Coronial and other death review systems can help identify institutional elder abuse if they are aligned to intercept appropriate cases. While retrospective in nature, coronial and other death review systems help society understand how and why a person died. Poor understanding of the nature and characteristics of institutional elder abuse, limited epidemiological, prevalence and incidence data and missing or misaligned reporting systems have hampered our ability to understand and address institutional elder abuse in residential aged care services (RACS). It is important to identify why deaths in RACS are not investigated, particularly deaths that arise from institutional elder abuse. This analysis involves examining coronial and other death review processes, and in particular the ‘triggers’ that initiate those processes. The analysis involves considering what we already know about deaths in RACS. We also need to understand how our systems' response to deaths by institutional elder abuse is potentially impacted by other factors including constitutional confusion and entrenched ageism. This paper suggests law reform solutions and legal process alternatives to improve our understanding and our approach to institutional elder abuse.

I. INTRODUCTION

Coronial and other death review processes can help identify institutional elder abuse if reporting systems are aligned to intercept appropriate cases. While retrospective in nature, coronial and other death review processes help society understand how and why a person died. Poor understanding of the nature and characteristics of institutional elder abuse, limited epidemiological and prevalence data and missing or misaligned reporting systems have hampered our ability to understand and address institutional elder abuse through public health policy and regulatory frameworks.

To understand the limitations of existing coronial and other death review processes, it is important to identify why deaths in RACS \(^1\) are infrequently investigated, even if they result from institutional elder abuse. This article examines the ‘triggers’ that initiate coronial and other death review processes and how they might be improved to better identify deaths from institutional elder abuse. It also suggests law reform and legal process solutions to improve

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\(^{1}\) For the purposes of this article, RACS are residential care as defined under s 41-3 of the Aged Care Act 1997 (Cth):

\(41-3\) Meaning of residential care

(1) Residential care is personal care or nursing care, or both personal care and nursing care, that:

(a) is provided to a person in a residential facility in which the person is also provided with accommodation includes:

(i) appropriate staffing to meet the nursing and personal care needs of the person; and

(ii) meals and cleaning services; and

(iii) furnishings, furniture and equipment for the provision of that care and accommodation; and

(b) meets any other requirements specified in the Subsidy Principles.

(2) However, residential care does not include any of the following:

(a) care provided to a person in the person’s private home;

(b) care provided in a hospital or in a psychiatric facility;

(c) care provided in a facility that primarily provides care to people who are not frail and aged;

(d) care that is specified in the Subsidy Principles not to be residential care.
the identification of deaths from institutional elder abuse. Firstly, we need to understand the context of institutional elder abuse.

Institutional abuse is an accepted subset or type of elder abuse.² It has been recognised since Townsend’s landmark study, *The Last Refuge*, was published in 1962.³ The World Health Organisation recognises the institutional setting of elder abuse:⁴

Abusive acts in institutions include physically restraining patients, depriving them of dignity (for instance, by leaving them in soiled clothes) and choice over daily affairs; intentionally providing insufficient care (such as allowing them to develop pressure sores); over- and under-medicating and withholding medication from patients; and emotional neglect and abuse.⁵

Despite this recognition, there is no accepted, authoritative definition of institutional abuse of older persons.⁶ Inherent difficulties in operationalising definitions, under-reporting and methodological problems in research studies have contributed to this.⁷ Institutional abuse is often described as maltreatment or abuse of a person by or from a system of power.⁸ Put simply, it is abuse by or within an institutional setting.⁹ These two aspects – circumstance and setting – also reflect how coronial and other death review processes are triggered. Research across institutional abuse suggests the predominance of perpetrators and abusers are systemic actors such as employees.¹⁰ This naturally depends on how we define the circumstances and setting of institutional elder abuse.

Perpetrators within an institutional setting are numerous and comprise biological and non-biological family members including co-residents such as spouses and visitors. In cases of staff on resident violence, workplace stressors are said to play an important role.¹¹ Similarly, in home care settings, carer stress has been linked to perpetration of elder abuse. The early view of caregiver abuse was that abuse was largely due to frustration caused by the stress and burden of caregiving, and ignorance of the rights and needs of the older person.¹² However, more recent research has found that the caregiver model does not explain the majority of cases of elder abuse.¹³

Older persons living in RACS are vulnerable to abuse,¹⁴ and are more likely to have some degree of cognitive impairment and/or a disabling condition.¹⁵ They are often frailer and more dependent on others for care and support and all approved care recipients reflect high level

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⁵ Ibid.
⁹ Ibid.
¹⁰ McDonald et al, above n 2.
¹³ Melanie Joosten, Freda Vrantsidis and Briony Dow, ‘Understanding Elder Abuse: A Scoping Study’ (Research Report No 16, University of Melbourne and the National Ageing Research Institute, 2017) 16.
¹⁴ McDonald et al, above n 2, 139.
¹⁵ Ibid.
needs. The impacts of elder abuse on older persons are grave; mortality rates for victims are three times higher. Obviously, a higher index of suspicion for investigation into the preventable factors around the death of an older person in RACS is warranted.

Ecological perspectives reveal institutional elder abuse occurs within a range of systems with a multiplicity of risk factors. Within the contemporary, Australian context:

Some taxonomies of abuse also include institutional elder abuse as a form of elder abuse — described as occurring when the ‘routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of individuals.’

Inquiries regularly reveal, but rarely name, the phenomenon that is institutional elder abuse. The New South Wales Parliamentary Inquiry into Elder Abuse recounted the shocking example of a man demeaned and treated roughly by RACS staff. That same Inquiry dedicated minimal time to the issue because it considered ‘that abuse of older people in aged care is an area of Commonwealth Government responsibility and thus outside the scope of this inquiry.’

II DEFINITIONS AND CONTEXT

A Types and Subsets of Institutional Elder Abuse

Institutional elder abuse includes all forms of elder abuse such as physical, psychological and financial abuse, as well as contextual examples of sexual abuse, resident on resident aggression and staff on resident violence. Australian studies on the sexual assault of older women in RACS have begun to uncover the extent of specific types of institutional abuse in Australia. Therefore, while RACS encounter all forms of elder abuse, they also appear to have some types particular to their circumstances and setting.

Accepted subsets of institutional abuse include ‘overt abuse’, ‘program abuse’ and ‘systems abuse’. RACS or their agents can be abusers in each of these subsets — that is, they are the circumstance. RACS are also the setting for various forms of violence and abuse, including abuse perpetrated by others such as family members, co-residents, visitors and staff. In some cases, RACS are both the circumstance and setting: where the RACS has an institutional awareness of, is complicit in, or is party to the abuse in some way. In overt abuse cases, the

16 See s 21-2 of the Aged Care Act 1997 (Cth): 21-2 Eligibility to receive residential care
A person is eligible to receive residential care if:
(a) the person has physical, medical, social or psychological needs that require the provision of care; and
(b) those needs can be met appropriately through residential care services; and
(c) the person meets the criteria (if any) specified in the Approval of Care Recipients Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of residential care.
21 Legislative Council General Purpose Standing Committee No 2, Parliament of New South Wales, Elder Abuse in New South Wales (2016) XI.
22 Ibid 70.
23 Rosemary Mann et al, ‘Norma’s Project: A Research Study into the Sexual Assault of Older Women in Australia’ (Research Report No 98, Australian Research Centre in Sex, Health and Society, June 2014).
abuse includes physical, sexual, psychological, emotional or verbal abuse by an institutional actor or agent such as a staff member or contractor. In cases of program abuse, the institution itself causes harm by its acts or omissions, such as operating below acceptable conditions or improper use of its power to modify the behaviour of a person. Complaints to the Aged Care Commission system often reflect a range of hybridised (overt and program) abuse issues. Breaches of the Aged Care Act 1997 (Cth) and related instruments such as the Charter of Care Recipients’ Rights and Responsibilities – Residential Care reveal overt and program abuses.\textsuperscript{25}

Systems abuse involves an entire care system that is stretched beyond capacity and causes maltreatment through inadequate resources. Recent inquiries have raised concerns about system-wide abuse in the RACS sector.\textsuperscript{26} Systems abuse is often reflected in cases reported by coroners where an element of the overall system fails older persons and leads to death. For example, in the Inquest into the Death of Margery Frost, the Coroner considered the adequacy of staffing levels in the context of an older woman’s death.\textsuperscript{27} Staff-resident ratios have program and system-wide relevance and are commonly raised as a matter of concern. Different types of institutional abuse do not occur in a vacuum and individual deaths can reveal idiosyncratic, programmatic and systemic failures.

