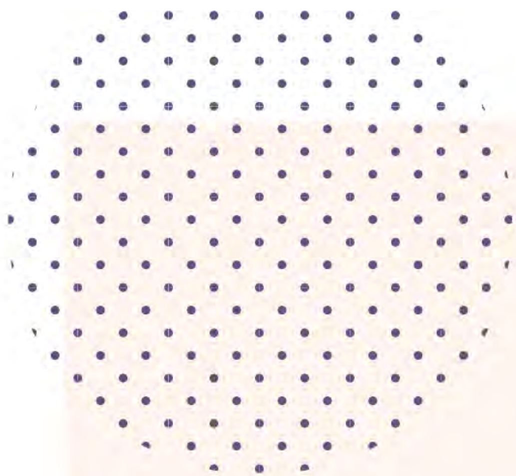
ROYAL COMMISSION INTO AGED CARE QUALITY & SAFETY: EXTRACTS FROM THE FINAL REPORT WHERE SEXUAL ABUSE IS BROUGHT UP/DISCUSSED



This is a joint publication of Celebrate Ageing and the Older Women's Network NSW

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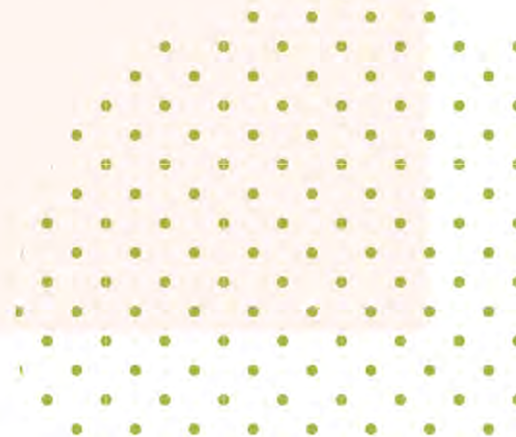
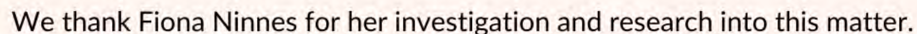


Background To The Paper

In 2019, the Older Women's Network NSW and Celebrate Ageing decided to work together to raise awareness of the issue of sexual assaults perpetrated against older women in residential aged care facilitites. It follows the work of Dr Catherine Barrett, founder of Celebrate Ageing, who documented the sexual assault of 94 year old Margarita Solis in her facility. She bravely decided to speak out and raise awareness of the issue in 2018.

The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018. It presented an opportunity for OWN NSW and Celebrate Ageing to provide submissions to the Royal Commission on the need to take the sexual assaults in residential aged care facilities seriously. In their final report, both Commissioners agreed that the current situation where up to 50 sexual assault cases taking place is a national disgrace.

This paper presents in table format extracts from the Final Report of the Royal Commission outlining where sexual abuse/assaults are mentioned. It is hoped that this will assist those researching this issue, as well as advocates, to work towards keeping older women safe in residential aged care facilities.



We thank Fiona Ninnes for her investigation and research into this matter.

