THE COMMUNIQUÉS

VOLUME 21. ISSUE 1.

February 2026 Edition

Residential Aged Care Communiqué

ISSN 1834-318X

NEXT EDITION
MAY/2026

Editorial

Welcome to the first edition of the Residential Aged Care Communiqué for 2026. This edition presents two cases where the nature and level of staff supervision provided for the residents was called into question. In one case the resident had a fall sustaining fatal head injuries. In the other case the resident was found deceased after an unexplained absence and the cause of death could not be ascertained. In both cases, the staff were aware that the residents had experienced similar incidents in the past and that there was an ongoing risk of harm.

There are at least three areas of commonality in these two cases which on paper look vastly different. First, both aged care facilities sought to respect the residents' autonomy. Second, the nature of the residents' cognitive impairment was not fully appreciated or understood. Third, the issue of what level of supervision was required and how it is implemented for the safety of the residents.

These cases offer a valuable opportunity for reflection and discussion with colleagues. Consider what other common factors were present and revisit previous editions of the Residential Aged Care Communiqué that explored similar issues, listed in the resources section.

Respect for autonomy and the concept of dignity of risk are well established and our team has contributed to the education and training on the topic through the Residential Aged Care Communiqué, government enquiries including the Royal Commission and academic research. The new Aged Care Act 2024 (Cth) strengthens the resident's rights of choice and independence and increases the onus on aged care providers to better support residents with doing what they want to do safely. A key lesson is that while respect for the residents' autonomy is essential, age care providers and staff must consider and mitigate the risk factors the contribute to serious harm and death.

The presence of cognitive impairment in aged care residents although very common is still underdiagnosed especially in the early stages of the disease and when the symptoms are atypical. In these situations, formal cognitive testing is required as well as a comprehensive assessment of the person's functional state. The standard cognitive tests Mini-Mental State Examination (MMSE) and Montreal Cognitive Assessment (MoCA) do not diagnose dementia, an abnormal score on the test may not be due to dementia—also a score in the normal range does not exclude dementia. To make things even more challenging is how different types of dementia manifest is not the same. For example, a person living with Alzheimer's dementia will have symptoms of memory loss and language difficulties, while a person with vascular dementia may have more symptoms around decision-making and planning. Understanding the nature of the condition and the individual should assist in determining the type of supervision required for developing appropriate safer care. Simply stating a person is 'living with dementia' is not enough for optimal care.

CONTENTS

PUBLICATION TEAM

Editor-in-Chief:
Joseph E Ibrahim

Consultant Editor
Nicola Cunningham

Designers:
Samuel Gillard
Paul Ikin

The Residential Age Care Communiqué is distributed by the not for profit group 'The Communiques Australia Inc'. (COI--A0106775D)

FREE SUBSCRIPTION

The Residential Age Care Communiqué is published on a quarterly basis and sent electronically. Subscription is free of charge. Please register your email address at:
www.thecommuniques.com

FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:
racc@thecommuniques.com

Editorial (continued)

The third issue of supervision remains vexed with no easy solution. Determining the type of supervision is very context dependent and what is required is often in the eyes of the beholder. It is worth noting that in both cases, the aged care facility staff considered the level of supervision was appropriate—however the coroners did not agree. While it is easy to become defensive in these situations, remember when coroners are making determinations they are in a position to be objective and consider all the facts and different perspectives. Note that the family and friends involved in each case also felt the level of supervision was below what they expected.

Finally, we are pleased to introduce and welcome our new case précis authors Dr Chris Vagias and Dr Madeline Andrews. Both are active in clinical practice in aged care and bring different perspectives and valuable insights to the cases.

Case #1
A long way from home

Case Number:
2019/00007049 (New South Wales)
Case Précis Author
Dr Chris Vagias
MD, FRACP
Geriatrician, Northern Health

i. Clinical Summary

Mr JT was 73-year-old man who was living alone in rural northern New South Wales and was renowned in his town for work ethic and community presence.

A spate of incidents and behavioural changes that were uncharacteristic of Mr JT led to admission to hospital, and from there a decision to enter residential aged care. At the time the Aged Care Assessment Service completed a needs assessment, the geriatrician formalised a diagnosis of dementia with frontal lobe impairment supported with a Montreal Cognitive Assessment that indicated deficits in frontal and executive function.

