Submission to the Australian Law Reform Commission:
Protecting the Rights of Older Australians from Abuse

submission of: [redacted]
(daughter of a victim of "unreportable assault" in a dementia unit)

My late mother was assaulted in a dementia unit three years ago. The assault perpetrated on my mother was classified as "non-reportable", as allowed by *Section 63-1AA(3)* of the current *Aged Care Act (1997)* in conjunction with the now *Accountability Principles 2014, part 7, section 53*.
This is legalised abuse.

This submission is based on personal experience of legislation in practice, in regard to protecting older Australians from abuse. My experience is: Current legislation does not protect, it enables.

In this submission I refer to and address the Issues Paper 47 (IP 47), specifically:
Question 11: *What evidence exists of elder abuse committed in aged care, including in residential …* care settings?
Question 15 What changes to the requirements concerning quality of care in aged care should be made to improve safeguards against elder abuse?
Question 17 What changes to the requirements for reporting assaults in aged care settings should be made to improve responses to elder abuse?
Question 18 What changes to aged care complaints mechanisms should be made to improve responses to elder abuse?
Question 19 What changes to the aged care sanctions regime should be made to improve responses to elder abuse?

I am very grateful to the Commission for addressing Question 17.

My responses focus on abuse committed by other residents in residential aged care, specifically assaults exempt from mandatory reporting, and give examples from the experiences of my late mother's assault.

Because such assaults are "unreportable", we have no idea how many of these there are, nor how they are being addressed.
Aged Care Facilities are businesses; it is not in their best interests to report assaults.

Accreditation Standards include *Standard 4.4*: Safety. In terms of protection against abuse, *Standard 4.4* is paramount. Any serious discussion of protecting the rights of older Australians from abuse must necessarily include making sure that *Standard 4.4* is upheld.

My late mother was assaulted in an aged care dementia unit in Melbourne. A man punched her in the chest and tried to suffocate her with a pillow – he was pulled off her by staff. The aged care provider deemed it an "unreportable assault." There had been at least one previous "unreportable assault" with a pillow by the same man, and preventative measures were supposed to be in place. They obviously weren't working. *Standard 4.4* was breached – more than once.

I didn't know the history until after my mother was assaulted, due to privacy laws. I also was not permitted to know what measures were subsequently put in place to manage the man's behaviour, but I was expected (as part of the process – legislated as the *Complaints Principles* [then] *2011,* now *2015*) to mediate with the Facility management and to say that I was satisfied with their actions to keep my mother safe. I never was; in reality, she needed to be safe from him, and I was not

permitted to know what was being done about him. The (then) *Complaints Investigation Scheme* did know, and they were not satisfied and issued two separate *Notices of Intention to Issue Directions* (as per the *Complaints Principles*); my mother and her assailant died before there was any further action, and the case was subsequently dropped.

Having been through the process involved regarding assault in residential aged care as per the *Aged Care Act*, I am aware that in reality the legislation protects the providers and enables assault and abuse.
Although the specific conditions as per the *Act* for treating an assault as non-reportable were not met by the aged care facility, the onus to address this was on me as the family representative, rather than on the government regulatory body. Although *Accreditation Standards* were breached, in particular *Standard 4.4 – safety*, and continued to be breached, nothing much happened.
Regulation of aged care facilities is ineffectual. Actions against non-compliance and breaching of *Accreditation Standards* is inconsequential. The provider involved with my mother was audited, found to satisfy all *Accreditation Standards* and reaccredited whilst the process of non-compliance for continuing to breach *Standards* was in progress. This process has not been rectified. With new changes splitting responsibility into three bodies, it is likely to be even more difficult than before. The new *Australian Aged Care Quality Agency* is supposed to regulate and monitor aged care compliance (*Corporate Plan 2016-2020*). It is not possible to do either when assaults are not reported and are not taken into account. Whether or not providers comply with specified actions of non-reportable assaults is not able to be monitored either, since their actions are part of what is not reportable. In my mother's case, the only reason why inadequate responses and non-compliance were recognised, both in relation to my mother's assault and the previous one, was because I and the previous person's family had made complaints. The assault on my mother demonstrated failure to adequately address the previous assault as per legislation, such that it to be non-reportable.
I was then required to mediate with the provider, rather than action being taken by the regulatory body. This automatically put me in a conflict situation with the provider, and things got worse.

The actions, tone and manner in which the circumstances of my mother's assault and my mother herself as a victim of assault were addressed, constituted abuse in itself. I believe this applied to her assailant, as well. My mother was treated as a commodity, a faulty piece of equipment that disrupted the otherwise smooth running of the residential aged care machine. The recorded act of aggression against her and the very real question of the continued threat to her safety were treated by the provider as a contentious complaint by a nuisance (me), rather than an actual and serious physical attack on a demented and helpless old lady, by a demented and distressed old man who obviously was not receiving care specific to his needs.

My sister notified Victoria Police, but they said they could not act on an "unreportable" assault.

My mother died six months later of complications from injuries sustained after being found on the floor between her bed and a chair, her feet tangled in sheets up on the bed. How she got there was not witnessed. The man who had assaulted her (and others) was still in a room two doors away. The woman between them had died in the interim, after being found on the floor beside her bed, which was at its lowest setting.
Section 63-1AA of the *Aged Care Act* enabled the aged care provider to be in control of the entire process, of staff (some lost their jobs) and of my mother.
It is my experience – and that of my late mother – that *Section 63-1AA(3)* of the *Aged Care Act 1997* and the accompanying *Accountability Principles 2014, Part 7, section 53* equates to legalised abuse within aged care dementia units, and that it further denies institutionalised individuals the

fundamental rights of safety, care, empathy, compassion, protection, dignity, health and well-being, and instead enables abuse, violent assault, exploitation and neglect, and as such is a violation of basic human rights.

