CONTACT DETAILS **Title** ☐ **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Dr** ☐ **None** ☑**Other (please specify)** Professor
First name: Joseph
Last name: Ibrahim
[redacted]
SUBMISSION We do not require our submission to be confidential. We do not require our submission to be "name withheld" **PUBLIC HEARING** We would like to appear as a witness at a public hearing.

Issues *The following issues from the terms of reference are relevant to our submission.*	
a. The impact of the changes that have been implemented since the VLRC last reported on Sexual Offences (2004), Evidence (2006), Jury Directions (2009) and Victims of Crime in the Criminal Trial Process (2016).	☐
b. Best practice approaches in other Australian and international jurisdictions for responding to sexual offences, with a view to identifying further opportunities for improvement in Victoria.	☒
c. The Victorian Royal Commission into Family Violence Report (2016) in so far as it relates to sexual offences within intimate partner relationships.	☐
d. The impact, if any, of technological advancements on the nature of sexual offending.	☐
e. Data and trends around the reporting of sexual offences, investigations, prosecution and conviction rates across Victoria, and any opportunities to improve data collection and reporting practices.	☒
f. Actual or perceived barriers which contribute to the low reporting of sexual offences, and the high attrition throughout the formal legal process of those who do report, including: g. Reasons why victim survivors of sexual offences may choose not to report the event to Police, or pursue a formal complaint; h. Reasons why complaints that are reported do not progress to charges; i. Reasons why charges do not proceed to trial; and j. Reasons why convictions may be difficult to achieve.	☒

k.	Whether Australian or international best practice suggests opportunities to address these real or perceived barriers, including through consideration of alternative mechanisms or processes to receive and resolve sexual offence complaints that are consistent with victim survivors' interests and the interests of justice.	☐
l.	The process and procedure for reporting, investigating and prosecuting sexual offences, and whether there are alternative models which would improve the resolution sexual offences for victim survivors.	☒
m.	The effectiveness of the 2014 reforms to the elements of sexual offences.	☐
n.	The application of sexual offences to children.	☐
o.	Whether the rules for giving evidence, directions given to juries and the time taken to resolve cases are meeting public expectations, and how this affects complainants.	☐
p.	How criminal prosecutions for sexual offences may interact with processes outside the system for resolving complaints, such as workplace or educational institution investigations, and in particular the findings of the Australian Human Rights Commission in its National Workplace Sexual Harassment Inquiry.	☐
q. r. s.	Best practice for supporting sexual offence complainants and witnesses in the justice system more broadly, including: How complainants give evidence in other contexts including in civil proceedings such as defamation and civil claims against institutions; and Any other matter that the VLRC considers necessary to reduce the trauma experienced by complainants and improve efficiency in the criminal justice system, while also ensuring fair trial rights.	☐

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14 December 2020
Victorian Law Reform Commission
GPO Box 4637
Melbourne, Victoria
Australia
3001

By email to: law.reform@lawreform.vic.gov.au

Dear committee,

The ***Health Law and Aging Research Unit*** welcomes the opportunity to provide this submission to the **Victorian Law Reform Commission's *Improving the Response of the Justice System to Sexual Offences***

About the Health Law and Ageing Research Unit

The Health Law and Ageing Research Unit (HLARU) is a multi-disciplinary team with expertise in public health, aged care, health care and medico-legal death investigation led by Professor Joseph Ibrahim. Contributors to this submission are Joseph Ibrahim, Daisy Smith and Meghan Wright.

The Health Law and Ageing Research Unit is the only group in Australia with a dedicated, co-ordinated, multidisciplinary approach with technical expertise in aged care, law, health care, public health, injury prevention and public policy focussed on Residential Aged Care Services (RACS).

The research program contributes to a reduction in premature deaths, improving quality of care and promoting respect for the rights, choice and freedoms for older persons. This is achieved by synthesising existing evidence to strengthen public health policy interventions, generating evidence from an examination of information from medico-legal investigations and education of health professionals. This research has contributed to the Australian Law Reform Commission's report 'Elder abuse-a national legal response' and Royal Commission into Aged Care Quality and Safety.

Sexual offences and Residential Aged Care

Elder abuse is any form of violence or mistreatment that causes harm to an older person and occurs within a relationship of trust. Sexual abuse is included in the term elder abuse. Elder abuse can happen in many contexts, including the home and residential aged care (RAC)[1]. RAC is

[1] Senior Rights Victoria. *Elder Abuse as Family Violence*. Victoria, 2018, p. 2, https://seniorsrights.org.au/wp-content/uploads/2018/05/Elder-Abuse-as-Family-Violence-FINAL.pdf. Accessed 18 July 2020.

an unique environment, governed by Commonwealth policies and legislation as well as the relevant State and Territory criminal laws. Aged care staff must adhere to the reportable assaults scheme under the Aged Care Quality and Safety Commission when residents are involved in a sexual offence.

Under the current system, approved providers are required to report certain allegations and/or suspicions of abuse in respect to RAC residents within 24 hours of the allegation being made, or from the time the approved provider starts to suspect, on reasonable grounds, that a reportable assault may have occurred [2]. As part of the Australian Law Reform Commissions recommendation formed from the Inquiry into Elder abuse – A National Legal Response [3] the introduction of the Serious Incident Response Scheme (SIRS) is due to come into effect 1st July 2021 [4]. Our submission's will focus on the current mandatory reporting obligations, current reporting exemptions and the current intentions of the SIRS.

Aged Care is governed at a federal level. Crimes committed (such as sexual assault or harassment) in aged care in Victoria are reported to the Aged Care Quality and Safety Commission—the national regulator, creating confusion for staff on when and how to involve the Victoria's legal system. In order to reform Victoria's approach to sexual offenses and protect the vulnerable, we ask that The Victorian Law Reform Commission advocate so that the federal level aligns with Victoria's best practice. In order to drive the most extensive and effective change all Victorian's must receive equal treatment under the law no matter their place of abode.

Elderly sex offenders

The nature and characteristics of elderly sex offenders remain a scientifically unexplored population. Although there's currently no clear and adequate offender profile available, elderly sex offenders may present with a unique set of problems of which includes their physical, medical and mental needs. This makes treatment and management of this populated vexed and often falls in the gaps between a health and/or criminal justice issue. The issues around the unclear profiles and the unknown risk of this population are discussed at the end of this submission.

Executive summary

Terms of reference (ToR) are referred to throughout the submission.

The Health Law and Aging Unit submits twelve recommendations. Recommendations cover initiatives at the micro-level (improve aged-care staff's awareness, attitudes and knowledge of sexual violence in RACS), meso-level (address system failures in recognition, reporting definitions, reporting and post-event management of sexual violence in RACS) and at the macro level (Government both federal and state/territory to review the current allocation of resources). A detailed copy of the recommendations is attached to this submission. From the twelve recommendations, we have outlined what we consider the most pressing below:

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2 Australian Government. Aged Care Quality and Safety Commission. *Guidelines for reporting Reportable Assaults* https://www.agedcarequality.gov.au/providers/compulsory-reporting-approved-providers-residential-aged-care-services/guide-reporting-reportable-assaults. Accessed 20 October 2020

3 Australian Government. Australian Law Reform Commission. *Responses to Serious Incidents of Abuse and Neglect.* https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/4-aged-care/responses-to-serious-incidents-of-abuse-and-neglect/ Accessed 20 October 2020

4Australian Government. Department of Health. *Serious Incident Response Scheme* https://www.health.gov.au/initiatives-and-programs/serious-incident-response-scheme-sirs#about-sirs Accessed 20 October 2020

- **Recommendation 6**. Government, both federal and state/territory, in partnership with RACS providers and key stakeholders, should ensure that every aged care service has the support, knowledge and skills to provide appropriate responses to residents who have experienced past or current sexual violence. This work should align with the international best practice and address:
    - Early detection of sexual assault.
    - Timely response and the preservation of evidence.
    - Long-term support of the victim-survivor and their family.
- **Recommendation 8**. A far more robust Serious Incident Response Scheme is required with expertise to conduct the analyses and the data including the responses to change practice be released to the public on a six-monthly basis.

  Particularly concerning in the KPMG report is a suggestion that some form of limits be placed on level and nature of reporting of sexual assault to align with available resources. We contend all unlawful sexual acts should be reported and adopt the most comprehensive approach to protecting residents.
- **Recommendation 9.** Australian Aged Care Commission is a regulator as such it is not equipped and does not have the specialised expertise to (i) determine what incidents constitute sexual (and therefore reportable) offences and (ii) analyse and determine preventive action for sexual violence. A separate national panel of experts in this field should be established to undertake this sensitive and complex work.

