**Reply to the Australian Law Reform Commission Discussion Paper 83 2016:**

**Protecting the Rights of Older Australians from Abuse**

**submission of: S Henderson**

(daughter of a victim of “unreportable assault” in a dementia unit)

I wish to reply to the *ALRC Elder Abuse Discussion Paper 83 2016* (Discussion Paper), specifically in relation to proposals and questions of part 11 (aged care). I refer to my previous submission (number 189).

I applaud the suggestion of proposal 11-3, to expand the scope of the type of incidents required to be reported under the *Aged Care Act*, and establish a reportable incident scheme. My mother was the victim of assault previously defined as non-reportable, as the assault was committed by a resident with a cognitive impairment. In my experience, having my mother’s assault determined as non-reportable reduced possible interventions, legal avenues, and my avenues of redress. As a result, I could not keep my mother safe. Proposal 11-3 would make important changes to address similar issues in the future.

However, it is my view that the proposed definition of ‘reportable incident’ in regard to the actions of another resident on a person (proposal 11-2(b)) negates the former proposal. This is because it establishes a higher threshold for reporting resident-on-resident incidents than would apply if incidents were committed by carers, or committed on other members of the community. In practice, this not only implies that aged care residents are not worthy of the same protections as other people, but if implemented would actually deny them protection. It is my view that proposal 11-2(b) would act to replace *Accountability Principles 2014, part 7, section 53*, which hides resident-on-resident abuse in aged care facilities.

In addition, there are two other legislative reforms that I consider need to be implemented to effectively address elder abuse:

1. making providers properly accountable for keeping residents safe, and providing clear and significant sanctions, including potential loss of accreditation, when they fail to do so; and
2. ensuring appropriate care by requiring providers to employ appropriately qualified staff (i.e. registered and enrolled nurses, rather than Personal Care Assistants (PCAs), in reasonable numbers, for high needs environments.

From my discussions with others in similar situations, I understand that the abuse of my late mother was typical of others in her situation as a resident of a high-care dementia unit. My family and I took great care in choosing residential facilities – in regional NSW and then in Melbourne – that we thought would provide the best possible social, medical, physical, nutritional and personal care for my mother, and where services were administered by skilled and professional staff. In both cases, the approved providers down-graded all of these services, including replacing skilled and qualified nurses with PCAs. In both places, my mother suffered injury, neglect and abuse as a direct and indirect result of these changes. This included neglect of her needs including subsequent injuries, and continued assault by another resident in my mother’s high care dementia unit.

As her representative, I was never consulted in regard to, or informed of, any changes to arrangements in the aged care facility. I was also rarely informed of instances such as injuries. It was the attitude of the facilities that my mother’s care was their domain, not mine. Often when she was injured, I was not advised. When she was assaulted, the approved provider made it very clear that my intervention was not appreciated, not necessary, and in their view, not appropriate. My mother had become a commodity of the aged care system, a non-person. This was enabled by federal legislation that did not make the provider properly accountable for providing a safe environment, or adequately penalise them when they failed to do so.

The specific issues of my mother’s assault are:

* she was assaulted in an aged care facility, in a secure dementia unit, by another resident with dementia;
* others were assaulted by the same person;
* these assaults were classed as “non-reportable” as the assailant had a cognitive impairment;
* the approved provider did nothing of substance to address or prevent the assaults;
* police were advised but said they could not act;
* the relevant government departments did not adequately respond to the assaults or the provider’s inappropriate and inadequate responses;
* the provider was reaccredited during the investigation of their lack of action of the assaults;
* the systemic issues of the legislation – as opposed to those of the aged care system – created a long, drawn-out process that enabled my mother’s continued neglect and abuse for five further months until her death, despite two separate *Notices of Intention to Issue Directions* from the Health Department;
* the approved provider was not held accountable for lack of duty of care;
* poor staffing, including in terms of training and qualifications, and numbers, resulted in continued neglect and injury (including during her final hours of life);
* my mother’s care plan was woefully inadequate and inaccurate, resulted in neglect and in physical injuries, and was the subject of a Health Department *Notice of Intention to Issue Directions*; and
* others’ family members were threatened and/ or intimidated by the approved provider such that they did not report or complain of assaults.

