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Editorial

Welcome to the final issue of the Residential Aged Care Communiqué for 2026. This edition revisits the clinical challenges of diagnosing and managing pressure injuries presented in the May 2026 issue of the Residential Aged Care Communiqué. The previous edition included a case of a resident who died from sepsis secondary to infected pressure wounds to examine the provision of care through the lens of decision-making capacity. The first case in this issue explores the familiar technical clinical aspects of managing pressure injuries and the second introduces the concept of terminal ulcers.

These cases are an opportunity to reflect on how the evolution of health care impacts on our perspective on pressure injuries in aged care settings. Pressure injuries, bed sores or decubitus ulcers have long been recognised. The issue became prominent in the second half of the 20th century when institutional care for older people or nursing homes was established. Initially pressure injuries were considered a sign of poor nursing care. A better understanding of the pathophysiological changes of ageing introduced the concept of inherent risks of pressure injury due to the person's health status.

The advent of safety science and systems thinking led to pressure injury rates being used as indicators of an organisation's quality-of-care with attention being directed to improving resources to prevent these injuries. The ageing population with an increased number of frail older people living with dementia has led to reassessing the possible causes of pressure injury. A new category of pressure injury, a 'terminal wound' has emerged—this is unavoidable tissue breakdown due to multiorgan failure which cannot be prevented despite optimal clinical practice.

Pressure injury management requires an understanding of two contrasting ideas. The first is well known—pressure injuries causing death were described as 'decubitus ominosus'. The second is not well known—dying from multiorgan failure causes pressure injuries described as terminal wounds. Optimal care for the older person requires health professionals in aged care settings to understand these differences.

We are fortunate to have two expert commentaries that give uniques insights into the topics. Shannon Xu a nurse practitioner in aged care and Associate Professor Barbara Hayes an academic in palliative care medicine.

CONTENTS

2. Editorial

3. **Case #1**
Missed opportunities

6. **Case #2**
Skin failure

8. **Commentary**
Terminal Wounds: Seeing the big picture

10. **Commentary**
Wound Communication

12. List of resources

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:
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Case #1
Missed opportunities

Case Number:
QLD 2022/875

Case Précis Author:
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Australian Centre for Evidence Based Aged Care, La Trobe University.

i. Clinical Summary

Ms MH was a 98-year-old female who entered a regional residential aged care facility as a permanent resident two years ago. Past medical history includes dementia, multiple deep venous thromboses requiring lifelong anticoagulation with warfarin, diabetes mellitus, chronic kidney disease, gout, atrial fibrillation and bronchiectasis. Functionally Ms MH required assistance with toileting and personal activities of daily living.

Around the start of a new year, Ms MH developed a poor oral intake associated with a loss of weight, repeatedly stated that she wanted to be left alone to die and frequently declined to adhere to her prescribed medications.



Over a period of three weeks, the aged care staff commenced a food and fluid monitoring chart, completed a referral for a dietitian's assessment and met with her family. Her general practitioner completed a clinical review determining the changes were related to progression of dementia and increased the dose of a prescribed antidepressant.

During this same period a Stage 2 pressure injury was detected prompting the initiation of a wound care program which included encouraging Ms MH to spend less time sitting, second hourly repositioning and an occupational therapy review which recommended pressure-relieving devices for chair and bed. Despite these interventions, over a two-week period, the wound became black and necrotic.

To complicate matters, Ms MH had three falls over a three-day period, with increased levels of confusion, agitation and incontinence. The ambulance service was contacted to transfer Ms MH to an acute care hospital when the laboratory alerted staff that the result of the blood test to monitor her warfarin dose, the International Normalized Ratio level was 8.4 (normal range is 0.8—1.0; therapeutic range is 2.0—3.5; risk of spontaneous bleeding range is 4.5—9.0).

Ms MH was confused with a tachycardia (heart rate 130 beats per minute), tachypnoea and febrile with temperature of 39.4 Celsius. On arrival at the emergency department the presence of a large, necrotic, foul-smelling, infected sacral pressure injury was noted. Laboratory tests revealed her International Normalized Ratio level was >10, C-reactive protein 318 mg/L (normal <5—10 mg/L) and blood lactate 5.4 mmol/l (0.5—2.2 mmol/L), blood cultures were also taken. Imaging studies of the brain did not reveal any acute intracranial pathology.

