Inquiry into Elder Abuse in Queensland

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Submission to the Education, Arts and Communities Committee

Inquiry into elder abuse in Queensland—April 2025

OFFICE OF THE HEALTH OMBUDSMAN

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Introduction

The Office of the Health Ombudsman (OHO) welcomes this opportunity to provide a submission on enhancing response to elder abuse in Queensland. As Queensland's independent health service complaints body, the OHO is committed to ensuring the safety and well-being of older persons, particularly those receiving health care and aged care services. Queensland's ageing population underscores the urgency of strengthening existing safeguards and response mechanisms.

1. Background

On 28 February 2025, representatives from the OHO attended the public briefing for the Education, Arts and Communities Committee (Committee) parliamentary inquiry into elder abuse in Queensland (Inquiry).

Following this briefing the OHO provided the Committee with written responses in relation to withholding medication, treatment or care for older consumers in a health care setting, following a question on notice from the Committee.

The term 'elder abuse' is used to refer to the abuse or mistreatment of older people. The OHO acknowledges that in First Nations communities, the term 'Elder' is a term of respect used for community leaders, and the term 'abuse or mistreatment of older people' can also be used to describe this form of abuse. In this written briefing, the term 'elder abuse' is used to be consistent with the language used by the Inquiry.

For the purposes of the data discussed in this submission, an older Queenslander is defined as:

- a consumer and/or complainant who is 65 years of age and older
- an Aboriginal and Torres Strait Islander complainant and/or consumer who is 50 years of age and over.

1.1 Jurisdiction of the OHO

The OHO began dealing with health service complaints on 1 July 2014. Under the *Health Ombudsman Act 2013* (the Act) and the *Health Practitioner Regulation National Law (Queensland)* (the National Law), the OHO has broad powers to deal with complaints and other matters relating to the health, conduct and performance of registered and unregistered health practitioners and the services provided by health service organisations. In handling complaints about registered practitioners in Queensland, the OHO shares regulatory responsibility with the Australian Health Practitioner Regulation Agency (Ahpra) and the 15 National Boards under the National Law. The OHO applies the National Code of Conduct for Health Care Workers (Queensland) when managing complaints about unregistered practitioners in Queensland.

Health service complaints and notifications are considered against the Australian Charter of Healthcare Rights. The Charter describes the basic rights that health service consumers can expect when receiving health care, including:

- access
- safety
- respect
- partnership
- information

- privacy
- give feedback.

These rights apply to all people in all places where health care is provided in Australia.

1.2 Working with Ahpra

Ahpra works with the 15 National Boards to help protect the public by regulating Australia's registered health practitioners. Ahpra supports the 15 National Boards in managing the registration and accreditation of registered health practitioners in Australia.

Under Queensland's coregulatory system, the OHO and Ahpra share certain responsibilities related to overseeing and regulating registered health practitioners. The OHO manages a single-entry point for all health service complaints in Queensland, including notifications and information regarding registered health practitioners and students. Complaints and notifications concerning registered health practitioners and students are jointly considered with Ahpra in accordance with Division 2A and 2B of the Act. The OHO also collaborates with Ahpra on approaches to deal with the range of issues identified in complaints and notifications about registered health practitioners.

The OHO retains the most serious matters relating to registered practitioners. A serious matter is described in section 91C of the Act as indicating either or both of the following:

- the practitioner may have behaved in a way that constitutes professional misconduct
- another ground may exist for the suspension or cancellation of the registered health practitioner's registration.

1.3 Sources of complaints

Complaints play a vital role in Queensland's health system. They provide insight into an individual's experience with a health service, and they promote professional, safe and competent practice to maintain a high standard of health service delivery.

Anyone can make a complaint to the OHO if they are not satisfied about a health service received or believe that a practitioner is a risk to public health and safety. Most health service complaints made to the OHO are by members of the public, including prisoner consumers who access the OHO through a dedicated prisoner complaints phone line. Other sources of complaints include registered health practitioners, employers of registered practitioners, health education providers and other organisations.

The OHO's 2023-2027 Strategic Plan outlines our commitment to optimising experiences and outcomes through delivering person-centred, trauma-informed, and culturally safe health service complaints management. The OHO delivers trauma-informed services through:

- continuous staff development and education to identify, understand and manage trauma
- ensuring internal processes minimise risk, remain flexible, and can be tailored to the needs of the OHO's service users
- mitigating the risk and impact of trauma to staff by providing sufficient support tools.

The OHO recognises, respects and values the cultures of Aboriginal peoples and Torres Strait Islander peoples and provides a culturally safe and sensitive complaints management service through a dedicated complaints advisor.