The aged care facility in the rural town could not meet his care needs. Mr JT was subsequently relocated to a town 140 km east of his home to an aged care facility which comprised 95 beds, with low, high and secure care wings. Mr JT entered the high care wing.

An initial comprehensive clinical assessment was completed by nursing staff, and he was noted to 'wander' and have issues with his memory. A validated tool was completed early after entering the aged care facility, with the score indicating 'minimal cognitive impairment.'

Mr JT struggled to accept the assistance and support that was offered, as he felt it was superfluous to his needs. His tendency to 'wander' within the age care facility was noted early in his stay and visual observations were commenced, which he found intrusive and upsetting. It was noted that he would walk about the facility at times without a clear aim.

It was noted that he often left to get a newspaper, and returned without issue, and that he liked to walk along the local river, collecting golf balls struck onto the banks from a nearby golf course.

Mr JT 'absconded' twice within the first three months of entering the aged care facility, and following the initial event, he was moved to the secure unit but returned to his original room shortly after. The first episode was documented as 'absconding', and police were involved, however he returned of his own volition without any external input.

When the general practitioner completed a scheduled review, it was noted that Mr JT was agitated and suggested some strategies that may assist to reduce the agitation. A follow-up review by the general practitioner a week later noted Mr JT was despondent and remained agitated about his plight. The impression at this time was that he may be depressed and thus was prescribed sertraline.

The aged care facility staff completed standardised tools to seek further funding to support his care, but these indicated the presence of mild cognitive impairment and minimal depression. Four days after this review, he 'absconded' again, and was found at the tourist information desk by the facility Chief Executive Officer. Mr JT was placed on frequent visual observations, and a month later these hourly observations were ceased.

Five months after his admission and on a hot summer day Mr JT left the aged care facility sometime in the morning via the front door. He told a fellow resident he was going to town to buy a budgie (a budgerigar is a small, long-tailed, seed-eating parrot native to Australia). At lunchtime, his absence was noted. At 2pm nursing handover nothing was mentioned about Mr JT's location. At 3pm, the resident who had seen Mr JT in the morning asked where he was as he had not seen him. Shortly after, when staff arrived to deliver Mr JT's regularly scheduled afternoon beer and found his room was empty. It was at this stage, staff felt something was awry as Mr JT rarely missed his afternoon beer.

The facility staff reported Mr JT was missing to police at 4.15pm and a search commenced at 5.25pm.

Four days after he went missing, searches were suspended. Almost one year later, Mr JT's partial remains were found on the banks of the river.

ii. Pathology

An autopsy was conducted by a forensic pathologist and a forensic anthropologist provided a report.

Mr JT's identity was confirmed with DNA matching from a sample provided by his daughter. The cause and manner of death could not be ascertained.

iii. Investigation

The death was referred to the Court as Mr JT was a missing person and the cause of his death was unknown.

The inquest focussed on Mr JT's cognitive care in the months leading up to disappearance and death. An additional point of enquiry was whether or not police search and rescue procedure was appropriate. Statements from Mr JT's general practitioner, the aged care facility nursing staff and care manager and the police were obtained as well as an expert opinion from a senior geriatrician.

The police informed the court the day of his disappearance was notable for its heat and rainfall, resulting in the nearby river running high and flowing quickly. This is where his partial remains were found. Of note, when police asked the aged care facility staff about Mr JT's health, they were told he had "diabetes and a heart condition," and when specifically asking about cognition, no issues were noted.

The general practitioner at the aged care facility had not received Mr JT's medical history from his previous general practitioner despite repeated requests to the aged care facility that this be obtained. There was no correspondence regarding Mr JT's dementia diagnosis until after his final disappearance. Also, the general practitioner was not informed on the first occasion that Mr JT had left the facility.

It was not clear from the evidence how the decisions were made and endorsed that Mr JT be able to leave the facility unaccompanied. Mr JT had completed and appointed an Enduring Power of Attorney several months before entering the aged care facility.

The aged care facility staff gave a statement during the coronial inquest highlighting that he was capable of 'going to the shops and coming back' and that 'he wasn't at risk.' As such there was not a heightened level of concern. A review of the CCTV identified the time MR JT left was at 9:18 am which was not witnessed by staff. The other occasions when his absence could have been noted included at lunchtime, at the 2pm nursing handover and at 3pm did not prompt staff to check for his whereabouts. Mr JT was had been absent for 6 hours before it was discovered and a total of 7 hours before police were notified.