Ms MH was diagnosed with septic shock and initially managed with fluid resuscitation and administered broad-spectrum antibiotics intravenously. Due to continued rapid deterioration care was transitioned to comfort measures following discussion with the family. Ms MH died shortly afterwards.



ii. Pathology

A forensic pathologist completed an autopsy noting the presence of a 6cm black, dried pressure ulcer to the sacrum with cavitation to a depth of 50mm involving fat, muscle, and bone (with early abscess formation and osteomyelitis). Culture of the sacral tissue grew mixed anaerobic bacteria along with Streptococcus mitis, the same organism found in the antemortem blood cultures. The cause of death was 'sepsis due to sacral pressure ulcer complicated by osteomyelitis against a background of dementia, frailty, cardiac amyloidosis, type 2 diabetes mellitus, chronic kidney disease and Factor V Leiden mutation (warfarin therapy)'.

iii. Investigation

The death was reported to the coroner due to concerns about the adequacy of pressure area management at the aged care facility. The family had expressed multiple concerns about the care prior to the hospital transfer some of which included staff had downplayed the seriousness of her illness; poor communication between staff and the general practitioner; staff did not act quickly enough; and staff did not seem to be equipped to manage with the increasing care needs.



The coroner obtained a preliminary independent clinical review from a medical practitioner asking if there was a missed opportunity to recognise and respond to Ms MH's clinical deterioration.

The clinical reviewer advised that wound healing was difficult due to poor mobility and poor nutrition and wound care was challenging due to intermittent resistance to care and ongoing faecal incontinence. The clinical reviewer considered that increased general practitioner involvement would have been desirable. Perhaps earlier antibiotic treatment and wound debridement may have altered the short-term outcome or that an alternative path with active palliation could have been considered.

The coroner notified the Aged Care Quality and Safety Commission. The Aged Care Quality and Safety Commission completed a regulatory review which included an evaluation by their Clinical Unit. This resulted in a number of findings, some of which included

1. Inadequate or inaccurate assessment of care needs including the assessment of pressure injury risk using an evidence-based assessment tool (such as Braden or Waterlow assessment). Poor documentation practices with the wound care charting, progress notes and incident reporting.

2. The use of inappropriate pressure injury prevention strategies and the inadequate implementation of strategies to prevent the development of pressure injuries as a result of poor care planning documentation practices. For example, the use of a 'donut' cushion when sitting is not recommended as it creates pressure. Also, it was not clear that the recommendations of the occupational therapist were implemented.

> **"The contributing system factors included a lack of skills and knowledge and clinical oversight by the registered nursing staff."**

3. Lack of staff skills and knowledge of pressure injury prevention, staging and the management of wounds including the assessment and management of wound related pain. Specifically, given the nature of the wound and Ms MH's comorbidities, more frequent regular reviews were required including assessment for pain.

4. Failure to recognise and escalate changes in the condition of Ms MH's skin integrity in a timely manner; a lack of clinical oversight of the care being provided and a failure to recognise that changed behaviours such as 'refusal of care' are indications of unmet care needs in people living with dementia.

5. The coroner noted the regulatory response by the Aged Care Quality and Safety Commission included an unannounced assessment of the facility finding non-compliance with the standard for human resources and that the facility had submitted a Continuous Improvement Plan to address the matter.

iv. Coroner's Findings

The coroner found that Ms MH died from complications of a sacral pressure ulcer which had not been managed appropriately. The contributing system factors included a lack of skills and knowledge and clinical oversight by the registered nursing staff.

The coroner stated the circumstances in which Ms MH died have been closely examined by the Aged Care Quality and Safety Commission. Noting the 'systemic care deficits which led to multiple missed opportunities' to have mitigated the risk of developing a pressure injury and 'once it developed, to take appropriate timely measures to manage its progressive deterioration.'

The coroner did not make any recommendations.

v. Keywords

Health care related death; residential aged care; skin integrity; pressure area risk assessment; pressure injury prevention, staging and management; wound care documentation; management of wound related pain; failure to recognise and respond to clinical deterioration; unmet care needs in people living with dementia.

Case #2
Skin failure

Case Number:
QLD 2025/4332

Case Précis Author:
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i. Clinical Summary

Mr B was a frail 86-year-old male who was a permanent resident at a regional aged care facility. Past medical history included Alzheimer's dementia with severe cognitive impairment, Parkinson's disease, hypertension, heart failure, osteoarthritis and benign prostatic hyperplasia. Mr B had substantially impaired functional status being immobile (bed or chair bound)—requiring a hoist for transfers and regular repositioning in bed and dual incontinence.

In late summer, a dietitian assessed Mr B due to ongoing loss of weight which was considered to be due to poor oral intake. Mr B continued to lose weight over the next six months despite staff's attempts to encourage food intake and dropped over 6 kg.

