Australian Government

Department of Social Services

Judge Ian L Gray
State Coroner
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Judge Gray

Thank you for your letter dated 29 September 2014 (your reference COR 2011 2017) to Mr Iain Scott, Group Manager, Aged Care Quality and Compliance, relating to the recommendations following the inquest into the death of Mrs Caterina Montalto. I am responding as the acting Group Manager of Aged Care Quality and Compliance.

Where Coroners make recommendations to the Department of Social Services either in relation to a specific case or a more general issue, the Department takes the Coroner's recommendations seriously and actively considers what action the Commonwealth can take.

The Complaints Principles (Principles) made under the *Aged Care Act 1997* (the Act) provide a mechanism for the management and resolution of complaints and other concerns about aged care services. Under these Principles, the Secretary or delegate may decide to take no further action in relation to an issue raised in a complaint if, amongst other things, the issue 'is subject to a coronial inquiry'. This is to ensure that the Department does not inadvertently interfere with investigations by police and the courts where they are the most appropriate authority to carry out these investigations. Once the Department had been informed of the involvement of the Coroner and the police, the Department took no further action under the *Aged Care Act 1997*, other than to assure the safety, health and wellbeing of the remaining residents. The Department continued to monitor the progress of the inquest with a view to taking further action as appropriate once the Coroner's findings were known.

Both the Department and the then Aged Care Standards and Accreditation Agency[1] (the Agency) have responsibilities for monitoring Commonwealth subsidised residential aged care homes to ensure approved providers comply with their obligations under the Act. The Agency conducted an unannounced visit to the service on 10 June 2011 and found that the service complied with the assessed standards. Subsequently, the Agency audited the service on 28 and 29 November 2011 and found that it met 44 of the 44 aged care accreditation standards expected outcomes.

Following receipt of the recommendations from the Coroner's inquest into the death of Mrs Caterina Montalto, the Department wrote to Arcare Pty Ltd (the approved provider), on 19 February 2014 requesting information on the actions taken by them in response to Recommendation 3.

[1] Now the Australian Aged Care Quality Agency

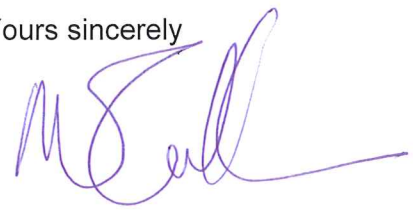
The Department was subsequently informed by Arcare that it had referred certain individuals to the Australian Health Practitioner Regulation Agency (AHPRA).

The Department considered this information, along with the outcome of the two Agency visits, and the further safety measures implemented by the approved provider contained in the Coroner's report. As a result, the Department was satisfied that appropriate actions had been taken in line with Recommendation 3 and that these were consistent with what the Department would consider in response to the Coroner's recommendation.

Under Division 86 of the Act, the Secretary or delegate may make publicly available certain information about an aged care service. However, this does not include the identity of individuals referred to AHPRA. This is 'protected information' under the Act, which it is an offence to disclose under section 86-2.

I would be happy to consider any further requests you may have in relation to this matter.

Yours sincerely



Michael Culhane
A/g Group Manager
Aged Care Quality and Compliance
14 November 2014