EDUCATION, ARTS AND COMMUNITIES COMMITTEE

Members present:
Mr NG Hutton MP—Chair
Ms W Bourne MP
Mr N Dametto MP
Miss AS Doolan MP
Ms K-A Dooley MP (substituting for Mr Krause MP)
Mr PS Russo MP (substituting for Ms McMillan MP)

Staff present:
Ms L Pretty—Committee Secretary
Dr A Lilley—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO ELDER ABUSE IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

Friday, 21 February 2025

Brisbane

FRIDAY, 21 FEBRUARY 2025

The committee met at 9.59 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into elder abuse in Queensland. My name is Nigel Hutton. I am the member for Keppel and chair of the committee. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. With me today are Ms Wendy Bourne, the member for Ipswich West; Mr Nick Dametto, the member for Hinchinbrook; Miss Ariana Doolan, the member for Pumicestone; Mr Peter Russo, the member for Toohey, who is substituting today for Ms Corrine McMillan, the member for Mansfield; and Ms Kerri-Anne Dooley, the member for Redcliffe, who is substituting today for Mr Jon Krause, the member for Scenic Rim.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Please remember to press your microphones on before you start speaking and off when you are finished. Please turn off your mobile phones or switch them to silent.

SMITH, Ms Shayne, Public Guardian, Office of the Public Guardian

CHAIR: Good morning, Ms Smith. Thank you for appearing before the committee today. I invite you to make an opening statement to the committee and then I will open it up to questions. Thank you.

Ms Smith: I would also like to begin by acknowledging the traditional custodians of the land on which we meet today and pay my respects to elders past and present. I thank the committee for your invitation to appear today. I am Shayne Smith. I am the Public Guardian. The position of the Public Guardian is an independent statutory officer and the Office of the Public Guardian—or OPG, as we like to call it—is an independent statutory office.

One of our primary functions is to safeguard the rights and interests of adults with impaired decision-making capacity, and we do that through a range of functions—primarily our investigations, our guardianship and our community visiting services. I also have a range of functions in relation to children but, in the interests of the inquiry today, I will take you through the primary functions that relate to adults and how they may work to safeguard against the abuse of older people.

Consistent with the Australian Institute of Health and Welfare, OPG considers an older person to be aged over 65 years, or over the age of 50 if they identify as Aboriginal or Torres Strait Islander. The Public Guardian Act 2014 safeguards against the abuse of older people by providing discretionary investigative functions. We can investigate allegations that an adult with impaired decision-making capacity is being abused, neglected or exploited or has inadequate or inappropriate decision-making arrangements.

In order to commence an investigation, investigators require sufficient information to establish a reasonable suspicion that the person has impaired capacity. In the 2023-24 financial year, 69 per cent of the matters investigated by the Office of the Public Guardian related to older people. This number has grown by seven per cent in the last two years—it was 62 per cent in 2021-22 and 69 per cent in 2023-24. Investigations can be complex and they often involve a range of allegations in the one matter. Last financial year, 39 per cent of allegations for older people related to financial abuse, followed by inadequate care, which accounted for 22 per cent. The remaining 39 per cent of allegations for this group was jointly made up of allegations of coercive control, neglect, invalidity of enduring powers of attorney and incompetence of decision-makers. From our investigations, we see that victims are commonly female—66 per cent—and the alleged perpetrator is usually a relative, most likely to be an adult son or daughter.

Guardianship is also an important safeguarding mechanism in situations where an older person has impaired decision-making capacity and is at risk of abuse, neglect or exploitation. In the absence of another appropriate or competent guardian, the Public Guardian may be appointed by QCAT or the Supreme Court as a last resort to make substitute decisions in relation to a person's personal matters. Personal matters can include decisions relating to, for example, where they might live, the provision of services and their health care. The Public Guardian can also be appointed as someone's attorney under an enduring power of attorney—a principal under that instrument can nominate the Public Guardian as their attorney. The Public Guardian can also make healthcare decisions for any Queenslander with impaired decision-making capacity as a statutory health attorney of last resort.

Guardians or attorneys are required by legislation to follow a structured decision-making framework when making substitute decisions for another person to ensure their rights are upheld to the maximum extent possible. This reflects the importance of decisions being made in line with a person's views, wishes and preferences. In 2023-24, OPG provided decision-making services to around 1,300 older people.

OPG also provides oversight of government funded services by administering a community visiting program to protect the rights and interests of adults with impaired decision-making capacity who reside at a visitable site. Visitable sites include places such as the Forensic Disability Service, inpatient authorised mental health services, level 3 accredited residential services—also known as boarding houses or hostels—and some places where NDIS participants reside. Older people may reside at these sites and receive community visiting services. Community visitors inquire into and report on the adequacy of services being provided and the appropriateness of those services. They also may assist a person to make a formal complaint about the services they receive to the relevant regulatory body—they facilitate that complaint.

OPG is committed to working closely with the government and key stakeholders to enhance safeguards for older people. I welcome this inquiry into elder abuse in Queensland and, once again, I extend my thanks to you for inviting me to appear today.

CHAIR: Thank you very much, Ms Smith.

Ms BOURNE: Thanks so much for coming today. I am very interested in what triggers a community visit. We spoke yesterday about Meals on Wheels. They visit a lot of people and they do so much more than deliver a meal; it is about combating social isolation. What triggers one of your community visits?

Ms Smith: The Public Guardian Act defines a visitable site for the purpose of our adult community visiting program and the legislation mandates that we must visit regularly. For most locations at the moment that is quarterly as it is an oversight service—we are not the primary regulator. Our community visitors undertake a risk assessment for each individual site. There may be risk factors present that may warrant more frequent visits. We have a visiting schedule for all of the locations that we visit but it is the legislation that defines where we visit.

CHAIR: One of the topics that has been covered previously in our hearings is around impaired capacity versus reduced capacity versus no capacity. In the role of the Public Guardian, obviously you work particularly with people within the field of impaired capacity. Do you believe that there is scope within the role of the Public Guardian to provide further support to people who may have a declining capacity? Are there barriers that would limit your capacity or is there something that we need to do in terms of the legislative framework to support that outcome?

Ms Smith: I would say that it differs for our different services. When the Public Guardian can be appointed as someone's substitute decision-maker, it is QCAT or the Supreme Court that make that declaration of incapacity. Through their hearing, they will look at the medical evidence and make that determination; it is not made by the substitute decision-maker.

In relation to investigations, our investigations just require a reasonable suspicion of impaired decision-making capacity, and that is done by seeking appropriate medical evidence to substantiate that initial threshold to commence an investigation. As I said, the sites our community visitors visit are defined under the legislation, but the people who reside there would have a range of capacities. Not everybody who resides at those sites would not have decision-making capacity; some would retain their own decision-making capacity. Does that answer your question?