As the daughter of an 82 year old assault and abuse victim whose rights were not only not addressed but were denied by legislated procedures, it is my opinion that there can be no serious claim of protecting older Australians against abuse without amending the legalised abuse which is *Section 63-1AA* of the *Aged Care Act*.

I thank you for the opportunity to present the attached submission.

I have included separate files relating to the assault on my mother, which constitutes a case study. It is my belief that it is imperative to do so in order for this Commission to have an understanding of the impacts of current legislation on assault victims/ real people, such as my late mother. I am more than happy to speak to anyone concerned, and to provide additional information if requested. I have substantial records pertaining to the assault and abuse of my mum.

sincerely,

[redacted]

11/09/2016

The history

My (now deceased) mother was reportedly asleep in her bed at night 20th March 2013 in a high-care dementia unit when another resident came into her room, punched her in the chest, and pulled a pillow out from under her head and held it over her face, yelling that there was a man in his bed. A care worker was alerted by my mother calling out, and was able to reach her in time to pull him off her and prevent him from suffocating her.

The aged care provider classified this assault on my mother as "unreportable".

This incident and its consequences over the next six months (until my mother's death) provided me with extensive personal experience of what is wrong with the legislation relating to "unreportable/ non-reportable assaults" in aged care facilities.
The man who assaulted her was an 84 year old ex-army man with dementia and PTSD. Other residents were also assaulted by the same man, some before my mother, some several times; it was continued abuse within the facility. There was a history of assaulting people in their beds with fists and pillows, and of pulling people from their beds. There was also a provider policy to not report assaults. The man had had an APAT assessment following a previous attempted suffocation, and was described as delusional, paranoid, and verbally and physically aggressive and violent toward staff and other residents. His behaviour was known to be escalating. As such, remedial measures were already in place as per legislative requirements in order to treat these assaults as "unreportable"; the family of a previous assault victim had apparently put in a complaint, the then *Complaints Investigation Scheme* found these in-place remedial measures to be inadequate – since the assault on my mother had taken place – but the facility's actions continued to be inadequate, both in regard to the care of my mother and management of the behaviour of her assailant.

This submission is necessarily focussed on my mother's experiences and perspectives, as my fight was to keep her safe.

However, it has always been my contention that the system failed both my mother and her assailant. It is actually difficult to give him that label, rather than call him by his name; I knew him: he was a pleasant old gentleman. It was not his fault that he had a combat history that resulted in PTSD. As an army man and a PTSD sufferer, he was also more prone to dementia than others. Because of his experiences – and because his individual care needs were not met – he attacked other people in the dementia unit, believing them to be the enemy.

Issue

1. Aged Care – Residential Care Abuse

Question 11: *What evidence exists of elder abuse committed in aged care, including in residential … care settings?*

Answer: *Evidence of resident-on-resident assaults in dementia units is effectively hidden by the exemption of these from mandatory reporting.*

67 The ALRC is interested in evidence or case studies about elder abuse in aged care

Please see the separate files relating to the assault on my mother, which constitute a case study. These separate files do not constitute anywhere near the complete documentation which I have. Should the Commission be interested in accessing further information from me, I am very willing to oblige.

This response focuses on abuse committed by other residents in residential aged care, specifically assaults exempt from mandatory reporting.

When an assailant has a cognitive or mental impairment, assault can be excluded from mandatory reporting. This creates a problem in addressing that assault, as it's technically never occurred. There are, though, two separate parts to assault: 1. on a person (victim), and 2. by a person (assailant).
In the case of resident-on-resident assault when the assailant has a cognitive or mental impairment, assault by a person effectively renders null and void assault on a person.
Abuse on such a victim is not addressed by the current legislation.
Their care and needs as a victim of assault are not addressed as abuse. This is abuse in and of itself.
The care and safety of my mother as the victim of assault were never adequately addressed. This situation was exacerbated by the provider's insistence that details of the assault and actions consequently taken, which impacted on my mother's care, were protected by privacy laws as pertaining to the assailant and the "non-reportable" nature of the assault.
She was neglected by the provider/ facility and by the regulatory bodies as a consequence.

The assault on my mother effectively disappeared.

The provision for "non-reportable assaults" within the regulatory framework necessarily hides the evidence of them. There is no readily accessible evidence of non-reportable assaults, even though these are instances of known elder abuse on people in residential aged care. We have no idea of how many there are, and as such these are excluded from the data of elder abuse.
It is asserted that most abuse of the older population is committed by family members, based on this incomplete data set. It is my experience that this contention – and it may be correct – has a detrimental effect on families making complaints to the *Scheme*, as well as it being inherent in *The Aged Care Compliance Policy Statement 2015-2017*: It is assumed that the family is in some way suspect; it is assumed that approved providers and aged care facilities are not.
Even when a family does make a complaint, the regulatory framework itself inherently empowers providers and disempowers families.

In my own experience, it was not that my mother was the only person assaulted in her unit, it was that I put in a complaint. There were many other assaults, classified as “non-reportable”, and as such hidden from evidence of abuse within that unit.

Anecdotally, in my experiences speaking as a participant at the [redacted], on [redacted] and on [redacted] radio as part of a forum on elder abuse ([redacted]), many aged care workers and family members contacted me privately afterward to tell me of “non-reportable” assaults which have not gone through the complaints process.
The incidence of these can be expected to increase, with the current *Guide for reporting reportable assaults* (Department of Health) elaborating on the impairments rendering an assault unreportable: *“Cognitive impairment refers to declining ability in judgement, memory, learning, comprehension, reasoning and/or problem solving and can result from a number of conditions, including dementia, delirium and/or depression*” and *“(m)ental impairment includes senility, intellectual disability, mental illness, brain damage, and severe personality disorder.*” As a psychologist myself, I find these definitions very concerning.
Increases in these assaults can also realistically be expected with increasing numbers of PTSD servicemen – who also have a higher incidence of dementia.