Towards the end of winter, nursing staff noted the presence of a left buttock Stage 1 pressure injury. The area was photographed, cleaned, dressed, and a wound management plan commenced. A week later it was noted Mr B had a Stage 1 pressure injury on the left heel.

Three days later, a Stage 1 pressure injury on the right heel had developed. At this time Mr B was having little oral intake and declined medications.



Mr B's sacral pressure injury deteriorated substantially over the next two weeks developing into a malodourous Stage 4 wound that appeared infected and sloughy. Mr B's general practitioner requested a wound swab and Mr B's son was informed about the sacral pressure injury and management plan.

A day or so later Mr B became drowsy, hypotensive with a blood pressure of 85/61 mmHg, tachycardic with a heart rate of 116 beats per minute, tachypnoeic with a respiratory rate of 28 breaths per minute and oxygen saturations on room air was 90%; temperature of 37.1 Celsius. Mr B's son was notified and requested his father be transferred to an acute care hospital.

At the hospital staff made a diagnosis of septic shock with the source of infection suspected to be the sacral pressure injury. After discussion with Mr B's son, he was admitted to hospital for palliative care and died within two days.

ii. Pathology

An autopsy by a forensic pathologist including a whole-body CT scan revealed a Stage 4 sacral pressure injury 9.7cm wide, 12cm long, and 4cm deep, a right heel pressure injury measured 5.5cm wide and 3cm long, and the left heel had two injuries. The cause of death was septic shock due to severe pressure injuries, Alzheimer's dementia with severe cognitive impairment, probable aspiration, congestive cardiac failure, immobilisation, hyperlipidaemia, hypertension, Parkinson's disease and severe frailty.



iii. Investigation

The death was reported by medical staff from the regional acute care hospital due to concerns about the sacral pressure injury and Mr B's son who questioned the quality of care provided by the aged care facility.

The coroner's investigation obtained information from the aged care facility staff, the general practitioner, the Aged Care Quality and Safety Commission (ACQSC) and an independent opinion from a palliative care physician who provides care for older persons in residential aged care settings.

The aged care facility staff explained to the coroner the pressure injury was not reported to the regulator (ACQSC) due to advice that this was not required. Following Mr B's death staff were provided with refresher training on wound management.

> **"The expert explained that some wounds or pressure injuries arise as a result of a dying process, and these will not heal despite optimal care."**

The aged care facility staff explained Mr B's son was informed of the pressure injury and regularly updated; this often took the form of leaving messages on his phone. The general practitioner stated that he saw Mr B about three weeks before he died when the pressure injury was at Stage 1 and that he was unaware that it had developed into a Stage 4 pressure injury. The general practitioner explained he did not have the opportunity to speak to Mr B's son despite asking for face-to-face meetings and leaving messages with nursing staff for Mr B.

Aged Care Quality and Safety Commission advised the coroner about the aged care facility approved providers' legislative responsibilities including the need for clinical governance and adhering to best practice with wound management. The coroner noted that inadequate wound management is a common clinical complaint received by the ACQSC and outlined multiple areas of suboptimal practice. These included the failure to document adequately, to reassess and review, to update plans, to document goals of wound care, to manage pain, and to escalate concerns to the general practitioner.

The expert opined that Mr B's death was inevitable as a result of multiorgan failure due to neurological failure with the underlying cause being dementia. That the care provided by the aged care facility staff was appropriate and the pressure injury was likely inevitable and always untreatable. Based on the documentation available to the expert it appeared the aged care facility staff did not recognise Mr B was dying. The expert opined that Mr B would have been able to receive the end-of-life care at the aged care facility and die comfortably without causing additional family distress.

The expert explained that some wounds or pressure injuries arise as a result of a dying process, and these will not heal despite optimal care. The expert noted this clinical scenario remained unrecognized by the Australian Commission on Safety and Quality in Healthcare. The expert stated that 'Mr B's sons' grief was complicated by an implicit assumption that a pressure area equals poor care'; that an open discussion with the family around the dying process in persons with dementia and occurrence of pressure injuries would have been helpful.

iv. Coroner's Findings

The coroner deemed the cause of death was Multiorgan failure due to neurological failure due to his underlying Alzheimer's dementia.

The coroner accepted that when Mr B developed his pressure injuries it was very unlikely the situation was retrievable. Mr B's condition had been deteriorating with loss of weight, malnutrition and multiple comorbidities—that no amount of wound care or interventions would have changed the outcome. The expert considered the pressure injury was a 'terminal wound' a term or concept that is relatively new to aged care.