The OHO is committed to accessibility and promoting awareness. Ensuring complaint resources are accessible for older people is essential, and the OHO provides multiple channels for

complaints, including phone support (for those with limited digital literacy), online complaint form, web chat and email.

In late 2024, the OHO launched a refreshed website to improve service accessibility and navigation, as well as updated content. The OHO also recently worked with Health Consumers Queensland to develop Easy Read resources for culturally and linguistically diverse people including 'How to make a complaint' and 'Let's have a yarn' for Aboriginal peoples and Torres Strait Islander peoples.

1.4 Reporting framework

1.4.1 Registered health practitioners

Registered health practitioners are those regulated under the National Law and must be registered with Ahpra and their respective National Boards.

Reporting arrangements for registered practitioners include:

- Mandatory notifications—registered practitioners, employers and education providers have a legal obligation to report certain types of misconduct to the OHO if they believe the practitioner has:
  - practiced while intoxicated by drugs or alcohol
  - engaged in sexual misconduct in connection with their practice
  - placed the public at substantial risk due to an impairment
  - made a significant departure from accepted professional standards.

  A registered health practitioner may also be required to make a mandatory notification about a student undertaking a program of study or clinical training that falls within the jurisdiction of the National Law if they become aware that the student has an impairment that, while undertaking clinical training, may place the public at substantial risk of harm.
- Voluntary notifications—anyone (including patients, colleagues, or the public) can report concerns about a registered practitioner to the OHO if they believe the practitioner's conduct is unsatisfactory or places the public at risk.

  A voluntary notification may also be made about a student undertaking a program of study or clinical training that falls within the jurisdiction of the National Law if:
  - the student has been charged with an offence, or convicted or found guilty of an offence, that is punishable by 12 months imprisonment or more
  - the student has, or may have, an impairment
  - the student has contravened a condition of their student registration, or an undertaking given to the National Board.

In Queensland, complaints about registered practitioners are jointly considered with Ahpra. Under joint consideration, data is shared by the OHO and Ahpra in real-time resulting in the timely progression of matters between both agencies, early clinical screening, and robust regulatory decision making. Matters can be:

- retained by the Health Ombudsman (for assessment, local resolution, investigation, or referral to a government entity)
- referred to Ahpra
- agreed to have no further action taken.

1.4.2 Unregistered health practitioners

Unregistered health practitioners are not required to be registered with Ahpra but still provide health services, such as aged care workers, personal carers, and nursing assistants. Unregistered health practitioners are subject to the Act and often care for older Queenslanders in a variety of settings including home care, aged care facilities, hospitals, private health care, and disability support services.

Unregistered practitioners can be reported to the OHO for consideration about whether there have been any breaches of the National Code of Conduct for Health Care Workers (Queensland) (Code of conduct for HCW). While there is no mandatory reporting framework, there is a requirement under Clause 4 of the Code of conduct for HCW to report concerns about the conduct of other health care workers that have placed or are placing clients at serious risk of harm. Complaints about unregistered practitioners are not jointly considered with Ahpra.

2. Nature and extent of elder abuse in Queensland

2.1 Defining elder abuse

Elder abuse is a serious and growing issue affecting thousands of Queenslanders each year. According to the World Health Organisation:

> *Elder abuse can be defined as 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 can take various forms such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or unintentional neglect.*

It can be perpetrated by family members, carers and even healthcare providers. While elder abuse occurs across all demographics, older persons with cognitive impairment, mental health concerns, disability, or social isolation are at heightened risk.

The true scale of the problem remains difficult to measure due to underreporting, data capture, stigma and barriers to disclosure. Recognising and taking appropriate action when confronted with actual or suspected elder abuse is everyone's responsibility.

In the context of provision of health services to older consumers, the OHO can receive complaints and notifications about the following types of conduct that may constitute elder abuse by health service providers (this list is not exhaustive):

- unreasonable use of force, for example hitting, pushing, shoving, or rough handling
- unlawful sexual contact or inappropriate sexual conduct, such as sexual threats or stalking, or sexual activities without consent
- psychological or emotional abuse such as yelling, name calling, ignoring a patient, threatening gestures, or refusing a patient access to care or services as a means of punishment
- stealing or financial coercion by a health service provider, for example if a health practitioner coerces a patient to change their will to their advantage or steals valuables from the patient
- neglect that includes withholding personal care, withholding treatment, withholding medication, untreated wounds, or insufficient assistance during meals

- inappropriate physical or chemical restraint, for example:
  - where physical or chemical restraint is used without prior consent or without notifying the patient's representative
  - where physical restraint is used in a non-emergency situation
  - when a health practitioner issues a drug to a patient to influence their behaviour as a form of chemical restraint.

