Victorian Institute of Forensic Medicine

# Residential Aged Care Communiqué

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## CONTENTS



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**Next issue: February 2019**

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## EDITORIAL

Welcome to the final issue for 2018. We present the findings of the Coroner's Inquest into a resident death at an aged care facility in Oakden, South Australia, that occurred in 2008. The finding was delivered in September this year, more than 10 years after the death of the resident.

Most readers are familiar with some aspect of the deficits in care at Oakden, which have been the subject of multiple investigations over the past few years leading to the closure of the facility. The recent announcement of the Royal Commission into Aged Care Quality and Safety will almost certainly consider what happened at Oakden once again.

In this issue, we will summarise the key aspects of the case, to help our readers gain a clear chronology of what happened and the implications for staff, aged care organisations, and the sector as a whole. A unique aspect in our presentation of the case in this issue, is that I provided an expert opinion to the South Australian Coroners Court during the inquest.

This issue also explores why there are multiple inquiries and why it is not really possible to avoid this situation. Common sense would dictate that one comprehensive and objective investigation would be enough to identify the underlying contributing causes for the failures at Oakden. But that is not how change or reforms in our community service, regulatory and justice system necessarily works. Hopefully our explanation of the need for multi-faceted investigations will be reassuring though unlikely to reduce the frustration for those seeking expeditious outcomes.

The following inquiries relevant to Oakden are publicly available. At a national level, there has been the Australian Law Reform Commission into Elder Abuse (2017); the Carnell-Paterson report commissioned by Federal Aged Care Minister; the Senate Community Affairs References Committee inquiry; the Standing Committee on Health, Aged Care and Sport inquiry. From South Australia, there has been a report by the Chief Psychiatrist (2017); the Independent Commissioner against Corruption (2018); and a coronial inquest into the death of a resident (2018). The Royal Commission into Aged Care Quality and Safety is underway and the Commission is due to report their initial findings late next year.

On a final note, we are about to close our call for expressions of interest to screen the film 'Dignity of Risk' which is ideally suited to address one of the new aged care quality standards. "Consumer dignity and choice" is a key focus for the standards (Standard 1) which come into effect on 1 July 2019. The requirement for each RACS is to be able to demonstrate *"each consumer is supported to take risks to enable them to live the best life they can."*

## Chronology of Oakden

This chronology of events is an abridged summary of the comprehensive description outlined in the report by the Independent Commissioner Against Corruption, South Australia. It is intended to give a sense of what happened.

