

The Impact of Sexual Violence in Residential Aged Care on the Rights of Older Women

*Submission to Independent Expert on the enjoyment of
human rights by older persons*

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CONTENTS

CONTENTS	2
GLOSSARY	4
PART 1: BACKGROUND	8
1.1 About the authors	8
1.2 Terms of Reference	8
1.3 Submission structure	9
PART 2: HUMAN RIGHTS OF OLDER WOMEN	12
2.1 Overview	12
2.2 International Legal Obligations	12
2.2.1 The right to life	13
2.2.2 Security of person and treatment with humanity and dignity	13
2.2.3 Prohibition of torture and CIDTP	14
2.2.4 The right to health	15
2.2.5 The rights to equality and non-discrimination	16
2.2.6 The right to an effective remedy	18
2.2.7 Other general obligations	18
2.3 Other Guidance	19
2.3.1 United Nations Principles for Older Persons (1991)	19
2.3.2 Vienna Declaration and Programme of Action (1993)	20
2.3.3 Declaration on the Elimination of Violence Against Women (1993)	20
2.3.4 Madrid International Plan of Action (2002)	21
PART 3: SEXUAL VIOLENCE AGAINST OLDER WOMEN IN AUSTRALIAN AGED CARE SERVICES	23
3.1 Definitions	23
3.1.1 Defining sexual violence	23
3.1.2 Residential Aged Care Services in Australia	23
Persons accessing RACs in Australia	24
3.2 Regulation of RACS	24
3.2.1 Aged Care Act	24
3.2.2 Aged Care Quality and Safety Commission	25
3.2.3 Current 'reportable assault' legislation for RACS	25
3.2.4 The Royal Commission into Aged Care Quality and Safety	26
3.2.5 The Serious Incident Response Scheme	26
3.3 Sexual Violence in RACS	28
3.3.1 Prevalence of Sexual Violence against Older Persons	28
3.3.2 Heightened risk of sexual violence in RACS settings	28

3.3.3 Prevalence of sexual violence against older women in RACS settings	29
3.3.4 Victim-survivor and perpetrator characteristics:	30
3.3.5. Impact of sexual violence on older women	30
3.4 Failures of the Current System	32
3.4.1 Prevalence of Ageism, Sexism, Rape Myths and Discrimination	32
3.4.2 Data Collection and Research Shortfalls	33
Inadequate national data collection	33
Ineffective use of available data	34
Paucity of Relevant Research Studies	35
Lack of Adequate Research Funding	35
3.4.3 Barriers to Accurate Reporting	35
Victim-survivor reporting	35
Staff perceptions of sexual violence	Error! Bookmark not defined.
Staff perceptions of cognitive impairment	36
Evidence of under-recognition and reporting	36
Deficiencies in mandatory reporting obligations	37
Deficiencies in proposed changes to regulations	39
3.4.4 RACS staff responses to incidents of sexual violence	41
Inability of RACS staff to respond appropriately to sexual violence	41
Failure of RACS providers to address resident perpetrators	42
3.4.5 Barriers to accessing justice through Australian Criminal Law	44
Victim-survivor reluctance to report and engage in prosecution	44
Establishing consent	45
Insufficient Evidence	46
Engagement by authorities	47
3.4.5 Staff perpetrators of sexual violence	47
3.4.7 Absence of Consultation with Older Women	49
3.5 Initiatives to address sexual violence in residential aged care services	50
The Royal Commission’s Recommendations	50
4. RECOMMENDATIONS	53
5. CONCLUSION	55

GLOSSARY

Term	Definition
ACFI	Aged Care Funding Instrument. ACFI is used to measure the level of care a resident's need, based on activities of daily living, resident's behaviour and complex health care. Outcomes are used to allocate Australian Government subsidy to RAC providers to care for residents.
ACQSC	Age Care Quality and Safety Commission. A regulator for aged care services established through the <i>Aged Care Quality and Safety Commission Act 2018</i> (Cth). To operate a residential aged care service within the federal aged care system, providers must first be accredited by the ACQSC.
Aged Care Act	The primary legislation governing the provision of aged care services. In 2007 amendments to the <i>Aged Care Act 1997</i> (Cth) provided new measures to protect aged care residents, including a regime for compulsory reporting of physical and sexual assaults that take place in aged care facilities.
Aged Care Act Section 63-IAA	Currently outlines the responsibilities of an approved aged care provider relating to an allegation or suspicion of a reportable assault. Reporting responsibilities are due to change under the Serious Incident Response Scheme (see below).
Aggravated sexual assault	Sexual assault that involves any of the following aggravating circumstances: oral and/or penetration of the vagina or anus by any part of the human body or by any object; inflicting injury or violence; possession/use of a weapon; consent prescribed/committed against a child or committed in company (i.e., by two or more people).
Cognitive impairment	When a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe.
Department of Health	Australian Government Department of Health. The department that administers the <i>Aged Care Act 1997</i> (Cth) and regulates the aged care industry on behalf of the Australian Government.
Disclosed incident	A resident has informed a RACS member of an incident of sexual violence.
Elder abuse	Elder abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. Elder abuse constitutes physical, psychological, emotional, sexual, financial abuse and neglect. Older women are more likely to become victims of elder abuse.

External reporting	Reporting to the ACQSC and/or police.
HLARU	Health, Law & Ageing Research Unit, Monash University.
Internal reporting	An incident report required by the RACS regardless of whether an incident constitutes a 'reportable assault' to the ACQSC and/or police.
Mandatory reporting	Reporting obligations of reportable assaults under The <i>Aged Care Act 1997</i> (Cth) section 63-1AA. Unlawful sexual contact, unreasonable use of force, or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory (as defined under the Act). Current exemptions exist. Reporting obligations are subject to change under the Serious Incident Response Scheme.
Non-aggravated sexual assault	Sexual assault not involving any of the aggravating circumstances as defined in 'aggravated sexual assault'.
Older women	Refers to women aged 65 and older. The term is inclusive of people who identify as women.
Perpetrator	A person who has, or is suspected of, engaging in sexual with, or in the presence of, another resident.
Provider	An organisation that has been approved to provide residential care under the <i>Aged Care Act 1997</i> (Cth).
RAC; RACS	Residential Aged Care; Residential Aged Care Service(s). Sometimes referred to as nursing homes, (residential) age care service/home/facility. RACS are for older adults who can no longer live at home and need ongoing help with everyday tasks or health care.
Resident	RAC resident. A person who lives in a RACS either permanently or temporarily. Literature may also refer to residents as 'consumers'.
Reportable assault/incident	As defined in the <i>Aged Care Act 1997</i> (Cth) section 63-1AA. In this context, this means unlawful sexual contact. This is due to change under the introduction of the Serious Incident Response Scheme.
Risk factor	Something that increases a person's chances of becoming victim to, or perpetrating, sexual violence.
Serious incident	An event which threatens the safety of residents.
Sexual assault	Physical contact, or intent of contact, of a sexual nature directed toward another person where that person does not give consent, gives consent as a result of intimidation or deception, or consent is proscribed (i.e., the person is legally deemed incapable of giving

consent because of youth, temporary/permanent (mental) incapacity or there is a familial relationship.

Sexual violence	A broader term to encompass any sexual act, or attempts to obtain sexual acts, that may not be codified in law as criminal but are harmful and traumatic. Sexual violence encompasses contact and non-contact sexual acts and is sometimes referred to as unwanted sexual behaviour.
SIRS	Serious Incident Response Scheme. A scheme for aged care designed to increase the detection of serious incidents by requiring reporting to an independent oversight body and responses to serious incidents. SIRS intends to replace current reporting obligations and is due to become effective on 1 August 2021. Current reporting exemptions will be removed, and definitions of a reportable assault will broaden under the SIRS.
Staff member	Any individual who is employed, hired, retained or contracted by a RACS provider directly or indirectly to provide care or other services.
Suspected incident	An impression or feeling, or belief based on reasonable grounds, that a resident might have becoming victim to, or perpetrated sexual violence.
The Royal Commission	Royal Commission into Aged Care Quality and Safety Commission. A Royal Commission is the highest-level of public inquiry in Australia. The Royal Commission was established by the federal government in 2018 in response to growing concerns about the quality of aged care in Australia. A final report was published 1 March 2021 in which outlines 148 recommendations to be considered by the Government.
Unlawful sexual acts	Unlawful sexual contact (i.e., rape) and unlawful sexual non-contact acts (i.e., threats to commit a sexual offence).
Unlawful sexual contact acts	Non-consensual sexual contact, which is or may amount to a criminal act under state/territory or Commonwealth legislation. These offences are commonly understood as sexual assault: which occurs when someone does not consent to engaging in a sexual act(s) with another person (e.g., non-consensual digital penetration, coerced sexual acts).
Unlawful sexual non-contact	Non-consensual sexual behaviour that does not amount to physical contact but which constitutes a criminal act or acts under state/territory or Commonwealth legislation (e.g., exhibitionism).

Unwanted behaviour	sexual	An umbrella term to encompass unlawful and unwelcome sexual acts. Unwanted sexual behaviour is also known as sexual violence.
Unwelcome behaviour	sexual	Sexual activity directed at, or in the presence of, another person that is non-consensual but may not be unlawful (e.g., unwelcome sexual conversations, innuendos, catcalls etc).
User Rights Principles 2014		Deals with security of tenure for residents, access for persons acting for residents, and the information the RACS provider must give residents in particular situations. The principles also describe rights and responsibilities of residents (and home care).
Victim-survivor		A person who is the target of sexual violence.
Witnessed incident		An incident of sexual violence personally seen or heard.

PART I: BACKGROUND

1.1 About the authors

The Castan Centre for Human Rights Law (Castan Centre), the Health Law and Ageing Research Unit welcome the Independent Expert's call for submissions on the issue of the rights of older women, and the opportunity to contribute to the consideration of such an important topic.

The Castan Centre, based in the Faculty of Law at Monash University in Australia, is an academic centre which aims to use its human rights expertise to create a more just world where human rights are respected and protected, allowing people to pursue their lives in freedom and with dignity. The Castan Centre has previously made a submission to the Independent Expert on the rights of persons in aged care during COVID-19 in 2020.

The Health Law and Ageing Research Unit (HLARU), also based at Monash University is led by Professor Joseph E Ibrahim, senior specialist in geriatric medicine. The Unit is the only group in Australia with a dedicated, coordinated, 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). HLARU has conducted extensive research into the treatment of older persons within aged care and has contributed to multiple national inquiries including the Aged Care Royal Commission Inquiry into Family, Domestic and Sexual violence (2020);¹ and the House of Representatives² and Victorian Law Reform Commission Inquiries into Improving the Criminal Justice System's Response to Sexual Offences (2020-21).³ Additionally, the research unit has authored a number of academic articles and other reports on the issue of sexual violence against older women in aged care.⁴

1.2 Terms of Reference

We recognise that the Independent Expert, Ms. Claudia Mahler is mandated by the United Nations Human Rights Council to report on developments, challenges and protection gaps in the realisation of the rights of older persons, including older women, which will be the focus of this submission.

We agree with the Independent Expert that older women make substantial contributions to our communities and economies. We also recognise that notwithstanding their contributions, older women continue to face discrimination, inequality, sexual assault and other violations of their fundamental rights in Australia. We note the Independent Expert's focus on 'how older women experience ageing differently and what specific human rights concerns and challenges they face', and in particular the examination of the causes of discrimination and inequality.

¹ Joseph Elias Ibrahim, Daisy Smith and Meghan Wright, Submission to Royal Commission into Aged Care Quality and Safety, *Inquiry into the Prevention and Management of Sexual Violence in Residential Aged Care Services* (12 November 2020) ('Submission to Aged Care Royal Commission').

² Joseph Ibrahim, Daisy Smith and Meghan Wright, Submission No 11 to House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry and Report on Family, Domestic and Sexual Violence* (20 July 2020) ('Submission to House of Representatives').

³ Joseph E Ibrahim, Daisy Smith and Meghan Wright, Submission to Victorian Law Reform Commission, *Inquiry into Improving the Response of the Justice System to Sexual Offence* (2020) ('Submission to VLRC'). Note that submissions to this hearing were not made public.

⁴ JE Ibrahim, A May and M Wright, *Recommendations for Prevention and Management of Sexual Violence in Residential Aged Care Services* (Monash University, 2019) ('Recommendations for Prevention and Management of Sexual Violence in RACS'); Daisy Smith et al, 'The Epidemiology of Sexual Assault of Older Female Nursing Home Residents, in Victoria Australia, between 2000 and 2015' (2019) 36 *Legal Medicine* 89 – 95 ('Epidemiology of Sexual Assault of Older Female Nursing Home Residents'); Daisy Smith et al, 'A Systematic Review of Sexual Assaults in Nursing Homes' (2018) 58(6) *The Gerontologist* 369-383.

This submission draws on the findings of several academic studies undertaken by the Health Law and Ageing Research Unit which illustrate the seriousness and extent of harms experienced by older women, and their impacts on the enjoyment of human rights by these women. In particular, this submission will focus on the following questions included in the Independent Expert's questionnaire:

<i>The following terms of reference relevant to our submission</i>		(Section), Paragraphs
1. What legal instruments, policies and programmes exist to address the particular challenges faced by older women, and how are they implemented and monitored?	✓	(2) 1 to (2) 3; (3) 4.3; 4.5; 4.7; (3) 5
2. What type of statistical data are collected on older women, if any, and is it disaggregated by age, gender, and other relevant factors? How are older women defined for the purposes of law, policy and data collection?	✓	(2) 2.7; (3) 3; (3) 4.2; 4.3; 4.7
3. Please indicate how older women take part in participatory mechanisms? Economic, social and cultural realities lived by older women	✓	(3) 4.7; (3) 5
4. What are the specific challenges and concerns faced by older women, including on the basis of their accumulated life experience as compared to older men, in enjoying their economic, social and cultural rights? Please provide related data and statistics, including disaggregated data, where available.	✓	(3) 4
8. What forms of structural and systematic discrimination do older women face (for example through laws, policies, traditional and customary practices, etc.) and what measures have been taken to address them?	✓	(3) 4.3 to 4.7; (3) 5
9. How do intersectional factors exacerbate the combined effect of ageism and sexism, including the perspective of older LGBTI women, older women with disabilities, older migrant women, older women belonging to indigenous and minority groups, etc.?	✓	(2) 2.5; (3) 4.1; 4.5
10. What forms does gender-based violence and abuse against older women take and how is such violence prevalent? Please share available data and statistics, including in relation to femicides.	✓	(3) 3.2; 3.4; (3) 4.1 to 4.3
12. Please share information about reporting, accountability, remedy and protective mechanisms available and targeted to older women victims of gender-based violence and discrimination.	✓	(2) , (3) 4.1; 4.3 (3) 5

1.3 Submission structure

The focus of this submission will be the impact of sexual violence in residential aged care services ('RACS') on the rights of older women in Australia. The submission will provide an overview of the known and current issues surrounding sexual violence that occurs in RACS affecting *both* men and women, because there is at present a paucity of disaggregated data and research specific to female populations in Australia.

Notwithstanding, research to date suggests that this issue disproportionately impacts upon residents identifying as older women, and in particular those with a range of physical and cognitive impairments.⁵ To remain accurate to published research we will use the term ‘residents’, though given women are disproportionately at risk of victimisation, we request the information presented is understood as an older women’s issue.

Following **Part I** of this submission, which provides important background information about the authors and the focus of the present submission, **Part II** will outline the relevant international human rights law relevant to this issue. **Part III** will then go on to examine the issue of sexual violence in RACS in Australia,⁶ and illustrate how the prevalence of such violence impacts upon the rights of older women in Australia. Our submission will focus in particular on the current mandatory reporting obligations, reporting exemptions, the intentions of the Serious Incident Response Scheme, the lack of adequate staff training on the issue and the gaps in the recent Royal Commission into Aged Care Quality and Safety Commission findings and recommendations. **Part IV & V** will go on to detail our recommendations relating to the Independent Expert’s terms of reference. Finally, **Part VI** will tabulate our recommendations to (i) a summary of evidence in support and (ii) corresponding terms of reference(s).

Listed below is an overview of our concerns and reflections:

International Law

- a) The absence of an International Convention on the Rights of Older Persons, with provisions relating specifically to the rights of older women and addressing issues such as gender-based violence against older women.

Australian Law and Policy

- a) The failure of the Australian Government to design, develop and implement clear policies on the issue of sexual violence in RACS.
- b) A failure of the Australian Government to design, develop and implement a national system or policy to manage residents with past sexual convictions, or sexually deviant behaviour due to illnesses such as dementia, in order to prevent sexual violence in RACS.
- c) The failure of RACS providers to consult with relevant stakeholders when managing and responding to sexual offences.
- d) The failure of the Royal Commission into Aged Care Quality and Safety Commission to address known issues regarding sexual violence in RACSs, protect residents, and support victim-survivors within their final recommendations.

⁵ See Ibrahim, Smith and Wright, *Submission to VLRC* (n 3); Ibrahim, May and Wright, *Recommendations for Prevention and Management of Sexual Violence in RACS* (n 3); Smith et al, *Epidemiology of Sexual Assault of Older Female Nursing Home Residents* (n 4); Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4); Rosemary Mann et al, Australian Research Centre in Sex, Health and Society, *Norma’s Project A Research Study into The Sexual Assault of Older Women in Australia* (Report, 2014) at <https://www.opalinstitute.org/uploads/1/1/5/3/9/15399992/res> (*‘Norma’s Project’*).