\textbf{B An Example of Hybrid Institutional Abuse: Restrictive Practices}

Using the definitions proposed earlier, many types of institutional elder abuse appear to be hybrids. One illustrative example is the use of restrictive practices (also called restrictive interventions) within and by RACS. Restrictive practices are ‘the deliberate or unconscious use of coercive power to restrain or limit an individual’s freedom of action or movement.’\textsuperscript{28} The key legislation governing the activities of federally funded aged care services in Australia — the Aged Care Act 1997 (Cth) — does not prohibit, legislate for, or regulate the use of restrictive practices to manage the challenging behaviours of some aged care residents.\textsuperscript{29} The Public Advocate of Queensland recently reported that ‘it is concerning that the inappropriate use of restraints in RACS in Australia has been a factor in the deaths of some people upon whom the restraints were applied...’\textsuperscript{30} The Administrative Appeals Tribunal equated the use of restrictive practices to breaches of the rights of residents under the Aged Care Act 1997 (Cth). In Saitta Pty Ltd v Secretary, Department of Health and Ageing,\textsuperscript{31} the Tribunal (per McDonald DP) was reviewing a RACS’ accreditation over a legion of quality of care issues:

\begin{quote}
A resident was observed an hour after breakfast had concluded sitting in the dining room (not at the table) with a lap belt restraining her. It was Dr Lett’s oral evidence that, as well as restraining the resident from undertaking normal activity, this is also a dangerous practice as the resident may try to wiggle out causing skin to tear or bruise or the resident to fall and injure him/herself. This is an example of an incident where even [if] it was a once off occurrence the fact of it happening is strongly indicative of serious non-compliance, as the restraint could easily be removed when the resident had finished her meal. The Tribunal is satisfied that there is non-compliance with Standard Pt 3 Item 3.5 (residents to be assisted to achieve maximum independence), Item 3.6 (right to dignity)
\end{quote}

\textsuperscript{25} Aged Care Act 1997 (Cth) sch 1.
\textsuperscript{26} House of Representatives Standing Committee on Health, Aged Care and Sport, Parliament of Australia, Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (2018) Terms of Reference.
\textsuperscript{27} Inquest into the Death of Margery Frost [2009] Queensland Coroners Court 1725 (31 May 2011).
\textsuperscript{28} Claire Spivakovsky, ‘Restrictive Interventions in Victoria’s Disability Sector: Issues for Discussion and Reform’ (Discussion Paper, Office of the Public Advocate, August 2012) 3.
\textsuperscript{30} Ibid ii.
\textsuperscript{31} [2008] AATA 681.
and Standard Part Item 4.4 (management actively working to provide a safe and comfortable environment consistent with residents’ needs).  

The decision reinforces that restrictive practices reflect overt abuse and program abuse. The Public Advocate of Queensland has argued that restrictive practices ‘may also constitute a breach of law and human rights.’ The absence of regulatory frameworks for the use of restrictive practice and interventions in RACS is the subject of numerous recommendations for urgent reform. It begs the question: are any restrictive practices legitimised, particularly for those who cannot consent to such practices? Are all restrictive practices abusive? This is a digression, albeit an important one, and we will return to the issue of restrictive practices as a potential trigger for coronial attention later in this article.

C Defining ‘Institution’

A key issue for institutional elder abuse is how ‘institution’ is defined. Recent Australian inquiries have taken a very broad approach to the term. The Royal Commission into Institutional Responses to Child Sexual Abuse defined ‘Institution’ as ‘any organisation, including children’s homes, religious organisations, missions and reserves, government agencies, schools, sports clubs, juvenile justice facilities and out-of-home care (foster, relative and kinship care).’ Such a broad-brush approach suggests that institutional elder abuse would incorporate an assortment of settings where older persons live or receive clinical or personal care. It seems uncontroversial that RACS would be included in even a narrow definition. Aged care in all its various manifestations has an institutional aspect and ‘institution’ would also include community-dwelling older persons receiving home-based aged care services. The focus of this article is deaths in RACS but the parallels between children and older persons in community-based care obviously warrant further consideration.

D Defining ‘Death’

That older persons die in RACS is not controversial. RACS are cruelly known as ‘God’s waiting rooms’. In 2015–16, 214,000 persons entered RACS. Based on recent data, nearly 80 per cent of residents died after an average length of stay of 34.5 months, and length of stay correlated with mortality. Accurate cause of death is essential for understanding how many older people have premature, preventable deaths, with implications for aged care services, healthcare expenditure, quality and safety, and human rights. How we define deaths is therefore also fundamental to identifying instances of institutional elder abuse.

The Australian Bureau of Statistics (ABS) uses a range of descriptors under causes and types of death. Causes of death are drawn from the International Classification of Diseases (ICD-10) diagnostic criteria and contain thousands of codes. The three principal types of death are

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32 Ibid [122].
33 Office of the Public Advocate of Queensland, Submission to the Standing Committee on Health, Aged Care and Sport, Inquiry into the Quality of Care in Residential Aged Care, February 2018, 3.
34 Australian Law Reform Commission, above n 20, [4.10]–[4.11].
37 Hitchen et al, above n 18, 1533.
38 Ibid, 1531.
natural, external and unknown.\textsuperscript{39} The same definitions are used by coroners for reporting deaths.\textsuperscript{40} As discussed later, coroners have the added role of deciding how the person died.

External cause deaths are those where the underlying cause of death is determined to be one of a group of ‘causes external to the body (for example intentional self-harm, transport accidents, falls, poisoning etc.).\textsuperscript{41} They include intentional and unintentional deaths. These types of deaths are often reported to coroners.\textsuperscript{42} They reflect issues across all subsets of institutional elder abuse. Suicide within RACS has received some attention but researchers are just beginning to explore this phenomenon and its possible prevention.\textsuperscript{43}

Natural cause deaths are deaths ‘due to diseases (for example diabetes, cancer, heart disease etc.) which are not external or unknown.’\textsuperscript{44} Natural cause deaths offer insights into clinical and personal care, disease management and other issues within RACS that may reflect institutional elder abuse. If the deaths of frail, older persons are inaccurately classified as natural, and any contributing modifiable factors are not identified, avoidable mortality cannot be highlighted and addressed.\textsuperscript{45} The term ‘premature death’ is also used at times.\textsuperscript{46} Interestingly, older persons over 70 years are excluded from this death classification.\textsuperscript{47} It might therefore be viewed as a somewhat discriminatory age proxy that equates the age of 70 years and older as being the right time to die. Unknown deaths are deaths where it is unable to be determined whether the cause was natural or external.\textsuperscript{48}

Quite apart from causes of death, the ‘Australian Cause of Death Statistics System’ also reports on ‘potentially avoidable deaths’ as measured by ‘potentially preventable deaths’ and ‘potentially treatable deaths’.\textsuperscript{49} ‘Potentially preventable deaths’ are those amenable to screening and primary prevention, such as immunisation, and reflect the effectiveness of the current preventive activities of the health sector.\textsuperscript{50} These deaths are of great interest for both program and system abuse identification. Deaths from potentially treatable conditions are those which are ‘amenable to therapeutic interventions and reflect the safety and quality of the current treatment system...’.\textsuperscript{51} These deaths potentially reflect overt and program abuse issues.

