Chapter 1

Introduction

> I witnessed so much bad culture in the place that was absolutely disgusting. It was disgusting. I would often think, 'Animals are treated better than these poor people.'[1]

1.1 This inquiry was established to review the effectiveness of aged care frameworks in ensuring vulnerable aged Australians receive quality care and are protected from abuse, with a focus in the first instance on the critical care failures in the Makk and McLeay wards of the Oakden Older Persons Mental Health Facility[2] (Oakden) in South Australia (SA). This facility has been the subject of a number of investigations, some of which are ongoing.

1.2 During the course of this inquiry, the Senate Community Affairs References Committee (committee) heard many personal accounts from family members regarding the poor care given to residents of Oakden. The committee is deeply concerned with the nature of the evidence presented to this inquiry which detailed the sub-standard, and in some cases abusive, treatment of highly vulnerable older Australians with cognitive or mental health impairments.

1.3 The committee is further concerned with evidence which points to systemic issues that negatively impact the quality of aged care services, not only at Oakden but throughout Australia.

1.4 This interim report is focused on the abject failures of the systems designed to provide oversight of care standards at Oakden. The committee's broader concerns regarding aged care quality frameworks, which the committee considers require review and consideration, are also outlined in this interim report.

Overview

1.5 In February 2016, Mr Bob Spriggs, a resident of Oakden, was admitted to the Royal Adelaide Hospital Emergency Department with unexplained significant bruising to his hip, a chest infection and severe dehydration. In June 2016, the Spriggs family made a complaint to the Principal Community Visitor (SA) who raised concerns with the Northern Adelaide Local Health Network (NALHN). After repeated unsuccessful attempts over four months to seek a response from NALHN and the Office of the Chief Psychiatrist (SA) regarding the complaint, the Principal

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1 Ms Deanna Stojanovic, Family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 71.

2 The Oakden Older Persons Mental Health Facility (Oakden) is comprised of three wards. The Makk and McLeay wards are long term Commonwealth subsidised Residential Aged Care for older people with neurocognitive disorders with severe and extreme behavioural and psychosocial symptoms of dementia (BPSD). The Clements ward provides transitional care for older people with complex, severe and enduring mental illness, while their clinical presentation is stabilised and appropriate longer term care options are identified.

Community Visitor noted the inaction in his annual report which was sent to the SA Minister for Mental Health and Substance Abuse (SA Minister) on 30 September 2016. The Principal Community Visitor also wrote to the SA Minister on 14 October 2016 to formally request a review of service delivery at Oakden and that NALHN meet with the Spriggs family regarding their complaint. The annual report was tabled in the SA Parliament on 7 December 2016 and generated media interest for the issues it contained. Subsequently, the Chief Executive Officer (CEO) of NALHN agreed to meet with the Spriggs family in December 2016 and after this meeting requested the Chief Psychiatrist undertake a review into Oakden.[3]

1.6 The Chief Psychiatrist's review *Oakden Report – Report of the Oakden Review* (Oakden report) was highly critical of the services provided at Oakden and found 'a system that gave all members of the Review little comfort. For each of us, we saw aspects of a mental health system that we had thought confined to history.'[4]

1.7 The Chief Psychiatrist made six recommendations regarding the quality and provision of clinical care at Oakden in his review, and ultimately recommended the facility be closed. The SA Government undertook to implement all six recommendations and subsequently decommissioned the Makk and McLeay wards at Oakden and relocated all residents into the Northgate Aged Care facility and the residential aged care sector.[5]

1.8 In order to implement the six recommendations of the Oakden Report, the SA Government established the Oakden Response Plan Oversight Committee and is providing $14.7 million to construct a new facility for older persons with mental health issues. This amount includes $1 million to develop a new contemporary model of care as recommended in the Oakden report.[6]

1.9 The Australian Government also took action in response to the incidents at Oakden. On 1 May 2017, the Federal Aged Care Minister, the Hon. Ken Wyatt AM MP, announced a review into aged care quality regulatory processes to be conducted by Ms Kate Carnell AO and Professor Ron Paterson ONZM.[7] The review's report, *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson

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3 Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian (SA) Government), *Oakden Report – Report of the Oakden Review* (*Oakden report*), April 2017, p. 1, Mr Maurice Corcoran, Principal Community Visitor, *Committee Hansard*, 21 November 2017, p. 25-28, Principal Community Visitor, *Annual Report, Mental health Services 2015-16* and Mr Maurice Corcoran, *Letter to The Hon Leesa Vlahos MP, Minister for Mental Health and Substance Abuse, 14 October 2016*, (tabled 21 November 2017).