Victoria Police were notified of the assault on our mother by my sister, but advised her that they could not intervene as the facility advised police that it was an “unreportable” assault.
A solicitor specialising in elder abuse recently advised me that this was incorrect advice based on misinterpretation of the act, and that once police were notified of the assault, they were in fact required to investigate. He regarded this confusion as the single most important reason for the necessity of my submission to this Commission.

It is important that <u>all</u> assaults, including currently non-reportable resident-on-resident assaults are made reportable so that data on them can be collected, the volume and outcomes of them can be known, and therefore we can begin to address them as abuse.

Aged Care – Residential Care Abuse Q11

Example 1: March 2013, police notified, police advised they could not take action
21st March, 2013: 10.15-10.30pm: My sister (NSW) phoned Vic police to report assault. Police officer expressed concern but assailant is of diminished capacity. Officer phoned [facility] & advised that Police were concerned. Police suggestion to [facility]: 15 minute obs be put in place on [the man] – is now more than 24 hours since assault

Example 2: April 2013, meeting with [support person] (ERA) & [executive manager] & [facility's mediator].
30th April, 2013: I prepared questions & provided individual copies. My concern: Safety of [mother] – severity of assault not considered, assault regarded as "by [the man]" rather than "on [mother". I refer to *Compulsory Reporting Guidelines* in force at the time of the assault: providers to consider the severity of an assault when deciding whether or not to report to police or the Department, & providers "strongly encourage(d)" to report (p. 8, re Accountability Principles 5.3). I ask at what point/ what would have to happen in order for the Provider to report an assault. Executive manager: ***"[Provider] will not report assaults.*** [redacted] *misunderstands the legislative requirements."*

Issue:

2. Aged Care – Quality of Care

Question 15: *What changes to the requirements concerning quality of care in aged care should be made to improve safeguards against elder abuse?*

Answer: *Safety from assault and other abuse needs to be prioritised and regarded as obligatory. Failure to keep a person safe from assault needs to result in serious consequences, rather than starting from the bottom of the ladder with "voluntary compliance". Assault as a result of failure to put in place adequate measures to manage known violent behaviour should result in automatic sanctions.*

This response focuses on abuse committed by other residents in residential aged care, specifically assaults exempt from mandatory reporting.

Quality of care is not a finite concept. In the legislation it directly relates to the *Accreditation Standards (Schedule 2).*
The wording of the *Accreditation Standards* is not as a bottom-line of acceptable conditions and minimal requirements which must be met in order for a provider to be approved. Instead, the *Standards* are written as aims, goals and objectives.

As a bottom-line, minimum legislated requirement, *Standard 4.4* is:

> "Management of the residential care service is actively working to **provide a safe** and comfortable **environment** consistent with care recipients' care needs."

As a measure of acceptable compliance, however, *Standard 4.4* becomes:

> "Management of the residential care service is **actively working to provide** a safe and comfortable environment consistent with care recipients' care needs."

This is not a theoretical potential problem. This is how it works in practice.

My mother's care was impacted by my complaint of her lack of safety.
Her care was also impacted by the provider's insistence that details of the assault and actions consequently taken were protected by privacy laws as pertaining to the assailant and the "non-reportable" nature of the assault, rather than to my mother as a victim. I was expected to "trust" that her needs – particularly safety – were met (they weren't), accept that I would not be told how (because this involved management of the man's behaviour), and yet also indicate in conciliation and mediation that I was satisfied that they were.
By reporting it to the *Scheme*, I alerted the *Scheme* that the provider was failing to manage the man's behaviour as per the previous assault, as well as the assault on my mother as a separate issue.

The total mismanagement of the "unreportable assault" on my mother was identified and acknowledged by the (then) *Complaints Investigation Scheme*, who issued two separate *Notices of Intention to Issue Directions* in relation to my mother; my mother died before there was any further action, and the cases (two) were subsequently dropped.

I was required to mediate with the provider, rather than action being taken by the regulatory body. This automatically put me in a conflict situation with the provider, and staff took sides: either for me and my assaulted mother, or for the assailant and management. This was not only totally ridiculous, but also harmful in that neither the safety needs of my mother and other residents, nor the needs of the man assaulting people were met; nor were they the priority.

Staff advised me that they were not permitted to speak with me, and some were openly hostile to me, my mother, and/ or each other. Staff spied on each other. Some lost their jobs as a consequence of speaking to me.
I have no doubt that attitudes of management and staff affected the care of my mother. There was hostility and secrecy and an apparent degree of "arse-covering". This may in part explain some of the circumstances leading up to and following my mother's death.

My mother's care plan was made available to me as a consequence of mediation, to address the question of her care needs being met, when I asked for a copy, as I had never seen it; there were omissions and inaccurate information. This resulted in abuse and neglect of my mother's specific needs.
A document detailing inaccuracies and omissions of my mother's care plan, prepared for a mediation meeting, is included as an appendix.
The assault was not in the care plan.
My mother had had dementia for 17+years, was at that time wheelchair bound, doubly incontinent, her responsiveness was intermittent, verbalisation extremely poor, and she had significant cognitive impairment. She had advanced degenerative lumbar disc and facets disease, which involved considerable pain and restricted movement. Her history included domestic violence.
I provided a detailed correction of the care plan, which was left unaltered such that the *Scheme* issued a new case and *Notice* three months later.

The *Quality of Care Principles 2014* stipulates that care must be provided to the standard referred to as the *Accreditation Standards*, and defined in *Schedule 2 (Accreditation Standards).*
Standard 4.4 implies that safety is a basic requirement, but facilities are measured only on their attempts toward this outcome and the avenues of redress do not reflect the seriousness of the breach.
Violation of *Standard 4.4* should be a criminal offence, or at the least a very significant issue.