Each of these death classifications are present in the cohort of deaths within RACS. Each one also potentially aligns with definitions of institutional elder abuse. Hitchen et al make a useful suggestion about the classifications at play in RACS:

> Three general aspects bear on whether and how a death should be investigated: Is it due to the progression of a medical condition (natural)? Is it expected given the person’s overall condition and their disease (premature)? Is it only attributable to the medical condition(s) and the person’s overall condition and not amenable to other factors (preventable)?\textsuperscript{52}

\textsuperscript{40} Ibid 33.
\textsuperscript{41} Ibid.
\textsuperscript{42} Ibid.
\textsuperscript{45} Hitchen et al, above n 18, 1532.
\textsuperscript{46} Ibid.
\textsuperscript{47} Ibid 1534.
\textsuperscript{48} Australian Bureau of Statistics, above n 39.
\textsuperscript{49} Ibid.
\textsuperscript{50} Ibid.
\textsuperscript{51} Ibid.
\textsuperscript{52} Hitchen et al, above n 18, 1535.
As we see later in this article, this classification mirrors how coroners’ laws have been framed in recent years. An additional complexity for post death investigation arises with the dignity of risk, in which patients’ right to self-determination and autonomy directly overrode prevention strategies. The ‘preventable death’ category might not be easily applied to these cases. This advice is given with the caution that ‘this determination requires vigilance and should not be accepted without question.’ Staff actions can look relatively harmless or even merciful at times, masking a neglectful or more sinister, even homicidal, reality. Another example is where a “preventable death” still occurs because staff are reckless or provide suboptimal care and then use the older person’s dignity of risk choice as “a shield” – to avoid their professional obligations and responsibilities.

Exploring the alignment of death classifications with what is known about the subsets of institutional elder abuse is clearly worthwhile. Hitchen et al have suggested an alternative classification approach. They suggest that a more nuanced classification of deaths in older people would permit improved assessment of the quality of care provided, including identification of health or life care practices that are unsafe or deleterious. Identified gaps can be addressed, and more generally, minimum standards set for such services.

The alternative suggested is for ‘treated’, ‘untreated’ and ‘untreatable’ to replace ‘premature’ and ‘preventable’. This might exclude deaths from institutional elder abuse such as external cause deaths where quality of care issues were something other than medical care.

In the end, we are interested in cases where institutional elder abuse causes or contributes to death, from which we might learn how to prevent the abuse and ultimately prevent death. From an investigative sense, Mosqueda and Wiglesworth called this cohort ‘suspicious elder deaths’. Coroners and medical examiners in the United States have benefited from inquiries into deaths in RACS, allowing some level of differentiation between accidental deaths and fatal elder abuse. This work mirrors Australian coroners’ work on externally caused deaths in RACS. It is, however, only one area of distinction in a complex field. Deepening our understanding about how death classifications reveal and reflect typologies of institutional elder abuse is key.

### III SOME FUNDAMENTAL LIMITATIONS

Beyond definitional issues, a number of problems hamper our ability to identify institutional elder abuse deaths. These include limitations in coronial and other death review processes, prevalence data and the impacts of constitutional confusion and ageism.

#### A Limitations of Coronial Systems

State coroners are a recent development in Australia. The South Australian Government appointed the first State Coroner in 1975 and other states and territories followed suit over the
following decades. The role of Australian coroners is more circumscribed than the historical role of the mediaeval Coroner, whose diverse role included collecting chance revenue from sources such as deodands, shipwrecks, treasure troves, royal fish and forfeited property of felons and brigands.

The modern coroner’s role is to take charge of a death investigation and make findings. They examine issues that arise from particular deaths.62 Their role is described by Hermagoras’ ‘elements of circumstance’: who, how, when, where and what.63 Inquests are formal judicial hearings into the causes and circumstances of death, in which the parties involved present evidence, cross-examine witnesses and are often represented by lawyers.64 All other death investigations are handled ‘in chambers’, where findings are reached on the basis of desk-based reviews of witness statements, police and medical examiner reports and other forensic evidence.65 Inquests occur within ‘a maelstrom of conflicting emotions’66 and in a best-case scenario can ‘facilitate understanding of the circumstances of death, forgiveness for error or fault and adoption of better and safer processes with the potential to avoid deaths occurring in comparable circumstances.’67

In Australia, nearly 20,000 deaths, or 12% of all deaths, are reported to coroners each year.68 Certain deaths are subject to mandatory reporting, while others rely on the discretion of third parties to report. Some types of deaths must be the subject of an inquest, while others are at the discretion of the Coroner. Coroners’ findings (whether for investigation or inquest) usually require the ‘how’ and ‘what’ of death. The ‘how’ equates to ‘the manner of death or mechanism of death and the context in which it occurred.’69 The ‘what’ focuses on the medical cause(s) of death, not the legal responsibility for it, or the circumstances in which it occurred.70

The overall inquest rate of reported deaths has been estimated at approximately 1 in 20 reported deaths.71 Coroners are disproportionately unlikely to hold inquests for deaths due to suicide and deaths among the elderly (65 years or older).72 This is even though persons over 65 account for more than half of reported deaths.73 Importantly for this article, the odds of discretionary (non-mandated) inquests declined with the age of the decedent.74 This is particularly important given the lack of mandated reporting or inquests for deaths in RACS.

Australian epidemiological research on premature deaths amongst RACS residents highlighted that coronial processes fail to identify factors to prevent deaths:75

> Premature and preventable deaths occur in nursing homes, and it follows that coroners have an important role in identifying factors that may prevent death and injury. However, formal coroners’ inquests examined fewer than 3% of the external cause deaths, and in 98.4% of all cases coroners made no recommendations about injury prevention. There

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63 W Vollgraff, W, ‘Observations sur le sixieme discours d’Antiphon’ (1948) 1(4) Mnemosyne 257; Coroners Act 2003 (Qld) s 45.
65 Ibid.
67 Ibid.
68 Studdert et al, above n 64, 314.
70 Ibid.
72 Ibid.
73 Studdert et al, above n 64, 315.
74 Walter et al, above n 71, 521.
75 Ibrahim et al, above n 44, 442.
were substantial variations between jurisdictions in the number of cases for which recommendations were delivered (0-21%).

This research presumed that all deaths directly or indirectly resulting from injury or non-natural causes must be reported to coroners. The study considered 21,672 reported deaths (18,383 natural cause and 3,289 external cause). Only 95 of the 3,289 external cause deaths resulted in inquests. Of those, about half (53) lead to recommendations that sought to identify preventative or remedial actions. Therefore, only 1.6% of all reported external cause deaths led to recommendations. Ibrahim noted, ‘disturbingly, there has been no reduction in the prevalence of these types of external cause deaths over the past 12 years.’