CHAIR: I think you have tried incredibly hard to answer my very convoluted question. I appreciate your aspiration. We have heard quite often from the community with regard to declining capacity of people having periods of lucidity. They have talked about people having a twilight time or

the sundowner effect. In terms of the Public Guardian's role, do you believe that there is an opportunity to increase the framework to provide support for vulnerable seniors in that space, to both support the empowerment of their capacity when it is available and meet their need when they are temporarily incapacitated?

Ms Smith: As I said, our investigators just require a reasonable suspicion. In the course of their investigation, they may find that someone can clearly make their own decisions and can retain that capacity. They would refer them to the other existing support services that we have here in Queensland. They do not just close the investigation; there would be a referral made for ongoing support, if that is required. If there is a question of incapacity, they would continue that investigation. Ultimately, that investigation is looking at the safeguards around that person and their decision-making arrangements. If they are unsure whether that person does need someone to support them with their decision-making, they would often make an application to QCAT to look at that further to make that determination.

Mr DAMETTO: Ms Smith, thank you very much for coming in, briefing us, giving us some evidence and answering our questions this morning. My question is with regard to guardianship orders: is there any correlation between those who may refer the said person for a guardianship order and those who eventually becoming the perpetrators of elder abuse of that person? Has the Office of the Public Guardian noticed any correlation between them?

Ms Smith: I might try to clarify your question. If the Public Guardian is appointed as their decision-maker, are we noticing any correlation that they may be perpetrators?

Mr DAMETTO: No. The person who has referred them to the Public Guardian in the first place—do they then become the perpetrator?

Ms Smith: I would say that, generally, perpetrators of abuse want to retain that either informal or formal decision-making role. It would be quite rare that they would seek the appointment of the Public Guardian, especially within that family environment. We see the abuse occur when they may be isolated from other family and friends and the alleged perpetrator might be the primary carer and also the decision-maker. That could be an informal arrangement or it could be under a power of attorney instrument, or they could actually be a formally appointed decision-maker. We often see applications being made to the tribunal, or to our investigation services, from other children, friends and family or someone else in their community who has concerns around the decision-making arrangement.

Mr DAMETTO: That clarifies what I was trying to get to the bottom of. Thank you.

Miss DOOLAN: Does your office experience a backlog of complaints to investigate? If so, why do you believe that might be?

Ms Smith: I have some information on that. This is a snapshot of the reports we received last financial year. We received 410 requests for investigations. We accepted 70 and declined 239. At the end of that period there were still around 100 we were assessing. The majority of those that were declined were on the basis that we had insufficient evidence to reach the threshold that the adult had impaired decision-making capacity. As I said, we would refer on to other services such as the Elder Abuse Prevention Unit or Seniors Legal and Support Service. The vast majority of the remaining declined were because, even though we receive a lot of contacts, most of them are just for advice and information. Not all will result in an investigation being opened. I think you would see very similar numbers in the New South Wales Ageing and Disability Commission and the South Australian Adult Safeguarding Unit.

Mr RUSSO: My question relates to enduring powers of attorney. Are you able to help the committee with ways that would help both parties understand their obligations? A lot of people who are appointed attorneys are often well intentioned and do not plan on doing anything, but in my view there is a gap in the knowledge base. Do you feel there would be a way to assist people in that complex relationship?

Ms Smith: I believe this is an extremely complex area because the motivation behind the actions of attorneys can be across a huge spectrum. Some may be legitimately unaware of their obligations and require education about those obligations and how to practically carry them out. At the other end of the spectrum there is intentional behaviour, so no amount of community education will influence that. It becomes very complicated when you are mixing a family dynamic—on top of that, money. It is even more so when an attorney could be the beneficiary under the will so they believe, 'It's coming to me anyway. What's the issue with some of that money being spent now?' Obviously, community education is always going to be important. There is a lot of information given

at the point of executing the documents. There is a very comprehensive guide that comes with a form. There are a range publications nationally and within the state. The issue is that everyone signs those documents thinking everything will be fine. It is human behaviour to think positively and that nothing will go wrong.

We see a lot of instruments that are very light-on in terms of the principal instructing of their own views and wishes or conditions around what the attorney can do. There is more education that can be done to make the documents more specific. I am not sure how we can influence this, but possibly education for the attorney at the time an enduring document becomes activated, because that document can be made potentially decades prior to it becoming activated and no-one remembers the guide they received at the time with the information. There are a few ways that could be done. Obviously, there are always people who may intersect with an attorney at the point of an activated document in terms of general practitioners carrying out capacity assessments or what we call mini mental state examinations. It is very difficult for them to recognise if the attorney is there and finding out who they are to provide information to. If we could harmonise the legislation and have a national register so there would be a requirement that, when an instrument becomes active, that register alerts people to it—perhaps at that point in time, before that register changes, there could be a requirement that an attorney has to do a refresher course or sign a declaration that they understand their obligations or even a mini quiz they have to undertake to do that. They are just my thoughts. I acknowledge that it is a very complex area.

CHAIR: The committee acknowledges that the feedback you are providing is very similar to other evidence we have heard. We do appreciate that looking for those actions and activities is very important.

Ms DOOLEY: Thank you for your presentation and the work that you do. It is very important work. Going on from your response, are there any legislative, policy or funding barriers that reduce the efficacy of your office and your role? If you could put forward any suggestions, it would be helpful.

Ms Smith: I believe that with an increase in community awareness it is really important to resource all of the response systems across Queensland, whether that is in the community, community legal centres or our agency. If people raise a complaint or make a disclosure, they have an expectation that something will be done about it. Sometimes people reach out only once, and if all of the services are at full and they are not adequately responded to then that may be the only time it is brought to anyone's attention.

In addition to that, in terms of our investigations, I would like to see a legislated notice period to respond to. For example, if we approach a general practitioner to seek information about someone's cognitive impairment or decision-making capacity, there is no legislative timeframe in which to respond. Sometimes it can take many months. We have the same issue with financial institutions. If there is an allegation of financial abuse and we are not sure which financial institution they bank with, we will contact Services Australia to see if they receive a pension and where that may be deposited to, but sometimes the responses can take many months. These compound and our investigations can end up being quite lengthy, which can increase the risk for the older person.

Ms DOOLEY: As a registered nurse, we talk about triaging. Is there a triaging component for physical or sexual abuse that needs to be acted upon quite urgently compared to some of those others? If you are waiting for reports from a GP or other agencies, I do see the need for a sense of timeliness.

Ms Smith: Absolutely.

Ms DOOLEY: How do you triage in those instances?

Ms Smith: If we are concerned there is an immediate risk of harm, we absolutely work with the other services throughout Queensland and have a coordinated response. If there is not enough time for an investigation, we will always do that. If we have enough information that the person has impaired capacity and we commence an investigation but there is an immediate risk of harm, I have a range of very powerful protective actions I can take. They are quite unique to Queensland. I can suspend an attorney under an enduring power of attorney for up to three months. Within that three-month period, if decisions need to be made it is either by the Office of the Public Guardian for personal decisions or by the Public Trustee for financial decisions. In matters that are very significant I have the ability to obtain from QCAT a warrant to remove someone from their environment where there is an immediate and significant risk of harm. Thankfully, we do that very rarely because in most cases we do not need to forcibly remove. We work with people, so there is a voluntary approach instead. There are protective actions that I can take where that immediate risk presents. In our intake process we have a risk matrix, for want of a better term, where we assess that risk as soon as we receive those disclosures.