Two Forms of Justice

Part 11.94 of the Discussion Paper states that a higher threshold is required for resident on resident incidents to be reported. Whilst I understand the need to avoid criminalisation of residents with cognitive impairments who engage in violent behaviour, the impact of threshold differences is that a person in an aged care unit is not afforded the same right to be safe from abuse as other members of the community. This undermines their rights and their safety, and puts them at risk of abuse.

This is contradictory to the introductory statements regarding “Intention”, 1.48-1.56, as well as to the consideration “that information relating to ‘minor’ incidents can assist in assessing risk” (11.98).

It is also contradictory to the opening statements of the “Terms of Reference” of the Inquiry as stipulated by the Attorney-General George Brandis in having regard to the rights of the elderly and legal responsibility for their safety.

It is obvious from sections 11.97 – 11.151 of the Discussion Paper (with the notable exception of 11.114, 11.115, 11.116 and 11.130) that the ALRC is very aware of the need to address abuse of aged care residents by broadening the definition of abuse in this context. The ALRC goes to great lengths to acknowledge the rights of the elderly and the many types of abuse that can occur, acknowledges psychological abuse, acknowledges the need to expand on the definition of abuse, but then ignores such assault on these people by proposing a higher threshold of injury to them before assault on them is to be acknowledged.

The ALRC notes (11.107) that “People with Disability Australia (PWDA) argued that the exemption risked creating ‘two forms of justice’: While we acknowledge the issue of criminalisation of people with cognitive impairments, co-residents should have their assaults taken seriously and should be given the opportunity to report to the police. Individuals should be supported to engage in the justice system, as violence is violence, and people with disability are entitled to a justice system response on an equal basis to others. There should not be two forms of justice: one for people without disability, and one for people with disability” (People with Disability Australia, Submission 167) – This is just as relevant an objection to Proposal 11-2(b).

I also refer to the Department of Health (Cth), Submission 113, p.3*,* which relates to current legislation: “Unreasonable use of force as defined in the Act is intended to capture assaults ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force on a resident. This may include hitting, punching or kicking a resident regardless of whether this causes visible harm, such as bruising” (my emphasis). This range is not covered by the proposed definition of an incident as per 11-2(b), and as such the proposal actually restricts rather than broadens those incidents to be reported, and also leaves the decision of whether or not to define injury as serious to the provider.

I recommend that proposal 11-2 (b) be amended to include assault, as per 11-2(a). This could also be qualified as per the Department of Health(above), viz: “This may include hitting, punching or kicking a resident regardless of whether this causes visible harm, such as bruising”.

Concealment of Abuse

Currently, the narrow definition of reportable assault conceals abuse which does not fit the definition. This is acknowledged in the Discussion Paper, part 11.147, which states that “(t)he narrow definition of the term ‘reportable assault’ effectively conceals incidents that may have serious consequences for the victim but, because they are not captured, are not required to be reported”. This is equally applicable to the suggestion of the new ‘reportable incident’ as defined in proposal 11-2(b). Consequences will not be recognised if the incident itself has been deemed not serious e.g. not sexual, not involving a weapon, not involving serious physical injury.

In addition, it would likely be difficult to determine when an incident formed part of a ‘pattern of abuse’ and therefore otherwise satisfying 11-2(b). This is because some assaults could go unreported (as per proposal 11-2[b]), making the pattern unobservable, at least to individuals with exposure to only some of it. In my experience, there was a pattern of abuse for my mother’s assailant – pulling/ pushing/ throwing people out of bed and holding pillows over people’s faces – but this was difficult to identify as an outsider, as instances where not reported. I had to rely on staff candour – and therefore on staff risking their jobs – to know about other instances. These issues would be continued under proposal 11-2(b) because individual instances may not be deemed reportable in their own right (e.g. a pillow may not be deemed a ‘weapon’), limiting the abilities of family members and staff, who may not be privy to all instances, to identify a pattern of behaviour.