- 1982 – Oakden facility opened as a psychogeriatric unit for older persons on the site of a hospital for South Australians with mental illness.
- 1998 – A decision was made to seek Commonwealth accreditation for Makk and McLeay Houses as residential care facilities under the Aged Care Act 1997 (Commonwealth), and to having those wards accredited as a nursing home.
- 2000 – Makk and McLeay were first accredited by the Federal Government's aged care accreditation agency for a limited period of one year.
- 2001 – Makk and McLeay were accredited for a further nine months.
- 2002 – Oakden campus was considered unsuitable to continue as a standalone aged care mental health facility.
- December 2007
    - o The Aged Care Standards and Accreditation Agency identified non-compliance with 25 of 44 standards and recommended to the Commonwealth Department of Health and Ageing that sanctions be imposed due to the assessment of the serious risk to the health, safety or wellbeing of persons receiving care.
    - o Dr Simon Stafrace and Mr Alan Lilly were commissioned to review and report on the Makk and McLeay Nursing Home.
- February 2008 – Mr Graham Rollbusch died at Makk House allegedly from being assaulted by another resident.
- April 2008
    - o A decision by the accreditation agency to revoke accreditation was overturned.
    - o ACH Group joined in partnership with the SA state government to assist in the day to day management of Makk and McLeay Houses.
- June 2008 – concerns about the standard of care at Oakden were reported to the State Health Ombudsman and the Health Complaints Commission both of whom declined to investigate.
- July 2008 – the accreditation body deemed Makk and McLeay to be fully compliant with the aged care accreditation standards.
- April 2010 – nursing staff reported a resident to have been restrained by two pelvic restraints secured to his chair, which were in turn secured to a wall mounted rail.
- June 2011 – the Northern Adelaide Local Health Network Health Advisory Council Inc. was established, and was responsible for the Oakden Facility with the Department of Health.
- June 2014 – The Royal Australian and New Zealand College of Psychiatrists (RANZCP) SA branch and the Minister for Mental Health and Substance Abuse met to discuss concerns about the conditions in the facility and medical staffing levels.
- March 2015 – The SA Chief Psychiatrist (Dr Groves) wrote to Oakden about incidents of restraint.
- December 2015 - Concerns were reported to the State Minister's office about an assault on a consumer at the Oakden Facility.
- February 2016 - Mr Robert Spriggs (consumer at the Oakden Facility) was referred to the Royal Adelaide Hospital after it was discovered he had significant bruising without explanation.
- June 2016
    - o Mrs Barbara Spriggs again raised concerns about the treatment and care of her husband Mr Spriggs.
    - o A resident died after being left unattended and choking on a piece of food.
    - o Dr Groves conducted an announced visit of the Oakden Facility. He was the first Chief Psychiatrist to visit since the establishment of this role in 2010.
- July 2016 – Mr Spriggs dies.
- October 2016 – An independent review of Oakden Services for Older People was recommended due to a lack of response regarding the Spriggs complaint; the Community Visitor Scheme had received a number of concerns from clients' families and community visitors regarding client treatment and care, and operational issues affecting the quality of care and services to clients.
- November 2016 – An anonymous complaint was made to the Office of State Minister about a consumer being secluded; a lack of paperwork; medications and bullying issues.
- December 2016 – Concerns were raised about the overall clinical governance in older persons mental health services across the state.
- January 2017 – A review by the SA Chief Psychiatrist, Dr Groves, was publicly announced.
- March 2017 – The Federal Government's aged care accreditation and regulatory authorities identified a serious risk to residents of Makk and McLeay
- April 2017
    - o Dr Groves finalised the Oakden Report raising serious concerns.
    - o The report was provided to the SA Minister who met with Mrs Spriggs and Dr Groves.
    - o The Oakden Report was considered by State Cabinet and made publicly available.
    - o The Minister made an announcement that Oakden would be closed and existing residents transferred to appropriate alternate facilities.
- May 2017 – The SA Coroner announced that the inquest into the death of Mr Rollbusch would be re-opened.
- June 2017 – Makk and McLeay Houses were closed and residents relocated.

The sequence of events that flowed on from here are familiar to most people, beginning with the Federal Ministerial Commissioned Review (Carnell-Paterson) followed by the Australian Parliament Senate, then House of Representatives Inquiries, and now the National Royal Commission.

# Case: Oakden revisited

**Case No:** Inquest Number SA 09/2017 (0269/2008)
**Précis author:** Carmel Young RNCCM, Department of Forensic Medicine, Monash University

### Clinical Summary

Mr R was a 70 year old male who entered Oakden's Makk House, an Older Persons Mental Health Service, in September 2005 and remained there as a resident for the next three years. His past medical history included frontal lobe dementia, ischaemic heart disease, and emphysema, for which he was on continuous oxygen.

Mr R was admitted to Makk House following a psychiatrist recommendation that this facility could manage his inappropriate sexual behaviours. To effect the change in residence, a public guardian was appointed as Mr R was considered to lack decision-making capacity as he had dementia and limited contact with family.

For the six months prior to his death, Mr R was receiving palliative care due to his underlying emphysema. Mr R was at this time predominantly bed-ridden and unable to move.

On the 28th February 2008 at 5am, three staff members commenced a round of the Unit. They were alerted to a problem when they heard another resident, Mr P yelling. Mr P's room was adjacent to Mr R's room and there was a small alcove immediately outside the two rooms that gave access to the doors of each room.

