



# Elder Abuse: One Report Too Many?

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**“Usual sledgehammer  
to crack a nut.”**

# Federal Government initiatives

- Increase in **unannounced spot checks** in residential care commenced 2006
  - Minimum of one per year per home
- **Police checks** for residential and community care workers introduced mid 2007
  - Expanded to cover non-contact staff in 2009
- **Compulsory reporting of missing residents** from beginning of 2009
  - Report within 24 hours to DoHA when a missing person is reported to the police
  - Discretion with provider about when an incident needs to be reported to the police

# Federal Government initiatives

- Complaints Resolution Scheme replaced by **Complaints Investigation Scheme (CIS)** from May 2007
  - Focus on investigation rather than mediation
  - New Office of Aged Care Quality & Compliance in Department of Health & Ageing (DoHA)
    - Originally \$90m for additional 100 staff
    - At June 2009, 156 CIS staff
    - 7500 investigations in 2007-08, with 930 breaches and 214 notices of required action issued to providers

# Federal Government initiatives

- **Compulsory reporting of assaults** in residential care from July 2007
  - Of physical or sexual assaults on residents by staff, residents or others
  - To police and DoHA within 24 hours
  - Whistleblower protection provisions for staff

# Compulsory reporting

- Requirement to report
  - Unlawful sexual contact with a resident
  - Unreasonable use of force with a resident
- Timeframe for reporting
  - To police and DoHA within 24 hours
    - Police investigate any criminal action
    - DoHA investigate provider compliance with Aged Care Act
- Discretion not to report
  - Alleged assaults perpetrated by residents with an assessed cognitive or mental impairment
  - Subsequent reports of same or similar incident

# Compulsory reporting: provider responsibilities

- Requiring staff members to report to
  - Provider
  - One of their key personnel
  - Another person authorised by provider to receive reports
  - Police; or
  - DoHA
- Having internal policy on abuse
- Training staff
- Maintaining records of assaults, resident assessments and behaviour plans

# Whistleblower protection

- A person qualifies for protection if
  - A staff member or approved provider
  - Disclosure made to appropriate person
  - Discloser provides name before making disclosure
  - Discloser has reasonable grounds to suspect a reportable assault has occurred
  - Disclosure made in good faith

# Whistleblower protection

- Under these conditions, discloser protected from
  - Criminal or civil liability (unless they are the perpetrator), or defamation
  - Termination of employment
  - Victimization
- These protections do not apply if confidential information released to wrong people

# Context

- Assault legislation
  - 2007 ABC Lateline revelations
    - Reported sexual assault mixed in with dubious allegations of poor practice from disaffected staff
  - Pick up by media outlets across Australia
    - Some cases 7+ years old
- Missing persons legislation
  - A handful of reports in media about missing people during 2008
- CIS review
  - 2009 ABC Four Corners story

## What strikes you about this?

“The introduction of compulsory police background checks for aged care workers and volunteers was one element of the Howard Government’s \$100 million response to the small number of serious instances of abuse of the elderly which came to light early in 2006.”

*Senator Santoro, media release 5  
January 2007*

# What strikes you about this?

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# Mandatory reporting?

- Arguments for
  - Ensures cases come to public attention
  - Puts issue on social agenda / may attract funding
  - Provides clear procedures
- Arguments against
  - Removes autonomy of older people
  - Most cases already known to service providers
  - Most reports from non-mandated sources
  - Problem is not finding cases, but doing something about them
  - Administratively costly and bureaucratic

# Mandatory reporting elsewhere

- Only adopted for elder abuse in North America
  - 44 US States and 2 Canadian Provinces
  - Reports to Adult Protective Services or Long Term Care Ombudsmen
  - Less than half of reported cases are substantiated
- Rejected by Australian State and Federal government committees
- Child protection model applied to elder abuse
  - Major problems with child protection systems
  - NSW Wood Special Commission found “Too many reports are being made to DoCS which do not warrant the exercise of its considerable statutory powers.” Only 13% of reported cases received home visits

# Success criteria for mandatory reporting

1. Accurately identifies most serious cases
2. Doesn't result in reporting of non-cases
3. Respects the rights of older people and follows procedural fairness for all parties
4. Improves chances of obtaining criminal convictions
5. Assists in prevention of abuse