As it stands, proposal 11-2(b) could re-instate old barriers removed by proposal 11-3, and in so doing ignore the impacts on victims, such as psychological injury. Psychological injury is not necessarily immediately apparent, and not necessarily apparent to the undertrained staff of aged care facilities, especially since it includes worsening of symptoms already apparent as dementia. Further, in my experience, it is often underestimated, and therefore may not be considered a ‘serious injury’, despite having significant consequences for the individual.

To use my experience as an example, my mother’s psychological injury was apparent to me (as a psychologist) but was denied by the executive manager and the approved provider, and my requests for a suitable specialist to be consulted were denied. As the incidents affecting her were unreportable, I had limited avenues of redress. Proposal 11-2(b) would not address this problem.

In addition, proposal 11-2(b) includes a number of potentially vague terms, which could be used to provide the discretion for facilities not to report incidents. For example:

* What is a “serious incident”? Serious in what way? Serious for whom?
* Who decides that the incident has caused the injury? What if an injury, such as psychological distress, appears later?
* How is “sexual offence” defined, and by whom?
* What is a “pattern of abuse”? How is a pattern determined when individual instances are not in themselves reportable?
* How is a “weapon” defined, and by whom? Is a pillow a weapon? A spoon? What if the pillow is used to attempt to suffocate someone?

Vague terms, and potential discretion, are problematic. Providers have a vested interest in not reporting assaults as doing so can impact their business. As long as the decision to report is in the hands of providers – by defining assault for some as anything less than assault for others, or by giving providers discretion in what constitutes a reportable incident – some assaults will continue to be unreported, and because they are unreported, will remain invisible. This has impacts for the individuals involved, and for the ability of compliance agencies to monitor practices more broadly – if incidents are unreported, then there is nothing to monitor.

Whilst I acknowledge that this higher threshold is an attempt to screen minor incidents out, assaults are not minor incidents. Proposals 11-1 and 11-2(a) are about reporting abuse (including assaults). A higher threshold should not be set under 11.2(b). To set a higher threshold, based on who the assailant is, is not ‘ensuring safety and quality [and] protecting the vulnerable’ (11.2), including my late mother whose assailant punched her in the face and attempted suffocation with a pillow – an assault which may still have been unreportable as per 11.2(b), and most certainly would have been unreported by that particular facility and approved provider.

In my view, 11.2(b) also renders 11.1 relatively meaningless. This is because there is no point in the Aged Care Complaints Commissioner overseeing providers’ responses to (reportable) incidents if providers have discretion in determining what is serious and therefore reportable. Providers can simply ‘cherry pick’ instances they are satisfied that they can, or have, responded to. This could then undermine attempts at broader reforms. If resident-on-resident assaults are occurring, this may be because appropriate strategies are not in place (as in my mother’s case). Failure to see these instances means we cannot evaluate the causes and responses.

In summary, it is my contention that 11.2(b) is effectively a substitute for *Section 63-1AA(3)* and the accompanying *Accountability Principles 2014, Part 7, section 53* – giving approved providers the power to determine what is and what is not reportable, and thereby allowing resident-on-resident assaults to go unchecked.

 Conflict of Interest

In my view, the legislation is often drafted to assume that age care providers see *themselves* as having, and act as if they have, a duty of care to their residents. Further, legislation often assumes that providers will do the right thing. However, this ignores the inherent conflict of interest in their being businesses designed to make a profit, and thereby minimise bad publicity.