The first staff member to arrive found Mr R deceased. He was lying face down in the entrance of his room with blood on the floor that appeared to have come from his head. Other staff responded to the urgent call for assistance, and the first staff member said that she heard Mr P say *"I think I have hit him too many times"*.

### Pathology

The cause of death following an autopsy by a forensic pathologist was given as *"Combined effects of severe pulmonary emphysema, ischaemic heart disease and recent trauma to the head and neck."*

The pathologist also noted that: *"'Circumstances surrounding the death suggest that the deceased may have been assaulted prior to death. On examination at autopsy there were numerous bruises, lacerations and superficial abrasions involving the head and neck, including a fractured nose. These injuries were consistent with a recent assault."*

> The information available from the clinical records was lacking, with few medical and nursing staff recorded entries in the progress notes for Mr R.

### Investigation

The State Coroner reopened the case into Mr R's death following the information that came to light with the inquiry into Oakden by the Chief Psychiatrist.

The coronial investigation was exhaustive with 17 days spent in the courtroom from May 2017 to September 2018. The coroner examined Mr R's and Mr P's medical notes, as well as multiple witness statements, both written and verbal, and expert opinions. There were a large number of issues that were examined, some of which included: how Mr R came to be on the floor with facial injuries; whether Mr R should have been a resident at Oakden; the care provided to Mr R and Mr P; what options or interventions were available to prevent resident assaults.

The information available from the clinical records was lacking, with few medical and nursing staff recorded entries in the progress notes for Mr R. The coroner was critical of this, describing the presence of a total of only 254 entries over 912 calendar days as evidence that, *"clearly reflects very poor note keeping and record keeping."*

It was clear Mr R did not want to be admitted to Oakden in 2005 and that his physical condition deteriorated as a resident, losing over 20kg during his stay. By September 2007 the medical officer deemed Mr R (weighing 40.8 kg) as being in 'palliative care' stages.

In December 2007, Oakden was given notice by the aged care accreditation agency that it had failed to comply with 25 out of the 44 expected outcomes. As a consequence, a nurse advisor was appointed to improve the care, and a psychologist was asked to review the residents. The psychologist was only able to review 12 of the 21 residents in the allocated six weeks.

Both found the documentation 'impoverished' and described the physical environment as 'appalling'. Both were critical of the lack of nutrition available to residents and noted that 69% were moderately to severely malnourished.

> In her internal report, she commented on the values, beliefs and attitudes of the staff members, describing that the staff appeared to have almost no training in how to manage elderly people with mental health impairment.

The nurse advisor reported that if a resident was a little bit difficult, the staff would say 'so you're not hungry, you don't want it OK' and the food would be returned to the kitchen. The nurse advisor also noted that very few medical reviews were completed and a number of residents had not had reviews recorded in their notes since early in the year. The nurse advisor resigned from their position at Oakden after a short period of time, believing that the facility was not engaged or committed to achieving the necessary improvements.

The psychologist described becoming increasingly traumatised by what she was seeing, and detailed her findings. In her internal report, she commented on the values, beliefs and attitudes of the staff members, describing that the staff appeared to have almost no training in how to manage elderly people with mental health impairment. Among other things, she believed that every single resident needed to have an immediate review by an experienced geriatrician.

Both the psychologist and nurse advisor believed that Mr P should have had closer supervision, and that he needed regular occupational or sensory stimulation.

Around this time, in January 2008, Mr R had been the target of two assaults by Mr P. In the first assault, Mr R was struck repeatedly by Mr P who also had dementia. The second assault occurred approximately two weeks later when Mr R was sitting in a chair and was approached by Mr P, who was swinging his fists, and swearing. Mr P then punched Mr R in the face. Mr P was verbally abusive for some time after the incident and repeatedly stated *'he's a bastard if I see him again I will punch him in the jaw.'* A third incident involved a staff member who approached an agitated Mr P and politely asked him to go to the other side of the ward. Mr P punched the staff member to the head with his right fist.