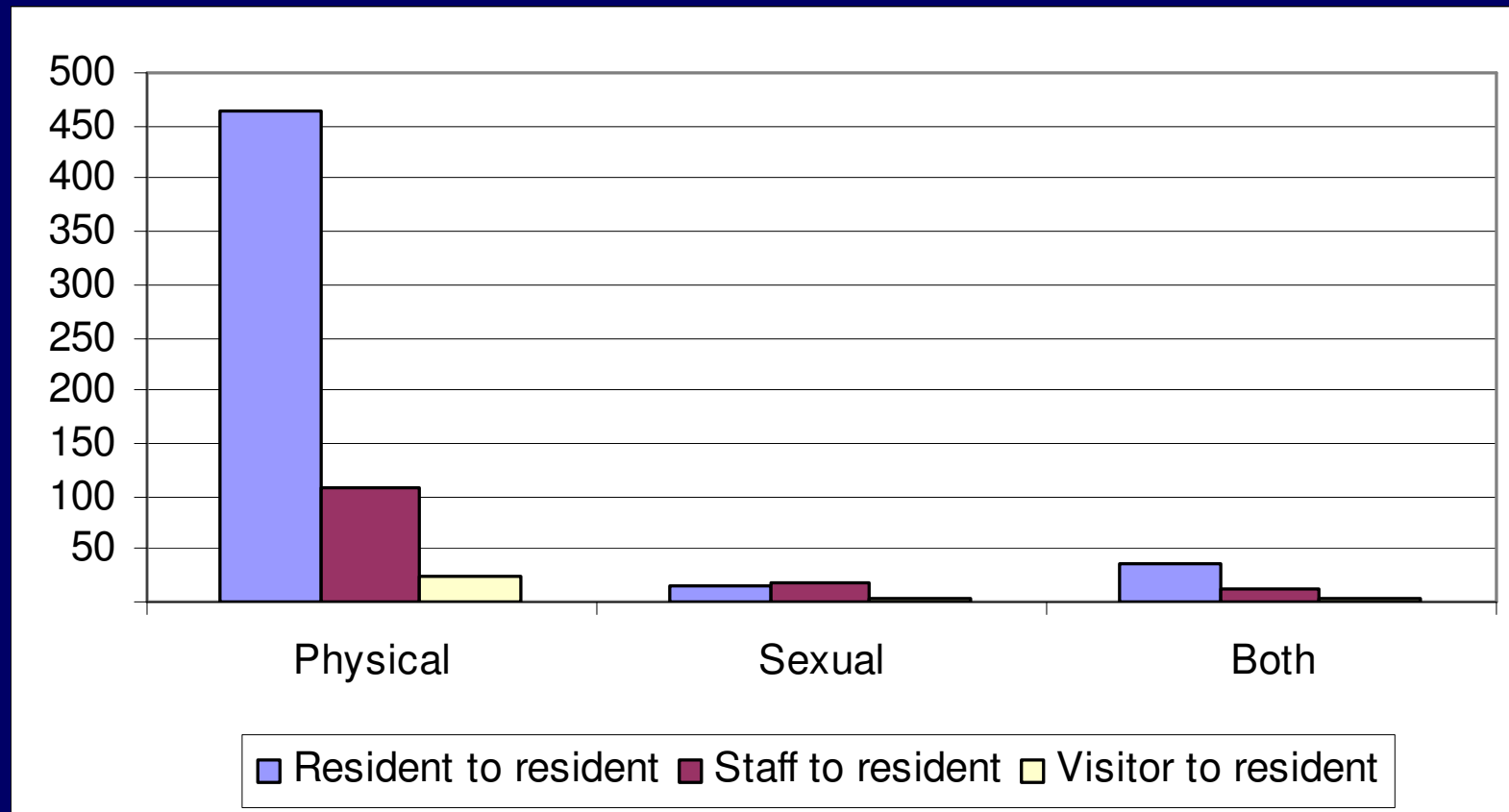
# ACSA Survey

- National ACSA survey on elder abuse reporting
  - Online at [www.agedcare.org.au](http://www.agedcare.org.au)
- Information sought on cases in 2 years from July 2007 to June 2009
- 243 responses:
  - From all states and ACT, but 57% from NSW [*Differences noted*]
  - 55% providers with only 1 aged care home
  - 51% operating in regional areas; 37% in large metropolitan areas; 30% in regional cities; 5% in remote areas
  - Three quarters of responses completed by facility management

# Reportable assaults

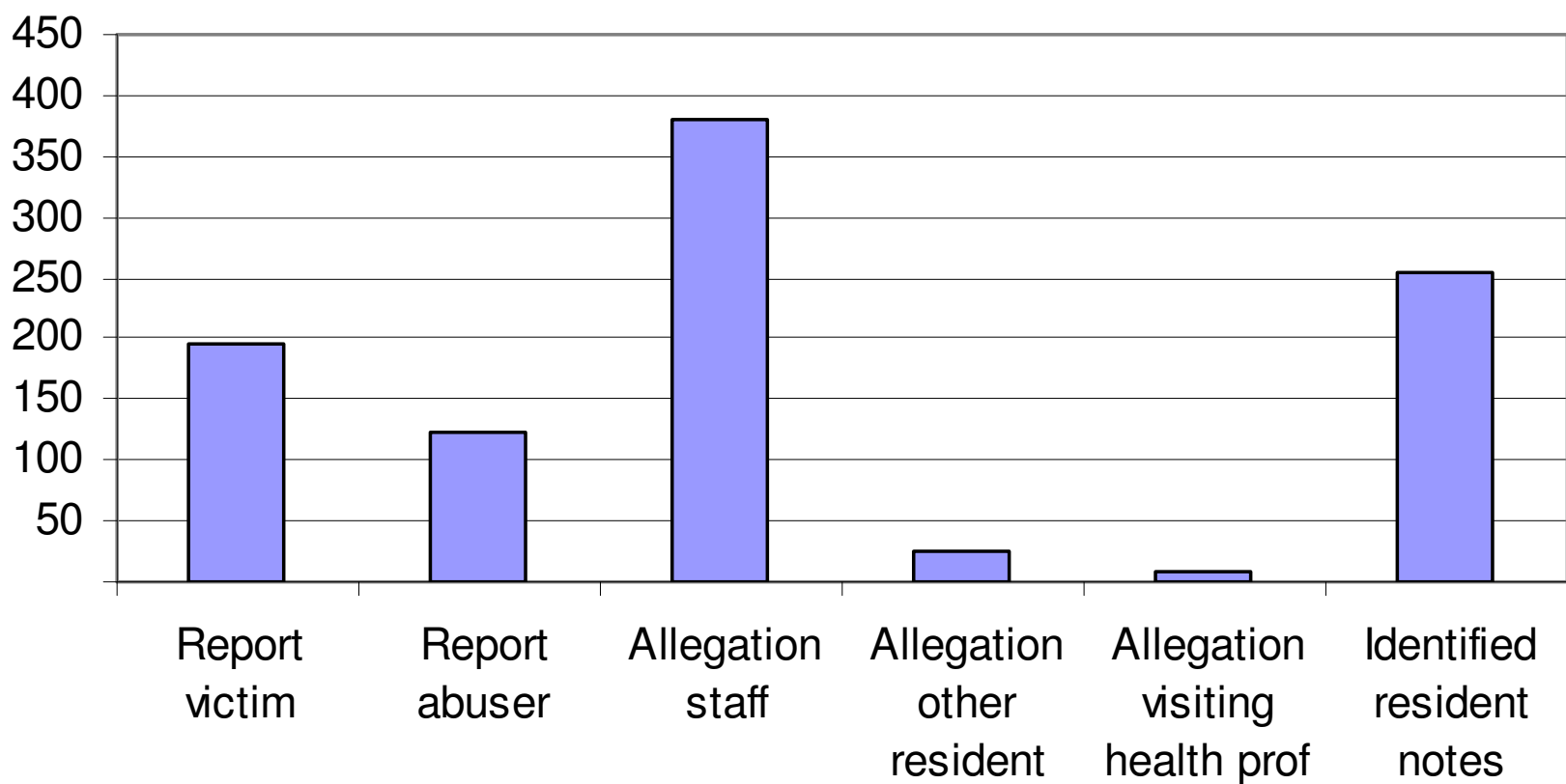
- 242 reports made about reportable assaults (average of 1.65 per respondent)
  - 136 from NSW at lower average of 1.58 per respondent
- 682 reportable assaults
  - 87% physical; 5% sexual; 8% both
  - Alleged perpetrator 75% resident; 20% staff; 5% visitor
  - 23 alleged cases involved more than 1 victim