⁶ Concepts such as elder abuse and sexual violence in community dwelling older adults will also be briefly discussed in order to provide context.

Discrimination and Victimization

- a) The failure of RACS providers to provide a safe environment which promotes victim-survivors to disclose violence without threat of being reprimanded or dismissed
- b) The failure of RACS providers to give victim-survivors of sexual violence in the same basic consideration 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).
- c) The failure of the Australian Government and RACS providers to deliver a compassionate, rights-based response to address victim-survivors' immediate and long-term care needs and ensure ongoing prevention of further harm.

Reporting

- a) The failure of the Australian Government to address complex, unclear and confusing reporting pathways. Proposed changes to reporting obligations that are counterintuitive to sexual violence best practice.

Training and Sensitisation

- a) The absence of comprehensive staff training for early detection of sexual violence, timely response, management, support and the preservation of evidence.
- b) The absence of information and training of staff about how to respond to sexual violence, which may deter disclosure and thereby deny support to victim-survivors.

Research and Data Collection

- a) The failure by the Australian Government to adequately examine the prevalence and nature of sexual violence in RACS, due to lack of disaggregated data, dedicated research, funding, exclusion of institutionalised populations.
- b) The failure of the Australian Government to utilise and make available to the public data that has been collected with respect to this group.

PART 2: HUMAN RIGHTS OF OLDER WOMEN

2.1 Overview

This section provides a summary of Australia's obligations under international human rights law in respect of older women, specifically in the context of gender-based violence, based on treaty obligations and the meaning of scope of such obligations as elaborated upon in General Comments/Recommendations of the relevant United Nations treaty bodies. It also briefly mentions relevant soft law obligations and guidance pertaining to gender-based violence against women, particularly sexual violence experienced by older women.

While we note the Independent Expert's knowledge and expertise in international human rights law, the purpose of this section is to underline Australia's international obligations which are put in question based on the empirical and qualitative evidence collected and set out in Part 3 below in respect of sexual violence perpetrated against older women in RACS. As such, this section provides the framework through which the subsequent parts of this submission should be considered.

This section also serves to underline the extensive and useful guidance for duty-bearers, including Australia, which international bodies have provided to respect, protect and fulfil the enjoyment of human rights for older women, from addressing discrimination and harmful stereotypes to providing legislative protections, enforcing those protections and providing adequate forms of redress for harms resulting from sexual violence in these institutions.

2.2 International Legal Obligations

There is presently no comprehensive international convention that relates to the rights of older persons.⁷ The rights of older women are enshrined in international treaties the *International Covenant on Civil and Political Rights* ('ICCPR'), the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR') and the *Convention on the Elimination of All Forms of Discrimination against Women* ('CEDAW') as well as other human rights instruments.⁸

International human rights obligations apply to violence perpetrated by public authorities, as well as any other person where the State fails to act with due diligence to prevent violations of right, or investigate and punish acts of violence, or provide compensation.⁹ The CEDAW Committee has made clear that States 'have an obligation to recognise and prohibit violence against older women, including those with disabilities, in legislation on domestic violence, sexual violence and violence in institutional settings'.¹⁰ Further, the Committee has called on States to 'investigate, prosecute and punish all acts of violence against older women'.¹¹

⁷ UN Committee on Economic, Social and Cultural Rights ('CESCR Committee'), *General Comment No. 6: The Economic, Social and Cultural Rights of Older Persons*, UN Doc E/1996/22 (8 December 1995) [13] ('General Comment No 6').

⁸ Human Rights Council, *Integrating the Human Rights of Women throughout the United Nations System*, Res 6/30, 33rd mtg (14 December 2007) 1 ('Integrating the Human Rights of Women'). See *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976) ('ICCPR'); *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976); *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 18 December 1979, 1249 UNTS 13 ('CEDAW'). See also *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 14 ('CRPD').

⁹ Human Rights Council, *Integrating the Human Rights of Women throughout the United Nations System* (n 8) [8]-[9].

¹⁰ Committee on the Elimination of All Forms of Discrimination Against Women ('CEDAW Committee'), *General Recommendation No 27 on Older Women and Protection of their Human Rights*, UN Doc CEDAW/C/GC/27 (16 December 2010) 6 [37] ('General Recommendation No 27').

¹¹ *Ibid* 6 [37].

The CEDAW Committee has emphasised that ‘gender-based violence impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under international law’ including the rights to equality; life; liberty and security; freedom from torture or cruel, inhuman or degrading treatment or punishment; the right to the highest standard attainable of physical and mental health and other key rights.¹² Impacts on some of the relevant rights in question are considered below.

2.2.1 *The right to life*

As the Independent Expert will be aware, the UN Human Rights Committee has made clear that the right to life ‘should not be interpreted narrowly’ but rather should be recognised as the right to enjoy a life with *dignity*.¹³ The Committee has observed that the duty to protect life obligates States to address general conditions in society that ‘may give rise to direct threat to life or prevent individuals from enjoying their right to life with dignity’.¹⁴ Importantly, violations of the right to life may extend to instances that create a threat to life and is not limited to instances where there has been a loss of life.¹⁵

The Human Rights Committee has also underlined that the right to life requires States to ‘take special measures of protection towards persons in situations of vulnerability’ including *victims of gender-based violence*.¹⁶ The Committee’s observations have been reaffirmed by UN Secretary General, Antonio Guterres, who in 2017 remarked that ‘sexual violence is a threat to every individual’s right to a life of dignity’.¹⁷ From the international framework, it is clear that sexual violence against older women raises grave concerns regarding the right to life regardless of whether or not a loss of life ensues. The evidence presented in Part 3 of women experiencing sexual violence in Australian RACS is proof of a life which does not align with the life in dignity envisaged under international human rights law.

2.2.2 *Security of person and treatment with humanity and dignity*

The right to personal security is protected under art 9 of the ICCPR.¹⁸ Further and relatedly, art 10(1) of the ICCPR which states that ‘[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person’.¹⁹ In its General Comment No. 35, the Human Rights Committee underlines that the right to security of person includes an obligation to respond to patterns of violence, including violence against women.²⁰ Article 10(1) complements art 9 and concerns the treatment of persons who have been deprived of liberty.

¹² Ibid 6 [7].

¹³ UN Human Rights Committee (‘HRC’), *General Comment No 36 (2018) on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life*, UN Doc CCPR/C/GC/36 (20 October 2018) [26] (‘*General Comment No 36*’).

¹⁴ Ibid 6 [26].

¹⁵ Ibid 2 [7].

¹⁶ Ibid 6 [23].

¹⁷ ‘Sexual Violence is a threat to every individual’s right to a life of dignity- UN Chief’, *United Nations News* (19 June 2017) at <https://news.un.org/en/story/2017/06/559822-sexual-violence-threat-every-individuals-right-life-dignity-un-chief>.

¹⁸ ICCPR (n 8) art 9. See also CRPD (n 8) art 14.

¹⁹ ICCPR (n 18) art 10(1).

²⁰ CEDAW Committee, *General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, UN Doc CEDAW/C/GC/35 (14 July 2017) [9] (‘*General Recommendation No 35*’).

The security of older women in RACS settings is endangered in many ways, including by continued cohabitation of victim-survivors and perpetrators of sexual violence, particularly where perpetrators are also residents or have cognitive impairments. This can have a detrimental impact on victim-survivors physical and mental wellbeing. This issue will be explored in further detail in section 3.4.4 of this report.

In addition, the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('OPCAT') defines a 'place of detention' in art 4(1) as 'any place...where persons may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'.²¹ Further, 'deprivation of liberty' is defined under art 4(2) as:

'any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave by order of any judicial, administrative or other authority'.²²

It is clear that some RACS, or certain units within RACS, may fall within the OPCAT definitions above and therefore trigger human rights obligations regarding the treatment of persons deprived of liberty. One such example, which is relevant in relation to our evidence in Part 3 below, is dementia areas of RACS where persons are not allowed to leave. The obligations to take steps to ensure that persons in RACS are treated with dignity and humanity by ensuring relevant regulatory frameworks that protects against sexual violence, are therefore crucial.²³

It is also worth noting that the above issues of security have been exacerbated by the COVID-19 pandemic, which has seen residents of RACS further restricted from leaving facilities. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2020) highlighted restricting visitors may impact formal and informal oversight mechanisms noting that:

'[w]ith the decrease in oversight comes an increase in the risk of violence, abuse, neglect and exploitation' and encouraged "governments to implement all necessary measures to protect and support people with disability in residential settings during the pandemic'.²⁴

Detailed consideration of the impact of COVID-19 on sexual violence in RACS is however beyond the scope of this submission.

2.2.3 Prohibition of torture and CIDTP

Related to the above rights concerning personal security and treatment with dignity and humanity is the prohibition of torture and other cruel, inhuman or degrading treatment or punishment ('CIDTP'). This prohibition is found in many human rights law instruments, notably the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ('CAT').²⁵

²¹ *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, adopted 18 December 2002, UN Doc A/RES/57/199 (entered into force 22 June 2006) art 4(1) ('OPCAT').

²² *Ibid* art 4(2).

²³ HRC, *CCPR General Comment No. 21: Article 10 (Humane Treatment of Persons Deprived of Their Liberty)*, UN Doc E/C.12/GC/21 (21 December 2009) [3] ('General Comment No 21').

²⁴ *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Statement of Concern: The Response to the COVID-19 Pandemic for People with Disability, 2020) at <https://disability.royalcommission.gov.au/publications/statement-concern-response-covid-19-pandemic-people-disability>.

²⁵ See eg, ICCPR (n 8) art 7.

While the threshold for torture and CIDTP is high, the Committee on the Rights of Women ('CEDAW Committee') has recognised that 'gender-based violence against women may amount to torture or cruel, inhuman or degrading treatment in certain circumstances' including in the case of rape.²⁶ This is important and demonstrates the gravity of the allegations and evidence of sexual violence in RACS presented in Part 3 of this submission.

As noted above, the definitions of 'places of detention' and 'deprivation of liberty' under OPCAT are broad and may encompass RACS or certain units within RACS. Fully and effectively implemented, the OPCAT framework of monitoring may play an important role in preventing gender-based violence, including sexual violence, in RACS.

Australia is in the process of implementing OPCAT which it ratified in December 2017. The National Preventive Mechanism (NPM) is held by the Office of the Commonwealth Ombudsman in Commonwealth places of detention which also holds a coordinating function in respect of NPMs established in states and territories. The latter jurisdictions designate a body/bodies to perform the NPM function in places of detention in their respective jurisdictions.

Further, due to the COVID-19 pandemic, both the country visits to Australia by the UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment ('SPT') and Working Group on Arbitrary Detention planned for 2020 were postponed.²⁷

In light of the above, while the OPCAT offers an important tool for monitoring and prevention of sexual violence in RACS, this is not fully implemented to protect against the sort of incidents we report in Part 3 below.

2.2.4 The right to health

Article 12 of the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR') further requires states to recognise 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.²⁸ As made clear by the World Health Organization, physical, sexual and psychological violence against women can have both short and longer-term impacts on physical, mental, sexual and reproductive health.²⁹

In Australia however, RACS providers have not provided specialist services to address mental and physical impacts of sexual violence, such as psychologists and trauma counsellors.³⁰ In fact, an independent report reviewing the sexual violence in RACS undertaken by KPMG found that staff at RACS facilities do not think that sexual violence impacts upon older persons in RACS at all (see detailed discussion in section 3.4.4).³¹

In the context of gender-based expressions of violence, States have an obligation to take measures to protect the right to health for all vulnerable and marginalised groups, 'including women and older

²⁶ CEDAW Committee, *General Recommendation No 35* (n 20) 6 [17].

²⁷ 'Explainer: United Nations and COVID-19', *Human Rights Law Centre* at <https://www.hrlc.org.au/united-nations-coronavirus>.

²⁸ ICESCR art 12.

²⁹ 'Violence against Women', *World Health Organisation* at <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

³⁰ KPMG, *Prevalence Study for the Serious Incident Response Scheme* (Report, November 2019) at <https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs> ('KPMG Report').

³¹ *Ibid.*

persons'.³² CESCR has in particular cited the 'failure to protect women against violence or to prosecute perpetrators' as a key example of a violation of the right to health.³³ CESCR has also expressed that the failure of a State to design adequate policies, allocate sufficient public resources, monitor the realisation of the right to health and adopt a gender-sensitive approach to health amounts to a violation of human rights under art 12.³⁴

As evident from the evidence presented in Part 3 below, protections against the perpetration of violence against older women in RACS are weak. At present the primary form of protection is provided through mandatory reporting obligations, which have been proven to be largely ineffective (see section 3.4.3). In addition, as noted above, perpetrators of sexual violence in RACS are often not immediately removed from facilities, which can leave victim-survivors and other at further risk of abuse (see section 3.4.4). RACS are provided with inadequate funding to ensure staff are properly trained to prevent and respond to incidents of sexual violence (see parts 3.4.3 and 3.4.4). The Australian Government has also failed to adequately fund further research into the prevalence and prevention of sexual violence in RACS settings. In addition, the Royal Commission into Aged Care Quality and Safety ('Royal Commission') in their final report, released March 2021 has made no dedicated recommendations to address sexual violence in RACS (see section 3.5). This makes clear that the Australian Government has failed to put in place adequate policies, allocate sufficient resources or ensure the realisation of the right to health for older women in RACS facilities.

2.2.5 The rights to equality and non-discrimination

Gender-based discrimination

Article 2 of CEDAW requires States to condemn discrimination against women in all its forms,³⁵ and to 'pursue by all appropriate means and without delay a policy of eliminating discrimination against women' through legislative and other measures.³⁶ Age is also confirmed to be a ground upon which it is prohibited to discriminate.³⁷ Further, art 3 of the ICESCR requires states to 'ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights'.³⁸ CESCR has emphasised in their *General Comment No 6* that States should 'pay particular attention to older women' who are often in 'critical situations'.³⁹

The CEDAW Committee in its *General Recommendation No 27* clarifies that older women face multiple forms of discrimination as they age, and rightly acknowledges that the discrimination experienced by older women 'is often a result of... maltreatment, neglect and limited access to basic services'.⁴⁰ We note in particular the Committee's observation that 'many older women face neglect because they are no longer considered useful in their productive and reproductive roles, and are seen as a burden on

³² CESCR, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)*, UN Doc E/C.12/2000/4 (11 August 2000) [35] ('*General Comment No 14*') (emphasis added).

³³ *Ibid.*

³⁴ *Ibid* 18 [52].

³⁵ 'Discrimination against women' is defined under CEDAW as 'any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field'. See CEDAW (n x) art 1.

³⁶ CEDAW (n 8) art 2; see also, e.g., ICCPR (n 8) arts 2(1) and 26; ICESCR (n 8) art 2(2).

³⁷ CESCR, *General Comment No 6* (n 7) 3 [11]. *Ibid* 3-4 [12]-[13].

³⁸ ICESCR (n 8) art 3.

³⁹ CESCR, *General Comment No 6* (n 7) [20].

⁴⁰ CEDAW Committee, *General Recommendation No 27* (n 10) 3 [11].

their families'.⁴¹ The CEDAW Committee has further emphasised that 'discrimination experienced by older women is often multidimensional' and *compounding*, with older women facing discrimination on the basis of gender, ethnic origin, disability, sexual orientation and gender identity and other grounds.⁴²

To combat gender-based discrimination in all its forms, the CEDAW Committee calls on States to, *inter alia*, adopt gender-sensitive and age-specific policies and measures;⁴³ ensure that older women are not discriminated against in such measures;⁴⁴ and repeal/amend existing instruments that discriminate against older women.⁴⁵ As we note throughout Part 3 below, there is no specific policies to prevent sexual violence in aged care in Australia.

Gender-based violence

The international human rights framework clearly states that gender-based violence constitutes a type of gender-based discrimination.⁴⁶ According to the CEDAW Committee, such violence can occur in all spaces, including the health service settings.⁴⁷ 'In all those settings', they state, 'gender-based violence against women can result from acts or omissions of the State or non-State actors'.⁴⁸ As noted in the introduction above, gender-based violence impacts on the rights considered in this section, as well as other rights which go beyond the scope of this submission.⁴⁹ The obligation to eliminate discrimination is immediate and 'delays cannot be justified on *any grounds*'.⁵⁰

Relevant to the aged care sector, obligations to prohibit gender-based violence extend to the need to prohibit 'acts or omissions of private actors empowered by the law of the State to exercise elements of governmental authority, *including private bodies providing public services, such as health care...*'.⁵¹ The CEDAW Committee has further added that the failure of a State to take all appropriate measures to prevent gender based violence against women, in cases where 'authorities are aware or should be aware of the risk of such violence' or have failed to investigate, prosecute, punish and provide reparations to survivors *constitute human rights violations*.⁵²

The CEDAW Committee also provides specific guidance on how legislative, executive, and judicial branches of government ought to protect women against gender-based violence. At the legislative level, the Committee called for States to adopt age-sensitive and gender-sensitive provisions to protect the rights of survivors of gender-based violence; at the executive States are required to allocate sufficient resources to prevent such violence from occurring and ensure reparations for survivors; and at a judicial level States must ensure that legal procedures involving allegations of gender-based violence are impartial, fair and unaffected by gender stereotypes.⁵³

⁴¹ Ibid 3 [14].

