upgrade of computer hardware.

It is also suspicious that neither the Executive Director of aged care services for Hibiscus House and Orchid House nor the Clinical Care Coordinator had been informed of the removal before it occurred. It would be expected that removal for any planned upgrade would have been communicated to the leadership team at the facility so contingency arrangements could be put in place. Moreover, removing the servers without notifying local management so it could put alternative arrangements in place shows a complete disregard for the care of residents.

Some staff also reported other signs of preparation for departure by Help Street on 10 July. This included taking down Help Street-branded notices in the staff room.

Help Street began the removal of items in earnest on the morning of 11 July with the presence of a removal truck on site reported from mid-morning.

The Inquiry identified the removal company after discussions with residents and family members and viewing media footage of the event. The company confirmed that the truck was booked at approximately 9am by Ms Telecia Tuccori, Help Street's Clinical Care Coordinator. Reception staff also indicated that on arrival the removal staff asked for Ms Tuccori by name.

The process of packing up items began at around 9am with Help Street management seen lifting the linen on residents' beds to check which mattresses had been purchased by Help Street. Furniture, crockery, cutlery, electrical appliances and health care supplies were packed up and removed.

The Inquiry heard reports of residents' belongings being upended onto their beds so that bedside tables could be removed.

In the midst of the Triple 0 call Ms Tuccori can be heard directing a staff member to "call [health care supply company] Triple S and get them to empty that store room".

In one particularly disturbing incident, care staff working on the morning of 11 July recounted trying to get thickened fluids from the kitchen for residents who were appearing dehydrated and whom they named to Help Street's catering manager. The request was refused by the catering manager who responded with words to the effect of "no, they're ours and we're taking them".

As with the demand for payment as a condition of continued service, Help Street's removal of items demonstrates a preoccupation with commercial considerations over the needs of residents. These actions were disrespectful and placed the residents of Hibiscus House and Orchid House at unnecessary risk.

By the time the Queensland Ambulance Service arrived on the scene at approximately 2:15pm, the "majority of medical equipment, food and other supplies [had been] removed from the premises" [7]. The process of removal continued even after the Ambulance Service asked for it to stop citing the risk to the safety of residents.[8]

Furthermore, the Inquiry heard from staff that some items – notably sensor mats – were removed from residents' rooms and locked in an office. Given these mats are used to assist in managing the risk of falls, removing them from rooms placed residents at risk. Locking them in an office rather than loading them onto the waiting truck also supports the finding that Help Street was seeking to damage People Care as much as possible. A plausible explanation for this course of action is that Help Street was deliberately attempting to make the scene as dangerous as possible before calling Triple 0. The deliberate and manipulative nature of this action is supported by the comments made by Help Street that "this can all stop if you just pay the money".

A similar conclusion can be drawn from the timing of discussions among Help Street management about its plans for the day. Ms Tuccori's testimony to the Royal Commission indicates that the plan to call Triple 0 was formed at a management meeting at approximately 9am on 11 July. Help Street then waited more than four hours before calling authorities during which time the removal of items was undertaken.

Testimony before the Royal Commission and the recording of the Triple 0 call also demonstrate that no attempts had been made by Help Street to identify respite or other alternative forms of care for the residents of Hibiscus House and Orchid House. This clearly demonstrates that Help Street actions were in no way motivated by concern for the people in its care. As Counsel Assisting the Royal Commission submitted: "It is hard to imagine a more complete and unsatisfactory dereliction by Mr Bunker and Help Street of the obligation (moral and perhaps legal) to provide care to the residents of Hibiscus and Orchid Houses." [9]

The Inquiry notes that written submissions lodged with the Royal Commission into Aged Care Quality and Safety on behalf of Ms Tuccori explain that she did not have managerial responsibility for Hibiscus House and Orchid House. The submissions infer that Ms Tuccori was acting under the direction of Help Street senior management and argue that she did not have authority to investigate the possibility of transferring residents to other facilities without a direction to do so from her superiors.[10]

Staff on duty were rounded up at approximately 1:30pm near the dining room area of Hibiscus House. Mr Bunker informed the gathered staff that Help Street had gone into liquidation so staff were all unemployed and should leave. He informed them that those who chose to stay would not be paid and if injured would not be covered by insurance.

The Inquiry is aware of mixed reports about Mr Miller's involvement at this 1:30pm meeting. Some residents and families reported Mr Miller saying simply: "Help Street, I want you off the premises." On the other hand, Help Street managers indicated that Mr Miller had made "a scene" [11] in which he made critical comments about the quality of care delivered by Help Street staff. Video footage seen by the Inquiry suggests that Mr Miller was agitated during this interaction.

After the meeting some staff reported the Clinical Care Coordinator walking around to staff who continued working to ask: "Are you staying or going?" They reported the Coordinator saying: "You won't be paid if you stay." Most staff chose to stay.

[7] HEOC Meeting minutes (14:30 hours) as attached to Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – WIT.0324.0001.0001 Statement of Patrick Turner
[8] HEOC Meeting minutes (14:30 hours) as attached to Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – WIT.0324.0001.0001 Statement of Patrick Turner
[9] Royal Commission into Aged Care Quality and Safety, Counsel Assisting's Submissions on Proposed Findings relating to Earle Have Case Study, p 59 (paragraph 200)
[10] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions – Submissions of behalf of Telecia Tuccori in response to Counsel Assisting's Submissions on proposed findings relating to Earle Haven Case study
[11] Royal Commission into Aged Care Quality and Safety, Brisbane Hearing 5 August 2019 – Transcript, testimony of Ms Telecia Tuccori

Emergency response

The emergency response was triggered when the Clinical Care Coordinator for Hibiscus House and Orchid House made a call to Triple 0 at 1:33pm.

During the call, Ms Tuccori 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."*

In reality, Help Street had not entered administration and the call was made at the same time staff were being told the news.

Some misinformation from this call appears to have pervaded the thinking of Queensland authorities. For example, the suggestion that the aged care provider had gone into liquidation was included in correspondence from the Queensland Minister for Health and Minister for Ambulance Services to the Commonwealth Minister for Aged Care and Senior Australians in the early evening of 11 July.

In addition, despite the removal of equipment and supplies being identified as a risk to residents originally, first responders did not believe they had the authority to stop this activity and it took around three hours for legal advice to the contrary to come through.

Finally, Queensland authorities operated on the basis that most staff had left when several stakeholders have informed the Inquiry that the number of staff on site was comparable to, or greater than, normal levels once staff who stayed after the nominal end of their shift or who came in on their day off were counted.

There are mixed reports about the way the events of the afternoon played out with the main image being one of confusion and chaos. The debrief of Queensland Government agencies on the events noted that:

> *There was uncertainty for responding agencies regarding the root cause of the disruption on scene with responding agencies receiving varying reports from staff and residents at the site. In the initial stages of the response, there were significant issues with Queensland Health staff maintaining the site and limiting access to others who were continuing to remove items."* [12]

There was significant variation in the experience of residents as well. One family reported leaving for the evening believing their loved one was well cared for and having been assured that everything was all right. In contrast, another family reported that their grandfather was not checked on for eight hours. The Inquiry heard from staff that Orchid House, which is further from the main entrance to Earle Haven, was calmer and had fewer items removed than Hibiscus House.

There also appears to have been communication challenges between emergency responders and staff from both People Care and Help Street. It was unclear to emergency responders who had responsibility for the site and who could be trusted. It is also possible that People Care staff were dismissive of the need for an emergency presence in a way which impeded effective communication.

The Gold Coast Hospital and Health Service (GC HHS) was first advised of the unfolding event by the Queensland Ambulance Service at around 2.15pm in a phone call from the Ambulance Service's Senior Operations Supervisor as he was driving to the scene. The GC HHS immediately declared a 'Code Brown' which refers to "any incident external to a GC HHS facility that will require the significant allocation of GC HHS resources".[13] This might include mass casualty events, disasters and major health incidents. 'Code Brown' events are categorised as Level 3 – the most severe in nature.

[12] Queensland Health, Earle Haven Retirement Village evacuation debrief report, 19 August 2019
[13] Gold Coast Hospital and Health Service, Emergency Preparedness Continuity Management Plan as attached to Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – WIT.0324.0001.0001 Statement of Patrick Turner

In accordance with the GC HHS's *Emergency Preparedness Continuity Management Plan*, a Health Emergency Operations Centre (HEOC) was activated at 2:30pm. It was the HEOC which had the primary role for guiding the emergency response and decision making.

This initiated a mammoth effort by the GC HHS. A crisis team was dispatched to Earle Haven including clinical staff, social workers and management.

It is estimated that 259 GC HHS staff were involved in responding to the incident, including 112 staff who either assisted on site or were involved with the HEOC. The others were staff on the morning shift at Gold Coast hospitals who were retained on duty until around 6pm when it was decided it would not be necessary for the residents of Hibiscus House and Orchid House to be relocated to hospitals.[14]

In parallel, the Ambulance Service began preparations for the potential of a mass evacuation including mobilising the necessary resources to undertake such an evacuation while maintaining services for the rest of the community. It is estimated that around 32 paramedics were involved in the operation.

From the perspective of the Queensland Government authorities responding to the situation there were three options under consideration:

- Keep the aged care facility operating temporarily
- Find 70 beds in surrounding aged care facilities
- Transport residents to hospital.

The Queensland Government's Chief Health Officer first learned of the incident at around 2:35pm through Queensland Health's media team.[15] At 3:05pm she requested the State Health Emergency Coordination Centre (SHECC) be activated. The SHECC "provided monitoring and intelligence functions, with the capability to coordinate deployment of resources and assistance to the Gold Coast if required (the need did not eventuate)" [16].

The Department was asked to send a liaison officer to the SHECC and it was in this context that it first became aware of the events unfolding at Earle Haven. People Care had sent an email to both the Department and the Aged Care Quality and Safety Commission at approximately 2pm on 10 July 2019 to advise that the arrangement with Help Street had been terminated. The email stated that the date of effect for the termination was 30 August 2019 and that People Care would continue to manage the aged care services after that date. There was no follow up by People Care on 11 July 2019 to advise that the situation had escalated and the potential for Help Street to cease operation immediately.

The Department's liaison officer arrived at the SHECC within 30 minutes and the Department's State Manager for Queensland and the Northern Territory also participated in SHECC teleconferences. However, federal officials were engaged in an advisory capacity and not as partners in managing the situation. Federal authorities were not engaged in the decision-making process of the GC HHS HEOC.

As one example, the Department provided a list of aged care facilities on the Gold Coast with vacancies but it was the GC HHS that contacted facilities and decided where people would be relocated. It does not appear that information about the compliance status of these facilities or other knowledge of the aged care services on the Gold Coast was sought from, or offered by, Department staff.

As the afternoon progressed, the Queensland Police declared an emergency and took control of the site. This allowed the police to stop the removal of further items and control the entry and exit of people to and from the premises.

[14] Queensland Parliament, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Investigation of the closure of the Earle Haven residential aged care facility at Nerang – Questions – Response to Questions Taken on Notice – Queensland Health
[15] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – WIT.0321.0001.0001 Statement of Dr Jeannette Young PSM
[16] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – WIT.0321.0001.0001 Statement of Dr Jeannette Young PSM

Attempts to resolve the situation

While the emergency response of Queensland authorities was under way, there were also attempts being made by People Care and members of the Earle Haven community to maintain services for the residents of Hibiscus House and Orchid House.

It is not the case that all staff left. Some chose to stay beyond their nominal shift time, others started work on the afternoon shift despite being told they would not be paid and some staff even came in on their day off when they heard what was happening. Former employees also returned to offer assistance.

The commitment of these staff displays the best aspects of the aged care industry demonstrating commitment and genuine passion about the wellbeing of the people in their care.

The community of Earle Haven banded together to support the residents of Hibiscus House and Orchid House. The Inquiry heard of family members and other volunteers who arrived to provide assistance.

Ms Karen Heard, a registered nurse who had previously managed the aged care services for both People Care and Help Street and had recently been engaged by People Care to undertake a series of clinical audits arrived at the site around 3pm with the intention of establishing temporary arrangements to maintain continuity of service. She made the two-hour drive to Earle Haven from her home after a request for assistance from Mr Miller. On her way Ms Heard made a series of phone calls to start to put these temporary arrangements in place.

The catering staff in the Earle Haven Lodge began to prepare food to serve to the residents of Hibiscus House and Orchid House for the rest of the day. This included afternoon tea and dinner of soup, chicken casserole and dessert. The kitchen in the Lodge is immediately adjacent to Orchid House and had provided full catering services for the residential aged care service until April 2019.

Although much had been removed at the instruction of Help Street senior management, it was possible for some of this to be quickly replaced. All catering equipment from when People Care catered for Hibiscus House and Orchid House was still in the village. Catering staff had a fridge, cutlery, crockery, cleaning equipment and most other things they needed delivered to both Hibiscus House and Orchid House during the afternoon and evening on 11 July. Indeed, the Inquiry heard that cleaning efforts were under way as the last evacuations were taking place.

Ms Heard reported to the Department and Queensland Ambulance Service that with the assistance of staff whom she had called in, volunteers and the Lodge kitchen it was possible for People Care to operate the service for approximately 72 hours. During this time, she anticipated being able to put in place longer-term arrangements.

There are doubts about how effectively People Care communicated to emergency responders its efforts to restore services. The Queensland Ambulance Service reported that Mr Miller told emergency responders they should leave and did not appear willing to assist. When asked, he could not provide concrete plans in relation to food, hygiene or staffing.

On the other hand, Mr Bunker, who seemed to have been deliberately precipitating an evacuation, was very happy to have conversations with emergency responders.

Decision

The decision was ultimately taken to evacuate all residents of Hibiscus House and Orchid House to other residential aged care facilities on the Gold Coast. The decision was based on a judgement that the facility was no longer safe for residents given the large amount of equipment and supplies that had been removed. Responders on the ground could not reconcile the advice from People Care with what they were seeing and so concluded that People would be unable to immediately resume service delivery.

The evacuation started at approximately 6pm on 11 July and finished at approximately 12:30am on 12 July. Once the decision was made, the evacuation was managed efficiently and professionally. Testimony given to the Queensland Parliament's investigation into the events at Earle Haven was that each movement was undertaken as though it were an individual job and with respect for the residents involved.

The next chapter will explore further the impact that the events of 11 July and the decision to evacuate had on the residents of Hibiscus House and Orchid House, and their families. This includes significant distress for residents at being removed from their homes.

Chapter Five will then look at some of the evidence about the risks and impact of moving frail elderly people from their home and consider whether there might be different ways of handling similar events in future that would avoid these adverse outcomes.

CH .2 — The impact of the events

Safety and wellbeing of residents

To understand the impact on residents and their representatives, letters were sent on 5 August 2019 to the next of kin as recorded by the Commonwealth Department of Health (the Department). Representatives were then invited to meet with Ms Kate Carnell AO. There were 32 representatives who accepted this invitation.

In addition to these meetings, a public call for submissions was made on 16 August 2019. A total of 20 written and verbal submissions were received to help inform the Inquiry.

For the 69 residents of Hibiscus House and Orchid House, the evacuation from their home and community on 11 July 2019 came without warning. The Inquiry heard of the trauma, stress and uncertainty on the day and in the many weeks following. Husbands and wives of more than six decades were separated. Money was taken out of residents' bank accounts on the morning of 11 July which was not due to be paid until the end of the month, only to be returned days later.

A spouse of one of the residents spent the afternoon watching and monitoring as the events were unfolding, only leaving for his home in the retirement village at 5.30pm as he was led to believe enough staff were present to provide care overnight. It wasn't until around midnight when the family (with one member living only metres away) were notified their loved one had been evacuated all alone at the age of 95. These examples from the day demonstrate how little prepared residents were to leave their home and how illinformed families were of the evacuation.

Some residents were told they would be away for only one or two days and packed accordingly – taking only one change of clothes. In the hurry of the evacuation process, some residents' walkers, dentures and hearing aids were left behind. The Department worked to catalogue all of these items and People Care arranged for them to be delivered to residents on Saturday 13 July 2019.

Three of the residents in Hibiscus House and Orchid House required hospitalisation during the events of 11 July. The family of one of these residents has shared their story for the Inquiry.

"We were never given the opportunity to find another home. This choice was taken away"

The impact of the events of 11 July 2019 is illustrated graphically by the story of one resident of Hibiscus House who was transported to a new facility in the dark, in the middle of a winter's night. Within seven minutes of reaching the new destination and before staff at the new facility could assess the level of care required, this resident experienced a fall. After being transferred to hospital, this resident was diagnosed with a subdural haematoma and ultimately passed away five weeks later.

For the family of this person, the decision to move their loved one into Earle Haven wasn't an easy choice. With rapid early-onset dementia and psychosis, finding a home where they would be sufficiently cared for and close to family was the priority. The family took comfort in the belief they had chosen the right facility as their loved one succumbed to the effects of dementia with loss of speech and mobility that soon followed.

The family recount the gradual decline in services from when Help Street began operating in April 2018. Firstly, they noticed the hairdresser would no longer attend, followed by a decline in staff numbers to a point where the facility seemed bare. The reliance of families to help with meal times was becoming more apparent. Even with declining staff numbers, the family spoke only positively of the staff who cared for their loved one.