# Number of alleged assaults



# Source of information

(Numbers reported)



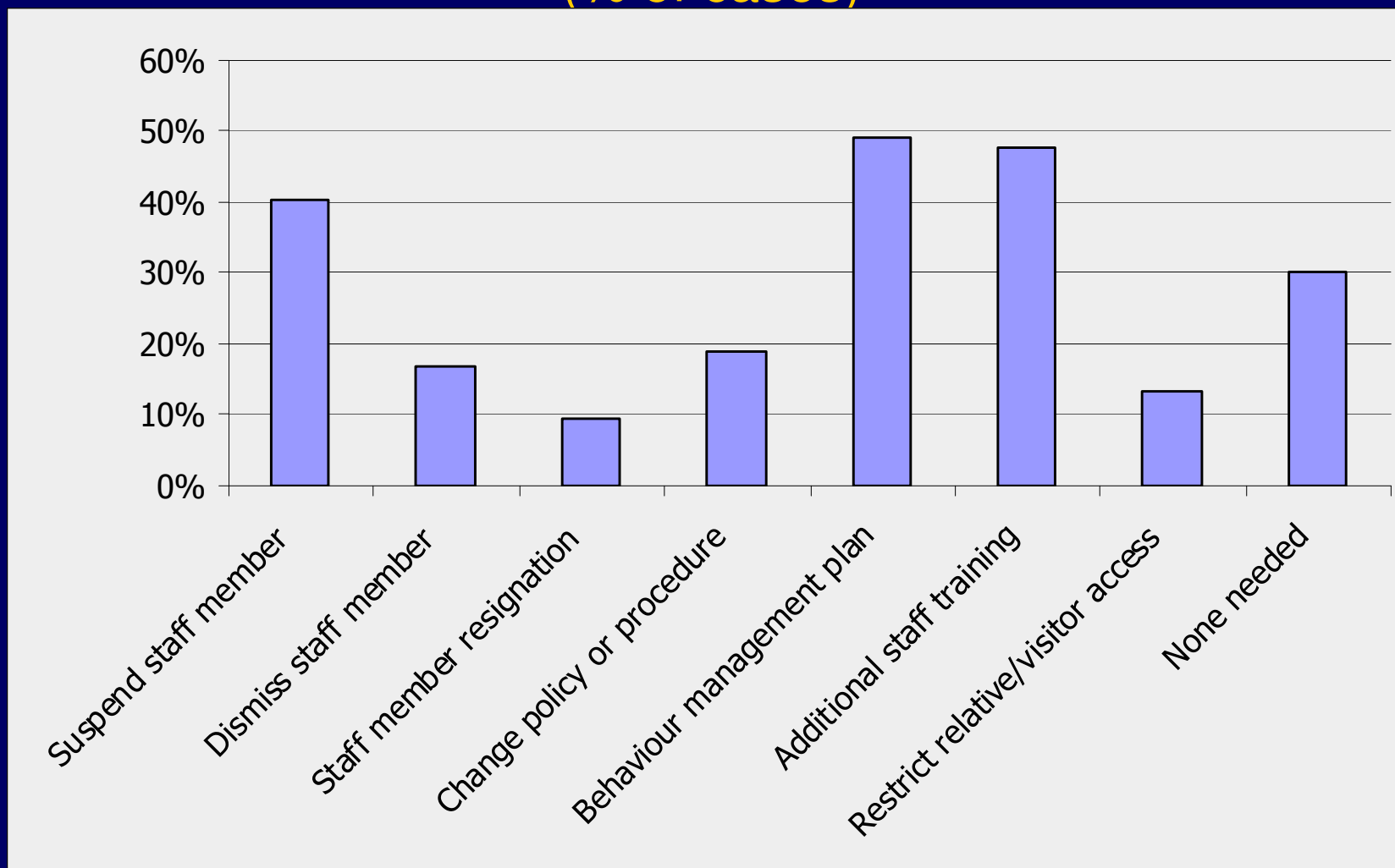
Tally may be greater than the total number of incidents due to multiple reporting of a single incident