Mr DAMETTO: With regard to the people who become perpetrators of elder abuse, from your experience are they doing it because they think it is the right thing to do or because they are quite malicious and callous?

Ms Smith: That is a difficult question.

Mr DAMETTO: I am sorry to ask such a difficult question.

Ms Smith: Sometimes it would be hard to reconcile the actions being taken without some intent and knowledge. Obviously, not everything that is raised with our investigations team amounts to abuse. There is also incompetence. That can be just from a lack of understanding what needs to happen. Small things: attorneys not realising they should not mix money. They should have a separate account for their mum; they should keep their money in their own account; they should keep receipts if they are paying. In terms of neglect, it could be that people are not aware of the services that may be available. We also see the scale of what is reported to us—very much so when the abuse becomes significant—and when the risk becomes more significant there has to be an element of intention there—

Mr DAMETTO: For example, just blatantly stealing from the person.

Ms Smith: That is right, or not paying the aged-care fees because they are living in the home and knowing that is creating housing and care instability for their parent.

Ms BOURNE: You talked about harmonising legislation. Do you think there are any other jurisdictions, either internationally or across Australia, that have a better response model than we do here in Queensland?

Ms Smith: I might defer to Dr Chesterman, who is speaking after me. As you have probably heard, in terms of adult safeguarding both South Australia and New South Wales since around 2019 have had adult safeguarding agencies. South Australia's sits within their Department for Health and Wellbeing and New South Wales has an independent commission. They have picked some of the good parts we have here in Queensland and they have built on that. Their services respond to all adults at risk. It just broadens the scope of what we have here in Queensland.

CHAIR: I would like to take you back to your opening statement. You said that when the role of the Public Guardian is to intervene and take over, you have a series of steps in place to protect the intent and aspirations of the individual under care. Can you provide us with any more information on that? It is obviously something we are very keen to ensure where attorney powers of attorney are brought in and used. How are they protected when the Public Guardian fulfils that role? Is this something that could be replicated in a more general sense for those acting as attorneys?

Ms Smith: Within the Guardianship and Administration Act, that relates to where the Public Guardian or a private guardian is appointed by the tribunal or court as a substitute decision-maker. It has a range of general principles that must be adhered to in carrying out the duties under that legislation when making substitute decisions. It requires that the views and wishes, as much as possible, can be sought from the person when decisions need to be made. That really is to make sure they are involved in that decision-making process. It also promotes their human rights.

In terms of when we investigate, we do not seek the consent of the person the investigation relates to, but our investigators will try to speak with that person to seek their views and wishes as part of that investigation to the greatest extent possible. Obviously, that is done within a risk assessment. It is very difficult if the older person is living with the perpetrator alone at the home; it could increase the risk of harm to the person if our investigators turn up on the doorstep. Trying to involve them as much as possible in relation to the matter is important.

CHAIR: On behalf of the committee, I would like to thank you for the time you have given us this morning and for the submission that you provided prior. We all recognise that quite often, particularly in your role, what you are seeing is the breaking point, where things have gone so far that now we are seeing the response to that. Your role is in providing supported decision-making and, to me, probably the most important part is engaging with the views and wishes to ensure that, while this is something that is being done for them, we are also taking them on that journey. Thank you for your time and thank you for your responses to our questions.

Ms Smith: Thank you.

Proceedings suspended from 10.32 am to 10.42 am.

CHAIR: Good morning. We will now resume the public hearing for the committee's hearing into the inquiry into elder abuse in Queensland. My name is Nigel Hutton. I am the member for Keppel and chair of the committee. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. With me here today are the committee members: the member for Ipswich West, Ms Bourne; the member for Hinchinbrook, Mr Dametto; the member for Pumicestone, Miss Doolan; as well as two substitute members in the member for Toohey, Mr Peter Russo, substituting for Ms Corrine McMillan, the member for Mansfield; and the member for Redcliffe, Ms Kerri-Anne Dooley, who is substituting today for Mr Jon Krause, the member for Scenic Rim.

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CHESTERMAN, Dr John, Public Advocate, Office of the Public Advocate

COLLEY, Ms Jacinta, Principal Policy and Research Officer, Office of the Public Advocate

MARTELL, Ms Tracey, Manager, Office of the Public Advocate

CHAIR: Good morning. Would you like to make an opening statement, after which the committee may have some questions for you?

Dr Chesterman: Thank you for the opportunity to be here to speak with the committee about this important elder abuse inquiry. I acknowledge we are on the traditional lands of the Turrbal and Yagara peoples and pay my respects to elders past, present and emerging. As members of the committee know, as the Public Advocate for Queensland, I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability. I am very pleased to be invited here today. I have here with me my colleagues Tracey Martell and Jacinta Colley, who did much of the writing of the adult safeguarding report to which I will refer. I want the committee to know that I am very keen to assist in whatever way I can in the important work it has ahead of it.

As members would know, I have an extensive interest in the topic of elder abuse which predates my taking up the position of Public Advocate over three years ago and has continued in my performance of this role. While I was at the Victorian Office of the Public Advocate, I was fortunate enough to undertake a Churchill Fellowship that focused on responding to harms faced by at-risk adults, with elder abuse a significant component of that work. Recently, I had the opportunity to revisit this Churchill Fellowship work with involvement in the Churchill Fellowship Policy Impact Program which included the development last year of a short article on adult safeguarding that I will ensure the committee has.

I was privileged to serve on the Australian Law Reform Commission's expert advisory committee when the ALRC conducted its groundbreaking inquiry into elder abuse which resulted in the report *Elder abuse—a national legal response*, which was published in 2017. I was also centrally involved in the push for a national prevalence study which became an ALRC recommendation and led to the Australian Institute of Family Studies completing the first ever National Elder Abuse Prevalence Study in 2021.

Of particular relevance to my work here in Queensland have been the recommendations from the Australian Law Reform Commission concerning enduring powers of attorney and the need to create in each state and territory an adult safeguarding agency. I have pushed for the harmonisation of financial enduring powers of attorney legislation throughout Australia. I co-authored last month an article on this with our national Age Discrimination Commissioner, Robert Fitzgerald. I have previously drafted a model of law as a way of progressing the call for the harmonisation of financial enduring powers of attorney laws throughout the country.

Among the key reasons for this push for harmonisation of our state and territory financial enduring powers of attorney legislation is the need for there to be greater knowledge among attorneys of their responsibilities under enduring powers of attorney. As we heard from the Public Guardian, sometimes poor behaviour stems from ignorance; sometimes it is more nefarious than this. Harmonisation would enable nationally consistent education on this topic. It would also lead to more regularised business practices among those institutions that frequently need to recognise and work with people appointed under enduring powers of attorney, particularly banks.