On the afternoon of 11 July 2019, like many other families, they first heard of the turmoil unfolding at the aged care facility through the media. Immediately, they made a call to Hibiscus House to find out what was happening. The family spoke to a member of staff late in the afternoon. With chaotic noise in the background, the family were told there were "no problems" and "don't come in". The next they heard anything was after midnight, when they were told their loved one had been transferred to hospital following a fall which had occurred immediately after they had been transported to the new facility.

The family question whether they did enough that night to ensure the safety of their loved one. They say that had they received a call before the evacuation they could have taken their loved one to their own home that night or travelled to the new facility alongside them.

Following the fall on 11 July, their loved one was never the same. The events that followed were traumatic. There were multiple transfers once admitted to hospital, another fall which exacerbated injuries and a rapid decline in wellbeing. The consequences of the fall on 11 July meant the right to a dignified end of life was complicated with the family having to "battle with Earle Haven and the hospital" during the last weeks of their loved ones life.

Based on the state of the facility, the family understand there may have been a need to move residents out of the home at some point. Nevertheless, they question the decision to call for an emergency evacuation that led to their loved one being transported late at night without choice and without family by their side.

In returning to Hibiscus House to collect a box of belongings weeks after the event, the family reported that the home, which previously had a "good reputation" and "used to be full of life", was now "cold and empty".

In all, eight residents were sent to hospital after being relocated to other residential aged care facilities and three residents have since passed away.

Families are grateful for the care received by their loved ones in their new environments once the evacuation occurred. However, dealing with new environments without personal belongings, as well as new staff and in some cases a lack of personal space, made for a strange and uncomfortable experience. Worst of all, however, was the uncertainty around when or if they would ever return home.

If some residents and their families were given the choice, they would have gone back to Hibiscus House and Orchid House immediately. In some instances this was caveated with “but without Help Street”.

The reasons for wanting to return included having a partner or family member living in the Village. An example of this was the wife of one of the evacuated residents who had been married 65 years and for whom this was the first time they had ever lived apart. The wife, who can no longer drive, is now unable to visit her husband whenever she likes. While a bus service was arranged first by People Care and then the Department, this did not provide the same freedom or convenience as living in the same village.

A second powerful reason was that Earle Haven was the evacuated residents’ home. On inspection of the facilities on 22 August 2019 (six weeks post evacuation), the rooms in Orchid House remained decorated with the residents’ belongings. The gardens, which some of the residents helped to tend, were still immaculate. Residents expressed how much they missed their home, their community and their belongings.

In addition, some residents were moved from single rooms to a facility with four beds to a room. They and their families missed the privacy and freedom afforded by a single room.

The Inquiry heard that some residents developed vomiting and diarrhoea after being transferred, which might have been attributed to the stress of the move. Others showed symptoms of grief and depression such as not eating, becoming very angry, wringing hands and shutting their eyes to disengage with staff and families. This demonstrates some of the negative side effects of the evacuation on residents of Hibiscus House and Orchid House.

There were reports that moving out of Hibiscus House and Orchid House has been beneficial for some residents. There have been improved clinical outcomes for some, such as increased weight and enhanced speech. Some residents received services in their new facilities that they never knew they were entitled to and were not available to them in Hibiscus House or Orchid House.

Nevertheless, there is a body of evidence that demonstrates forcibly relocating frail elderly residents – even to a better facility – can result in worse outcomes in terms of mortality and morbidity. This evidence will be explored in more detail in Chapter 5.

Impact on families

Families shared with the Inquiry how difficult the decision is to place a loved one into permanent care. Safety and care was seen as a basic expectation when choosing an aged care facility. A key factor in some families choosing Hibiscus House and Orchid House was the opportunity to be co-located with loved ones in the Earle Haven Retirement Village. This allowed them to maintain their social interactions and age together in the one facility, with tiers of services to support them when needed.

For many families on 11 July 2019, including those living in the Village, the first they heard of their loved ones being evacuated was through either the news or social media. The Inquiry heard from one family who tried to contact Hibiscus House upon seeing what was unfolding on social media, only to be told "they could not tell me anything and that I should not visit as I would not be admitted". Some families were notified after the evacuation by receiving a phone call at around midnight.

In one instance, a family was told their loved one had been transferred to a particular facility, only to find out when they arrived at the site late in the night that the elderly person in question had been transferred to a different facility. Other families didn't find out where their loved ones were moved to until the following morning.

Families shared their gratitude towards the care received from emergency services on the day. Nevertheless, some families, including those present at Hibiscus House and Orchid House on the day, question the need to declare an emergency evacuation in such a hurry and without notifying families first. Families were not involved in decisions about where the best place for their loved ones to be transported would be, with these decisions made by Queensland Health authorities.

The flow-on impact of the events on 11 July 2019 on families has been stressful, time consuming and costly. Families attended numerous meetings at Earle Haven with People Care and government officials over the weeks that followed. Many found these meetings disappointing because they could not get a clear answer to the question that was most important to them: will our loved ones be able to return home, and if so, when?

Some families in consultation with the residents took the opportunity to move into new facilities right away. Others took longer to make this decision in the hope they could return to Hibiscus House and Orchid House. Ultimately the facilities closed.

Families were assured they would not be financially worse off from the relocation to new facilities. The Department worked to minimise the financial impact of the relocations, including by providing a liaison with the Department of Human Services, and covering daily accommodation charges while residents were in temporary placements. The Inquiry heard that despite this assistance, some families did face financial uncertainty after deciding a new, third facility would be better suited for their loved one, further adding to the stress of the situation.

Other costs (or potential costs) incurred by family members as a result of the relocations included time off work to attend to their loved ones in their new environment, attend meetings and to deliver personal items from Hibiscus House and Orchid House.

For some families the impact also included the potential loss of value to their independent living homes in the Earle Haven Retirement Village. Given the media attention on the Earle Haven site as opposed to the specific Hibiscus House and Orchid House residential aged care facilities, families are fearful the value of their homes will have declined if they need to sell, including those who may need to move villages to be close to their relocated loved ones.

The Inquiry heard how the impact of the events on 11 July 2019 spread beyond families of residents and into the wider Earle Haven community. The community wanted their residents to come home and to be cared for by the staff they knew and trusted. They wanted the community to feel whole again.

The Inquiry also heard that people across the Village were fearful after the events of 11 July that they too could be forced out of their homes as a result of business decisions made by the Village's owner.

Impact on staff

The Inquiry heard the impact on staff began well before 11 July 2019. A number of staff told the Inquiry that under Help Street they were in constant fear of losing their jobs, and a number of long-standing staff had left due to this culture. Care staff reported to the Inquiry they felt intimidated and devalued by the new management.

In February 2019, the Queensland Nurses and Midwives' Union (QNMU) became involved in employee pay disputes with Help Street, including award breaches and unpaid superannuation. After unsatisfactory dealings with Help Street management, the QNMU filed a dispute with the Fair Work Commission in April 2019. As at October 2019, the disputes over pay, leave entitlements and unpaid superannuation remain unresolved.

By early July, QNMU industrial disputes escalated to clinical care issues, with union members concerned about the standards of care. The union reported it was preparing to formally engage with People Care about these concerns but that action was overtaken by events.

On 11 July 2019, contrary to media reports that staff had walked out, the care staff of Hibiscus House and Orchid House continued to work despite being told they would not be paid. They placed the needs of residents before themselves. Many morning staff stayed beyond their shift. Staff arriving for their afternoon shift stayed on after being told they would not be paid as they arrived for work. People who weren't rostered on that day or who no longer worked at the site received phone calls from their colleagues and came in to lend a hand. Some staff remained until around midnight.

The Inquiry heard that the registered nurse rostered on the night shift stayed on site after the evacuation was concluded just in case any of the receiving facilities needed information about a resident. This nurse only went home after she could hand over to People Care's nurse administrator on the morning of 12 July.

It was clear from meeting with a number of the staff and the QNMU that the media reporting of a "staff exodus" had a profound impact on these dedicated nurses and carers. In contrast to the senior management of Help Street and People Care, the nursing and care staff prioritised the needs of the residents in their care. Their commitment and compassion should be celebrated.

As outlined in Chapter 1, other staff from the Village also took steps to support continuity of service in Hibiscus House and Orchid House. Notably this included catering staff from the Lodge who took steps to resume catering services and provided food to the residents on the afternoon and evening of 11 July.

The effort displayed by the care staff at Hibiscus House and Orchid House, and across the Village demonstrated the best aspects of the aged care sector in ensuring residents are cared for to the best of their abilities.

Following the events of 11 July, staff were of the impression their employment had been terminated. They also received their pay late with payments that were ultimately made by People Care as opposed to their employer, Help Street. The QNMU made attempts to seek staff entitlements from Help Street under the condition of employment termination, only to be informed by a Help Street lawyer that employees had instead been stood down under section 24(c) of the *Fair Work Act (2009)* without pay.

On 26 August 2019, Help Street Villages (Qld) Pty Ltd was placed into liquidation. The Inquiry understands that staff entitlements had not been paid at that time.

The majority of care staff at Hibiscus House and Orchid House are considered low income earners. The lack of pay and employment has had a significant impact on their quality of life. A number have received hardship payments from QNMU. The Inquiry also heard from one staff member who upon nearing retirement age had elected to salary sacrifice a significant contribution to her superannuation through Help Street, only to find out the money was never placed in her superannuation account.

Another staff member was owed around $16,000 and facing the prospect of selling her family home.

Staff are understandably upset to lose their employment, with some staff having worked at Hibiscus House and Orchid House for almost two decades. The uncertainty around when and if the facilities would reopen, and when and if they would get paid and receive their entitlements has been the cause of most of their stress. However, the impact of the events on the displaced residents of Hibiscus House and Orchid House was also clearly distressing for them.

Impact on other aged care providers

The events of 11 July also had a significant impact on the aged care providers that took in evacuated residents from Hibiscus House and Orchid House. Seven providers agreed to offer a temporary home to the evacuated residents with little warning, limited information about the care needs of the people they were receiving and, because the requests were not made by either the approved provider or the Department, no certainty about the funding arrangements to support delivery of care. This response displays the goodwill and humanity of most aged care providers.

The Inquiry also heard that other aged care providers actively contacted the Department to indicate their willingness to take in evacuated residents.

Nonetheless, taking in people at short notice had an impact. Some providers needed to bring in additional staff to care for the evacuated residents and all needed to spend time getting to know the residents and their care needs. Following the removal by Help Street of the IT servers at Hibiscus House and Orchid House on 10 July, it took until 2 August for the Department to receive access from Help Street and disperse residents' electronic records to the new facilities. The circumstances of the evacuation meant that receiving providers were not in a position to engage staff who had previously worked at Hibiscus House and Orchid House and so many relied on agency staff who were unfamiliar to the residents.

The impact was particularly concentrated at one facility which took in 34 people. The Inquiry heard that this provider needed to source additional equipment, including bedding, to take on such a large number of residents. In addition, one of the two nurse advisors engaged by the Department to support residents and families spent a significant amount of her time supporting this facility with the task of understanding and documenting the needs of residents who had moved from Hibiscus House and Orchid House.

There was also a financial impact on the receiving providers, particularly the one taking on a large number of residents. The providers handled this impact with significant goodwill and in many cases this temporary arrangement became permanent where providers entered into negotiation with residents and their families to avoid or minimise any additional cost arising from the change.

People Care, which continued to receive Australian Government subsidy payments up until the end of July 2019 passed on the subsidy payments to the relevant provider for each resident.

The Department also worked directly with receiving providers to manage the financial impact of taking on additional residents. This included arranging for August and September subsidy payments for any residents who had not relocated permanently to be paid directly to the host provider rather than to People Care. However, this assistance required a manual workaround which took time to implement and for some providers had not been completed by early October 2019. This meant that receiving providers were out of pocket for a period of time.

The Inquiry also heard that People Care had not passed in a timely fashion Refundable Accommodation Deposits (RADs), and associated interest, to new providers as residents relocated permanently. This behaviour reflects poorly on People Care, further indicating an interest in financial matters over the needs of residents.

CH .3 — The history of People Care and Help Street

The history of Earle Haven

The Earle Haven Retirement Village (the Village) at Nerang on the Gold Coast is the third largest registered retirement village in Queensland, originally founded by Mr Arthur Earle OAM, a grazier and realtor, who came to the Gold Coast in 1964 and purchased more than 1,200 hectares of land situated between Nerang and Mudgeeraba.

The Village consists of 506 leased independent living units and serviced apartments, and residential aged care facilities. It was purchased by Mr Arthur Miller of Miller Enterprises Pty Ltd in 2002.

The Village offers a number of residential living options with graduated levels of care:

- a selection of one, two and three-bedroom independent living units
- 112 serviced apartments known collectively as The Lodge which provide residents with shopping, meal preparation, cleaning and laundry services
- 89 residential aged care beds in Hibiscus House and Orchid House.

Residents at the Village value the progressive levels of independent living and care options available at Earle Haven. The grounds of the Village are well maintained and it is easy to see why people describe Earle Haven as their home. Facilities include a bowling green, pool, workshop and a store operated by the art and craft group. The on site commercial kitchen provides meals to residents of The Lodge and also operates as a restaurant/ café for people residing in the independent living units.

Hibiscus House is a 59-bed facility, with a combination of single rooms and rooms suitable for couples, each with an ensuite. Orchid House is a 30-bed facility made up of single rooms, each with an ensuite, as well as one respite room.

Hibiscus House and Orchid House include secure outdoor areas which residents could access and well maintained gardens. Renovations were recently undertaken to increase the number of single rooms and provide an ensuite in each room.

Copies of the *Earle Haven Chronicle* seen by the Inquiry suggest residents of Hibiscus House and Orchid House were part of the wider Earle Haven community. There are regular references to volunteers from the Village assisting at events or donations from the arts and craft group. Staff from People Care Pty Ltd would frequently attend Earle Haven residents' committee meetings. It appears this engagement lessened following the decision to contract aged care services to Help Street.

Corporate arrangements

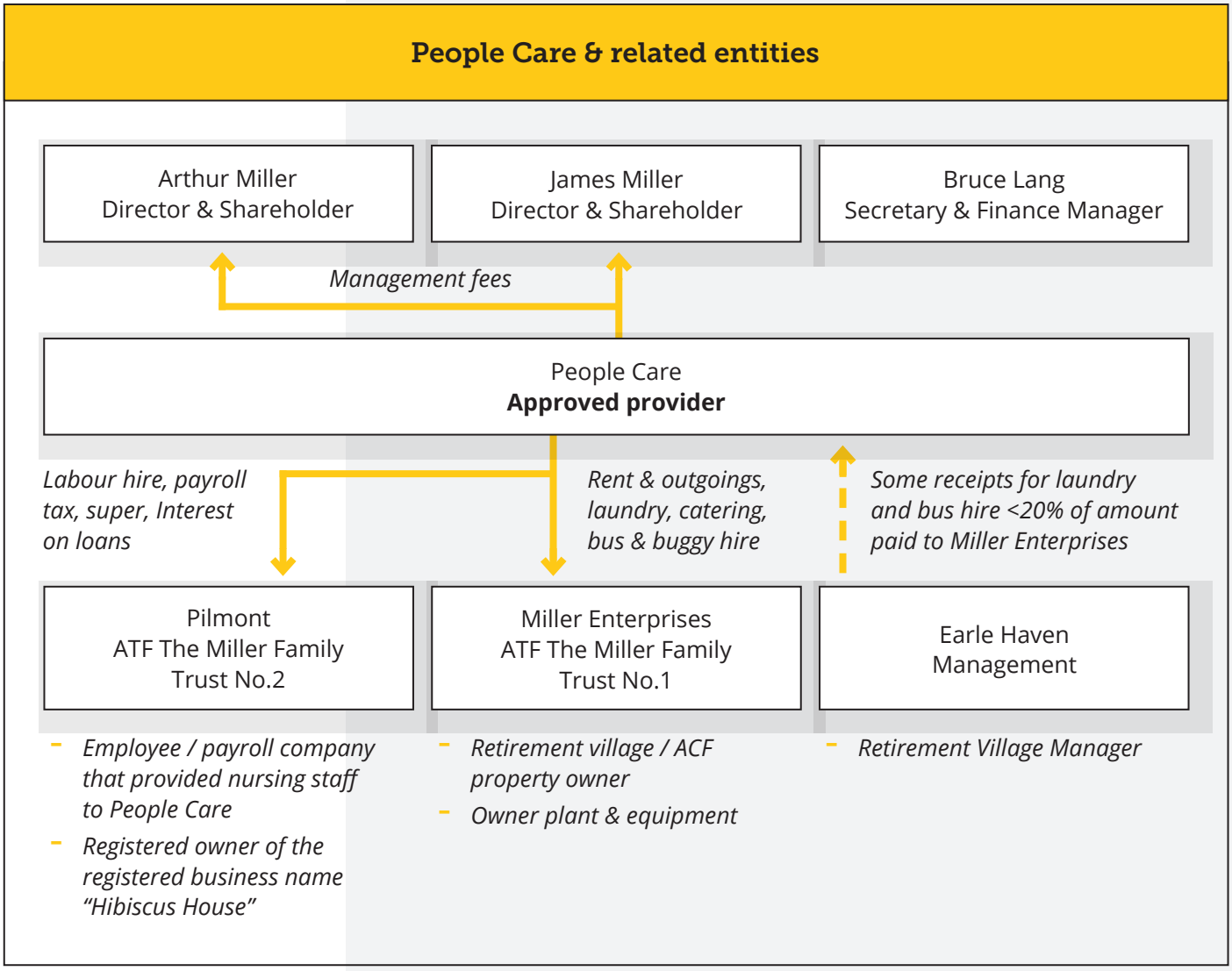
Before the sub-contracting arrangements with Help Street were put in place, a group of companies operated the Earle Haven site. All of these companies were related to Mr Miller and included two family trusts.