Aged Care – Quality of Care Q15

Example 1: April 2013, care plan inadequate and inaccurate
April 2013, There were over 50 inaccuracies in her care plan, from basic to serious e.g. It was recorded that she did not wear glasses – my mother had worn glasses for 40 years, and had multi-focals from the 1990s. I had kept buying new glasses for years while she was in that facility, replacing missing ones.
There were 19 additional conditions/ injuries/ incidents of which the facility had been advised and which the care plan did not specify and of which the director of care stated he was unaware, e.g. past shoulder dislocations, advanced Degenerative Disc and Facet Disease, detailed personal history (including domestic violence, and fear of death and of nursing homes, and identified triggers). Subsequent examination of my mother by an appropriate professional revealed that staff had been unaware of my mother's pain levels, that they had been exacerbating pain and past injuries by pulling her up by her arms and lifting her arms above her head to dress and requiring that she brush her own hair, that she was not being "her happy little self" but rather grimaced and laughed when in pain (on the Abbey Pain Scale, which they used).

Example 2: July 2013, provider issued with a *Notice of Intention to Issue Directions*
31st July 2013: I was advised by the *Scheme* that they had issued the provider with a *Notice of Intention to Issue Directions* in regard to their concerns of the continued safety issues of my mother – not "implementing a change recommended by an external expert" in regard to management of the man's behaviour.
This failure by the provider breached a requirement of the Aged Care Act, necessary in order to treat the assault on my mother as non-reportable.

Example 3: August 2013, dislocation of left shoulder after being found on floor
24th August 2013, my mother dislocated her left shoulder following an unwitnessed incident which left her on the floor. She was found half in and out of bed, sitting against a chair on the floor with her feet tangled in the sheets. It took three days for her dislocated shoulder to be noted by the doctor, and for her to be sent to hospital.
27th of August, in hospital, my mother underwent several surgeries to reset her shoulder. On 28th, she had an asthma attack post-op and aspirated on her own vomit, resulting in a chest infection and subsequently in pneumonia. Her shoulder was relocated and she was returned to the aged care facility; she died of pneumonia at the facility 14 September 2013. During her stay at hospital, many staff, including the surgeon, noted that her injuries were not consistent with a fall from bed. She had significant bruising on and around her left shoulder, and bruising on her elbows, chest, face and right arm.

Example 4: September 2013, failure to clearly notify family of palliative condition
My mother had been returned to the facility from the hospital when she was no longer palliative.
10th September 2013: early morning. I had with the GP what I regarded to be a pre-emptive discussion of what was to happen should my mother again be in a condition of imminent death, so as to not repeat the hospital experience. The GP regarded it and recorded it such I had been notified. Had I known, I would have been with my mother for five days and nights. Family and friends would have been notified and come to Melbourne.

Aged Care – Quality of Care Q15

Example 5: September 2013, family members not aware of palliative condition
14th September 2013 (Saturday): 11.15am, the day of her death, I arrived to visit my mother, unaware that she had been palliative since 10th. Staff on duty were of the opinion that I had been told (was in her progress notes). I had stopped to buy skirts for my mother, as per staff requests to assist in their changing of her, due to her double incontinence. Family members were not answering phones. Apart from my daughter and son-in-law who were away for the weekend 5-6 hours drive away and out of mobile range until the afternoon, family members live interstate (NSW). My mother died while my brother's plane was still in the air. No other family members or friends had time to support my mother, or give me respite so that she could be best supported as she died. It is possible she died thinking no-one else cared enough to be there. She had 3 children, 5 grandchildren, 2 great grandchildren, and associated spouses as well as friends.

Example 6: September 2013, dislocation of left shoulder during palliative care
14th September, I arrived 11.15am. The RN said a doctor was coming with pain medication. Staff were pleasant and empathic (some overly so), but seemed unskilled. I spent 1½ hrs removing a thick brown substance from my mother's mouth: breathing improved. She had a dislocated left shoulder since 3pm after PCAs changed and repositioned her (twisted). The humeral head was visible sticking out of her chest. I called staff back, and requested they reposition her, and requested pain medication. I pointed out the humeral head; they indicated they hadn't noticed. I continued to request pain medication. They brought me tea, coffee and meals and left a "palliative care" brochure on the bed. I was told that the pharmacy had closed, and there was none on site. A locum arrived with medication after 6pm. He said he'd have come earlier, had he known. He noted that she was "using every muscle in her body to breathe"; her entire body puffed up, she had subconjunctival haemorrhages in both eyes. Staff were in and out, crying and wanting to "say goodbye". She turned blue and cold 7.45pm. She remained conscious throughout, distressed. She died 8.54pm.

Example 7: September 2013, inaccurate documentation in progress notes
14th September, [Mother]'s Progress Notes 12:11:58pm: statements attributed to me were not made by me, e.g. "it's the time to let go mum, Mum has suffered for last 6 years". I have not called my mother by anything but her first name for 30+ years, & I certainly made no reference to suffering, or to 6 years. I most certainly did not make any sentimental statements or comments in front of staff; my job was palliative care of my mother.
Progress Notes 12:22:55pm: "Information on palliative care... given to [redacted] as [redacted] is very emotional and teary". I was not "emotional & teary". My demeanour was as for palliative care: calm, caring, reassuring and supportive. I spent hours relating happy memories to my mother. A staff member dropped a pamphlet on my mother's bed, with words to the effect that this would help. I threw it in the bin.
Progress Notes, Verification of death: "[mother] passed away at 2100 peacefully" False.

Aged Care – Quality of Care Q15

Example 8: removal of disc players
14th September 2013, my mother's disc player and music discs had been taken from her room by staff and used for the palliative care of other residents. The player and some discs were returned after I queried their whereabouts in a meeting after the assault, and the Director of Care said that that is what had happened to them. My mother's favourite music discs were not in her room for her own death.