On the topic of adult safeguarding, in 2022 my office completed a two-volume report on adult safeguarding in Queensland which drew on consultations in a series of round tables throughout the state. The second volume of my report was tabled in Queensland parliament on 8 December 2022. This report contained 17 recommendations, key among which were the recommended creation of an adult safeguarding commissioner in Queensland and the creation of adult safeguarding networks throughout the state. The idea behind the adult safeguarding networks is to energise community members to take greater interest in what is happening around them. These networks would enable the skilling up of local services and at the same time allow experts to meet to discuss particularly complex situations in their local areas. The networks could be geographically based as well, in some instances as grouped around characteristics of marginalised groups.

My proposal regarding the appointment of a Queensland adult safeguarding commissioner aligns very closely with the Australian Law Reform Commission recommendations on adult safeguarding, which have also received support in the final report from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability and in the report emanating from the independent review into the NDIS. Not to put too fine a point on it, the creation of the Office of Queensland Adult Safeguarding Commissioner would be a signature and meaningful elder abuse reform that would chart a new path and provide the leadership to enable our state to tackle this rife and complex problem.

In addition to the two-volume adult safeguarding report, my office has produced a two-page summary placemat on this topic that I will ensure the committee has, and perhaps I will seek leave to table that in a minute, along with another document that I will mention.

On terminology, I make the point that my report and subsequent work on adult safeguarding has elder abuse as a significant component of that, in the same way the Australian Law Reform Commission inquiry was into elder abuse, but its recommendations focused on at-risk adults.

Following the Australian Law Reform Commission report, we had two jurisdictions make significant change to their adult safeguarding arrangements. We had the Public Guardian reference those a moment ago. New South Wales created the independent Office of the Ageing and Disability Commissioner, and South Australia created the Adult Safeguarding Unit within a government department. We here in Queensland are yet to act.

In saying this, I do note we have some excellent services here in Queensland. I work very closely with the Elder Abuse Prevention Unit, Caxton Legal Centre, ADA Australia, Queensland Law Society and others, as well as our statutory agencies. I am on the recently created Southern Downs Elder Abuse Response panel, which I played a small part in helping to establish, but we have significant gaps. These gaps are best demonstrated by asking this question: when a person is living in the community who is clearly not faring well but does not have a pressing medical concern and is not the obvious victim of a crime, who do you call? In the absence of any agency with responsibility here, we of course call emergency services. If a person has a significant cognitive disability, they can find themselves entering the adult guardianship system. This is often not of great benefit to the individual and it comes at great cost to the state. It can also amount at times to a form of victim blaming in ways that I can describe later should the committee wish me to do so.

The alternative I have proposed is less use of our emergency services and less use of adult guardianship and our adult guardianship agencies. In place would be the proposed Office of the Queensland Adult Safeguarding Commissioner, which could immediately act to link a person to services which will often be federally funded ones, incidentally, in the disability and/or aged-care fields. In making this suggestion, members of the committee will be well aware that other broad reforms that are relevant to the committee's work have been recommended by the disability royal commission, for instance, in the field of adult guardianship. As I say, adult guardianship is often used—and I would say overused—as a response to elder abuse.

There is a way of bringing all of this together to update and reframe our adult guardianship laws so that they focus more on supporting people to make their own decisions and, at the same time, make a signature reform in the elder abuse field. My suggestion on how to do this is to legislate

to reframe our guardianship laws and create the role of Adult Safeguarding Commissioner in what might be called an adult support and safeguarding act. I have a short, two-page guide to that idea that I can also hand to the committee and which I can seek leave to table in a moment.

The final point I would like briefly to note is that the topic of social isolation and loneliness is very important, of course, to the committee's work. Social isolation and loneliness are risk factors for elder abuse. I want the committee to know that my office is joining with ADA Australia in supporting COTA Queensland, which will be hosting three forums this year—in Brisbane next month, and the other two are likely to be in Townsville and Longreach—where we are focused on identifying innovative ways of addressing these broad and likely growing problems. Thank you for your attention. I am very happy to answer any questions you would like to ask me.

CHAIR: Thank you very much, Dr Chesterman, for that very thorough presentation. We look forward to having the opportunity to review some of the documentation.

Ms BOURNE: Thank you so much, Dr Chesterman, for that comprehensive opening statement. You have talked about some of this in your opening address, but can you describe a model that would see legislation, policy enforcement and intergovernmental cooperation working more cohesively, and what legislative changes could facilitate this model?

Dr Chesterman: Certainly. The proposal that is referred to is for the creation of new legislation to replace our guardianship legislation, and there would be amendments to other pieces of legislation as well, including the Public Guardian Act, the QCAT Act and the Powers of Attorney Act. The title would be—I have given it a title as just an idea—the 'Adult Support and Safeguarding Act', where we would make the reforms recommended by the disability royal commission in limiting adult guardianship to situations of absolute necessity but also empowering an agency which I have proposed which is similar to the agency that exists in New South Wales, the Ageing and Disability Commissioner, which would have a role in investigating situations concerning at-risk adults. That agency, if it were an independent commission, would have the ability to conduct investigations, subject to certain legislative criteria. It would need usually the consent of the person themselves before conducting an investigation, unless there was a serious risk to the wellbeing of that person, but it would then have a role in helping to link the person to services, whether they are state or federally funded ones. That is the reform idea. I can flesh that out further if you would like me to do so, and certainly we will talk about this in the written submission we will make to the committee.

Ms BOURNE: We had enduring power of attorney raised with us on the Gold Coast in terms of justices of the peace or commissioners of declarations signing off on those enduring powers of attorney. Do you think that is a good model? Do you think that should be done by a lawyer, given it is such an important decision that is being made by a family?

Dr Chesterman: That is a really good question. In weighing this up, you are always trying to balance two things. You do not want it to be too hard for people to complete an enduring power of attorney. At the same time, you want to have safeguards in place so that these very important documents are actually going to work to the benefit of the person. I think there is an argument that, ideally, you would seek legal advice before completing an enduring document. There is a question about whether we restrict the authorised witnesses of enduring documents to just lawyers and not extend that to justices of the peace. That is something that I am certainly open to being convinced about, as one of the safeguards we could put in place.

I think one of the key safeguards we need—and this was a matter that was discussed with the Public Guardian just prior to my appearance here—is: how do we ensure attorneys know what their responsibilities are? That is a key question. The reason this is difficult is that attorneys often will play the role once in their life, maybe twice, and it will often be some time after the enduring document is completed, so even with a discussion at the time of the completion of the document it may be 10 years before it is activated. How do we make sure the attorney knows what their responsibilities are? As I was saying before and we know, sometimes misuse of enduring powers of attorney happens through negligence; sometimes it is inappropriate behaviour that is knowing. Either way, we need to make sure attorneys know what their responsibilities are.

