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Your Ref

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The Chairman
Mr Trent Zimmerman MP
House of Representatives Standing Committee on
Health, Aged Care and Sport
Parliament House
CANBERRA ACT 2600

Email: Health.Reps@aph.gov.au

Dear Mr Zimmerman

RE CALL FOR SUBMISSIONS – AGED CARE QUALITY OF CARE

This submission is divided into parts and for convenience we set out those parts:

- **INTRODUCTION**
- **AGED CARE COMPLAINTS COMMISSION**
- **AGED CARE ACT 1987 AUTHORISES A FAILURE OF LEGAL CONSEQUENCES**
- **THE UTILITY OF CARE RECIPIENT'S RIGHTS – RESIDENTIAL AGED CARE**
- **THE VIRTUE OF MAKING RESIDENT RIGHTS ENFORCEABLE – EMPOWERMENT**
- **CONTRACTING FOR SERVICES REASONABLY FIT FOR PURPOSE**
- **IMPLEMENTING THE REFORM PROPOSAL**

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INTRODUCTION

We are responding to the call for submissions by the House of Representatives Committee on Health, Aged Care and Sports of which you hold the Chair, for its mandate to inquire into and report on the Quality of Care in Residential Aged Care Facilities in Australia.

The Committee has been asked to report upon, in whole or part the following Terms of Reference:

1. *associated reporting and response mechanisms, including the treatment of whistle blowers;*

2. *The effectiveness of the Australian Aged Care Quality Agency, the Aged Care Complaints Commission, and the Charter of Care Recipients' Rights and Responsibilities in ensuring adequate consumer protection in residential aged care; and*

3. *The adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.*

We propose to address just some of the Terms [generally 2 and 3], in the submissions which follow.

2. *The effectiveness of the Australian Aged Care Quality Agency, the Aged Care Complaints Commission, and the Charter of Care Recipients' Rights and Responsibilities in ensuring adequate consumer protection in residential aged care.*

The Australian Aged Care Quality Agency and the Aged Care Complaints Commission together comprise the mechanisms by which the Secretary, who holds the ultimate authority over Providers and their aged care business investment, is advised and upon whose reports and recommendations, disciplinary action is taken.
This is a basic outline of what are understood as the various processes for complaints handling and the inclusion of one or more of these techniques will depend upon the individual case circumstances:

- provider resolution – the complaint is resolved by agreement between the resident or her/his representative and the Provider
- conciliation – intervention of the Complaints Commissioner through a representative to attempt to conciliate the parties
- mediation – the parties may agree to have the issue between them mediated by an independent person
- investigation – this may occur at any stage depending upon urgency and circumstances.

To make it clear, the more serious and harmful kinds of injury and trauma which can occur in the course of being cared for in an aged care facility includes the following:
Pain Relief
Medication Error

Infection Control
Wound Management
Nutrition
Hydration
Falls + Mobility
Here is another insight into the potential harm which can occur while residents are in a residential care service:

Choking
Medication administration errors
Physical restraint
Proper management of respite care[1].

Although sanctions may well address the need for action on one side of the equation for care – the Provider – there is nothing for the individual who has been seriously harmed or injured by the failure of care. That is because the system is driven by regulation and depends for its outcomes on the regulatory provisions for the incident. In this writer's view, herein lies the deep fault line which affects the outcomes for individuals.

AGED CARE COMPLAINTS COMMISSION

The media release upon commencement of the complaints service said this:

Australia's 'independent' Aged Care Complaints Commissioner starts work this week, to handle and investigate any complaint relating to a Commonwealth subsidised residential or home-based aged care service.

There has always been an impression conveyed by the Commonwealth administrators of the aged care scheme and strongly supported by the aged care providers, that complaints through the channels provided by the Aged Care Act 1997 – namely the Aged Care Complaints Commissioner and the previous iterations of the same theme going back to the beginning of the Scheme - are a complete answer to the problems for residents which may arise in the system. This approach has not changed. It is submitted this is an unfair and incorrect, perhaps even misleading impression to convey to those entering into residential aged care.

There are serious shortcomings in the structure of the complaints scheme as presently managed by the Aged Care Complaints Commissioner [ACCC].