Example 9: September, 2013,
15th September2013, 9am: unanswered call to me from the facility – no message left
10.35am: phone message left from facility: "Please call".
Facility staff phoned my distraught older sister in NSW and said she needed to have our mother's body removed as they needed to show the room to the family of a new dementia patient.

Issue:

3. Aged Care – Reporting alleged and suspected assaults: (non-reportable assaults)

Question 17: *What changes to the requirements for reporting assaults in aged care settings should be made to improve responses to elder abuse?*

Answer: *Having been through this process, it is my firm conviction that all assaults on a person should be reportable. Current responses to elder abuse in the case of a "non-reportable assault" do not address the assault victim. There should be no such thing as an exception to mandatory reporting of an assault.*

This response focuses on abuse committed by other residents in residential aged care, specifically assaults exempt from mandatory reporting.

The exemptions from reporting assaults committed by a care recipient with a cognitive or mental impairment reflect the understanding that such individuals are not personally responsible for their acts of violence, and as such remedial rather than punitive measures are appropriate. I am not contending this.

However, there are added consequences of *Section 63-1AA(3)* for abuse victims:
The assault on a person is disregarded. The protection of the law, both as administered by police and by relevant government departments and personnel, is denied the victim and instead is left to the discretion of the aged care facility – which conducts its own investigation as to the identity of the assailant, and which may or may not follow legal requirements, and is not liable if it does not. This is in violation of the Universal Declaration of Human Rights, Articles 2, 3, 6, 7, 25(1), 28 and 29.
This was actually addressed as a concern back in 2007, in a submission to the *Inquiry of the Community Affairs Committee* before the Bill was passed, viz: section 1.54 of the Report of that Inquiry: "*There was concern that the discretion in relation to assaults by aged residents with mental impairments would detract from approved providers' obligations to provide a safe environment for all aged care residents* [my emphasis]. *The Aged Care Crisis Team* (submission 11) *noted:*

> *We see here no requirement of the provider to exercise 'duty of care'. A frail elderly person, powerless to defend him/herself is not afforded protection and has no recourse when the provider does not adequately manage the resident with dementia."*
>
> This was precisely what happened to my mother, six years later, and three years further on it continues to happen to others.

The assault on my mother was classified by the Provider as a non-reportable assault.
However, requirements for doing so were not met.

In order to treat an assault as non-reportable, there are requirements (*Accountability Principles 2014, part 7, section 53),* viz:

- *(a)* the assailant is a resident, and
- *(b)* there must be pre-existing assessment of cognitive or mental impairment, and
- *(c)* *"within 24 hours… the approved provider puts in place arrangements for management of the care recipient's behaviour"* (my emphasis), and
- *(d)* there are records of *(b)* and *(c)*

My emphasis in subsection *53(c)* is to highlight a problem in addressing abuse in the complaints and accountability stages, as the provider need then only show that they have put into place these "arrangements" for doing something rather than actually doing something effective. (see discussion of *Accreditation Standard 4.4*, under "2. Aged Care – Quality of Care".)

The provider's implementations of these conditions are not monitored, nor known to the regulatory body, as they are themselves non-reportable, as they are part of the non-reportable assault. However, if family makes a complaint to the regulatory body, then these implementations do then become noticed and monitored.
A complaint of a subsequent non-reportable assault by the same assailant is of itself evidence that *53(c)* has not happened in regard to the first non-reportable assault: The provider is not effectively managing the person's behaviour.

Providers can continue to classify assaults – and subsequent assaults – as non-reportable, and their failure to manage violent behaviour is thus not detectable, unless a complaint is made. This can continue indefinitely. This, again, is legalised abuse.

I am a psychologist trained in and working with trauma. I had concerns regarding unsuitable and inadequate measures and unrecognised problems, and requested that a suitably qualified professional be consulted regarding my concerns. This did not happen and unsuitable and inadequate measures continued to be implemented. I continued to request that *Accreditation Standard 4.4* ("provide a safe environment") be addressed, to no avail.

I became personally aware of the experiences of other families of "non-reportable" assault victims (of the same man), that they had felt intimidated by management to remain quiet and make no complaint. Reasons given were fear of retribution by way of neglect/ mistreatment/ eviction of their family member, and blaming of the victims (by management) as exhibiting difficult behaviours themselves at some time.

The emphasis of the federal law is on the assault by a person with a cognitive impairment, which leaves the assault on a victim inadequately addressed. Discretionary reporting hides the incidence and severity of assaults, particularly in residential aged care dementia units. At the time of the assault on my mother, the legislation included the statement that: "*These discretionary circumstances do not prevent an approved provider from reporting an assault to the Police or the Department, where this may be the most appropriate response. Depending on the level of severity of an assault on a resident and in cases where a resident is seriously harmed, the Department strongly encourages providers to report.*" This has been replaced in the new *Guide for Reporting Reportable Assaults*: "These limited circumstances do not prevent an approved provider from reporting an assault to the police or the department." Both the recommendation to report and the reference to severity have been removed. It has been my experience that the priority of providers is as any business: staying in business, cost-effectiveness and profit, and accordingly, avoidance of negative publicity. Reporting abuse (particularly from a repeat offender) is not good for business.

Aged Care – Reporting alleged and suspected assaults: (non-reportable assaults) Q17

Example 1: prior to 20th March 2013, assaults, strategies in place
20th March 2013, the director of care advised me that there had been previous assaults by the same man, at least one involving attempted suffocation with a pillow.
15th April 2013, the Scheme: "behavioural strategies were in place following the previous incident, but immediately prior to your mother's assault it was quite clear that they weren't working" and "it was clear that the strategies in place were not adequate because the assault on your mother took place".

Example 2: prior to 20th March 2013, assailant identified as potentially dangerous to residents and staff
There had been an APAT assessment following a previous unreported assault. The man was described as delusional, paranoid, and verbally and physically aggressive and violent to residents and staff.