Miss DOOLAN: Dr Chesterman, the committee has heard from stakeholders that one of the more common barriers to reporting elder abuse is the shame and embarrassment people have faced, especially in cases where close family members have perpetrated the abuse. Can you comment on this problem, and how can the government better protect people who do not wish to report the abuse?

Dr Chesterman: That is a really important question, and it is one of the reasons I initiated the adult safeguarding work that this office has done. We have existing laws, for instance, in the field of domestic and family violence and they have an increasing resonance within the broader community.

Elder abuse will often be, but not always, a form of domestic and family violence. We know that 'elder abuse' is not actually a strict legal term, but often if will come within what we identify as domestic and family violence. However, the paradigm in elder abuse scenarios is often different to the paradigm in domestic and family violence, where you will typically have a person wishing to end a relationship, often a woman. In elder abuse, it will typically be an adult child who commits the abuse, and oftentimes the victim will be unwilling to report it for the reasons you specify—because they will want the abuse to end but they will want the relationship somehow to continue. That makes an unwilling victim. In the Australian Institute of Family Studies' prevalence study we heard that one in six or seven people are subject to elder abuse in any year; however, two in three do not report it, for the reasons you say. That, for me, is the most alarming statistic. Two in three people do not report elder abuse. One of the reasons is that they do not want their relationship with the offender jeopardised.

The idea behind the creation of an adult safeguarding agency, in my recommendations about a commissioner, is that it would be alive to that nuance, and it would be a place where you can call and their first role will be to check in with the person about what the person wants to happen, rather than coming in with a full criminal justice response—that may be appropriate down the track, but it may not be; you just do not know at that initial stage—to encourage people to contact that agency, which can exercise some discretion in how it goes about checking what the person wants to happen. I can flesh that out further if you would like me to do so.

Mr DAMETTO: Doctor, with regard to some evidence we have been able to gather so far, that state government departments could perhaps be operating in silos rather than in conjunction with each other, how would the appointment of a commissioner perhaps bring departments together to work to solve this, from a more holistic point of view?

Dr Chesterman: That is a terrific question. It would be one of the central tasks of the new agency to establish those relationships. The idea would be for us to have less use of adult guardianship. There would be a range of ways in which you can do that. The commissioner's role and the role of the office would be to work with those agencies not only at the state level—for instance, Health would be a key relationship—but also at the federal level—obviously Aged Care would be important too—and work with the relevant complaints commissioners and so on. That is the key role of the commissioner. It is not something you necessarily legislate, but in their operations they would have to work very closely with other agencies. They would have the key role.

This is one of the problems at the moment: there is no agency that has the key role. If a guardian is appointed—and often the Public Guardian will be appointed—then that guardian has responsibilities to make the personal decisions to which QCAT has specified in their relevant order, but that is in that situation. Outside of that, it is not clear who has the lead role. The Adult Safeguarding Commissioner under my proposal would have the lead role. It would fall on them. They would need to work collaboratively with other agencies but they would have the responsibility.

Ms DOOLEY: Dr Chesterman, I want to acknowledge the remarkable work that you have done over a lifetime. I really appreciate your contribution today. I think it is very clear. It has obviously come from a lot of research and experience with your Churchill Fellowship, so thank you.

My question is around the commissioner role, if that were to be appointed, and community education, particularly for health professionals and police. From my experience as a registered nurse, over many years there have been different organisations that are tasked with creating educational modules. For nurses it is compulsory. Interestingly, I am from the Moreton police district. The police are now having to respond to elder abuse, but there is no compulsory education for police. I appreciate that their role is very complex, but they identified that as a gap. We are trying to put together modules. Do you think this commissioner role could have an educational component it to as well?

Dr Chesterman: I do. Thank you for your praise of our office. I do want to recognise my colleagues who are here—Jacinta and Tracey. I could not do the work I do without them. I want to thank them for their work.

The commissioner would have that role. The proposed commissioner would need to work closely with Queensland police and ambulance in particular, too. I know that in the round tables we held in the lead-up to the production of our report one of the comments was that emergency services are called to situations where they are unable to do much.

One instance that energised me and stayed with me was when an ambulance officer at one of the round tables said that she had recently been contacted by a person in the community who said, 'Someone is not well on one of the main streets.' The ambulance officer said to the person, 'Have

you asked how they are?' The person said, 'No. I just called emergency services.' The ambulance officer said, 'What am I supposed to do?' There was no obvious health emergency that required the person to be taken by ambulance.

Who has a role there? That is where I would say that the place to contact in that situation would be the Adult Safeguarding Commissioner, who may well come across a situation where a health response is required, in which case they need to work closely with the health service. They may uncover evidence of criminality, in which case linking with Queensland police will be important. They will have that education role, too, about what members of the public should do. This is particularly energising for me. The best safeguard we can have is members of the community looking out for each other. How can we tell people what they might do in situations where they have a concern? The Adult Safeguarding Commissioner will be the place to contact. Equally, they will be the place to be educating people and our professional services about what their role is and what to do in situations of concern.

Mr RUSSO: Dr Chesterman, you offered to flesh out the role of the Adult Safeguarding Commissioner. Are you able to do that now for us?

Dr Chesterman: Certainly. What sort of detail would you like? I could give you some ideas about size.

Mr RUSSO: Yes.

Dr Chesterman: We have put together a rough calculation. The comparators here are the New South Wales Ageing and Disability Commissioner, which has, I think, in excess of 30 staff. The South Australian Adult Safeguarding Unit has a bit more than 20. Were a decision made to move down this track, there is some modelling that could be done. Our initial thinking would be effective full-time staffing of about 29 people, with a possible budget of about $12 million. I am also suggesting that there would be a significant reduction in our adult guardianship expenditure. That is one of the areas where there would be savings in this proposed model, because there would be changes to the responsibilities of some of our adult guardianship agencies.

I have spoken a lot with the inaugural New South Wales Ageing and Disability Commissioner, who is now our Age Discrimination Commissioner, Robert Fitzgerald. One of the key roles played by the Ageing and Disability Commissioner's staff where they get a call is to maintain contact with a person for up to months at a time where they check in. We are not talking about situations of obvious criminality, but they will check in with a person and ask, 'How are things going? Have you linked in with services?' They may have had conversations with the adult child who is problematic in that scenario, but they will maintain contact sometimes over a period of months to see what is happening. They will also investigate where there is sufficient concern to justify that, but the model will be very much on having a significant cohort of staff involved in reaching out and maintaining contact with affected people.

You also need to have that investigative role and investigative arm for situations of concern or in particular where the person is unable to be contacted. That is a very significant concern when someone in the community, for instance, has raised a concern about someone they have not seen much of lately and they have become very withdrawn. There is a need for the agency to get to talk to that person which may result in an investigation. There are a range of possible tasks that the staff would employ, but those I have described would be the main ones.