The information presented is drawn from a combination of Professor Joseph Ibrahim's evidence to the (i) House of Representatives Inquiry into Family, Domestic and Sexual Violence and (ii) Royal Commission into Aged Care Quality and Safety, our published research including a systematic review[5] and analysis of empirical data[6] and our recommendations following consultation with stakeholders[7].

Implementing the recommendations made in our submission should increase engagement by the community, sector and government on the issue of preventing and managing sexual violence in RACS.

This submission accurately sets out the evidence that I am prepared to give to the **Victorian Law Reform Commission's *Improving the Response of the Justice System to Sexual Offences.*** This submission is true and correct to the best of my knowledge and belief.

The views I express in this submission are my own based on my education, training, research and experience. They are not intended to represent the views of my employers or any specific organisation.

5 Smith D, Bugeja L, Cunningham N, Ibrahim JE: A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist 04/2017; DOI:10.1093/geront/gnx022

6 Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J, Bugeja L. The Epidemiology of Sexual Assault of Older Female Nursing Home Residents, in Victoria Australia, between 2000–2015. Legal Medicine. 2018

7 Wright M, May A and Ibrahim JE (ed). 2019. Recommendations for prevention and management of sexual violence in Residential Aged Care Services. Monash University: Southbank. ISBN-13: 978-0-9941811-7-6 Copyright © Monash University 2019

Thank you for your consideration of our submission.

Please contact Professor Joseph Ibrahim, Head of the Health Law and Research Unit, in relation to this submission.

Yours sincerely,

Professor Joseph E Ibrahim MBBS GradCertHE PhD FAFPHM FRACP

Attachments
Please find attached

1. Wright M, May A and Ibrahim JE (ed). 2019. Recommendations for prevention and management of sexual violence in Residential Aged Care Services. Oct 2019 Monash University: Southbank. ISBN-13: 978-09941811-7-6
2. Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J et al. The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015. Legal Medicine. 2019 Feb 1; 36:89-95. https://doi.org/10.1016/j.legalmed.2018.11.006
3. Smith D, Bugeja L, Cunningham N, Ibrahim JE: A systematic review of sexual assaults in nursing homes. The Gerontologist 04/2017: DOI: 10.1093/geront/gnx022
4. Residential Aged Care Communiqué. November 2019 (ed). Vol 14. Is 4. https://static.wixstatic.com/ugd/cef77c_8f032cb1f67e4966a1c5628e95ef4aab.pgf
5. “Prevention and management of sexual violence in residential aged care services seminar.” 2019. Hosted by Monash University and the Victorian Institute of Forensic Medicine. Melbourne, Victoria.

Structure of submission

The following submission is intended to give an overview of the known and current issues surrounding sexual offences which occur in residential aged care services (RACSs). At the end of this submission, we present our recommendations, to which the Victorian Law Reform Commission's Issue Papers questions are referenced throughout[8].

Sexual violence in residential aged care services

1. Listed below are our concerns and reflections:

   a) A lack of comprehensive staff training for early detection of sexual violence, timely response and the preservation of evidence.

   b) Complex, confusing and a lack of clarity in reporting pathways.

   c) A lack of information and training of staff about how to respond to sexual violence may deter disclosure and thereby deny support to victim-survivors.

   d) Lack of an environment which promotes victim-survivors to disclose violence without threat of being reprimanded or dismissed

   e) A lack of victim-survivors of sexual violence in RACSs being provided with the same basic principles as others in the community, i.e. being believed, respected and supported, being provided with practical information and offered opportunities to make informed choices about response and support.

   f) A lack of a compassionate response to address victim-survivors' immediate and long-term care needs as well as ongoing prevention of any further harm.

   g) A failure to have a national system or policy to manage residents with past sexual convictions, or sexually deviant behaviour due to illnesses such as dementia.

   h) A lack of RACS utilisation of relevant stakeholders when managing and responding to sexual offences.

Background and definitions of sexual violence and sexual assault in the context of residential aged care

2. The language within scientific and legal literature referring and, defining sexual assault is inconsistent. Our previous publish research uses the term 'sexual assault.' However, for the purpose of this submission, we will adopt the term 'sexual violence' to refer to *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.*[9]*"* Consequences of inconsistent definitions creates issues with the detection, management and reporting of sexual violence in RACS. We will further address this throughout our submission.

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8 Victorian Law Reform Commission. Improving the response to the Justice System to Sexual Offences, Issue Papers A-H. https://lawreform.vic.gov.au/sites/default/files/VLRC_Sexual%20Offences%20Issues%20Papers-A-H_combined_web.pdf Accessed 20 October 2020

9 The World Health Organisation. World report on violence and health. Chapter 6 Sexual Violence; Geneva:2002 p. 149.

3. Current Commonwealth policy and legislation defines reportable assault in RACS as unlawful sexual contact acts[10]. This is due to change in July 2021 (addressed later in our submission). To remain accurate, the terms 'sexual violence' and 'sexual assault' will be used interchangeably. Outside the scope of RACS, sexual assault is defined as non-consensual sexual contact of any kind[11], and is considered the most hidden; least acknowledged and, least reported form of elder abuse[12]. In the aged care context, where questions of capacity and consent are complicated by cognitive impairments, whether an act is against the law or unwanted is more difficult to identify. These issues pose complex challenges for aged care providers, as it is important to protect the safety interests of individuals, whilst balancing the rights of other residents to express their sexuality and engage in meaningful relationships. RACS residents are entitled to a safe environment that affords them both protection from harm and respects their interests, preferences, personal choices and decisions.

Forms of sexual violence in residential aged care services

4. Sexual violence includes a wide range of sexual acts inclusive of rape and other unwanted sexual contact. It may also include inappropriate touching and the use of sexually offensive or unwelcomed language. It is important to recognise non-penetrative or noncontact sexual acts such as exhibitionism, sexual threats, unwelcome sexual discussions, sexual jokes or comments, and unwelcome sexual interests as these also cause distress to RACS residents.

5. Sexual assault is considered the most hidden form of elder abuse. This makes it difficult to accurately estimate its prevalence. Prior to 2007, it was estimated there were around 20,000 unreported cases of elder abuse, neglect and exploitation in Victoria. There are multiple barriers as to why sexual offences in residential aged care (RAC) are not reported, beginning at the macro and meso levels, that is legal systems and RAC service provider factors.

Barriers to reporting sexual offences in residential aged care: Mandatory reporting obligations

6. Lack of consistent use of terms and definitions in our nation's State and Territories' criminal laws creates confusion for aged care and inconsistency in reporting. RAC sector is a unique environment, which is governed by Commonwealth policies and legislation as well as and the relevant State and Territory criminal laws. The Aged Care Act 1997 (Cth) section 63-1AA currently defines a reportable sexual assault to be an unlawful sexual contact act (such as digital or genital penetration). It unfortunately excludes unlawful non-contact acts (such as the threat to commit a sexual offence or exhibitionism) and unwelcome acts (similar to sexual harassment - suggestive comments, jokes and requests that are unwelcome). These are subject to change in July 2021 under the introduction of the Serious Incident Response Scheme (SIRS) and will be discussed within this submission.

7. Current reporting pathways are acknowledged to be complex and confusing[13]. Due to inconsistencies between definitions, including legal definitions and definitions of Acts that

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10 Australian Government. Aged Care Quality and Safety Commission. Guidelines for reporting Reportable Assaults. Available at https://www.agedcarequality.gov.au/providers/compulsory-reporting-approved-providers-residential-aged-care-services/guide-reporting-reportable-assaults. Accessed 20 October 2020

11 The World Health Organisation. World report on violence and health. Chapter 5 Abuse on the Elderly; Geneva: 2002 p. 126.

12 Smith D, Bugeja L, Cunningham N, Ibrahim JE: A systematic review of sexual assaults in nursing homes. The Gerontologist 04/2017: DOI: 10.1093/geront/gnx022

13 Mann, Rosemary et al. Norma's Project A Research Study into The Sexual Assault of Older Women In Australia. Australian Research Centre In Sex, Health And Society, Melbourne, Australia, 2014, https://www.opalinstitute.org/uploads/1/5/3/9/15399992/researchreport.pdf. Accessed 14 July 2020.

govern the operation and regulation of all Aged Care services, the Australian Department of Health prevalence rates outlined below are not representative of true incidence of sexual violence in RACS.

8. Exemptions to RAC providers reporting a "reportable assault" currently exist in mandated pathways. These pathways are complex and difficult to understand and too easily misjudged by RAC staff. This may lead to underreporting of incidents and a misperception that rates are low. An example is the exemption of reporting when the resident perpetrator has a diagnosed cognitive or mental impairment. Under the revised SIRS this exemption will be removed.