The land on which Hibiscus House and Orchid House is located is owned by Miller Enterprises Pty Ltd (Miller Enterprises) which is one of the two family trusts. People Care made payments to Miller Enterprises for rent, laundry, catering, bus and buggy hire.

Pilmont Pty Ltd, the second family trust, was an employee or payroll company which provided nursing staff to People Care. Pilmont was also the registered owner of the business name "Hibiscus House".

A further firm, Earle Haven Management Pty Ltd is the company responsible for managing the retirement village.

The figure below shows the relationship between the companies, including the direction of payments in 2016-17.



In 2016-17, 75 per cent of all People Care's expenses were paid within this group. The payments were purportedly made on a commercial basis, including a margin, but no information could be provided to the Inquiry about how these terms were reached. Structures like this are legal and typically associated with minimising income tax and maximising the return to trust beneficiaries.

The finding that the arrangements between related companies at Earle Haven were designed to maximise the return to the beneficiaries of the Miller family trusts is further supported by charging patterns in costs that should vary according to occupancy rates of the residential aged care facilities but did not.

BRI Ferrier observed that the related-party transactions were applied, in part, to subsidise the retirement village's operations, and used to divert cash generated by the aged care provider to related entities. The rates charged by Miller Enterprises Pty Limited for laundry and catering services were significantly in excess of the industry averages. The high rates is a strong indicator that related party transactions were used to reduce the ACF's profitability and transfer value from the ACF to related parties. In doing so, cash available to reinvest in ACF resources and facilities was minimised. Consequently, People Care became reliant on those related parties to fund its operating activities and capital expenditure to upgrade the aged care facilities. That reliance is reflected in the significant related-party trade creditor balances and inter-company loans payable. The interest paid on the inter-company loans was another mechanism for diverting People Care's cash to beneficiaries of the Miller family trusts.

BRI Ferrier concluded that the amount of funding moved from People Care to related entities undermined the financial viability of the aged care business. As we will see later in this chapter, this had a profound impact on the potential for Help Street to establish a viable operation, which in turn created risks to the residents of Hibiscus House and Orchid House.

First, however, the report will explore the history of People Care as an approved provider of aged care services before the arrangement with Help Street.

People Care as the approved provider of Hibiscus House and Orchid House

People Care first started delivering aged care services under a previous name and owner in 1971 and was deemed to have approved provider status for residential and community aged care under transitional provisions when the *Aged Care Act 1997* (the Aged Care Act) came into effect.

Mr Miller purchased People Care and its approved provider status when he acquired the Earle Haven Retirement Village in 2002. Mr Miller began operating the aged care facility at this time along with his wife who was a qualified nurse. Mrs Miller retired from her role in 2005.

It appears that Mr Miller had first applied to operate Hibiscus House and Orchid House through his other company Pilmont Pty Ltd but this was refused in December 2001 because sanctions had been recently imposed on another aged care facility operated by Mr Miller and his wife. The transfer of ownership of People Care to Mr Miller was described in a subsequent application to the Department of Health (the Department) as a way of allowing Mr Miller to take over operation of the aged care services in spite of this decision.

People Care made an application to the Department in November 2005 to also become an approved provider of flexible care. The Department appears to have encouraged People Care to include residential and community care in the application the purpose of establishing specific approval under the Aged Care Act rather than under the transitional provisions. Providers deemed to have been approved under the transitional provisions of the Aged Care Act were limited to the services they were operating the day before the Act came into effect. This limitation could be lifted through an application for approved provider status under the Act.

The application was approved in December 2005. The decision noted the previous refusal for Pilmont Pty Ltd, which was declared in the application, but also noted that the other facility in question had subsequently been sold having been assessed as fully compliant with the standards.

While there is no evidence before the Inquiry that this decision to grant approved provider status was incorrect, the way Mr Miller acquired approved provider status is echoed by the initial discussions between People Care and Help Street which were about the purchase of the aged care business. The fact that approved provider status can be acquired through a sale agreement with limited oversight by the Department generates a risk of potentially unsuitable entities entering the system.

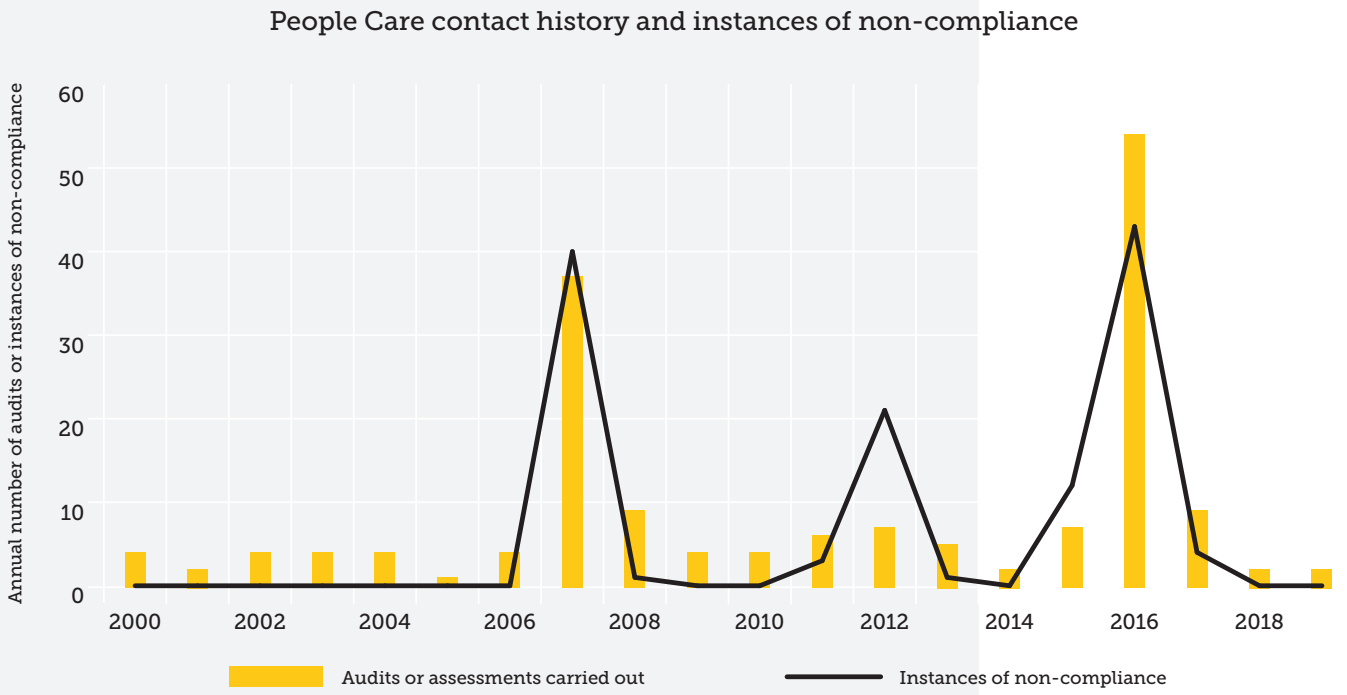
People Care's performance against the Quality Standards

People Care's history of compliance has already been well documented by both the Royal Commission into Aged Care Safety and Quality (the Royal Commission) and the investigation being undertaken by the Queensland Parliament's Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. Counsel Assisting the Royal Commission, in particular, has published detailed observations on this history in written submissions. The Inquiry has referred to all of this material in undertaking its analysis.

The purpose of this Inquiry is not to revisit each sanction, instance of non-compliance and assessment contact in detail. Rather, we will look at People Care's history with a view to identifying warning signs of the events of 11 July 2019 and any opportunities where potentially the events could have been prevented.

People Care does not have a perfect history of compliance with the Aged Care Quality Standards and was sanctioned on three occasions before entering into its arrangement with Help Street. Nevertheless, it is also true there were periods of full compliance. This history is set out below in Figure 1 which shows the number of assessment contacts by aged care regulators and the number of instances of non-compliance with quality standards identified each year.

Figure 1. Number of contacts with aged care regulators and identified non-compliance from 2000 to 2019[17].



Sanctions were imposed on People Care three times – in 2007, 2016 and 2017. Such sanctions are only applied in some circumstances; either when there is an immediate and severe risk to the health, safety or wellbeing of care recipients or when the service does not rectify continued non-compliance.

By way of broad comparison with the aged care sector, in 2017-18 regulators imposed sanctions on 21 approved providers[18]. This represents 1.2 per cent of all providers. People Care's history of multiple sanctions would therefore suggest that it had a lower than average level of compliance with its obligations under the Aged Care Act.

The culture and approach to care of People Care

Consistent with the submissions of Counsel Assisting the Royal Commission, one of the major risk factors for both the occurrences of non-compliance with quality standards and for the events of 11 July 2019 appears to have been the approach taken by key personnel at People Care to their responsibilities and the culture this created at the service.

Information provided to the Inquiry indicates that over a long period of time, families have attempted to have their issues and concerns about the running of Hibiscus House and Orchid Houses addressed without appropriate response. There have also been reports by consultants engaged to assist People Care, government officials and advocacy organisations that it was a difficult organisation to work with. Specific examples of this culture are set out below.

[17] Contacts relate to the scheduled visits as detailed in the Home/Service Details reports:
- Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 CTH.4010.2000.0678 – Home Details Report - RAC ID 5223
- Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 CTH.4000.1019.3391 – Home Details Report – Orchid House
- Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 CTH.4000.1003.5269 – Service Details Report HCS ID 700137

[18] Australian Government Department of Health, *2017-18 Report on the Operation of the Aged Care Act, p 78.*

In 2007, the Aged Care Standards and Accreditation Agency reported in a serious risk report on Hibiscus House that:

> *Management are not responsive to issues raised, including sufficiency of equipment, staffing requirements, risks in the care environment, and adverse clinical indicators."* [19]

There are also multiple reports of Mr Miller dismissing his responsibility as the managing director of an approved provider and indicating that he was too busy to be more involved in the operation of the aged care facility.

For example, at a meeting following the imposition of sanctions in 2016, Mr Miller is reported to have said that "the residential facilities are a small part of his business", that he "has too many things on his plate" and that unhappiness at the facility was "not his responsibility as he employs Nurse Unit Managers and they are responsible for all other employees and if there is a good working environment then nurses will stay".[20]

The Inquiry understands Mr Miller has made similar remarks on other occasions, including at the meeting for residents and relatives following the imposition of sanctions on 13 July 2019.

Counsel Assisting the Royal Commission has submitted that remarks of this nature should have "raised an alarm bell about whether an approved provider is, in fact, suitable to be an approved provider".[21] The Inquiry agrees that the comments are concerning from a person who is supposed to have ultimate responsibility for the conduct of an aged care provider. However, it may be that rather than reviewing the status of an approved provider, a more nuanced regulatory response offering greater potential for service continuity would be to encourage a more appropriate management structure for the approved provider. Chapter 5 will explore this possibility further.

The nurse advisor appointed following the 2016 sanctions reported significant concerns to the Department. This included resistance to making further investments to provide the equipment needed to meet recipients' care needs and a concern that any improvements implemented would not be sustainable after the nurse advisor's appointment finished.

In 2017, the Department received advice from a home care provider that had been delivering services to residents in the Village. It was alleged someone from People Care was yelling at one of the provider's case officers. The case officer was accused of stealing People Care's care recipients.

Aged and Disability Advocates Australia, the provider of aged care advocacy services in Queensland, reported to the Queensland Parliamentary Inquiry that residents found it difficult to get People Care to seriously consider their concerns and there was a climate of fear:

> *In testimonies the owner/manager was singled out for [his] unapproachability and dismissive attitude in respect to concerns, allegedly avoiding contact with residents wherever possible. On the rare occasions concerned stakeholders were able to raise their concern with him, he was reported as being dismissive, rebuffing the issues as not a legitimate concern, or shifting responsibility for the issue onto some other party. While some reported Mr Miller as 'rude and pompous' and unapproachable, most residents reported they were afraid of him."*[22]

[19] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – CTH.1002.1001.1753 - Serious risk report – Hibiscus House.
[20] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – CTH.4000.1012.3959 - Post meeting brief - Care Recipients/Relatives meeting
[21] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions - Counsel Assisting's Submissions on proposed findings relating to Earle Have Case study, page 12
[22] Queensland Parliament, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Investigation of the closure of the Earle Haven residential aged care facility at Nerang - Aged and Disability Advocate Australia submission

Staff from the Aged Care Complaints Commissioner also report that Mr Miller was difficult to speak with in relation to complaints and/or would deflect concerns by saying he could not be expected to know everything going on in a large facility.

This culture at People Care was a risk factor in the events of 11 July. As we saw in Chapter 1, the positions taken by People Care and Help Street were the main reason that a contract dispute descended to a state that emergency services had to be called in.

Intentions to cease providing aged care services

People Care has indicated over a period of time that it would prefer not to be operating aged care services and appears to have spoken to a number of prospective buyers and operators before engaging Help Street to run the care operations of Hibiscus House and Orchid House.

In 2015, during an assessment contact of People Care's home care service, the nurse manager indicated to Quality Agency staff that they would be seeking to broker out home care services.

The nurse advisor in 2016 who expressed concerns about the willingness of People Care to make sustainable improvements indicated that a major factor impacting on People Care's willingness to remedy non-compliance or improve care was that it no longer wanted to continue to provide aged care. Records indicate the Quality Agency was monitoring the quality of services at Hibiscus House and Orchid House during this time while the Department also worked to help preserve the relationship with People Care and the nurse advisor. With hindsight, a better outcome may have been achieved if the Department had more tools at its disposal to assist People Care transition out of aged care in a way which maintained service continuity.

There are records between 2015 and 2017 indicating People Care was exploring options to broker out its services, including some records that name specific providers as interested or undergoing due diligence on taking over the services. In the end, however, none of these possibilities came to fruition until the agreement with Help Street in 2018.

In at least one instance, the Department was advised by the other party that an "extremely volatile environment"[23] and a failure by People Care to respond to requests in the negotiation process were the reasons the proposal did not progress.

The combination of the culture of People Care, approach of its key personnel and apparent desire to cease provision of aged care services should perhaps have led aged care regulators to be more actively engaged in supporting a transition to new management arrangements.

[23] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1, CTH.4000.1019.5354 - Emails re People Care Pty Ltd transfer comsumer to [TY]

The engagement of Help Street

The first contact between People Care and Help Street was when Help Street was engaged to deliver podiatry services at Hibiscus House and Orchid House. More substantive conversations began between the senior management of Help Street and Mr Miller when Help Street became aware that People Care may be for sale. Mr Miller's testimony was that it was Help Street that approached him to start the negotiations.[24]

It soon became apparent that Help Street did not have the necessary capital to fund the purchase and an alternative arrangement was reached. It is, however, instructive that the purchase of People Care was the first option considered because, as we have seen, there is limited oversight of the sale and purchase of companies with approved provider status.

The intended purchase would have meant Help Street was able to operate as an approved provider - including delivering home care services outside Earle Haven - without any assessment by regulators of its suitability to provide aged care. Given Help Street's behaviour on 10 and 11 July, it is the Inquiry's view that this would have created a substantial risk.

In the end, People Care, Miller Enterprises and Help Street reached a Heads of Agreement in early April 2018. The agreement established the principles for an arrangement where Help Street would begin to manage People Care's aged care services and make payments towards the purchase of People Care from the money earned. It was intended that a lease agreement, contract for the sale of People Care to Help Street and management agreement for Help Street's operation of the services until the purchase was complete would all be entered into subsequently. None of these agreements were ever concluded.

Under the heads of agreement, Help Street was required to:

- manage day to day operations of the services
- provide a full clinical team
- take on existing People Care employees
- ensure compliance with the Aged Care Quality Standards and maintain the accreditation status of Hibiscus House and Orchid House.

Help Street was also required to pay rent to Miller Enterprises for Hibiscus House and Orchid House and to utilise the laundry and catering services provided by Mr Miller's group of companies for an agreed fee.

The seeds of the disastrous collapse of service delivery on 11 July 2019 were sown in the terms of this agreement.

In the first instance, neither People Care nor Help Street appears to have undertaken sufficient due diligence. This oversight was particularly significant on the part of People Care given that, as the approved provider, it should have considered the potential impact of the proposed arrangement on the people who were in its care.

People Care did not undertake suitable due diligence to satisfy itself that Help Street had the competency and resources to manage the aged care services and provide a continuity of care to residents and home care recipients. In Mr Miller's testimony to Queensland Parliament's investigation into the events at Earle Haven, he said he engaged Help Street based largely on trust and the credentials presented to him by Help Street management[25]. Help Street also advised Mr Miller of its global business presence which, according to Mr Miller, appeared reliable.