The coroner provided a copy of the findings to multiple agencies including the Royal Australian College of General Practitioners, the Aged Care Quality and Safety Commission, and the Australian Commission on Safety and Quality in Health Care. The coroner encouraged:

a. the development of guidelines for the management of pressure injuries which differentiate between a retrievable/ treatable wound as distinct from a wound that becomes irretrievable or 'terminal'

b. Initiatives to improve the management of residents with irretrievable pressure injuries so the person is able to die with comfort, dignity, and respect.

v. Keywords

Pressure Injuries; Pressure Care Management; Terminal Wounds; Palliative Care; Residential Aged Care Facility.

Commentary

Terminal Wounds: Seeing the big picture

A/Prof Barbara Hayes FAChPM, PhD

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The case of Mr B and coroner's findings highlight a challenge when caring for a person with advanced dementia approaching the end of their life; that of how to manage pressure injuries, and other comorbidities. The term, terminal wounds, is being used in some settings to describe these skin breaks that occur in a person who is imminently dying.

Dementia is currently an incurable and progressive condition that results in death. This is due to ongoing loss of brain function that controls many functions other than cognition. As well as cognitive impairment, it results in reduced mobility, muscle strength, swallowing, interest in eating and drinking, and increased incontinence. The person's body wears out physically as well as cognitively. The pattern of decline is determined by the type of dementia, but all have the same end: death.

We once thought we might be able to slow this physical decline by increasing nutrition via medical means, such as a nasogastric tube or PEG (percutaneous endoscopic gastrostomy). The evidence showed otherwise.[1] Additional nutrition did not change the course of dementia, and it increased the risk of aspiration. Reduced nutrition is a consequence of dementia progression; not the cause of the dementia progression. Minimal oral intake of fluid, food and medication is a sign that death is approaching, along with increased sleeping, reduced awareness and interaction with others, and delirium. Development of persistent pressure ulcers can also be a sign. In advanced dementia, the causes of pressure ulcers are poor nutrition, declining mobility and loss of tissue beneath the skin – all of which worsen close to death. Pressure ulcers may develop despite high-quality pressure care, because of these underlying factors.



When a person is dying from dementia, or other chronic conditions, comorbidities need to be managed with good palliative care. Reversing the comorbidity may be possible but, if not, the aim should be to minimise the progression and ensure that symptoms are well-managed. Sometimes, circumstances restrict ideal pressure care. A painful fracture on one side of the body will limit the options for positioning. Dementia also increases infection risk.[2] It is not a failure that a person dies with a pressure area, if the preventative care has been done as well as the circumstances permit, and symptoms and suffering were well-managed. Pressure areas that can't be prevented or healed, may well be a sign of impending death; a consequence of the decline but not the cause of the decline.

"Diagnosing dying is critically important because when a person is dying, all care should be focussed on comfort, rather than restoring health."

We need to step back and look at the person's overall condition *(the big picture)*, rather than seeing them just as a list of problems to be managed. This is not unique to people with dementia, but the very gradual decline of dementia can make it difficult to recognise when the person is reaching the end of their life. Diagnosing dying is critically important because when a person is dying, all care should be focussed on comfort, rather than restoring health. When treating to make a person well, interventions that are uncomfortable may be justifiable. When a person is dying, non-beneficial interventions that cause discomfort should be avoided. Eating/drinking is for pleasure only. Additionally, it is also important to treat symptoms with appropriate regular and PRN medications.

This includes treatment of painful pressure areas.

We need to look at the whole person and not just their parts, to recognise dying and manage it optimally. We also need to communicate this to families.

References

1. Gillick MR. Rethinking the role of tube feeding in patients with advanced dementia. N Engl J Med. 2000;342(3):206-10.

2. Sepsis Alliance. Sepsis and dementia [Internet]. 2026 [cited 2026 Oct 14]. Available from: https://www.sepsis.org/sepsisand/dementia/

Commentary
Wound Communication

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Wound care is more than applying a dressing or completing a task. Assessment should consider not only the wound itself, but also the resident's pain, mobility, behaviour, continence, overall condition and response to care.

A key challenge in residential aged care is maintaining continuity of clinical information and ensuring changes in a resident's condition are recognised, reported and escalated appropriately. The aged care home's Registered Nurses (RNs) and Enrolled Nurses (ENs) are usually managing multiple residents and it is not possible to observe every aspect of care a resident receives. Nursing staff rely on the care workers who spend the most time with residents and are often the first to notice changes during personal care, wound dressing changes, repositioning or mobilisation.



Clinical communication and continuity of care require a stable team which is difficult to achieve with regular staff turnover and the use of casual or agency staff leading to additional gaps in care.