Example 3: March 2013, assault, after previous assaults, and with strategies in place 20th March 2013, a staff member heard my mother call out (from bed, around 9pm), found a man punching her in the chest with one hand and holding a pillow over her face with the other. She pulled the man off my mother, preventing suffocation.

Example 4: March 2013, assault, RN's voice message alerting family delayed, no further attempts by management to contact family
3.30pm 21st March, 2013: Voice message from RN downloaded onto my mobile advising me of assault – had been left 8.44pm 20/03/13

Example 5: March 2013, assault, RN advised Mandatory Report Incident
21st March, 2013: I phoned. The RN on duty advised me that there were no obvious injuries, that it was a mandatory report incident, as it was an assault. I discussed with RN that better for [mother] that I not go immediately (sundowning time, concern re distressing for [mother]); I trust this RN. I advised I would be in at 9am to meet with director of care.

Example 6: March 2013, police notified, police advised they could not take action
21st March, 2013: 10.15-10.30pm: My sister (NSW) phoned Vic Police to report assault. Police officer expressed concern but assailant is of diminished capacity. Officer phoned [facility] & advised that Police were concerned. Police suggestion to [facility]: 15 minute obs be put in place on [the man] – is now more than 24 hours since assault

Example 7: March 2013, inadequate response
22nd March, 2013: Meeting with director of care [facility] (wasn't there at 9am, I advised I would remain until he came & that I would phone the *Scheme*)
10.30am: director of care arrived.
Initial suggestions put to me as strategies regarding the assault on my mother: (i) I take my mother home (ii) pay for extra care or (iii) move in myself to keep her safe. Other strategy suggested: laminated photos of residents to be put on their doors to remind them which was their room, and so stop the assailant from entering the wrong one.

Aged Care – Reporting alleged and suspected assaults: (non-reportable assaults) Q17

Example 8: March 2013, *Scheme* responded to complaint by advising we go back for 2nd meeting and insist observations be put in place
22nd March, 2013: *Scheme* advised that it was imperative that we go back for another meeting before the end of the day (Friday) and insist that 15(?) minute observations be put in place, so that they would be in place over the weekend.

Example 9: March 2013,
22nd March, 2013: 4pm: 2nd meeting with director of care [facility], this time with my daughter. Advised him we have been in touch with the *Scheme*, & need to know that appropriate measures are put in place immediately (it is late Friday afternoon). Director of care: "*I have to say, I'm feeling ambushed. I have to ask you to leave my office. I have to make a call. Give me five minutes*."

Example 10: March 2013, personalised army photos on assailant's door
There was a poster-sized collection of personalised army photos on the man's door, including march-pasts of soldiers with rifles, and four individuals in combat uniform sitting in front of a tank.
March 2013, I advised the provider and facility staff and the *Scheme* of the role of these as triggering combative behaviour each time the man left, entered, or passed his room. I was told that they would remain, as this was his right.
9th April 2013, a *Scheme* officer conducted a site visit at the facility. She suggested removal of the same personalised army photos.
I continued to request the removal of the photos, and of consultation with an adequately and suitably qualified person. I was told the photos would remain, that his family "would not permit" their removal, as "they are his identity".

Example 11: April 2013, meeting with ERA support person & executive manager & facility's mediator/ educator.
30th April, 2013: I prepared questions & provided individual copies. My concern: Safety of [mother] – severity of assault not considered, assault regarded as "by [the man]" rather than "on [mother]". I refer to *Compulsory Reporting Guidelines* in force at the time of the assault: providers to consider the severity of an assault when deciding whether or not to report to police or the Department, & providers "strongly encourage(d)" to report (p. 8, re *Accountability Principles 5.3*). I ask at what point/ what would have to happen in order for the Provider to report an assault. Executive manager: ***"[Provider] will <u>not</u> report assaults.*** [redacted] *misunderstands the legislative requirements."*

Example 12: April 2013, inadequate strategies in place
As at 30th April (6 weeks after the assault) the strategies in place were:

(i) denying my mother access to her room during the day and leaving her in the common lounge/dining (with the assailant)
(ii) placing a red satin ribbon across her doorway with blu tac
(iii) sighting her every 15 minutes (not in her care plan)
(iv) sighting him every 10-15 minutes
(v) phone calls to me at the end of every shift

Aged Care – Reporting alleged and suspected assaults: (non-reportable assaults) Q17

Example 13: July 2013, provider issued with a Scheme *Notice of Intention to Issue Directions*
31st July 2013: email from the *Scheme* that they had issued the provider with a *Notice of Intention to Issue Directions*, "*in relation to the assault on your mother and her ongoing safety*", specifically "*not implementing a change recommended by an external expert*" in regard to management of the man's behaviour, and also "sub-issues" since 18th April, which caused the *Scheme* to have

- *"concern that the male care recipient involved in the incident has an underlying psychiatric condition and is therefore inappropriately placed in the Service*
- *concern that staff did not adequately manage his behaviours prior to the incident and immediately afterwards*
- *concern that management at the Service failed to communicate with you as next of kin in a timely manner immediately after and subsequently to the incident*
- *concern that as the legislation allows the approved provider the discretion not to report an assault when the offender has a cognitive deficit, that these types of incidents are going undetected"*

Issue:

4. Aged Care – Complaints and sanctions

Question 18: *What changes to aged care complaints mechanisms should be made to improve responses to elder abuse?*

Answer: *There should be a greater role of compliance agencies early in the process, rather than relying on families to pursue issues of safety in regard to assault and other abuse for aged care residents who are again assaulted, abused, or die before an outcome is reached.*

This response focuses on complaints of assaults committed by other residents in residential aged care, specifically assaults exempt from mandatory reporting.

The complaints mechanisms interfere with the sanctions mechanisms.

Because of the systematic nature of the complaints process, the relevant considerations detailed in the sanctions section of the *Act* are not applied.