[24] Queensland Parliament, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Investigation of the closure of the Earle Haven residential aged care facility at Nerang - Transcript 20 September 2019, p17

[25] Queensland Parliament, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Investigation of the closure of the Earle Haven residential aged care facility at Nerang - Transcript 20 September 2019, p16-17

People Care failed to recognise that Help Street's global CEO was, at that time, being considered by the Australian Securities and Investments Commission (ASIC) for disqualification from acting as a company director. Mr Bunker was later disqualified from acting as a company director in June 2018.

For its part, Help Street does not appear to have critically assessed the proposed agreement or the value assigned to People Care. It is unlikely Help Street had access to accurate information about People Care's financial position and it did not approach the Department like other potential purchasers of People Care did in the past.

There is also no evidence that Help Street ever developed a plan for returning the operations at Earle Haven back to a profitable position.

The agreement appears to have set Help Street up to fail financially. Significantly, the heads of agreement continued payments to companies controlled by Mr Miller for rent, laundry and catering. Although the amount of rent to be paid was reduced, BRI Ferrier's assessment is that the financial terms of the agreement were designed to maximise the return to People Care and its related entities, while simultaneously transferring risk and the responsibility for resolving the aged care facility's financial problems to Help Street.

The agreement meant it would have been very difficult for Help Street to establish a viable business at Earle Haven, let alone make the payments toward the purchase of People Care as anticipated by the Heads of Agreement. As a result, outsourcing the aged care facility's management on these terms was not in the best interests of the care recipients.

It may have been possible for a successful business agreement to be reached between People Care and Help Street. This would have required People Care to be upfront about its financial position and for the two parties to work together to improve the financial viability of the facility. For example, this may have involved:

- collaboratively designing and implementing an action plan to address the suboptimal bed occupancy levels in Hibiscus House and Orchid House
- agreeing on a more sustainable approach to services that were provided by Mr Miller's group of companies or a mutually agreeable transition to new arrangements.

Finally, the heads of agreement between People Care and Help Street did not establish appropriate governance and oversight frameworks. The agreement did not include any:

- reporting requirements or performance expectations for Help Street
- measures to allow People Care to be confident of Help Street's continued viability
- agreement on a process for discussing and approving maintenance and upgrades to Hibiscus House and Orchid House
- mechanism for an orderly transition of management back to People Care if arrangements were terminated.

People Care has indicated there was regular contact with Help Street's facility manager and CEO for Australia and New Zealand about how the service was operating. However, the Inquiry has not seen any evidence about how frequently this contact occurred or any record of what was discussed. There was certainly no formal reporting of performance. As we will see below, even relatively informal conversations about performance became difficult from late 2018.

Regulatory oversight of the contract between People Care and Help Street

On 23 March 2018, the Aged Care Quality Agency informed the Department that during a recent visit its staff had heard People Care was working to transfer the approved provider status to Help Street from 1 April 2018.

Following a conversation by phone between People Care and the Department on 23 March 2018, the Department emailed the Quality Agency to advise there would be no change in the approved provider but that the company was trialling a contract arrangement with Help Street to manage the residential aged care facility. The Department requested People Care formally advise the Department of these arrangements.

People Care notified the Agency via email on 23 March 2018 (the same afternoon) that from 1 April 2018, Help Street would be contracted to manage Hibiscus House and Orchid House for People Care. People Care would continue to hold the approved provider status.

It does not appear the Department was informed of this email by the Agency. Staff from the Department have indicated that, as a consequence, they assumed the proposed contracting arrangement did not proceed and had no visibility of the contract with Help Street before 11 July 2019.

A Notification of a Material Change Form, the formal mechanism which informs the regulators of significant changes, was never submitted to the Department by People Care. Neither was the need for one raised by either the Agency or Department.

On 18 July 2018 the Quality Agency undertook an assessment contact at Hibiscus House and Orchid House. The purpose of this contact was both to assess the impact of the new subcontracting arrangement with Help Street and to respond to a referral from the Aged Care Complaints Commissioner. The agency ultimately concluded that the facility met each of the quality standards assessed on that visit.

The scope of this assessment contact indicates that the Quality Agency was alert to the risks associated with the new subcontracting arrangement and that it took action to assess what impact the arrangement had on the quality of care being delivered. However, by not following up on the nature of the contractual relationship between People Care and Help Street, both the Quality Agency and the Department were operating without important information that would have helped them to more accurately assess the risks to the residents of Hibiscus House and Orchid House.

After the initial assessment contact in July 2018, the Quality Agency, and then the Aged Care Quality and Safety Commission, undertook three further assessment contacts with People Care – in August 2018, January 2019 and June 2019. Both of the 2019 assessment contacts were unannounced. On all three occasions, each of the quality standards assessed was found to be met.

In addition to these assessment contacts, complaints officers from the Quality and Safety Commission visited Hibiscus House and Orchid House in April and May 2019 to discuss the number of complaints received.

Regulatory activity was demonstrably under way in relation to Hibiscus House and Orchid House during this period. However, with the benefit of hindsight there were some warning signs that were missed. It is also likely that better information sharing and coordination between the various regulatory teams would have helped to identify and respond to these warning signs. This issue will be discussed further in Chapter 4.

One example where better coordination may have resulted in a different outcome was action taken by the prudential teams in the Department during 2019. People Care was late in submitting its Aged Care Financial Report for 2017-18 and then provided only a partial response which included a number of errors. On 13 June 2019 the delegate decided it would not be proportional to take further action on People Care's non-compliance given that some information had been submitted and that it was only two weeks before the end of the next financial year.

There is no indication that the prudential team was aware of, or sought, information about People Care's compliance history, that unwillingness to engage with regulators had been identified on a number of occasions or that significant new contractual arrangements had been entered into during the reporting period. As Counsel Assisting the Royal Commission has submitted, it is likely that had this information been available to the delegate, a different decision would have been made.[26]

It is also likely that those regulatory teams that were aware of the arrangement between People Care and Help Street would have been interested to know that People Care was having difficulty providing complete and accurate financial reports.

[26] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions - Counsel Assisting's Submissions on proposed findings relating to Earle Have Case study.

Help Street's management of Hibiscus House and Orchid House

The Inquiry has already expressed its significant concern about the behaviour of senior Help Street management on 11 July and identified the mistakes made in entering into the arrangement with People Care. Nevertheless, the Inquiry accepts that there were also genuine attempts by Help Street to make some enhancements when operating the aged care services at Earle Haven. This included:

- changing rostering arrangements so that a registered nurse was on site every night
- the introduction of an electronic information management system
- replacing some equipment which was no longer serviceable
- engaging new catering, cleaning and laundry services.

Help Street also sought to change employment arrangements from casual to permanent contracts and engage a new pharmacy provider.

Several of these changes are consistent with Help Street looking for efficiencies in order to better manage its financial position. In many instances, Help Street indicated it had been able to achieve better service at a lower cost. This would have been a feasible outcome given BRI Ferrier's analysis that the rates for catering and laundry services were inflated.

There were also people and organisations who were disadvantaged by these changes which resulted in some agitation against the changes themselves and against Help Street.

Despite these efforts and the fact that regulators had assessed the service as meeting quality standards on multiple occasions, the view heard most frequently by the Inquiry was that there had been a decline in services since Help Street took over management. There were a small number of family members who indicated care had been better under Help Street.

One family reported their loved one was initially very happy at Earle Haven, enjoying her own private room and able to take the bus to the supermarket to purchase her groceries. Later, however, she mentioned that staff appeared to lack adequate training and the quality of the food had noticeably declined.

The Inquiry team was informed by a number of families about issues with residents' care plans being out of date and frequently not followed. There were also reports of dirty rooms, cluttered corridors and unsatisfactory care and communication with families. These concerns were also raised in clinical audits undertaken by Ms Karen Heard, a registered nurse who had previously managed the aged care facility for both People Care and Help Street and had been engaged by People Care.

Care staff felt Help Street management did not focus on the best interests of the residents. One example was the purchasing of large pot plants with pebbles which residents with dementia would be found trying to eat. Care staff also complained there was not enough hygiene supplies due to lack of money and that broken equipment would not get fixed. It should, however, be noted that some staff also reported similar difficulties in having equipment repaired before Help Street began operations.

The Inquiry heard multiple complaints about the quality and quantity of food during Help Street's tenure although it was not possible to confirm whether these related to incidents before or after the changes Help Street made to catering in April 2019. There had also been complaints and findings of non-compliance about food before Help Street was engaged to operate the service.

The concerns of residents and their families were reflected in the high volume of complaints to regulators. The complaints authority received six complaints in 2017, eight complaints about the services in 2018 and 16 in the first part of 2019. Some of the more serious complaints related to falls, poor wound management, a lack of staff and residents being left in wet urine soaked beds.

There was a spike in the number of reportable assaults at Hibiscus House and Orchid House with 15 assaults reported to the Department during the time Help Street was managing the service. The number of reports received was one of the reasons for the 25 June 2019 assessment contact. By comparison, only one assault was reported in 2016 and none in 2017.

Across the aged care sector, the incidence of reports of suspected or alleged assaults in 2017-18 was 1.6 per cent[27] of all people receiving permanent residential aged care which would indicate the number of reportable assaults during Help Street's tenure was significantly higher than normal.

[27] Australian Government Department of Health, *2017-18 Report on the Operation of the Aged Care Act, p 79*

The relationship between People Care and Help Street

We have already seen in Chapter 1 that significant animosity and lack of trust had developed between People Care and Help Street. This section will explore in more detail how the relationship progressed to this point.

Financial

Help Street began to experience cash flow issues early in the relationship with People Care, starting with its default on the purchase price instalments required under the heads of agreement. This was the first signal that Help Street was not sufficiently capitalised to meet its financial, operating and capital commitments under the agreement.

In September 2018, Help Street failed to make a payment for operating expenses for services provided by companies related to Mr Miller.

A pattern of correspondence also began from around September 2018 with both People Care and Help Street complaining about payments due from the other party. Complaints included invoices that were paid late, not paid in full or adjusted unilaterally by the other party. The Inquiry has not sought to establish the rights and wrongs of these claims and without access to Help Street's financial information could not have done so accurately. Nevertheless, the correspondence clearly demonstrates that financial aspects of the relationship were already a major irritant by September 2018.

Consistent with analysis in the previous section about the shortcomings of the heads of agreement, there is clearly no shared understanding about the amounts each party owed to the other or an established process for resolving disagreements.

In January 2019, Help Street undertook to make weekly repayments of $30,000 to reduce the amount owed to People Care and its related entities. Mr Miller indicated to the Inquiry that Help Street made just one payment of $30,000 while according to Mr Lang, four payments were made. In any event, Help Street did not persist with those repayments.

The Queensland Nurses and Midwives' Union (QNMU) was alerted in February 2019 that its members working for Help Street had not been paid correctly, including superannuation entitlements – another indicator of Help Street's cash flow problems.

From around April 2019, Help Street requested that People Care transfer Government subsidies on time to ensure that Help Street could continue to pay staff. The Inquiry heard that the pay day for Help Street staff needed to be moved back to provide some contingency for People Care being late in passing on the subsidy payments. This indicates both the significance of the delays on the part of People Care and the perilous state of Help Street's financial situation.

Aged care regulators do not appear to have been aware of these concerns about Help Street's financial viability, even after the QNMU filed a dispute with the Fair Work Commission in April 2019.

By July 2019 there were competing claims from both People Care and Help Street that they were owed money by the other party. People Care alleges that Help Street owed $18,378 to its related entities for what appears to be utilities. For its part, Help Street claimed in late June that People Care owned it $101,688 relating primarily to outstanding May and June 2019 Government subsidies that had not been passed on.

Delivery and governance of services

According to Mr Miller, for the first six months Help Street was operating, services were running quite well. In support of this assertion, Mr Miller particularly notes the findings of the Quality Agency in its assessment contacts on 18 July 2018 and 14 August 2018 with all the assessed quality standards being met.

A series of irritants to the relationship developed from around the six-month mark leading to the ultimate breakdown in the arrangement. Many, but not all, of these had financial dimensions.

There was some discussion between the parties about the contracts that would sit under the heads of agreement but no real progress appears to have been made. A particular obstacle seems to have been Help Street's inability to obtain the guarantee or insurance which Mr Miller wanted to cover People Care in the event of a default by Help Street or the imposition of sanctions.

Eventually, Mr Miller asked his insurance broker to assist Help Street in sourcing a suitable product. It appears it was the insurance broker who identified the business history of Mr Kristofer Bunker, Help Street's Global CEO, may have been a factor in them not being able to obtain insurance and that Help Street's global operations may not have been as extensive as they first appeared.

There is mixed evidence about when Mr Miller himself became aware of this history. Mr Bunker maintains that Mr Miller was aware he was being considered for disqualification as a company director from the beginning of the relationship but Mr Miller has suggested he found out following his insurance broker's inquiries. Mr Miller has indicated that after learning about this history he initially decided he would give Help Street a chance anyway.

In November 2018, Ms Karen Parsons started in the role of Executive Director of Aged Care Services replacing Ms Heard who had chosen to retire. Ms Parsons had experience in similar roles at aged care facilities but Mr Miller disagreed with her appointment because she was not a nurse. We have already seen in Chapter 1 that there was significant tension between Ms Parsons and Mr Miller and it appears this began very soon after she started in her role.

Such tension between key personnel of the same aged care service would have created difficulty in the smooth running of the facility and the ongoing relationship between the two organisations. The Inquiry would suggest that this tension should have been a significant red flag for regulators had it come to their attention.

Care staff told the Inquiry they were actively discouraged from sharing information with Mr Miller and that they would be questioned by Help Street key personnel if they were seen speaking with him.

On 20 March 2019, Mr Miller attended a meeting with residents and families that had been called by the local pharmacy that had lost business as a result of Help Street's decision to engage an alternative pharmacy provider. Mr Miller told the Inquiry this decision by Help Street started to create animosity across the Village. During this meeting, a large number of complaints about the quality of aged care services were also aired and Mr Miller has indicated that this was when he particularly began to have concerns about the arrangement with Help Street.

Help Street has said it made the pharmacy change because of a number of errors and in search of a more cost-effective arrangement. The company also claims it was clear when communicating the change that residents of Hibiscus House and Orchid House would still be able to use the local pharmacy if that was their preference. It appears that the pharmacy provider continued to agitate about the changes after the 20 March meeting and that this agitation further heightened the feeling of conflict around the aged care facility.

In late March 2019, Help Street advised Mr Miller it would not continue to use the laundry and catering services offered by his group of companies and that it intended to engage other subcontractors. Help Street has indicated this decision was based on both cost considerations and in response to complaints it had received about the quality of both of these services.

It is likely, on the basis of the information available to the Inquiry, that this decision would have had a significant and adverse financial impact on Mr Miller. Help Street staff consistently identified the decision to cease using Mr Miller's catering and laundry services as a critical tipping point in the relationship. As one example of this, Mr Miller refused to continue providing personal laundry services once the commercial laundry work had been moved to another provider and gave Help Street only 10 days to implement new arrangements for personal items.

The changes are often referred to in subsequent correspondence between Mr Miller and Help Street. Help Street staff further indicate that it was a subject Mr Miller raised on multiple occasions in the arguments on 11 July.

On 30 May 2019 a meeting was organised at the request of Help Street for the Quality and Safety Commission to provide an education session for residents, families and staff. Prior to the education session, a meeting was held with Quality and Safety Commission officers, People Care and Help Street in relation to concerns at the facility and internal complaints processes. It appears the Quality and Safety Commission specifically asked for People Care to be present so they could assess whether the approved provider was being made aware of the complaints and taking appropriate action in response.

At this meeting, it was explained to regulators that Help Street's facility manager did not have direct contact with Mr Miller despite both of them working on the Earle Haven site. Rather the facility manager would escalate anything that needed Mr Miller's attention to Help Street's CEO for Australia and New Zealand. In the Inquiry's view, this information should have raised concerns for regulators about the stability of the contracting arrangement in place and the potential impact on the residents of Hibiscus House and Orchid House.

Mr Miller wrote to Help Street the day after this meeting, expressing his concerns about the services being delivered. That letter confirms his verbal advice to the meeting that he engaged Ms Heard to undertake a series of clinical audits to assess the quality of services being delivered and readiness for the new quality standards. The audits were to start on 4 June 2019.

The commissioning of a clinical audit was an appropriate step for the approved provider to take in these circumstances. Nevertheless, it took place in the context of a deteriorating relationship in which Help Street staff report hearing rumours that 'Mr Miller is going to press every button that he can to get Help Street out'.[28] While Help Street staff indicated that they engaged with the audit process, it appears that their perception about Mr Miller's motivations coloured their interpretation of the process and its outcomes.

It appears that Mr Miller had begun to take steps to resume operation of the aged care services at Earle Haven even before the notice of termination was drafted in early July. On 26 June, Mr Miller advised officials of the QNMU that he was working to end the relationship with Help Street and earlier that month, a large delivery of new linen was made. Other residents of the Village reported hearing rumours that Mr Miller would terminate the agreement with Help Street and even Help Street staff speculated that the linen delivery was in preparation for him resuming control of Hibiscus House and Orchid House.