References to sexual abuse in the 2021 Aged Care Royal Commission

A Summary of the Final Report[1]	Page 68	Substandard care can also take the form of deliberate acts of harm and forms of abuse—including physical and sexual abuse and abuse from inappropriate restrictive practices. Abuse is an extreme example of substandard care and reaches into the realm of criminal behaviour… The abuse of older people in residential care is far from uncommon. In 2019–20, residential aged care services reported 5718 allegations of assault under the mandatory reporting requirements of the Aged Care Act. A study conducted by consultancy firm KPMG for the Australian Department of Health estimated that, in the same year, a further 27,000 to 39,000 alleged assaults occurred that were exempt from mandatory reporting because they were resident-on-resident incidents. In our inquiry, we heard of physical and sexual abuse that occurred at the hands of staff members, and of situations in which residential aged care providers did not protect residents from abuse by other residents. This is a disgrace and should be a source of national shame. Older people receiving aged care should be safe and free from abuse at all times.
A Summary of the Final Report[2]	Page 140	The estimated number of alleged incidents of unlawful sexual contact in 2018–19 could be as high as 2520, or almost 50 per week. This is a disgrace and should be a source of national shame. A serious incident reporting scheme is an important way to ensure that approved providers respond appropriately to incidents of abuse and neglect. The existing compulsory reporting scheme in aged care is unsatisfactory. It has a limited scope of incidents that must be reported, and information reported by approved providers is not used effectively. In 2017, the Australian Law Reform Commission and the Carnell-Paterson review expressed similar concerns about the existing scheme and recommended that a new serious incident scheme for aged care be introduced. The Australian Government has announced a new scheme will commence on 1 July 2021. This scheme will require reporting of a much wider range of incidents than is currently the case. The expanded scope of incidents covered is a welcome development and will greatly improve the regulator's oversight of abuse and neglect in residential aged care. However, expansion of the coverage of the scheme only addresses one of the defects in the current arrangements. Without an expansion of the scheme to home care, purposeful action on the reports of serious incidents, and greater transparency around the scheme, the abuse will continue. Further improvements are required. The objectives of the new Serious Incident Response Scheme should be clearly set out in legislation. In our view, the central object of any serious incident reporting scheme must be to protect people receiving aged care services from harm.

[1] https://agedcare.royalcommission.gov.au/publications/final-report-executive-summary
[2] Ibid

Recommendations[3]	Page 206	**Recommendation 2: Rights of older people receiving aged care** The new Act should specify a list of rights of people seeking and receiving aged care, and should declare that the purposes of the Act include the purpose of securing those rights and that the rights may be taken into account in interpreting the Act and any instrument made under the Act. The list of such rights should be: … b. for people receiving aged care i. the right to freedom from degrading or inhumane treatment, or any form of abuse
Final Report Volume 2[4]	Page 45	Since 1 July 2007, the Australian Government has required approved providers of residential aged care to report certain alleged or suspected physical and sexual assaults against residents. This requirement does not apply if the alleged perpetrator is a fellow resident with a diagnosed cognitive or mental impairment and the provider puts in place arrangements to manage the alleged perpetrator's behaviour. In June 2020, the Australian Government announced that it would introduce a Serious Incident Response Scheme from July 2021.[332] This scheme will require reporting of a broader range of serious incidents, including incidents of abuse in aged care where the resident who allegedly commits an incident has a cognitive or mental impairment.
Final Report Volume 2[5]	Page 96-97	**Sexual abuse** The accounts of sexual abuse that we heard about were deeply concerning. Ms Lisa Corcoran, who moved into residential aged care when she was in her late 30s, gave evidence that she was sexually and physically assaulted while living in aged care.[32] 'Elizabeth', a registered nurse, recounted an incident where a female resident living with dementia wandered into another resident's room and was sexually assaulted.[33] Ms Susan Walton, an assistant in nursing, gave evidence about a resident living with dementia who was 'wandering, sexually advancing towards ladies'.[34] A number of public submissions included accounts of sexual abuse of people by residential aged care staff members. The following account was provided by the wife of a man living in residential care: My 71 year old husband is a resident in aged care because of advanced Parkinson's disease. On the night of December 31 2018 he was horrifically sexually abused by 2 night duty staff resulting in a very red, swollen and grazed penis. 1 nurse a female held him down while the other, a male masturbated him. He is frightened, withdrawn and very distressed.[35]

[3] https://agedcare.royalcommission.gov.au/publications/final-report-list-recommendations
[4] https://agedcare.royalcommission.gov.au/publications/final-report-volume-2
[5] Ibid