2.2 OHO data and observations

The OHO's data doesn't explicitly record incidents of elder abuse in complaints and other matters. This presents a real challenge in obtaining an accurate analysis of the nature and extent of elder abuse, as a common reporting requirement to capture these issues does not exist.

When we are dealing with an individual matter—for instance an alleged assault or abusive conduct towards an older person—we may refer to it constituting elder abuse in our reasoning to take immediate action for example, however the issue recorded in our case management system would relate to the specific nature of the conduct.

Due to this, for the purposes of this submission we have mapped our issue categories to include cases relating to 'alleged assaults', 'rough and painful treatment', 'financial exploitation' etc. in order to identify the number of matters that may fall within the definition of elder abuse.

Appendix A contains the OHO case management system 'issue categories' mapped to an elder abuse category as potential indicators of elder abuse. Please note that the 'issue category' reflects the conduct/performance identified in the complaint about a health service provider, not the type of abuse suffered by the consumer/victim. To provide a more detailed analysis would be a resource intensive and time-consuming task involving review of each individual complaint. This process has not been undertaken for the purpose of this submission.

The 2021 Census Data reports that the proportion of Queenslanders aged 65 years and older is 17 per cent.[1]

Table 1 All health service complaints (HSC) and own-motion investigations (OMI) where at least one consumer was 65 or older or 50 or older for Aboriginal and Torres Strait Islander by financial year

Financial year	Count	As a proportion of total HSC and OMI	Compared to Australian Bureau of Statistics (ABS) baseline*
2019-2020	1485	15.1%	-3.0%
2020-2021	1422	14.7%	-3.2%
2021-2022	1359	13.7%	-4.1%
2022-2023	1233	13.8%	-4.4%
2023-2024	1384	14.5%	-3.3%
Grand total	**6883**	**14.4%**	**-3.6%**

*Note due to limited data, the comparison to ABS baseline could only be done in the context of people aged 65 years and over. This does not include all persons classified as an older person in the OHO data.

[1] 2021 Queensland, Census All persons QuickStats | Australian Bureau of Statistics

As shown in Table 1, the proportion of OHO data featuring an older person is consistently below the baseline proportion of the 2021 census.

Of this data, the following table shows matters that may have involved some form of elder abuse, using the mapped issue categories.

Table 2 HSC and OMI where at least one consumer was 65 or older or 50 or older for Aboriginal and Torries Strait Islander by financial year with issue categories mapped to elder abuse

Financial year	Count	As a proportion of total HSC and OMI	Compared to ABS baseline*[2]
2019-2020	546	36.8%	5.6%
2020-2021	504	35.4%	5.2%
2021-2022	532	39.1%	5.4%
2022-2023	453	36.7%	5.1%
2023-2024	506	36.6%	5.3%
Grand total	**2541**	**36.9%**	**5.3%**

*Note due to limited data, the comparison to ABS baseline could only be done in the context of people aged 65 years and over. This does not include all persons classified as an older person in the OHO data.

Table 3 HSC and OMI where at least one consumer was 65 or older or 50 or older for Aboriginal and Torries Strait Islander by financial year with breakdown of types of elder abuse mapped to issue categories

Form of abuse	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total
All forms of abuse	45	52	47	62	45	251
Emotional abuse	142	141	154	100	132	669
Financial abuse	40	33	38	27	25	163
Neglect	257	242	263	225	250	1237
Physical abuse	123	107	111	101	100	542
Sexual abuse	11	10	1	6	18	56
Grand total	**546**	**504**	**532**	**453**	**506**	**2541**

The issue categories mapped to neglect represent 48.68 per cent of total complaints about elder abuse, followed by emotional abuse and physical abuse.

Of these, the following table shows a breakdown of consumers indigenous status.

[2] 2021 Queensland, Census All persons QuickStats | Australian Bureau of Statistics

Table 4 HSC and OMI where at least one consumer was 65 or older or 50 or older for Aboriginal and Torries Strait Islander by financial year and indigenous status

Indigenous status	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total
Aboriginal	47	23	40	35	46	191
Both Aboriginal and Torres Strait Islander	6	7	3	2	5	23
Non-indigenous	229	134	129	116	160	768
Torres Strait Islander	1	1	2	3	2	9
Unknown*	267	340	359	299	295	1560
Grand total	**546**	**504**	**532**	**453**	**506**	**2541**

*Indigenous status is not a mandatory field on our complaint form or in the OHO case management system, complainants are not required to provide this information.

Health service providers are comprised of health service organisations (e.g. hospitals, residential aged care facilities, in-home health care providers, medical practices and other service providers such as rehabilitation facilities) and health service practitioners that are either registered practitioners (e.g. general practitioners, registered or enrolled nurses) or unregistered practitioners (e.g. assistants-in-nursing, personal carers). A single complaint may identify one or more health service providers.