It is entirely appropriate that Mr Miller and People Care had begun to make these preparations and they support Mr Miller's statements that he had planned to continue service delivery after a period of transition with Help Street. Nevertheless, there appear to have been missed opportunities during this period of time. For People Care, perhaps this should have been the time for more detailed contingency planning about resumption of services.

There were also missed opportunities here for regulators.

[28] Royal Commission into Aged Care Quality and Safety, Exhibit 8-3 – WIT.0327.0001.0001 – Statement of Ms Karen Parsons

For example, it is clear that while Mr Miller was willing to take the QNMU into his confidence about his difficulty with Help Street, this was not the case with regulatory authorities. It may be worth contemplating arrangements in future to encourage providers to voluntarily disclose financial or contractual challenges. At the very least this would allow the responsible Commonwealth authorities to monitor further developments. It may also allow appropriate support mechanism to be put in place to ensure continuity of service delivery.

Given that by late June it was an open secret that the relationship was at risk of breakdown, there is also a question about whether the level of tension should have been apparent to the assessment team that visited on 25 June. The Inquiry does not have enough information to assess whether this team should have been aware of this tension but it would be useful to consider how regulators might better inform themselves of these types of dynamics in future.

Significantly, there does not appear to have been a cooperative effort by People Care and Help Street to resolve the issues in their relationship. The general tone of correspondence between the two parties turned to one of blame.

Help Street indicated it tried to meet with Mr Miller to discuss options but he did not always attend. None of the written correspondence seen by the Inquiry includes any specific suggestions from Help Street about how the relationship could be rectified.

Mr Miller's letter to Help Street of 31 May 2019 purported to offer some solutions. The letter notified Help Street that Ms Heard had been appointed to undertake a series of clinical audits and asked that People Care, as the approved provider, be notified of any complaints. These are both appropriate steps for People Care to take to assure itself about the quality of care being delivered but were not solutions to the fundamental problems in the arrangement with Help Street.

The only suggestion that touched on these problems was that Help Street might access People Care's marketing team, for an agreed fee, in order to increase occupancy in Hibiscus House and Orchid House. Given People Care's responsibilities as approved provider, it would have been appropriate for it to seek to work cooperatively with Help Street to address the concern that low occupancy was affecting the viability and quality of a services and not seek to create an additional revenue stream.

The breakdown of the relationship culminated in the notice of termination which was handed to Help Street on 10 July and which triggered the disastrous events of 11 July. While the notice of termination references concern about welfare, the correspondence around the dispute indicates a greater interest in financial aspects of the arrangement and the potential risk to People Care if non-compliance was identified.

What can be learnt from this experience?

This Chapter has focused primarily on the history of People Care and its relationship with Help Street. In doing so, we have identified a number of areas that warrant further attention from aged care regulators to prevent events like those on 11 July.

These include the:

- culture of an approved provider and attitude of its key personnel
- corporate structure, financial and contractual arrangements of approved providers
- sale of businesses with approved provider status.

We have also seen the importance of enhanced information sharing both among aged care regulators and with other authorities.

Chapter 5 will discuss what can be done better in these areas in future. First, however, Chapter 4 will look more closely at the role aged care regulators played – both before and after 11 July 2019.

CH .4 — Actions of aged care regulators

Actions of the aged care regulators prior to 11 July

Chapter 3 provided an overview of the engagement of aged care regulators with People Care and, after April 2018, Help Street. The Royal Commission into Aged Care Quality and Safety has also explored the actions of regulators, including in detailed written submissions from Counsel Assisting.

This Chapter will analyse the actions of regulators prior to 11 July 2019 with particular attention to the terms of reference of the Inquiry; that is, with a view to better preventing and managing similar events.

This Chapter will also look at the actions of aged care regulators after the events of 11 July.

On the whole, aged care regulators had limited visibility of the financial arrangements of People Care and its related entities. From April 2018 onwards, regulators also had limited visibility of the contractual arrangement between People Care and Help Street. There are three main reasons for this:

- the design of the prudential oversight scheme in aged care
- a gap in communication between the Commonwealth Department of Health (the Department) and the then Australian Aged Care Quality Agency (the Quality Agency)
- a lack of follow up on the information that was available.

With regard to the first factor, the prudential requirements established by the *Aged Care Act 1997* (the Aged Care Act) and subordinate legislation are focused on the security of Refundable Accommodation Deposits and are not designed to give visibility of these type of sub-contracting arrangements or other non-financial risks that might be present in an approved provider's commercial arrangements. The arrangements do not adequately contemplate the risks to quality of care and continuity of service that may arise because of the corporate structure, financial or contracting arrangements of an approved provider.

In a similar way, the regulation of quality undertaken by the newly formed Aged Care Quality and Safety Commission (the Quality and Safety Commission) could better incorporate financial and corporate matters into its assessment of risk.

Regulation of People Care's financial and prudential performance

Approved providers of residential aged care are required to submit an annual Aged Care Financial Report, accompanied by an audited General Purpose Financial Report and Annual Prudential Compliance Statement by 31 October each year. It is through this mechanism that regulators assess the financial position of each entity.

However, the reports only provide a limited window into the financial and corporate affairs of approved providers. Providers are only required to report financial information at a single point in time each year and are not required to provide information about related parties that may be relevant to their stability or solvency. As we saw in Chapter 3, People Care is one part of a group of companies operating at Earle Haven and the relationship between the companies was complex. These arrangements, and the associated risks, were effectively invisible to the Department.

In assessing the financial viability of People Care, in early 2016, the prudential team in the Department rated People Care a "severe risk" due to losses for the preceding two years[29]. In addition, People Care's financial reports dated 30 June 2015 had shown current liabilities exceeding current assets by $4.8 million[30].

As a result of this information and assessment of severe risk, the Department wrote to People Care requesting information about the company's ongoing financial viability. A response from People Care indicated that although it had incurred operating losses, its ongoing viability was guaranteed by Mr Miller and the other related companies operating at Earle Haven[31].

[29] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – CTH.1002.1010.2736 Minutes – DOH/AACQA Case Liaison Meeting
[30] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – CTH.1002.1001.1335 s9-2 Notice & cover letter signed – People Care
[31] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – CTH.1002.1001.1316 – Response to letter dated 10 April 2016 – request for information under section 9-2 of the Aged Care Act 1997

The Department did not make any enquiries to verify the statement that the People Care's on-going viability was guaranteed by Mr Miller and his group of companies, for example by asking for copies of the relevant guarantees or assessing the viability of the related companies. Had they done so, they may have ascertained that the statement made by Mr Miller was inaccurate. Although the Inquiry has no reason to doubt the statement reflected Mr Miller's genuine intention, there were no binding guarantees in place. This highlights the need for greater capability to interrogate financial information submitted by aged care providers.

The Department again considered taking regulatory action in relation to People Care's compliance with financial reporting requirements in early 2019. People Care was issued a Notice of Non-compliance on 22 January 2019 for failing to submit its 2017-18 Aged Care Financial Report, audited General Purpose Financial Report and Annual Prudential Compliance Statement. Reports were subsequently lodged but contained omissions and errors. The Department made multiple attempts to obtain the missing information over the following months without success.

Other than continuing to chase People Care, the only option available to the Department in response to the failure to provide complete and accurate information was to impose sanctions. On 13 June 2019, the Department decided not to impose sanctions on the basis it would be disproportionate for failing to submit a complete set of reports. It was also noted the end of the financial year was only a couple of weeks away which would trigger a new requirement for financial reports from People Care (albeit four months later). The Department consequently decided to take no further action.

This decision was made, however, without visibility of the contractual arrangement with Help Street that had commenced during the reporting period or other aspects of People Care's history.

Communication gaps

This points to a second theme in the actions of regulators prior to 11 July: gaps in communication which meant that key risks were not identified or acted upon.

The decision about what action to take in relation to People Care's failure to provide complete and accurate financial reporting would have been more robust if it had been informed by discussions with teams responsible for regulating other aspects of People Care's performance.

It would have been even better if it was possible for the information about Help Street to be entered into a shared system across all aged care regulatory functions. Such a system would have reduced the reliance on corporate knowledge held by certain individuals and made the information more readily available to officers who were dealing with People Care.

A centralised database for real time information sharing was one the recommendations of the *Review of National Aged Care Regulatory Processes* undertaken in 2017. The Inquiry understands that work is underway to implement such a system and that it is intended to be available for Commonwealth officers in mid-2020. This work must continue to be a priority. The events examined by this Inquiry also demonstrate clearly the importance of financial information being incorporated into such as system.

The decision in relation to financial reports is not the only example of communication gaps identified by this Inquiry. As we saw in Chapter 3, information about the arrangement between People Care and Help Street was not shared effectively between the Quality Agency and the Department. We will also see later in this Chapter that the complaints and quality monitoring functions tended to be siloed and there was a lack of effective communication between them.

Removing these silos was also the reason for another of the recommendations from the *Review of National Aged Care Regulatory Processes*: the creation of the Quality and Safety Commission. This Commission was established on 1 January 2019, initially bringing together the complaints and quality monitoring functions. A further set of regulatory functions will move from the Department to the Quality and Safety Commission from 1 January 2020, subject to the passage of legislation through Parliament.

The Inquiry heard about the work the Quality and Safety Commission has already undertaken to combine the complaints and quality monitoring functions. This work is commendable and should continue. The Inquiry is, however, conscious that developing a more joined up approach to regulation requires more than just machinery-of-government changes. Chapter 5 will discuss the importance of investing in the right capability and in building the right culture to ensure that the work underway in the Quality and Safety Commission has the desired impact.

Follow up on the arrangement with Help Street

It is also true that the Department should have followed up when written confirmation about the planned arrangement with Help Street was not received after the phone call with People Care's representative on 23 March 2018. The suggestion that an approved provider would sub-contract the management of its aged care facility to an organisation with little or no aged care experience should have been flagged as something warranting further attention. There is, however, no evidence that an assessment of the suitability of Help Street to deliver aged care services to residents of Hibiscus House and Orchid House was ever undertaken.

There is a requirement for approved providers to notify the Department of material changes which may affect their continued suitability to provide aged care. The arrangement with Help Street was certainly a material change for People Care but, as Counsel Assisting the Royal Commission has noted, there is some ambiguity about when this obligation is triggered[32]. What is clear is that neither the Department nor the Quality Agency sought such a notification and it is possible People Care felt it had discharged its obligations with the email advice to the Quality Agency of 23 March 2018.

As pointed out by Counsel Assisting the Royal Commission, the significance of a possible sub-contracting arrangement should have been magnified by the historical difficulties at the facility[33]. This is particularly so, given the contracting arrangement came 15 months after a six-month period of sanctions. The Inquiry understands the Departmental official with the requisite corporate knowledge about People Care was on leave on 23 March 2018 and so the risk was not identified.

This highlights the need for a shared system to capture the history of approved providers. The fact that there wasn't one meant pertinent information was not readily available.

The Quality and Safety Commission suggested to the Inquiry that the arrangement may have welcomed at first by regulatory staff as a positive development given recent non-compliance by People Care and concerns that had been raised about its ability to achieve sustainable improvements in the quality of care being delivered. This could have been the case but regulators did not have the sufficient information about Help Street's experience, the details of the contract or financial sustainability of the deal to validate their confidence.

In response to the Quality Agency knowledge of the contractual arrangement between People Care and Help Street, an unannounced assessment contact was carried out on 18 July 2018 to assess the impact of the new management arrangement as well as undertake an investigation following a referral from the Complaints Commissioner.

[32] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions - Counsel Assisting's Submissions on proposed findings relating to Earle Have Case study, page 39 paragraph 132

[33] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions - Counsel Assisting's Submissions on proposed findings relating to Earle Have Case study, page 37 paragraph 128 and page 38 paragraph 1331

The referral from the Complaints Commissioner noted only one other previous complaint had been received since 1 January 2016, with no related issues. On this occasion it appears the Quality Agency was misinformed by the Complaints Commissioner in relation to the number of previous complaints received.

The Complaints Commissioner had in fact received numerous complaints between 1 January 2016 and 20 June 2018 with a number relating to falls and staffing. This demonstrates the risk in relying on second-hand information-sharing across the complaints and quality functions, as opposed to a shared system.

The visit on 18 July 2018 considered, amongst other things, the expected outcomes in relation to human resource management, clinical care and medication management. All assessed expected outcomes were met.

Considering the primary reason for the assessment was the new arrangement with Help Street, assessing one of the nine expected outcomes under *Accreditation Standard-1-Management systems, staffing and organisational development* in hindsight appears to lack depth in assessing the risk of the new management structure.

The report indicates the assessment team was aware of the recent change in management at the facilities. However, the specific interview questions and review of documentation focused only on whether there were appropriately skilled and qualified staff to ensure services were delivered in accordance with the standards. Key findings included care recipients and staff were informed of the changes to the management team and that 60 per cent of the staff transitioned to Help Street. The staff who were interviewed also indicated they were satisfied with the arrangement.

While the Quality Agency clearly understood that the new arrangement with Help Street posed potential risks to the continuity of service delivery and to the support of residents, it does not appear this knowledge was shared widely, even after the establishment of the Quality and Safety Commission. This is demonstrated by an email response to a complainant on 24 April 2019 that included the statement "The possibility of the approved provider (People Care Pty Ltd) entering into a business relationship with Help Street to provide care is not a matter I am able to take into account."

The Quality and Safety Commission reviewed People Care's human resource management again in an assessment contact carried out on 11 January 2019. In total, there were three unplanned assessment contacts carried out during the time Help Street was managing the facilities, with six of the 44 standards assessed over the 16-month period, as well as one planned assessment carried out on the home care services. All expected outcomes were assessed as being met although a full review audit designed to measure the performance of an approved provider against all requirements of the Quality Standards was not undertaken.

Service delivery concerns raised with regulators

In 2018 the Complaints Commissioner received six complaints regarding Hibiscus House and Orchid House with concerns related to health care, fees and charges, inadequate skilled staff, food and catering and consultation and communication. In 2019, the Quality and Safety Commission received 16 complaints with concerns relating to health care, personal care, client safety, choice and dignity, fees and charges, inadequate skilled and numbers of staff and food and catering.

In reviewing a number of these complaints and speaking with families, some of whom submitted complaints, the Inquiry found many were given a rating above minor and concerns about Help Street's management of services were raised on a number of occasions.

It is also significant that multiple case officers handled complaints in relation to Hibiscus House and Orchid House over the six-month period. This arrangement would have limited the capacity to form a view of the cumulative risk arising from multiple complaints.

Family representatives of residents in Hibiscus House and Orchid House expressed to the Inquiry their disappointment and frustration with the management of their complaints in the lead up to 11 July 2019.

From a process perspective, the complaints appear to have been managed with priority given to meeting internal performance expectations rather than achieving outcomes for the person making the complaints. Of the complaints reviewed by the Inquiry, most complaints were closed within the due date set by the Quality and Safety Commission. This is consistent with the overall reporting of all complaints for 2017-18 where 93 per cent achieve early resolution[34]. However, the outcomes achieved for the complainants is less clear.

The case notes of one complaint shows no evidence of the desired outcome of "appropriate care to be provided to all residents" being met. Instead the outcome achieved prior to the complainant being advised that the case would be closed is "Referral made to [Quality and Monitoring Group]".

This appears to be consistent with a number of complaints reviewed by the Inquiry. From a consumer perspective, the referral of a complaint to another section of the same regulatory body without notification or a satisfactory outcome being achieved is disappointing.

Senior executives from the Quality and Safety Commission acknowledged improvements could be made in this area and advised the Inquiry that processes were being updated to give complainants greater visibility of the actions taken after a complaint is referred to the Quality and Monitoring Group.

It also appears some complaints about the quality of care delivered by Help Street were met with disinterest, perhaps because there is limited accountability for sub-contracted organisations. A complainant who raised concerns about the quality of care delivered by Help Street was advised by the Commission:

> *"I understand that Help Street provide aged care services under a business relationship with People Care Pty Ltd. As the Approved Provider under the Act, People Care Pty Ltd is ultimately responsible for the care and services at Orchid House and Hibiscus House.[35]"*

In addition to the aged care regulators, there were concerns raised with other state and Commonwealth government authorities in relation to Hibiscus House and Orchid House, as well as the wider Earle Haven Retirement Village. Chapter 2 highlighted the involvement of the Fair Work Commission in relation to staff wages. In the same way, the Australian Taxation Office would have been interested in issues surrounding staff superannuation entitlements. Chapter 3 discussed the role of the Australian Securities and Investments Commission in the disqualification of Help Street's Global CEO, Mr Kristofer Bunker.

The Queensland Department of Housing and Public Works, the state agency with responsibility for retirement villages, had also been involved with the Earle Haven Retirement Village and indicated to the Inquiry that it felt there were opportunities for better engagement with aged care regulators.

Due to the fragmented nature of the aged care and retirement village sector spanning state and multiple Commonwealth authorities, there was not one authority with the full picture to understand the level or risk prior to the event. This is compounded by the number of systems used to manage information across the aged care functions of the Quality and Safety Commission and the Department.