9. The work of the Opal Institute has identified that the "Limited Circumstances" clause in reporting means that some aged care service providers do not interpret or report sexual violence perpetrated by a cognitively impaired person as constituting an incident of sexual violence [14]. This is problematic as scientific research identifies persons with cognitive impairments to be most at risk of becoming victim to, or engaging in, sexual violence.

Barriers to reporting sexual offences in residential aged care: Mandatory reporting obligations – The Evidence

10. Mandatory reporting obligations have not improved the reporting of sexual offences that occur in RACSs. This is evident through the long standing low reported prevalence rates. In 2015–2016 the Australian Department of Health was notified of 396 reports of alleged or suspected unlawful sexual contact of residents in RACSs in Australia[15]. In 2017-2018 there were 547 reports, [16] this rising to 739 reports (2018-2019)[17]. In a decade, alleged or suspected unlawful contact of residents in RACSs nationally have rose from 239 reports (2009-2010)[18] to 816 reports (between 2019-2020)[19].

11. Our research team reviewed forensic medical examinations of reportable sexual assault incidents (as defined by The Act Care Act 1997 (Cth)) that occurred in accredited RACS in Victoria between 2000-2015. Incidents were reported to and examined by the Clinical Forensic Medicine team, a division of Victorian Institute of Forensic Medicine. Based on the data reported by the Commonwealth we expected Victoria would have 80-120 sexual assaults of residents reported in RACS per year (equating to approximately 1,200 assaults during the study

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14 Submission To The Royal Commission Into Aged Care Quality And Safety, Regarding: Sexual Abuse/Assault Of Older Women. The Opal Institute, Melbourne, Australia, 2019, p. 6, https://www opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf. Accessed 18 July 2020.

15 Australian Government. Department of Health. 2015–16 Report on the Operation of the Aged Care Act 1997. Canberra ACT: Department of Health; 2016. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2015-16-ROACA.pdf. Accessed 20 October 2020

16 Yon, Yongjie et al., Elder Abuse Prevalence in Community Settings: A Systematic Review and Meta-Analysis. Health. The Lancet Global. 2017.

17 Australian Government. Department of Health. 2018–19 Report on the Operation of the Aged Care Act 1997. Canberra ACT: Department of Health; 2019. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2018-19-ROACA.pdf. Accessed 20 October 2020

18 Australian Government. Department of Health. 2009–10 Report on the Operation of the Aged Care Act 1997. Canberra ACT: Department of Health; 2010. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2009-10-ROACA.pdf. Accessed 20 October 2020

19 Australian Government. Department of Health. 2019–20 Report on the Operation of the Aged Care Act 1997. Canberra ACT: Department of Health; 2020. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf. Accessed 10 December 2020

period). The 28 cases reported to the forensic investigation team over the 15-year study period suggest serious under-recognition and under-reporting[20].

12. Although underreporting of sexual assault is common among all age groups, rates of underreporting are greater for older victim-survivors and greatest for RACS residents. Issues addressed in paragraphs 5-9 means the current system (prior to the introduction of the SIRS) is not accounting for a large proportion of sexual violence in RAC. The introduction of the SIRS is intended to capture a broader range of acts, irrespective of the current exemption of cognitive impairment.

13. An insight to a more accurate prevalence rates is highlighted in the 2019 KPMG prevalence study for the SIRS[21]. The purpose of this report was to understand resident-resident unlawful sexual contact and unreasonable use of force incidents which are currently exempt from reporting.

14. “Type 1 incidents” - meet the Age Care Act 1997 definition of a reportable assault, but which are currently exempt from reported (e.g. unlawful sexual contact exhibited by a cognitively impaired person) and “Type 2 incidents” – other incidents that do not meet the definition of a reportable assault but are recorded by the approved provider (e.g. unlawful sexual non-contact acts or unwelcome sexual behaviour).

15. Data was collected for a 6-month period (1 Feb 2019 - 31 July 2019), from 178 providers. This equates to, 6.6% of services and 4.3% of approved providers in Australia, as at 30th June 2019, there were 2,717 RAC services, operated by 873 approved providers of RAC [22].

16. The KPMG report concluded, that at a national level over a 12-month period, there could be up to 38, 898 incidents (unreasonable use of force and sexual violence Type 1 & 2 incidents). Of the 1,259 Type 1 incidents, 56 (4.4%) were classified unlawful sexual contact, with the majority of these incidents being rape and sexual assault, including touching the resident’s genital area without consent (31/56, 54.4%).

17. The barriers to reporting sexual offences in RACSs discussed in paragraphs 6-12 are not a reflection of poor staff attitude. It is due to the grave responsibility placed upon a workforce to detect ill-defined offences and manage complex incidents. The challenge of the new SIRS is shifting to a culture were staff are knowledgeable of what constitutes a sexual offence, and they feel empowered, not fearful, of reporting[23].

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[20] Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J, Bugeja L. The Epidemiology of Sexual Assault of Older Female Nursing Home Residents, in Victoria Australia, between 2000–2015. *Legal Medicine.* 2018

[21] Australian Government. Department of Health. *Prevalence Study for the Serious Incident Response Scheme.* https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs. Accessed 20 October 2020

[22] Australian Government. Department of Health. *2018–19 Report on the Operation of the Aged Care Act 1997*. Canberra ACT: Department of Health; 2019. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2018-19-ROACA.pdf. Accessed 20 October 2020

[23] Australian Government. Department of Health. Report on the Outcome of Public Consultation on the Serious Incident Response Scheme for Commonwealth funded Residential Aged Care. https://www.health.gov.au/sites/default/files/documents/2020/02/report-on-the-outcome-of-public-consultation-on-the-serious-incident-response-scheme-report-on-the-outcome-of-public-consultation-on-the-serious-incident-response-scheme-for-commonwealth-funded-residential-aged-care.pdf. Accessed 20 October 2020

Barriers to reporting sexual offences in residential aged care: Aged care residents and Victorian law

18. As discussed in paragraph 6, the RAC sector is a unique environment, which is governed by Commonwealth policies and legislation as well as and the relevant State and Territory criminal laws.

19. As discussed in paragraph 4 there are multiple forms of sexual violence that are potentially harmful and occur in RACSs, these include non-contact acts, such as sexual harassment – unwelcome behaviour that could make a person feel offended, humiliated or intimidated[24].

20. For example, our understanding of the Equal Opportunity Act 2010 makes sexual harassment unlawful in certain areas of public life (e.g. workplace and school). However, this does not seem to cover incidents of resident-to-resident sexual harassment in RACS as it is considered the residents home, and yet it is the staff workplace. The Aged Care Act 1997 does not include unwelcome sexual acts within its definition of a reportable assault creating a gap within legislation whereby residents appear not to be protected.

21. Further, in workplace related sexual harassment complaints primarily the individual exhibiting the behaviour is considered responsible, though in some instances the employers may also be held responsible. This makes for vexed questions in relation to the RACS provider setting and enforcing codes of conduct and enforcement for staff, volunteers, external workers, residents, families and friends.

22. It is also unclear if RAC staff are aware or understand that sexual offences that do not constitute reportable assaults as defined by the Aged Care Act 1997 (Cth) (such as unlawful con-contact acts) are still required to be reported to the police irrespective as these still may constitute a criminal act.

Barriers to reporting sexual offences in residential aged care: Current practice regarding management of sexual violence/assault

23. In 2007, amendments to the Aged Care Act 1997 (Cth) provided new measures to protect aged-care residents, which included a regime for compulsory reporting of physical and sexual assaults in people in aged care. Section 63-1AA of the Aged Care Act 1997 (Cth) outlines the responsibilities of an approved provider relating to an allegation or suspicion of a reportable assault. If an allegation is received or suspected, the approved provider is responsible for reporting the allegation/suspicion as soon as reasonably practical, and in any case within 24 hours to the police and government department Secretary.

24. One important exemption from the Act's mandatory reporting requirements (contained within part 7 of the Accountability Rules) is that providers do not need to lodge a report when an alleged or suspected assault has been perpetrated by a resident with an assessed cognitive or mental impairment.[25] As discussed in paragraph 6 -9 & 22, reporting obligations are complex and confusing and are subject to change in July 2021 (paragraph 12).

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[24] Victorian Equal Opportunities & Human Rights Commission. Sexual Harassment. https://www.humanrights.vic.gov.au/for-individuals/sexual-harrassment/. Accessed 11 December 2020

[25] See ss 52 and 53 of the *Accountability Principles 2014* made under s 96 of the *Aged Care Act*.