4 *Oakden report*, p. 115.

5 SA Government, *Submission 28*, p. 3.

6 SA Government, *Submission 28*, p. 3.

7 The Hon. Ken Wyatt AM, MP, Minister for Aged Care, 'Federal Aged Care Minister to Commission Review of Aged Care Quality Regulatory Processes ', Media Release 1 May 2017 and 'Appointment of Panel to review National Aged Care Quality Regulatory Processes', Media Release 11 May 2017.

review), was published in October 2017 and made ten recommendations.[8] The Australian Government immediately moved to implement recommendation 8, unannounced audit visits, while it considered the entire review in detail, a process still underway at the time of drafting this interim report.[9] It is expected that a response to the other recommendations of the review will be included in the 2018–19 Federal Budget.[10]

1.10 The Australian Aged Care Quality Agency (Quality Agency) also took action, commissioning Nous Group to undertake a review of Quality Agency accreditation and quality monitoring processes. The Nous Group report was released on 31 July 2017 and made four key recommendations, each with short term and long term steps to improve Quality Agency processes.[11] The Quality Agency accepted all recommendations, and moved immediately to implement key recommendations such as revising their risk framework and expanding their case management. A small number of recommendations were referred to the Department of Health (Australian Government) or the Aged Care Regulation Review for further consideration.[12]

1.11 A more detailed discussion of the responses of the SA and Australian Governments to the systemic failures of relevant aged care oversight frameworks is contained in Chapter 3.

Key events

1.12 The following table provides a summary of the key events in the history of service delivery at Oakden.

8 Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report*, October 2017, pp. xi-xiii.

9 The Hon. Ken Wyatt AM, MP, Minister for Aged Care, 'Quality review released: Aged care assessment visits to be unannounced', Media Release 25 October 2017.

10 Ms Catherine Rule, First Assistant Secretary, Department of Health, *Committee Hansard*, 5 February 2018, pp. 17, 20.

11 Nous Group, *External independent advice: Australian Aged Care Quality Agency*, 31 July 2017.

12 Australian Aged Care Quality Agency, *Quality Agency Response to Nous*, available at https://www.aacqa.gov.au/about-us/response-to-nous-report, accessed 3 January 2018.

Table 1.1–Timeline of Oakden

November 1982	Oakden facility opened as a psychogeriatric unit for older people with a history of mental illness. At the time of the Oakden report, the service had expanded to also cater for older people with neurocognitive disorders with severe and extreme behavioural and psychosocial symptoms of dementia (BPSD). Staff consisted of Mental Health Nurses and Enrolled Nurses (ENs) as well as other specialist and allied health staff.
1998	SA Health gained Commonwealth Quality Agency accreditation to change classification of Makk and McLeay wards from an SA Health funded mental health facility to a Commonwealth-funded Residential Aged Care Facility (RACF) – which applies lower funding per bed. Consistent with other RACFs, Personal Care Assistants were introduced and ENs encouraged to undertake medication training to allow them to perform tasks previously allocated to Registered Nurses.
1999	A series of concerns led to Acting CEO of North West Adelaide Health Service to organise an external review of the Quality of Care for Older Persons Mental Health Services at Oakden. The review made a number of recommendations about the organisation and funding of services at Oakden.
2001	Initial privatisation discussions undertaken between SA Government and a not for profit organisation.
2001–2007	During this period, Oakden was only granted Commonwealth aged care accreditation for 12 month periods (with one 2-year period). Oakden report later concluded these shorter than usual periods of accreditation should have raised attention regarding quality of care issues.
February – July 2007	Quality Agency accreditation audit of Oakden found facility failed 6 expected outcomes and recommended sanctions, which were not enacted by the Department of Health (Australian Government). Department of Health issued a notice of non-compliance for one unmet outcome.
October 2007	Quality Agency accreditation audit found Oakden met all expected outcomes.
December 2007	Failed Quality Agency accreditation audit – facility did not meet 26 of Commonwealth's 44 expected outcomes and sanctions were imposed. ACH Group entered into a joint partnership with SA Health to assist with the operations of the services.
January – April 2008	After a series of unannounced visits and audits, a non-compliance notice was issued by the Department of Health.