The lack of a single source of truth on aged care providers, in relation to quality, compliance, complaints and financial performance did not allow for adequate action to be taken by authorities prior to 11 July 2019. Improvements in cooperation and information sharing between aged care regulators and other state and Commonwealth regulatory authorities could reduce the risk of an event such as that which occurred at Hibiscus House and Orchid House.

[34] Australian Government Aged Care Complaints Commissioner, *Annual Report 2017/18, page 1*
[35] Royal Commission into Aged Care Quality and Safety, Exhibit 8-1 – CTH.4010.9000.0294 – Emails re complaint ref [TV]

After 11 July 2019

The Queensland Health Emergency Operations and Coordination Centres that were activated for the emergency response continued operating until approximately 5pm on 12 July 2019 to address community enquiries. From early 12 July, aged care regulators were on site acting in response to the consequences of the events the day before.

Support for residents and families

The Department immediately engaged two nurse advisors, with one initially providing clinical support for the 34 residents who were moved to the Nerang Nursing Centre. Critical supplies such as continence aids were also sent to Nerang to support the sudden influx of residents. The Department was able to secure the paper records of approximately half the residents who lived in Hibiscus House and Orchid House and had them sent to the facilities where residents were evacuated.

On 12 July 2019, the Quality and Safety Commission undertook welfare checks of relocated residents. It was generally reported that residents were settled although there were some cases of distress identified.

The findings that residents were settled contrasts with evidence, outlined in Chapter 2, which was given to the Inquiry by both the families and representatives of those who were moved and the Queensland Nurses and Midwives' Union. This could reflect the fact that welfare checks were necessarily taken over a shorter period of time than would have been available to families or nursing staff in the receiving facilities.

Residents' personal belongings were catalogued and photographed by Departmental officers to reduce the risk of items going missing. Essential items such as walking and hearing aids that were left behind in the evacuation were delivered to the residents.

The Department of Human Services diverted social workers to support families and started contacting families within 48 hours of relocation.

To support family members living in the Earle Haven Retirement Village wishing to visit their relocated loved ones, the Department wanted to set up transport services. Initially, People Care assured the Department this was a service it could provide using the transport available in the Village. Shortly after, however, the Department received complaints from individuals who were unable to visit their loved ones. As a result, the Department set up a transport service operating twice daily. This service continued until the last resident was permanently relocated. Although this service was well received, it didn't provide the same flexibility for family members as being co-located with their loved one.

The Department and nurse advisors met with families and residents to discuss options for permanent moves. A list of 10 residential aged care facilities with vacancies was provided to families and a further list including those with independent living options was given to support family members if they chose to relocate with their loved one. The conflicting information from People Care and the Department, as discussed in Chapter 2, in relation to ongoing services at Earle Haven made these decisions difficult.

Compliance action and sanctions imposed following the events

The Quality and Safety Commission undertook a full review audit on 12 July. *The Aged Care Quality and Safety Commission Rules 2018* provide that a review audit may be undertaken if "the Commissioner considers, on reasonable grounds, that the approved provider may not be complying with the Aged Care Quality Standards in relation to the service". In addition, the Commissioner must undertake a review audit if requested to do so by the Secretary of the Department. Such a request was made on 17 July 2019.

In undertaking the review audit, the assessment team travelled to the facilities that had received residents from Hibiscus House and Orchid House and spoke to 26 residents and 22 representatives of the residents. The audit found that People Care met none of the quality standards and triggered a series of consequences for the organisation and its owner:

13 July 2019	The Department imposed sanctions on People Care in relation to Hibiscus House and Orchid House.
9 August 2019	The Department imposed sanctions on People Care in relation to Home Care services.
23 August 2019	The Aged Care Quality and Safety Commission revoked the accreditation of Hibiscus House and Orchid House with effect from 24 November 2019.
23 August 2019	The Department issued People Care with a notice that it was considering revocation of its status as an approved provider of aged care.
1 October 2019	The Department advised People Care that its residential aged care places had been revoked. This was a consequence of the 13 July sanctions which provided that the places would be revoked if the aged care service at Hibiscus House and Orchid House was closed.
16 October 2019	The Department revoked People Care's approved provider status with effect from 23 October 2019.

There are some incongruity between the outcomes of the Quality and Safety Commission's assessment contact on 25 June 2019 where all assessed outcomes were met, and the full review audit on 12 July 2019 where no standards were met. In the Inquiry's assessment, the differences in outcomes are a result of:

- missed warning signs on 25 June
- decisive action taken on 12 July in response to a critical incident
- the effective change in day-to-day management of the facility between the two dates
- the impact of the event on residents and their representatives who were interviewed for the review audit carried out on 12 July.

The assessment contact carried out on 25 June was in response to complaints received by the Quality and Safety Commission. A decision was made to assess three out of the 44 expected outcomes:

- 2.4 Clinical care
- 4.4 Living environment
- 4.8 Catering, cleaning and laundry services.

It was not a comprehensive audit, unlike the one carried out on 12 July.

There were warning signs that could have been identified on 25 June such as the high level of restraints. It was found psychotropic medications were used on 71 per cent of residents and physical restraints were used on 50 per cent. A senior executive from the Quality and Safety Commission gave evidence to the Royal Commission that this level of restraint was "at the very high end".[36]

[36] Royal Commission into Aged Care Quality and Safety, Brisbane Hearing 8 August 2019 – Transcript, testimony of Ms Ann Wunsch

The assessment team during the visit had discretion to revise their scope in response to this information, but chose not to do so. Given that clinical audits of Ms Karen Heard, a nurse advisor engaged by People Care, conducted only weeks earlier had identified issues with documentation and consent for restraint, it is possible that had the assessment contact team decided to adjust its scope it would have also identified risks and non-compliance in this area.

The report following the contact on 25 June had not been shared with People Care for comment before the events of 11 July. As a result, no further action had been taken by the Quality and Safety Commission on the issue of restraint despite the very high levels identified.

It also appears the assessment team on 25 June did not have access to Ms Heard's clinical audit. Given this audit identified significant issues in relation to malnutrition and dehydration, it may have resulted in a different outcome, or at least further enquiries, in relation to catering which was within the scope of the Quality and Safety Commission's assessment contact.

While People Care was the approved provider for the duration of Help Street's management term, effectively Help Street had assumed full responsibility for managing the aged care services. The date of the review audit by the Quality and Safety Commission on 12 July was the first day in which People Care had been back in direct control of operations at Hibiscus House and Orchid House. On 12 July, the People Care team had the task of rebuilding the service and filling the gaps left by Help Street. This highlights both the difficult task that assessors would have faced and the manner in which the agreement with Help Street fell short of People Care's obligations as an approved provider.

Regulators must have known the likely outcome when they commenced the review audit on 12 July given that there would be no residents as a result of the evacuation undertaken by Queensland authorities and that servers containing residents' records and other documents has been removed by Help Street on 10 July 2019.

To make matters more complex, the review audit carried out on 12 July was assessed using the new Quality Standards which came into effect on 1 July 2019.

Under the heads of agreement, Help Street should have been preparing staff for the new standards and one of Mr Miller's concerns had been how little it had done in this regard. The Inquiry understands that some training had been provided by Help Street to staff but this may not have been sufficient to prepare for the new standards. Nevertheless, ultimate responsibility for meeting the new standards sat with People Care as the approved provider and this could not be abrogated.

The Quality and Safety Commission interviewed a number of care recipients as part of the 12 July review audit in their new locations. However, it is understandable that those who were interviewed would have been negative towards the services delivered at Hibiscus House and Orchid House having been evacuated from their home throughout the night.

People Care was unable to meet any of the new Quality Standards and was assessed as posing an immediate and severe risk to people for whom it was caring.

Given the severity of the incidents that occurred on 11 July, the actions by regulators appear to have been motivated by a desire to take decisive action and a genuine wish to do the right thing for the residents evacuated from Hibiscus House and Orchid House.

However, it is possible that some of the assessment on 12 July was coloured by this motivation and that this accounts for some of the variation from the 25 June assessment contact. Perhaps the most obvious example of this is in relation to the physical environment.

The findings of the two different assessment processes are laid out in the table below:

25 June	12 July
"the service environment reflects the safety and comfort needs of care recipients... including noise and light levels"	"the building would need...some renovation to meet the requirements of this standard...[there is] limited access to natural light"

When taken together, the genuine desire to help and the regulatory actions commencing on 12 July could be taken to suggest the review audit and sanctions were viewed by regulators as ends in themselves. The Inquiry is of the view that regulators should first have identified the best outcome from the perspective of care recipients and then determined their action accordingly. This outcome may have been better achieved by taking steps to support the resumption of services at Hibiscus House and Orchid House (whether by People Care or another organisation) and facilitating the return of evacuated residents.

The Inquiry does not dispute the need for stern or concerted regulatory action after the events of 11 July. However, the reality is that despite good intentions, the actions of regulators have not achieved the outcome most important to the residents of Hibiscus House and Orchid House and their families; that is, the opportunity to go home. In some regards, regulatory action made this outcome less likely. The revocation of People Care's places with effect from 1 October 2019 removed the possibility that either the places could be sold to another approved provider with the possibility of services resuming at Earle Haven.

The Inquiry, however, also recognises that the Department and the Quality and Safety Commission are constrained in their regulatory choices and that this may limit their ability to balance the need for stern action in response to serious failures in care and the desire of people to remain in their home. The sanctions currently available can lead to closure or reduction in the services offered by a specific provider or facility but it cannot require problematic key personnel to be removed or force a smooth transition to a new operator at the same facility. This is something which will be discussed further in Chapter 5.

People Care must bear a significant part of the blame for the fact that people have not been able to go home to Hibiscus House and Orchid House. The sanctions imposed on 13 July did not prevent People Care from resuming services for the residents who had been evacuated but there is limited evidence that serious preparations were made for this to occur. Despite advice to residents and families to the contrary, it appears that People Care had decided it no longer wished to operate a residential aged care facility shortly after the events of 11 July.

Equally, People Care could have moved more quickly to find a buyer for its business or the residential aged care places it held. The Inquiry understands the Department attempted to facilitate discussions with a number of interested parties but that none of these discussions led to acceptable terms being reached. This appears to follow a pattern of previous attempts by People Care to broker out or sell its business.

Action taken against Help Street

Immediately upon hearing the actions of Help Street and allegations that they may flee the country, the Department notified Australian Border Force and the Australian Federal Police. Referrals were also made to the Australian Securities and Investments Commission and the Australian Taxation Office in relation to staff not being paid wages and superannuation. The action taken by these authorities is beyond the scope of this Inquiry.

In terms of regulatory powers under the Aged Care Act, the sub-contracting arrangement as detailed earlier in this chapter prevents aged care regulators from taking any further action against Help Street. The Act expressly permits sub-contracting arrangements but is clear that the responsibilities established by the Act, and penalties for not fulfilling those responsibilities, continue to rest with the approved provider.

Chapter 5 will discuss ways in which sub-contracting arrangements could be better regulated in future, including measures in relation to approved providers' key personnel.

What improvements can be made to the regulation of aged care?

This Chapter has focused primarily on the actions of the aged care regulators. There are a number of areas identified for improvements to better manage, or reduce the risk of a collapse in service delivery.

These include:

- ensuring regulators have the capability to interrogate financial and contractual information submitted by aged care providers particularly in relation to risks to stability of service delivery or quality of care
- better oversight and regulation of sub-contracting arrangements
- ensuring the Quality and Safety Commission has the right resources, capability and culture to effectively scrutinise information and manage high risk providers
- information sharing and cooperative action between the various aged care regulatory functions and other authorities.

CH .5 – What can we learn from the events?

The preceding Chapters have reviewed the events of 11 July 2019 and the history that led to them. This Chapter will seek to learn from the reflections on those events and develop recommendations to better prevent and, if necessary, manage similar events in the future.

In developing its recommendations, the Inquiry has been particularly informed by the views expressed by the residents of Hibiscus House and Orchid House, their families and representatives. We heard very clearly from these groups that Hibiscus House and Orchid House was their home and that they should have been able to receive quality care there. It is the Inquiry's view, therefore, that continuity of safe and quality service in place should generally be the primary object of regulatory action in the aged care sector. This should also be the primary objective in responding to any disruption of care.

In making recommendations about improvements to regulatory arrangements, the Inquiry does not wish to diminish in any way the culpability of the senior management of People Care and Help Street for the events of 11 July. The Inquiry echoes the submissions of Counsel Assisting the Royal Commission that:

> *"the residents of Orchid and Hibiscus Houses were used as bargaining chips in the broader commercial dispute between Messrs Bunker and Miller. Both Mr Bunker and Mr Miller put their own interests above those of the residents, but a higher degree of culpability applies to Mr Bunker for Help Street's abrupt cessation of services on 11 July 2019, whereas Mr Miller's conduct from 8 July to 11 July 2019 could more accurately be described as recklessness as to the interests of the residents at Earle Haven".*[37]

While it is necessary for the aged care regulatory system to better guard against such events, it is the Inquiry's view that a different group of individuals would have been able to resolve the contractual dispute in a more constructive fashion. Several of the recommendations outlined below go to the question of ensuring that there are appropriate controls and accountability mechanisms in place for the executives responsible for the delivery of aged care services.

Looking back at the lessons identified in the preceding Chapters, the Inquiry is of the view that the action to better prevent and manage events like those of 11 July fall into six broad categories:

- 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 managing 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 planned and coordinated responses to emerging situations in aged care facilities.

[37] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions - Counsel Assisting's Submissions on proposed findings relating to Earle Have Case study, page 59, paragraph 203

Greater regulatory capacity and coordination

We have seen in Chapters 3 and 4 that there were gaps in the Commonwealth's regulatory approach in relation to People Care and Help Street. This took the form of both lapses in information sharing and a tendency of officers to focus on their specific role rather than the whole picture.

This is similar to findings made in the *Review of National Aged Care Quality Regulatory Processes* (the Review) of which Ms Kate Carnell AO was also an author. As discussed in Chapter 4, the Inquiry acknowledges that work has begun in response to the Review's recommendations. This includes the establishment on 1 January 2019 of the Aged Care Quality and Safety Commission which combined the complaints and quality monitoring functions that had previously sat in separate agencies. Further functions are intended to be transferred to the Commission in 2020. The Inquiry heard that in addition to the formal transfer of these functions work has been undertaken to develop shared work practices across the functions that now make up Commission.

The Inquiry also understands that work is underway on recommendation two of the Review which related to a centralised database for real-time information sharing.

Nevertheless, the events of 11 July highlight there is still further work to be done in achieving a single, joined up approach to aged care regulation. The different understandings between the Quality and Safety Commission and the Commonwealth Department of Health (the Department) in relation to the arrangement between People Care and Help Street is one example highlighting this need; as is the decision not to further pursue financial reporting issues in June 2019.

The Inquiry has also seen that even after their amalgamation on 1 January in some regards the complaints and quality monitoring functions were still operating as discreet teams. Work is underway to address this but the observation points to the ongoing need to develop a new culture and ways of working in the Quality and Safety Commission which go beyond placing existing functions together in a single agency. This work of culture building is an important foundation for the new Commission and warrants dedicated resources.

The Inquiry therefore makes the following recommendations:

Recommendation 1

Progress as a priority the amalgamation of aged care regulatory functions in the Aged Care Quality and Safety Commission. This should include functions relating to approved providers' compliance with prudential responsibilities.

Recommendation 2

Ensure the planned delivery of an information portal which provides a single, real-time view of all information about approved providers which is available to both the Department of Health and the Quality and Safety Commission. This should include financial and prudential information as well as complaints and quality monitoring data.

Recommendation 3

Further invest in staff training and other resources to support a shared culture within the newly expanded Quality and Safety Commission which emphasises information sharing and cooperative action between the Commission's various functions.

Recommendation 3 may require the Australian Government to provide additional resources for the Quality and Safety Commission in the short term so that staff can undergo necessary training while maintaining the Commission's other activities at normal levels.

As outlined in Chapter 4, there were times when it appears that regulators did not actively follow up on information which could have allowed a greater understanding of the risks present at Hibiscus House and Orchid House. For example, neither the Department nor the Quality and Safety Commission sought specific information about the agreement between People Care and Help Street or Help Street's experience in delivering aged care services.

We have also seen there were occasions, including some in 2019, on which complaints appear to have been handled with a primary focus on internal procedures and performance measures rather than outcomes for complainants. This led the families of the residents of Hibiscus House and Orchid House to express frustration with the way complaints were handled.

One stark example of not following up on action was a suggestion in 2016 that a report would be prepared on People Care's suitability as an approved provider. Counsel Assisting the Royal Commission concluded on the basis of evidence available that this report was ultimately not prepared. While it appears it was a nurse advisor appointed by People Care who proposed to prepare this report, the Inquiry concurs with Counsel Assisting that this was "an instance of [the Department] appreciating the importance of the red flags raised about People Care, but failing to follow through with regulatory action"[38].

We have also seen there was no attempt to join up the various pieces of information and regulatory action in order to act in a concerted and coordinated fashion. At times, People Care was discussed by Service Provider of Concern (SPOC) meetings which include representatives of the Department and the Quality and Safety Commission. Services at Hibiscus House and Orchid House were not, however, discussed at SPOC meetings while they were being managed by Help Street.