Ms DOOLEY: Something that came up in my clinical practice prior to being elected is around complaints with the NDIS around sexual misconduct of either carers or family. I appreciate we are talking about elder abuse. In a previous presentation we heard that in the Indigenous community it is at the age of 50 that our First Nations and Torres Strait Islanders are identified as aging. My concern is around the slowness of, say, the NDIS Quality and Safeguards Commissioner in responding. I have heard complaint after complaint. They report concerns of physical and sexual abuse but it is not followed up in a timely manner. I really like the idea of the New South Wales Ageing and Disability Commissioner. Do you think that is a model we could implement here? Would they have powers to investigate in a timely manner?

Dr Chesterman: Yes. I will seek leave to table two documents. We have an infographic which paints the picture. The challenge we have is with our federal agencies. There have been many concerns with the NDIS Quality and Safeguards Commission, which I recognise is under new leadership now. I have had concerns about the role of the NDIS Quality and Safeguards Commission. I have also had concerns about the Aged Care Quality and Safety Commission. Their legislative role is in relation to services provided—NDIS services, aged-care services.

Indeed, the Aged Care Quality and Safety Commission, to use an example, has a serious incident response scheme and has a guide that says, 'Are funded providers required to report', for instance, elder abuse that they see but which is not directly connected with the service? They do not have a responsibility to report that to the federal commission. The commission says they may have responsibility to report it at state or territory level but not to the commission. The commission's role is only in relation to funded services. That is a real shortfall, in my opinion. It means that you have people at risk.

Yes, there is a place for complaints authorities. We need to have those complaints authorities, but they cover services that tend to be provided or not provided. They do not look at the gamut of a person's life. We need someone who has that whole perspective. For instance, if we had an adult safeguarding commissioner they would go and see whether, yes, there is a problem within an Indigenous community or an NDIS funded service or an aged-care service. They may well make a referral to one of those federal commissions but they have responsibility for ensuring the welfare of the individual. That is the prime reason for this.

Ms DOOLEY: Thank you for clarifying that. That is excellent.

Ms BOURNE: Dr Chesterman, do you have an opinion on whether elder abuse should be made a criminal offence in Queensland?

Dr Chesterman: That is an important question. I am very glad you have raised it. I have wrestled with this over years. I wrestled with it when I was on the advisory committee for the Australian Law Reform Commission, which ended up recommending there not be a new crime of elder abuse. In my adult safeguarding report I recommended there not be a new crime. Having said that, overall, on balance, I think, no, there should not be a new crime, for reasons I can specify. It is not a strong view because I can see there would be a community education aspect to creating a new crime.

The reason I still fall on the side of saying `probably not' is that I struggle to think of a scenario which we would criminalise that is not already a crime. There is one jurisdiction in Australia—the ACT—which legislated to create a new crime in 2020. I checked on Wednesday, so as at two days ago there have been no prosecutions under that law. There was one begun but one of the parties died, but there have been no prosecutions under that new law. I struggle to think of a scenario which we would criminalise that is not already a crime. We have theft. We have dishonestly inducing a person to make or revoke a power of attorney. We have failure to provide necessities of life already in our Criminal Code.

CHAIR: Before I take a final question, I will give you the opportunity to seek leave to table the documents you are seeking to provide. Would you like leave to table some documents?

Dr Chesterman: Thank you, Chair, for prompting me on that. I appreciate that.

CHAIR: Is the committee happy to receive the documents? There being no objection, they are so tabled.

Mr DAMETTO: On the back of the question from the member for Ipswich West, although you have not previously supported a new criminal offence, would you consider backing the idea of adding an aggravation component to offences that already exist, similar to what happens with someone over 65 who is being physically abused or assaulted?

Dr Chesterman: Yes, that is an interesting question. I might take that on notice, if I may, and take it back to the office and have a think about how our existing aggravated offences might play out or might be insufficient in the elder abuse space. I might take that on notice, if I may.

Mr DAMETTO: Yes—for example, theft or extortion.

Dr Chesterman: Yes, where we are particularly focusing on the vulnerability of the victim. Thank you for that.

Mr DAMETTO: Thank you for taking that on notice.

CHAIR: Thank you very much to the representatives from the Office of the Public Advocate for coming and speaking to the committee today and being so willing to take on board our questions. Recognising that there is a question on notice, your response will be required by close of business on Thursday, 27 February, if we can have that noted, so we can include that in the deliberations from our committee hearing today. Thank you for your time.

Dr Chesterman: Thank you to the committee for having us.

BEASLEY, Ms Prue, Director, Office of the Health Ombudsman

COULSON BARR, Dr Lynne, OAM, Health Ombudsman

CHAIR: I now welcome representatives from the Office of the Health Ombudsman. I invite to you make an opening statement, after which the committee may wish to ask you some questions. Thank you for your time today.

Dr Coulson Barr: I would also like to start by acknowledging the traditional custodians and first peoples of the lands on which we meet today, the Turrbal and Yagara people, and also pay my deep respects to all elders past, present and emerging. Thank you for the opportunity to provide some insights from the work of the Office of the Health Ombudsman. We refer to ourselves as the OHO, so I will do that throughout the hearing.

This is a really important inquiry into elder abuse in Queensland. I will speak briefly about some aspects of the OHO's work and experience that I think are relevant to the committee's areas of focus. I have grouped it into the areas of the nature and extent of elder abuse that we see through our health service complaints, our window into looking at how effective the systems are that support older Queenslanders and then some opportunities to improve responses. I might leave those thoughts to your questions.

In terms of the nature and extent of elder abuse, the OHO was established with the key objective of protecting public health and safety. As a single point of entry for all health service complaints in Queensland, we can provide insights into the nature and extent of abuse of older persons that are identified in complaints in a health service setting or in a notification about a health service practitioner or a health practitioner. In terms of the five recognised forms of elder abuse—namely, physical, sexual, psychological/emotional, financial and neglect—we receive complaints that cover the whole spectrum of what would be classed as elder abuse in the context of a provision of a health service. For the committee's information, we deal with complaints about public and private health services, and registered and unregistered health practitioners. That includes staff who are providing a support service to a health service. That gives us a very broad jurisdiction and it can include security staff, patient support staff, food staff et cetera.

We also receive information from the Queensland Police Service, which I will refer to as the QPS, about matters where a health practitioner has been charged or convicted of a criminal offence in certain circumstances. These are offences that can occur either in or outside practice. They could fall within the definition of elder abuse. Examples can be family violence offences, alleged assaults, threats, theft or fraud offences. This is an arrangement that is unique in Queensland. It is possible through an agreement that both the OHO and Ahpra, the Australian Health Practitioner Regulation Agency, have with the QPS. It is a real strength of our model. We can take protective actions, such as immediate registration action, or issue what is called an interim prohibition order, where we assess that a practitioner poses a serious risk to persons or that it is otherwise in the public interest to maintain the public confidence and trust in health services. We can also investigate these matters to determine whether there are grounds for disciplinary action in the case of registered practitioners, and with unregistered practitioners we can investigate and consider whether a prohibition order is warranted.