Due to these behaviours Mr P was placed in a separate room in Makk House, isolating him from the other residents for a period of approximately two weeks. After that time however, he was returned to having the usual access to Makk House.

One question that was difficult to resolve was how Mr P came to be in Mr R's room. A feature of Makk House was that the residents' rooms had doors that were locked with a key from the outside, this design feature was intended to reduce any uninvited residents from entering the room. Although the door was locked externally, it could still be opened by the occupant from the inside, thus permitting the resident to leave at any time.

Despite Mr P's repeated outbursts, he did not receive regular reviews by a senior medical practitioner to aid in improving the management of his behaviour.

During the inquest, an expert opinion was sought from a geriatrician who noted Mr R had lost considerable weight and was being palliated without a clear understanding of the causes and without a formal medical diagnosis.

Further, the expert noted that Mr R could have been relocated to another facility as he was predominantly bed bound and did not appear to be creating any behavioural management issues for staff or any other resident. That relocation should have occurred after the initial assaults.

The geriatrician stated that the public advocate, as Mr R's guardian should have been contacted when his condition changed, and consulted about a relocation plan following the assaults. Finally, the expert commented that Mr P's clinical needs were not being met. Despite Mr P's repeated outbursts, he did not receive regular reviews by a senior medical practitioner to aid in improving the management of his behaviour.

**Coroner's Comments and Findings**

The coroner concluded that Mr R did not die from a fall but that Mr P inflicted some of the more serious injuries leading to death. The coroner was not convinced from the available evidence that Mr R should have been placed in Makk House in the first place.

The coroner also made specific mention that it was *"inappropriate for counsel for the Minister for Health to have submitted that Mr R's death was precipitated 'perhaps a smidgen earlier than it might have otherwise taken place' by the assault upon him by Mr P"*. The coroner went on to say that *"to trivialise the assault by the use of the expression 'smidgen' is extremely unfortunate. I reject the submission and expressly disassociate myself from any suggestion…"*.

The coroner recommended adoption of *"a register of resident-to-resident aggression in the aged care sector to be supported by a system of mandatory reporting of such incidents, and that it apply regardless of the residents' cognitive status."* And *"that the Minister for Health raise with his counterparts the proposition that such registers should be duplicated across the other States and Territories, or better still that there be the adoption of a national register at the Commonwealth Government level."*

## Final call: "Dignity of Risk"

Professor Joseph Ibrahim (Monash University) or 'Prof Joe', is touring across Australia with the film "Dignity of Risk" in 2019. The film won "Best Narrative Film Category" at the 2017 Global Impact Film Festival and "Best Film Animation" at the Social Justice Film Festival (Seattle USA, October 2018).

To register your expression of interest please go to this link: https://goo.gl/forms/foexsKXjbGdFqqCP2

## Editor's Comments

There are so many different lessons to be drawn from this inquest however, these cannot all be covered here. Instead the commentary focuses on issues that may not have previously received much attention.

The first issue is that residents should be in a facility that meets their needs. There is debate about whether or not Mr R should have been admitted to Makk House, and why he was not relocated when his condition changed. The Independent Commissioner Against Corruption questioned whether Oakden was actually needed, as following its closure *"many of the consumers have been moved into mainstream aged care facilities, which raises an issue as to whether it was necessary in the first place for such consumers to be located at the Oakden Facility."* This issue was also considered in the case of Mr R who may not have died if he had not entered Makk House or if an opportunity had been taken to relocate him following the initial assaults or when his health status changed.

A third issue, which may come as a surprise to our readers, is the small number of recommendations made by the coroner.

Another issue highlighted by the coroner was how episodes of resident-to-resident assault (RRA) are perceived differently and at times trivialised. When we trivialise these events, we fail to escalate or act in a way to prevent harm recurring. Our team researched aged care staff perceptions of RRA. The views about RRA were extraordinarily diverse, with participants viewing RRA as being either 'dangerous and unpredictable' or, conversely, as an 'expected behaviour or normal' in Residential Aged Care Services. Neither view is helpful in promoting an approach that optimizes management of residents with these types of behaviours. We must be aware of the potential for RRA and seek to reduce the occurrence of these incidents and the risk of harm.