# Reporting timeframes

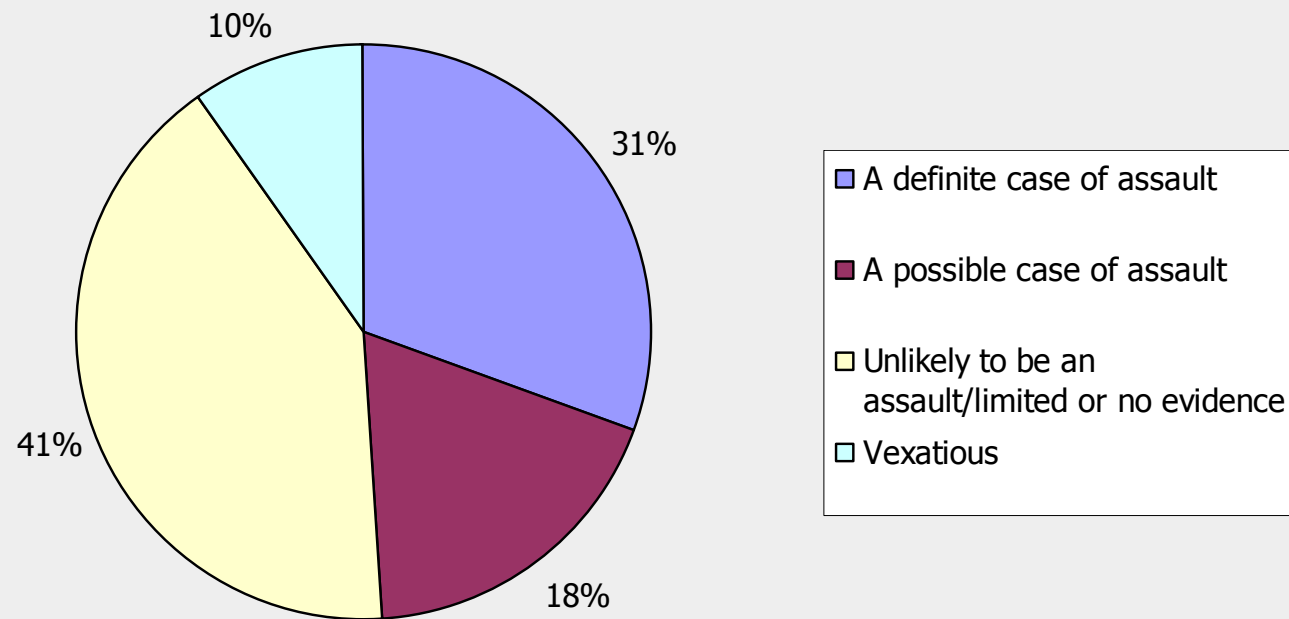
- To Police
  - 51% reported all cases on time
  - 31% most or some cases
  - 18% none
- To DoHA
  - 55% reported all cases on time
  - 34% most or some cases
  - 11% none