		One woman wrote to tell us that her mother was the victim of sexual assault in residential aged care: she was repeatedly subjected to sexual assault by the night staff. She was so terrified of them that she would not tell me at first about what was happening. The men involved had threatened to kill her if she spoke about what they were doing. This was also happening to the woman in the room with her. Sexual assault in nursing homes is something that needs to be brought into open discussion.[36] A number of public submissions outlined incidents of sexual abuse between residents. One person who made a submission said a staff member had told her: As she [staff member] moved closer, she saw that the male person, who she recognised as the man who occupies the room across the hallway, had his hand placed inside the incontinence pad and underwear that our mother was wearing.[37] Another person described an incident where his mother was sexually assaulted: The latest was a sexual assault which occurred whilst she was in her room in her bed, perpetrated by one of the other residents who was able to wander freely into her room and assault her.[38]
Final Report Volume 2[6]	Page 142	The number of allegations of sexual assault has increased over the past six years in line with overall assaults. There were 426 allegations of sexual assault in 2014–15, which increased to 851 reports in 2019–20. As concerning as these figures are, they significantly understate the true extent of alleged assaults in residential aged care because resident-on-resident alleged assaults are generally not reportable. A 2019 report by KPMG analysed assault data submitted by 178 residential aged care services. Its analysis found that resident-on-resident alleged assaults were significantly more prevalent than suggested by publicly available figures.[406] The estimate was that 26,960 to 38,898 physical or sexual assaults per year were occurring that were exempt from reporting across Australia.[407] When these estimates are added to the existing assault allegations for the 2018–19 financial year, the incidence of assaults increases from 2.16 to 13–18 per 100 residents.[408] Alarmingly, the report indicated that as many as 1730 additional reports of sexual assault may result if a broader definition of reportable assault was applied.[409] Again, the data shows a significant problem, but it does not provide an adequate basis to ascertain the extent of substandard care principally because the reports are of unproven allegations which are rarely investigated.
Final Report Volume 2[7]	Page 160 - 161	The number of allegations of sexual assault have increased over the past six years in line with overall assaults. There were 426 allegations of sexual assault in 2014–15, which increased to 851 reports in 2019–20.[488] This is deeply concerning. This increase in the reporting of allegations of assault, including sexual assault, was far greater than could be accounted for by the increase in permanent residents over the same time period. Many of these reports alleged

[6] Ibid
[7] Ibid

serious instances of substandard care, with the accused abusers consisting of staff members, family members and strangers.

The number of reportable assaults may be underestimated due to some poor reporting practices. A representative for Japara Mitcham explained that an incident had not been reported because she considered it to be ‘rough handling’ rather than assault, despite evidence from the Chief Executive Officer of Japara that ‘there are no separate criteria applied in distinguishing rough handling from reportable assaults’.[489]

The actual rate of assaults is likely to be much higher than is captured in this data because not all assaults are required to be reported. Allegations of assault where the victim is a staff member, family member or other non-resident are not included within the data. Most significantly, the reporting requirement does not apply if the alleged perpetrator is a fellow resident with a diagnosed cognitive or mental impairment and the provider puts in place arrangements to manage the alleged perpetrator’s behaviour.[490] Yet, we know that over half of all permanent residents had a diagnosis of dementia in 2019 (53%).[491] Instances of this type of assault could be indicative of poor care for people with complex behaviours.

As an example, the residential care service with the highest number of reports in 2018–19 (42 reports during the year) reported allegations of abuse that involved residents with a diagnosed cognitive impairment.[492] The residential service explained that it had an internal policy to report all assaults affecting residents, even if these assaults were exempt from reporting. In contrast to this conscientious reporting, many other providers only report those assaults they are required to report. For example, between 10 July 2015 and 6 February 2019, Oberon Village recorded 82 assaults in its reportable assault register.[493] Only 10 of these were reported to the Australian Department of Health. The remaining 72 assaults involved residents with a diagnosed cognitive impairment, making them exempt from reporting requirements.