Expert commentary was provided by a senior geriatrician, who delineated the differences in purposeful venture from the facility, and aimless or obsessive wandering (of which, Mr JT may have displayed both). The geriatrician was not critical of his care, nor decisions to have him accommodated outside of the secure care area. The geriatrician highlighted the deleterious impact of being held in a secure care area and how important coming and going freely might have been given his reluctance to live in a facility.

"The dichotomous nature of safety and autonomy was the key opinion conveyed, and attention was then drawn to risk mitigation strategies that might be used once these competing interests are identified."

The dichotomous nature of safety and autonomy was the key opinion conveyed, and attention was then drawn to risk mitigation strategies that might be used once these competing interests are identified. Tracking devices were raised as a possibility (as it was not clear if he was using one regularly) and the support of Dementia Support Australia suggested.

iv. Coroner's Findings

The coroner was unable to determine the cause and manner of death, but noted it was possible Mr JT had a "medical emergency, fall or other accident".

The coroner deemed that the lack of medical records was a 'missed opportunity' for those caring for Mr JT.

Whilst accepting the view that Mr JT needed some freedoms, they opined that more could have been done to ensure his safety. In addition, the delays to recognising unplanned or prolonged absences were identified as an issue, and the facility systems were vulnerable (with no regular headcount, sign-out or ability to narrow down the direction he took after his departure).

The coroner noted that a compulsory report was made to the Department of Health, and a complaint was made to the Aged Care Quality and Safety commission. A finding of risk was made and the facility engaged a consultant to improve its processes (including risk assessments, improved security and head counts).

The facility was sold, the aged care licences transferred to another operator, and the corporation was dissolved three years after the disappearance. As such, the coroner did not make any recommendations.

v. Author's Comments

The clear system vulnerabilities and possible solutions proposed by the coroner, independent consultant and expert witness are highly appropriate and their consideration is consistent with a minimum standard of care, therefore I will discuss these no further.

Mr JT's tragic case has left me reflecting deeply on the importance of accurate diagnosis and communication of cognitive impairment, which the coroner alluded to but did not explore in depth. It has highlighted the importance of a universal language we use to frame clinical care. Ultimately, any number of strategies might have reduced the risk of Mr JT's eventual death, but there is inherent bias against their use if the problem at hand is not appropriately 'labelled.'

"Several opportunities were missed to acknowledge MR JT's dementia, which precluded robust risk mitigation strategies from being employed. "

Several opportunities were missed to acknowledge MR JT's dementia, which precluded robust risk mitigation strategies from being employed. Notwithstanding the coroner's opinion, failure to interpret his preferences and behavioural patterns through the lens of dementia precluded the facility from truly understanding his care needs.

It is my opinion these compounded errors contributed more than any other factor to the manner of Mr JT's death. Although some risks were identified, strategies to manage were piecemeal and the incongruent perceptions of his abilities and needs was laid bare in the inquest. In addition, this lack of a 'dementia syntax' did not allow accurate assessment of risks and his guardians, nor family, were afforded any opportunity for explicit discussions regarding his dignity of risk.

vi. Keywords

Aged care, unexplained absence, autonomy, undiagnosed dementia, supervision, delayed health information communication

Case #2
Falling short

Case Number:
COR 2021 005736, Victoria
Case Précis Author
Dr Madeline Andrews
MBBS
Advanced Trainee in Geriatric Medicine

i. Clinical Summary

Mr NV was a 92-year-old male who entered a metropolitan residential aged care facility six months ago as a permanent resident. Mr NH's past medical history included dementia with cognitive decline, recurrent falls resulting in a chronic subdural haematoma, hypertension, a permanent pacemaker and chronic kidney disease.

Prior to entering the aged care facility Mr NV lived alone at home as his wife's care needs required a move to an aged care facility. Mr NV managed at home with the support of his family and was mobilising independently with a four-wheel frame.

In late autumn, Mr NV spent a period of time as an inpatient at a small private hospital for a diagnostic and management workup of cognitive impairment with hallucinations. Within one day of discharge, he presented to major metropolitan teaching hospital acutely unwell where he was admitted and treated for aspiration pneumonia.

Approximately, two weeks later at the start of winter, Mr NV entered the same aged care facility that was caring for his wife.

Over the next four months Mr NV had six falls the third of which required a further admission to another acute care hospital for management of a head injury and rib fractures.