August 2008	Standards deemed improved and Quality Agency accreditation audit once again found Oakden met all expected outcomes. Accreditation extended to April 2009.
February 2009	Site visit conducted and Oakden found to have met all standards. Accreditation granted for another 12 months.
2010	ACH Group ended partnership and Oakden returned to the full management responsibility of SA Health local Mental Health Services with continued Commonwealth funding for Makk and McLeay wards. At that time Oakden was found by the Quality Agency to have met all 44 standards and accreditation granted for three years.
July 2011	SA Community Visitor Scheme commenced operations. Visits to Oakden began. Oakden staff reported feelings of job uncertainty over future of the facility and that many allied health service positions were left vacant for long periods when staff were on leave or resigned.
March 2013	Quality Agency grants accreditation for a further three years.
2013	Community Visitor Scheme reported four residents passed away and that a doctor at Oakden requested a visiting geriatrician for complex medical conditions but did not receive a response to this request.
May 2014	Community Visitor Scheme reported Oakden staff concerned there was not a psychologist at the facility.
July 2014	Community Visitor Scheme reported another three residents died due to pneumonia within the facility. Staff commented that the need to document use of restraints was time consuming.
2015	Community Visitor Scheme reported staff dismayed by discontinuation of funding for a social worker at the facility. Community Visitor Scheme wrote to the Executive Director of Mental Health about allied health staff levels.
13 January 2016	Mr Bob Spriggs admitted to hospital after receiving 10 times the prescribed amount of antipsychotic medication.
February 2016	Mr Spriggs referred to the Royal Adelaide Hospital Emergency Department with significant bruising to his hip for which there was no satisfactory explanation. Mr Spriggs also had a chest infection and was highly dehydrated.
February – March 2016	Quality Agency audit was conducted and accreditation granted for a further three years.

1 June 2016	Spriggs family made complaint to Principal Community Visitor.
7 June 2016	Principal Community Visitor forwarded complaint to Director of Nursing at Oakden. Reached agreement to have consumer liaison officer carry out an investigation.
9 June 2016	Principal Community Visitor forwarded complaint to Chief Psychiatrist and asked for investigation.
20 July, 25 July, 30 August, 2 September 2016	Principal Community Visitor unsuccessfully sought response from NALHN and Chief Psychiatrist on request for Oakden investigation.
September 2016	Community Visitor Scheme reported staff raised concerns there was no occupational therapist or social worker available on site.
30 September 2016	Principal Community Visitor included reference to lack of response to Spriggs' family complaint in annual report presented to Minister.
14 October 2016	Principal Community Visitor wrote to Minister regarding length of time to respond to Spriggs' family complaint and asked for a formal review of services.
November 2016	Quality Agency unannounced assessment contact visit – Oakden met all assessed expected outcomes.
7 December 2016	Principal Community Visitor annual report tabled in SA Parliament which generated media interest in issues.
Mid December 2016	CEO of NALHN met with Spriggs family.
20 December 2016	CEO of NALHN requested the Chief Psychiatrist conduct an external independent review of Oakden due to concerns about the level of clinical care being provided.
17 March 2017	Quality Agency audit – 15 of 44 standards not met – 3 sanctions were imposed and accreditation period reduced to October 2017.
20 April 2017	Chief Psychiatrist's Oakden report released containing 6 recommendations.
	SA Government response to Chief Psychiatrist's report released - accepted all 6 recommendations.
1 May 2017	Federal Aged Care Minister commissioned Carnell Paterson review.
25 May 2017	Independent Commission Against Corruption (ICAC) investigation announced into the management and delivery of services and care at Oakden. There was no specified reporting