In 2019, the Australian Department of Health engaged consultancy firm KPMG to complete an analysis of assault data submitted by 178 residential aged care services. Its analysis found that resident-on-resident assaults were significantly more prevalent than suggested by publicly available figures.[494] KPMG estimated that 26,960 to 38,898 physical and/or sexual assaults per year were occurring that were exempt from reporting across Australia.[495] When these estimates are added to the existing assault allegations for the 2018–19 financial year, the incidence of assaults increases from 2.16 to 13–18 per 100 residents.[496] This is much higher than the incidence of 2.4% for allegations of assault reported by people over 15 years of age who live in the wider community.[497] Alarmingly, the KPMG report indicated that as many as 1730 additional reports of sexual assault may result if a broader definition of reportable assault was applied.

We heard that in some cases family members encourage their loved ones to move into residential care because they felt that it would be safer for them or because safety was a concern.[499] But on the contrary, people living in residential aged care likely face a much higher risk of assault than people living in the community.

Final Report – Volume 3A: The new system[8]	Page 262	Police checks are currently required for all staff employed by approved providers and providers delivering care under NATSIFACP or the Commonwealth Home Support Programme. We support the retention of 'precluding offences'—that is, offences that preclude a person from working in aged care—particularly those involving murder or sexual assault.[114] Criminal history checks will be a component of the personal care worker registration that we propose in Recommendation 77. But the various aged care programs in existence at present have different thresholds for the kinds of convictions that preclude a person from any employment in aged care. In particular, NATSIFACP precludes people from aged care work on the basis of a broader range of offences. For instance, a driving offence involving the death of a person may preclude someone from working in aged care.[115] In our view, some convictions should exclude people from aged care employment, but the threshold must be consistent across all of the types of aged care available under the new aged care system. There are instances where providers should be able to exercise discretion and put in place mitigation strategies for other, less serious, convictions. The current NATSIFACP manual focuses on the risk of harm to people receiving aged care and provides instruction on how to weigh up relevant considerations about a person's criminal history.[116] The Aboriginal and Torres Strait Islander Aged Care Commissioner should draft guidance to all aged care providers to assist them to exercise their discretion when employing Aboriginal and Torres Strait Islander people with a criminal record.
Final Report – Volume 3B: The new system[9]	Page 522 - 523	**14.5 Serious incident reporting** The level of neglect and abuse in aged care is unacceptably high. In 2019–20, residential aged care services reported 5718 allegations of assault, including 851 allegations of sexual assault.[196] We have received 588 submissions mentioning sexual abuse. There were 426 allegations of sexual assault reported to the Australian Department of Health in 2014–15, compared with the 2019-20 figure of 851.[197] This is more than two reports per day on average, every day of the year. While these figures are extremely concerning, as set out in Volume 2, the actual extent of abuse in aged care is even higher than these figures reveal. The aged care compulsory reporting scheme excludes an alleged assault by a resident with a diagnosed cognitive or mental impairment, where the provider has put in place arrangements to manage the alleged perpetrator's behaviour.[198] It has been estimated that in 2018–19, there were between 26,960 and 38,898 unreported assaults in residential aged care services.[199] When these estimates are added to the reported 5233 assault allegations for the 2018–19 financial year, the number of alleged assaults in residential aged care was between 32,193 and 44,131. Changes to the current reportable assaults scheme in relation to unlawful sexual contact could result in an additional 1730 incidents of unlawful sexual contact in residential aged care being reported.[200] When that

[8] https://agedcare.royalcommission.gov.au/publications/final-report-volume-3a
[9] https://agedcare.royalcommission.gov.au/publications/final-report-volume-3b

estimate is added to the reported 730 unlawful sexual contact allegations for 2018-19, the estimated number of alleged incidents of unlawful sexual contact in 2018–19 could be as high as 2520 or almost 50 per week.[201] This is a disgrace and should be a source of national shame.

…

A compulsory reporting scheme helps to ensure that approved providers respond appropriately to incidents of abuse and neglect. However, reporting alone will not ensure such an outcome unless measures are taken to address the risk of harm, and people who are abused or neglected receive appropriate medical, psychological and other support.