It has been my personal experience that an approved provider does not necessarily act in an ethical, professional, caring, or even legal manner. The assumption that they will is naïve and potentially dangerous for individual residents of aged care facilities – the assaults on my own mother and others in her dementia unit are examples of the outcome of such an assumption.

I have read most of the submissions to the ALRC, and note that they include many other documentations of similar circumstances and incidents, and of inadequate responses and questionable conduct by approved providers.

If approved providers had care and well-being of their elderly residents as their priority, rather than their business interests, then they would be concerned about and actively investigating incidents of abuse, championing transparency, employing appropriately trained and qualified staff, ensuring effective staffing ratios, conferring with family members, ensuring safety and comfort of residents, providing appropriate medical attention, providing evidence-based activities and treatments, providing nutritionally balanced meals, and through their combined representative associations be actively and conscientiously involved in improving their standards of care, including by decreasing the incidences of abuse in their facilities. They are not. Further, even if some do act in this way (and I have not heard of any this wholesome), legislation should not be drafted to assume this is the norm.

In reality, many facilities will put profit above care. As such, they will not report negative incidents in their facilities, unless forced to do so. There can be no discretion and no opportunities for creative interpretation. Legislation should be drafted to *require* reporting of anything which could satisfy the definition of assault, as used for other members of society, regardless of the perpetrator. It isn’t about blame, it’s about protecting the vulnerable.

Accountability of Approved Providers

The Discussion Paper notes that “ensuring quality of care is perhaps the best safeguard against abuse and neglect” (11.9). However, my view is that the quality of care framework is undermined by inconsistent and ineffective legislation.

The Discussion Paper notes the *Principles* in the *Aged Care Act* (11.6), and the various responsibilities of the Department of Health (11.11), the Australian Aged Care Quality Agency (11.12-11.15) and the Aged Care Complaints Commissioner (11.16). However, whilst this regulatory framework is rigorous or might be rigorous on paper, in practice it is not enforced and not enforceable.

There need to be legislated directives, not just aims, goals and objectives. The Discussion Paper recognises that “(a)pproved providers owe a duty of care to care recipients” (11.138), but there are no proposals addressing the failure to do so. Duty of care violation needs to be addressed by legislation.

In 11.9, the Discussion Paper recognises that there are “significant concerns about systemic issues relating to the quality of care in aged care, and the processes for monitoring quality” (my emphasis). However, concluding that “addressing such concerns requires considerations of a systemic character that are more suited to a broader review” smacks of passing the buck, and is simply not good enough.

Certainly, there are systemic problems within the aged care system, and these do need to be addressed. However, many of these are enabled by the current legislation, and could – and should – be addressed by legislative reform, making aged care providers accountable for breaching of standards.

There are also systemic problems within the associated legislation, and the Law Reform Commission is the appropriate forum to address these. The various pieces of legislation relating to rights, responsibilities, principles, sanctions, complaints, abuse, assaults, accreditation standards, duty of care, and “(t)he task of ensuring that approved providers meet their responsibilities in relation to quality of care” (11.10) are spread over a number of different pieces of legislation, do not match up, interfere with each other, and at times contradict each other. Together, they are confusing at best, and in practice ineffectual. As a result, approved providers are not accountable in terms of duty of care. This is the biggest problem facing the matter of abuse in aged care, and it can only be addressed by the Law Reform Commission.

There is a massive discrepancy between the ALRC’s attention to abuse of the elderly in the community and those in residential aged care. Residents of dementia units are the most vulnerable – that’s a big part of why they are there. Just as carers, family members, POAs and others are the carers of the elderly in the community, so do the approved providers have this role in aged care facilities. Just as restrictions and accountability applies to carers of those in the community, so too is there need for restrictions and accountability measures to be put on approved providers, in order to protect residents against abuse.

Changes such as requiring facilitiesto provide adequate care, and penalising them if they don’t, would only negatively impact providers failing to provide quality of care, enabling abuse and breaching accreditation standards and the rights of residents. Reputable and compliant approved providers would surely welcome such legislative reform.