The rate of inquest varied by Australian jurisdiction from 0-8% of reported external cause deaths, and the rate of recommendations varied from 0-21%. Crucially, and in line with previous comments, this cohort only included cases from the National Coronial Information System (NCIS). This meant it was limited to deaths that had been reported to a coroner. Therefore, the study missed deaths that had not attracted coronial attention. Additionally, the cohort did not look at natural cause deaths, which in the absence of a mandated process have a substantially lower rate of report, investigation or inquest. The findings of this study, one might suggest, are the tip of the iceberg.

Notwithstanding the low rate, coroners’ inquests do consider issues of institutional elder abuse. In the findings of an Inquest into the Death of Caterina Montalto, the Victorian Coroner considered a case where no report was made until a whistleblowing staff member made a disclosure. The deceased’s death was ‘covered up’ and the inquest revealed serious accountability issues within the facility. High among them was the need for staff to understand and comply with the obligation for coronial reportability. A Queensland example, the Inquest into the Death of Albert Biffin, considered a range of issues including continuity of care and competence of staff. This inquest also highlighted the importance of clinical records, an issue canvassed more thoroughly later in this article. In the Inquest into the Death of Ruth Ann Dicker, the Coroner looked at death by neck compression caused by a lap sash seatbelt on the deceased’s wheelchair. Ibrahim makes the point that choking accounted for 7.9% of all external cause deaths and is by definition preventable.

Areas of attention for coroners looking into deaths in RACS have included a veritable grab-bag of issues, including: falls, choking, the use of restraints, fire safety, medication, end of life care, lifting and hoisting equipment, resident-on-resident aggression, personal hygiene (bathing, showering, toileting), emergency treatment, resuscitation, wound management (pressure sores, ulcers), disease management and control, (gastroenteritis, influenza), catheterization, aspiration, dental care (dentures, oral hygiene) and constipation. Many of these issues involve aspects of institutional elder abuse at overt, program and system levels.

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76 Ibid 445.
77 Ibid 442.
78 Ibid 445.
79 Ibid 444.
80 Ibid.
81 Ibid 446.
82 Ibid.
84 Ibid 2-3.
85 Ibid 19, 52.
86 Ibid 20.
88 Inquest into the Death of Ruth Ann Dicker [2013] Coroners Court of South Australia (14 August 2013).
89 Ibrahim et al, above n 44, 445–6.
Prior to statutory jurisdictions, common law courts only intervened when there was an ‘insufficiency of inquiry’ into a cause of death.\(^91\) Currently, courts only intervene where specific statutory criteria are made out to warrant orders such as a fresh coronial investigation or inquest. State and territory coronial laws are largely uniform and use relatively consistent terms and definitions. Births, Deaths and Marriages law in all Australian jurisdictions provide certification procedures within a prescribed period of death or its discovery. Where a death is reportable, a certificate is not issued and the death is reported to the coroner. The failure to report a death is an offence in all Australian jurisdictions.

How then is it that deaths in RACS are not reported? All Australian jurisdictions use statutory ‘triggers’ that require reporting of certain deaths to coroners. These deaths are known as ‘reportable deaths’.\(^92\) This is different to the ICD death classifications.\(^93\) The definition of deaths that must be reported to coroners varies slightly across the six states and two territories.\(^94\)

Deaths are reportable to coroners by virtue of circumstance (examples include violent or unnatural, sudden, unknown cause, suspicious or unusual) or setting (examples include custody, care or recent health procedure). This aspect can be called ‘reportability’. A death in RACS is not a prescribed circumstance or setting in any Australian jurisdiction. The term ‘death in care’ is a common class of reportable death but each jurisdiction has a narrow or constrained definition that excludes RACS.\(^95\)

Health care deaths are reportable in most jurisdictions but have limited application to a death in a RACS. The trend for medical-setting reportable deaths in eastern seaboard states’ coronial laws has centred on the criteria that the death was not a reasonably expected outcome.\(^96\) This obviously aligns with Hitchen et al’s notion that death investigations might follow the question of whether death was expected. This has some utility within the RACS setting if reporting was honestly and dutifully undertaken. Cases like Montalto potentially render this sort of trigger ineffectual.\(^97\) This Australia-wide constrained reportability means that deaths in RACS are not subject to the same level of accountability as other deaths in care.

Take Queensland’s scheme as an example — under the Coroners Act 2003 (Qld) ‘reportable deaths’ include ‘deaths in care’.\(^98\) The definition of ‘deaths in care’ does not include a death in RACS.\(^99\) Guidelines specifically note this exclusion.\(^100\) Accordingly, deaths in RACS only come to the attention of a coroner when they are reported by virtue of circumstance because the opportunity to report based on setting is completely absent. Excluding obvious, irrelevant triggers (the person is unknown or died in a police operation), the death would only come to the attention of a coroner if the death was violent or otherwise unnatural,\(^101\) suspicious,\(^102\)

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\(^91\) R v Cardiff City Coroner, Ex Parte Thomas [1970] 3 All ER 469.


\(^94\) Studdert et al, above n 64, 315.

\(^95\) Coroners Act 2017 (NT) ss 18; Coroners Act 1997 (ACT) ss 3C; Coroners Act 1993 (SA) ss 3; Coroners Act 1995 (Tas) ss 3; Coroners Act 2008 (Vic) ss 3, 4, 11; Coroners Act 1996 (WA) ss 3, 17.


\(^97\) Inquest into the Death of Caterina Montalto [2013] Coroners Court of Victoria 2011/2017 (18 December 2013).

\(^98\) Coroners Act 2003 (Qld) s 8.

\(^99\) Ibid s 9.


\(^101\) Coroners Act 2003 (Qld) s 8(3)(b).

\(^102\) Ibid s 8(3)(c).
health care related, or where a cause of death certificate was not issued. In a RACS setting, a likely report is where the examining medical practitioner refuses to certify cause of death or the death was externally caused. However, this does not always occur, even in the face of evidence. Mosqueda and Wiglesworth use the example of advanced bedsores to highlight this point. Or, as they note, it may be as simple as the authority with the obligation to report failing to examine the whole body.

Age proxies are evident in some legislative schemes. The Coroners Act 2009 (NSW) s 38(2)(a) uses age 72 to further constrain reportability. The Act limits the need to report where a person aged 72 years or older dies an unnatural or violent death after sustaining an injury from an accident, being an accident that was attributable to the age of that person, that contributed substantially to the death of the person, and was not caused by an act or omission by any other person. This must impact on the rate of report, and consequently on investigations and inquests in New South Wales RACS. Age proxies like this reinforce ageist views that deaths in RACS are outside the warrant of coronial oversight. These types of provisions are not examples of positive discrimination, rather, they reinforce the view that the older the decedent, the less need for a post-death investigation.

Operational policies recognise the consequences of limited reportability and provide specific procedures for making referrals to the Office of Aged Care Quality and Compliance or Office of the Aged Care Quality Commissioner. Nonetheless, referrals may be entirely within scope, this clearly represents a different approach to other deaths in care. The Coroners Act 2003 (Qld) specifically includes deaths in care facilities under the Disability Services Act 2006 (Qld), Forensic Disability Act 2011 (Qld), Mental Health Act 2016 (Qld), Public Health Act 2005 (Qld), Child Protection Act 1999 (Qld), and Corrective Services Act 2006 (Qld). So then, what of other death review processes?

B Limitations of Domestic Violence Death Reviews

Family violence death reviews do not effectively target elder abuse or institutional elder abuse. Some Australian jurisdictions use these specialised processes in cases of family or domestic violence or homicide. Operating within coronial processes, death reviews have a qualitative (individual case) and quantitative review function. The review 'looks into cases of domestic violence and uses these as a window, or a lens, into systems, services and communities, identifying opportunities for intervention, prevention or where the story may be changed.'