⁴² Ibid 3 [13].

⁴³ Ibid 5 [29].

⁴⁴ Ibid 6 [30].

⁴⁵ Ibid 6 [31].

⁴⁶ See eg, CEDAW Committee, *General Recommendation No 35* (n 20) 7 [21].

⁴⁷ Ibid 7 [20].

⁴⁸ Ibid.

⁴⁹ Ibid 6 [7].

⁵⁰ Ibid 8 [20].

⁵¹ Ibid 9 [24(1)(a)] (emphasis added).

⁵² Ibid 9 [24(2)(b)].

⁵³ Ibid 10 - 11 [26].

Negative stereotyping of older women

Related to the issue of gender-based discrimination and violence is the issue of negative stereotypes of older women. Specifically, under art of CEDAW, States have an obligation to take all appropriate measures to modify 'social and cultural patterns of conduct' with a view to eliminating prejudices, practices and stereotypes based on the idea of the inferiority or superiority of a sex.⁵⁴ Negative stereotypes of older women can, as evidenced in section 3.4.1 of our submission, increase the risk of, and serve as a barrier to obtaining action and redress in response to sexual violence in RACS.

The CEDAW Committee has also recognised that 'gender stereotyping...can have harmful impacts on all areas of the lives of older women, in particular those with disabilities' and can affect family relationships, portrayal in the media, health care and other service provider's attitudes, access to health care, and importantly can result in sexual violence as well as 'psychological, verbal and financial abuse'.⁵⁵

2.2.6 The right to an effective remedy

Older women have the same right as everyone else to a full and effective remedy in the case of a human rights violation, such as gender-based violence. As stated throughout this section, gender-based violence is both a serious type of gender-based discrimination as well as an act which impacts upon a range of other human rights.

The CEDAW Committee has specifically noted that older women, including older women with disabilities, should be provided with information on their rights and how to access legal services.⁵⁶ Further, the CEDAW Committee has called on States Parties to ensure that older women are enabled to obtain redress and resolve human rights infringements.⁵⁷

However, as mentioned in part 2.2.4 and discussed in detail in section 3.4.3, RACS resident sexual assault survivors are unlikely to be provided with information regarding support systems. This is in part due to a failure to perceive incidents as serious or impactful⁵⁸. Further, as set out in Part 3, older women in Australian RACS struggle to access justice following instances of sexual violence which evidence suggests is significantly underreported and which does not easily move through the existing legislative framework.

2.2.7 Other general obligations

Data collection

The CEDAW Committee has called for the collection, analysis and dissemination of data disaggregated by sex and age to obtain a fuller picture of the situation of older women in a country.⁵⁹ This is important in the area of sexual violence because in Australia the paucity of accurate, disaggregated data has led to underreporting of the issue, and by extension has hindered the accuracy of research, and efficacy of reforms with respect to reporting and documentation. Data collection flaws still include exclusions

⁵⁴ CEDAW (n 8) arts 5, 10(c).

⁵⁵ CEDAW Committee, *General Recommendation No 27* (n 10) 3 [16] (emphasis added).

⁵⁶ *Ibid* 6 [33].

⁵⁷ *Ibid* 6 [34].

⁵⁸ *KPMG Report* (n 30).

⁵⁹ CEDAW Committee, *General Recommendation No 27* (n 10) 6 [32].

of certain populations and sexual acts, ill-defined and questionable reporting requirements and a failure to analyse incident data to inform policy and legislation. Part 3 highlights that this has undermined research efforts in this area (see section 3.4.2) and has undercut the effectiveness of mandatory reporting obligations in Australia (see section 3.2.3).

Staff training

To prevent human rights violations from arising in the first place, the CEDAW Committee has pointed to the need for public authorities and other institutions to be given training specifically on age and gender-related issues to build knowledge around the issues which affect older women.⁶⁰

The Royal Commission has however recently acknowledged the Australian aged care workforce is insufficiently trained to meet the complex demands of residents in RACS; or to respond to adverse events such as incidents of sexual violence⁶¹. Despite this however, there continues to be no dedicated, mandatory and specific training regarding sexual health, sexuality or sexual violence for RACS staff. This is discussed in detail in Part 3.

2.3 Other Guidance

2.3.1 United Nations Principles for Older Persons (1991)

In their Resolution 46/91, the UN General Assembly adopted the *United Nations Principles for Older Persons* ('the Principles').⁶² The Principles provide guidance for State action that impacts upon older persons, many of which are relevant to the present discussion.

Principle 5, for example, states that 'older persons should be able to live in environments that are *safe* and adaptable to personal preferences and changing capacities'.⁶³ Principle 12 emphasises that 'older persons should have access to social and legal services to enhance their autonomy, protection and care',⁶⁴ and Principle 13 goes on to state that 'older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a *humane and secure environment*'.⁶⁵

Particularly relevant to the issue of sexual violence in aged care facilities, Principle 14 states that:

*'Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy, and for the right to make decisions about their care and quality of their lives...'*⁶⁶

⁶⁰ CEDAW Committee, *General Recommendation No 6* (n X).

⁶¹ *Royal Commission into Aged Care Quality and Safety* (Final Report, Executive Summary, 2021) 46 at <https://agedcare.royalcommission.gov.au/publications/final-report-executive-summary> ('*Royal Commission Final Report*').

⁶² *United Nations Principles for Older Persons*, GA Res 46/91, UN GAOR, UN Doc A/RES/46/91 (16 December 1991) ('*Principles for Older Persons*').

⁶³ *Ibid* principle 5 (emphasis added).

⁶⁴ *Ibid* principle 12.

⁶⁵ *Ibid* principle 13 (emphasis added).

⁶⁶ *Ibid* principle 14.

Principles 17 and 18 make clear that ‘older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse’,⁶⁷ and that they should be treated fairly regardless of age, gender, disability or other protected status.⁶⁸

RACS are unique environments, housing residents with complex comorbidities.⁶⁹ Questions regarding consent, capacity and intent often cloud incident understanding, management and prevention efforts, including the management of victim-survivors and resident perpetrators. Part 3 highlights the significant barriers older women in RACS face to live free from sexual violence, access services and achieve justice, whilst also discussing the flaws in resident perpetrator knowledge and management.

2.3.2 Vienna Declaration and Programme of Action (1993)

In 1993, the World Conference on Human Rights made a non-binding declaration considering the promotion and protection of human rights as a ‘matter of priority for the international community’.⁷⁰ The Declaration notably reaffirmed States responsibility to ‘promote universal respect for, the observance of and protection of, all human rights and fundamental freedoms for all’.⁷¹ that gender-based violence and ‘all forms of sexual harassment and exploitation...are incompatible with the dignity and worth of the human person, and must be eliminated’.⁷²

2.3.3 Declaration on the Elimination of Violence Against Women (1993)

That same year, the UN General Assembly adopted Resolution 48/104, known as the *Declaration on the Elimination of Violence against Women*. In the Declaration, the Assembly recognised violence against women as ‘an obstacle for the achievement of equality, development and peace’,⁷³ and affirmed that violence against women amounts to a violation of their fundamental rights.⁷⁴

The Declaration defined violence against women to include ‘physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse and other forms of violence’.⁷⁵ The General Assembly called for a number of specific acts by States in order to achieve this aim, including ‘exercising due diligence to prevent, investigate and punish acts of violence against women’;⁷⁶ the development of legislation that punishes offenders and provided mechanisms for survivors to access justice and effective remedies;⁷⁷ the comprehensive development of legal, political, administrative and cultural norms to protect women against violence;⁷⁸ and ensure ‘to the maximum extent feasible in light of their available resources’ specialised support, rehabilitation, counselling, health and social services for women.⁷⁹

⁶⁷ Ibid principle 17.

⁶⁸ Ibid principle 18.

⁶⁹ *Royal Commission Final Report* (n 61) 46.

⁷⁰ *Vienna Declaration and Programme of Action*, UN GAOR, UN Doc A/CONF.157/23 preamble (‘*Vienna Declaration*’).

⁷¹ *Vienna Declaration* (n x) (25 June 1993) [1].

⁷² *Vienna Declaration* (25 June 1993) [18].

⁷³ *Declaration on the Elimination of Violence against Women*, GA Res 48/104, UN GAOR, UN Doc A/RES/48/104 (20 December 1993) preamble.

⁷⁴ Ibid.

⁷⁵ Ibid art 2(b).

⁷⁶ Ibid art 4(c).

⁷⁷ Ibid art 4(d).

⁷⁸ Ibid art 4(f).

⁷⁹ Ibid art 4(g).

Other relevant measures included the adoption of appropriate measure to eliminate prejudices and stereotyped roles for men and women, promote research on violence against women, and importantly the ‘adoption of measure directed towards the elimination of violence against women *who are especially vulnerable to violence*’.⁸⁰

2.3.4 Madrid International Plan of Action (2002)

The 2002 Madrid International Plan of Action on Ageing (‘MIPAA’), developed by the UN Second World Assembly on Ageing, was created to guide governments, non-government organisations and others on the issues of older persons, development, advancing health and ensuring enabling and supportive environments for older persons.⁸¹

A key object of the MIPAA was the elimination of all forms of neglect, abuse and violence against older persons.⁸² The Plan of Action recognised ‘the process of ageing brings with it declining ability to heal’, meaning that older survivors of abuse ‘may never fully recover physically or emotionally from trauma’.⁸³ MIPAA also acknowledges that ‘older women face greater risk of physical and psychological abuse’, exacerbated by discriminatory public attitudes, and the non-realisation of the human rights of these women.⁸⁴ The impact of sexual violence on older women is discussed in detailed within Part 3 of this submission.

The Second World Assembly on Ageing recommended numerous measures for States in order to address the above issues, and eliminate neglect, abuse and violence against older persons. Recommendations including sensitising professionals and educating the public on the issue, its characteristics and cause;⁸⁵ enacting legislation and strengthening legal efforts to eliminate abuse;⁸⁶ encouraging cooperation between Government, non-government organisations and civil society to address elder abuse;⁸⁷ minimising the risks to older women of ‘all forms of neglect, abuse and violence’, including through public awareness campaigns and protection for older women;⁸⁸ and supporting further research into relevant issues.⁸⁹ A number of our submissions detailed in Part 4 are reflective of these sentiments.

In addition, the Assembly called for States to establish services for survivors of abuse and rehabilitation arrangements for abusers;⁹⁰ encourage reporting of elder abuse by health and social service professionals, as well as the general public;⁹¹ and ensure the appropriate training in care-related professions.⁹² As aforementioned and detailed in Part 3, current understanding of resident perpetrators of sexual violence is limited. Resident perpetrators are often deemed a medical rather

⁸⁰ Ibid art 4(j)-(l) (emphasis added).

⁸¹ UN Second World Assembly on Ageing, *Political Declaration and Madrid International Plan of Action on Aging* (8 -12 April 2002) art 1 (‘MIPAA’).

⁸² Ibid art 5.

⁸³ Ibid [107].

⁸⁴ Ibid [108].

⁸⁵ Ibid [110(a)].

⁸⁶ Ibid [110(c)].

⁸⁷ Ibid [110(e)].

⁸⁸ Ibid [110(f)].

⁸⁹ Ibid [110(g)].

⁹⁰ Ibid [111(a)]-[111(b)].

⁹¹ Ibid [111(c)].

⁹² Ibid [110(d)].

than a criminal justice issue (section 3.4.5) due to complex profiles, including physical and/or cognitive impairments (section 3.3.4). Despite, this management of such perpetrators are poorly understood by RACS staff and research teams, further thwarting efforts to prevent incidents and protect those vulnerable.

PART 3: SEXUAL VIOLENCE AGAINST OLDER WOMEN IN AUSTRALIAN AGED CARE SERVICES

'The benchmark has been so low for such a long time, we have become numb to the rights of older people, including the risk to be free from sexual assault' -

- Dr Catherine Barrett, Director of the Opal Institute⁹³

3.1 Definitions

3.1.1 Defining sexual violence

For the purpose of this submission, we will adopt the term 'sexual violence' as defined by the World Health Organisation ('WHO'), 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.'⁹⁴

Sexual violence includes a wide range of sexual acts inclusive of contact and non-contact acts. Rape and other unwanted sexual contact are inclusive of this definition. It may also include inappropriate touching and the use of sexually offensive or unwelcomed language. It is important to recognise that non-penetrative or non-contact sexual acts such as exhibitionism, sexual threats, unwelcome sexual discussions, sexual jokes or comments, and unwelcome sexual interests can also cause distress and negative impacts. Just as in the community, all forms of sexual violence can occur in residential aged care services.

Although we have adopted the term 'sexual violence' it is important to note that other similar terms are used interchangeably by researchers and agencies when use relevant terminology interchangeable to remain accurate when evaluating reporting obligations, prevalence rates and previous research initiatives. For example, within the scope of RACS and the community, the sexual assault of older persons is often defined as non-consensual sexual contact of any kind,⁹⁵ and is considered the most hidden, least acknowledged, and least reported form of elder abuse.⁹⁶

3.1.2 Residential Aged Care Services in Australia

We will also be defining 'residential aged care services' ('RACS') as per the definition provided by the Australian Government Department of Health ('Department of Health'). This refers to special-purpose facilities which provide accommodation and other types of support, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to residents over 65 years old. Such services are provided to people who can no longer live independently and care for themselves at home.

⁹³ Paul Gregorie, 'Sexual assault is rife within residential aged care facilities', *Sydney Criminal Lawyers* (6 March 2021) at <https://www.sydneycriminallawyers.com.au/blog/sexual-assault-is-rife-within-aged-care-facilities/>.

⁹⁴ World Health Organisation, *World Report on Violence and Health: Chapter 6 Sexual Violence* (Report, 2002) 149.

⁹⁵ The World Health Organisation. *World Report on Violence and Health: Chapter 5 Abuse on the Elderly* (Report, 2002) 126.

⁹⁶ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

As of 30 June 2020, there were 2,722 RACS, operated by 845 approved providers⁹⁷. There are over 366,000 people employed in the aged care workforce, including nurses, personal care workers, support staff and allied health professionals.⁹⁸ Volunteer workers also make a significant contribution across the sector.

Persons accessing RACs in Australia

As of 30 June 2020, 16% of Australia's population was aged 65 years and over (4.1 million people) and 2% were aged 85 years and over (517,000 people).⁹⁹ By 2030 it is estimated that 18.1% of Australia's population will be aged 65 years and over (5.4 million people) and 2.4% (719,500 people) will be 85 years and over¹⁰⁰.

The two main factors driving the increasing demand for aged-care services are the ageing population and the associated increasing number of persons with dementia. By 30 June 2020, there were 183,989 people receiving permanent residential aged care ('RAC'). In 2019-2020 there were 244,363 people who received permanent RAC at some time during the year, an increase of 1,751 from 2019-2019. In 2019-2020, the average age of admission to permanent RAC was 82.5 years for men and 84.8 years for women. Just over half of all RAC residents with an Aged Care Funding Instrument ('ACFI') assessment had a diagnosis of dementia.

3.2 Regulation of RACS

3.2.1 Aged Care Act

RACS are regulated under a patchwork of legislative instruments. Some RACS are government-funded, meaning they are subsidised and funded by the Australian Federal Government. These RACS are regulated under the *Aged Care Act 1997 (Cth)* ('Aged Care Act') and the *Quality of Care Principles 2014 (Cth)* ('Quality Principles'). The Aged Care Act regulates government funding, subsidies and fees, approval of RACS providers, standards and quality of care, the rights of persons receiving care and non-compliance with regulations.¹⁰¹

Government-funded RACS are run by 'approved providers' which may be a public, not-for-profit, community, faith-based or charitable entity or a private entity. The Department of Health approves applications for approved providers, and this is overseen by the Aged Care Act, whilst the Aged Care Quality and Safety Commission ('ACQSC') assesses the services to make sure providers meet quality standards.¹⁰² RACS providers have obligations under the Aged Care Act to ensure that there are adequate numbers of appropriately skilled staff to meet the individual care needs of residents.

⁹⁷ Australian Government Department of Health, *2019–20 Report on the Operation of the Aged Care Act 1997* (Report, 2020) at <https://www.health.gov.au/news/announcements/2019-20-report-on-the-operation-of-the-aged-care-act-1997> ('2019-20 Report on the Operation of the Aged Care Act').

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

¹⁰¹ Ibid; 'Aged Care Laws in Australia', *Australian Government Department of Health* (2021) at <https://www.health.gov.au/health-topics/aged-care/about-aged-care/aged-care-laws-in-australia>.

¹⁰² 'About Residential Aged Care', *Australian Government Department of Health* at <https://www.health.gov.au/initiatives-and-programs/residential-aged-care/about-residential-aged-care>.

Non-government funded RACS, also known as ‘supported residential services’ are regulated by State and Territory level legislation. Examples of such services include retirement villages and other private operations. The focus of the present submission will however be on government funded RACS.