% of cases where providers made reports

# Other actions taken by provider (% of cases)

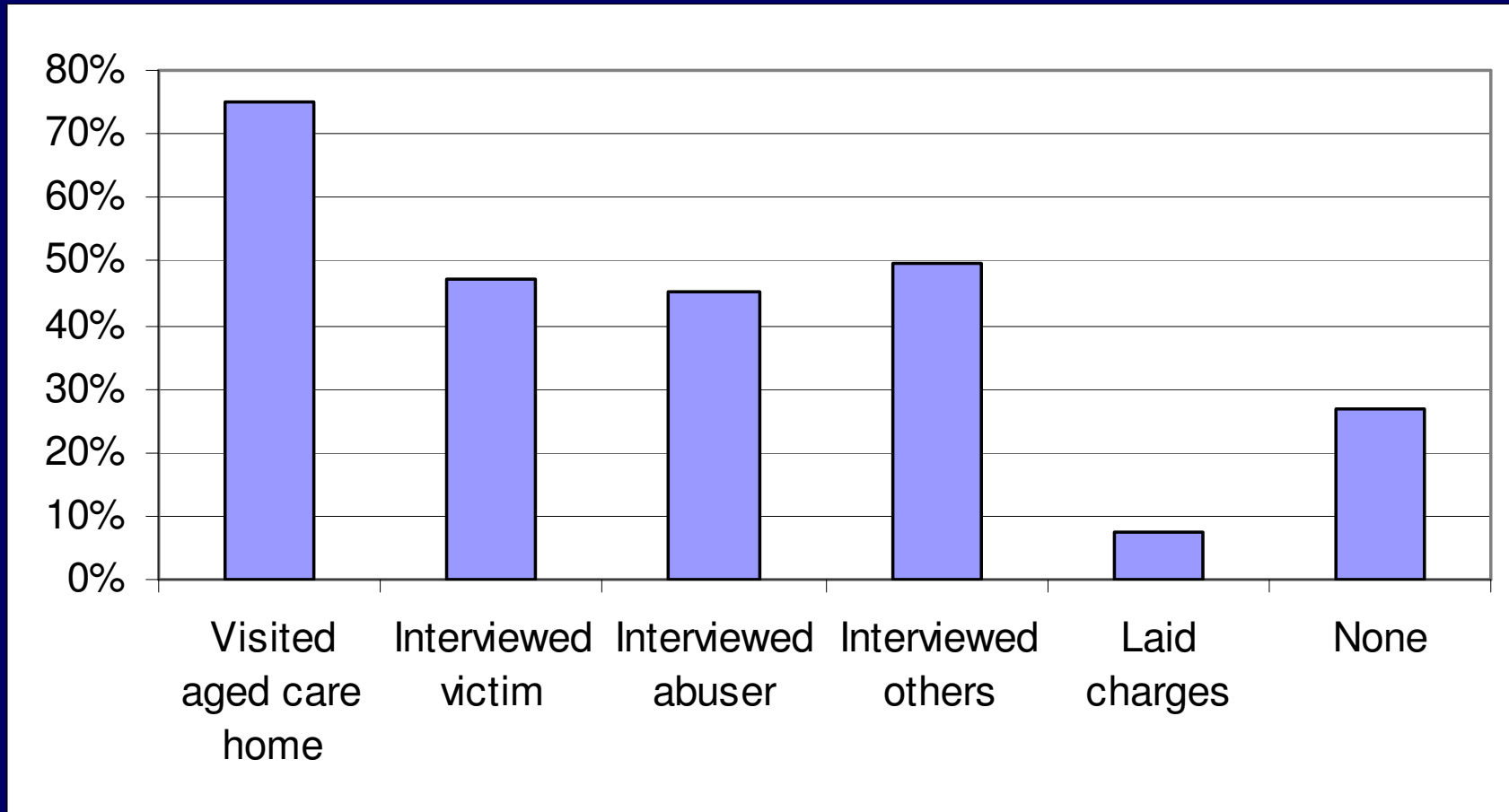


# Providers verdict on status of reportable assaults



NSW 44% unlikely; 15% vexatious

# Police actions

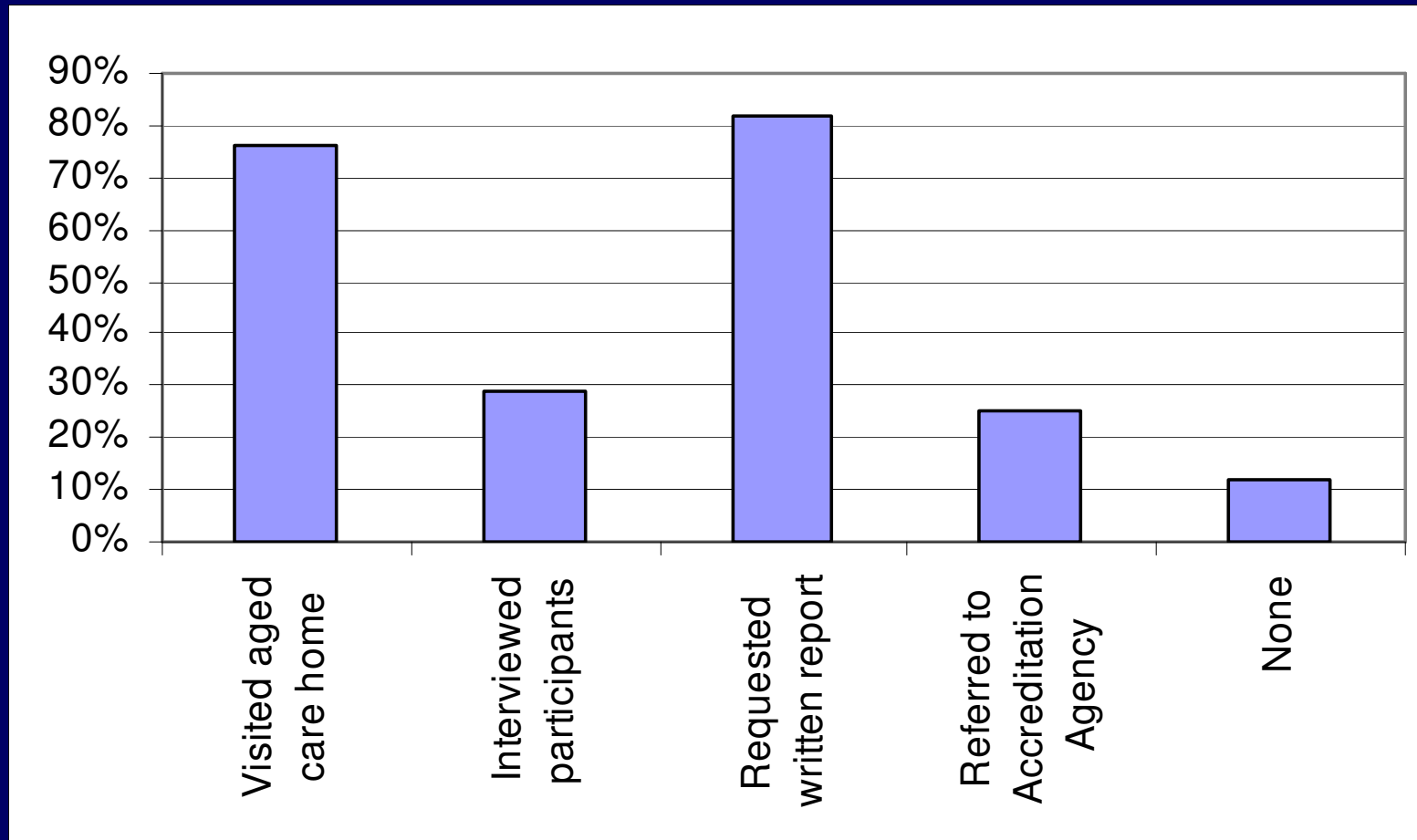