Table 5 HSC and OMI where at least one consumer was 65 or older or 50 or older for Aboriginal and Torries Strait Islander by financial year with issue categories mapped to elder abuse and health service provider breakdown

Type	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total
Organisation	379	339	342	297	311	1668
Registered	171	161	208	156	200	896
Unknown	1	0	0	0	0	1
Unregistered	17	12	13	24	43	109
Grand total	**546**	**504**	**532**	**453**	**506**	**2541**

Note: Some matters may involve a combination of the above groups.

In terms of clinical setting, of significance during the sample period:

- approximately 55 per cent of complaints indicative of some form of elder abuse fell within the general medical setting, followed by nursing at 15.5 per cent.

Of the matters considered potentially indicative of elder abuse across the sample period where the OHO took further relevant action[3] to deal with the matter, on average (approximately):

[3] Section 38 of *Health Ombudsman Act 2013*.

- 40.22 per cent were closed with no further relevant action[4]
- 25.66 per cent were assessed
- 13.54 per cent were managed in local resolution
- 2.72 per cent were investigated
- 1.42 per cent resulted in immediate action
- 0.51 per cent progressed to Director of Proceedings (DoP)
- 2.05 per cent were conciliated
- 13.54 per cent were referred to another entity to manage.

It should be noted that a matter may move through multiple relevant actions before being finalised (i.e. a serious matter may be assessed and then investigated before progressing to DoP).

Section 92 of the Act enables the OHO to refer a matter to an appropriate state or Commonwealth entity to manage the complaint. Where it is an entity of the state, that entity must report back to the OHO on the outcome of the matter. Where it is an entity of the Commonwealth, the OHO will still seek to remain an 'interested party' and have in place information sharing agreements with some key agencies, such as the Aged Care Quality and Safety Commission (ACSQC).

A referral to another entity may occur at the intake and triage stage, where it is identified another agency is already actively managing a matter or is best placed to manage the new matter, or alternatively, may occur following an initial assessment or investigation of the matter.

Where a matter relates to the performance/conduct of a registered practitioner, a matter may be referred to Ahpra to manage as part of the OHO's co-regulatory relationship with Ahpra in Queensland.

Of the matters referred to another entity by the OHO for management in the sample period, on average (approximately):

- 15.4 per cent were referred to Ahpra
- 2.95 per cent were referred to the Aged Care Quality and Safety Commission
- The remaining percentage was referred to other entities, such as Queensland Hospital and Health Services, National Disability Scheme and Queensland Police Service.

These complaints and notifications can also be seen as a positive indication that services and complainants are recognising and reporting concerns about the potential mistreatment and abuse of older persons to the OHO, and this includes services who correctly make either mandatory or voluntary notifications to the OHO under the *Health Practitioner Regulation National Law (Queensland)* about the conduct of their own staff.

In matters received from the Queensland Police Service (QPS), the age or date of birth of the victim is not always provided or known to the OHO and in some cases is not recorded, therefore the portion of total matters could be potentially higher.

[4] These include matters that may have received initial advice and assistance, and matters which could not be progressed due to insufficient information.

3. Effectiveness of current systems that support older Queenslanders

It is important to recognise the role of effective complaints processes in identifying issues of concern and enabling early action and intervention to safeguard and support older Queenslanders.

Anyone can make a complaint to the OHO. Concerns can also be raised anonymously or on a confidential basis. Having a single point of entry for all health service complaints is also a significant strength of the model in Queensland.

Another strength is the OHO's ability to take protective action, such as a suspension or restrictions on practice when a health practitioner is charged or convicted of an offence, which can include offences relating to elder abuse. There is also a heightened focus across the nation on the vital role that health practitioners play in early detection, recognising and responding to family violence—which can include forms of elder abuse—and the importance of maintaining public trust and confidence in health practitioners.

It is in the public interest for the community to have confidence in the integrity and trustworthiness of health practitioners who have access to and are required to treat patients in highly vulnerable positions. The foundation of trust is imperative for the public to seek and receive safe and effective healthcare.

Currently, responses to elder abuse can involve multiple agencies. Section 30 of the Act states:

> *The health ombudsman must consult and cooperate with other public entities with functions that are relevant to, or may impact on, the health ombudsman functions.*

To that end the OHO has established relationships with key stakeholders in this area to address abuse of older Queenslanders.

3.1 Working with Queensland Police Service

In Queensland, the QPS notifies and provides certain information to the OHO when registered practitioners are charged/convicted of criminal offences in certain circumstances. This is done through an agreement between QPS, Ahpra and the OHO. The OHO may also be notified by the QPS when an unregistered practitioner is charged or convicted, and the conduct indicates that the unregistered practitioner may pose a serious risk.