Complaints of assaults, including those currently classed as "non-reportable", need to be identified as such, prioritised and dealt with immediately in accordance with an appropriate response from the regulatory bodies.
As soon as it is determined that an assault has occurred, it should bypass the level of the *Aged Care Complaints Commissioner* and the processes of education, support and voluntary compliance, and be with the Department of Health, with immediate regulation and enforcement of appropriate action if necessary. Assessment as to risk to safety of any individual should be immediate, and non-compliance considered as per *section 65-2* of the *Act*.
Severity of each assault, both of the nature of the assault (e.g. suffocation, strangulation, knife attack) and the injuries involved, need to be considered as part of this identification, as well as being specifically addressed as appropriate responses.
It should not be possible for a provider to be reaccredited during the process of investigation, regulation or monitoring, as these are in relation to non-compliance.
In the event of any assault in a facility, a provider should be concerned about sanctions, not promising or making token efforts to try to improve.

It has been discussed above (Question 15) that breaching of previously-defined minimum *Standards* does not result in immediate action by the regulatory body. The legislation (the *Complaints Principles 2015*) refers to the complaint of breaching of responsibilities in *Part 2, section 6(1)*: "*A person may make a complaint to the Aged Care Complaints Commissioner raising an issue or issues about an approved provider's responsibilities under the Act or under the principles made under section 96-1 of the Act*." At this point, there has been a complaint, but breaching of "*responsibilities under the Act or under the principles*" has not been proven.
Even once they have, the legislation (*Part 2, section 7*) then provides a bureaucratic process of increasing degrees of action. This is what is applicable under the current legislation when *Standard 4.4* (safety) has been breached, when an assault has been shown to have occurred: The legislated powers of the *Aged Care Commissioner* are to either:

(b) quickly resolve the issue to the satisfaction of the complainant by giving assistance and advice to the complainant or the approved provider [my emphasis] *to which the issue relates; or*

(c) undertake a resolution process.

Examples of *(b)* are given in *Note 2:*

(a) assist the complainant to clarify the issues to enable the complainant to raise them directly with the approved provider; [my emphasis]

(b) telephone the approved provider on behalf of the complainant to discuss and resolve the issue raised by the complainant; [my emphasis]

(c) advise the approved provider of the approved provider's rights and responsibilities under the Act and, in doing so, facilitate the resolution of the issue. [my emphasis]

The resolution process as a response to "unreportable" assault is totally inadequate.
The failure of a provider to uphold their responsibility under the *Aged Care Act* to keep a resident safe from abuse is not addressed as a violation of federal law, but rather as if it were a civil matter between the assault victim and the provider. Families of victims of assault are not prepared for this, either emotionally or practically.
The legislation provides a bureaucratic process of increasing degrees of action, (*Part 2, section 7*). This effectively treats the breaching of responsibilities/ *Standards* – including *Standard 4.4* – as an unfortunate minor misdemeanour, involving voluntary action of the provider, providing encouragement for the facility/ provider to comply, providing education and support to the provider, and giving the provider opportunity and time (precious to an assaulted and unsafe dementia patient) to address the violation of responsibility. Moreover: This process requires the family to mediate with the facility and to indicate when they are "happy" with the facility's efforts to meet what in another section of legislation [Sanctions – *Section 65-2(2)*] is regarded as obligatory and the responsibility of government regulatory bodies to uphold.

In the meantime, family members are kept away from visiting their assaulted loved-one, fighting to keep them safe.

The only hope of reaching the minimum, bottom-line *Accreditation Standards* in this process – the only way of having any possibility whatsoever of protecting an older person in a dementia unit against abuse – is that family is aware of and educated in the labyrinth of Aged Care legislation, as well as the associated government bodies and their roles: the *Aged Care Act*, the *Accreditation Standards*, the *Quality of Care Principles*, the *Complaints Principles*, the *Accountability Principles*, the *Security and Protection Bill*, the *Aged Care Compliance Policy Statement*, the *Complaints Investigation Scheme* – now the *Australian Aged Care Quality Agency,* the *Department of Health,* and the *Aged Care Complaints Commissioner.*
Not everyone has such a dedicated family, or any family at all.
Even if they do, families are often struggling emotionally with the consequences of their loved one having dementia. Dementia patients are vulnerable, old, and unwell. They generally don't live long. Assault does not strengthen their longevity.
Under the current complaints process, not only is onus put on the family, but by the time anything is effectively done, the victim is dead, the case is dropped, and the whole process starts again for the next person.
This is not simply unjust: It is not even a sensible solution in these circumstances.

Despite becoming a lounge-chair expert in Aged Care legislation in regard to protection against assault in approved residential facilities, I still was not able to keep my mother safe, neither in terms of assault – because the legislation itself prevented me from protecting her – nor the subsequent fallout from my attempts to do so.
In addition, for many reasons, I was the only regular visitor my mother had. I was self-employed, had to adjust my working hours in accordance with stress levels so that personal stress did not impact on my work, adjust them again so that I allowed for personal debriefing and support, and so I had time to learn about my mother's rights and prepare for mediation meetings, and attend these meetings as well as continue to visit my mother – who needed me with her now more than ever.

The *Complaints Investigation Scheme* advised me that the assault on my mother was the most severe by this man so far. I was expected to reach a point in meetings where I acknowledged that I was satisfied that my mother was being adequately cared for and safe. That I was never going to reach this conclusion because she had already been assaulted, was regarded (by the provider) as evidence of my non-compliance, hostility and unreasonable attitude. Despite numerous meetings, my sincere attempts at mediation for the sake of my mother, and involvement of the *Complaints Investigation Scheme,* the safety of my mother and other residents was never adequately addressed. The *Scheme* issued two separate *Notices of Intention to Issues Directions,* both four months after the assault. One was in regard to my mother's care needs; the other, management of the assailant's behaviour.