Recent inquiries in Queensland, New South Wales, and Victoria regarded aspects of elder abuse as falling within the sphere of domestic and family violence. There is an ongoing definitional debate about these issues that cannot be fully aired in this article. Suffice to say there are many areas of overlap between elder abuse and other forms of interpersonal violence.
The United Nations has suggested that violence, abuse and neglect experienced by older women combined elements from elder abuse (or older adult mistreatment), abuse of vulnerable adults and intimate partner violence. Taking a step aside from this definitional quagmire, opportunities exist to use the alignment between aspects of elder abuse and family violence to review deaths from institutional elder abuse.

In Queensland, the Domestic and Family Violence Death Review and Advisory Board’s Procedural Guidelines set out a case identification system using definitions from the Domestic and Family Violence Protection Act 2012 (Qld) (DFVPA) and the Coroners Act 2003 (Qld). The Procedural Guidelines outline detailed ‘case identification and selection’ information and a process for death reviews. The definition of ‘domestic and family violence death’ includes a relevant relationship between the deceased and a second person.

The trigger for review relies on an expansive definition of ‘domestic violence’, which includes ‘emotional or psychological abuse’ and ‘economic abuse’, both of which are commonly experienced forms of elder abuse, even if economic and financial abuse may overlap but should not be conflated. Estimates put ‘emotional or psychological abuse’ at 1-6% and economic or financial abuse at 1-9%, and they commonly coalesce in hybrid abuse. Notwithstanding the breadth of the definition of domestic violence, which obviously encapsulates many aspects of elder abuse, the triggers for a death review have limited prospects of occurring with respect to institutional elder abuse as the provision now stands. There is of course the opportunity to consider any violence that led to a death occurring between an older person and another with whom they are in a ‘family relationship’.

However, one important trigger potentially exists for an ‘informal care relationship’. The definition of informal care relationship excludes parent/child and commercial care arrangements. However, a death review might be triggered in a home care setting if there was an informal care relationship. It may also apply to an informal care relationship within an institution, say between a visitor and older person. There are cases of older persons, especially women, who depend on others to provide informal care in exchange for receipt of carer payment or carer allowance from Centrelink. Where these relationships involve violence, abuse or neglect, they are in a twilight zone between in-home overt abuse and domestic violence. Section 20 of the DFVPA defines an informal care relationship as one that exists between two persons if one of them is or was dependent on the other person (the carer) for help in an activity of daily living.

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118 Ibid 14.
119 Domestic and Family Violence Protection Act 2012 (Qld) s 8.
120 Ibid s 11.
121 Ibid s 12.
122 Kaspiew, Carson and Rhoades, above n 115, 5.
123 See definition of ‘Relevant Relationship’ at s 13(a) and ‘Family Relationship and Relative’ at s 19 of the Domestic and Family Violence Protection Act 2012 (Qld).
124 Domestic and Family Violence Protection Act 2012 (Qld) s 20.
125 Ibid.
126 Ibid.
One term absent from the DFVPA is ‘neglect’. Definitions coalesce around ‘acts’ as opposed to ‘omissions’. This is an important distinction and point of divergence between elder abuse and family and domestic violence. Many serious cases of elder abuse, and also child abuse, involve omissions, such as neglect and the failure to provide necessities of life. Despite this, there seems to be no reason why an act of neglect should not be included in domestic and family violence definitions, and this might be worth consideration by state parliaments. It may be the view of legislators that those for whom the DFVPA is crafted are invulnerable to neglect.

In the United States, Elder Death Review Teams study and learn from suspicious elder deaths and facilitate communication amongst agencies to identify barriers and fill gaps. How a death becomes the jurisdiction of a coroner has been subject of analysis in the United States with mixed results. Mosqueda and Wiglesworth found inconsistency across the essential areas: screening processes, data sets, trigger events and definitions. Australia’s National Coronial Information System has been highlighted as innovative, and a unique national repository. However, as noted earlier, the NCIS’ utility is ultimately limited by reportability. So how much do we actually know about deaths in RACS?

C Prevalence and Incidence Studies

Prevalence studies are essential to identify how many older adults are mistreated in institutions at a given point in time or during a given time frame. Incidence studies provide information about how many persons are abused for the first time during a specified time period. A significant limitation of most elder abuse studies is that they do not include older persons in RACS. Accordingly, prevalence studies into elder abuse rarely capture the true picture and extent of institutional elder abuse. Therefore, most prevalence studies can only reflect a partial view of the nature and extent of elder abuse. Prevalence studies have principally focused on private households:

Studies of the prevalence of elder abuse have been conducted in several countries, including Canada, the UK, Portugal, Ireland, Spain, Israel and the USA ... [in] each of the listed prevalence studies, the focus was on older people in private households who were deemed to have the cognitive capacity to participate in the study. Older people living in residential aged care facilities and those who lived in private dwellings but did not have sufficient cognitive capacity to discuss their circumstances and experiences in an interview were excluded from the estimation of the prevalence of elder abuse in these studies.

This situation is concerning given that older persons in RACS and those living in private dwellings with cognitive impairment are at greater risk of abuse than any other population of older persons. The inclusion of these people would give us a very different picture of elder abuse, and national prevalence research should address this gap. If we know so little about the prevalence of institutional elder abuse, how much do we actually know about deaths in RACS?

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127 Mosqueda and Wiglesworth, above n 60.
128 Ibid 7.
129 Ibid 10–11.
131 McDonald et al, above n 2.
132 Ibid 150.
133 Kaspiew, Carson and Rhoades, above n 115, 5.
D  Prevention of Death

There already is a substantial evidence base on deaths from institutional elder abuse. It remains, however, partially hidden within other sources of data. Ibrahim and his colleagues provided a comprehensive analysis of preventable deaths in RACS with recommendations on a wide range of external-caused and preventable deaths including choking,\textsuperscript{135} medication,\textsuperscript{136} physical restraints,\textsuperscript{137} respite,\textsuperscript{138} resident-to-resident aggression,\textsuperscript{139} suicide,\textsuperscript{140} and unexplained absences.\textsuperscript{141} Many of the circumstances analysed by Ibrahim and others fall within accepted definitions of institutional elder abuse and are flags for death investigation.

A common thread in the research is the need for improvement in the information reported to police or coroners.\textsuperscript{142} Ibrahim recommended ‘[a]mending the relevant Coroners Act in each jurisdiction to make deaths occurring in respite or within seven days after discharge from respite care a reportable death.’\textsuperscript{143} This is a good starting point for coronial reform but does not go far enough. The primary data source for the retrospective study was information generated for coroners’ investigations of injury-related deaths that occurred in RACS, which must be reported to coroners in accordance with state and territory legislation.\textsuperscript{144} The report was limited in the sense that ‘other areas of neglect and abuse e.g. sexual assault and deprivation of freedom of movement, did not lead to deaths that were reported to the coroners. Therefore, we were not able to examine them.’\textsuperscript{145} This conclusion is correct and exemplifies the problem of constrained reportability in two ways. Firstly, it assumes that all deaths that should be reported are. Secondly, it misses deaths that did not need to be reported under current reporting obligations. The combination of these two factors means we only ever see a portion of a more substantial cohort.