A strategy for escalating incidents and having a structured multidisciplinary approach is essential. Our recommendations on this topic were published last year in *"Recommendations for prevention of injury-related deaths in residential aged care services"*. The Commonwealth Department of Health is also considering new models of care with plans for "Specialist Dementia Care Units" for people who experience very severe behavioural and psychological symptoms of dementia. The intention is to establish at least one unit in every Primary Health Network across Australia.

A third issue, which may come as a surprise to our readers, is the small number of recommendations made by the coroner. Based on the number of inquiries into Oakden we may have expected substantially more recommendations. This can be understood by returning to the purpose of a coronial investigation. The coroner is able to make recommendations pertinent to the specific case and pertaining to prevention of death. The opportunities were limited in this case because Oakden was closed at the time of the inquest and the coroner does not seek to blame individuals.

Other issues highlighted by this case are the perennial problems in residential aged care, whether mainstream or specialist services, that we should be better at addressing now. These include: appropriate levels of documentation in the clinical records; regular clinical review; escalation and reporting of adverse events within the organisation; and respecting resident choices and keeping the legally responsible decision-maker, in this case the public advocate, informed at each significant change in a resident's condition.

# Inquiries: An explanation of the different types in aged care

Alice Holmes and Joseph Ibrahim

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With so many inquiries into the provision of aged care in Australia, it is timely to stop and look at the role of each type of inquiry and their potential impacts. Rather than cover all the different forms of inquiries into resident harm or premature and preventable deaths, we have concentrated on the types of inquiries recently conducted into Oakden.

### *Royal Commission into Aged Care Quality and Safety*

The recently announced Royal Commission (RC) is the highest form of inquiry in the Australian system of government. It can only be declared by the Governor General and is usually convened to investigate systemic corruption. The Royal Commissioners have immense powers (including coercive powers such as phone tapping) allowing for the most thorough investigation. Interestingly, once it commences, the RC cannot be stopped by government. However, a RC is limited to investigating what is included in the terms of reference.

> Coronial inquests do not purport to investigate criminal charges or civil wrongs – they do not apportion blame.

The terms of reference announced are very broad, including investigation of choice, dignity, clinical care, mental health, nutrition, and systems ensuring high quality care. The RC must report on the terms of reference and may also expose any criminal offences or civil wrongdoings within the sector. RCs usually take a few years to complete, cost tens of millions of dollars, and the government is not required to implement their recommendations.

### *Coronial Inquest into death of a resident of Oakden*

Coronial Inquests are held in each State and Territory as a public court hearing; however, there are more restrictions and a far narrower scope in this form of review. A coroner may only hold an inquest in respect of a particular death, usually of one individual, that is being investigated. The court is bound by legislation specific to its jurisdiction. There is not a national coroners court.

The coroner examines the circumstances surrounding the resident's death to ultimately determine how and why the resident died. Coronial inquests do not purport to investigate criminal charges or civil wrongs – they do not apportion blame. Coroners may make recommendations that are specific to the circumstances of the death.

> Each state has an independent body or commissioner that investigates corruption within the public sector.

### *Australian Law Reform Commission into Elder Abuse (ALRC)*

The ALRC researches and provides recommendations for law reform, upon the advice of the Attorney-General. It does not have the power of a RC and it does not investigate individual deaths. The ALRC role is an advisory one that is limited to reform of legislation, for example, reform of the Aged Care Act. The objective is to make better laws for our community.

In May 2017, the ALRC published their report on elder abuse following extensive community consultations over a two-year period. The report covered a vast range of legal issues pertinent to older Australians including wills, guardianship, superannuation and care in the context of elder abuse. The ALRC made many recommendations including 14 recommendations that were specific to the prevention of abuse and neglect in residential aged care services. These reviews usually lead to changes in the law albeit this occurs very slowly.