In any case, the SPOC meetings operate primarily as a vehicle for information sharing. It appears that what was needed for the services operated by People Care was more than just information sharing. What was needed was a coordinated approach in which the various functions agreed on the action required and who was accountable for ensuring action was taken and that it achieved the desired outcomes.

In this regard, measures underway to consolidate regulatory functions within the Quality and Safety Commission would be complemented by adopting work practices which ensure coordinated and timely action.

The Inquiry therefore recommends:

Recommendation 4

The Quality and Safety Commission should appoint a Senior Responsible Officer or Case Manager for each high risk provider. This officer will have responsibility for ensuring effective information sharing and timely action.

As we saw in Chapter 4, there were warning signs in fields covered by other regulators – including the Australian Securities and Investment Commission, the Fair Work Commission, Australian Taxation Office and state-based regulators of retirement villages. For example, it is the Inquiry's view that information from ASIC about the history of Help Street's Global CEO or from the Fair Work Commission about missed payments to staff could have alerted aged care regulators to risks to service continuity before 11 July.

Other non-government bodies also indicated that they were identifying growing concerns with the quality of services at Hibiscus House and Orchid House and the sustainability of the arrangement between People Care and Help Street. This included: Aged and Disability Advocates Australia and the Queensland Nurses and Midwives Union. The Inquiry's sense from conversations with these organisations was that there is an opportunity for regulators to develop a closer relationship with organisations representing aged care consumers and staff in order to facilitate easier exchange of information.

The Inquiry therefore recommends:

Recommendation 5

The Quality and Safety Commission should enhance its cooperation and intelligence sharing with other regulatory authorities and stakeholders.

[38] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions - Counsel Assisting's Submissions on proposed findings relating to Earle Have Case study, pages 13-14, paragraph 43.

Greater oversight of financial and commercial arrangements

Greater visibility of financial and corporate information would have allowed regulators to better manage risks and protect the rights of care recipients. As we saw in Chapter 3, regulators were not aware of the details of the arrangement between People Care and Help Street.

The current prudential oversight arrangements established by the *Aged Care Act 1997* (the Aged Care Act) are primarily focused on the security of Refundable Accommodation Deposits (RADs). This is important for both the individuals who have paid RADs and the Australian Government which guarantees them. However, the events of 11 July clearly demonstrate that the corporate structures, financial and contractual arrangements of approved providers can result in risks to quality and continuity of care.

Regulators therefore need greater visibility of these arrangements and the capability to interrogate them rigorously. This will require both changes to the prudential requirements set out in law and the approach of regulators.

The Inquiry saw gaps in the regulators' capacity to interpret and interrogate financial information. An example of this was in 2016 when People Care assured the Department that even though it had incurred operating losses, its ongoing viability was guaranteed by Mr Miller and the other related companies operating at Earle Haven. As we saw in Chapter 4, this advice was technically incorrect but the Department did not take any steps to assess its accuracy.

Accepting the advice at face value, and not developing a deeper understanding of the flow of funds between the related companies operated by Mr Miller, also has direct relevance to the events of 11 July 2019. We saw in Chapter 3 that the agreement between People Care and Help Street planted the seeds of the failure of the arrangement in financial terms by retaining commercial arrangements with other companies controlled by Mr Miller that had led People Care to be operating at a loss. Some of this information was available to regulators through People Care's annual financial returns but may have been more clearly understood if there was greater transparency of related party transactions. In either case, when regulators became aware of the sub-contracting arrangements, they should have made enquiries to ensure that the arrangements would mitigate, not amplify, any risks to the ongoing viability of the facility.

In order to provide greater oversight of these arrangements, the Inquiry recommends:

Recommendation 6

The Australian Government should finalise as a matter of priority reforms to aged care prudential arrangements, including to:

- revise metrics used for assessment of Annual Prudential Compliance Statements to incorporate measures which may indicate risk to quality of care
- introduce specific liquidity and capital requirements
- provide greater visibility of corporate structure and related-party transactions
- require updates to material changes in ownership or management arrangements
- allow regulators to request updated financial information at any time.

Recommendation 7

Approved providers that do not meet the specified liquidity and capital requirements be automatically placed on a watch list and required to submit a detailed plan to rectify the situation.

Recommendation 8

Approved providers should be required to report to regulators the financial information of:

- any related parties providing guarantees for the approved provider
- any organisation sub-contracted to manage the delivery of aged care services.

The events of 11 July, and the history of People Care, particularly highlight the need for more stringent requirements in relation to the financial viability of approved providers. We have seen that People Care could not continue as a going concern without the support of its related entities and that Help Street began experiencing cash flow issues shortly after it began operating at Hibiscus House and Orchid House. These cash flow issues created substantial risks for quality and continuity of care which were ultimately realised.

To provide greater visibility of these risks and ensure approved providers are giving them adequate attention, the Inquiry recommends that the Australian Government:

Recommendation 9

Update the Governance Standard in the *Fees and Payments Principles 2014 (No. 2)* to require approved providers to assess on a quarterly basis their liquidity and ability to continue as a going concern. This should extend to any sub-contractor responsible for the management of care services.

Recommendation 10

Clarify that the requirement in section 9-1 of the *Aged Care Act 1997* to advise aged care regulators of material changes would apply to any identified issues about an approved provider's ability to continue as a going concern.

These changes to the financial reporting requirements need to be matched by the capability of regulators to act on the information available. This includes ensuring that the information is effectively shared across all regulatory functions as already discussed above.

It also requires sufficient staff with the right skills to enable regulators to confidently interrogate and challenge financial information submitted by aged care providers. As we saw in Chapter 3, the complex set up of the group of companies that operated at Earle Haven made it difficult to fully understanding the true financial situation of the approved provider of aged care. In light of this, regulators need both greater transparency of reporting from approved providers and the expertise to critically examine the information provided.

Finally, regulators also need the skills and work practices to identify the risks which financial and corporate arrangements might generate in terms of quality or continuity of care. For example, if the Quality and Safety Commission had been able to assess the contractual arrangement between People Care and Help Street at the assessment contact intended to monitor the new arrangement on 18 July 2018 a more detailed and accurate outcome may have been achieved. Instead, the assessment of the new management reviewed only the impact on human resource management.

To address all of these needs, the Inquiry recommends that the Australian Government:

Recommendation 11

Ensure aged care regulators have the capacity to understand risks to quality of care that might arise from an approved provider's financial or contractual arrangements, including by:

- increasing the capacity of aged care regulators to effectively scrutinise financial information.
- providing the Quality and Safety Commission with the capacity to include people with expertise in contracts and accounting in the team undertaking assessment contacts where there is an indication that there are risks associated with the approved provider's financial or contractual arrangements.

Similarly, regulators need to be able to offer assistance when an approved provider reports that there are risks associated with their financial viability or contracting arrangements. This is both necessary to help ensure continuity of care and also desirable to encourage providers to share concerns honestly and early rather than hide them for fear of punitive action.

To this end, the Inquiry recommends that:

Recommendation 12

The Australian Government make available business or financial advisory services to providers who voluntarily disclose significant financial and/ or contractual risks which may impact on the stability of service delivery.

Support of this nature commenced in October 2019 following a Government commitment in February 2019. The program is currently intended to run until 2021.

This assistance is welcomed by the Inquiry, however, it is suggested that the Department ensure that the prioritisation process for assistance under the scheme will accurately identify as a priority the types of financial and contractual risks present at Hibiscus House and Orchid House. The use of the service should also be monitored to inform considerations of the amount of funding provided and possible extension beyond the current end date.

Greater oversight of the purchasing and sub-contracting of approved provider status

There are a range of legitimate reasons why an approved provider may wish to sub-contract the management of its care and such arrangements are explicitly permitted by the Aged Care Act. However, as we have seen in Chapters 3 and 4, there is not currently adequate regulatory oversight to manage the risks of such arrangements.

The current regulatory arrangements allowed Help Street to be engaged into a role where it was responsible for the care of residents at Hibiscus House and Orchid House, and the recipients of home care packages through People Care, without any assessment of its experience or capacity to perform that function.

Moreover, the heads of agreement between People Care and Help Street was a significant risk factor in terms of quality of care because Help Street was largely unaccountable in the way in undertook its work. The agreement did not provide for sufficient oversight of the quality of care or spell out performance expectations against which Help Street would be assessed. The shortcomings of the heads of agreement were discussed in Chapter 3.

We have also seen that the nature of the agreement meant that there is limited action which can be taken against Help Street or its management for the collapse of services on 11 July. Although Help Street had assumed control of the services in practice legal responsibility remained with People Care and regulators were only able to direct punitive action at People Care following the events. Indeed, even the power of regulators to require the production of information under the Aged Care Act would only apply in relation to People Care as the approved provider and not Help Street.

To address this shortcoming in current arrangements, the Inquiry recommends:

Recommendation 13
The Australian Government amend the Aged Care Act so that management of care services can only be sub-contracted to an approved provider.

The Inquiry notes that a degree of caution will be required in defining the detail of these legislative amendments. The intention is not to prevent an approved provider entering into contracts with specialist providers of services such as catering, cleaning or allied health. It is also not intended to prevent an approved provided engaging a member of their key personnel on a contract basis or filling gaps in their roster with agency staff. The specific intention of the recommendation is to address situations where an approved providers seeks to contract out its responsibility for the management of care services.

As a complement to this recommendation, the Australian Government should put in place measures to assess whether the terms of specific outsourcing arrangements for the management of aged care services are in the best interests of the care recipients.

As we saw in the case of Hibiscus House and Orchid House, Help Street's organisational capacity and experience was only part of the problem. The terms of the agreement also created risks for quality and continuity of care; both in terms of the governance arrangements which were absent from the agreement and the financial sustainability of the arrangement.

It is also instructive that the discussions between People Care and Help Street began as negotiations for purchase of the People Care business and its associated approved provider status. This highlights a significant risk which would allow parties to enter the aged care system with approved provider status and with no oversight from regulators. We saw in Chapter 3 that Mr Miller was able to work around concerns in 2001 about his firm Pilmont Pty Ltd operating Hibiscus House and Orchid House by purchasing the People Care business.

This gap is particularly highlighted in comparison to arrangements for the transfer of residential aged care places from one approved provider to another. Where an arrangement of this type is being considered the approved provider must notify the Department in advance and there is a requirement that it be considered by the Secretary or her delegate. The Secretary or delegate can require that the provider resolve any concerns about the proposed transfer and ultimately has the power to veto the proposed arrangement.

It is the Inquiry's view that the purchasing or sub-contracting of the role of approved provider is at least equally as serious, and demands the same level of oversight, as a transfer of places. The Inquiry recommends:

Recommendation 14

The Aged Care Act be amended to require notification of sub-contracting of management of care and/or sale of a business with approved provider status before they take effect.

Recommendation 15

The amended Act require the Secretary of the Department to consider whether the proposed arrangement is in the best interest of care recipients and provide the power to veto the arrangements.

Better managing the risks associated with key personnel and organisational culture

As we saw in Chapter 3, there was a culture at People Care over an extended period of time which was dismissive of feedback and did not place adequate weight on the best interests of the people in receipt of care. People Care's Managing Director was particularly responsible for establishing and perpetuating this culture. In the Inquiry's view this was the underlying cause of People Care's non-compliance with its obligations and the area on which regulators should have focused in order to prevent future non-compliance.

Senior management at Help Street similarly appeared to have been focused on commercial considerations at the expense of the residents in their care.

Moreover, at the time the heads of agreements was reached Help Street's Global CEO, Mr Bunker, was being considered by ASIC for disqualification as a company director. This disqualification took effect in June 2018.[39] Had this been known by regulators, it should have raised significant red flags about the sustainability of the arrangement with People Care and the risks it posed to quality of care.

The manner in which the events of 11 July evolved are the most dramatic evidence possible that the senior management at both People Care and Help Street did not give due weight to the care of frail older people. The Inquiry has already stated its view that the contract dispute could have been managed in a way that did not result in such a complete collapse of service delivery.

Up until 2016 aged care providers were required to report changes in its key personnel to the Department. The Inquiry understands that prior to these changes the Department would receive around 10,000 notifications a year and that they would be manually entered into spreadsheets which limited the usefulness of the data. It is clearly undesirable to return to this arrangement which created unnecessary effort for both approved providers and the Department.

Nevertheless, the complete removal of a requirement to report changes in key personnel has created a blind spot for aged care regulators. Under the heads of agreement, senior management of Help Street were acting as key personnel for People Care but following the 2016 changes this information was not available to regulators.

When an organisation applies for approved provider status it is normal for key personnel to be assessed for previous business dealings and experience in delivering aged care. This process would have raised concerns about both Mr Bunker and Help Street's CEO Australia and New Zealand, Mr Lamb. However, no such assessment was undertaken when they assumed responsibility for delivery of services at Hibiscus House and Orchid House.

The Inquiry finds that this is a gap in the aged care regulatory environment which needs to be addressed and so recommends:

Recommendation 16
The Australian Government revisit the requirement for approved providers to report changes in key personnel.

This change should not simply see a reinstatement of the previous arrangements which clearly generated a large amount of information which could not be meaningfully used. In developing a more modern approach to key personnel changes, consideration should be given to appropriate IT changes to simplify the reporting process for providers and to ensure information can be readily utilised by regulators.

Consideration could also be given to reducing the number of reports which need to be made; either by revising the number of roles for which changes must be reported or allowing some more routine changes to be reported as part of the annual financial reports already provided to regulators.

[39] Royal Commission into Aged Care Quality and Safety, Exhibit 8-13 - RCD.9999.0164.0001 - Notice of disqualification from managing corporations issued by Delegate of the Australian Securities and Investments Commission relating to Kristofer Andrew Bunker

The history of People Care and events of 11 July also suggest that the current requirements that apply to key personnel of approved providers need to be enhanced. Under current legislation an approved provider must not engage a person as one of their key personnel if that individual:

- is personally insolvent and under administration
- has been convicted of an indictable offence
- is of unsound mind.

Mr Bunker was not excluded from acting in a key personnel during Help Street's operation despite being disqualified from operating as a company director by ASIC. More significantly, the senior management of both People Care and Help Street continue to meet the definition of suitable key personnel despite their significant culpability for the events of 11 July and apparent disregard for the residents of Hibiscus House and Orchid House on that day.

The Inquiry therefore recommends:

Recommendation 17

The Australian Government introduce provisions to allow the disqualification of specific individuals from acting as key personnel of an approved provider.

In addition to addressing the role which individuals can play in perpetuating a culture that creates risk to care recipients, this recommendation would also allow aged care regulators to take a more nuanced approach to providers who are repeatedly not compliant with their responsibilities. Requiring an approved provider to engage new key personnel in one or more roles may support sustainable improvements in care without the risk to continuity of service that comes with revocation of accreditation or approved provider status. The history of People Care making improvements with nurse advisors in place and then reverting to non-compliance supports this hypothesis.

The recommendation would also introduce a greater level of personal accountability for the key personnel of aged care providers. It is perverse that the aged care service operated by People Care has been closed down, the residents of Hibiscus House and Orchid House are unable to return home but the senior management who are responsible for that outcome are still able to manage or even purchase other aged care providers.

It is also important for regulators to have a greater focus on organisational culture and key personnel in determining their approach to specific aged care providers. As we saw in Chapters 3 and 4, the organisational culture of People Care was the underlying risk factor behind its instances of non-compliance and the deteriorating relationship between People Care and Help Street was a risk factor not picked up by regulators in the first half of 2019.

In light of this, and taking note of other observations earlier in this section, the Inquiry recommends:

Recommendation 18

The risk profiling tool being developed for use by the Quality and Safety Commission should consider:

- the responsiveness of approved providers to feedback from consumers and the manner of their response to identified cases of non-compliance
- the nature of any sub-contracting arrangement in relation to management of care services
- the relationship between parties responsible for care, especially when management of care services has been sub-contracted
- intelligence from other regulators.

Sanction options which better balance the need for decisive action with the desire of people to remain in their homes

In the case of Earle Haven, the result of the sanctions imposed and subsequent revocation of places is that there is no longer government funded places which People Care could sell at Hibiscus House and Orchid House. The only options for resuming residential aged care services at Earle Haven would be either for Mr Miller to lease the buildings to another approved provider with available places in their possession or to deliver privately-funded care, exempt from government subsidies and regulation.

We saw in the preceding chapters, the people relocated from Hibiscus House and Orchid House just wanted to go home. While not disputing that sanctions were warranted, the consequence of the sanctions imposed have made this less rather than more likely. We also heard from the families and representatives of residents that if returning home wasn't an option they would have liked a quick answer and that also did not happen. Instead, the revocation process took months to provide families with the certainty they needed to make decisions about their loved ones future home.

This was further complicated by People Care sending mixed messages about whether it would or would not continue services, and because sanctions did not prevent resumption of services to existing residents, regulators could not give a definitive answer. The Inquiry understands People Care had discussions with other providers, some introduced by the Department, but could not agree on terms. The Inquiry also understands People Care may not have expected the revocation of places to happen as quickly as it did, so may have underestimated the need for urgency in the negotiations with other providers.