3.2.2 Aged Care Quality and Safety Commission

To operate RACS within the federal aged care system, approved providers must first be accredited by the regulator for aged care services, the ACQSC, which was established through the *Aged Care Quality and Safety Commission Act 2018 (Cth)*¹⁰³. The ACQSC has various functions in addition to accreditation, including the handling of complaints, provision of education, and ‘consumer’ engagement.¹⁰⁴ From 1 July 2019, approved providers of government-funded aged care services must comply with the *Aged Care Quality Standards* (‘Quality Standards’) against which the ACQSC monitors compliance¹⁰⁵.

3.2.3 Current ‘reportable assault’ legislation for RACS

In 2007, amendments to the Aged Care Act 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-IAA of the Act outlines the responsibilities of an approved RACS provider relating to an *allegation* or *suspicion* of a reportable assault. A reportable assault is defined as unlawful sexual contact or unreasonable use of force perpetrated against a resident. If an allegation is received or suspected, the approved provider is responsible for reporting the allegation/suspicion as soon as reasonably practicable, and in any case within 24 hours to the police and the ACQSC.¹⁰⁶ In addition, the Act expressly provides that where a resident involved in an incident or suspected incident has a cognitive impairment, the facility is *exempt* from reporting requirements. Reporting requirements are due to change under the introduction of the Serious Incident Response Scheme which is due to launch 1 April 2021 (discussed below).¹⁰⁷

¹⁰³ *Aged Care Quality and Safety Commission Act 2018 (Cth)* pt 2

¹⁰⁴ *Ibid* pt 3.

¹⁰⁵ ‘Guidance and Resources for Providers to support the Aged Care Quality Standards’, *Aged Care Quality and Safety Commission* (Guidance Document, December 2019) at https://www.agedcarequality.gov.au/sites/default/files/media/Guidance_%26_Resource_V11.pdf.

¹⁰⁶ ‘Guidelines for reporting Reportable Assaults’, *Aged Care Quality and Safety Commission* (15 March 2021) at <https://www.agedcarequality.gov.au/providers/compulsory-reporting-approved-providers-residential-aged-care-services/guide-reporting-reportable-assaults>.

¹⁰⁷ ‘What is the SIRS? Serious Incident Response Scheme: A Fact Sheet for Aged Care Providers’, *Australian Government. Aged Care Quality and Safety Commission* (2021) at <https://www.agedcarequality.gov.au/sites/default/files/media/What%20is%20the%20SIRS%20-%20A%20fact%20sheet%20for%20aged%20care%20providers%20-%2019%20March%202021.pdf> (‘What is the SIRS?’).

3.2.4 The Royal Commission into Aged Care Quality and Safety

*‘At times in this inquiry, it has felt like the government’s main consideration was what was the minimum commitment it could get away with, rather than what should be done to sustain the aged care system so that it is enabled to deliver high quality and safe care’.*¹⁰⁸

- Commissioner Lynelle Briggs,
Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety (‘the Royal Commission’) was established by the federal government in 2018 in response to growing concerns about the quality of aged care in Australia. As of 5 June 2020, the Royal Commission had received more than 10,500 submissions from residents, their families, staff, RACS providers, academics and relevant organisations and government agencies across Australia. Of these, the Royal Commission received 588 submissions which mentioned sexual violence in RACS. Over two years’ worth of evidence was collected during this period, as well as countless prior reports highlight an aged care system in crisis.

The Royal Commission’s final report was published 1 March 2021.¹⁰⁹ Amongst the 148 recommendations, the report calls for a new system underpinned by rights-based Act, alongside increased funding based on need in the sector, increased regulation and transparency of the aged care system, and improvements to workforce conditions and capability. These recommendations are discussed in detail throughout this submission, and in particular in under section 3.5.

Notably, the Commission, has proposed the introduction of a new Act (Recommendations 1-3) in order to achieve the fundamental reforms recommended in their findings¹¹⁰. The Commission has described the purpose of the new Act as:

*‘to ensure that older people have an entitlement to high quality aged care and support and that they must receive it. Such care and support must be safe and timely and must assist older people to live an active, self-determined and meaningful life in a safe and caring environment that allows for dignified living in older age’.*¹¹¹

In essence such an Act would seek to place ‘people at the centre of aged care and focus on the safety, health and wellbeing of older people.’¹¹²

3.2.5 The Serious Incident Response Scheme

The Serious Incident Response Scheme (‘SIRS’) is a new initiative aiming to prevent and reduce incidents of abuse and neglect in RACS subsidised by the Australian Government.

Under the SIRS, RACS providers are required to identify, record, manage, resolve and report all serious incidents that occur, are alleged or suspected to have occurred, whereby the resident is the target/victim-survivor. RACS providers will also need to have an effective incident management system in place in order to manage and respond to all incidents as well as minimise the risk of incidents

¹⁰⁸ Royal Commission Final Report (n 61) 46.

¹⁰⁹ Ibid.

¹¹⁰ Royal Commission into Aged Care Quality and Safety (List of Recommendations, 2021) at <https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-recommendations.pdf>.

¹¹¹ Royal Commission Final Report (n 61) 80.

¹¹² Ibid 78.

occurring. This will have a significant impact on approved providers that do not have a system for investigating and taking action in response to incidents.¹¹³

The ACQSC will monitor and oversee RACS providers' investigation of, and response to, an incident, and will be empowered to conduct investigations of such incidents. The ACQSC will *importantly not provide any direction on how to manage the serious incident*.

The SIRS covers a broader range of currently non-reportable incidents, removes the exemption to report where the perpetrator is a cognitively and/or mentally impaired resident, and includes incidents that involve staff or visitors. The SIRS will be discussed in detail in sections 3.4.3 & 3.4.4 of this submission. The SIRS is set to commence on 1 April 2021.¹¹⁴

¹¹³ Aged Care Quality and Safety Commission, *What is the SIRS?* (n 107).

¹¹⁴ 'Frequently Asked Questions', Australian Aged Care Quality and Safety Commission (2021) at <https://www.agedcarequality.gov.au/sirs/frequently-asked-questions>.

3.3 Sexual Violence in RACS

3.3.1 Prevalence of Sexual Violence against Older Persons

The Australian Bureau Statistics ('ABS') *Recorded Crime – Victims* reports (which annually publish statistics on personal and household offences reported to and recorded by police, as well as collected in administrative data systems) indicate that there is a stark difference between older women's experience of sexual offences as compared to older men.¹¹⁵ For the purpose of this survey, sexual offences were classified as 'sexual assault', 'aggravated sexual assault' and 'non-aggravated sexual assault' (defined in the submissions glossary).¹¹⁶

Data from these reports between years 2010-2019 is currently available and indicates that in all Australian states, more sexual offences were recorded against older women than older men.¹¹⁷ In 2010, the national sexual offences victimisation rate for older women aged 55 - 64 years was 17.7%, compared to only 2.8% of older men aged 55 - 64 years in 2010. In 2019, this increased to 34.6% and 14.4% for older women and men respectively (55 - 64 years). Similarly, the national sexual offences victimisation rate for older women aged 65 years and over was 9.9%, compared to 1.1% for older men aged 65 year and over in 2010. In 2019, this increased to 16% and 3.5% for older women and men respectively (65 years and over).

These findings dispel deep rooted myths that age is a 'protective factor' against sexual assault. It also highlights how sexual assault continues to be a form of gender-based violence against women throughout women's' lifespan.

Importantly however, there are concerns with the way in which this data is collected, which will be explored in section 3.4.2. Due to these issues, the ABS' findings are very likely an underestimation of true incidence of sexual assault of older persons.

3.3.2 Heightened risk of sexual violence in RACS settings

In Australia, there is increasing recognition that institutionalised care settings, including RACS, have characteristics that contribute to 'situational risk factors' for sexual violence.¹¹⁸ Characteristics include but are not limited to: high stress working environments, inadequately trained staff, low-quality screening practices for employee recruitment, high resident to staff ratios, co-housing of residents, unethical reporting systems, and the high presence of cognitive impairments in residents.¹¹⁹ Due to these factors, sexual violence in these contexts reflects not only crimes committed by the perpetrator of violence, but also broader failures on the part of the institution to protect residents and uphold their duty of care.

Another key issue relevant to the aged care context that can heighten the risk of sexual violence is the question of capacity to consent for sexual activity, which is often complicated by cognitive impairments in older persons. For example, 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

¹¹⁵ Australian Bureau Statistics *Recorded Crime - Victims*. 2019. <https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-victims/latest-release>. Accessed 24 March 2021

¹¹⁶ Ibid.

¹¹⁷ Ibid.

¹¹⁸ C Tarczon and A Quadara, Australian Institute of Family Studies, *The Nature and Extent of Sexual Assault and Abuse in Australia* (Report, 2019) at <https://aifs.gov.au/publications/nature-and-extent-sexual-assault-and-abuse-australia>.

¹¹⁹ *Royal Commission Final Report* (n 61) 78.

staff or the resident who is perpetrating the violence to misinterpret non-consensual sexual behaviour between the residents as consensual because there is no apparent resistance or obvious distress.

The above issues are also made more complex by the impact of ageism, sexism and other forms of prejudice that can permeate RACS. This issue will be examined in detail in section 3.4.1 of this submission, but broadly speaking this refers to preconceptions that older people and people with physical or cognitive impairments are vulnerable, not credible, and marginal members of society. These can have the effect of allowing perpetrators of sexual violence, in particular staff perpetrators, in these settings to offend with relative impunity.

Given the challenges in this context, aged care providers must take care to balance in their assessments of such situations, the right of older persons to express their sexuality and engage in meaningful relationships, with the right of older persons to a safe environment that affords them protection from harm and respects their preferences, personal choices and decisions. This issue is exacerbated by the lack of resources, support and training for RACS staff, which will be explored in detail in throughout this submission.

3.3.3 Prevalence of sexual violence against older women in RACS settings

Despite the constraints regarding the identification and measurement of the full extent of sexual violence among institutional populations (discussed in detail in section 3.4.2 of this submission) research from a number of sources indicates that victimisation in RACS settings specifically is widespread and most commonly affects older women.¹²⁰

International annual prevalence estimates for all abuse subtypes reported by residents included: psychological abuse (33.4%), physical (14.1%), financial (13.8%), neglect (11.6%) and sexual abuse (1.9%).¹²¹ These rates were higher compared to the prevalence rates in the community settings as reported by older adults which indicated: psychological (11.6%), physical (2.6%), financial (6.8%), neglect (4.2%), and sexual (0.9%) abuse.¹²²

In Australia, the available data indicates an increase in reports of alleged or suspected unlawful sexual conduct in RACS settings. For example, between 2015–2016 the Department of Health was notified of 396 reports of alleged or suspected unlawful sexual contact of residents in RACs in Australia.¹²³ This number has increased in subsequent years, with 547 reports in 2017-2018,¹²⁴ and 739 reports in 2018-2019,¹²⁵ and 816 reports between 2019-2020.¹²⁶ It is important to again recognise here that the current issues with data collection and research (detailed in section 3.4.2 of this report) mean that the above rates likely underestimate the true incidence of sexual violence in RACS in Australia.

¹²⁰ KPMG Report (n 30); Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4); Mann et al, *Norma's Project* (n 5).

¹²¹ Y Yon et al, 'The Prevalence of Elder Abuse in Institutional Settings: a Systematic Review and Meta-Analysis' (2018) 29(1) *European Journal of Public Health* 58-67 ('*The Prevalence of Elder Abuse in Institutional Settings*').

¹²² Y Yon Y, C Mikton, Z Gassoumis and K Wilber, 'Elder Abuse Prevalence in Community Settings: a Systematic Review and Meta-analysis' (2017) 1 *Lancet Global Health* 365-6.

¹²³ Australian Government Department of Health, *2015–16 Report on the Operation of the Aged Care Act 1997* (Report, 2016) at https://www.gen-agedcaredata.gov.au/www_ahwgen/media/ROACA/2015-16-ROACA.pdf.

¹²⁴ Australian Government Department of Health, *2016–17 Report on the Operation of the Aged Care Act 1997* (Report, 2017) at https://www.gen-agedcaredata.gov.au/www_ahwgen/media/ROACA/2016-17_Report_on_the_Operation_of_the_Aged_Care_Act_1997.pdf.

¹²⁵ Australian Government Department of Health, *2018–19 Report on the Operation of the Aged Care Act 1997* (Report, 2019) at https://www.gen-agedcaredata.gov.au/www_ahwgen/media/ROACA/2018-19-ROACA.pdf.

¹²⁶ Australian Government Department of Health, *2019–20 Report on the Operation of the Aged Care Act* (n 97).

3.3.4 Victim-survivor and perpetrator characteristics:

Due to the limitations of data collection and publication, what we know and understand about victims and perpetrators of sexual violence in RACS is limited.

From available data however, RACS resident victim-survivors of sexual violence are predominately older (80 years and above) Caucasian females with a form of mental and physical impairment.¹²⁷ RAC residents are particularly vulnerable to sexual violence due to their dependency on caregivers, health problems, and the co-housing of residents, sometimes with potentially dangerous older individuals with sexual assault backgrounds.¹²⁸

Information about the factors that make a resident more likely to become a *perpetrator* of sexual violence is also limited. This is because sexual violence in RACS settings continues to be stigmatised, and sexual violence committed by certain perpetrators (i.e., those with cognitive impairment) underreported (see section 3.4.2). A wide range of perpetrators may sexually assault RACS 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).¹²⁹

Whilst some research indicates that residents are more likely than staff to become perpetrators,¹³⁰ other experts argue this assumption is false, and rather that available data presents an inaccurate depiction of perpetrator profiles due to incomplete and inadequate reporting requirements (see section 3.4.2).¹³¹ These researchers contend that existing patterns of reporting have led to an underestimation of incidents perpetrated by staff and visitors who are more able to effectively conceal their actions or are likely deemed more credible due to ageist and sexist attitudes.¹³²

3.3.5. Impact of sexual violence on older women

At present, there are limited longitudinal studies examining the short- and longer-term impacts of sexual violence against older women in RACS. Existing case series evidence in related areas however indicate that victim-survivors of such violence face severe consequences.

The Health Law and Ageing Research Unit has conducted a systematic review of the literature on this issue, and found that only three studies to date have documented post-survivor response.¹³³ Alarmingly, over 50% of victims in the study (n = 20) died within a year of assault.¹³⁴ Long-term health and medical consequences of sexual assault, within any age group, is underreported, however available research suggests that older sexually assaulted women suffered from 50% to 70% more gynaecological, central nervous system, and stress-related problems and are at risk of post- traumatic stress disorder.¹³⁵ Considering older persons have an increased risk of mortality after traumatic experiences

¹²⁷ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

¹²⁸ Ibid.

¹²⁹ Ibid.

¹³⁰ Ibid.

¹³¹ Mann et al, *Norma's Project* (n 5).

¹³² Ibid.

¹³³ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

¹³⁴ Ibid.

¹³⁵ JM Cook JM, S Dinnen and C O'Donnell C, 'Older Women Survivors of Physical and Sexual Violence: a Systematic Review of the Quantitative Literature' (2011) 20(7) *Journal of Women's Health* 1075-1081 ('Older Women Survivors of Physical and Sexual Violence').

or if suffering from anxiety disorders,¹³⁶ it is reasonable to postulate that sexual violence can contribute to an accelerated death for this age group.

Researchers have also found that older women rape victim-survivors are more likely than younger victim-survivors to sustain genital injury during a sexual assault.¹³⁷ 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.¹³⁸ In addition, sexually transmitted infections ('STIs') may also be passed on during sexual assault. Medical researchers have made clear that older women are at greater risk of contracting STIs during intercourse than younger women, because changes that take place during menopause can cause internal abrasions and tears that make STI transmission more probable.¹³⁹

As with any sexual assault survivor, there is a range of emotional, behavioural, and psychological responses, including symptoms related to post-traumatic stress. For older women compared to younger women, sexual violence carries added social stigma and can often result in embarrassment, self-blame, and fear.¹⁴⁰ This is exacerbated by the fact that many older victim-survivors live alone or lack supportive family and social networks.¹⁴¹ Loneliness and social isolation increases the emotional trauma and limits the possibilities of treatment, which can have the effect of heightening the adverse psychological impacts in this demographic post-assault.¹⁴² In addition, victim-survivor's emotional responses, such as agitation; distress and confusion, can mirror symptoms of cognitive impairment.¹⁴³ This can in turn make it difficult for RACS staff to distinguish whether changes in behaviour are due to sexual violence, or are symptomatic of underlying health conditions or illnesses, discussed in section 3.4.3. This is also fuelled by a misguided conception that persons with cognitive impairment are not capable of sustaining emotional or psychological trauma from a traumatic event, which has been disproven.¹⁴⁴

Lastly, there are also significant consequences for partners, family members, friends, aged care staff and support workers of victim-survivors in RACS. Research describes high rates of 'secondary traumatisation' or 'vicarious trauma', by which they mean 'the effects of the sexual assault on people who were not the primary victim of the assault but are nonetheless adversely affected by it'.¹⁴⁵ This can have a 'ripple effect' of dealing with sexual violence in RACS.¹⁴⁶

¹³⁶ EJ Lenze and JL Wetherell 'A Lifespan View of Anxiety Disorders' (2011) 12(4)*Dialogues Clinical Neuroscience* 381-399.