The existing compulsory reporting scheme in aged care is unsatisfactory for a number of reasons. First, the scope of incidents that must be reported is too limited.[205] Second, the number of reported incidents at each facility and in relation to individual approved providers, is not made publicly available. Third, information reported by approved providers is not used effectively by the regulator to ensure aged care workers who may pose a risk are identified and that appropriate preventative measures are taken.

Before 31 December 2019, all compulsory reports were made to the Australian Department of Health. An officer of the Department gave evidence that the Department's approach to reports before late 2018 was 'mainly focussed on late reporting and low reporting', rather than the care and wellbeing of people receiving aged care services who may be affected.[207] On 1 January 2020, responsibility for the compulsory reporting scheme was transferred from the Department to the Aged Care Quality and Safety Commission.[208] However, while there have been some administrative changes made by the Commission, these changes were not accompanied by any legislative change to the scope or the design of the compulsory reporting scheme.[209]

In 2017, both the Australian Law Reform Commission and the Carnell-Paterson review expressed similar concerns about the existing scheme we have described and recommended that a new serious incident scheme for aged care be introduced.[210] The Australian Government has belatedly recognised that current arrangements for reporting serious incidents should be strengthened. On 2 April 2019, it announced the introduction of a serious incident response scheme, which will commence on 1 July 2021.[211]

The new serious incident reporting scheme will require reporting of a much wider range of incidents than is currently the case. Providers will be required to report:

- unreasonable use of force
- unlawful or inappropriate sexual conduct
- psychological or emotional abuse
- unexpected death

		• stealing or financial coercion by a staff member • neglect • unlawful use of physical or chemical restraint • unexplained absence.[212] The expanded scope of incidents covered by the new scheme is a welcome development and will greatly improve the regulator's oversight of abuse and neglect in residential aged care. The removal of the cognitive impairment exemption is particularly important given that approximately half of the people living permanently in residential aged care have a diagnosis of dementia, and in view of the estimate of the high number of alleged assaults that currently fall within this exemption.[213] However, expansion of the coverage of the scheme only addresses one of the defects in the current arrangements. Without an expansion of the scheme to home care, purposeful action on the reports of serious incidents and greater transparency around the scheme, the abuse will continue.
Final Report – Volume 3B: The new system[10]	Page 524	The objectives of the new Serious Incident Response Scheme should be clearly set out in legislation. This should guide the response of the Quality Regulator to reports of serious incidents. According to the Australian Government, the goals of the new Serious Incident Response Scheme are to strengthen aged care systems, to reduce the risk of abuse and neglect, build providers' skills so they can better respond to serious incidents, and ensure people receiving aged care have the support they need.[215] In our view, however, the central object of any serious incident reporting scheme must be to protect people receiving aged care services from harm.
Final Report – Volume 3B: The new system[11]	Page 524	**14.5.2 Serious incidents in home care settings** We consider that the new Serious Incident Response Scheme should be extended to cover allegations of certain serious incidents perpetrated by aged care workers against people receiving aged care in home settings.[217] It is hard to justify the lack of oversight of allegations of abuse and neglect in home settings. As Mr Fitzgerald stated, 'the highest risk for older people in the aged care system is within the home' because 'there is not the line of sight that you normally see in residential services'.[218] In residential care, there is the potential for a line of sight by multiple workers, visitors and health practitioners, that is absent in home settings. … The need for oversight of serious incidents in home settings will increase as more people receive aged care in their homes for longer, and in view of the likely increase in levels of frailty and cognitive impairment in people receiving home care. Frailty is directly linked to vulnerability.[221] Risk can also be increased by factors such as isolation, and a high dependence on aged care services.