This would be ‘ensuring safety and quality [and] protecting the vulnerable’ (11.2).

Accreditation and Sanctions

Similar to the above discussion, it is my view that there are insufficient penalties for providers providing sub-standard care, including inadequate sanctions and limited risks to their accreditation. In my experience, even when providers are being investigated for non-compliance, the options for redress are limited, and providers can be reaccredited while issues are outstanding.

Part 11.26 of the discussion paper refers to the proposed *Single Set of Aged Care Quality Standards* ([www.agedcare.health.gov.au](http://www.agedcare.health.gov.au)) as “(f)urther reform… for quality assurance processes in aged care” and refers to this as in place of ALRC law reform. However, this is policy reform, not legislative reform. It does not address consequences for failure to meet standards, but rather “encourage(s) innovation, excellence and continuous improvement” (my emphasis).

I reiterate my previous assertions:

1. “Because of the systematic nature of the complaints process, the relevant considerations detailed in the sanctions section of the *Act* are not applied.” (Submission 189, p.18)
2. “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.” (Submission 189, p.19)
3. “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.*” (Submission 189, p.18)
4. “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.” (Submission 189, p.18)

The Department of Health does monitor compliance; however, when it comes to taking action and imposing standards, points 1 and 2 (above) apply. Nothing useful happens.

In reference to 11.14, viz: “Where the Quality Agency identifies a serious risk to care recipients, the service provider and Department are notified immediately” – I again note that the Quality Agency has failed to identify such situations, and that providers have been reaccredited during the investigative process of the Department of Health, and whilst residents have been at risk of further assault.

The facility my mother was in was both audited (visited) and reaccredited by the Agency following my mother’s assault, and while there were inadequate measures in place to protect my mother from future harm. These inadequate measures were subsequently the subject of a *Notice of Intention to Issue Directions* from the Health Department because they had not been improved on and my mother continued to be at risk three months later – after reaccreditation. Agency personnel were actually in the building doing their inspection at the same time I was there in a mediation meeting (known to the Health Department), trying to ensure something more than a ribbon blu-tacked across her doorway was implemented to keep my mother safe. Several assaults had occurred in the dementia unit on that site, at least two had been reported, at least one was still under investigation as not adequately responded to, the assailant was still not being adequately managed, and yet the Agency did not recognise any risk.

The framework isn’t working in practice.

In reference to parts 11.84-11.90 of the Discussion Paper, standards should not replace legislative reform to address non-compliance. Further, a “voluntary *National Aged Care Quality Indicator Program*” (11.26; my emphasis) does not in any way equate with legislation.

It is very clear from the Submissions made to the ALRC that the lack of legislative requirements for compliance and the lack of consequences (sanctions) are major contributors to abuse of the elderly in aged care residential facilities. Encouraging businesses to comply does not equate with and has no place in replacing direct and clear legislation addressing abuse of the elderly. Providers who do not comply with quality standards should not be able to be approved and accredited. Providers who breach the rights of residents in aged care facilities should not be in business.

To genuinely address abuse of the elderly, it is imperative that the “toothless tiger” (11.86) and the “gaps” (11.82 and 11.83) be addressed by the ALRC. To fail to do so is to highlight this Inquiry as yet another “toothless tiger”.

Inappropriate Staffing: PCAs in High-Care

The lack of appropriately trained staff contributed to my mother’s neglect and abuse. I have noted similar issues in relation to staffing, qualifications, skill mix and staff-patient ratios, in other submissions.

It is my understanding that the ALRC contention that these issues are going to be dealt with by the Aged Care Legislated Review is not shared by the Aged Care Legislated Review – at least as at 08/02/2017 (Aged Care Legislated Review Consumer Workshop, Melbourne) – in which case this vitally important issue is in danger of being overlooked.