25. Whilst we advocate for the introduction of the SIRS, we are concerned that some form of limit will be placed on the level and nature of reporting. Further, we believe the considered new definitions of a reportable assault outlined in the SIRS Model for Implementation to be more confusing than current reporting obligations [26]. The classification of incidents based on victim-survivor impact is confusing, poorly defined and ill-informed. These concerns are highlighted in paragraphs 39 to 43.

26. Further, the introduction of this scheme also intends for the Australian Quality and Safety Commission to oversee the RACS investigation and response to the reported incident. RACS will therefore need to develop a system for reporting the outcome of investigation, including action taken, to adhere to this new scheme. There are two issues, first the aged care provider is a business operator and not a forensic or criminal investigator. Second, the Aged Care Quality and Safety Commission is a regulator and not a suitable organisation to: (i) manage sexual violence, (ii) to judge whether an incident constitutes sexual violence or is a manifestation of cognitive impairment (e.g. a delusion), (iii) judge the extend of harm pose to the person who has experienced the incident of sexual violence.

Barriers to reporting sexual offences in residential aged care: Victim-survivor and perpetrator characteristics

27. In 2019-2020, 244,363 people were residing in RAC at some time during the year[27], an increase of 1751 from 2018-19[28]. As of June 30th 2019, 64% of RAC residents were rated as needing high care levels for cognition and behaviour[29]. At 30th June 2020, 51.9% of RAC residents with an Aged Care Funding Instrument (ACFI) assessment had a diagnosis of dementia[30]. Given the complex profiles and potentially vulnerable nature of RAC residents, there are also barriers to reporting at the micro level.

28. RAC resident victim-survivors of sexual assault are predominately Caucasian females with a form of mental and physical impairment. A wide range of perpetrators may sexually assault RAC residents, including family members, personal assistants, support staff, service providers, medical staff, transportation staff and other residents (of which the majority are cognitively/mentally impaired).

29. RAC residents are particularly vulnerable to sexual assault due to their dependency on caregivers, health problems, and the co-housing of residents, sometimes with potentially dangerous older individuals with sexual assault backgrounds. Negative stereotypes such as that older people are asexual, their greater dependency on others, potential divided loyalty to staff

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[26] Australian Government. Department of Health. *Serious Incident Response Scheme for Commonwealth funded residential aged care- model for implementation.* https://www.health.gov.au/resources/publications/serious-incident-response-scheme-for-commonwealth-funded-residential-aged-care-model-for-implementation. Accessed 10 December 2020

[27] Australian Government. Department of Health. 2019–20 Report on the Operation of the Aged Care Act 1997. Canberra ACT: Department of Healtxh; 2020. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf. Accessed 10 December 2020

[28] Australian Government. Department of Health. *2018–19 Report on the Operation of the Aged Care Act 1997*. Canberra ACT: Department of Health; 2019. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2018-19-ROACA.pdf. Accessed 20 October 2020

[29] Australian Government. Australian Institute of Health and Welfare. *People Using Aged Care- GEN Aged Care Data.* https://www.gen-agedcaredata gov.au/Topics/People-using-aged-care. Accessed 20 October 2020

[30] Australian Government. Department of Health. 2019–20 Report on the Operation of the Aged Care Act 1997. Canberra ACT: Department of Healtxh; 2020. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf. Accessed 10 December 2020

members or residents are unique barriers to reporting, detecting, and preventing sexual violence in RACSs.

30. Victim-survivors of sexual offences in RAC face significant barriers to reporting. These include: lack of awareness of their rights, communication barriers (language difficulties, disability, illness or cognitive impairment), subtle power dynamics (such as existing relationships prior to entering aged care), cultural dynamics, victim-survivor's may not want to have matters taken out of their control and not disclose incidents and/or they may not wish to report due to fear of being shamed, disbelieved or punished.

31. Another major barrier is the collective failure to detect sexual violence is happening in RAC (refer to prevalence rates in paragraph 10-11 & 13-16). Staff expect sexually disruptive and aggressive behaviours as a usual occurrence for persons with a cognitive impairment. This creates three issues:

31.1. First, sexual violence exhibited by persons with cognitive impairment is likely to be labelled "normal "leaving incidents unactioned, perpetrators not managed, and incidents not reported.

31.2. Secondly, witnesses are not common in any incidents of sexual violence in any population. This means that aged care staff are dependent on either survivor disclosures or recognising trauma indicators that an incident has occurred. This is problematic as trauma indicators are likely to be missed or dismissed by staff who deem these as "disruptive" or "expected" behaviours. People with dementia also often face significant verbal communication barriers and are less likely to be believed if able to disclose incidents.

31.3. Thirdly staff and the community are more willing to dismiss the seriousness of sexual violence when the target is cognitively impaired. Perceptions that persons with cognitive impairment will not remember or are not impacted by such incidents are inaccurate, harmful and dehumanising.

32. A failure to detect and report incidents of sexual violence in RAC equates to a failure to manage and respond to both resident survivors and (alleged) perpetrators. Residents who report sexual offences should be provided with emotional support, medical services and be protected from all unsupervised contact with the offender. Emotional and psychological support should be available to victim-survivors of contact and non-contact acts of sexual violence and measures should be taken to assess the culpability, risk and management of resident (alleged) perpetrators.

Barriers to reporting sexual offences in residential aged care: Staff education and training

33. The barriers in reporting obligations highlight more serious issues beyond inaccurate prevalence rates. Prevalence rates discussed in paragraphs 10-11 & 13-16 undoubtedly highlight barriers to detection and reporting, but also accentuate inadequate education and training efforts of RAC staff regarding the detection, reporting and management of sexual violence in RAC. Currently there are no mandatory education units regarding resident's sexuality, sexual health and rights or sexual violence management and prevention.

34. Negative stereotypes regarding older people make recognition of sexual violence towards older people harder, and therefore reporting and sentencing less likely. Staff and/or family may find it difficult to believe or accept that a resident has been a victim of a sexual offence. This has roots in longstanding beliefs that old people don't or should not have sex. Being unwilling to accept

old people are sexual or being disgusted by this notion, creates a risk that incidents of sexual violence will be ignored or minimised [31] Even plausible disclosures are often met with disbelief by professionals due to doubt that it could be a possibility[32]. Erroneous beliefs that sexual violence is rare, that allegations are frequently fabricated (due to resident conditions like dementia), and that true survivors will always manifest certain reactions, all serve to jeopardise professional responses and thorough investigation (paragraphs 38-42). Disclosures might also be discounted or rendered invisible if they are made by residents who respond in unexpected ways because of their cognitive impairment. Services should seek to promote positive staff attitudes and seek to counter stigmas surrounding ageing and sexuality.

35. Our recent research using semi-structured face-to-face and telephone interviews with active RACS staff, key stakeholders and health and policy topic experts (n=26) *(under publisher's review)* found that senior internal and external stakeholders believed RAC direct-care staff, especially personal care assistants, are not currently educationally well equipped for: the changing care environment and the occurrence of adverse events and issues around sexuality and consent in RAC. Participants advocated for the improvement of education and training and noted that training dedicated to sexual violence in RAC was uncommon [33].

36. As with any sexual assault survivor, there is a range of emotional, behavioral, and psychological responses, including symptoms related to post-traumatic stress. Victim-survivor's post-assault emotional response, such as agitation; distress and confusion, can mirror symptoms of cognitive impairment. This highlights the potential difficulties for RAC staff in distinguishing whether the behavior is due to sexual violence or is a symptom of a health condition/illness.

37. The current lack of training on the identification of sexual violence in RAC can prevent staff from recognising trauma related behaviours[34] which naturally hinders detection, reporting and management of sexual offences. Additionally, research shows education of RAC staff in the promotion of positive sexual relationships has the potential to minimise sexual violence incidents over time[35].

Barriers to reporting sexual offences in residential aged care: Services utilised by residential aged care providers when sexual offences occur

38. Outside the realm of RAC, it has become evident the need of services to collaborate when responding to sexual offences. Within RAC the current and future reporting obligations place a high level of responsibility on ill-equipped RAC staff to detect incidents which are not clearly defined and are complex in nature. The current system keeps incidents largely "in-house" whereby RAC staff are responsible to detect, report and respond to both victim-survivors and resident perpetrators. This is problematic given the basic education and training shortfalls

31 Mann, R., Horsley, P., Barrett, C., & Tinney, J. (2014). Norma's project - a research study into the sexual assault of older women in Australia. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University

32 Ashmore T, Spangaro J, McNamara L. 'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities. International Journal of Mental Health Nursing. 2015;24(2):139-148.