In terms of the complaints about health services that concern alleged incidents that involve older consumers, we assess the nature of the issues raised. We have a range of options about how we deal with those matters, including resolution, referral and investigation. We also have an MOU with the Aged Care Quality and Safety Commission that facilitates information sharing and referrals. That is where a practitioner or a service may be an aged-care provider as well as providing a health service.

For this hearing we undertook an analysis of our data to cover a four-year period, from 2020 to 2024. We identified matters involving at least one consumer who was 65 years or older. I note the member for Redcliffe's comments about Aboriginal and Torres Strait Islander communities, and we are conscious that we may not have captured all persons who would be identified as an older person. Our data may not be fully representative so I have provided the indicative data for the committee's consideration.

We found that the proportion of matters that involved what we will call an older consumer were fairly consistent over those four years, at about 13 per cent of all of our complaints. The proportion of older persons in the Queensland population is 17 per cent, so it is a bit less than proportional. We are also mindful that the proportion of older persons accessing health services is actually much

higher—in acute care it could be as high as 50 per cent. We are conscious that the insights we are capturing through those complaints may not capture the full range of people's experiences in accessing health services and where issues of elder abuse might be identified.

One of the OHO's strategic objectives is to increase accessibility and awareness of complaints processes for people who might experience barriers in making complaints. I am aware that the committee have heard about some of those barriers for older people. We have a number of strategies in place including producing Easy Read materials and outreach activities to promote awareness of our services. We are also committed to providing person centred, trauma informed and culturally safe approaches to make it easier for people who might find it difficult to raise their concerns. We are very conscious that that can be the case for older persons, who might find it difficult to complain or access information about how to complain. It emphasises the importance of anyone being able to make a complaint and to raise an issue on someone's behalf and also the importance of supports being available within a service so it is easier for people to raise concerns or to identify concerns when they happen.

One of the challenges we have had in analysing our data, which I think has been raised already with the committee by other organisations, is that we do not explicitly record elder abuse as a category in complaints. I think you have probably heard that again and again. I think it is a real challenge in getting a true picture of the nature and extent of elder abuse, because it is not a common reporting requirement. When we are dealing with an individual matter, though, we may name an issue as elder abuse in terms of our reasons for, for instance, taking immediate action; however, when we record those matters in our complaint management system we are all bound by issue categories. We talk about the nature of the conduct, not that it is a higher level elder abuse. However, we were able to map all our issue categories, such as alleged assaults, rough and painful treatment, financial exploitation—we have a whole list—and map those that would fall within a definition of elder abuse, so we have been able to get some data for you. I have a qualification that it is indicative data because of those challenges in terms of getting an accurate picture.

What we have found is that, over that four-year period, when we have identified those matters that involve at least one consumer 65 years and older—and, again, that may not capture all people who would identify as older persons—where a concern has been raised about some form of potential elder abuse, the average is 23 per cent of all the matters that involve an older person involve a potential situation of elder abuse, and that represents three per cent of all of our complaints. We do not deal directly with all matters because we have a range of ways in which we deal with matters, such as referrals, so we cannot say how many of those were substantiated, but it is obviously really concerning. About a quarter of health service complaints involving an older consumer raised some form of concern around their treatment that could fall within the category of potential elder abuse. I think it points to the need to better understand the appearance of older persons in health services and settings where they receive health services, so that can include disability services and aged-care settings.

While that proportion is really concerning, it could also be seen as a positive indication that services and complainants are actually raising those issues. Where they have concerns about the potential mistreatment or abuse of an older person, they are raising them with an external agency like us. That includes services that are correctly making either a mandatory or a voluntary notification to us under the Health Practitioner Regulation National Law. That can be about conduct of their own staff. That is a safeguard that services are rightly recognising where conduct may fall within the category of a mandatory or voluntary notification where there is a concern around the treatment of an older person. I think that is a positive situation in our current safeguards.

I want to make an additional note on the figures. We do not always receive and record the age details of victims in criminal matters that we get notified about by the police and that occur outside practice because they are focusing on the practitioner's conduct, so the proportion of total matters could be higher. We have a gap in our data on that. We will be providing a detailed submission so we will be unpacking that data in more detail. I just wanted to give you that overarching picture. Do you want me to speak a bit about the effectiveness of the current systems or would you like to me to pause?

CHAIR: Take a moment to share your thoughts on that.

Dr Coulson Barr: We have given some thought to the effectiveness of the current systems to safeguard and support older Queenslanders. I think it is important to recognise the role of effective complaints processes, as I have indicated, in identifying issues of concern and enabling early action

and intervention. For the OHO's process, I think it is important to note that anyone can make a complaint and that concerns can be raised anonymously or on a confidential basis. That is an important mechanism where concerns can be raised to an external agency. Having that single point of entry for all health service complaints is a strength, because people do not need to think about where to take an issue. They know that if it has something to do with health then they raise it to our agency.

Another strength of the model in Queensland is our ability to take protective action, such as suspension or restrictions on practice, where a health practitioner is charged or convicted of an offence, which can include offences that would fall within the category of elder abuse. Across the nation, there is also a heightened focus on the vital roles that health practitioners play in early detection, recognising and responding to family violence, and that can include forms of elder abuse, and also the importance of the public having trust and confidence in health practitioners. When a health practitioner is charged with a serious offence, particularly one involving elder abuse, it is important that action is taken to maintain that public confidence and trust.

Lastly, I note that last November the OHO published a position statement on family violence that outlines the role that health practitioners play in relation to family violence. We heard earlier about how elder abuse can fall within the broader definition of family and domestic violence. That position statement outlines how we work with the QPS, the consequences for health practitioners when they engage in family violence and also support services for victim-survivors of family violence. That includes the elder abuse helpline that is in our position statement. This statement supports a joint position statement on family violence by regulators of health practitioners that was published by the OHO, Ahpra and the national boards and the regulators in New South Wales, that is, the Health Professional Councils Authority and the New South Wales Health Care Complaints Commission. That was an outcome of co-regulatory work that we started in late 2023. This work is all part of the OHO's broader objectives to promote professional and safe practice by practitioners and ensure high standards of health service delivery. We do this through performing our complaints and regulatory functions as well as our education engagement activities. I will stop there, Chair, and I welcome any questions.

CHAIR: We do look forward to the opportunity of seeing your written statement. Briefly speaking with the committee secretary, that data piece will be really important to us. We recognise that with each of the agencies we have engaged with there has been myriad data. While we recognise there is no one point of truth, we are looking to get some synergies from across that data to help inform us. I appreciate you undertaking that piece of work.

Ms BOURNE: Thanks so much, Dr Coulson Barr. I hope this is a question that is relevant to the work that do you. This morning we heard a good question from the member for Hinchinbrook about government agencies working in silos. We have also had a presentation on the 16 HHSs and the way they manage elder abuse in each of those HHSs. I think there are four that are doing it very well. I was interested in what you were talking about around reporting. Each of those HHSs are community led so they all manage it a little differently. Can you comment on your capacity for current government resourcing to meet your office's needs to managing all of that reporting?