¹³⁷ CA Poulos and DJ Sheridan, 'Genital Injuries in Postmenopausal Women after Sexual Assault' (2008) 20(4) *Journal of Elder Abuse and Neglect* 323-335.

¹³⁸ A Burgess, *Elderly Victims of Sexual Abuse and Their Offenders* (Report, 2006) at <https://www.ojp.gov/pdffiles1/nij/grants/216550.pdf>

¹³⁹ Ibid; See also Poulos and Sheridan (n 137).

¹⁴⁰ RL Lazar, 'Me too? The Invisible Older Victims of Sexual Violence' (2020) 26(2) *Michigan Journal of Gender and Law* at <https://repository.law.umich.edu/cgi/viewcontent.cgi?article=1222&context=mjgl/>.

¹⁴¹ Ibid.

¹⁴² KS Rook, 'Gaps in Social Support Resources in Later Life: An Adaptational Challenge in Need of Further Research' (2009) 26(1) *Journal Social Personal* 103-112.

¹⁴³ Smith et al, *Epidemiology of Sexual Assault of Older Female Nursing Home Residents* (n 4).

¹⁴⁴ Mann et al, *Norma's Project* (n 5).

¹⁴⁵ B Raunick, I Lindell, D Lynn and T Backman, 'Vicarious Trauma Among Sexual Assault Nurse Examiners' (2015) 11(3) *Journal of Forensic Nursing* 123-8.

¹⁴⁶ Cook, Dinnen and O'Donnell, *Older Women Survivors of Physical and Sexual Violence* (n 135).

3.4 Failures of the Current System

3.4.1 Prevalence of Ageism, Sexism, Rape Myths and Discrimination

The findings from the Royal Commission indicate that ageism is a systemic problem in the Australian community that needs to be addressed.¹⁴⁷ Ageism is particularly problematic in the context of sexual violence in aged care for a number of reasons.

Firstly, ageist attitudes and assumptions about older people can affect the delivery of care a resident receives. In particular, concepts such as sexuality and sexual intimacy in older persons are considered poorly understood and difficult to manage in RACS, especially where persons with cognitive impairments are involved.¹⁴⁸ As a result, the sexual health needs of older people have largely been ignored in research, policy and practice, despite evidence that older adults are engaging, or want to engage in, a range of sexual practices.¹⁴⁹

In addition, numerous studies point to a direct link between ageism and elder abuse, with findings indicating that discriminatory attitudes towards aging can contribute to trivialising, excusing, dismissing, or justifying such abuse.¹⁵⁰ Even plausible disclosures are often met with disbelief by professionals due to doubt that it could be a possibility.¹⁵¹ This is rooted in erroneous beliefs that sexual violence against older women is rare, that allegations are frequently fabricated (due to resident conditions like dementia), that no one would assault older women (because they are stereotyped as undesirable) and that true victim-survivors will always manifest certain reactions. Disclosures might also be discounted or rendered invisible if they are made by residents who respond in unexpected ways because of their cognitive impairment. Being unwilling to accept old people are sexual, being disgusted by this notion, or deeming older women as undesirable, marginalised members of society creates a risk that incidents of sexual violence will be ignored or minimised.¹⁵²

Given that negative stereotypes regarding older people, specifically older women, make *recognition* of sexual violence towards older people harder, this also in turn undermines reporting, managing, preventing and sentencing of incidents and offences.¹⁵³ For example, staff and/or family may find it difficult to believe or accept that a resident has been a victim of sexual violence. As a result, they may fail to report it, or take appropriate steps to prevent future harms to victim-survivors and others. Consequently, preventable adverse events, such sexual violence, continue to be a major form of resident harm.

In addition, attitudes towards gender and deep-rooted sexism also impact on older women and their experience of sexual violence. Sexism is predicated upon the notion that biological sex divides men and women into distinct, separate and hierarchically ordered groups. The Health, Law and Ageing Research Unit have learnt from anecdotal evidence that what emerges from this social arrangement

¹⁴⁷ See generally *Royal Commission Final Report* (n 61).

¹⁴⁸ F Villa, M Celdrán, J Fabà and R. Serrat, 'Staff Members' Perceived Training Needs Regarding Sexuality in Residential Aged Care Facilities' (2016) 38(4) *Gerontology and Geriatrics Education* 443–452.

¹⁴⁹ A Lyons et al, 'The Sex, Age, and Me Study: Recruitment and Sampling for a Large Mixed-methods Study of Sexual Health and Relationships in an Older Australian population' (2017) 19(9) *Culture, Health & Sexuality* 1038–1052.

¹⁵⁰ Rae Kaspiw, Rachel Carson and Helen Rhoades, *Elder Abuse: Understanding Issues, Frameworks and Responses* (Research Report No. 35, November 2018); Australian Law Reform Commission, *Elder Abuse-A National Legal Response* (ALRC Report 131) (14 June 2017); Seniors Rights Service, *Abuse of Older People: A Community Response* (Final Report, 1 May 2018).

¹⁵¹ T Ashmore, J Spangaro and L McNamara, 'I was raped by Santa Claus': Responding to Disclosures of Sexual assault in Mental Health Inpatient Facilities' (2015) 24(2) *International Journal of Mental Health Nursing* 139-148.

¹⁵² Mann et al, *Norma's Project* (n 5).

¹⁵³ 'Elder Abuse', World Health Organisation (2020) at <https://www.who.int/news-room/fact-sheets/detail/elder-abuse>.

in RACS is a tolerance by staff of sexual harassment and unwanted sexual jokes, a fear of confronting sexist and inappropriate sexual behaviour, and a dismissive attitude towards disclosures of sexual assault.

The above issues of ageism and sexism are exacerbated in particular for women with intersecting vulnerabilities. For example, the ABS has highlighted that women with a disability, women of colour (especially culturally and linguistically diverse and Indigenous women), as well as women with diverse gender identities and sexualities are at greater risk of sexual violence.¹⁵⁴ Additionally, disability severity correlates to prevalence of sexual violence. In 2020 for example, it was recorded that those with severe disabilities were twice as likely to experience sexual violence than those with other disabilities, and three times more likely than those without a disability in Australia.¹⁵⁵

People who exist in the intersection of any of the aforementioned demographics who are also older persons, whether they live in a RACS or in the community, are particularly vulnerable to sexual violence.¹⁵⁶ Alarming, although the media frequently reports on abusive situations in RACS, there has been limited public pressure for effective and sustainable changes to policy and law in this area.

3.4.2 Data Collection and Research Shortfalls

There are presently significant barriers to measuring the extent of sexual violence against older persons in both RACS settings and the broader community in Australia. These include deficiencies in national collection of data, the paucity of research specific to this issue, the ineffective use of collected data, and overall a lack of funding to support further research in this area. As a result, there is also a paucity of research regarding the extent to which elder abuse occurs in both these.¹⁵⁷ These issues will be discussed in further detail as follows.

Inadequate national data collection

The first key issue relates to the failure to collect data relevant to the issue of sexual violence in RACS settings. At a national level, national surveys often contain exclusionary criteria that precludes consideration of relevant subject groups. For example, the ABS generally excludes institutional populations from major data collections, such as ABS household surveys.¹⁵⁸ This means that older women in RACS settings are not included in many national data analyses. Similar issues occur at an international level, with international surveys often also containing exclusionary criteria that limits proper recognition of the extent of the problem. For example, the International Violence Against Women Survey (‘IVAWS’) specifically excludes women with an illness or disability from the survey sample.¹⁵⁹ Other surveys fail to address and consider the issue of sexual violence against older persons

¹⁵⁴ Australian Government Department of Health, *2019–20 Report on the Operation of the Aged Care Act* (n 97).

¹⁵⁵ Australian Government, *2019-2020 Report on People with Disability in Australia* (Report, 2020) at <https://www.aihw.gov.au/getmedia/ee5ee3c2-152d-4b5f-9901-71d483b47f03/aihw-dis-72.pdf.aspx?inline=true>.

¹⁵⁶ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

¹⁵⁷ Aged Care Quality and Safety Commission, *Experimental Estimates of the Prevalence of Elder Abuse In Australian Aged Care Facilities* (Research Paper No 17, 2020) at <https://agedcare.royalcommission.gov.au/sites/default/files/2020-12/research-paper-17-elder-abuse-prevalence-aged-care-facilities.pdf>; World Health Organisation, ‘Elder Abuse’ (n 153).

¹⁵⁸ Tom Wilson et al, ‘What is the Size of Australia’s Sexual Minority Population?’ (2020) 13 *BMC Research Notes* 535.

¹⁵⁹ H Clark and B Fileborn, Australian Institute of Family Studies, Australian Centre for the Study of Sexual Assault, *Responding to Women’s Experiences of Sexual Assault in Institutional and Care Settings* (Report, 2011).

altogether, such as the Royal Commission's experimental estimates of elder abuse in Australian RACS, which did not include sexual violence/abuse of residents.¹⁶⁰

The second critical issue with research and data collection relates to the inconsistent use of key terminology relating to sexual violence. For example, the ABS uses the term 'sexual assault', which it deems to exclude incidents of violence that occurred before the age of 15, which are instead categorised as 'sexual abuse'.¹⁶¹ The ABS definition of sexual assault also excludes 'unwanted touching', which it instead defines as 'sexual harassment'.¹⁶² The inconsistencies in usage of these terms results in the distortion of reported prevalence rates of both recent and historical incidents older women may have been subjected to.

Thirdly, the Australian Government does not nationally collect or publish specific data on the prevalence of elder abuse. Notably, there is currently a study underway by the Australian Government Institute of Family Studies, which is expected to be released later in 2021.¹⁶³ The findings of this study however will report on older community dwellers only, and as such sexual violence in RACS settings remains largely concealed.

The above issues flow on to impact the design, development and implementation of policy and law on the issue of sexual violence against older persons in RACS settings. Without accurate and complete data, the nature, extent and impacts of this issue remain under recognised, which can in turn undermine the development of effective prevention strategies.

Ineffective use of available data

Notwithstanding the general absence of relevant data to this issue in Australia, there is some collection of RACS sexual assault incident data by the ACQSC in the form of annual reports. Importantly however, this data only reflects the prevalence of incidents deemed 'reportable' under the Aged Care Act under the reportable assault scheme (see section 3.3.3).¹⁶⁴

In addition, there is limited indication that this data is being used *effectively*. Indeed, while this information has been collected since 2008, there are no known publicly available analyses of the data beyond basic incident frequencies. Therefore, it appears that despite collecting this data for over a decade, it has not been effectively used to inform policy or legal change in this area.

The Health Law and Ageing Research Unit estimates that a total of 3000-5000 reportable sexual assaults in RACS have accumulated. The group posits that these should be analysed and used to promote lessons for prevention of sexual violence in RACS and better management of the issue in Australia. At a minimum, the data should be released to the public and to independent researchers for interrogation and analysis.

¹⁶⁰ Aged Care Quality and Safety Commission, *Experimental Estimates of the Prevalence of Elder Abuse in Australian Aged Care Facilities* (n 157).

¹⁶¹ Nicola Henry, 'Rape, Sexual Assault and Sexual Harassment: What's The Difference?', *The Conversation* (2020) at <https://theconversation.com/rape-sexual-assault-and-sexual-harassment-whats-the-difference-93411>.

¹⁶² Ibid.

¹⁶³ Kaspiew et al (n 150).

¹⁶⁴ Australian Government Department of Health, *2019–20 Report on the Operation of the Aged Care Act* (n 97).

Paucity of Relevant Research Studies

In addition to the above data collection and usage concerns, there are several other issues with research into sexual violence against older women in RACS in Australia. In particular, there is a general paucity of government-led and independent research in this area. This is in stark contrast to other areas of research into sexual violence, such as the impact of sexual violence among children, adolescents, and adults, which has been extensively studied.

There is also considerable inconsistency in the use of terminology and methodologies, and a lack of accurate and detailed information on the number and nature of incidents. Studies on elder abuse are also often framed through medical models, which limits the focus to the health care needs of the victim-survivor. While this is important, it limits consideration of elder abuse as a legal, and more specifically, a human rights issue.

In addition, there is limited information available regarding alleged *perpetrators* of RACS sexual violence (beyond race and gender). This issue is especially complex given that perpetrators of sexual violence in this context can be both staff and residents, some of whom within this latter group may have cognitive impairment themselves.¹⁶⁵ The barriers to understanding perpetrators of sexual violence in RACS contexts in turn hinders the proper and timely identification of risk factors for offending, and ultimately can halt the effective development of preventative measures.

In addition, there exists an absence of international and multi-jurisdictional studies that use prospective and systematically collected data. Existing research does not adequately portray the characteristics of sexual violence in RACS in Australia, nor globally, and so there is limited ability to learn from best practice approaches from international jurisdictions. Without a quality standard of holistic research, we have little to guide us on how to properly report, investigate, and manage sexual violence in RACS.

Lack of Adequate Research Funding

Finally, there is a broad lack of funding for further research in this area. Research into sexual violence in RACS in Australia a relatively data poor area with limited access to secondary information sources that are commonly used in health. Subsequently, it is often very expensive to obtain. Research requires investment. A dedicated and specific funding support is needed rather than just opportunities to apply for competitive grants available to all health and aged care academics.

3.4.3 Barriers to Accurate Reporting

Victim-survivor reporting

Older women who experience sexual violence in RACS settings face considerable barriers to reporting. Reasons for this include a lack of awareness of reporting mechanisms and their legal rights; communication barriers (i.e. language difficulties, disability, illness or cognitive impairment); difficulty navigating subtle power dynamics (i.e. existing relationships prior to entering aged care, staff-resident relationships); difficulty arising from cultural dynamics (e.g., ageism, sexism, cultural history of being silenced); and issues of stigma and discrimination (including fear of being shamed, disbelieved or punished) which often lead victim-survivors to refrain from disclosing incidents.

¹⁶⁵ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

Staff perceptions of cognitive impairment

There has been limited attempts to understand the RACS staff's perception of sexual violence in RACS. The HLRU has conducted research to gain insight to RACS staff awareness and experience of sexual violence in aged care which can be made available upon request of the Expert Witness post-journal acceptance. ¹⁶⁶

From available research it is understood RACS Staff may experience difficulty recognising sexual violence where this involves perpetrators who have cognitive impairments. To explain, research indicates that staff typically expect sexually disruptive and aggressive behaviours to be a usual occurrence for persons with a cognitive impairment.¹⁶⁷The problem with this is threefold:

- a) First, sexual violence exhibited by persons with cognitive impairment is likely to be labelled 'normal' leaving incidents unactioned, perpetrators not managed, and incidents unreported.
- b) Secondly, given that sexual violence often occurs in private, witnesses are not common in any incidents of sexual violence in any population.¹⁶⁸ Accordingly, RACS staff are often dependent on either survivor disclosures, or identifying trauma indicators to try to assess incidents that occur. In the context of cognitive impairments however, trauma indicators are likely to be missed or dismissed by staff who deem these as 'disruptive' or 'expected' behaviours.¹⁶⁹ Further, people with dementia also often face significant verbal communication barriers and are less likely to be believed if able to disclose incidents.¹⁷⁰
- c) Thirdly, RACS staff and the community are generally more willing to dismiss the seriousness of sexual violence when the target is cognitively impaired.¹⁷¹ Perceptions that persons with cognitive impairment will not remember or are not impacted by such incidents are inaccurate, harmful and dehumanising.¹⁷²

Evidence of under-recognition and reporting

Although underreporting of sexual violence is common among all age groups, rates of underreporting are greater for older victim-survivors and greatest for RACS residents. As examined in section 3.4.2 & 3.4.3 the current reporting system (prior to the introduction of the SIRS) is not effectively accounting for a large proportion of sexual violence in RACS facilities.

The Health Law and Ageing Research Unit research team undertook research relevant to this discussion in 2018. The group reviewed forensic medical examinations of reportable sexual assault incidents (i.e., unlawful sexual contact acts, as defined by the Aged Care Act) that occurred in accredited RACS in the state of 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 federal government, the researchers expected that approximately 80-120 sexual assaults of residents would be reported annually in Victorian RACS

¹⁶⁶ D Smith, M Wright and JE Ibrahim, *Aged Care Nurses Perception of Unwanted Sexual Behaviour in Australian Residential Aged Care Services: A Pilot Study* (forthcoming).

¹⁶⁷ Ibid.

¹⁶⁸ Haley Clark, Australian Institute of Family Studies, *What is the Justice System Willing to Offer? Understanding Sexual Assault Victim/Survivors' Criminal Justice Needs* (Report, 2010) 28 at <https://aifs.gov.au/sites/default/files/fm85d.pdf>.

¹⁶⁹ De Giorgi and Series (n **Error! Bookmark not defined.**).

¹⁷⁰ Mann et al, *Norma's Project* (n 5).

¹⁷¹ Ibid.