	date.
9 May – 14 June 2017	Quality Agency made 31 audit visits, finding that 15 standards were still unmet up to the facility's closure.
14 June 2017	SA Government decommissioned Makk and McLeay wards. 14 residents relocated to Northgate Aged Care facility and 12 relocated into the residential aged care sector.
June 2017	Oakden Response Plan Oversight Committee established to provide oversight and guidance to SA Health in implementing the six recommendations outlined in the Oakden report.
July 2017	SA Health established six expert working groups to implement each of the Chief Psychiatrist's recommendations.
31 July 2017	The Nous Group report released on 31 July 2017 made four key recommendations, each with short term and long term steps to improve Quality Agency processes. The Quality Agency accepted all recommendations.
October 2017	Carnell Paterson review published. Made 10 key recommendations.
	Commonwealth Government revokes NALHN's approval as a Commonwealth-subsidised provider of aged care.

Source: SA Government, *Submission 28*; Oakden report; Carnell Paterson review; *Committee Hansard*, 21 November 2017 and 5 February 2018; Nous Group, *External independent advice: Australian Aged Care Quality Agency;* Department of Health (Australian Government), answers to questions on notice, 5 February 2018.

1.13 A full timeline of the Australian Government interactions with the Oakden facility, including audits, sanctions and various orders for compliance, for the ten years preceding the facility's closure, is included as Appendix 1 to this report.

Interim report structure

1.14 Following this introductory chapter, this report consists of three subsequent chapters:

- Chapter 2 outlines the evidence specific to incidents of poor care and abuse at Oakden;
- Chapter 3 details the responses to date from the Australian and SA Governments; and
- Chapter 4 outlines broader concerns raised beyond issues specific to Oakden, and contains the committee's conclusions and recommendations.

Conduct of inquiry

1.15 On 13 June 2017 the Senate referred this inquiry to the committee with a reporting date of 18 February 2018 and the following terms of reference:

(a) the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;

(b) the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;

(c) concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;

(d) the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;

(e) the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;

(f) the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and

(g) any related matters.[13]

1.16 To assist submitters and witnesses in focusing their evidence, the committee published the following clarification on the inquiry website:

> This inquiry was referred to the committee in response to the reported incidents in the Makk and McLeay Aged Mental Health Care Service at Oakden in South Australia, and will examine the current aged care quality assessment and accreditation framework in the context of these incidents.[14]

Submissions

1.17 The inquiry was advertised on the committee's website and the committee wrote to stakeholders inviting them to make submissions.

1.18 The committee also issued a media release to promote public awareness about ways individuals could engage with the inquiry. The media release was published on the committee's website and tweeted using the @AuSenate handle.

1.19 The committee invited submissions to be lodged by 3 August 2017. Submissions continued to be accepted after this date. The committee agreed that to

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13 *Journals of the Senate*, No. 42, 13 June 2017, pp. 1384-1385.

14 Community Affairs References Committee, *Inquiry webpage*, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality.

protect the privacy of individuals providing sensitive material, all submissions from individuals would be accepted as confidential, unless requested otherwise.

Public hearings

1.20 The committee held two public hearings, on 21 November 2017 in Adelaide and on 5 February 2018 in Canberra. The committee also held a confidential hearing in Adelaide on 22 November 2017.

Acknowledgments

1.21 The committee would like to thank all those who participated in this inquiry as submitters and witnesses. The committee would like to particularly acknowledge the family members of residents at Oakden who provided crucial evidence to the committee by revisiting very traumatic personal experiences. Without committed family members advocating for loved ones, issues such as the failure of care at Oakden would never come to light. In the words of one such family member:

> We will happily remain the Oakden families, if for one reason only, and that is to allow the state and country to never forget that their old way of treating our elderly is over. We will forever hold them to account and see a complete overhaul of the care received and expected.[15]

15 Mr Stewart Johnston, Family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 59.