% of cases where providers made reports

# Criminal charges or convictions

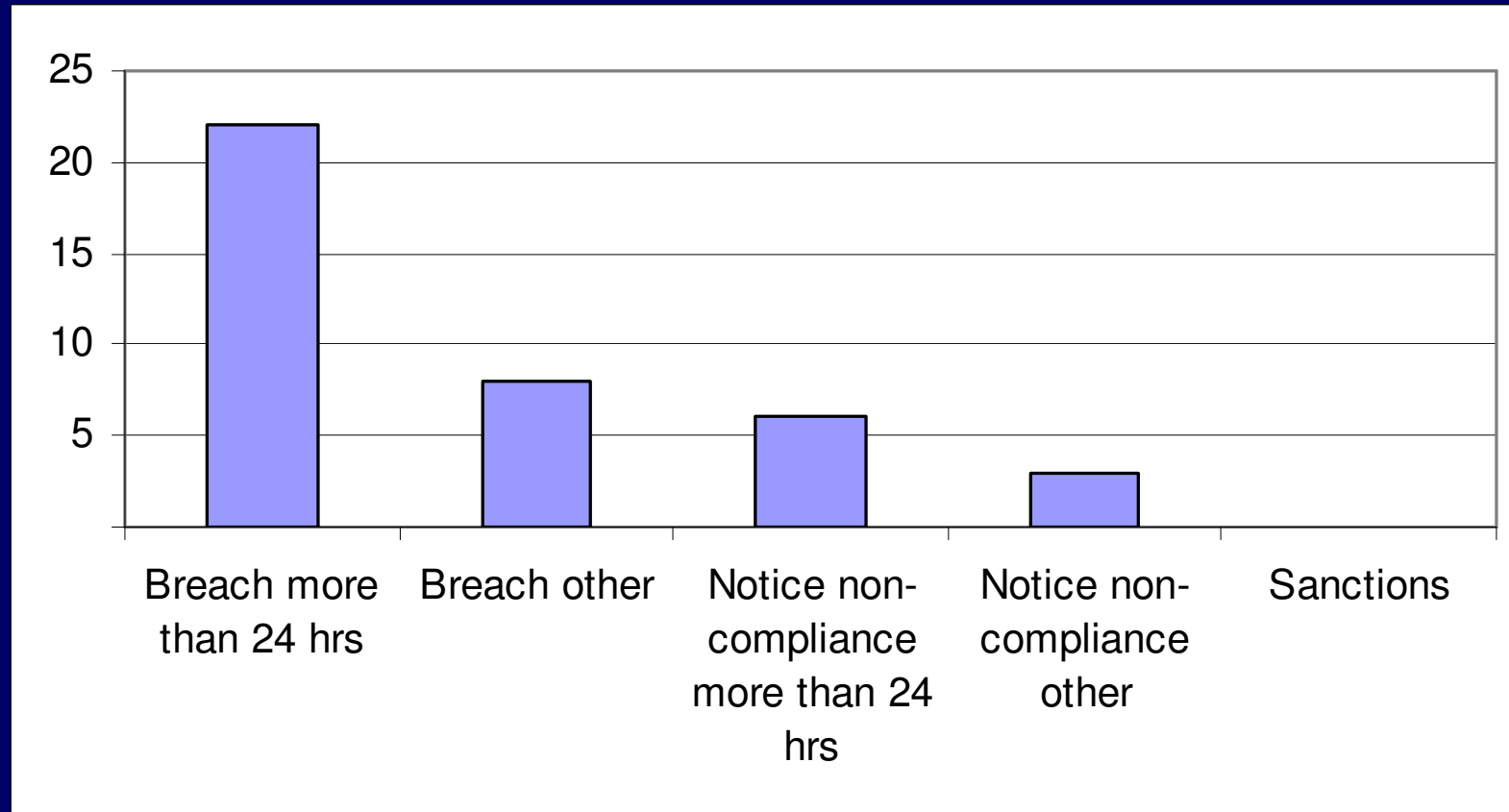
- Only 7 charges laid by police (1% of reportable assaults)
- 3 court convictions (0.4% of reportable assaults)