Dr Coulson Barr: I might firstly talk about how we engage with HHSs in terms of our reporting, just to give a context in terms of the work we do as part of the discharge of our functions. We engage with each HHS directly in terms of the nature of the matters that they report to us and look for any similarities or differences in their reporting. We have also offered to some hospital and health services—well, we have offered it across the board—to share our data in terms of the nature of matters that are being made directly or reported to the OHO and how that compares to their own complaint and notification data to see if there are any similarities and differences and if there are any gaps in areas where perhaps they are not identifying the issues that are coming directly to us. That is a way of driving improvements or gaps in reporting.

We also alert HHSs, depending on their size and the amount of engagement we have with them, reminding them about the breadth of our jurisdiction. For instance, they can notify concerns around support staff—like actions of security staff, patient support staff, wards people et cetera—because they are within our jurisdiction as they come within the definition of unregistered practitioners. Some of those staff may be contract staff so not employed by the HHS, but it is important that those HHSs know that they can report that conduct to us because we can take action about the ability of that practitioner to work in other similar settings and assess whether that practitioner creates a risk. That is what we do as part of our engagement with HHSs to maximise the use of reporting to make sure the issues that need to come to us are brought to our attention by the HHSs.

In relation to resourcing, we have had budget submissions in terms of our growing numbers of complaints and the complexity and seriousness of matters. We are not alone in that scenario so we are engaging in discussions of what we need going forward, given the nature of the issues that we deal with.

Miss DOOLAN: Thank you for the important work that you do. GPs are often the first point of contact for matters of personal health. What responsibilities or requirements apply to GPs in reporting suspected abuse of their senior patients?

Dr Coulson Barr: There is not a mandatory reporting for GPs. In terms of the Medical Board's code of conduct for medical practitioners, there is an obligation on medical practitioners to look at the needs and rights of their patients and to take appropriate action. It is not a mandatory obligation, like child protection reporting. We would be looking at the obligations of a practitioner if a matter came to us in terms of whether they had appropriately responded to the person's needs.

Mr DAMETTO: Thank you for giving evidence this morning and for being very well informed on the topic of elder abuse. My question is with regard to any complaints you get directly and some commentary around withholding medication and withholding treatment and care.

Dr Coulson Barr: Are you talking about within a health setting?

Mr DAMETTO: That is correct, yes.

Dr Coulson Barr: In terms of the types of complaints that we receive, I could not tell you about the extent. Medication issues are quite a feature of complaints that are made to the OHO. In terms of withholding treatments, Prue is looking to see if we have any data on that. Could I take that question on notice? It is quite granular detail in terms of where we would find that data.

Mr DAMETTO: Thank you.

Ms DOOLEY: I appreciate your work and your presentation this morning. You were here and heard Dr Chesterman's presentation and evidence. Would the OHO support an aging and disability commissioner or an adult safeguarding unit as proposed by Dr Chesterman and the Queensland Public Advocate?

Dr Coulson Barr: When I was listening to Dr Chesterman's presentation I was thinking how the proposal of an adult safeguarding commissioner or that model would address one of the areas that I have identified as an area of potential improvement. Could I speak to that specifically in terms of our perspective?

Ms DOOLEY: Certainly, yes.

Dr Coulson Barr: One of the areas we have identified is the need to consider what communication supports and assessments might be needed to investigate potential or alleged cases of abuse of older people, particularly those who have limited communication and capacity or cognitive impairments. It is a common issue that we deal with when we are having reported issues. The common statement is that the person does not have capacity and is therefore not interviewed. There is a real gap there in terms of investigative processes within services and also, I have to say, with our office in terms of how to ensure we are giving the maximum opportunity for the person who has been impacted to provide their account, because people have some communication. There are behavioural indicators. How do we give the specialist resources that we need to make sure we are understanding as much as possible what may have occurred in a scenario?

I have suggested it would be helpful to have something like a specialist advice service about the types of ways you can provide communication support so someone can be supported to give their account. How do you actually use communication partners—people who know that person really well—to provide evidence of indicators that might indicate that abuse or assault has occurred? How do you make those assessments? That kind of service would fit really well within a broader adult safeguarding commission, because it would provide that specialist support that is needed by offices like ours. It would also assist services when they are faced with a scenario where they have had a report of a potential abuse or assault and they feel they cannot get the evidence directly from the person.

Ms DOOLEY: Thank you. That is very helpful.

Mr RUSSO: Does your office handle complaints in relation to aged-care facilities? I am conscious that there is probably a framework under federal legislation. I just wanted to put that caveat on it because it may not fall within your remit.

Dr Coulson Barr: We have an overlapping jurisdiction in terms of aged-care settings because health services can be provided within aged-care settings and we have jurisdiction to deal with complaints about the provision of health services. We have a very detailed memorandum of understanding about how we can share information with the Aged Care Quality and Safety Commission and make referrals where appropriate. We can both respectively take regulatory action, because the Aged Care Quality and Safety Commission has a different remit to us because we deal with the provision of health services and health practitioners, who can move between settings. Prue is responsible for the memorandum of understanding and working relationship with aged care. Prue, is there anything you can comment there?

Ms Beasley: No, other than to say that we are very proactive in our engagement with the Aged Care Quality and Safety Commission. They have similar responsibilities to us in terms of protecting public health and safety. If the Health Ombudsman takes any action, we are able to inform the Aged Care Quality and Safety Commission so they can make an assessment of what regulatory action they may need to take as well.

CHAIR: Thank you. I have a final question with regard to the capacity to collect data. In other contexts we have the national disability data collection survey that is undertaken in schools each year. I recognise in this field that each party that has come before us—both agencies as well as non-government agencies—uses very different data points to inform, based solely on their own understanding. Do you believe there would be any benefit in a statewide data collection survey at some point to try to collate this data on a regular basis, as opposed to the amalgamation of data, when it comes to things such as an inquiry?

Dr Coulson Barr: I would very much support that. I think what you have found with all of us who have come to provide evidence to the committee is the challenge of mining our own data and not having an agreed definition or dataset. To get a picture of what is the true nature and extent of this issue, the first thing is to have those agreed data definitions and to bring our data together. We have found it very instructive ourselves to undertake this exercise for the committee. If that were a requirement, I think it would bring together the combined efforts of agencies to look at what picture we are all seeing.

CHAIR: Thank you for the work of your agency in our community. There was a question taken on notice and I ask that the answer be provided by close of business on Thursday, 27 February so we can include that information in our deliberations. That concludes this hearing. I thank everyone who has participated today. I thank our Hansard reporters as well as our committee secretariat. The transcript of these proceedings will be available on the committee's webpage in due course. I now declare this public hearing closed.

The committee adjourned at 11.40 am.