[10] Ibid
[11] Ibid

Final Report – Volume 3B: The new system[12]	Page 525	There is limited data on the extent of abuse and neglect by aged care workers against people receiving aged care services in their home, in part due to the lack of regulatory oversight of such incidents. The Australian Department of Health is commissioning a study into the prevalence of serious incidents occurring in home and community aged care, which is scheduled to be completed by 30 June 2021. That study will also examine options for extending a serious incident response scheme to home and community care. … Any serious incident response scheme in aged care must have the capability to detect patterns in reports that indicate an ongoing risk to the safety of people receiving aged care services. Such a scheme should be a critical tool to enable the Quality Regulator to identify risk proactively. When a new report is received by the regulator, those responsible for conducting an initial assessment should be able to identify immediately whether an aged care worker named in that report has been the subject of an earlier report. It is of concern that the compulsory reporting scheme does not currently have this capability.
Final Report – Volume 3B: The new system[13]	Page 528	**Recommendation 100: Serious incident reporting** The Australian Government should, in developing a new and expanded serious incident reporting scheme: a. ensure that the scheme: i. addresses all serious incidents, including in home care, regardless of whether the alleged perpetrator has a cognitive or mental impairment ii. enables the matching of names of individuals accused of being involved in a serious incident with previous serious incident reports 2. require the Quality Regulator to publish the number of serious incident reports on a quarterly basis at a system-wide level, at a provider level, and at a service or facility level 3. impose a requirement on an approved provider to provide a plan detailing the action it intends to take in response to a reported incident and the report of any investigation of the incident the provider has undertaken or caused to be undertaken 4. confer statutory powers on the Quality Regulator to enable it to: i. require a provider to take specified remedial action in relation to an incident within a specified period ii. require a provider to investigate an incident in a manner and within a timeframe specified

[12] Ibid
[13] https://agedcare.royalcommission.gov.au/publications/final-report-volume-3b

		iii. oversee the investigation of and response to a serious incident by a provider iv. require a provider to take other action in relation to the incident that the Quality Regulator considers reasonable in the circumstances v. investigate the circumstances surrounding the incident.
Final Report – Volume 3B: The new system[14]	Page 529	Enforcement is an important part of ensuring that the regulatory system deters poor quality or unsafe care. It must be credible and effective.
Final Report – Volume 3B: The new system[15]	Page 533	We consider that the introduction of civil penalties and accessorial liability strikes the appropriate balance between these different considerations. It will introduce accountability for serious failings in the provision of aged care and expand the options available to the Quality Regulator for dealing with serious instances of non-compliance. The regulator will be more likely to bring civil proceedings than criminal proceedings for a breach of the general duty or the requirements regulating the use of restraints in residential aged care. The grounds for accessorial liability reflect those in the *Regulatory Powers (Standard Provisions) Act 2014* (Cth).[279] We note that certain conduct in the context of aged care which causes harm to an older person may also constitute a criminal offence.[280] This will not change in the new aged care system we propose. Suspected criminal conduct should be referred to the police.
Final Report – Volume 3B: The new system[16]	Pages 931 - 932	The importance of the implementation of recommendations to the success of a royal commission or inquiry has been identified previously. In particular, previous inquiries have made recommendations for the establishment of mechanisms to maximise the chances of the successful implementation of their recommendations and to ensure public accountability. … We have noted elsewhere that a failure to implement recommendations has been too common following inquiries into aged care. That is why we emphasise that reporting is a necessary, but not sufficient, requirement to impose upon government to ensure that our recommendations are implemented in a timely manner.
Final Report – Volume 3B: The new system[17]	Page 932	**Recommendation 145: Report on recommendations** By 31 May 2021, the Australian Government should report to Parliament about its response to the recommendations in our final report. The report should indicate whether each recommendation directed to the Australian Government is accepted, accepted in principle, rejected or subject to further consideration. The report should also include some detail about how the recommendations that are accepted will be implemented and should explain the reasons for any rejections.

[14] Ibid
[15] Ibid
[16] Ibid
[17] Ibid

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Older people receiving aged care should be safe and free from abuse at all times.

Aged Care Royal Commission