# DoHA actions



% of cases where providers made reports

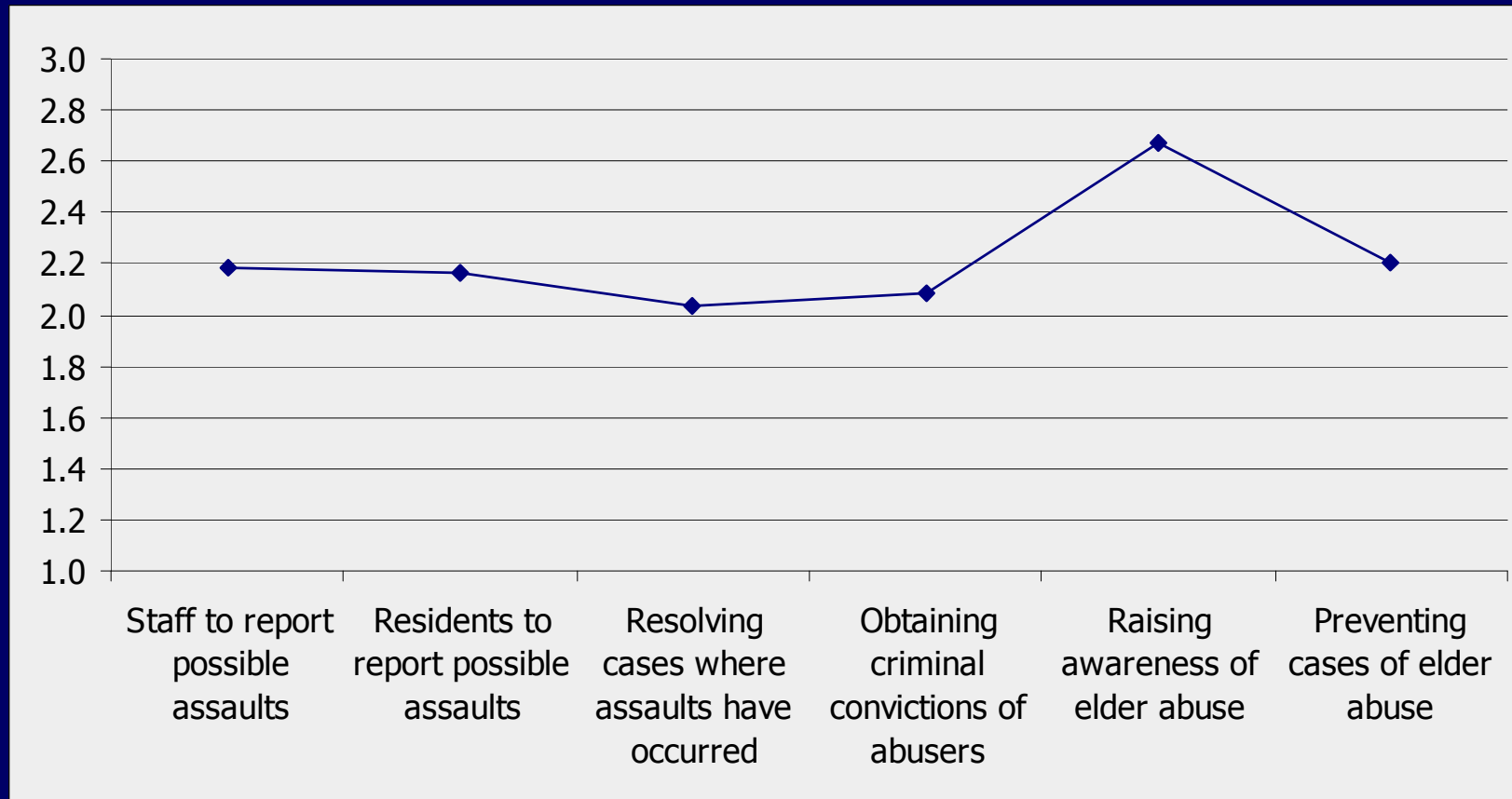
# Compliance action against providers



# Media issue?

- Only 4 cases resulted in reports in media (0.6% of reportable assaults)
- All in NSW
- In 2 cases aged care home not identified
- In 1 case, relative went to media before reporting to home management

# Has legislation made it easier or more difficult?



1 = made more difficult; 2 = no change; 3 = made easier

# Success Criterion 1

## Accurately identifies most serious cases

- Initial concern was to respond to serious assaults by staff

### *Result*

- Three quarters of reportable assaults are resident to resident incidents

# Success Criterion 2

**Doesn't result in reporting of non-cases**

## ***Result***

- Half of “reportable assaults” unlikely to actually be assaults or are vexatious

# Success Criterion 3

**Respects the rights of older people and follows procedural fairness for all parties**

## ***Result***

- Older people denied right to say “No” to police or DoHA involvement
- Three quarters of breaches issued to providers for missing arbitrary 24 hour deadline
- No timeframe applied to DoHA or police

# Whose rights?

“The right of a resident to choose NOT to have such an action reported should be reinstated. It's their life. It is and should remain only a police matter. The investigative processes undertaken by the Department are extravagant given the nature of the experiences here.”

# Whose rights?

“I also believe that the department have infringed on a residents rights in one instance by insisting that the matter be reported to the attending GP against the express wishes of the resident concerned.”

# Consequences

“We were breached because we did not have a register-log, despite the fact that this was our only case. I felt that was unfair.”

# Conflicting responsibilities

“There are issues around two conflicting legislations. Whistleblower protection for reporters of elder abuse - we take this seriously but had to answer an unfair dismissal case at the industrial commission which cost the facility a large amount of money because the IR legislation allows staff to be informed if a complaint is made against them. Including the name of the person making the allegation/complaint. We chose to protect the identity of the reporter of the assault and had to pay out a staff member that we dismissed over an elder abuse incident.”

# Success Criterion 4

**Improves chances of obtaining criminal convictions**

## ***Result***

- Only 1 in 100 reports result in charges being laid; 1 in 200 in criminal convictions
- 5.7 times more likely to result in legal action against provider than alleged abuser

# Gaining convictions

“We went through hell!!! No-one could help us!! We were given advice about what to do from anyone and everyone other than santa claus!!. We were unable to get the man convicted of his sexual offences because the courts do not allow third party witnesses.”

# Success Criterion 5

## Assists in prevention of abuse

### *Result*

- Providers confirm success in raising awareness of abuse
- Poor experience of fairness and effectiveness of investigation processes discouraging reporting

# Positive results

- “The compulsory reporting has improved our system and clarified for staff what to report. We have included compulsory reporting in our orientation program for new staff, and the compulsory reporting brochure we developed is included in the new staff kit.”
- “We have now moved on from our initial frustrations with the system. We have put a process in place that allows us to manage any allegations quickly and efficiently.”

