**327. V Fraser and C Wild**

Name: V Fraser and C Wild

Proposal 2–1

Yes, at a very miminum it would be highly advantageous to have a national register. There would need to be consistency with the legislation Australia wide and consideration of who can access the register so that it can be effective. There needs to be consistency in language around "what informs decision making" ie. moving towards more supported decision makers. A great thing about a register is that someone is checking the validity of documents before they are uploaded (required to be truly effective). A focus on consistency and accountability amongst legal practioners and/or J.Ps to properly assess capacity to sign documents is required (especially if older person is in hospital) - thinking about how this would be governed?

Proposal 2–2

Absolutely there needs to be. In terms of undereporting there is a risk of missing reporting of elder abuse in a person who has a cognitive impairment, if there is not a third party to raise the alarm. How would we capture this group? The same applies to the CALD population due to language barriers and use of interpreters in primary health settings as well as some cultural norms and taboos around the topic.

Proposal 3–1

We ccknowledge that in the elder abuse framework , people are vulnerable for reasons other than lack of capacity (in which time a guardian or advocate would be requested). Currently for people to be appointed a guardian or to have an investigation, they go to VCAT in which the first criteria is for the person to have a diagnosis of a disability that impairs decision making. It would be beneficial for other vulnerable older people to have access to OPA to investigate elder abuse even if they have legal capacity or it has not yet been determined ie. socially isolated/housebound, physical disability and reduced access to healthcare, hearing and vision impaired.

Proposal 3–2

We agree with this proposal.

Proposal 3–3

We agree with this proposal. The challenge for health workers (social workers) is that we can request to see a copy of an EPOA and bank authority however this can be refused and we do not have any power to enforce this. It would be beneficial to have an idependent body that holds this power.

Proposal 3–4

We agree with this proposal.

Proposal 3–5

It would be good to have a central body that has the powers to further investigate or advise in matters of suspected abuse.We support the 'no wrong door approach' in theory however some practice concerns would be:

Adequate training of staff in their response;

Awareness that given the sensitive nature of some of the disclosures, it would be pertinent that these are managed skillfully otherwise there is a risk that people will disengage with the process.

There are also issues with timeliness given the current delays in awaiting tribunal ordered investigations (a resource issue).

Proposal 5–1

This is crucial.

Proposal 5–2

There are some concerns with the turnaround process. In a hospital setting, people may make financial EPOAs that require immediate effect. There is a potential that this could be delayed by a registration process (particularly to access residential care). The registration portal would need to be appropriately resourced in order to respond to urgent timeframes and validity of documents.

Proposal 5–3

Consideration needs to be given to who can access this register eg. G.Ps, certain healthcare professionals, aged care facilities, case managers. It may be a risk to give access to the register to the general public or persons concerned due to potential conflict and placing people in further danger. It would be good to consider a general screen for persons concerned to view and  a 'backend' that a nominated group of professionals can view for further information. Varying levels of access (similar to the my aged care keys).

Question 5–1

Police, Aged Care facility management, hospital social workers, G.Ps, case managers RDNS, bank staff sufficiently trained, OPA guardians, VCAT members, state trustees. This should be a single national register. We have concerns about the suggestion that enduring documents be added to My Health Records as an only source of storage. We envisage there would be inconsistencies with this process and rely too heavily on hospital and medical clinic administrative staff.

Question 5–2

Random checks may have more authority than relying on attorneys to provide annual reports.

Proposal 5–4

This could potentially make the process more complex. We support this on the basis that witnesses need to consider whether the person appeared to understand the nature of the document that they are signing. This is crucial, however we would be concerned about training needs and accountability around witnessess being able to properly and confidently assess a persons understanding of what they are signing. This raises issues with global competence versus domain specific. We have noted that current informally managed processes have resulted in the document not being completed properly as per practice experience. Who checks that the documents are completed properly?

Proposal 5–5

Agreed, consideration needs to be given to 'intentional' acts versus 'unintentional' acts. Professionals would need to assess such circumstances thoroughly.

Proposal 5–6

We support this however foresee challenges where an adult child needs to sell a property for the older person to enter  residential aged care. There is anticipated conflict of interest where there same asset is identified in the will and/or this adult child may be executor of the will.

Proposal 5–7

How do we govern this? In our experience, these questions have not been asked of potential attorneys at tribunal hearings.

