**Submission to the Australian Law Reform Commission on Elder Abuse**

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**Elder abuse cases**

Case 1

* 78 year old lady, lived on own, very involved in community activities in rural town, independent in all activities of daily living and cognitively intact. Past medical history of mild hypertension and gluten intolerance (coeliac disease). She had a total knee replacement with good recovery, and returned home from hospital to find that her daughter had arrived to stay with her (there had been very little contact for previous 15 years).
* Over following 8 weeks, mother lost weight, had lots of abdominal problems, withdrew from social activities. GP was concerned about a possible bowel malignancy and he admitted her to hospital where her symptoms improved considerably.
* Went home with an occupational therapist to do a discharge home visit as the daughter had not been contactable. Patient found that daughter had left and that jewellery and silverware were missing.
* On looking in the pantry cupboard, the occupational therapist found half used packet of bread improver (with gluten as its main component). Daughter appears to have been attempting to “poison” her mother.

Case 2

* 72 year old lady with early dementia. She had a stroke with marked R sided weakness, had rehabilitation, and then went to high care residential aged care facility as she required 24 hour care.
* Her husband was not happy with her care at the facility and insisted on taking her home (which she also wanted). Unfortunately he was unable to provide the level of care even with assistance of paid carers that his wife needed, and a situation of “moderate neglect” was described by service providers, who were then sacked by husband.
* Husband felt to have cognitive impairment and lack of insight into ability to care for wife.
* Daughter removed mother from residential care facility and placed her in facility close to her home and 150kms from husband.

Case 3

* 81 year old man living with his niece. Referred to aged care services by GP with the GP letter saying“…something funny is going on ….”
* Unusual bruising over chest and back, and initially patient denied anything was wrong. Eventually admitted that his niece was hitting him with telephone when he tried to use phone, and was locking him in his room.
* Niece denied anything was wrong and an application was made to the Guardianship Board for guardianship and financial management.
* An order was made, and organized for a move back to his country town to hostel care

Case 4

* 82 year old lady, lived alone till daughter and family moved in with her.
* Dtr restricted access of other family members, kept mother in her room, refused to let GP in
* Eventually her sister came on her birthday and pushed her way in
* She found her sister starved and dehydrated, and called ambulance

Case 5

* 81 year old man, in residential care due to moderately severe Alzheimer’s disease
* Tendency to occasionally shout his words rather than speaking them
* Often found to have unexplained injuries and bruising, with both staff and other residents thought to be hitting and grabbing him

Case 6

* 78 year old lady, recently moved from home to low level residential care following hospital admission with pneumonia
* Cognitively intact, but all financial affairs handled by a lifelong friend (enduring POA)
* Daughter appeared and has taken mother to a solicitor, got her to change her will, revoke the current POA and have herself appointed. She has now put house on the market and sold car
* Mother is very upset but feels powerless to do anything (“she’s my daughter and I love her”)

Case 7

* 81 year old man, son moved in with him after divorce
* Friends noticed weight loss, depression, change in personality, withdrawing from bowls and volunteering for Meals on Wheels
* Noted by GP to have bruising, depression, referred to Aged Care Team for “falls and frailty assessment and checking for elder abuse”
* Admitted to “some problems” with son when asked the 2 questions, but felt he couldn’t deny his son what he asked for
* Guardianship Tribunal application for financial management to protect this man’s finances and property (with his permission)
* Assistance with housekeeping and shopping organised, regular GP visits, friends pick him up for bowls
* All attempts to engage son unsuccessful and has recently moved away

**Further comments on Issues Paper questions**

Question 35. Education for health professionals is essential in the development of knowledge and the raising of awareness to allow for recognition of elder abuse. GPs in particular have a major role in the identification and also management of abuse cases, and staff in Emergency Departments also need the education in order to be confident in the recognition of abuse.

Question 36. All health care professionals should have some responsibility for identifying and responding to abuse. Because older people who are victims of abuse very often have health problems, there is a clear role for health care professionals, but police, solicitors, accountants, bank staff will also have a role in some situations.

Question 37. Health Justice partnerships such as the VAST (Vulnerable Adults Specialist Team) in the US and the Melbourne service are a good model for management where there are legal issues. However in many cases there may not need to be legal/justice interventions and their involvement may slow responses.

Question 38.

Question 39. An widening of the role of Guardianship Tribunals is supported as per Para 171.

Question 40. Less formality may be good, but some formality is important to stress the authority of the tribunal/court, and the seriousness of the situation.

Question 41. As suggested.

Question 42. “Vulnerable adults” may be better terminology than “elderly”

Question 43. Not sure how often these laws are used.

Question 44. Protection orders (AVOs) can be very useful to allow the abuser to remain in the home but have their behaviour restricted. Police can take these out on the older person’s behalf. The “shame” component involved in the need for a court appearance is also valuable.

Question 45. The problem with requiring abuse to be reported formally is that it will not be formally recognised by some workers so they will not to have to report it. Having a clear and simple on-referral mechanism as set out in various protocols is likely to ensure a better response.

Question 46. Only a small number of elder abuse cases require police input. Having a Vulnerable Adults Officer (as in NSW) allows police to seek advice without having to formally open an investigation and may be more acceptable to the older person.

Question 47. Having social work/welfare officer staff available is appropriate, but also staff who can physically assist a frail older person if necessary.

Question 48.

Question 49.

Question 50. If there is a lesser burden of proof for civil offences, this may be appropriate.