33 May, M., Smith, D., Young, C., & Ibrahim, J (Under review). Organisational change in Australian residential aged care services: Interviews assessing the sector's general readiness to change and readiness to address sexual violence

34 Mann, R., Horsley, P., Barrett, C., & Tinney, J. (2014). Norma's project - a research study into the sexual assault of older women in Australia. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University

35 McAuliffe, L., Bauer, M., Fetherstonhaugh, D., & Chenco, C. (2015). Assessment of sexual health and sexual needs in residential aged care. Australasian Journal on Ageing, 34(3), 183-188. doi: 10.1111/ajag.12181

discussed in paragraphs 33-37 but also unusual and impractical given the expertise a staff member would have to possess in order to fulfill this requirement sufficiently.

39. In general, RACS have limited collaboration and knowledge transfer between employees. In other healthcare settings, such as general medical practice, quality of care is upheld through such knowledge transfers (collaboration) and creates greater opportunity for understanding of international best practice in care. In the context of sexual violence, lack of basic training is not a result of a lack of availability of education and training. Our interviews found that despite sexual violence organisations having the capacity to collaborate with RACS and offer advice and training on how to RAC staff to respond to victim-survivors, these were not commonly being utilised by RAC providers [36].

40. The effect of ill-trained RAC staff is highlighted by the recent KPMG SIRS report. The report considered victim-impact in the 31/56 incidents that constituted rape and sexual assault, including touching the resident's genital area without consent. The response was anomalous, with RAC staff reporting 58.1% (18/56) survivors suffered no impact [37]. This is counterintuitive, alarming and raises serious questions about RAC staff's understanding and ability to consider the magnitude of sexual violence.

41. Further, victim-survivors captured in this study were reported by RAC staff to suffer minor physical and psychological injury or discomfort, resolved without formal medical or psychological treatment 11/31 (35.5%), and 2/31 (6.5%) were classified as unknown impact [38].

42. It appears none of the survivors received any formal medical or psychological interventions following being raped/sexually assaulted. It is well known that the trauma of sexual violence can extend far beyond the actual incident and it is best practice to consult and with professional and specialised services in order to response to victim-survivors. Results from the KPMG report support the notion that RACS are not utilising available and necessary specialised sexual violence organisations, despite staff and RAC providers not being equipped to self-govern these incidents (paragraphs 33-37). Results also illustrates how stigma and staff attitudes towards sexual violence (discussed in paragraph 34) have grave effects as barriers to reporting sexual offences in RACs.

Barriers to reporting sexual offences in residential aged care: Summary

43. There are numerous barriers to reporting, which stem mainly from the collective failure to detect sexual offences within RACS. Sexual offences in RACSs are difficult to ascertain due to: unclear and confusing reporting obligations and definitions, complex reporting pathways; reticence of reporting; disagreements around assault definitions; the absence of standardised terminology and measurements among the research community; complex victim-survivor and perpetrator profiles; lack of training and education efforts; lack of collaboration between

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[36] May, M., Smith, D., Young, C., & Ibrahim, J (Under review). *Organisational change in Australian residential aged care services: Interviews assessing the sector's general readiness to change and readiness to address sexual violence*

[37] Australian Government. Department of Health. *Prevalence Study for the Serious Incident Response Scheme.* https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs. Accessed 20 October 2020

[38] Australian Government. Department of Health. *Prevalence Study for the Serious Incident Response Scheme.* https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs. Accessed 20 October 2020

stakeholders; absence of suspicion on the part of RACS staff; difficulties in obtaining a history from residents with dementia; ambiguous clinical signs and denial by carers.

44. These barriers to reporting naturally contribute to why sexual offences in RACSs are unlikely to proceed to the criminal justice system. Sexual offences also may not proceed to the criminal justice system for reasons discussed below.

Why reports of sexual offences in residential aged care may not proceed to the criminal justice system – Victim-survivor and perpetrator characteristics

45. Issues with current reporting exemptions are discussed in paragraphs 6, 8 & 18-26 . Incidents whereby a resident perpetrator has a diagnosed cognitive or mental impairment are exempt from being reported to the Aged Care Quality and Safety Commission. However, it is unclear whether RACs are aware that there is a criterion that has to be met in order to apply this exemption, and whether they understand that incidents still need to be reported to the police irrespective of the Commissions reporting obligations. Further, it is unknown whether staff understand there is no exemption if the victim-survivor is cognitively or mentally impaired, or if they believe an allegation to be false.

46. A common issue to reporting sexual offences is that the presence of cognitive impairment of the victim-survivor and/or resident perpetrator may prejudice the possibility of a prosecution taking place as it is widely recognised that persons with cognitive impairment face significantly greater barriers to accessing justice and victim support[39]. As discussed in paragraph 9 & 28, both victim-survivors and resident perpetrators of sexual violence in RAC are often cognitively impaired.

47. Further, the law requires a person to have the capacity to have the required intention to commit a sexual offence. The presence of cognitive impairment may limit the ability for RACS and/or police to identify whether an act was unlawful. Police may decide that proceeding with a prosecution is not practical due to factors like the length of the prosecutorial process, the limited capacity of correctional facilities to accommodate care needs of older perpetrators and/or the low likelihood of a resident perpetrator receiving a custodial sentence, especially if they have high personal care needs. Resident perpetrators are therefore deemed a medical issue rather than a criminal justice issue.

48. Determining whether a sexual act is consensual is fraught with complexities in any population, though especially so in incidents occurring in RACS. The law also requires a person to have the level of mental capacity to give lawful consent to participate in sexual activities. There is not a legal test for capacity to make decisions about sexual relationship that fits neatly into a resident assessment--making this a vexed subject.

49. RAC staffs are expected to strike a balance between protecting residents whilst allowing resident autonomy (detailed in paragraph 3). Currently, staff are not supported or sufficiently trained to navigate this balance. Additionally, residents with a cognitive impairment may not be aware or able to comprehend the nature of what is happening to them during sexual activity. This may lead staff or the resident who is perpetrating to consider the sexual behaviour between the residents as consensual because there is no apparent resistance or obvious distress.

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39 Gray A, Forell S, Clarke S. Cognitive impairment, legal need and access to justice. Sydney: Law and Justice Foundation of NSW; 2009. Available from: https://www.researchgate.net/publication/277558675. Accessed 7 July 2020

50. Another issue is that the victim-survivor does not wish to engage with the prosecutorial process, or family members may dissuade them from doing so, for example, in the hope of avoiding re-traumatisation. Attempts to achieve justice for vulnerable victim-survivors may not be the best course of action. The collection of forensic evidence, recounting incident statements and the prosecution process can be distressing for any victim-survivor, especially those with cognitive or mental impairments or those at the end of their life[40]. However, this should be determined by the victim-survivor, whenever possible.

Why reports of sexual violence in residential aged care may not proceed to the criminal justice system – Forensic characteristics

51. Physical or somatic indicators or witness accounts are the most common means by which RAC staff are alerted to an incident. As discussed in paragraphs 31.1-31.3 indicators may be missed or dismissed, witnesses are not common, and disclosures may not be believed. Witnesses and reliable incident accounts are crucial to ensure successful prosecution. Sexual offences in any setting are one of the most difficult crimes to prosecute, due to the required elements of intent and lack of consent, but this is more complicated for incidents that occur in RAC (paragraphs 45-47).

52. Forensic evidence has had an unprecedented impact on the criminal justice system and has made charging alleged offenders easier. The preservation of forensic evidence is often overlooked during incidents in RAC because it is counterintuitive to what usually happens in aged care – RAC staff are there to help residents get dressed, bathed and keep their living space tidy therefore, forensic evidence is likely to be lost or destroyed in aged care settings. As discussed in paragraphs 23 25 & 38-42 RAC staff face an enormous amount of responsibility when incidents of sexual violence occur, which is outside the scope of current training and education.

53. Anecdotal evidence from RAC staff suggested at times police maybe unwilling to become involved when an incident occurs with cognitively impaired persons. This is detrimental for any victim-survivor wishing to prosecute as without official incident statements and the attempt to collect forensic evidence, it is unlikely prosecution efforts will be successful. It is imperative we have a clear protocol and understanding of roles and responsibilities between services for incidents of sexual violence in RAC. It is also vital police have the resources and/or are sufficiently knowledgeable and trained to converse with and/or interrogate persons with cognitive impairment (and other complex medical conditions).

Management of people who have committed sexual offences in residential aged care

54. Under the Aged Care Act 1997 (Cth) RACSs operators are responsible for the protection of residents and staff and for the welfare of resident perpetrators. When perpetrated by someone with impaired inhibitions and diminished judgment, Australian authorities often consider sexual misconduct as a medical and psychosocial problem rather than a legal matter. Dismissing the fact that some individuals may have impaired inhibitions and diminished judgement but still have the capacity and be fit to stand for a criminal trial.