It was now the middle of springtime; Mr NV was joined by his family for lunch. On finishing his meal, his family assisted him back to bed for a nap. Later that day, facility care staff escorted him to the communal dining area for afternoon tea. The nursing facility reported they encouraged his participation in various lifestyle activities to maintain his social engagement and enrichment. His walker was left next to his chair.

The next time Mr NH was sighted, he was found on the floor of his bathroom, unresponsive and with an evident traumatic head injury. The registered nurse on duty attended, found he was not breathing and was unable to detect a pulse. Emergency services were contacted promptly, and Victoria Police and Ambulance Victoria paramedics attended shortly thereafter. No signs of life were identified, and Mr NV was pronounced dead at the scene.

ii. Pathology

A forensic pathologist conducted an examination of Mr NV which included a postmortem CT scan of the body and a toxicological analysis.

The cause of death was 'head and neck injuries sustained in a fall in a man with multiple co-morbidities'. The CT scan identified fractures to the left side of his head and orbit, and to the second cervical vertebra with dislocation. The toxicological analysis identified clinically indicated drugs in therapeutic concentrations.

iii. Investigation

Mr NV's death was reported to the coroner in accordance with the Coroners Act 2008, as it fulfilled criteria for a reportable death. Mr NV's daughter also filed a written request for an inquest into the death on behalf of herself and her brother, citing concerns around the care provided by care facility staff. Their concerns included:

- Their father was not adequately supervised and was able to leave the dining room unassisted.
- That their father's slow and unsteady gait should have attracted staff attention.

The focus of the coronial investigation was limited in scope 'to the circumstances in which Mr NV left the dining room returned to his room'.

Evidence was obtained from the aged care facility, the forensic pathologist and Mr NV's general practitioner.

A review of the care provided identified that on admission to the facility, Mr NV was assessed as being at a high risk for falls and was noted as requiring half-hourly observations to mitigate this risk. The assessment used the Falls Risk Assessment Tool as per guidelines, and this tool was updated through his stay. In addition, multiple falls risk reduction strategies had been implemented which were reasonable and balanced recognising his wishes and dignity of risk. The strategies included use of a sensor mat, call bell within easy reach, optimisation of footwear, gait aids and supervision for transfers, mobilising and during mealtimes.

> "Falls remains a major cause of morbidity and mortality among older adults, particularly among those who reside in aged care."

Closed Circuit Television (CCTV) footage from the aged care facility showed a period of 16 minutes in which Mr NV had managed to mobilise from the dining room to his bedroom, with neither his walker nor the assistance or supervision of staff.

The law firm representing the aged care facility responded in writing to the coroner stating:

- it was not clear on the evidence the level of supervision provided was inadequate, and that collective monitoring was performed and sufficient,
- the need for 30-minutely observations did not extend to one-on-one care, or to monitoring of his every entrance to or exit from the dining room,
- the cause of death was likely due to natural causes.

iv. Coroner's Findings

The coroner made several findings and one recommendation.

First, the falls prevention policies and mitigation strategies were appropriate and balanced. The coroner acknowledged the aged care facility had made appropriate assessments and changes to Mr NV's management to reduce the risk as much as possible. The coroner also specified that supervision during mealtimes and 30-minutely observations could overlap and could be collective (not necessarily one-on-one).

Second, that Mr NV was not adequately supervised by staff during his afternoon tea on the day of his death. It was determined that an adequate level of collective supervision would have allowed for staff to detect Mr NV mobilising unaided and unsupervised and potentially enabled them to intervene. The coroner stated that even if adequate supervision had been provided, it may not have prevented the death as Mr NV remained at a high risk of falls and serious injuries due to his underlying health and comorbidities.

Third, that no evidence had been provided to challenge the forensic pathologist's opinion as to the cause of death.

The coroner made one recommendation. That the aged care facility 'review its staffing arrangements in its dining rooms to ensure that there is adequate supervision of residents during mealtimes.'

v. Author's Comments

Falls remains a major cause of morbidity and mortality among older adults, particularly among those who reside in aged care.[1] The causes of falls are numerous, stemming from a combination of intrinsic (e.g., cognitive impairment) and extrinsic (e.g., environmental) factors only some are modifiable.

Mr NV had multiple risk factors for falls including impulsivity and poor safety awareness in context of cognitive impairment, as well an unsteady gait requiring the use of a 4-wheel frame. The list of prescribed medications was not available in the finding however these were noted to be at therapeutic concentrations in the post-mortem toxicology report. It is well understood that medications may cause falls due to overdosing or when it is in a toxic range. Less well understood is that medications may contribute to an increased risk of falls even when in the therapeutic range. Examples include benzodiazepines, antipsychotics and antidepressants

cause impaired balance and reflexes when taken at the appropriate dose.