### *Bodies Against Corruption (IBAC or ICAC)*

Each state has an independent body or commissioner that investigates corruption within the public sector. Their role is to receive and act on complaints of public sector corruption and to investigate and expose the corruption. Like coronial inquests and royal commissions, ICAC/IBAC utilise an inquisitorial role in their investigations. In South Australia, ICAC launched a separate public investigation into Oakden following the release of the South Australian Chief Psychiatrist's report.

This investigation yielded an extensive report, ultimately finding that the Northern Adelaide Local Health Network and a number of individuals were engaged in maladministration. ICAC made a number of recommendations with their finding. ICAC/IBAC is able to refer matters to the Office of Public Prosecutions; however, the decision to launch proceedings lies with the State-based Director of Public Prosecutions and not ICAC/IBAC.

### *Parliamentary Committee Inquiries*

A parliamentary inquiry is undertaken by current members of parliament who form a committee to focus on a particular topic. A parliamentary committee inquiry is confined by the terms of reference for the inquiry, often developed by the committee and the Minister who is responsible for the topic of the inquiry. Thus, the committee can investigate a broad area of concern and is not necessarily confined to a particular incident.

Submissions are then received and considered from organisations and members of the public. There may be hearings, discussions and inspections of facilities. The committee then provides a report which is generally presented to Parliament and may ultimately result in changes to policy and law reform.

The Australian Parliament's Standing Committee on Health, Aged Care and Sport recently released a report from its inquiry into the Quality of Care in Residential Aged Care Facilities, and the Senate Community Affairs Reference Committee's final report is pending. Such parliamentary committees do not have the same extensive powers of a Royal Commission.

***Ministerial Commissioned Review***

The government may commission a review into an incident or area of concern, generally with independent reviewers. This may be triggered by a certain event such as in the Oakden incident, where the Federal Aged Care Minister commissioned a review of the aged care quality regulatory process.

These reviews are confined to the terms of reference set out at the start, and are usually short and quick. The review is submitted to the commissioning minister who decides whether it remains confidential or is released publicly. Minister Wyatt publicly released the Carnell-Paterson report and acted on some of the recommendations contained in the review.

***Organisational Inquiry***

Individual organisations may conduct their own inquiries into part of, or the whole of an organisation. These typically occur when serious issues have been raised, often by residents or their families, or staff members.

It is quite common for people to be confused about the wide variety of inquiries that seem to duplicate one another's work with little in the way of action to address the underlying causes.

An example of this is where the CEO of the Northern Adelaide Local Health Network requested that the South Australian Chief Psychiatrist exercise their power to undertake an independent review into Oakden. The CEO could also have asked their own staff or a separate external group to conduct the review and manage the situation internally (as had occurred with Oakden in 2008).

The review led by the Chief Psychiatrist in 2017 identified serious statutory breaches which required that the State Minister for Mental Health and Substance Abuse be advised of the findings.

***Other types of investigations***

While the list may seem overwhelming, there are many other investigatory or regulatory bodies we have not detailed, including the Aged Care Complaints Commissioner, the Aged Care Quality Agency, the Commonwealth Department of Health and, the Australian Health Practitioner Regulation Agency.

***Understanding investigations***

It is quite common for people to be confused about the wide variety of inquiries that seem to duplicate one another's work with little in the way of action to address the underlying causes.

The key to understanding how an inquiry relates to our day to day lives and professional practice are to consider:

- Commissioning authority – who is it, do they have a clearly defined purpose in law, and why is an inquiry being launched?
- Governance of inquiry – who is responsible for conducting the investigation, what are their skills and what are their powers of investigation?
- Degree of independence – are the investigators independent or can their findings be influenced by the commissioning authority?
- Terms of reference – what is the scope of the inquiry, what can be examined and what is out of bounds?
- Resources – how much time, money and staff are available to conduct the inquiry?
- Opportunity for fact finding – what is the scope of the information gathering, who will be invited to give evidence?
- Reporting and recommendations – will the full report be made public and are the recommendations likely to be implemented?
- Return on investment – is the cost and time involved likely to benefit the community?