While general practitioners (GPs), nurse practitioners (NPs) and wound clinical nurse consultants (Wound CNCs) are making the decisions about the care plan, they are often not present during wound care or mobilisation. It's at these times of activity that changes in pain, behaviour or wound appearance are most noticeable. As a result, clinical decision-making relies heavily on what the care staff observe, document and communicate on a daily basis. For example, a note stating "please review wound" in a GP/NP communication book does not explain what has changed or why a review is required.

Nurses should be prepared to communicate why a review is required and to specify what changed and when as well as details about the wound pain, any new triggers, how it is affecting care and mobility. Details such as what interventions have already been tried, and how the resident and the wound responded help avoid repeating interventions that have failed. Providing the GP or NP with this level of detailed, accurate clinical information is essential as often they will not have observed the resident during dressing changes or mobilisation.

Clinical processes should not rely on one experienced nurse who knows the resident well, instead a clear escalation pathway is essential to guide care staff. This guide addresses what should be reported to the RN, when a planned review by a GP, NP or Wound CNC is required and situations where an unplanned and urgent escalation is needed. The information needs to be documented clearly so that any clinician reviewing the resident understands what changed, what actions were taken, outcome of those actions, and what further assessment or interventions are required.



In Ms MH's case, the pressure injury did not deteriorate in isolation; her overall health changed with evidence of increasing confusion, agitation, resistance to care, recurrent falls and worsening incontinence. These changes should have been considered collectively as potential indicators of deterioration and unmet care needs.

For people living with dementia, pain can easily be misinterpreted as a Behavioural and Psychological Symptoms of Dementia (BPSD). Cognitive and communication impairment may make it difficult for a resident to recognise, localise or verbally express pain. Instead, pain may present through agitation, calling out, guarding, withdrawal, reduced mobility or resistance to care. A new or noticeable change in behaviour should therefore prompt consideration of pain as an underlying cause, particularly when the behaviours occur during wound care, repositioning or mobilisation.

Pain during wound care or mobilisation is vital clinical information.

“Pain should be viewed as information that may signal a change in the resident’s condition or their care needs—it should not be viewed simply as a symptom to treat with analgesia.”

It may indicate wound deterioration, infection, ongoing pressure, an uncomfortable dressing, positioning-related pain or another clinical issue. Pain should be viewed as information that may signal a change in the resident’s condition or their care needs—it should not be viewed simply as a symptom to treat with analgesia.

Pain management is also more than administering analgesia or completing a pain chart. Nurses should consider when the pain occurs, what triggers it, whether analgesia or other comfort measures are required before, during and after wound care, repositioning or mobilisation. New, persistent or increasing pain, particularly when it affects mobility, wound care or a resident’s ability to tolerate care, should prompt reassessment and appropriate escalation to the GP, NP or Wound CNC.

A practical wound management process should support a clear flow and cycle
Observe →Report → Assess → Treat → Escalate → Document → Review

List of Resources

1. Pressure injuries Standardised care process. Available at https://www.health.vic.gov.au/sites/default/files/2022-12/standardise-care-pressure-injuries.PDF

2. Pressure Injuries: The International Guideline (2026). The 4th edition of The International Guideline provides evidence-based recommendations for preventing and treating pressure injuries, implementation advice, and a quality audit guide with 20 indicators. The electronic version is free to download. Available at: https://www.internationalguideline.com/the-international-guideline

3. Holloway S, Ahmajärvi K, Frescos N, Jenkins S, Oropallo A, Slezáková S, Pokorná A. Holistic Management of Wound-Related Pain. J Wound Management, 2024;25(1 Sup1). S1-S84. DOI 10.35279/jowm2024.25.01.sup01

4. Gethin G, Kottner J, Lamza A, Meaume S, Megal C, Conde Montero E, Rawlinson F, Ryan H, Probst S. Palliative wound care. Recommendations of the management of wound-related symptoms. J Wound Management, 2025;26(1 Sup1):S1-S40. DOI: 10.35279/jowm2025.26.01.sup01

5. La Trobe University's Australian Centre for Evidence Based Aged Care (ACEBAC) 'A palliative response to care'. Available at: https://shortcourses.latrobe.edu.au/aged-care-education-and-training-acet
   This a free online, modular aged care education and training course designed specifically for staff in residential aged care settings. The module features engaging content, activities, case studies, and quizzes.

6. Saguatti I, Baldessarini R, Caleffi D, Cannizzaro D, Ferri P. Terminal ulcers in end-of-life care: a scoping review. BMC Palliative Care. 2026;25(1):52. doi:10.1186/s12904-026-02000-8.
   This recent review summarises terminology, diagnostic criteria, causes, prevention and management of terminal ulcers.

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