Last year, the OHO partnered with QPS and Ahpra to develop the Self Service of Document Retrieval (SSoDR) to improve timeliness and efficiency of OHO accessing information on criminal charges and convictions of health practitioners. Further to this, the OHO has embedded a position within the QPS, known as the Health Ombudsman Liaison Officer (HOLO). The HOLO undertakes real-time monitoring for health service practitioners subject to investigation, charged or convicted with serious criminal offences. Where necessary the OHO's Immediate Action team can assess the risks and public interest considerations on these matters and enable the Health Ombudsman to make timely decisions about whether immediate action should be taken to protect public health and safety and maintain confidence in the health system.

Where complaints received by the OHO involve criminal behaviour—such as physical abuse, sexual assault or financial exploitation—the OHO can refer such matters to the QPS for criminal investigation. By sharing information with the QPS, the OHO can ensure that perpetrators—whether healthcare staff, caregivers or family members—are held accountable.

3.2 Working with Aged Care Quality and Safety Commission and National Disability Insurance Scheme

The OHO's Memorandum of Understanding (MOU) with the Aged Care Quality and Safety Commission (ACQSC) and National Disability Insurance Scheme (NDIS) has been in place since 2019.

Following the introduction of new powers in relation to aged care workers in September 2024, the OHO and ACQSC refreshed the existing MOU. The MOU sets out arrangements for the sharing of information and referral of information between the OHO and ACQSC. This assists the ACQSC as national regulator of aged care service providers, to ensure aged care providers are compliant with the *Aged Care Act 1997* and also for the OHO to take appropriate regulatory action to protect the health and safety of the public.

Where lawful and appropriate, the OHO pro-actively notifies ACQSC where immediate action is taken in relation to a person who is also an aged care provider. This assist ACQSC to consider whether any further regulatory action is appropriate to protect older Australians in the aged care sector.

The OHO and NDIS are currently reviewing existing MOU arrangements, and this work is on-going. The revised arrangements are similar to ACQSC.

These MOU arrangements are essential for protecting vulnerable individuals, as many people are at risk of harm due to disability, age or health conditions. Sharing information helps identify and prevent abuse, neglect and poor-quality care for older Queenslanders. It also assists in preventing systemic failures if complaints, investigations or regulatory actions are done in silos, as patterns of misconduct may go unnoticed.

Information sharing allows agencies to detect and address systemic issues early. The agreements can also assist with avoiding duplication of investigations, as agencies can share information/data, and streamline investigations and regulatory actions, reducing delays in addressing concerns.

Collaboration with these agencies ensures better protection oversight, and service quality for older Queenslanders relying on healthcare and aged care.

3.3 Position statement on family violence

In December 2023, a Co-regulatory Family Violence Working Group was formed between the OHO, Ahpra and the National Boards, the Health Professionals Councils Authority, Health Care Complaints Commission and New South Wales Councils.

The working group aims to achieve consistency in regulatory practice and outcomes in relation to notifications about registered practitioners that involve an allegation of family violence. The working group also explores opportunities to align regulatory approaches to alleged perpetrators and victims-survivors of family violence, with a focus on principles and position statements to inform these approaches.

Through this extensive collaboration, the working group developed an agreed position on family violence and a consistent regulatory approach in relation to registered health practitioners who engage in family violence. Family violence includes a family relationship meaning that elder abuse falls within the definition of domestic and family violence.

The working group also sought feedback from the National Lived Experience Advisory Council for family, domestic and sexual violence.

As a result of this work, the Joint position on family violence by regulators of health practitioners was published by all entities in late November 2024.

To support this joint statement, an OHO position statement on family violence in respect to health practitioners (both registered and unregistered) who provide health services in Queensland was also published. The OHO outlines the role health practitioners play in the relation to family violence, how the OHO contribute to the outcomes in the Domestic Violence and Prevention Strategy 2016-2026, how the OHO works with QPS and the consequences for health practitioners who engage in family violence.

The OHO and co-regulators also produced Easy Read versions of both position statements for accessibility, along with an extensive list of tailored support services, including the Queensland Elder Abuse Helpline.

This work forms part of the OHO's broader objectives to promote professional and safe practice by practitioners, ensuring high standards of health service delivery. The OHO achieves this through our complaints and regulatory functions, as well as education and engagement activities.

3.4 Human rights protections

The OHO is committed to respecting, protecting and promoting human rights in our decision making and actions[5].

The *Human Rights Act 2019* (HR Act) promotes and provides protections for human rights in Queensland, requiring public entities to act and make decisions that comply with human rights. The OHO is both a public entity and referral entity under the HR Act. All human rights apply to all people—including older people. All adults have the right to decisions about their lives such as the healthcare and support services they may need. The OHO and Queensland Human Rights Commission (QHRC) have a referral arrangements agreement in place[6].