¹⁷² Ibid.

facilities (equating to approximately 1,200 assaults during the total study period). In reality however, only 28 cases were reported to the forensic investigation team over the 15-year study period, suggesting serious under-recognition and underreporting of the issue.¹⁷³

An insight into more accurate prevalence rates of unlawful sexual contact in RACS is provided in the Royal Commission's final report, which estimates that the national number of alleged incidents of *unlawful sexual contact* to be as high as 2520, or almost 50 per week.¹⁷⁴ This number still excludes other forms of sexual violence (given exemptions discussed section 3.4.3). This figure is therefore still an underestimation of true incident occurrences. The stark differences between these figures and those published by the Department of Health (outlined above) illustrates how mandatory reporting obligations have not improved the reporting of sexual violence in RACS. This is especially concerning given this is currently the only measure implemented by Australian Government dedicated to sexual violence in aged care.¹⁷⁵

An insight into more accurate prevalence of *sexual violence* in aged care has been provided through an independent study conducted by KPMG in 2019.¹⁷⁶ The purpose of this report was to understand resident to resident sexual violence, and unreasonable use of force incidents which are *currently exempt from reporting*. Incidents included 'Type 1' incidents (those that constitute 'reportable' assaults under the Aged Care Act but are currently *exempt* from reporting – i.e., where cognitive impairment involved) and 'Type 2' incidents (those which do not meet the definition of a 'reportable' assault, such as 'unlawful sexual non-contact' or 'unwelcome sexual acts'). Data was collected over the 6-month period (1 February 2019 - 31 July 2019) from 178 aged care providers. This equates to 6.6% of services and 4.3% of approved RACS providers in Australia. As of 30 June 2019, there were 2,717 RACS services operated by 873 approved providers.¹⁷⁷

The findings estimated that approximately 38,898 Type 1 and 2 incidents of physical and sexual violence occur annually within Australian RACS.¹⁷⁸ Within the six-month study period, 1,259 Type 1 incidents were reported, of which 56 (4.4%) were classified unlawful sexual contact. The majority of these incidents were rape and sexual assault, including touching the resident's genital area without consent (31/56, 54.4%). Further, there were 455 Type 2 incidents. Unfortunately, only the quantum of incidents that occurred during the data collection period was captured, as so we continue to have an incomplete picture of the *nature*, prevalence and impact of sexual violence in RACS.

Deficiencies in mandatory reporting obligations

In addition to the above, there is a failure on the part of the Australian Government to design, develop and implement effective policies and laws to prevent and manage sexual violence in RACS settings. In particular, there is a clear absence of specific and targeted policies and law on this issue, and the existing protections (i.e., mandatory reporting obligations) contain critical flaws.

Mandatory reporting obligations are currently the only specific measure implemented by Australian Government dedicated to sexual violence management in aged care.¹⁷⁹ These measures are however fraught with various issues, including ineffective collection and use of data (*discussed above in section 3.4.2*) as well as a lack of clarity around how to operate within established reporting schemes. This

¹⁷³ Smith et al, *Epidemiology of Sexual Assault of Older Female Nursing Home Residents* (n 4).

¹⁷⁴ See generally *Royal Commission Final Report* (n 61).

¹⁷⁵ *Ibid.*

¹⁷⁶ *KPMG Report* (n 30).

¹⁷⁷ Australian Government Department of Health, *2019–20 Report on the Operation of the Aged Care Act* (n 97).

¹⁷⁸ *KPMG Report* (n 30).

¹⁷⁹ See generally *Royal Commission Final Report* (n 61).

section will focus on the latter issue and illustrate how inconsistencies in the use of key terminology in law and policy between Australian states and territories, as well as exemptions in current reporting schemes undermine the efficacy of protections against sexual violence in RACS settings.

The first key issue with respect to mandatory reporting obligations in the ‘Reportable Assaults Scheme’ is the inconsistent use of relevant terminology federal, state and territory policies and legislation. To explain (as detailed in section 3.2) RACS are broadly regulated under federal level policies and legislation (i.e., the Aged Care Act). However, as sexual violence is also a criminal law issue, sexual violence in RACS settings is also partially governed by state and territory criminal law. The use of terminology by these jurisdictions has not yet been harmonised. Of particular concern is the fact that the terminology used in federal level policy and legislation is much more restrictive than broader criminal law definitions (see section 3.4.2). The Reportable Assaults Scheme, for example, defines ‘reportable’ incidents of sexual violence in RACS as ‘unlawful sexual contact acts’ (i.e., rape) but excludes ‘unlawful non-contact acts’ (i.e., threats to commit a sexual offence or exhibitionism) and ‘unwelcome acts’ (which are similar to sexual harassment and include suggestive sexual comments, jokes and requests that are unwelcome).¹⁸⁰

Excluding certain sexual acts from reportable assault legislation makes it difficult to accurately record, analyse and devise preventative mechanisms for the different forms of sexual violence that older women are subjected to in RACS settings. Notably, some of these issues will be subject to change in July 2021 under the introduction of the SIRS (see section 3.2.5 & 3.4.3).¹⁸¹

A further relevant issue is the existence of *exemptions* to mandatory reporting requirements. These exemptions are complex, and can be misunderstood by staff at RACS, particularly where staff members are inadequately trained (see sections 3.4.2 & 3.4.4).¹⁸² For example, under the current ACQSC reporting scheme, RACS staff are not required to report sexual assault incidents where the perpetrator of the act is a resident with diagnosed cognitive or mental impairment.¹⁸³ Importantly, specific criteria must be met in order for this exemption to apply, and all incidents must still be reported to the police irrespective of the ACQSC reporting obligations.¹⁸⁴

The lack of clarity around this exemption has however been found by non-government organisation the Opal Institute to result in the under-identification and underreporting of sexual violence perpetrated by persons with cognitive impairments.¹⁸⁵ This is particularly problematic given that research has indicated that persons with cognitive and/or mental impairments are at high risk of becoming victim to, or perpetrating, sexual violence in aged care.¹⁸⁶

This can have harmful flow on effects, including creating data and research deficits, contributing to a misperception that rates of sexual violence in RACS are low, and ultimately undermining protections for victim-survivors of sexual violence in these contexts. In addition, excluding certain acts of sexual violence also has the effect of promoting a culture whereby some incidents are deemed ‘not serious’ and whereby incidents can be ‘pardoned’ depending on the incident type and the perpetrator of the incident. This fails to take into account the very serious impacts on victim-survivors of sexual violence

¹⁸⁰ Y Yon et al, *The Prevalence of Elder Abuse in Institutional Settings* (n 121) 58-67.

¹⁸¹ Ibid.

¹⁸² Mann et al, *Norma’s Project* (n 5).

¹⁸³ Australian Government Department of Health, *Aged Care Laws in Australia* (n 101).

¹⁸⁴ Ibid.

¹⁸⁵ Catherine Barrett, the Opal Institute, ‘Regarding Sexual Abuse/Assault of Older Women’, Submission to the Royal Commission into Aged Care Quality and Safety, 6 at <https://www.opalinstitute.org/uploads/1/1/5/3/9/15399992/sexualabuse.pdf>.

¹⁸⁶ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

(discussed in section 3.3.5). Results of the KPMG report also illustrates how stigma and staff attitudes towards sexual violence (see section 3.4.1) can serve as considerable barriers to reporting and responding to sexual violence in RACS settings. Exemptions further limit direction and assistance where incidents occur, which is exacerbated by the inadequate training of staff in these contexts. Exemptions also serve as a barrier to holding RACS providers accountable for incidents that occur within their institutions.

Deficiencies in proposed changes to regulations

a) Changes to mandatory reporting under SIRS

As discussed in section 3.2.5 the SIRS will replace the current mandatory reportable assault scheme (due to commence 1 August 2021) to help combat both the inaccuracies of published incident data and the numerous issues with current mandatory reporting laws. This includes removing the exclusion of certain sexual acts, exemptions to report when incidents involve cognitively and/or mentally impaired perpetrators, and complex and confusing reporting pathways and obligations.

Under the SIRS the exemption to report where an incident is perpetrated by a person with an assessed cognitive or mental impairment will be removed. Further, reportable offences will broaden to include all forms of sexual violence, not just those with direct physical contact.¹⁸⁷ All incidents (that are alleged, witnessed or suspected), are still reportable to the ACQSC and the police are still required to be notified if an incident constitutes a criminal act. RACS staff will also be required to judge and report the impact an incident has had on the victim-survivor and the 'seriousness' of an incident. We detail below why we do not support this final requirement.

Whilst the introduction of the SIRS has the potential to correct inaccurate prevalence rates, there has still been no commitment from the Australian Government to release annual reports for the purpose of incident analysis. Issues with data collection methods (discussed in section 3.4.2) therefore remain applicable even after the introduction of the SIRS. Analysing incident data collected could provide researchers with a more holistic view of incident characteristics, including victim-survivor, perpetrator and RACS characteristics, and rates of prevalence in the various Australian states and territories. This is vital to overcoming current gaps in understanding the nature of sexual violence incidents in RACS settings, the characteristics of victim-survivors and perpetrators. This could go on to also assist in the design, development and implementation of effective prevention and management measures.

It is important to acknowledge that changes to mandatory reporting obligations alone will not effectively address the issue of sexual violence in RACS settings. Beyond the SIRS, the Australian Government will need to make a concerted effort to shift ageist and sexist attitudes prevalent in RACS settings to address other underlying issues that impact upon reporting, such as barriers faced victim-survivors in reporting, as well as staff perceptions of what constitutes 'real' sexual violence. Efforts beyond creating more inclusive reporting procedures also need to be developed and adopted nationally in order to start to prevent the occurrence of sexual violence in RACS facilities.

b) Oversight mechanisms under SIRS

The introduction of the SIRS also intends for the ACQSC to oversee the RACS investigation and response to the reported incident. RACS providers 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 key concerns arising from this. The first is that RACS providers are business operators, not

¹⁸⁷ Australian Government Department of Health. *Serious Incident Response Scheme for Commonwealth Funded Residential Aged Care- Model for Implementation* (Report, 2020) at. <https://www.health.gov.au/resources/publications/serious-incident-response-scheme-for-commonwealth-funded-residential-aged-care-model-for-implementation>.

forensic or criminal investigators. Without appropriate training therefore, RACS will not necessarily be able to appropriately manage sensitive issues relating to sexual violence with the adequate care and due diligence. Secondly, the ACQSC is a government regulator, meaning that it is not a suitable organisation to manage incidents of sexual violence, or to judge whether an incident constitutes sexual violence or is a manifestation of cognitive impairment. Nor are they able to assess the extent of harm a victim-survivor has experienced resulting from the incident. It is necessary therefore that where incidents of sexual violence occur, that police authorities be notified, perpetrators appropriately managed, and victim-survivors be provided with appropriate supports, as well as offered mechanisms for redress.

c) Victim impact and incident ‘seriousness’ reporting requirements

As mentioned above, the introduction of SIRS will require RACS staff members to classify the ‘seriousness’ of an incident based on the impact the incident has had on the affected resident.¹⁸⁸ The impact will be gauged off whether the staff member believes it fits into one of the following categories: ‘no impact’ (or least harm); ‘minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions’; ‘physical or psychological injury or illness requiring onsite medical or psychological treatment’; ‘physical or psychological injury or illness requiring a hospital admission (but not permanent)’; ‘permanent physical or psychological impairment’; ‘fatality or severe permanent physical or psychological impairment’ (or most harm).¹⁸⁹

Whilst the Australian Government offer training for RACS regarding the changes of the new SIRS,¹⁹⁰ to date, training does not appear to detail *how* RACS should determine ‘seriousness’ and ‘impact’. More importantly, analysis of this nature requires in depth and often cross-disciplinary expertise that not all staff will readily be able to provide.¹⁹¹ Even in circumstances where this expertise is present it is seen as harmful by best practice standards to evaluate and categorise someone’s trauma from sexual violence. This requirement lacks credible scientific basis given there are no global measures of victim impact and that responses to traumatic events are personal, unique, and unquantifiable. The findings of the KPMG prevalence report (discussed in section 3.4.4) highlight the magnitude of error of this reporting obligation.¹⁹² The SIRS was not designed in line with best-practice sexual violence standards, or a trauma-informed approach and gives rise to serious ethical considerations.

The current and proposed new system is also problematic as it makes RACS staff responsible for the detection, response and reporting of incidents of sexual violence, therefore regulations keep incidents largely ‘in-house’. This is unusual and impractical given the expertise RACS staff would have to possess in order to fulfil this requirement sufficiently. This issue is further complicated by the lack of training and education of staff (discussed in section 3.4.4),¹⁹³ and the limited collaboration and knowledge transfer between employees.¹⁹⁴ This responsibility will also have a significant impact on approved providers that do not have a system for investigating and taking action in response to incidents.¹⁹⁵ It also limits the opportunity for independent external oversight to ensure that reporting is accurate and adequate.

¹⁸⁸ Royal Commission Final Report (n 61) 41.

¹⁸⁹ Royal Commission Final Report (n 61) 78.

¹⁹⁰ See eg, ‘Abuse, Unexplained Absences and SIRS’, *Altura Learning* (2021) at <https://www.alturalearning.com/courses/abuse-unexplained-absences-and-sirs/>.

¹⁹¹ Royal Commission Final Report (n 61) 29.

¹⁹² KPMG Report (n 30).

¹⁹³ Ibid.

¹⁹⁴ Ashleigh May, ‘Probing Organisational Change in Residential Aged Care Services: Assessment of Sector Readiness to Address Sexual Violence Melbourne, VIC’ (Honours Thesis, Monash University, 2019) (*‘Probing Organisation Change in RACS’*).

¹⁹⁵ Ibid.

3.4.4 RACS staff responses to incidents of sexual violence

There are numerous issues arising from the inadequate training of staff to manage sexual violence in RACS settings. Firstly, there is clear evidence that RACS staff at present are ill-equipped to respond to and appropriately report incidents of sexual violence in aged care. In addition, it appears that RACS providers are not accessing availability training and education resources offered by organisations specialising in sexual violence.

Inability of RACS staff to respond appropriately to sexual violence

RACS staff play a vital role in managing sexual violence in their RACS.¹⁹⁶ Education of RACS staff in the promotion of positive sexual relationships has the potential to minimise sexual violence incidents over time.¹⁹⁷ A capable and trained workforce is essential if the incidents which cause extensive physical and psychological consequences for victim-survivors are to be properly addressed.

Currently however, there is a clear lack of training on the identification of sexual violence in RACS, which in turn can prevent staff from recognising trauma and trauma-related behaviours. This goes on to hinder the detection, reporting and management of sexual violence.¹⁹⁸ This situation is compounded by an existing lack of clarity about how RACS staff should manage incidents, and support victims-survivors and perpetrators.¹⁹⁹ It has also been noted that direct-care staff (especially personal care assistants) are *not currently educationally equipped* for the complex changing care environment and the occurrence of adverse events and issues around sexuality and consent in RACS.²⁰⁰

The effect of ill-trained RACS staff is also highlighted by the recent KPMG Report (previously discussed in section 3.4.3).²⁰¹ The report considered victim-impact in incidents that constituted rape and sexual assault (31 of 56 incidents reported), including touching the resident's genital area without consent. The response was anomalous, with RACS staff reporting 18/56 (58.1%) survivors suffered 'no impact'.²⁰² Further, 11/31 (35.5%) victim-survivors captured in this study were reported by RACS staff to suffer only 'minor' physical and psychological injury or discomfort, resolved without formal medical or psychological treatment, and 2/31 (6.5%) were classified as having an 'unknown impact'.²⁰³

It also appears that none of the victim-survivors received any formal medical or psychological interventions following being raped or otherwise sexually assaulted.²⁰⁴ It is well known that the trauma of sexual violence can extend far beyond the actual incident and that consultation with professional and specialised services is necessary in order to respond to the needs of victim-survivors.²⁰⁵ These findings are both counterintuitive and alarming and raise serious questions about RACS staff

¹⁹⁶ Royal Commission Final Report (n 61) 69.

¹⁹⁷ Linda McAuliffe et al, 'Assessment of sexual health and sexual needs in residential aged care' (2014) 34(3) *Australasian Journal on Ageing*, 183-188, 183

¹⁹⁸ Mann et al, *Norma's Project* (n 5) 24 -25.

¹⁹⁹ Ibrahim et al, *Recommendations for Prevention and Management of Sexual Violence in RACS* (n 4) 18.

²⁰⁰ May, *Probing Organisational Change in RACS* (n 194).

²⁰¹ *KPMG Report* (n 30) 33.

²⁰² *Ibid.*

²⁰³ *Ibid.*

²⁰⁴ *Ibid.*

²⁰⁵ Professional and specialised services relevant to the management of victim-survivors and/or resident perpetrators of sexual violence in RACS include forensic specialists, geriatricians, specialist organisations such as sexual violence and/or dementia organisations, sexual violence counsellors and/or psychologists, legal teams and police.

understanding and ability to consider the magnitude of sexual violence. The impact of sexual violence is discussed in detail in section 3.3.5.