Proposal 5–8

Agree

Proposal 5–9

Agree that records need to be kept however complexities surround legitimate arrangements where properties have been co-purchased, this is common from practice experience.

Proposal 5–10

Yes, consistency is paramount.

Proposal 5–11

changing of the term could be cause for more confusion.

Proposal 5–12

Proposal 5–13

Agreed, how would this be monitored?

Proposal 6–1

Yes.

Question 6–1

For practicalities it may be difficult to enforce compulsory training. Information needs to be routinely provided about the role (considering culturally and linguistally diverse community needs with this). An online training package as an option would be beneficial to some groups of people (videos, examples, scenarios). Consider portal for guardians/administrators as a 'go to' place for support (from peers as well), questions and education.

Proposal 6–2

Yes.

Question 6–2

Question 6–3

In theory it would be best practice for the represented person to attend every hearing, however practicalities can make this difficult. If the represented person is not present at the tribunal hearing, what efforts have been made to explore the persons previously stated wishes? This question should be asked in the application form and tribunal process.

Proposal 7–1

Yes

Proposal 7–2

Concerns around assessing the persons capacity/competence to make this decision in the first instance. This is really no different to appointing an EPOA and should be treated with the same level of seriousness. This reverts back to training of bank staff  and considering levels of perceptiveness around the situation presented to them.

Question 7–1

It would be beneficial for the superannuation Industry Act be ammended to prescribe certain arrangements for the managment of self managed superannuation funds in the event that a trustee loses capacity.

Question 7–2

Proposal 8–1

Agree

Question 8–1

The definition of family should be broad enough to cover situations where one partner in a defacto relationship passes away and the surviving spouse may wish to enter into a family agreement with their deceased partner's child or niece/nephew.

Proposal 9–1

Consideration needs to be given on how to govern "the importance of ensuring thatg the person understands the nature of the document and knows and approves of its contents, particularly in circumstances where an unrelated person benefits. We need to consider how this is documented in the hospital setting, how is capacity determined by legal practitioners and is this documented in the medical file? There are examples where this has taken place in the hospital setting without any staff being informed at the time, no documentation completed and where the patient has lacked capacity from a medical perspective.

Proposal 9–2

Proposal 9–3

Proposal 10–1

Agree

Proposal 10–2

Agree, where possible and practicable. Considerations  of speech and hearing impariments as well as where English is not a first language need to be addressed. Onsite Centrelink services in hospitals would be beneficial in responding to potential elder abuse and reducing the risk. There are often limitations as Centrelink does not have an outreach model in the aged care/health sector (ACAS, hospitals, aged care facilities).

Proposal 10–3

Agree.

Proposal 10–4

Agree, streamlined training for bank and centrelink staff (considerations of front line staff in all relevant industries). Enhancing the financial literacy of older persons in agreements that involve Centrelink is critical to safeguarding against financial abuse.

Proposal 11–1

Proposal 11–2

Agree that the definition needs to widen to "reportable incident". We agree with the definition "a" and should perhaps widen to explicitly include emotional abuse and verbal abuse.

Proposal 11–3

Whilst the remedy may be different, this should still be reported. They may be organisation wide strategies that can be implemented if incidents repeatedly occur (a way to identify behavioural approaches, physical enironment and location  and resident mix/matching).

Proposal 11–4

Agree

Proposal 11–5

Agree

Question 11–1

A sexual offence, sexual misconduct, act of violence or assault, fraud/financial abuse

Question 11–2

2 years

Question 11–3

Proposal 11–6

Agree

Proposal 11–7

Agreed - consistent policies/procedures across all aged care facilities would be recommended

Proposal 11–8

Agree, this would be a disempowering process.

Proposal 11–9

Agree. Yes there should be a protocol for responding to suspected and confirmed cases of elder abuse which would inlcude mandatory safety planning for staff. This would need to form part of an annual discussion process (mandatory training) and general workplace culture.

Proposal 11–10

Agree, the families would also need to be considered in this process. It may be difficult for families to 'speak up' due to fear of their loved one being treated differently as a result. Issues of power within residential care facilities would need to be considered.

Proposal 11–11

Agree, where and when appropriate for the resident and staff. It would be good to consider a process where the official visitor could also confer with families.