As a referral entity, the OHO has powers to deal with human rights complaints relating to health services. In these matters, the OHO:

- will deal with the human rights part of the complaints under the Act[7]
- will refer the complaint to the QHRC with the complainant's consent.

The OHO will usually proceed under the assumption that where a complainant has made a complaint about a health service that also involves the potential limitation of a person's protected human rights, they intend for the matter to be handled by the OHO under the Act.

Further, s73(2) of the HR Act states the QHRC may (with the complainant's consent) choose to refer a matter to the OHO when it falls within jurisdiction of the Act.

Upon finalisation of a health service complaint that is also a human rights complaint, the complainant will be advised of their options to contact QHRC if they are not satisfied with the OHO's response.

The HR Act includes several rights that may be limited by elder abuse, including some which impose a positive obligation on entities to take protective action to ensure those rights are fulfilled. Rights which may be limited by elder abuse in the context of a health care setting are:

- right to life (section 16)
- the right to protection from torture, cruel, inhuman or degrading treatment (section 17)
- the right to privacy and reputation (section 25)
- the right to liberty and security of the person (section 29)

[5] OHO 2023-2027 Strategic Plan.
[6] Section 74 *Human Rights Act 2019*.
[7] Section 66 (2)(a) *Human Rights Act 2019*.

- the right to freedom of movement (section 19)
- the right to health services (section 37).

In 2023, the OHO revised and refreshed its Human Rights Policy and Procedures and provided tailored training to staff about identifying and recording limitations on human rights. As a consequence, OHO's data from 2023-24 onwards provides a more accurate picture of matters where human rights have been potentially limited. In 2023-24 there were 31 matters involving at least one consumer 65 or older or 50 or older for Aboriginal and Torries Strait Islander by calendar year where OHO staff identified and reported that human rights have been potentially limited.

4. Opportunities to improve response to elder abuse in Queensland

The OHO has identified the following opportunities to improve responses to elder abuse in Queensland in the context of regulating health services.

4.1 Data collection

Effective data collection on elder abuse is essential for understanding its prevalence, identifying risk factors and improving intervention strategies. Currently data on elder abuse in Queensland is fragmented across multiple agencies, making it difficult to get a comprehensive picture of the issue. The absence of a centralised elder abuse reporting system hinders the ability to track trends and implement effective interventions.

One of the challenges in analysing the OHO's data is that incidents of elder abuse in complaints and other matters are not explicitly recorded. This presents a real challenge for the OHO to get a true picture of the nature and extent of elder abuse, as there is not a common reporting requirement to capture these issues.

This indicates the need to better understand the experiences of older persons in health services, and in settings where they receive health services, such as in aged or disability care.

Agencies having an agreed definition and reporting requirement on matters of potential elder abuse would provide a clearer understanding of the nature and extent of elder abuse in Queensland. This information could then inform policy responses and track the effectiveness of interventions.

4.2 Reporting

Queensland could consider extending mandatory reporting laws to cover all forms of elder abuse in healthcare and community settings, similar to child protection laws. Currently, mandatory reporting is only required by approved providers under the *Aged Care Act 1997* (Commonwealth), but there are gaps in state-regulated settings too. For example, while residential aged care facilities and approved providers are subject to regular audits and mandatory reporting obligations as per the Serious Incident Response Scheme (SIRS), community and other healthcare settings are not subject to mandatory reporting obligations of elder abuse. This leaves gaps in the data collection from these other healthcare and community settings. By expanding mandatory reporting, Queensland could develop a more accurate understanding of elder abuse and create more effective prevention strategies.

4.3 Training

Health care workers must be better equipped to identify and respond to elder abuse. Regular training to recognise abuse indicators, respond to disclosures and make appropriate referrals should be prioritised for health practitioners in hospitals, general practice, allied health and aged care services.

The OHO continues to see incident reports about alleged assaults of older consumers where it is recorded that there was no evidence of harm, referring to physical harm, without reference to psychological harm.

There is the need for enhanced responses and training across sectors on recognising elder abuse and the nature of harms, particularly psychological harms for older persons who have limited capacity to communicate or who are cognitively impaired. The OHO is committed to ensuring that OHO's staff are supported and trained to recognise and effectively respond to incidents of elder abuse.

4.4 Communication supports

Elder abuse often involves complex situations where an older person may need to engage with multiple systems, agencies or services to ensure their concerns are fully addressed and their safety and rights are protected. Having accessible and responsive complaints processes both within service settings and external bodies such as the OHO, are critical to identifying and recording any issues early on to prevent incidents and improve the safety and quality of services.