Ibrahim, Bugeia and Ranson also looked at the issue of using medico-legal death information to improve RACS care for older persons.\textsuperscript{146} They suggested this rich source was underused\textsuperscript{147} and blamed three myths for the lack of use of the data: firstly, that deaths in RACS are not preventable or at least inevitable; secondly, that public health gains are too small; and thirdly, that it is someone else’s charter or responsibility.\textsuperscript{148} The first is completely undermined by recent work on prevention. The second requires separate expert consideration. It is the third myth that is most interesting as it plays into the mythology of central Commonwealth responsibility. Ibrahim, Bugeia and Ranson suggested that ‘not one entity was responsible for systemically aggregating and analyzing medico-legal death data.’\textsuperscript{149} This article accepts that their point is true but suggests that the problem is far deeper. Is it the case that the states and territories have failed to take responsibility for ensuring coronial and other death review processes including RACS?

\textsuperscript{135} Joseph Ibrahim, Recommendations for Prevention of Injury Related Deaths in Residential Aged Care Services (Monash University, 2017) 14–16.
\textsuperscript{136} Ibid 16–19.
\textsuperscript{137} Ibid 19–21.
\textsuperscript{138} Ibid 21–2.
\textsuperscript{139} Ibid 22–3.
\textsuperscript{140} Ibid 23–4.
\textsuperscript{141} Ibid 24–6.
\textsuperscript{142} Ibid 41, 55, 67, 87, 103–4.
\textsuperscript{143} Ibid 171.
\textsuperscript{144} Ibid 47.
\textsuperscript{145} Ibid 36.
\textsuperscript{146} Ibrahim, Bugeja and Ranson, above n 130.
\textsuperscript{147} Ibid 255.
\textsuperscript{148} Ibid 257.
\textsuperscript{149} Ibid 258.
E The Chilling Effect of Constitutional Power

Has the spectre of constitutional control had a chilling effect on coronial and other death review processes with respect to deaths in RACS? Has Commonwealth legislative superiority seen aged care excluded from important post death accountability? Who has the legislative power to deal with aged care? The short answer to these questions is that aged care is both a Commonwealth and a State responsibility. States have broad legislative powers that often encompass aged care and work cooperatively to provide services to older persons.

Lacey noted that the mythology of Commonwealth constitutional control and capacity in aged care is 'based on an incomplete understanding of the Commonwealth’s constitutional power.' She contended that '[t]he reality — based on the Commonwealth’s legislative powers as set out in s 51 of the Constitution — is that the Commonwealth has only a partial ability to effect a legal framework for preventing and responding to elder abuse.' She calls it the 'myth of an all-encompassing Commonwealth legal and policy dominance in the ageing portfolio.' So it seems that while the Commonwealth does not have complete constitutional control over aged care, the actions of the States in this area reflect otherwise, whether by agreement, ceding or surrender.

The external affairs power is mooted as a source for specific elder abuse frameworks. It allows the establishment of underpinning frameworks, which could include those aimed at institutional elder abuse, as far as they implement existing standards found in various multilateral instruments. It might be more useful to have a specific international instrument to rely upon. A Convention on the Rights of Older Persons has been mooted for some time and its feasibility and possible content is the subject of mandates within the Open-ended Working Group on Ageing. Debates around rights that should be contained in a convention have included the right to freedom from abuse in institutional settings.

F The Impact of Ageism

It is easier for the community to consider most deaths of older people and especially those in an aged care setting inevitable, rather than actively seeking to identify preventable factors.

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150 The Commonwealth’s most obvious powers for aged care lie at s 51(xxiii) and s 51(xxiiiA) of the Constitution.
152 Ibid 101.
153 Ibid 103.
154 Kaspiew, Carson and Rhoades, above n 115, 21–2.
156 Follow-up to the Second World Assembly on Ageing, GA RES 65/182, 65th sess (4 February 2011); Towards a Comprehensive and Integral International Legal Instrument to Promote and Protect the Rights and Dignity of Older Persons, GA RES 67/139, 67th sess (13 February 2013); Measures to Enhance the Promotion and Protection of the Human Rights and Dignity of Older Persons, GA RES 70/64, 70th sess (22 February 2016).
158 Hitchen et al, above n 18, 1532.
If ageism is more prevalent than sexism and racism, this question needs to be asked: Is ageism partly responsible for system failures such as the absence of coronial and other death processes for deaths in RACS, the lack of prevalence and incidence data, the failure to align existing processes where opportunities exist, and the failure to improve obvious systemic failings or gaps? The notion of a virtual age queue is relevant here, in that societal allocation of practical and figurative resources tends to favour the middle-aged, as long as the line keeps moving, everyone generally gets his/her privileged turn. However, those at the back of the line are dependent on those at the front transitioning away in order to keep the line moving.

Does a virtual age queue also remove any chance of accountability when older persons suffer institutional elder abuse leading to death? In the United States the elderly age of a decedent was a factor influencing investigators towards a decision in which the death was assumed to be natural. If children are the only other group in society who are merely distinguished by their age, why do they not suffer the same lack of accountabilities? The sorts of systems to report, respond and remediate abuse are far more comprehensive.

IV LAW REFORM AND LEGAL PROCESS SOLUTIONS

Discovering elder mistreatment post mortem is problematic in part because the resources are inadequate and the personnel inadequately trained for the purpose, but also, and perhaps primarily, because the science of differentiating abuse and neglect from natural causes is in its infancy. The prevalence of these occurrences is unknown and as long as they go undetected, it will remain so.

Unless reforms are made, institutional elder abuse will remain beyond the reach of our understanding and beyond the reach of legal processes designed to prevent future deaths. We will continue to entrench ageist attitudes about the lives and deaths of older Australians. It also means we will continue to have systems of institutional care that lack accountability for the most vulnerable persons, in the most extreme cases.

However, as suggested by Ibrahim et al, ‘aggregating and analysing data from coroners’ findings provides information about the nature and burden of nursing home deaths and an evidence base for public health prevention strategies.’ It is clearly worth moving to improve our evidence base. How can we achieve this? A number of possible solutions exist:

1. Clarifying key definitions;
2. Reforms to aged care regulation;
3. Enabling other post-death investigative processes; and
4. Engaging in coronial law reform to fine-tune existing systems.

A Clarifying Key Definitions

Clarifying key definitions is necessary to move forward in this space. Key definitions include elder abuse, institutional elder abuse, death classifications, and coronial reportability. Work

161 Mosqueda and Wiglesworth, above n 60, 3–4.
163 Mosqueda and Wiglesworth, above n 60, 10.
currently underway to develop Australian definitions of elder abuse must take into account the lived experience of older persons living in RACS. This is particularly important in any foundational definition building exercise. The inclusion of institutional elder abuse in elder abuse definitions would ensure that any National Plan on Elder Abuse is designed with the needs and personal safety of vulnerable older persons in mind. By 2050, 3.5 million older Australians will be using aged care services.\(^{165}\) This alone is reason for the inclusion of RACS in key definitional work.

### B Aged Care Regulatory Reform

Alongside the National Plan on Elder Abuse, aged care regulatory reform has shown to be necessary given incidents of abuse at various RACS and other services such as Oakden in South Australia. The recent Legislative Review of the Aged Care Act 1997 (Cth) noted that, ‘the Department of Health (the department) is currently working with the sector to develop a new set of quality standards and processes to apply across all of aged care, called the Single Aged Care Quality Framework.’\(^{166}\) These standards should provide an evidence base for post-death investigation.

While the Oakden Aged Mental Health Care Service was not a RACS, the subsequent Oakden Report\(^{167}\) and Carnell-Paterson Report\(^{168}\) highlighted many areas of necessary aged care reform. The abuse at Oakden is likely symptomatic of other institutional settings for older persons. The Carnell-Paterson Report noted, as many others have over time, that restrictive practices can lead to deaths of older persons in institutional care and urgent reforms were needed for this issue.\(^{169}\) It also highlighted reforms needed to serious incident reporting systems.\(^{170}\) Issues raised as potentially coming within the reporting scheme include physical restraint, elder abuse, resident on resident aggression, suicide attempts or self-harm, choking, and unexplained absences.\(^{171}\) Unfortunately, Carnell-Paterson did not consider the coronial system’s response to deaths in aged care.