Failure of RACS providers to address resident perpetrators

In the context of sexual violence in RACS settings, a lack of basic training for staff is not a result of a lack of *availability* of education and training. 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 are believed to not be commonly being utilised by RACS providers.²⁰⁶ This is supported by the results of the KPMG Report, which further indicate that RACS providers are *not utilising available and necessary specialised sexual violence organisations*,²⁰⁷ despite the fact they and their staff are not themselves adequately equipped to self-govern these incidents.²⁰⁸

The Royal Commission has also made clear that staff are not presently educationally equipped to manage the complexities of care and adverse events that can occur.²⁰⁹ There are currently no mandatory education units regarding residents' sexuality, sexual health and rights, or sexual violence management and prevention.²¹⁰ Furthermore, it has not yet been established what sexual violence content or topics are most needed or would be most useful to RACS staff. In order to address this, the Health Law and Ageing Research Unit has developed and piloted an e-learning intervention (2020) that provides Australian RACS nurses with content to better detect, manage, report and prevent unwanted sexual behaviour that occurs between residents. This is the first Australian evidence-based intervention specific to unwanted sexual behaviour in RACS and has been evaluated by participants.²¹¹ Results of the evaluation are in pre-publication, though can be provided upon request of the Expert Witness post-journal acceptance, though the implementation of intervention demonstrated the feasibility of such training at modest cost. This is particularly pertinent to an under-resourced aged care sector and to staff who experience competing demands on their time.

a) Management of resident perpetrators

Whilst we acknowledge the purpose and focus of this inquiry is victim-survivor focused, sexual violence that occurs in RACS also requires consideration of resident perpetrators, which is a complex issue. It is essential this is discussed in order to understand how resident perpetrator management complexities can compound the safety and pursuit of justice for older women survivors.

As discussed in section 3.4.3 the KPMG prevalence report provided a more accurate insight of the occurrence of sexual violence in RACS, reporting 1,259 'Type 1' incidents within the 6-month study period²¹². For each 'Type 1' incident RACS staff were asked to select all actions that were taken in response to the incident,²¹³ of which only 3/1,259 (0.2%) incidents were reported to the police.²¹⁴

²⁰⁶ May, *Probing Organisational Change in RACS* (n 194).

²⁰⁷ *KPMG Report* (n 30) 33.

²⁰⁸ *Royal Commission Final Report* (n 61) 70.

²⁰⁹ *Ibid*

²¹⁰ Ibrahim et al, *Recommendations for Prevention and Management of Sexual Violence in RACS* (n 4)

²¹¹ Daisy Smith et al, 'Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services' (forthcoming)

²¹² *KPMG Report* (n 30) 31-32.

²¹³ RACS staff reporting an incident during the study could select more than one RACS response for an individual incident. Type 1 incidents are inclusive of unreasonable use of force and sexual assaults considered reportable under the Aged Care Act but are exempt from reporting e.g., cognitive impaired resident perpetrator exemption.

²¹⁴ *KPMG Report* (n 30) 31.

Further, 123/178 RACS providers reported two or more 'Type I' incidents,²¹⁵ of which 97/123 (78.9%) indicated the same resident was involved, whilst 60/178 (33.7%) reported seven or more incidents of which all involved the same resident.²¹⁶ Repeat perpetrators are particularly concerning given resident perpetrator management shortfalls discussed below, and the apparent lack of external services utilised for resident survivors of sexual violence (see section 3.4.4).

The management of resident perpetrators is largely the responsibility of RACS providers. Under the SIRS as detailed in (see section 3.2.5 & 3.4.3). RACS providers will need to have an effective incident management system in place which includes both the victim-survivor and the resident perpetrator.²¹⁷ The onus is on providers to determine if the incident was (i) intentional; or, (ii) responsive to an 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 RACS staff,²¹⁸ 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 (discussed below). This may leave the victim-survivor feeling profoundly unsafe, irrespective of whether the resident perpetrator acted with intent or not.

a) Resident perpetrator relocation

Under the Aged Care Act, security of tenure provisions that are contained in the *User Rights Principles 2014* (Cth) ('Principles') are intended to provide aged care residents with high levels of certainty.²¹⁹ This means that a RACS providers can only ask a resident to leave if they have perpetrated sexual violence when it has been 'intentional' and has caused 'serious damage to the facility, serious injury to an employee or to another resident'.²²⁰ Difficulties with determining intent are described above. Further, it is unclear how the terms 'serious damage' and 'serious injury' are defined and would be measured. Additionally, regardless of the behaviour or the damage caused, the provider cannot ask the resident to leave 'until suitable alternative accommodation is available that meets the care recipient's long-term needs'.²²¹ This may be a long, difficult and unsuccessful process given RACS are required to disclose to potential new RACS providers the reason for relocating the resident in question.²²²

If an incident involves a resident with cognitive impairment and 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.²²³ Further, 'usual' law

²¹⁵ A total of 178 approved RACS participated in the study in which 28 RACS reported zero 'Type I' incidents and 123 RACS reported two or more Type I incident within the 6-month study period.

²¹⁶ This was asked about all incidents at an aggregate level and was not captured at an individual incident level. For example, if a service reported five incidents, the data collected cannot discern whether the same resident was involved in all five incidents or that the same resident was involved in two incidents and the remaining three incidents involved different residents.

²¹⁷ *Aged Care Commission 'What is the SIRS?' (n 115) 1-3.*

²¹⁸ *Royal Commission Final Report (n 61) 70.*

²¹⁹ *User Rights Principles 2014* (Cth) Part 2; See also 'Moving Residents Between Residential Aged Care Rooms', *Australian Government Department of Health* (8 December 2020) at <https://www.health.gov.au/initiatives-and-programs/residential-aged-care/managing-residential-aged-care-services/moving-residents-between-residential-aged-care-rooms>.

²²⁰ *User Rights Principles 2014* (Cth) ss 1, 2(e).

²²¹ *User Rights Principles 2014* (Cth) s 3.

²²² *User Rights Principles 2014* (Cth) s 7.

²²³ Evidence to House of Representatives Social and Legal Affairs Committee Inquiry into Family, Domestic and Sexual Violence, 13 October 2020 (Joseph Ibrahim and Daisy Smith) at

enforcement solutions do not viably apply to sexual assaults involving resident perpetrators.²²⁴ 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.²²⁵

b) Staff knowledge regarding resident perpetrators

Management of resident perpetrators who remain in RACS 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.²²⁶

Education and training of RACS should be specifically tailored to staff needs and knowledge shortfalls. We currently do not have a comprehensive understanding of the topics that will be most relevant and useful to RACS staff regarding sexual violence management and prevention. Furthermore, whilst it is true regular training and education is needed, the need to utilise relevant legal, clinical and forensic specialists should be emphasised when managing both resident victim-survivors and perpetrators. At present, these specialists are not being broadly utilised and so women residing in RACS remain at risk.²²⁷ Efforts to educate the RACS workforce regarding sexual violence will be most effective if educational shortfalls or topics of relevance are known and implemented, and paired with facility-based interventions, protocol and relevant organisational support. Unfortunately, Australian Government has failed to develop and implement such interventions.²²⁸

3.4.5 Barriers to accessing justice through Australian Criminal Law

The issue of sexual violence necessarily implicates engagement with the Australian criminal justice system. Notwithstanding, Australian criminal law is not presently well equipped to appropriately respond to sexual violence against older persons in aged care. There are numerous reasons for this, including a reluctance by victim-survivors to report incidents and engage in criminal law prosecutions, the difficulties in establishing the requisite elements of absence of consent (particularly where sexual incidents involve persons with cognitive impairment),²²⁹ as well as the barriers to obtaining sufficient evidence to convict in such cases.²³⁰ These will be examined in further detail as follows.

Victim-survivor reluctance to report and engage in prosecution

According to the Australian Institute of Family Studies, sexual violence crimes are among the most difficult to prosecute given the low rate of reporting of sexual offences, attrition of cases at various stages of trial procedures, treatment of complainants, difficulty obtaining sufficient evidence, overall

<https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommrep%2F2811795d-d851-41e4-9067-94af25d5c0eb%2F0000%22> ('House of Representatives Hearing Testimony').

²²⁴ Submission to House of Representatives (n 2) 12.

²²⁵ Tyler Corson and Pamela Nadash, 'Providing Long-term Care for Sex Offenders: Liabilities and Responsibilities' (2013) 4(11) *Journal of the American Medical Directors Association*, 787–790

²²⁶ Petra Joller P et al, 'Approach to inappropriate sexual behaviour in people with dementia' (2013) 59(3) *Canadian Family Physician*, 255-260.

²²⁷ KPMG Report (n 30) 30-33

²²⁸ Royal Commission Final Report (n 61) 205-309.

²²⁹ Daisy Smith and Joseph Ibrahim, 'Comment: Sexual Assault in Aged Care' (2019) 8(5) *Australian Journal of Dementia Care*, 1. ('Sexual assault in aged care comment')

²³⁰ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

distrust by victim-survivors of the criminal justice system, and the prevalence of myths and stereotypes around sexual crimes.²³¹ Victim survivors of sexual violence are also often discouraged from reporting or seeking justice for sexual violence crimes due to fear being disbelieved or blamed.²³²

These issues are exacerbated in the context of sexual violence against older women due to issues of ageism and sexism, including prevalence of views that depict older persons (particularly those with physical and cognitive impairments) as vulnerable, undesirable and not credible (see section 3.4.1). This can both discourage reporting of incidents, as well as the pursuit of justice through criminal law, which can be an intimidating, difficult and even re-traumatising process.²³³ In particular, the collection of forensic evidence, recounting incident statements and the prosecution process can be distressing for older persons, particularly those with cognitive or mental impairments.²³⁴ Victim-survivors may subsequently not wish to engage with the prosecutorial process, or family members may dissuade them from doing so, for example, in the hope of avoiding this re-traumatisation.

Establishing consent

It is important to note that each Australian state and territory has its own legislation and common law for sexual offences.²³⁵ Broadly speaking however, these laws require a person to have the level of mental capacity to give lawful consent to participate in sexual activities.²³⁶ Each jurisdiction has their own way of defining consent, or lack thereof, however this is generally understood to mean the 'free agreement between all parties involved, with no coercion, force or intimidation of any kind', where the individual(s) involved actively displays their consent and willingness to participate in sexual activity.²³⁷

There is however no legal test for capacity to make decisions about sexual relationships that fits neatly into a resident assessment, making this a challenging process.²³⁸ It may be difficult to ascertain for example whether resident to resident sexual activity is consensual, and particularly so in the case where one or several parties engaging in the sexual activity have a cognitive impairment such as dementia.

²³¹ Bianca Fileborn, 'Sexual assault laws in Australia ACSSA Resource sheet', *Australian Institute of Family Studies* (February 2011) at <https://aifs.gov.au/publications/sexual-assault-laws-australia> ('*Sexual Assault Laws in Australia*')

²³² Kristen Diemer, Anastasia Powell and Kim Webster, 'Four in ten Australians think women lie about being victims of sexual assault', *The Conversation* (30 November 2018) at <https://theconversation.com/four-in-ten-australians-think-women-lie-about-being-victims-of-sexual-assault-107363>. Note that this issue is currently at the forefront of public debate in Australia following a series of allegation of sexual crimes in Australian institutions including Parliament. See eg, Stephanie Dalzell and Jack Snape, 'Third Woman Alleges She was Sexually Assaulted by the Same Man Accused of Raping Brittany Higgins', *ABC News* (22 February 2021) at <https://www.abc.net.au/news/2021-02-22/third-woman-alleges-sexual-assault-same-man-as-brittany-higgins/13177536>. For an international example see also Majorie Sable et al, 'Barriers to Reporting Sexual Assault for Women and Men: Perspectives of College Students' (2006) 55(3) *Journal of American College Health*, 157-161

²³³ Marla Eisenberg et al, 'Sexual Assault Reporting and Emotional Distress Among College Female-Identified Victims/Survivors' (2019) 15(4) *Journal of Forensic Nursing*, 222-230; Tejaswinhi Srinivas and Anne DePrince, 'Links between the police response and women's psychological outcomes following intimate partner violence' (2015) 30(1) *Violence and Victims*, 32-48

²³⁴ Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

²³⁵ Fileborn (n 231).

²³⁶ Ibid.

²³⁷ Fileborn (n 231).

²³⁸ Martin Lyden, 'Assessment of sexual consent capacity' (2007) 25 *Sexuality and Disability*, 3-20 at <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-14/25-sexual-offences-3/consent-4/>.

While sexual offences in any setting are often particularly challenging to prosecute, they are especially difficult in the RACS context due to the complexities of resident-to-resident sexual violence, cognitive impairment and capacity to consent.²³⁹ The issue of consent is made particularly complex where a person, or persons, engaging in sexual activity have cognitive impairments such as dementia.²⁴⁰ Under Australian criminal law engaging in sexual activity with a person who is not able to give consent amounts to a sexual offence.²⁴¹ In practice in the RACS context however, it is RACS staff who are often expected to appropriately identify, respond and report incidents.²⁴² As discussed at length in sections 3.4.3 & 3.4.4 of this submission, RACS staff are often not sufficiently trained nor adequately supported to appropriately navigate this process, nor balance the needs to ensure resident autonomy with the protection of residents from experiencing sexual violence. This can result in under recognition, as pose challenges to proving absence of consent in criminal cases.

Further, when sexual violence is perpetrated by someone with impaired inhibitions and diminished judgment, Australian authorities may consider sexual violence as a medical and psychosocial problem rather than a legal matter,²⁴³ thus dismissing the fact that persons with such impairments may still have capacity to offend with intent'.²⁴⁴ Police may decide that proceeding with a prosecution is not practical due to factors such as 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.²⁴⁵ Whilst we concur the prosecution of resident perpetrators is not always practical, especially in incidents whereby the resident has clear impairments to cognition and judgements, a failure to address this gap in appropriate management of resident perpetrators reflects a failure to care and protect those who are most vulnerable.

Insufficient Evidence

Physical or somatic indicators or witnessed accounts are the most common means by which RACS staff are alerted to an incident.²⁴⁶ As discussed in section 3.4.3 of this submission, 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.

Forensic evidence has had an unprecedented impact on the criminal justice system and has made charging alleged offenders easier.²⁴⁷ The preservation of forensic evidence is often overlooked during incidents in RACS however,²⁴⁸ because it is counterintuitive to what usually happens in aged care – RACS 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. RACS staff again face an

²³⁹ 'Sexual assault in aged care comment'(n 238).

²⁴⁰ Laura Tarzia, Deirdre Fetherstonhaugh and Michael Bauer, 'Dementia, sexuality and consent in residential aged care facilities' (2012) 38 *Journal of Medical Ethics*, 577-578.

²⁴¹ See, eg, *Crimes Act 1900* (NSW) s 61HA(5)(a); *Crimes Act 1958* (Vic) s 36(g); *Criminal Law Consolidation Act 1935* (SA) s 46(3)(e); *Criminal Code* (Tas) s 2A(2)(i); *Crimes Act 1900* (ACT) s 67(1)(i); *Criminal Code* (NT) s 192(2)(d).

²⁴² Tarzia, Fetherstonhaugh and Bauer, *Dementia, sexuality and consent in residential aged care facilities* (n 240) 577-578.

²⁴³ Ibid; Tracey Johnstone, 'Ageing prisoners are challenging the system inside and out', *Seniors News* (14 March 2019) at <https://www.seniorsnews.com.au/news/ageing-prisoners-are-challenging-the-system-inside/3659430/>.

²⁴⁴ Joseph Ibrahim and Daisy Smith *House of Representatives Hearing Testimony* (n 223).

²⁴⁵ Catherine Barrett, Submission to The Royal Commission into Aged Care Quality And Safety, *Sexual Abuse/Assault Of Older Women* (10 September 2019)

²⁴⁶ Mann et al, *Norma's Project* (n 5) 11 – 71.

²⁴⁷ Heather Waltke et al, 'Sexual assault cases: Exploring the importance of non-DNA forensic evidence' (2018) 279 *National Institute of Justice* 1-11.

²⁴⁸ Mann et al, 'Norma's project' (n 5) 11-71; Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4).

enormous amount of responsibility when incidents of sexual violence occur, which is outside the scope of current training and education.²⁴⁹ This may lead to the improper management of evidence that can in turn reduce the likelihood of successful conviction for sexual crimes.

Engagement by authorities

Further, anecdotal evidence from RACS staff suggests that at times police may be unwilling to become involved when an incident occurs with cognitively impaired persons.²⁵⁰ This is detrimental for any victim-survivor wishing to prosecute as without timely official incident statements and the attempt to collect forensic evidence, prosecution efforts may be unsuccessful.²⁵¹ It is imperative police authorities have a clear protocol and understanding of roles and responsibilities between services for incidents of sexual violence in RACS. 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).

3.4.5 Staff perpetrators of sexual violence

Where incidents of sexual violence involve staff perpetrators, distinct issues to those discussed above arise. Healthcare staff who engage in sexual violence are in clear breach of their professional codes of conduct as healthcare professionals, as well as acting contrary to criminal law. Notwithstanding the serious implications of staff to resident sexual violence, in RACS there appears to a reluctance in some instances to view such incidents as 'crimes'.²⁵²

Instead, some responses to staff-resident incidents of sexual violence commonly focus on *what* took place (i.e., if the activity actually constitutes 'reportable' sexual violence) particularly where the incident involves less overt forms of sexual violence. Unwanted non-contact acts, such as mocking, or making sexualised jokes or comments may not be deemed reportable by witnesses or RACS staff.