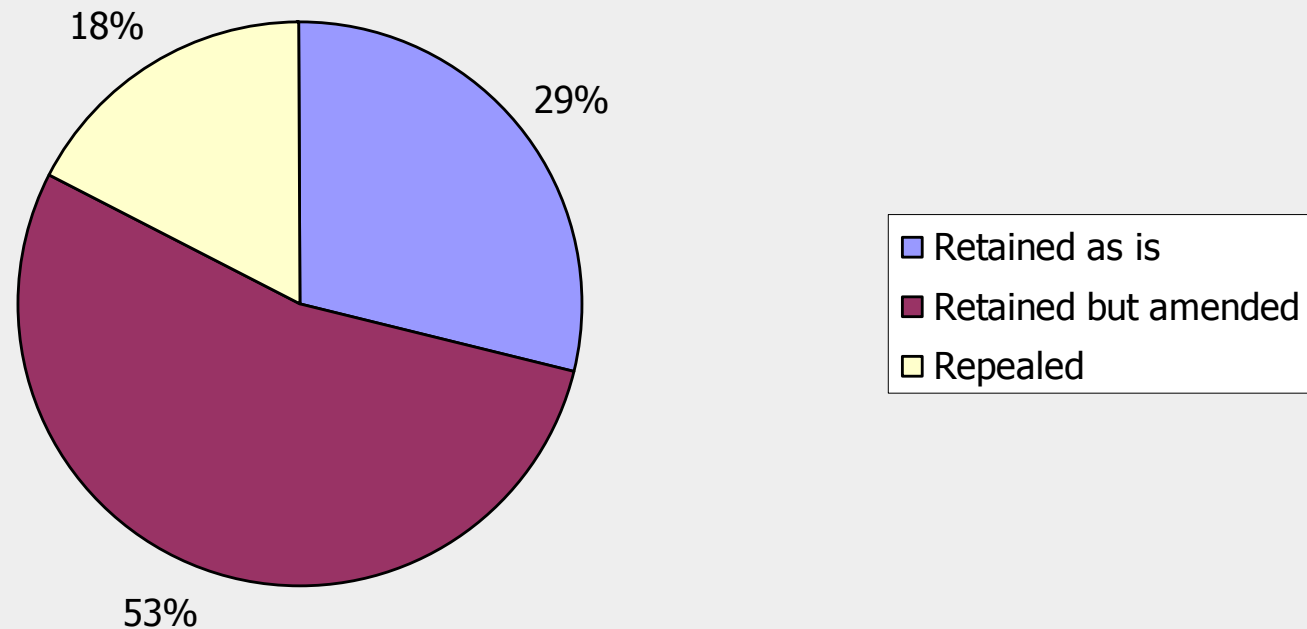
# Why not to exercise discretion to report

“One of the ... incidents was not reportable as the resident who assaulted the other resident had dementia. We did report as a courtesy because the victim was hospitalised, but what was really disappointing was the DHA arriving on our doorstep unannounced and requiring us to drop everything for the day to participate in a very grueling investigation. They found that we acted appropriately before during & after the incident, but it was not a pleasant experience and I will certainly think twice before reporting voluntarily again.”

# Consequences

“When this incident occurred, a mother assaulted her son who was a resident of our facility. I as manager reported and recorded the incident as required by the law and within the terms of the legislation. However I was investigated to ensure I did not breach any of the requirements of the legislation. This investigation assumed I as manager was guilty until proven innocent. What an absurd way to ensure cases like this are reported, how did this action by the department support me in protecting the resident? Would I be likely to report such incidents again when I know this is how I will be treated? Absolutely not unless there was a serious assault which I knew required a conviction of the assailant.”

# What should the future be for mandatory reporting?



# A better way

- Commission research on the scope and nature of elder abuse in Australia
- Fund training of aged care staff and police
- Fund police checks and explore proper staff vetting procedures
- Make the Complaints Investigation Scheme fair
- Recognise staff burnout is a major risk factor in residential care and therefore fund aged care adequately
- Respond to abuse in domestic settings, where more older people are at risk

# Making it work better

“Elder Abuse reporting to the Department should be made following an internal investigation and follow up by police if necessary. Reporting to the Dept. is premature before these steps are taken. ... The reporting deadline of 24 hours needs to be changed to 1 week, whilst police are under-taken the appropriate investigation. Reporting to the Dept. should then incorporate police findings. Department should only act on those findings and not be judge and jury and police investigators all in the same breath (separation of powers required most definitely).”

# Making it work better

- “CIS system encourages vexatious and anonymous reports. These should be excluded, while confidential reports allowed.”
- “Please remove 'suspected' abuse. If a demented resident states that a staff member has assaulted them, a report has to be made. If there is an ongoing pattern of behaviour from such a resident with documentation and behaviour forms to prove such, the mandatory reporting process wastes everyone's time as it is only a behaviour rather than actual abuse.”

# Making it work better

- “We support Police Checks and thorough staff 'screening', selection and orientation processes to assist in ensuring our staff are fully aware of appropriate and professional care standards. We believe that appropriate selection, orientation and training of staff, volunteers and contractors is a more effective process in the prevention of resident abuse.”
- “Improve course content of Aged Care Certificate to cover Elder Abuse in greater depth.”

# Are police checks enough?

- “There should be an elder protection register (like the child protection register) that employers have access to. At present staff members can simply get a job elsewhere as the new employer has no knowledge of previous problems.”
- “I feel that there should be a register for personal care workers, to allow monitoring, investigation and work restrictions as exists for div 1 and 2 nurses.”

# Conclusion

- Abuse is real, and needs to be taken seriously
- Over-reacting due to moral panics hasn't helped
- Current reporting legislation **must** be repealed or significantly amended
- Work with ACSA and the State Associations to make it happen!