55. This leaves management of resident perpetrators as largely the responsibility of RACS providers. The onus is on providers to determine if the incident was (i) intentional or, (ii) responsive to an

40 Australian Journal of Dementia Care (2019). *Comment: Sexual Assault in Aged Care*. https://journalofdementiacare.com/sexual-assault-in-aged-care/. Accessed 18 July 2020.

unmet need or, (iii) due to an inability to understand social norms. RACS providers will then need to determine the management of the resident. Again, not only is this outside the scope of most RAC staff, but unlike sexual offences that occur in the community, victim-survivors and resident perpetrators are likely to continue to be housed and have access to one another. This may leave the victim-survivor feeling profoundly unsafe, irrespective of whether the resident perpetrator acted with intent or not.

56. Management of resident perpetrators of sexual violence is not well researched and current options such as restrictive practises, relocation, environmental and behavioural strategies are laden with personal, social, ethical, clinical and legal issues. Relevant legal, clinical and forensic specialists should be sought when managing resident perpetrators, though we are not confident these specialists are utilised.

57. If intent is established, concerns persist regarding the feasibility and purpose of the prosecution of residents, and whether prosecution is the best outcome in all cases, specifically where the offender has dementia. Further, "usual" law enforcement solutions do not viably apply to sexual assaults involving resident perpetrators. Similarly, there are concerns as to: (i) who would be enforcing such orders (RACS or police), (ii) who would be punished (the offending resident or the facility), and (iii) the extent of the revisions to correctional facilities necessary in order to accommodate older perpetrators with potentially high care needs.

58. Lastly, victim-survivors of sexual offences are often considered as the ones needing to prove the incident occurred. This is difficult for RAC survivors of sexual offences to achieve, given their complex and vulnerable profiles (paragraphs 28-29), barriers to reporting including communication difficulties (paragraphs 30), and consent issues (paragraphs 45-47). Further, community attitudes that position older people and people with physical or cognitive impairments as vulnerable, not credible, and marginal members of society, allow other perpetrators (such as staff, family or visitors) to offend with relative impunity.

Research and recommendations to reduce sexual violence in residential aged care services

59. Little is currently known about the outcomes of RACS sexual assault as no longitudinal studies have been conducted, but existing case series evidence in related areas suggests it may result in severe consequences for victim-survivors and resident perpetrators.

60. In our systematic review of the literature[41], three studies documented post-survivor response. Importantly, over 50% (n = 20) of victims died within a year of assault. Long-term health and medical consequences of sexual assault, within any age group, is underreported, though available research suggest sexually assaulted women suffered from 50% to 70% more gynecological, central nervous system, and stress-related problems and are at risk of post-traumatic stress disorder (PTSD).

61. Considering older people have an increased risk of mortality after traumatic experiences or if suffering from anxiety disorders, it is reasonable to postulate, the sexual assault can contribute to an accelerated death.

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41 Smith D, Bugeja L, Cunningham N, Ibrahim JE (2017). *A Systematic Review of Sexual Assaults in Nursing Homes*. The Gerontologist; DOI:10.1093/geront/gnx022

62. Researchers have found that older adult rape victim-survivors are more likely than younger victim-survivors to sustain genital injury during a sexual assault [42]. Older adult victim-survivors are commonly physically frail with co-morbid conditions and thus may be at greater risk for physical injury during an assault. Sexually transmitted infections (STIs) may also be passed on during sexual assault. Older women have a greater risk of contracting STIs during intercourse than younger women, because increased postmenopausal vaginal mucosal friability can cause abrasions and tears, making STI transmission more probable.

63. There is a misguided notion that a person with cognitive impairment is not capable of sustaining emotional or psychological trauma from a traumatic event such as being a target of sexual violence as discussed in paragraph 31.2 This idea is entirely untrue. Paragraphs 35-37 discuss RAC staff failure to detect emotional and/or psychological harm of resident rape and sexual assault survivors.

64. Our nation's leadership and governance failures to address the needs of persons with dementia especially those in RACS who are targets of sexual violence is unconscionable and inhumane.

65. Virtually no evidence-based research exists currently to guide clinicians on how to prevent or manage sexual violence in the RACS context and many aspects of the phenomenon are poorly understood. Listed below are the known research initiatives regarding the topic:

66. We have completed and ongoing research into how to address reducing sexual violence in RACSs. In 2019, two Honors student completed theses examining the subject. In 2020, we developed and piloted an online educational course for RAC nurses. This addressed detection, management and prevention of unwanted sexual behaviour between residents. The pilot was evaluated as highly positive from participants (n=44).

67. We are aware of, and our team consulted on, a 2018 literature review led by Emma Turner and Riaza Rigby of Russell Kennedy Lawyers that was commissioned by the Department of Health and Human Services (Victoria)[43].

68. We understand this project[44] led by Victor Harcourt of Russell Kennedy Lawyers addresses many of the complex issues in preventing and managing sexual violence in RACSs. While out team have a copy of that report, I am not aware if it is publicly available.

69. The Opal Institute (Older People and Sexuality), founded by Dr Catherine Barrett in 2016, launched a national resource titled the 'Power Project' in February 2018. It is intended as a resource for service providers and others wishing to keep up to date with strategies for change for preventing and responding to sexual violence of older women, including those residing in RACS[45]. The project demonstrates how neglected sexual violence in RACS still is, how slow the pace of change has been and how much work still needs to be done[46].

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42 Poulos, C. A., & Sheridan, D. J. (2008). *Genital injuries in postmenopausal women after sexual assault*. Journal of elder abuse & neglect, 20(4), 323–335. https://doi.org/10.1080/08946560802359243

43 Department of Health and Human Services (Victoria) funded Literature Review on Unwanted Sexual Contact in Residential Aged Care facilities. 2018

44 Department of Health and Human Services (Victoria) funded project into 'Unwanted sexual contact between residents in residential aged care facilities.

45 "The Power Project". OPAL Institute, 2020, https://www.opalinstitute.org/power-project.html. Accessed 18 July 2020.

46 Submission To The Royal Commission Into Aged Care Quality And Safety, Regarding: Sexual Abuse/Assault Of Older Women. The Opal Institute, Melbourne, Australia, 2019, p. 6, https://www.opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf. Accessed 18 July 2020.

70. Our research team also hosted a one-day seminar on the 28th August 2019 discussing the prevention and management of sexual violence in RACS. The seminar was led by experienced and knowledgeable experts in the field of aged care, law and policy and forensic medicine. The seminar was designed for aged care workers, nurses, managers and, healthcare professionals who wished to know more about policy, practice and what the future may hold[47]. We have audiovisual record of the seminar and are willing to make this available to the Inquiry.

71. Whilst these initiatives are important and valuable, change must be systematic and come from both State and Federal Government[48].

Current data collection regarding sexual violence in residential aged care

72. Elder abuse is often framed through medical models, which limits the focus to the health care needs of the victim-survivor. There is also limited information regarding alleged perpetrators of RACS sexual violence (beyond race and gender). This is unfortunate and surprising as profiling perpetrators may identify risk factors for offending. As perpetrators comprised both staff and resident this creates very complex issues for identifying and responding to sexual violence incidents.

73. There is also an absence of multi-jurisdictional studies, using prospective, systematically collected data, as well as existing investigatory processes and documentation on service provision regarding sexual violence in RACSs.

74. Reports are released annually regarding the operation of the Age Care Act[49]. These simply state the number of reportable assaults in RACS in Australia notified to The Aged Care Quality and Safety Commission (formerly the Commonwealth Department of Health). This information has been collected since 2008, yet it is unknown what, if any, deeper analyses of this data occurs beyond basic incident frequencies. We estimate a total of 3000-5000 reportable sexual assaults in RAC have accumulated and these should be analysed and used to promote lessons for prevention and better management in Australia. This data could provide us with a more holistic view of incident characteristics, state by state, and including victim-survivor, perpetrator and RACS characteristics, if used to its potential. We argue that it should be released to a research team to interrogate.

75. Sexual violence of older people remains difficult to characterise owing to the paucity of studies, the diversity of methods and definitions, and the lack of detailed information regarding number and nature of incidences. Research regarding the impact of sexual violence among children, adolescents, and adults has been extensively studied, yet research has omitted older people from such scientific enquiry.

76. Existing research does not adequately portray the characteristics of sexual violence in RACSs nationally or globally and so prevention initiatives are restricted. Without a quality standard of holistic research, we have little to guide us on how to properly report, investigate, and manage sexual violence in RACSs. Research should seek to broadly operationalise definitions and

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47 "Preventing and Management of Sexual Violence in Residential Aged Care Seminar" hosted by Monash University, Health Law and Aging Unit, Melbourne, Australia. 2018

48 Submission To The Royal Commission Into Aged Care Quality And Safety, Regarding: Sexual Abuse/Assault Of Older Women. The Opal Institute, Melbourne, Australia, 2019, p. 6, https://www.opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf. Accessed 18 July 2020.