Other common risk factors for falls in those living in aged care facilities include persons requiring assistance with dressing and personal care, insomnia, depression, vertigo, poor balance, use of centrally-acting medications (antidepressants, benzodiazepines, antipsychotics and anxiolytics), polypharmacy and sensory problems (hearing, vision, sensation).[1]

Older adults in residential aged care are also at high risk of injury from falls, exceeding that of their community counterparts.[2] Fractures are the most common type of injury and often lead to poor outcomes.[3] Older persons living in care facilities are more likely to be diagnosed with osteoporosis but are far less likely to undergo bone mineral density testing or receive treatment.[4]

Multimodal interventions are cited as the most effective means of reducing the risk of falls.[5] While supervision does reduce risk, it is not sufficient alone and it is highly dependent on adequate staffing, which is an ongoing issue plaguing the aged care sector.[6]

Exercise (particularly balance and weight-bearing exercise) has been shown to significantly reduce risk, as well as improve bone health and consequently the risk of fracture. However, consistent access to physiotherapists, exercise therapists or community exercise programs remains highly variable among residential aged care facilities, and even amongst residents of same facility.[5]

Addressing bone health, ensuring adequate staffing and consistent access to evidence-based exercise programs remain critical areas of focus in the pursuit of reducing falls in our older persons living in care.

vi. References

1. Incidence and Risk Factors of Falls Among Older People in Nursing Homes: Systematic Review and Meta-Analysis - PubMed
Shao L, Shi Y, Xie XY, Wang Z, Wang ZA, Zhang JE. Incidence and Risk Factors of Falls Among Older People in Nursing Homes: Systematic Review and Meta-Analysis. J Am Med Dir Assoc. 2023 Nov;24(11):1708-1717. doi: 10.1016/j.jamda.2023.06.002. Epub 2023 Jul 8. PMID: 37433427.

2. Treatment for osteoporosis in Australian residential aged care facilities: consensus recommendations for fracture prevention - Duque - 2010 - Medical Journal of Australia - Wiley Online Library
Duque, G., Close, J.J., de Jager, J.P., Ebeling, P.R., Inderjeeth, C., Lord, S., McLachlan, A.J., Reid, I.R., Troen, B.R. and Sambrook, P.N. (2010), Treatment for osteoporosis in Australian residential aged care facilities: consensus recommendations for fracture prevention. Medical Journal of Australia, 193: 173-179. https://doi.org/10.5694/j.1326-5377.2010.tb03839.x

3. Injury in Australia: Falls - Australian Institute of Health and Welfare
Falls. Australian Institute of Health and Welfare, 24 June 2025, https://www.aihw.gov.au/reports/injury/falls

4. Osteoporosis Diagnosis and Management in Long-Term Care Facility - ScienceDirect
Erwin A. Aguilar, Sean D. Barry, Charles A. Cefalu, Abir Abdo, William P. Hudson, James S. Campbell, Thomas M. Reske, Machaon Bonafede, Kathleen Wilson, Bradley S. Stolshek, Carly J. Paoli, Nguyet Tran, Lung-I Cheng, Osteoporosis Diagnosis and Management in Long-Term Care Facility, The American Journal of the Medical Sciences, Volume 350, Issue 5, 2015, Pages 357-363, ISSN 0002-9629, https://doi.org/10.1097/MAJ.0000000000000562.

5. ACSQHC Preventing falls and harm from falls in older people: best practice guidelines for Australian Residential Aged Care Services
Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Residential Aged Care Services. Australian Commission on Safety and Quality in Health Care. 26 June 2025, Sydney; ACSQHC, 2025.

6. Aged Care Royal Commission Final Report: Care, Dignity and Respect Volume 2
Final Report: Care, Dignity and Respect: Volume 2 - The current system. Royal Commission into Aged Care Quality and Safety. 1 March 2021, https://www.royalcommission.gov.au/aged-care/final-report

vi. Keywords

Aged care, Falls prevention, Supervision, Osteoporosis, Fractures

List of Resources

Acknowledgements

This initiative has been made possible by the voluntary contributions of the authors and editors in collaboration with 'The Communiques Australia Inc'.