The range of options available to regulators in response to adverse events are principally geared toward removing or limiting an approved provider's ability to operate. There are fewer options designed to support the smooth transition to a new provider or service arrangement which would ensure continuity of care. Otherwise, the focus is primarily to return an approved provider back to compliance with its responsibilities. The Counsel assisting the Royal Commission concluded in regards to this theme:

> *"quality regulators and officials with power to impose sanctions appeared to be overly pre-occupied with the question of compliance with minimum quality standards, the procedural steps that apply in cases of detected non-compliance, and with the apparent objective of managing People Care back from its frequent bouts of non-compliance to compliance virtually at all costs. This seems consistent with hesitancy on the part of [Department of Health] to impose unconditional revocations of approval or deviate from the objective of managing approved providers back to compliance."*[40]

[40] Royal Commission into Aged Care Quality and Safety, Post-hearing submissions - Counsel Assisting's Submissions on proposed findings relating to Earle Have Case study, pages 62-63, paragraph 217

A better option for the residents in the care of a provider deemed to be unsuitable or unwilling may be a requirement for the provider to sell the business as a condition for avoiding the revocation of places.

There are provisions in the Aged Care Act allowing approved providers to avoid the revocation of places if they are transferred to another approved provider. Requiring the sale of the facility or approved provider business may be preferable to transfer of places in some cases because it increases likelihood that the arrangement would see continuity of service delivery at the specific location.

To facilitate a direct approach to solving the issue without impacting residents, the Inquiry recommends:

Recommendation 19

The Australian Government amend the Aged Care Act so that an additional alternative to revocation of approved provider status is an undertaking to sell the approved provider company and/ or specific services under its control.

This level of government intervention is warranted due to the vulnerability of care recipients, as we saw in the case of Earle Haven. Like any market, providers who do not perform well should no longer be in business. To ensure stability for those in care, government must have the powers to require a smooth transition to a more appropriate provider as an alternative option to revoking the places and closing services altogether.

In cases like that of People Care, such a sanction may also be more transparent for providers by allowing regulators to clearly express the view that the provider is no longer suitable and to set an unambiguous timeframe for the provider to transition out.

The proposed introduction of a disqualification scheme for key personnel would also assist regulators in better balancing the need for decisive action with the needs of care recipients. In the case of smaller, privately owned providers like People Care, disqualifying the owner under such a power would require them either to sell the business to another provider or to appoint an appropriately skilled board to take over management of the service.

Better responses to emerging situations in aged care facilities

With the benefit of hindsight, the judgement that Hibiscus House and Orchid House were unsafe underestimated the potential to quickly replace items taken from the site and to bring in resources to continue care. While the Inquiry acknowledges legitimate doubts about People Care's estimates that they could keep the service running for 72 hours, it appears that the option of bringing in external resources to stabilise the situation was not sufficiently considered. Such an outcome was also obstructed by the ongoing dispute between People Care and Help Street which made it difficult for authorities to get a clear picture of what was going on.

It also appears that in determining the safety of the site, authorities may not have given sufficient weight to the danger in moving frail elderly people from their home without sufficient planning. Most residents at Hibiscus House and Orchid House were high care, some with dementia. The evacuation had a profoundly negative effect on the residents and their families. This is consistent with a body of literature which shows that "moving people [in residential aged care] even to a better facility can result in worse outcomes in terms of mortality and morbidity"[41]. Factors found to adversely impact the wellbeing of people in residential aged care facilities when suddenly relocated include loss of social supports[42], changes in environment and unfamiliar routines[43].

In light of the impact on residents and their representatives, the Inquiry recommends:

Recommendation 20
Residents of aged care facilities should only be evacuated in life-threatening situations (such as fire or flood).

While not denying problems with the care provided or the events of 11 July, many of the residents and their families, as previously discussed in Chapter 2, question the need to call for an evacuation usually reserved for fires or floods where there is an immediate threat to life. Even some of the Help Street staff whom the Inquiry spoke with indicated that while there was potential for danger to the residents of Hibiscus House and Orchid House if the situation on 11 July was not resolved, they were not in immediate danger at 1:33pm when the Triple 0 call was made.

The impact on mortality and morbidity of the relocation of frail elderly people from their home can be reduced by careful planning[44]. Such planning should take into account preparation of residents and families to minimise stress, limiting disruption to routines and social interactions. The literature reviewed by the Inquiry suggests this preparation can take three to six months.

While one of the arguments in favour of the evacuation was the absence of records for the residents, the reality is that this was a risk regardless of where the residents were given that receiving facilities also had no records for the people involved. Following the events, the Department of Health was provided with the paper-based records of 35 of the 69 residents, all of which had been located on site. These were provided to the facilities to which the residents were relocated. Additionally, the resident's paper based medication charts were available on site throughout the 11th July.

[41] Royal Commission into Aged Care Quality and Safety, Brisbane Hearing 9 August 2019 – Transcript, testimony of Professor John Braithwaite, p 4795

[42] Mello S, O'Connor KA. Morbidity and mortality following relocation of highly dependent long-term care residents: A retrospective analytical study. Journal of gerontological nursing. 2016 Oct 6;42(11):34-8

[43] Beirne NF, Patterson MN, Galie M, Goodman P. Effects of a fast-track closing on a nursing facility population. Health & Social Work. 1995 May 1;20(2):116-23.

[44] Gutman GM, Herbert CP. Mortality rates among relocated extended-care patients. Journal of Gerontology. 1976 May 1;31(3):352-7

While making this observation with the benefit of hindsight, the reality of the day would not have easily allowed such a calm and methodical analysis of what was going on. In particular, the efforts of first responders would have been severely hampered by:

- the deliberate attempts of Help Street to damage Mr Miller
- the animosity between the parties
- active resistance from People Care personnel to the involvement of Queensland Health authorities.

The Inquiry makes this finding in the hope of identifying options to better respond should a similar event ever occur in future. It is not the Inquiry's intent to suggest the outcome of 11 July was the responsibility of emergency responders. The blame must lie squarely with the senior management of Help Street and People Care who allowed the situation to descend into disarray.

Amid the chaotic and acrimonious scene, Queensland authorities responded to the information on hand not knowing who to trust or to what level the instability was impacting the wider Earle Haven community of 1000 residents.

To better respond and manage situations such as that which occurred at Earle Haven on 11 July 2019, the Inquiry recommends:

Recommendation 21

The Department of Health should develop a response plan for emerging situations where there is risk of an imminent collapse in the provision of aged care services (the plan).

- The plan should include provision for rapid access to resources to assist in stabilising service provision.
- The plan should be communicated to all aged care providers to encourage early notification to the Commonwealth and to state/ territory governments.

The lack of a plan to manage the situation in place on 11 July meant the impact on state health resources on 11 July was significant. The Inquiry heard how 259 Gold Coast Hospital and Health Service (GC HHS) staff were either directly involved in the evacuation or were staff across the GC HHS hospital network who were placed on standby in case all residents were required to be transferred to hospital.

Additionally, the Queensland Parliamentary hearing heard how emergency departments across the GC HHS started clearing beds and space in case that was needed to receive residents. Doctors were also asked to clear beds in the wards if there were patients who could be discharged home safely[45].

This diversion of such resources across the GC HHS demonstrates the capability of the state authorities to respond to emergency situations. This response should be reserved for life threatening situations given the impact on state health resources. A plan for an imminent collapse in aged care services would ensure these resources are used only during life threatening events, and that the Commonwealth aged care regulators are able to access resources to manage situations like Earle Haven without the need to evacuate.

The plan would need to be supported by the right resources and expertise. This would include the capacity for regulators to send people with appropriate skills to a facility in order to stablilise a service and plan for the longer term needs of care recipients.

[45] Queensland Parliament, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Investigation of the closure of the Earle Haven residential aged care facility at Nerang - Transcript 11 Sept 2019

In events like those of 11 July it may also be appropriate for Commonwealth regulators to assert control over a facility in order to facilitate the task of stabilising service delivery. It was unclear to first responders on 11 July who was responsible for Hibiscus House and Orchid House. In addition, the response of the approved provider was not welcoming of the involvement of external agencies and this would have made it difficult to contemplate continuing service delivery on site.

Uncertainty about the resources needed to maintain service delivery until a long term solution could be found would also have been a factor in the decision-making process of first responders. While the option of sheltering in place was considered by emergency responders, the GC HHS would have had more resources at its disposal to implement this option if it had worked in collaboration with or been led by the Commonwealth aged care authorities.

We saw in Chapter 4 that, from the perspective of residents, the most desirable outcome of regulatory action would have been the quick resumption of quality services at Hibiscus House and Orchid House. Regulators need tools which are better adapted to this purpose.

Giving Commonwealth regulators the power to appoint an independent manager for a facility would address all of these issues and so the Inquiry recommends:

Recommendation 22

Aged care regulators should have the power to appoint an independent manager to stabilise an aged care service at imminent risk of collapse.

In developing the response plan discussed in Recommendation 21 and implementing Recommendation 22, consideration should be given to contracts with state or national aged care workforce providers to enable immediate access to resources. It should also consider the relationship the Department has with other aged care providers most of whom are more than willing to assist in urgent situations.

In terms of the Commonwealth's response to the events of 11 July, the Inquiry heard that it took the Department's Queensland state office some time to access next of kin information for residents from My Aged Care. As part of the plan, the Department needs to consider the current controls in place to ensure rapid access to key resident information. Controls should not hinder access to information during critical times, whilst maintaining privacy controls.

On 11 July, the emergency services were advised of the collapse in aged care services at Hibiscus House and Orchid House before the Commonwealth authorities responsible for aged care. The Inquiry understands this directive was given by Mr Bunker, who had never engaged with the department in relation to aged care services. People Care had sent advice to aged care regulators on 10 July that the agreement with Help Street had been terminated but did not follow up on 11 July when matters began to escalate. Had the providers of care considered the potential role of the Department in assisting in stabilising service provision a different outcome would almost certainly have been achieved.

On 11 July, the Department was not engaged as part of the decision-making team on the ground as part of the Health Emergency Operations Centre (HEOC) and so their knowledge of the aged care system and providers locally was not fully available to those making decisions. The Department reports that in previous similar scenarios it has been able to work quickly with other aged care providers to stabilise an aged care facility and care for people in place.

To successfully coordinate responses in collaboration with state and territory governments, the Inquiry recommends:

Recommendation 23

There should be agreed protocols between the Commonwealth and each state and territory for situations involving the imminent collapse of service provision at residential aged care facilities:

- the protocols should clearly allocate decision-making authority depending on the nature of the situation.
- the basic premise of these protocols should be that evacuation from a residential aged care facility should only take place in a life threatening situation because the process of evacuation can itself be life threatening.

The idea behind this recommendation is that the Department is engaged early in the decision making process when there is any situation involving risks to service provision at residential aged care facilities. There should be a shared understanding of state and territory emergency response plans when the emergency covers such events as fire, floods and any other emergency situation currently recognised.

The protocols should not replace state and territory emergency management protocols. They should support these existing protocols to guide authorities in responding to and managing situations involving the imminent collapse of service provision at residential aged care facilities.

In addition to the distress experienced by residents of Hibiscus House, Orchid House and the retirement village at Earle Haven, the Council on the Ageing (COTA) Queensland in its written submission to the Inquiry highlighted the impact of the situation on "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."[46] This recognises the impact of the evacuation on the reputation of the sector.

The benefit of this recommendation is that it will give certainty to residents of aged care facilities that a disruption in service delivery due to administrative arrangements will not lead to a potentially life threatening evacuation. The need for residents to be cared for in place will be at the forefront of this protocol.

[46] Council on the Ageing (COTA) Queensland written submission to the Qld Parliamentary Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Investigation: Closure of the aged care facility at the Earle Haven Retirement Village in Nerang

Possible offences identified during the Inquiry

Chapter 4 noted that significant action has been taken against People Care following the events of 11 July and that there are limitations on the actions that aged care regulators can take against Help Street. There are, however, some investigations underway by other authorities. If adopted, the recommendations of this Inquiry would ensure in future cases companies like Help Street would be subject to the same responsibilities and potential sanctions as any approved provider. In addition, Recommendation 18 would allow key personnel who acted in the same fashion as Help Street's senior management to be subject to disqualification from holding similar roles in future.

In addition, there should be an investigation into possible offences under the Health Practitioner Regulation National Law for inciting and/ or directing registered health professionals to engage in misconduct. The Inquiry will refer relevant information to the Queensland Health Ombudsman for consideration.

Conclusion

The events of 11 July were deplorable and should never have occurred.

The senior management of People Care and Help Street should have worked through their dispute in a more constructive fashion and placed the interests of care recipients ahead of their own personal interests.

Without diminishing the culpability of these individuals, aged care regulators should have been more alert to the risks presented by the senior management personnel at both People Care and Help Street and by the agreement between the two companies itself. Regulators should also have had a greater array of tools to deal with the situation on 11 July so that an evacuation could be avoided and to more effectively respond to the failure in care demonstrated by People Care and Help Street.

The Inquiry has been deeply touched by the stories of the impact which the events of 11 July had on residents of Hibiscus House and Orchid House, their families and representatives. We are grateful to them for the time and emotional energy that has gone into sharing their experience. We know that many are still hurting from the hurried evacuation on 11 July and wishing they could return home.

The Inquiry is also grateful to the staff who have taken the time to speak with us. We particularly admire that even after being told they would not be paid, staff stayed at Hibiscus House and Orchid House to care for the residents. It is unconscionable that the actions of Help Street's senior management mean these staff are still waiting for their entitlements to be paid.

This Inquiry cannot undo the events of 11 July or take away the pain that those events have caused. It is, however, incumbent on all of us to learn the lessons of the events and to take action to ensure they are not repeated. The Inquiry offers its findings and recommendations as a contribution to that effort.

Appendix A

Objectives

The Inquiry is charged with examining the circumstances leading to a collapse in the provision of aged care services for the residents of the Earle Haven Retirement Village (the Service) and the events that occurred on Thursday 11 July 2019 and their aftermath (the Events).

The Inquiry is to be led by Ms Kate Carnell AO and 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.

Terms of reference

1. The Inquiry is to examine:
    i. the impact and consequences of the Events on the safety and wellbeing of residents of the Service and their representatives;
    ii. the management and operational structure of the Service and the governance, management and operational structure of the approved provider and owner People Care and its sub-contractor HelpStreet and the key personnel acting on their behalf in relation to the Service;
    iii. the contractual relationship between People Care and HelpStreet and whether there were any provisions in that contractual relationship designed to avoid or mitigate the Events;
    iv. whether there were appropriate risk management and emergency planning procedures in place for the Service and whether they were activated either prior to or during the Event;
    v. whether the governance arrangements in place at the Service were adequate or presented particular risks to residents of the Service and the Commonwealth;
    vi. whether the contractual arrangements between the approved provider and a subcontractor to run the Service presented particular risks to the continuity of service delivery and to the support of residents of the Service and the Commonwealth.
    vii. what actions were taken by either People Care or HelpStreet to alert State or Commonwealth authorities to the potential, and then actual, collapse in the provision of aged care services at the Service;
    viii. whether the Events could have been prevented and, in particular, whether the existing monitoring and regulatory arrangements put in place for the Service by: a) the Department of Health and b) the Aged Care Quality and Safety Commission, were adequate and how they might be improved;
    ix. the differentiating roles and responsibilities of the state government and the Commonwealth government in preventing and managing such events and whether different arrangements may have assisted in detecting or responding to the Events;
    x. the financial arrangements in place between People Care, HelpStreet, and any residents of the Service and the appropriateness of the arrangements in ensuring compliance with their legal obligations under the relevant legislation and the protection of the rights of the residents;
    xi. the adequacy of controls in place to manage the Refundable Accommodation Deposits of residents of the Service and People Care's compliance with its prudential responsibilities as an approved provider;

xii. the legislative framework which applies to the provision of aged care services and in particular:

i. whether sufficient powers, processes or other arrangements exist to identify in advance the risk of events like that which occurred at the Service;

ii. whether sufficient powers exist for the Commonwealth to manage events like that which occurred at the Service;

iii. whether sub-contracting arrangements, like those between People Care and HelpStreet, present particular challenges in ensuring regulatory compliance;

iv. whether sufficient powers exist to stop any suspected illegal acts including fraud within aged care services;

v. whether sufficient offences and penalties exist to deter and punish conduct inconsistent with the objects of the Aged Care Act; and

xiii. whether improvements could be made to the administration of aged care to better manage, or reduce the risk of, an event such as that which occurred at the Service.

2. The Inquiry may make any recommendations related to its findings including recommendations for legislative reform, systemic change or on matters incidental to its findings.

3. The Inquiry may:

i. seek any information relevant to its work and in particular any document or financial statement from any person, company, department, agency or other entity;

ii. ask questions of any person, company, department, agency or other entity; and

iii. invite public submissions.

4. The Inquiry will keep the Minister for Aged Care and Senior Australians, Senator the Hon Richard Colbeck, appraised of its progress including any difficulties in meeting timeframes.

5. The Inquiry is required to submit its findings and recommendations to the Minister for Aged Care and Senior Australians, Senator the Hon Richard Colbeck, in October 2019.