49 Australian Government. Department of Health. Report on the Operation of the Aged Care Act 1997. Canberra ACT: Department of Health; 2020. https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf. Accessed 10 December 2020

reporting of sexual violence in RACSs to increase the quality and understanding of this phenomenon. Research should also progress using an ecological perspective, a bifocal framework focusing simultaneously on the victim-survivor and institutional caregiver as dyad.

77. Research requires investment. We need dedicated and specific funding support. Rather than just an opportunity to apply for competitive grants available to all health and aged care academics. The issues are threefold, it is a research deprived environment with a very small number of academics involved, it is a relatively data poor area with limited access to secondary information sources that are commonly used in health and it is often very expensive to obtain, finally there is very little data about quality of care, quality of life that is standardised and gathered nationally.

Research regarding elderly sex offenders

78. Elderly sex offenders are often overlooked and considered a health problem as opposed to being dealt with by the Criminal Justice System. This is because elderly sex offenders may present with a unique set of problems of which includes their physical, medical and mental needs.

79. The Australian Bureau of Statistics (ABS) in 2020, reported male offender rates of sexual assault recorded by the police for offenders aged 55-64 years and 65years+ was 35 per 100,000 and 30 per 100,000 respectively [50].

80. Mandatory minimum sentencing and decreased tolerance for early releases, means there has been an increase in older prisoner populations throughout Australia [51]. In Australia 2020, the median age of prisoners was highest at 44.6 years for sexual assault and related offence (highest mean age of all offence types) [52].

81. Sexual offences also typically carry longer terms, resulting in sex offenders being released in older adulthood. Literature suggests difficulties in post-release planning and support for older prisoners, despite the likelihood for its need to be amplified [53]. People who have been incarcerated for longer periods are likely to have more difficulty adjusting to community living, because of losses such as lost family and social support, housing, possessions and the capacity to be employed [54].

82. Elderly sex offenders comprise a unique population for treatment, risk evaluation and risk management though empirical data on offender characteristics and management is sparse despite elderly sex offenders not being a trivially small group.

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50 Australian Institute of Health and Welfare (2020). Sexual Assault in Australia. Canberra. https://www.aihw.gov.au/reports/domestic-violence/sexual-assault-in-australia/contents/summary. Accessed 10 December 2020

51 Baidawi, S., Trotter, S., Browning, C., Collier, C., O'Connor, P., Sheehan, D (2011). Older prisoners—A challenge for Australian corrections. Trends & issues in crime and criminal justice. 426 https://www.aic.gov.au/publications/tandi/tandi426. Accessed 10 December 2020

52 Australian Bureau of Statistics (2020). Prisoners in Australia. https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release#:~:text=Back%20to%20top-,Key%20statistics,prisoners%20per%20100%2C000%20adult%20population. Accessed 10 December 2020

53 Baidawi, S., Trotter, S., Browning, C., Collier, C., O'Connor, P., Sheehan, D (2011). Older prisoners—A challenge for Australian corrections. Trends & issues in crime and criminal justice. 426 https://www.aic.gov.au/publications/tandi/tandi426. Accessed 10 December 2020

54 Kingston, P., Le Mesurier, N., Yorston, G., Wardle, S., Heath, L. (2011). Psychiatric morbidity in older prisoners: unrecognized and undertreated. Int Psychogeriatric. 23 (8) 1345-60. https://pubmed.ncbi.nlm.nih.gov/21489341/. Accessed 10 December 2020

83. Our research on elderly sex offenders is currently in process of data analysis. We are currently conducting a 7-database search of peer-review literature conducted between 1966 – December 2020 with the aim to examine the socio-demographic and clinical characteristics of elderly sex offenders.

84. From the 27 articles found and examined so far, none have reported on the rehabilitation efforts of elderly sex offenders and very few (n=3) have reported treatment methods. This is surprising given the potential impracticality of sentencing this population.

85. Previous research reports elderly sex offenders may be released and resettled into RACS after fulfilling sentences[55]. Management of elderly sex offenders in RACS is complex as there is not only a duty to protect other resident's but a duty to respect and provide care for all residents, including those with previous or current criminal histories. *If* RACS are aware of a resident's criminal history, RACSs are responsible to take action to prevent any abuse. However, as previously discussed in this submission, in Australia there is a lack of codified, enforced policies and intervention strategies on how to prevent abuse in RACS. Therefore, RACS are at risk of being in regulatory noncompliance when housing previously convicted elderly sex offenders.

86. Further, our researching interviewing RAC stakeholders (under review) found stakeholders reported to be frequently understaffed and under resourced [56], making management of potentially high-risk individuals difficult as the two main risk factors of sex offending in RACSs are (i) having access to vulnerable victim's and (ii) inadequate supervision [57]. In order to create a safe and dignified care environment for all residents and to prevent RACS becoming liable for any breaches, a collaboration among relevant stakeholders and agencies is necessary[58].

87. The lack of longitudinal research makes it difficult to form solid conclusions on the effects of age and sexual recidivism. Research literature does not suggest a zero-risk, and suggests some individuals, despite increasing age, will continue to be a risk [59].

88. For example, elderly sex offenders with neurogenerative diseases (e.g. dementia) may re-offend if the condition was left untreated and/or unmanaged, and so from a clinical perspective the individual translates into "high risk." In this example, the management and rehabilitation efforts for this individual would be entirely different to an elderly sex offender who is high-risk due to other factors (such as sexual disorders)[60], thus highlighting the important consideration when analysing the effects of age and sexual recidivism.

89. While some elderly sex offenders may pose little threat in RACSs, (or in the community), the effect of age and sexual recidivism is a developing area of interest, with limited attempts of

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55 Johstone, T. (2019). Ageing prisoners are challenging the system inside and out. AgeCare Insite. https://www.agedcareinsite.com.au/2019/04/ageing-prisoners-are-challenging-the-system-inside-and-out/. Accessed 10 December 2020.

56 May, M., Smith, D., Young, C., & Ibrahim, J (Under review). Organisational change in Australian residential aged care services: Interviews assessing the sector's general readiness to change and readiness to address sexual violence

57 Baidawi, S., Trotter, S., Browning, C., Collier, C., O'Connor, P., Sheehan, D (2011). Older prisoners—A challenge for Australian corrections. Trends & issues in crime and criminal justice. 426 https://www.aic.gov.au/publications/tandi/tandi426. Accessed 10 December 2020

58 Corson, R., & Nadash, P. (2013). Providing long term care for sex offenders: liabilities and responsibilities. Journal of the American Medical Directors Association. 4(11), 787–790. https://pubmed.ncbi.nlm.nih.gov/24094899/. Accessed 10 December 2020

59 Booth, B. (2016) Elderly Sexual Offenders. Current psychiatry reports. 18(4): 34. https://pubmed.ncbi.nlm.nih gov/26893232/. Accessed 10 December 2020

60 Booth, B. (2016) Elderly Sexual Offenders. Current psychiatry reports. 18(4): 34. https://pubmed.ncbi.nlm.nih gov/26893232/. Accessed 10 December 2020

longitudinal scientific inquiry [61]. Research should be undertaken to pursue to determine the characteristics of elderly sex offenders and determine the risk of this population

Recommendations

90. All recommendations support immediate and long-term measures to prevent violence against women residing in RACS. These recommendations are aimed at a federal level to drive the most extensive and effective change. However, they need to be accepted and implemented by each individual state and territory. State and territories need to lobby federal government to implement these changes. A fundamental principle is that all citizens of Victoria should have the same legal and human rights and access to the same services irrespective of their place of residence.