The Oakden Report did highlight the importance of a clinical record:

> Ultimately, the clinical record of a person is one of the most important reflections of what has happened during the provision of their Health Care. At its most fundamental, the clinical record is relied upon when [c]ourts and [c]oroners need to determine what has occurred. Clinical records need to meet standards and those that do not are a window into the system and those providing the care.\(^{172}\)

The utility of RACS’ clinical records in a post-death investigation would be heightened if reforms are made to aged care regulation. Firstly, a system of regulation and accountability could be implemented for the use of restrictive practices, including the recording and reporting of the use of practices and interventions. Secondly, an effective serious incident reporting and response scheme could be developed.\(^{173}\) A third area of reform could be the effective suitability screening of RACS workers.\(^{174}\) Each reform addresses an absence of protective safeguards against institutional elder abuse. Each reform would put in place

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\(^{167}\) Aaron Groves (Chief Psychiatrist (WA)), The Oakden Report (Department for Health and Ageing (SA), 2017).

\(^{168}\) Kate Carnell and Ron Paterson, ‘Review of National Aged Care Quality Regulatory Processes’ (Report, Department of Health (Cth), 25 October 2017).

\(^{169}\) Ibid. See also recommendation 7.

\(^{170}\) Ibid recommendation 6.

\(^{171}\) Ibid 111–14.

\(^{172}\) Groves, above n 167, 77.

\(^{173}\) Australian Law Reform Commission, above n 20, [4.1]–[4.6].

\(^{174}\) Ibid [4.9].
obligations that would provide a yardstick against which an assessment can be made about the experience of the older persons prior to and leading up to death. They would each be reflected on the face of relevant RACS records, including clinical records, about whether institutional elder abuse might be a factor in an older person’s death. This would be particularly so in cases of staff on resident violence, resident on resident aggression, and in cases of overt abuse and neglect. Imagine looking back over the clinical record of a recent decedent that revealed a range of these occurrences – for example, a history of restrictive practices or a number of serious incident reports or both. There exists excellent potential for alignment of reformed clinical records with triggers for deeper post death investigation.

C Other Post-Death Investigations

There are other agencies that might have a greater involvement in post-death investigations connected to institutional elder abuse. These include public guardians, public advocates, the Aged Care Complaints Commission and the Australian Aged Care Quality Agency.

1 Public Guardians and Public Advocates

There is an existing mandate for public guardians and public advocates to be involved in individual and systemic complaints of institutional elder abuse. In Queensland, proposed amendments to the Public Guardian Act 2014 (Qld) would allow the Public Guardian to investigate a complaint or allegation after an adult’s death. Section 19 provides the Public Guardian with broad powers to investigate ‘a complaint or allegation that an adult is or has been neglected, exploited or abused.’¹⁷⁵ There is very limited judicial consideration of the extent or operation of this power. It appears to be limited to matters relating to ‘adults with impaired capacity for a matter’ and the Office of the Public Guardian’s own policy reflects this, even though it has not been confirmed by judicial finding.¹⁷⁶ The Public Guardian is already empowered under the Guardianship and Administration Act 2000 (Qld) to engage in systemic advocacy on behalf of adults with impaired decision-making capacity. The recent work of the Public Advocate has included the impact of restrictive practices on older persons in aged care.¹⁷⁷

2 Aged Care Complaints Commission and Australian Aged Care Quality Agency

The Aged Care system is currently in a state of flux and has been called a ‘national concern’.¹⁷⁸ The Aged Care Complaints Commission (ACCC) system provides some opportunity to investigate deaths from institutional elder abuse. The Commissioner has stated that the Commission has ‘a limited window on elder abuse.’¹⁷⁹ Like many statutory authorities, the ACCC’s jurisdiction is prescribed to certain areas. The Commissioner has given examples of cases within jurisdiction:

- Inappropriate chemical or physical restraint;
- Inappropriate use of force;
- Seclusion or not involving the person receiving care in social and other activities of the service;
- Neglect and other gaps or omissions in care; or

¹⁷⁵ Public Guardian Act 2014 (Qld) s 19.
¹⁷⁷ Office of the Public Advocate Queensland, above n 29.
¹⁷⁹ Aged Care Complaints Commissioner, Submission No 148 to Australian Law Reform Commission, Inquiry into Protecting the Rights of Older Australians from Abuse, August 2016, 8.
• Not allowing a person receiving care to make their own decisions.\textsuperscript{180}

These examples align closely with the WHO description of elder abuse within an institutional setting. The \textit{Aged Care Complaints Principles 2014} (Cth) are silent on whether investigation can occur after the death of a RACS resident. However, a complaint may be made by a ‘person ... raising an issue or issues about an approved provider’s responsibilities under the Act or under the principles made under section 96-1 of the Act.’\textsuperscript{181} ‘This renders death irrelevant beyond the logistical and evidentiary limitations it imposes. The \textit{Guidelines for the Aged Care Complaints Commissioner} describe complaints on behalf of deceased RACS residents through an example ‘... a complaint relating to a deceased person could be made more than a year later where the family has been grieving and has not yet felt ready to make a complaint.’\textsuperscript{182} There is also a corresponding provision to allow refusal of a complaint where ‘the issue is subject to a coronial inquiry.’\textsuperscript{183} The ACCC policy notes:

\begin{quote}
[I]f a complainant alleges that the failure to administer correct medication caused a death, the delegate may decide to take no further action in respect of that issue because determining the cause of death is a matter for the coroner.

If there are issues about care that are not directly related to the coronial inquiry, such as where someone has concerns about the continence management of a person receiving care immediately before they died, such issues can be resolved without interfering with a coronial inquiry.\textsuperscript{184}
\end{quote}

Once more we see other systemic actors reliant on the constraints of the coronial system. However, the policy is clear that the investigation of a complaint not subject to coronial or other death review processes is open to the ACCC. The question arises: Is investigation by the ACCC an appropriate substitute for coronial processes? The short answer is no, for a range of reasons, including that death investigations should be the purview of judicial officers, who hold the powers to conduct thorough investigations and report findings publicly. The ACCC has provided industry alerts on topics with clear alignment to institutional elder abuse such as oral health and dental hygiene, lap belts on wheelchairs, manual lifting, fire safety, bed poles, call bells and smoking.\textsuperscript{185} These issues align with Ibrahim’s research and the findings of coroners, and they contribute to the existing evidence base of institutional elder abuse.\textsuperscript{186}

The suite of Aged Care Principles includes \textit{Quality of Care Principles 2014} (Cth), and \textit{User Rights Principles 2014} (Cth). The \textit{User Rights Principles} set out care recipients’ rights in residential care, which includes ‘to be treated with dignity and respect, and to live without exploitation, abuse or neglect.’\textsuperscript{187} Other principles include rights to quality care appropriate to his or her needs,\textsuperscript{188} to live without discrimination or victimisation,\textsuperscript{189} and to live in a safe, secure and homelike environment.\textsuperscript{190} These values should be a yardstick for post-death investigation. Given all of this, clarifying the ACCC’s jurisdiction in cases of institutional elder abuse pre- and post-death is a priority.