Perhaps the most disappointing aspect of all of these inquiries is that although most result in recommendations for change; none can mandate that the recommendations be implemented.

This highlights just how crucial it is to be involved in the review and implementation of recommendations after an inquiry concludes and not to assume that once it finishes that the factors that caused harm have been removed.

# List of Resources

**1. Royal Commission into Aged Care Quality and Safety**

Royal Commission into Aged Care Quality and Safety. Available at: https://agedcare.royalcommission.gov.au/Pages/default.aspx.

**2. Coronial Inquest into death of a resident of Oakden**

Finding of Inquest South Australia Coroners Court into the death of Graham Rollbusch. South Australia Court Administration 2018. Available at: http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/774/ROLLBUSCH%20Graham.pdf.

**3. Australian Law Reform Commission into Elder Abuse (ALRC)**

Australian Law Reform Commission. Elder Abuse— A National Legal Response Final Report. Commonwealth of Australia, Canberra. May 2017. Available at: https://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_31_may_2017.pdf.

**4. Bodies Against Corruption (IBAC or ICAC)**

*Lander B., Oakden: A Shameful Chapter in South Australia's History. Independent Commissioner against Corruption.* 28 February 2018. Adelaide SA. Available at: https://icac.sa.gov.au/sites/default/files/ICAC_Report_Oakden.pdf.

**5. Parliamentary Committee Inquiry**

The Standing Committee on Health, Aged Care and Sport. Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia. October 2018. Commonwealth of Australia 2018. ISBN: 978-1-74366-800-9. Available at: https://goo.gl/SVbhFU

**6. Ministerial Commissioned Review**

Carnell K., and Paterson R., Review of national aged care quality regulatory processes. Parliament House Canberra. October 2017. Available at: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/10_2017/review_report_final_23_october_2017.pdf.

**7. Organisational Inquiry conducted by external experts**

Staface S and Lilly A., Final Report on the Review of Makk and McLeay Nursing Home. April 2008
Available at: https://goo.gl/j2yADn

Groves A, Thomson D, McKellar D and Procter N. (2017) The Oakden Report. Adelaide, South Australia: SA Health, Department for Health and Ageing. Available at: https://goo.gl/auMmFT

**8. Resident-Resident Aggression resources**


1. Jain B, Willoughby M, Winbolt W, DLoGiudice D, Ibrahim J. Stakeholder perceptions on resident-to-resident aggression: implications for prevention.
*Australian Health Review.* https://doi.org/10.1071/AH17282

2. Murphy B, Bugeja L, Pilgrim J, Ibrahim JE: Deaths from Resident-to-Resident Aggression in Australian Nursing Homes.
*Journal of the American Geriatrics Society* 11/2017; 65(12)., DOI:10.1111/jgs.15051

3. Ferrah, N., Murphy, B.J., Ibrahim, J.E., Bugeja, L.C., Winbolt., M., LoGiudice, D., Flicker, L., & Ranson, D. (2015). Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review. *Age Ageing* 44(3): 356-364.

4. Ibrahim JE (ed)
*"Recommendations for prevention of injury-related deaths in residential aged care services"* Health Law and Ageing Research Unit, Monash University 2017. Available at: www.vifmcommuniques.org/?p=5194

5. RAC-Communique May-2015 Vol 10 (2) Resident Aggression

6. RACC-Communique Jun-2014 Vol 9 (2) BPSD


**9. Specialist Dementia Care Units Consultation Paper**

In 2016, the Australian Government announced it would establish Specialist Dementia Care Units (SDCU) to support people who experience very severe behavioural and psychological symptoms of dementia. The Government committed to establish at least one SDCU in each of the 31 Primary Health Network regions. Discussion document is available at: https://consultations.health.gov.au/ageing-and-aged-care/specialist-dementia-care-units/


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## FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:
racc@vifmcommuniques.org

## DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed.

We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health and Human Services, Victorian Institute of Forensic Medicine or Monash University.

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