This issue is also made complex where RACS staff are in close physical contact with residents in the course of their duties. For example, in a 2008 Victorian case, a female resident of an RACS was sexually assaulted by a male personal care assistant. The victim-survivor was 85 years old at the time of the offence and suffered from dementia and incontinence. The perpetrator and another female carer (witness),²⁵³ were cleaning the victim-survivor when the witness observed the perpetrator 'roughly' digitally penetrate the victim-survivor. The defence argued that cleaning between labial folds or skin folds was sometimes necessary part of cleaning and providing care to the resident. The prosecution argued against this contention, noting that digital penetration is never required plus noting specific procedures including using a face washer are required during such activities.

Despite the accused being charged in this instance, incidents of sexual violence against older women, like all incidents of sexual violence in any population, are subject to the context of how RACS staff and provides, police, prosecutors, defence teams, courts and the wider community view what constitutes 'real sexual violence.' This provides further indication that there is a need in Australia to

²⁴⁹ Mann et al, 'Norma's project' (n 5) 11-71; Smith et al, *A Systematic Review of Sexual Assaults in Nursing Homes* (n 4); *KPMG Report* (n 30) 30-33; May, *Probing Organisational Change in RACS* (n 199); Wright et al 'Sexual violence in RACS recommendations' (n 4) 1-23.

²⁵⁰ May, *Probing Organisational Change in RACS* (n 194).

²⁵¹ Judy Cashmore, Alan Taylor and Patrick Parkinson 'The Characteristics of Reports to the Police of Child Sexual Abuse and the Likelihood of Cases Proceeding to Prosecution after Delays in Reporting' (2017) 74 *Child Abuse & Neglect*, 49-61.

²⁵² Mann et al, 'Norma's project' (n 5) 11-71.

²⁵³ The perpetrators and witness in the incident described in-text were both qualified personal care workers and as part of their duties would be required to clean and bathe residents.

address prevalent ageist and sexist attitudes and rape myths (see section 3.4.1) to ensure incidents are (i) recognised as incidents; (ii) accurately reported and (iii) prosecuted.

3.4.7 Absence of Consultation with Older Women

Importantly, older women, especially those residing in RACS, remain effectively silenced within scientific inquiry, legislative, policy and programme development. Gold standard systems for reporting and managing sexual violence recognise that co-design with victim-survivors is required.²⁵⁴

We acknowledge that in recent years Australia has made great progress, implementing co-designed systems for reporting and responding to disclosures of sexual violence in other populations.²⁵⁵ It has now been recognised internationally that central to victim-survivor recovery must be giving power back to them in decision making processes.²⁵⁶

Conversely however, in the context of aged care, there are only few known initiatives that have consulted older RACS sexual violence survivors,²⁵⁷ and even these have been flawed. For example, the Royal Commission accepted submissions from a broad range of people including residents and family members of residents. As noted in section 3.2.4 there were 588 submissions received which mentioned sexual violence from a range of sources (residents, families, academics etc.) Notably however, of the 148 recommendations included in the final report, not one recommendation was specifically dedicated to sexual violence (discussed below in section 3.5). This demonstrates the difficulty of older women to achieve their right to live free from sexual violence.

²⁵⁴ The Opal Institute, 'She too' *OPAL Institute* at <https://www.opalinstitute.org/shetoo.html>.

²⁵⁵ Australian Government, 'Elder abuse – A national legal response final report' *Australian Law Reform Commission* (May 2017) at https://www.alrc.gov.au/wp-content/uploads/2019/08/elder_abuse_131_final_report_31_may_2017.pdf.

²⁵⁶ Gunnur Karakurt and Kristin Silver, 'Therapy for Childhood Sexual Abuse Survivors Using Attachment and Family Systems Theory Orientations' (2014) 42(1) *The American Journal of Family Therapy*, 79-91

²⁵⁷ We acknowledge and support the work of The Opal (Older People and Sexual Rights) Institute founded by Dr Catherine Barrett in 2016. Along with researching the topic, The Opal Institute also launched a national resources entitled 'The Power Project' (2018) intended as a resource for RACS and others wishing to keep up to date with strategies for management and prevention of sexual violence in RACS. The Power Project demonstrates how neglected the topic still is, how slow the pace of change has been, and how much still needs to be done.

3.5 Initiatives to address sexual violence in residential aged care services

- 'Despite the possibly limited impact of the Aged Care Royal Commission on human rights reforms to aged care policy and practice, the evidence coming out of the inquiry confirms the urgency of increased engagement by human rights scholars and practitioners with care homes as a site of widespread and profound human rights violations.'²⁵⁸
- Linda Steele et al, Health and Human Rights Journal

As discussed in section 3.4.2 there is inadequate data collection and research on sexual violence in RACS. Section 3.4.4 further highlights that staff are educationally ill-equipped to manage and prevent such incidents and given the results from the KPMG report detailing victim impact, more need to be done to protect survivors.²⁵⁹

Sections 3.4.4 and 3.4.5 also demonstrate that there is limited collaboration between services, which: defies best practice support for survivors of sexual violence, places an enormous responsibility on a sector already deemed in a critical state and, fails survivors as they are unlikely to receive the necessary medical and psychological support services required post-incidents (see section 3.4.4). Additionally, there are many barriers to justice for victim-survivors of sexual violence and their families (section 3.4.5). Given these grave shortfalls, what does the Royal Commission offer as solutions?

The Royal Commission's Recommendations

Royal Commissions have broad powers to hold public hearings, call witnesses under oath, compel evidence, and drive systemic federal and high-level change. Hence, the Royal Commission into Aged Care Quality and Safety was an opportunity to rectify or work towards many of the cultural, policy, organisational and training issues detailed throughout this submission.

The Royal Commission published its final report on March 1 2021, after receiving 588 submissions related to sexual violence. In the report, the Commission made 148 unique recommendations. Alarming however, notwithstanding the substantial number of submissions, as well as prior reports and research which have pointed to the issue of sexual violence in RACS, the final report of the Royal Commission dedicated *no specific recommendation* to sexual violence.

Below are some recommendations from the Royal Commission Final Report (RCFR) we wish to comment on:

- a) RCFR Recommendations 1-3: A new Act to replace the Aged Care Act and Principles

Whilst we do not oppose the development of a new act, it is important to note that such an act must directly address the issue of sexual violence in RACS settings in order to create meaningful and sustainable change on this issue. An example of a failure to do this was seen with amendments to the Aged Care Act in 2007 (section 3.2.3), which did not address this issue, and have allowed for the harms discussed throughout this submission to continue. Furthermore, whilst the proposed new act features concepts of 'safety', 'protection' and 'dignity', there is a disappointing absence of reference to *how* protecting and advancing rights of residents will be achieved.

²⁵⁸ Linda Steele et al, 'Human Rights and the Confinement of People Living with Dementia in Care Homes' (2020) 22(1) *Health Human Rights*, 9

²⁵⁹ *KPMG Report* (n 30) 30-33.

b) RCFR Recommendation 7: Development of an Aged Care Advisory Council.

It is recommended that this Council be constituted by such people of eminence, expertise and knowledge of RACS as the Minister sees fit. We argue a single council is not sufficient to tackle the issues in aged care. Too broad a council will be ineffective as different expertise are required for different issues. To respond effectively to elder abuse in aged care requires an Elder Abuse in Management and Prevention Advisory Council, in which people are drawn from all relevant stakeholders. Sexual violence and physical violence should be developed in separate Councils as per our recommendation 4.

c) RCFR Recommendation 13 pt. 2: Embedding high quality aged care to meet particular needs and aspirations of people receiving care.

We support this recommendation though believe information regarding sexuality and sexual rights of a resident be included as these are important aspects of a person's wellbeing. We also argue RACS should be required to work with relevant stakeholders and organisations when managing incidents of sexual violence as per our recommendations 2 and 8c.

d) RCFR Recommendations 78-79: Mandatory minimum qualification of person care workers and review of certificate-based courses for RAC.

We support this recommendation, though advocate for the following education units to become mandatory core competencies: sexuality and sexual health in older persons; effects of ageism and sexism and; management and prevention of sexual violence. We also argue RACS providers and staff should be supported to offer and undertake such programs regularly. A single educational program will not qualify or provide staff with the required level of skill necessary to manage incidents of sexual violence and so programs should be offered annually were appropriate (as per our recommendation 6).

e) RCFR Recommendation 82: Review of health profession's undergraduate curricula

As aforementioned above, undergraduate curricula must also cover topics regarding sexuality, sexual health and sexual violence in older persons. Without tackling Australia's broader social views on older persons, action will not be taken by professionals. Elder abuse, specifically sexual violence should also be a topic covered in undergraduate courses (as per our recommendation 6).

f) RCFR Recommendation 100: Serious Incident Reporting.

We have extensively detailed the issues with the proposed SIRS throughout section 3.4.3. We do not support the victim impact or incident seriousness aspect of the reporting obligations, nor do we agree the Commission has the expertise to undertake its proposed role in incidents. We also argue RACSs should be *required* to work with relevant stakeholders and organisations when managing incidents of sexual violence. Lastly, we argue recommendation 100 should include an obligation to publish data more in depth analysis of incidents, or release data to relevant research teams to analyse as per our recommendation 8a, 8b, 8c and 10.

g) RCFR Recommendations 107 & 114: Aged Care Research and Innovation Fund & Immediate funding for education and training to improve quality care.

Unfortunately, sexual health, sexuality and sexual violence prevention is not detailed in the proposed agenda of research for either of these recommendations. Information presented in Part 3 of this submission highlights why this is needed.

Sexual violence is recognised internationally in best-practice settings to require a unique approach for preventing, reporting, responding and managing long-term. The Royal Commission categorised sexual violence under the heading 'sub-standard care', which also includes 'unplanned weight loss'. Recommendations in the report are given to address all forms of sub-standard care. It is unclear how approaches to preventing, detecting and managing sexual violence (a crime) are similar to the issue of unplanned weight loss.

Finally, there was some division between the two commissioners when finalising the recommendations. Across the 148 recommendations, there were 43 points of disagreement between the two commissioners. Disagreements could risk delays in implementation or Government 'picking and choosing' recommendations. There is a long-standing critique of government inaction on Royal Commission recommendations for systemic reform.²⁶⁰ Without specific and dedicated measures addressing sexual violence in RACS, the efficacy and completeness of the Royal Commission's recommendations are critically undermined.

²⁶⁰ Jessica Robyn et al, "Institutional violence against people with disability: Recent legal and political developments' (2018) 29(3) *Current Issues in Criminal Justice*, 261-267.

4. RECOMMENDATIONS

All recommendations support immediate and long-term measures to prevent sexual 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. A fundamental principle is that all Australian citizens should have the same legal and human rights and access to the same services irrespective of their place of residence.

Recommendations have been structured to guide you to which 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:

Recommendation 1. The development of an international Convention on the rights of older persons, containing specific protections for older women against discrimination and all forms of sexual violence. (ToR 1)

Recommendation 2. National, regional and local initiatives are required to improve public, political and aged care staff awareness and knowledge of sexual violence in RACSs. (ToR 1, 8, 11 & 12)

Recommendation 3. 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, older people, and older persons sexuality. (ToR 1, 8, 11 & 12)

Recommendation 4. 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. (ToR 1, 8, 11 & 12)

Recommendation 5. 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 the 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. (ToR 1, 11 & 12)

Recommendation 6. To review and address the known systems failures in recognition, reporting definitions, reporting, and responding to sexual violence including post-event management for both victim-survivors and resident perpetrators. (ToR 1, 2, 10 & 12)

Recommendation 7. Government, both federal and state/territory, in partnership with RACS providers and key stakeholders should ensure that every aged care service has the support to access the training '*Preventing Unwanted Sexual Behaviour*' to provide appropriate responses to residents who have experienced past or current sexual violence. (ToR 1, 11 & 12)

Recommendation 8. 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). (ToR 2 & 10)

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

Recommendation 8a. An analysis of the implementation of the SIRS including responses to change practice. We recommend this be released to the public on a six-monthly basis. (ToR 2 & 10)

Recommendation 8b. A particularly concerning aspect of the SIRS is the reporting obligation of victim impact and incident “seriousness”. 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 (ToR 5, 8, 9, 11 & 12)

Recommendation 8c. SIRS requirements to mandate that RACS are to collaborate with relevant stakeholders (e.g., sexual violence organisations, dementia care specialists, forensic specialists etc.) when managing an incident of sexual violence (both victim-survivor and perpetrator relevant stakeholders). (ToR 1 & 11, 12)

Recommendation 9. A separate national panel of experts and stakeholders in this field should be established to undertake this sensitive and complex work (ToR 1, 2, 3, 10 & 12) 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.

Recommendation 10. The data held under the Operation of the Aged Care Act 1997 concerning reportable assaults were released to allow experienced research team(s) to interrogate the nature of sexual offences in RACSs. (ToR 1, 2, 3, 10 & 12)

Recommendation 11. Dedicated and specific funding support for short- and long-term research covering sexual violence in RACS (detection, management and prevention), and resident perpetrators (profiles, sentencing, management and rehabilitation) (ToR 1, 2, 3, 10, 11 & 12)

Recommendation 12. 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) (ToR 1 & 12)

Note that recommendations 6, 10 and 11 have been endorsed by the House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry and Report on Family, Domestic and Sexual Violence*.²⁶¹

²⁶¹ House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry and Report on Family, Domestic and Sexual Violence* (List of Recommendations, 1 April 2021) recommendations 46, 47, 52, 53 at https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Familyviolence/Report

5. CONCLUSION

The above submission indicates a number of areas in which the Australian Government is currently failing to respect, protect and fulfil the fundamental rights of older women in aged care. The submission has sought to make clear that Australia has clear obligations with respect to this issue under international human rights law, and other international level guidance. Notwithstanding, at present there is a lack of clear and effective policy and legislation to address this issue.

In addition, the continued prevalence of ageism, sexism, rape myths and discrimination are fuelling damaging stereotypes of older women, and have served as obstacles to the proper identification, response and redress of sexual violence in residential aged care settings. Furthermore, significant problems with the collection and use of data, and the general absence of targeted research in this area has led to a lack of understanding and awareness of the nature, prevalence and impacts of sexual violence against older women in aged care and has in turn failed to prompt effective policy and legal change on this issue.

In residential aged care facilities themselves, reporting problems; inaccurate and inappropriate staff perceptions and knowledge about sex, sexual relationships, sexual violence, and the perpetrators of sexual violence in the context of aged care; as well as a clear lack of adequate training for RACS staff have served as barriers to the identification and reporting of sexual violence. They have also often resulted in a failure by staff to provide victim-survivors of sexual violence with adequate and appropriate support following incidents and have significantly undercut already weak mechanisms for redress.

As regards meaningful reform in this area, the Australian Government has failed to appropriately consult with older women, and advocacy organisations in order to formulate effective protections and pathways to redress. Further, while the recent Royal Commission's recommendations with respect to aged care quality and safety represent a welcome step in the right direction, the Commission's failure to specifically address the issue of sexual violence in RACS means that many of the abovementioned issues will remain unaddressed, and the safety, wellbeing and rights of older women in these settings will remain endangered.

6. Tabulated Terms of Reference(s) (ToR) & Recommendations

Recommendation	ToR	Summary of evidence in support
1-4	1, 8, 11 & 12	Sexual offences in RACS facilities 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, and lack of clear and effective international and national level law and policy. Implementing recommendations 1-4 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.
5	1, 11 & 12	RACS facilities 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.
6-8	1, 2, 10, 11 & 12	<p>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, definitions, data collection and practices).</p> <p>Current aged care systems of managing sexual violence do not reflect best practice and training and education of RACS is inadequate. There needs to be a greater consultation with sexual violence experts as well as mandatory educations regarding older people and sexuality and sexual violence units. These are imperative for a response to a sexual violence in RACS. Improving systems, collaborative between services and education of RAC staff will undoubtedly help to reduce secondary trauma of victim-survivors. Education should be developed using an evidence-based approach, evaluated and offered routinely if effective.</p>
8a-c	1, 2, 5, 8, 9, 10, 11 & 12	Whilst we advocate for the introduction of a SIRS we do not agree with the reporting obligation to determine victim impact and incident seriousness. Firstly, as it is unclear how RAC staff are to interpret the seriousness of incidents. Secondly, it is entirely unsuitable for the seriousness of incidents to be subjected to RACS staff or the Commission's interpretation. Thirdly, the findings from the KPMG prevalence report highlight the

		<p>failings of such requirements and lastly, the requirement is precarious to RAC staff culture, which the Royal Commission has already deemed ageism a systemic problem.</p> <p>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.</p> <p>As staff are inadequately trained to manage any adverse event, it is entirely inappropriate to keep management of incidents in-house. We believe RACS should be required to collaborate with relevant services (geriatricians, trauma counsellors, forensic experts etc.) in order to provide the best practice response and care.</p>
9-11	1, 2, 3, 10 & 12	<p>There are several data collection concerns outlined within this submission, mainly the inclusion of older persons in institutions and/or those with cognitive or mental impairments.</p> <p>Whilst we recognise the introduction of the SIRS will work to fix Government collected data, there is still no initiative to release this data to experts. 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. Analysis of such data would allow us to create informed and tailored policies.</p> <p>Research also needs to be funded if we are to correct the known failings described within this submission.</p>
1 & 12	1 & 12	<p>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. This issue remains under the introduction of the SIRS.</p> <p>Results from the KPMG report show a significant number of repeat perpetrators in reportable assault incidents, though significantly low notification to police authorities by RACS staff. 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.</p>