Should this situation have changed such that the Review will be the body responsible for aged care staffing issues, then I would ask the ALRC to refer relevant submissions to the Aged Care Legislated Review to ensure these submissions are available to inform discussions of staffing. Further, given that these staffing issues are so much a part of elder abuse, would it not be appropriate for the ALRC to make recommendations to the Aged Care Legislated Review?

Should this not be the case, and staffing issues not be addressed by the Review, then staffing concerns within aged care facilities need to be recognised, considered and addressed by the ALRC in terms of contribution to abuse of the elderly within residential aged care facilities.

 “The task of ensuring that approved providers meet their responsibilities in relation to quality of care is shared by the Department of Health, the Australian Aged Care Quality Agency …, and the Aged Care Complaints Commissioner” (11.10).

In my view, under-trained staff, such as PCAs, have no place working as carers in high-care facilities. Family members arrange placement in high-care dementia units for the precise reason that the dementia sufferer is high-care, and as such beyond the family’s expertise to care for. The reasonable expectation is that staff in such units have the skills to administer required care. Not to provide such care constitutes neglect. However, the appropriate level of care cannot be given by PCAs.

PCAs should not replace specifically trained and highly qualified staff, such as registered nurses, who are capable of administering the high level of care a dementia sufferer requires. There are many examples, including in submissions made to ALRC, of PCAs’ lack of expertise directly and indirectly resulting in abuse and neglect. It is also questionable whether PCAs have any more expertise than the family members who recognise their own inadequate skills and so seek high-care placement for their elders: PCAs are only personal care assistants. There is a place for them, but not in high-care needs situations. Just as only specifically trained and qualified teachers, child-care workers, lawyers and surgeons are able to practise in their fields, so should there only be qualified nurses in dementia units. However, as a result of the use of PCAs, to the expense of nurses, properly qualified staff are no longer in facilities in any number that renders them effective in their work. Lay people should not occupy positions of the highly skilled: It is dangerous, it is enabling abuse, and as such this in and of itself constitutes neglect of the elderly. Proposals are needed to address these systemic issues recognised in 11.9 of the Discussion Paper.

That approved providers can accept residents as high-care but then not provide high care surely constitutes failure to provide appropriate quality of care. To accept people with high-care needs without having the means or the intention of being able to provide such care is not ethical, is preconceived, and should not be legal.

In the case of my late mother, her high-care status was initially downgraded to low care (resulting in neglect) because the only appropriate placement was in a facility that designated its dementia unit as “low-care, dementia specific”. I was told that if I didn’t agree to this down-grading, that my mother wouldn’t be able to be accepted into the facility. Her new status as low care then necessitated the payment of a bond to the approved provider. This constitutes financial abuse.

In summary, whilst I support many of the recommendations of the ALRC Discussion Paper, including principally 11.3, it is my view that the changes proposed under proposal 11.2(b) undermine other outcomes.

Defining harm by reference to the perpetrator ignores the impact on the victim. Further, obscurity of syntax in legislation invites different interpretations, which then create loopholes. These are precisely the type of loopholes that enabled the actual assault on my mother, the failure of the approved provider to address the consequences of the assault, improve her safety going forward, or manage the assailant’s behaviour, as well as the failure of government bodies to take any significant action. I recommend 11.2(b) be amended to require providers to report ‘assault’ as defined for any other member of society, regardless of the perpetrator. As outlined previously, this is not about blame, it’s about keeping victims safe.

In addition, it is my contention that for significant reform to be realised, providers need to be:

* able to be held to account under legislation, and able to be sanctioned or de-accredited when they fail to provide a safe environment; and
* required to employ appropriately trained staff (i.e. nurses) in high needs environments.

I would like to direct the ALRC’s attention to the former, and request that my and others’ submissions be addressed for the latter, either by the ALRC in this Inquiry or passed on to the Aged Care Legislated Review with recommendations, as is applicable.

S Henderson