[1] These matters and others were identified in a 2017study by the Health Law and Ageing Research Unit department of Medicine at Monash University in Recommendations For Prevention Of Injury-Related Deaths In Residential AgedCare Services, Editors Joseph E Ibrahim, Lyndal Bugeja, Georgia Aitken & Sylvia Pomeroy.

1. The ACCC has no independent power to impose sanctions - that requires the authority of the secretary of the Department of Health [Sanctions principles]
2. There is a mechanism which is entirely ignored by the complaints regime and that is the Australian Consumer Law which implies guarantees of quality and fitness in contracts for service
3. The possibility that aged care residents and their families and delegates may need to turn to the law for redress has never been mentioned so far as I have seen in any information or guides for the complaints system.
4. The complaints system is severely limited in its capacity to address significant trauma, injury or distress experienced by a resident as a result of some action or omission of an aged care worker - there are no awards of damages and more importantly, no power to require restorative measures which might partly compensate and remediate for significant mental or physical injury or trauma.
5. The only power in the hands of the department is the ultimate sanction of withdrawal of accreditation - very unlikely in an individual case - usually applicable in cases of systemic and serious care shortfalls.

AGED CARE ACT 1987 AUTHORISES A FAILURE OF LEGAL CONSEQUENCES

At the outset it is necessary to understand that the Aged Care Act 1987[2] expressly disallows any legal consequences arising from a breach of the Act, whether civil or otherwise. That is, except for the consequences for breach provided for in the Act itself. Those are the provisions which we intend to examine, in the comments which follow and in the context of complaints.

Other actions and claims are preserved if they are brought under other areas of law, such as for example, a claim for negligence or a claim under the Australian Consumer Law.

It is submitted that most people – Providers and residents and their supporters – are oblivious to the removal of what many people may believe is an outcome of entering into residential aged care in the first place, namely the legal right to adequate care and protection granted through the resident supportive Resident's Rights and Responsibilities.

It is the Secretary of the Department [not the Complaints Commissioner] who manages the system and who is responsible to the Minister, and who alone has the right to impose sanctions. The obligations of Providers when they are found to be in default, are provided for in section section 65.1 of the Aged Care Act. That section obliges Providers to comply with Parts 4.1 [Quality of Care], 4.2 [User Rights] and 4.3 [Accountability] of the Act. In addition the explanatory notes to the section state:

> AGED CARE ACT 1997 - SECT 55.1
>
> **What this Part is about**

[2] See sect 56-4

> A person who is an approved provider in respect of an aged care service has general responsibilities to users, and proposed users, of the service who are approved as care recipients of the type of aged care in question. Failure to meet those responsibilities may lead to sanctions being imposed under Part 4.4.

The complaints system and protection of the resident rest upon two main bases which are expressed in the Aged Care Act. The first is the statement of Rights and Responsibilities. The second is the Complaints system itself described in the Complaints Principles 2015. The authority of the Complaints Commissioner is spelled out in section 12 of the Principles, who may:

- request the approved provider to examine and attempt to resolve the complaint and report back to the Commissioner;
- request that the complainant (if any), the approved provider and any other person participate in a conciliation process;
- undertake an investigation of the issue; or
- refer the issue to mediation.

There are two 'bottom line' points to be made as regards the interests of the resident and relevant outcomes. First, there is no authority to require anything but attendance from the Provider, and second, if the Provider is in breach of the Aged Care Act itself, the only recourse is to ask the Secretary to intervene and – perhaps – impose sanctions.

What this means is the resident's complaint is left entirely in the hands of the Commissioner and the Secretary. The aged care regime directs residents to the complaints system and suggests no other alternatives, even when there may be others. This seems quite unfair to residents all of whom have a disability of some kind and to whom there is a duty of care.

Consider for example a case in which the resident may have suffered minor harm, resulting from any one or more of the issues referred to in the example below. It is our submission that an individual case of harm is unlikely to warrant the Secretary to impose sanctions. There would often be no utility in dealing with a one-off issue by, for example, installing an adviser or requiring staff to attend training.

One example may suffice. Consider a case where carers or assistant nursing staff ask the registered nurse after observing for several days, an elderly resident in pain, to see to her in case something is wrong requiring more than short term pain relief [which didn't seem to be working], The registered nurse first removes the resident's bedclothes and asks staff to lie her straight in the bed. It becomes apparent immediately that the resident has a broken hip and that accounts for her moaning and expressions of pain. She has had a fall which may [or may not] have been reported in the daily notes.