\begin{itemize}
\item \textsuperscript{180} Ibid 4.
\item \textsuperscript{181} \textit{Aged Care Complaints Principles 2014} (Cth) cl 6(1) citing the \textit{Aged Care Act 1997} (Cth) s 96-1.
\item \textsuperscript{182} See \textit{Guidelines for the Aged Care Complaints Commissioner} (Australian Government, Version 2.0, 2017), 57 [5.29].
\item \textsuperscript{183} \textit{Aged Care Complaints Principles 2014} (Cth) cl 8(e).
\item \textsuperscript{184} Guidelines for the Aged Care Complaints Commissioner, above n 182, 57.
\item \textsuperscript{186} Ibrahim et al, above n 44; Ibrahim, above n 135.
\item \textsuperscript{187} \textit{User Rights Care Principles 2014} (Cth) Schedule 1.
\item \textsuperscript{188} Ibid 1(d).
\item \textsuperscript{189} Ibid 1(b).
\item \textsuperscript{190} Ibid 1(e).
\end{itemize}
The Australian Aged Care Quality Agency (AACQA) is responsible for accreditation and monitoring of RACS in Australia.\(^{191}\) The ACCC can refer matters to the AACQA where ‘if, in the course of dealing with a complaint, the Complaints Commissioner identifies matters that could indicate an issue of a systemic nature (that may affect some or all people receiving care at a service).’\(^{192}\) Many of the issues subject of investigation and finding by the AACQA would fall within the definition of institutional elder abuse. The serious risk statutory decisions are a clear example of this. While these matters can be the subject of AACQA’s consideration, they have no particular role to investigate individual deaths in RACS. Despite this, the nature of those cases also fits within possible triggers for post-death investigation of institutional elder abuse. Triggers could include notifications of consideration of serious risk and any accreditation decisions flowing from that process.

Recent parliamentary inquiries have considered how the ACCC and AACQA provide accountability for quality of care in light of the failures at Oakden.\(^{193}\) The Senate has recommended a new Single Aged Care Quality Framework which would combine the ACCC and other bodies.\(^{194}\) Additionally, new Aged Care Quality Standards are being developed.\(^{195}\) Draft standards include consumer dignity, autonomy and choice, personal care and clinical care, lifestyle services and supports, and service environment.\(^{196}\) In any event, structural changes to the ACCC and AACQA systems should ensure those agencies or their successors are fine-tuned to detect and deal with complaints of institutional elder abuse at individual, program and systemic levels.

### D Coronal Law Reform

When the Coroners Act 2003 (Qld) was debated, it was said that it would include a focus on identifying emerging patterns.\(^{197}\) Deaths in RACS are not a new or emerging pattern. Rather, deaths in RACS simply fail to be investigated because of the barriers noted in this article. This is not a criticism of coronial systems. Rather, it is a reflection of their functionality, and their built-in, systemic limitations. Coronial and death review laws should be amended to ensure proper inclusion of deaths in RACS as a reportable setting and circumstance. Using Queensland’s coronial laws as an example, reform could be achieved in several ways.

A new class of reportable death could be added to the Coroners Act 2003 (Qld). This might be framed in a number of ways. It might be a new subset of reportable deaths, namely, ‘a death in residential aged care’ or ‘a residential aged care related death’,\(^{198}\) a new subset of health care related deaths\(^{199}\) or a new subset of deaths in care.\(^{200}\) Each option needs careful consideration.

The finer detail about when such a death is reportable should include the circumstances detailed in this article. Settings would include RACS. Circumstances could include:

- Types of causes of death that align with possible institutional elder abuse such as potentially avoidable deaths, including those deaths that were potentially preventable or potentially treatable;

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\(^{191}\) Ibid 1(g).

\(^{192}\) Ibid 6.

\(^{193}\) See Community Affairs Committee, above n 178; Standing Committee on Health, Aged Care and Sport, Parliament of Australia, Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia (2017).

\(^{194}\) Community Affairs Committee, above n 178, 67.


\(^{196}\) Ibid.

\(^{197}\) Queensland, Parliamentary Debates, Legislative Assembly, 1 April 2003, 1059 (M Lawlor).

\(^{198}\) Coroners Act 2003 (Qld) s 8(3).

\(^{199}\) Ibid s 10AA.

\(^{200}\) Ibid s 9(1).
Where the decedent was involved in a critical, serious or reportable incident, including where the decedent had been involved in resident on resident violence or staff on resident violence;

- Where a report had been made to the RACS about the violence or abuse of a visitor;
- Where a Public Guardian or Public Advocate had been investigating quality of care at the RACS;
- Where the decedent had a restrictive practices history;
- Where staff suitability concerns had been raised or were relevant to the decedent; and
- Where a complaint had been made to, or an investigation initiated by, a relevant agency about breaches of aged care quality care standards or legislative principles.

Clear drafting would ensure that amendments were consistent with the Australian Constitution. The scope of model laws could be considered by the Australian Law Reform Commission or the Law, Crime and Australian Community Safety Council.

### E Overseas Models

Overseas models might assist in identifying best practice in reportability of deaths in aged care. Ontario uses a ‘Geriatric and Long Term Care Review Committee’ (GLTCRC) to assist and advise a coroner investigating deaths of older people in residential aged care.\(^{201}\) It has a focus on all homicides involving residents of long term care or retirement homes. The GLTCRC also reviews cases where systemic issues may be present or where significant concerns have been identified by the family, investigating coroner or Regional Supervising Coroner.\(^{202}\) Between 2004 and 2016, it reviewed 282 deaths and made 639 recommendations.\(^{203}\) It appears similar in function to Queensland’s Domestic Violence Death Reviews. Importantly, the GLTCRC work has a systemic and preventative focus:

> Reviews and recommendations prepared by the GLTCRC are widely distributed to service providers, long term care providers and other relevant agencies and organizations throughout the province. Our role is to provide information to relevant organizations that will subsequently lead to improvements in processes, policies and initiatives, with the goal of preventing future deaths in similar circumstances.\(^{204}\)

Referrals to the GLTCRC are made by the Office of the Chief Coroner in the event that expert or specialised knowledge is needed to further the coroner’s investigation, and/or when there are significant concerns or issues identified by the family, investigating Coroner, Regional Supervising Coroner, or other relevant stakeholders.\(^{205}\) The Committee has recently noted that ‘although physical abuse and neglect causing death is not often seen in the cases reviewed by the GLTCRC, elder abuse in its many forms is often a peripheral or contributory issue.’\(^{206}\)

Of course, the GLTCRC model has limitations, including that the GLTCRC is advisory in nature and it only reviews deaths that meet the criteria for mandatory referral, (ie homicides in long term care or retirement homes), or discretionary referral, (ie where systemic issues or implications may be present).\(^{207}\) Certainly, it provides another model for improving our understanding of institutional elder abuse.

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202 Ibid iii.
204 Ibid i.
205 Ibid 2.
207 Ibid.
V CONCLUSIONS

Awareness of a problem but not knowing the extent or nature of it makes it difficult to create evidence-based policies that would provide a blueprint for resources and programs necessary to ameliorate the abuse.\textsuperscript{208}

This article raises some of the systemic issues impacting on our ability to identify and understand deaths contributed to or caused by institutional elder abuse. It particularly addresses the problem of limited reportability within coronial and other death review processes and has sought to raise some practical solutions for consideration. Ibrahim summarised this urgent need by saying that ‘improving the quality of care for older people living in RACS in Australia requires a better understanding of how, why, where and when residents die.’\textsuperscript{209} We must move beyond the underlying assumption that elder deaths are all natural deaths.\textsuperscript{210}

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\textsuperscript{208} McDonald et al, above n 2, 140.
\textsuperscript{209} Ibrahim et al, above n 44, 11.
\textsuperscript{210} Mosqueda and Wiglesworth, above n 60, 37.