91. Recommendations have been structured to guide you to which issue paper and/or terms of reference they correspond to. This is presented in a table at the end of the listed recommendations. Our recommendations from 2019 are described in detail in the attached documents. In brief these are:

92. **Recommendation 1.** National, regional and local initiatives are required to improve public, political and aged care staff awareness and knowledge of sexual violence in RACSs. (Issue Paper A, ToR f)

93. **Recommendation 2.** The aged care community (staff, providers, regulatory and governing bodies and advocates) should create a public communication strategy that improves the perception of aged care and older people. (Issue Paper A, ToR f-j)

94. **Recommendation 3.** Government, both federal and state/territory, should review how the current allocation of resources impacts on the likelihood of sexual violence, efforts to prevent sexual violence, and management of an incident. (Issue Paper A, ToR e)

95. **Recommendation 4.** Government, both federal and state/territory, along with RACS providers should support the development of partnerships with a variety of stakeholders in the fields of prevention and management of sexual violence. This would be the first step to coordinating Australia-wide multidisciplinary, co-located elder abuse prevention and management services. These services should be located in geographically based hubs, but function as a national system reporting to government. These hubs could encompass existing services including: legal services, police, counselling services, sexual violence response teams, long-term mental health support services, and aged care navigators. (Issue Paper A, ToR b &k)

96. **Recommendation 5.** To review and address the known systems failures in recognition, reporting definitions, reporting, and responding to sexual violence including post-event management. (Issue Paper A & F, ToR f-j)

97. **Recommendation 6**. Government, both federal and state/territory, in partnership with RACS providers and key stakeholders, should ensure that every aged care service has the support, knowledge and skills to provide appropriate responses to residents who have experienced past or current sexual violence. This work should align with the international best practice and address:

61 Craig, A. (2008). How should we understand the effect of age on sexual recidivism? Journal of Sexual Aggression. 14(3) 185-198. https://www.tandfonline.com/doi/abs/10.1080/13552600802073132?journalCode=tjsa20. Accessed 10 December 2020

a. Early detection of sexual assault.

b. Timely response and the preservation of evidence.

c. Long-term support of the victim-survivor and their family. (Issue Paper A, ToR b, k-l)

98. **Recommendation 7.** The Australian Government should acknowledge and aid the implementation of existing research and uphold the agreed set of national research priorities (proposed in the National Plan to Respond to the Abuse of Older Australians). (Issue Paper A, ToR e)

99. In addition, we make the following recommendations based on knowledge acquired over the past 12-18 months:

100. **Recommendation 8**. a far more robust Serious Incident Response Scheme is required with expertise to conduct the analyses and the data including the responses to change practice be released to the public on a six-monthly basis.

101. Particularly concerning in the KPMG report is a suggestion that some form of limit be placed on level and nature of reporting of sexual violence be considered to align with available resources. All unlawful sexual acts should be reported. It is unclear how RAC staff are to interpret the seriousness of incidents, as there are no global measures to assess victim impact. Global measures do not exist as the experience of trauma is highly personal and can manifest with different (often undetectable) indicators, and on different timelines, depending on the person affected. It is therefore entirely unsuitable for the seriousness of incidents to be subjected to RAC staff or the Commission's interpretation.

101.1. Incidents whereby RAC volunteers are the alleged perpetrators and residents the victims should also be included in the reportable definition. (Issue Papers D, ToR b, e, f-j)

102. **Recommendation 9.** A separate national panel of experts and stakeholders in this field should be established to undertake this sensitive and complex work. (Issue Papers A, C & D, ToR b, o, q) as the Australian Aged Care Commission is a regulator and is not equipped or does it have the expertise to analyse and determine preventive action for sexual violence.

103. **Recommendation 10.** The data held under the Operation of the Aged Care Act 1997 concerning reportable assaults be released to allow experienced research team(s) to interrogate the nature of sexual offences in RACSs.(Issue Papers A, ToR e)

104. **Recommendation 11:** Dedicated and specific funding support for short and long term research covering sexual violence in RACS (detection, management and prevention), resident perpetrators, and elderly sex offenders (offender profiles, sentencing, management and rehabilitation). (Issue Papers A, F, ToR e)

105. **Recommendation 12:** A review of Victorian laws to ensure there are no gaps within legislation whereby residents are not protected (e.g. The Equal Opportunity Act 2010). (Issue Paper C)

106. **Recommendation 13:** Clear protocols and an understanding of roles and responsibilities between community, health, aged care and criminal justice services be developed for incidents of sexual violence in RAC. This includes resources for police to better manage conversing with and/or interrogate persons with cognitive impairment (and other complex medical conditions) (Issue Paper A & D).

Recommendation	Issue Paper	Issue Paper Question	Summary of evidence of support
1-3	A	*"What would make it easier for people who have been sexually harmed to get the supports and services they need, so they can decide whether to report the sexual harm?"*	Sexual offences in RACSs are likely to be missed or dismissed by staff. The common obstacles faced by political groups, the public and staff in the aged care sector are derived from a lack of knowledge of this topic. Implementing recommendations 1-2 will aid in dispelling current stigmas and myths around sexuality and sexual violence in older people. This is the first step to generate change. An increase in awareness and knowledge will inadvertently improve management of incidents and responding to survivors as will reviewing the allocation of resources.
4	A	*"How can we improve how other services and systems work with the sexual assault system, so that people are supported to seek justice?"* *"How can collaboration within the sexual assault system be improved, so that the justice system responds effectively to sexual harm?"* *"How can we improve how other services and systems work with the sexual assault system, so that people are supported to seek justice?"* *"How can we reduce the trauma of victim survivors in the justice system"*	RACSs keep sexual offences largely "in-house" and are failing to utilise medical, psychological and forensic services that may be necessary to manage incidents, and support both survivors and resident perpetrators. Creating a central hub where experts and stakeholders from relevant fields come together to manage serious incidents provides an opportunity for a unified standard of care. The results of a central hub will aid to educate both aged-care and sexual violence stakeholders. Transferring knowledge and best practice between relevant stakeholders will undoubtedly help to reduce secondary trauma of victim-survivors.
5-7	A	*"What are the opportunities for, and benefits of, improving data, research and evaluation in relation to sexual offending?* *"How can we reduce the trauma of victim survivors in the justice system"*	More research and consultation need to be undertaken to create an effective system. This should focus on the known system failures discussed within our submission (e.g. reporting obligations and definitions). Current aged care systems of managing sexual offences do not reflect best practice. There needs to be a greater consultation with sexual violence experts.

			Current education and training of RAC staff is not adequate. Staff awareness and adequate education regarding older people and sexuality and sexual violence is imperative for a response to a sexual offence. Improving systems and education of RAC staff will undoubtedly help to reduce secondary trauma of victim-survivors.
8-9	D & E	*“Do you support access to alternative ways of reporting sexual harm?”* *“Is there a need to change any laws on evidence or procedure for sexual offences?”*	Whilst we advocate for the introduction of a SIRS we believe the proposed definitions of a reportable assault to be more confusing than current reporting obligations. It is unclear how RAC staff are to interpret the seriousness of incidents and it is entirely unsuitable for the seriousness of incidents to be subjected to RAC staff or the Commission’s interpretation. Further, the proposed definition is precarious to RAC staff culture and attitudes surrounding sexual violence in RAC. Incidents whereby RAC volunteers are the alleged perpetrators and residents the victims should also be included in the reportable definition As the Aged Care Quality and Safety Commission is a regulator, they are not suitable organisation to: (i) manage sexual violence, (ii) to judge whether an incident constitutes sexual violence or is a manifestation of cognitive impairment (e.g. a delusion), (iii) judge the extend of harm pose to the person who has experienced the incident of sexual violence.
10-11	A & F	*“What are the opportunities for, and benefits of, improving data, research and evaluation in relation to sexual offending* *“Do responses to sexual offending sufficiently address the diverse needs of different people who have committed sexual offences?”*	There is a need to analyse the existing data held by the Aged Care Quality and Safety Commission to understand the full extent and nature of the sexual offences in RACs. There needs to be initiative to improve the response to resident perpetrators of sexual violence especially those with cognitive or

			mental impairments as the current system places responsibility to manage these complex exhibitors. Research into elderly sex offenders also needs to be funded in order to gain accurate offender profiles and management strategies.
12-13	A, C & D	*“Is there a need to change any of Victoria’s sexual offences, or their application?”* *“What other issues need to be addressed to improve the experience of the police investigation process for adults who have been sexually harmed?”* *“Is there a need for a stronger focus on governance or shared outcomes in the response of the justice system to sexual harm?”* *“How can we improve how other services and systems work with the sexual assault system, so that people are supported to seek justice?”* *“How can collaboration within the sexual assault system be improved, so that the justice system responds effectively to sexual harm?”*	Aged care is governed by Commonwealth policies and legislation as well as and the relevant State and Territory criminal laws. What constitutes a sexual offence may not constitute a reportable assault under the current Aged Care Act 1997 (Cth) section 63-1AA. It is unclear if RAC staff are aware that an incident that may not be reportable to the Commission is still reportable to the police if it constitutes a criminal offence. Sexual harassment laws do not seem to cover resident-resident offences, leaving residents unprotected. Further anecdotal evidence indicates police do not respond to RAC calls to investigate sexual offences in facilities if incidents involve cognitively impaired persons. Survivors of sexual offences in RACS deserve the same rights and services regardless of cognitive impairment. Clear protocols and understanding of roles and responsibilities between services including police, should work to achieve this.