I became personally aware of the experiences of other families of assault victims (of the same man), that they had felt intimidated by management to remain quiet and make no complaint. Reasons given were fear of retribution by way of neglect/ mistreatment/ eviction of their family member, and blaming of the victims (by management) as exhibiting difficult behaviours themselves at some time. My mother died six months after the documented assault, from complications from injuries sustained after being found in a twisted, upright position with her bottom on the floor between her bed and a chair, her feet tangled in soiled sheets up on the bed. How she got there was not witnessed. The man who had assaulted her (and others) was still in a room two doors away. The woman between them had died in the interim, after being found on the floor beside her bed, which was at its lowest setting.

Aged Care – Complaints and sanctions Q18 – complaints

Examples 1-13 are as for
Aged Care – Reporting alleged and suspected assaults: (non-reportable assaults) Q17

Example 14: April 2013, the facility is audited for reaccreditation
[ ]April, 2013- [ ] May, 2013: Unbeknown to me, the *Aged Care Standards and Accreditation Agency* was conducting its audit of the facility, whilst I was participating in mediation on the premises.

Example 15: May 2013, the *Aged Care Standards and Accreditation Agency* reaccredits the facility, whilst investigations are still underway
[ ] May, 2013: the *Aged Care Standards and Accreditation Agency*: "Following an audit we decided that *this home met 44 of the 44 expected outcomes of the Accreditation Standards*. This home remains accredited until [ ] 2015. We made our decision on [ ] May 2013."

Example 16: July 2013, the *Scheme* create a new case, and issue *Notice of Intention to Issue Directions*
31st July, 2013: email from the *Scheme*: *"On 2 July 2013 you noted the inadequacies that you had identified prior to the meeting on 7 May 2013 and noted that the physio had since reassessed your mother in terms of her transfers.*
On 16 July 2013 you contacted the Scheme and noted the inadequacies in the care plan. However, the care plan was dated 22 April 2013 and your concerns had been raised and changes agreed upon at the meeting on 7 May 2013.
Nevertheless, the Scheme followed up your concerns with [director of care] who said that she had spoken to you in relation to a number of your concerns and that you were happy that your mother had been reviewed by the physio was being transferred in a lifting machine and wheelchair (confirmed in your email of 2 July). She noted that the care plan in question was dated 22 April and it has since been updated. She was to arrange a time to reconvene with you to discuss the concerns.
On 29 July 2013 the Scheme received your email (sent 27 July) with the care plan dated 26 July 2013. I agree that although there are some amendments, these are minimal and this is unacceptable given the time the approved provider has had to respond.
Therefore the Scheme has created a new case in relation to the care plan issues ([redacted]*) and has issued a Notice of Intention to Issue Directions to the approved provider to formally ensure that your mother's care needs are reassessed, the care plan is updated as agreed and the that you are consulted in relation to the changes".*

Question 19 *What changes to the aged care sanctions regime should be made to improve responses to elder abuse?*

Answer: Division 65 of the Aged Care Act addresses the problems with the complaints process, but the application of the complaints process directly prohibits the implementation of 65-2-(2): "whether the non-compliance threatens or would threaten the health, welfare or interests of current and future care recipients is to be the Secretary's paramount consideration".

This response focuses on abuse committed by other residents in residential aged care, specifically assaults exempt from mandatory reporting.

Because the complaints process begins with mediation, and seems to rarely get any further, the sanctions don't seem to be used.

Safety and protection of people against abuse in Residential Care Facilities is not automatic and is not simple. In the case of those who have the misfortune of being in a dementia unit and assaulted by another resident, it is my personal experience as the daughter of a woman who was so assaulted, that there is no enforceable protection, and the legislation actually enables assault and further assault.
The relevant legislation is a minefield of contrary requirements and definitions, and the realistic outcome is that old ladies and old men in the care of approved providers in locked dementia units are perfect targets for neglect and abuse under the very laws that any ordinary Australian would expect are there to protect them.

The only guaranteed outcome of my mother's assault was that because of the legislation, there was absolutely nothing that I could do to protect her. My mother has now been dead for three years. The changes in relevant legislation since then are such that: Were the assault on my mother to occur now, it would be even harder for me to protect her. Protecting her should never have been my job after I and other family had cared for her in her own home for 11+years with dementia: It should have been that she was protected from abuse and assault by being resident in an accredited high-care aged care facility.
There should never be such a thing as a "non-reportable assault". It is an abomination of human rights.

I was aware, throughout meetings of conciliation and mediation, by the actions suggested, that I have considerably more expertise in regard to appropriate measures as to the assailant's behaviour than was being presented to me. I was aware, professionally, that these people were not in any way acknowledging the needs of my mother's assailant. I tried to address this: I was shut down.
That I knew what I was talking about professionally, turned out to be in my mother's disfavour – I was regarded by the provider as a consummate know-it-all.

It is my opinion that there are two distinct and conflicting issues at stake: (i) addressing abuse of elderly people and as such keeping them safe, and (ii) ensuring that there are (enough) facilities to house elderly people in need of care, and as such encouraging and assisting providers to stay in business.
The current situation as addressed by Federal Law concerns the second, at the expense of the first.
Aged care providers are given the legislative right to monitor their own practices, are effectively protected against consumer complaints, decide what level of care they will provide and how they will do so, make their own decisions as to whether or not to report their own misconduct, and whether or not to report abuse that has occurred within their facility.
This continues largely because it is assumed that the aged care provider has as its priority "*the health, welfare or interests of current and future aged care recipients*" (*The Aged Care Compliance Policy Statement 2015-2017,* p.5). This is naïve, to say the least; the priority of providers is as a business: staying in business, cost-effectiveness and profit, and accordingly, avoidance of negative publicity. Reporting assault is possibly the worst thing for business in the aged care facility sector.

There is a massive conflict of interest here.
sincerely,

[redacted]
11/09/2016