When reviewing incidents of potential elder abuse, it is not uncommon for agencies such as the OHO to be advised that the older person does not have capacity to be interviewed. It is important that investigations of such incidents, whether by services or by external bodies like the OHO, consider what supports may be necessary to assist an older person to provide the account of what has happened to them, This may include communication assessments or supports for older persons who have limited capacity to communicate or who are cognitively impaired. It would be helpful if there was a specialist advice service that could provide advice, guidance and resources on approaches obtain accounts/evidence from older persons who may have limited communication skills/issues of cognitive impairment, or a specialist service that could be engaged to directly support an older person in investigations of potential abuse. [8]

4.5 Public awareness

The OHO notes the useful resources and guides developed by the Department for Families, Seniors, Disability and Child Safety, including the Queensland Government Elder Abuse Awareness Campaign. Expanding this campaign to raise awareness about elder abuse, similar to domestic violence prevention initiatives, would be an important way to empower victims and encourage reporting. Existing Helplines, online reporting tools and community outreach should be enhanced to increase the reach and accessibility for older persons, particularly those in rural and remote areas and Aboriginal and Torres Strait Islander communities. Implementing awareness strategies can help educate the public, empower older Queenslanders and strengthen system protections against elder abuse. A comprehensive approach combining media outreach, education, professional training and partnerships will ensure the elder abuse is recognised, reported and prevented in Queensland.

[8] Such specialist services could potentially be included in an Adult Safeguarding Commission which has been proposed by the Queensland Public Advocate adult-safeguarding-vol-2-final.pdf

5. Conclusion

Elder abuse is a significant and growing issue in Queensland, affecting some of the state's most vulnerable individuals. Queensland has a well-established framework for supporting older persons and while some progress has been made towards improving regulatory oversight, further action is needed to address gaps in reporting, service coordination and prevention strategies. The OHO remains committed to working collaboratively with government agencies, healthcare providers and community organisations to protect vulnerable older Queenslanders from abuse by evaluating and improving our tailored approaches to managing complaints about older consumers and by contributing the insights from complaints data to elder abuse prevention and intervention strategies.

Appendices

Appendix A

The OHO's case management system 'issue categories' mapped to an elder abuse category as potential indicators of elder abuse. Please note that the 'issue category' reflects the conduct/performance identified in the complaint about a health service provider, not the type of abuse suffered by the consumer/victim.

Issue category	Issue—Level 1	Type of elder abuse
Access	Access to facility	
Access	Access to subsidies	
Access	Refusal to admit or treat	Neglect
Access	Remoteness of service	
Access	Service availability	
Access	Waiting lists	
Code of conduct for HCW[9]	Clause 1—Provision of safe and ethical services	All forms of abuse
Code of conduct for HCW	Clause 10—Practising under the influence of alcohol or unlawful substances	
Code of conduct for HCW	Clause 11—Mental or physical impairment	
Code of conduct for HCW	Clause 12—Financial exploitation	Financial abuse
Code of conduct for HCW	Clause 13—Sexual misconduct	Sexual abuse
Code of conduct for HCW	Clause 14—Privacy	
Code of conduct for HCW	Clause 15—Record keeping	
Code of conduct for HCW	Clause 16—Indemnity insurance	
Code of conduct for HCW	Clause 17—Display code and other information	

[9] HCW—Health Care Workers.

Issue category	Issue—Level 1	Type of elder abuse
Code of conduct for HCW	Clause 2—Consent	All forms of abuse
Code of conduct for HCW	Clause 3—Appropriate conduct in relation to treatment advice.	
Code of conduct for HCW	Clause 4—HCW to report concerns about other HCW	
Code of conduct for HCW	Clause 5—Response to adverse events	
Code of conduct for HCW	Clause 6—Infection control	
Code of conduct for HCW	Clause 7—HCW diagnosed with infectious medical conditions	
Code of conduct for HCW	Clause 8—Claims to cure serious illnesses	
Code of conduct for HCW	Clause 9—Misinformation/misrepresentation – product/service/quals/training	
Communication and information	Attitude/manner	Emotional abuse
Communication and information	Inadequate information provided	
Communication and information	Incorrect/misleading information provided	
Communication and information	Special needs not accommodated	All forms of abuse
Consent	Consent not obtained or inadequate	
Consent	Involuntary admission or treatment	Physical abuse
Consent	Uninformed consent	
Discharge and transfer arrangements	Delay	
Discharge and transfer arrangements	Inadequate discharge	
Discharge and transfer arrangements	Mode of transport	
Discharge and transfer arrangements	Patient not reviewed	
Enquiry	Ahpra process	
Enquiry	Ahpra registration	
Enquiry	Billing and/or costs	
Enquiry	Clinical records	
Enquiry	Compensation	
Enquiry	Health insurance	
Enquiry	Infection control	
Enquiry	Interstate health service complaint	
Enquiry	Medication	

Issue category	Issue—Level 1	Type of elder abuse
Enquiry	Mental health/treatment authority	
Enquiry	OHO process	
Enquiry	Other enquiry	
Enquiry	Overseas health service complaint	
Enquiry	Product issues	
Enquiry	Queensland Health	
Enquiry	Refusal to treat	
Enquiry	Request for legal advice	
Enquiry	Training questions from a provider	
Enquiry	Waiting lists	
Environment/management of facility	Administrative processes	
Environment/management of facility	Cleanliness/hygiene of facility	
Environment/management of facility	Physical environment of facility	
Environment/management of facility	Staffing and rostering	
Environment/management of facility	Statutory obligations/accreditation standards not met	
Fees and costs	Billing practices	
Fees and costs	Cost of treatment	Financial abuse
Fees and costs	Financial consent	Financial abuse
Grievance processes	Inadequate/no response to complaint	
Grievance processes	Information about complaints procedures not provided	
Grievance processes	Reprisal/retaliation as result of complaint lodged	
Health Ombudsman Act 2013 offence	115—Offence of contravening order	
Health Ombudsman Act 2013 offence	262(1)—Offence for taking reprisal	
Health Ombudsman Act 2013 offence	264(1)—False or misleading information	
Health Ombudsman Act 2013 offence	272(2)—Confidentiality	
Health Ombudsman Act 2013 offence	78—Offence of contravening order	
Health Ombudsman Act 2013 offence	90P—Offence of contravening (prohibition order)	

Issue category	Issue—Level 1	Type of elder abuse
Information	Compliment/positive feedback for a provider	
Information	Notice of coronial inquest	
Information	OHO copied in on correspondence	
Information	Queensland Health Police Liaison Unit	
Medical records	Access to/transfer of records	
Medical records	Record keeping	
Medical records	Records management	
Medication	Administering medication	Physical abuse
Medication	Dispensing medication	
Medication	Prescribing medication	
Medication	Supply/security/storage of medication	
Professional conduct	Annual declaration not completed or completed incorrectly	
Professional conduct	Assault	Physical abuse
Professional conduct	Attendance	
Professional conduct	Boundary violation	Sexual abuse
Professional conduct	Breach of condition	
Professional conduct	Conflict of interest	
Professional conduct	Discriminatory conduct	Emotional abuse
Professional conduct	Emergency treatment not provided	Neglect
Professional conduct	Excessive treatment	
Professional conduct	Experimental treatment	
Professional conduct	False/misleading statements and/or information	
Professional conduct	Financial fraud	Financial abuse
Professional conduct	Illegal practice	All forms of abuse[10]
Professional conduct	Inappropriate behaviour	All forms of abuse
Professional conduct	Inappropriate collection, use or disclosure of information	
Professional conduct	Medico-legal conduct	
Professional conduct	Misrepresentation of qualifications	
Professional conduct	National Law breach	
Professional conduct	National Law offence	
Professional conduct	Offence by student	

[10] Additional filter to include keywords relating to elder abuse in summary field.

Issue category	Issue—Level 1	Type of elder abuse
Professional conduct	Response to adverse event	
Professional conduct	Sexual misconduct	Sexual abuse
Professional health	Mental impairment—substance misuse, abuse or addiction	
Professional health	Mental impairment—cognitive impairment	
Professional health	Mental impairment—mental illness	
Professional health	Mental impairment—other	
Professional health	Physical impairment	
Professional performance	Competence	
Professional performance	Coordination of treatment	
Professional performance	Delay in treatment	Neglect
Professional performance	Diagnosis	
Professional performance	Inadequate care	Neglect
Professional performance	Inadequate consultation	
Professional performance	Inadequate prosthetic equipment	
Professional performance	Inadequate treatment	
Professional performance	Infection control	
Professional performance	No/inappropriate referral	
Professional performance	Public/private election	
Professional performance	Rough and painful treatment	Physical abuse
Professional performance	Teamwork/supervision	
Professional performance	Unexpected treatment outcome/complications	
Professional performance	Withdrawal of treatment	
Professional performance	Wrong/inappropriate treatment	Physical abuse
Reports/certificates	Accuracy of report/certificate	
Reports/certificates	Cost of report/certificate	
Reports/certificates	Refusal to provide report/certificate	
Reports/certificates	Report written with inadequate or no consultation	
Reports/certificates	Timeliness of report/certificate	
Research/teaching/assessment	Conducting research in an unethical manner or not with approval granted	
Research/teaching/assessment	Inaccurate or misleading reporting of research findings	
Research/teaching/assessment	Inadequate clinical teaching or assessment	