What is the utility of the complaints format? The outcome may well be a training course for the carers and assistant nursing staff. But in the scheme of things there is nothing but [perhaps] an apology to the family for the days [and nights] of needless pain and suffering.

Meanwhile the resident may be in residual pain left without specialist medical and pain relief attention, rehabilitation services and so on, which might otherwise be available, if funds were applied to the particular case, or if the person were a fit and able and employed member of the community.

A likely outcome may be elevation of the resident's need for more care and attention under the Aged Care Funding Instrument [ACFI], but usually with the extra funds going into the Provider's bank without any [transparent] corresponding increase in staffing. How much better would it be for the resident , in the particular case, if there were an increase in the range of medical and care services including medical health specialists and remedial therapies for the resident concerned, which the results of the harm suffered, may require.

In the end, the Complaints system is, in the experience of this writer, unable to address the issues of individuals who have suffered harm or injury, but is oriented towards addressing systemic issues affecting a group, or the whole of the residents in a particular aged care home.

It is worth setting out in summary the extent of the consumer's or resident's rights which are found in the second schedule to the User Rights Principles – a very low spot on the 'totem pole of importance' in the legislation. Indeed, it could hardly be lower. That is so perhaps because these rights are not intended to be enforceable, despite the lofty descriptions they bear.

THE UTILITY OF CARE RECIPIENT'S RIGHTS – RESIDENTIAL AGED CARE

Right – "Each care recipient has the right"	**The utility of enforceable application/s of the right by an independent decision maker following arbitration as an available step resulting from a shortfall in care to an aged care resident**
(a) to full and effective use of his or her personal, civil, legal and consumer rights	A generalised statement which is meaningless unless understood to mean that steps will be taken by the provider to accommodate any disability which may undermine "full and effective use" of civil and legal rights and to restore them. An example may be assisting the hearing of a claim in which a decision binding upon both parties [resident and Provider] in the aged care premises themselves where the resident is not mobile. This would be particularly helpful for an arbitration hearing, for example.
(b) to quality care appropriate to his or her needs	This is an important 'right' and is often [although there are some commendable exceptions with some Providers] omitted from the residential care contract or otherwise treated in a way which renders a promise of care according to the appropriate standards, unenforceable at common law for breach. There is however always the prospect that an implied 'guarantee of service' might be claimed

	under the Australian Consumer Law, but there are limitations to such a claim, such as the impact of the Civil Liability legislation on claims for damages for pain and suffering. If capable of being arbitrated – especially at the aged care home, a claim would be a realistic option for someone with disabilities.
(c) to full information about his or her own state of health and about available treatments	When an issue arises in the course of care and treatment leading to harm or injury, there are limited rights to access aged care home records. This right, if enforceable, could assist a resident to ascertain the cause of a medical incident, thus avoiding the convoluted and slow processes which are often followed, such as by the issue of a subpoena. Issuing a subpoena assumes that there is a current claim issued or filed in a legal jurisdiction. If the objective however is to achieve a just and efficient means of redress for harm caused, then this clause should be expanded beyond "state of health" to ensure all relevant records may be accessed. This is especially important where remedial health therapies may be required to restore the resident to their former state of ability and the issue is whether responsibility lies upon the Provider. A further extension of this "right" should be considered. That is , to extend the right to the person who holds the delegated authority of the resident under formal orders or under an Enduring Power of Attorney, and also including 'persons responsible' or similar [see for example sect. 36 Guardianship Act 1987 [NSW]].
(d) to be treated with dignity and respect, and to live without exploitation, abuse or neglect	This is a right which if enforceable could be useful in seeking restoration of dignity coupled with respect, in cases where, for example, toileting and the neglect which can occur when pads are not removed and replaced at appropriate times, for a resident unable to do that for themselves. It is hardly unreasonable to make the comparison with infants whose needs for 'nappy' change are similarly neglected. In the latter case, the person

	responsible is likely to be severely criticised for neglect. It is submitted the same opprobrium should attach in the residential care setting and this "right" may assist if it became actionable. The toileting neglect is likely actionable under the implied service guarantees of the ACL but again, there are barriers and there is no recorded litigated case for any cause arising under the aged care system, known to this writer.
(e) to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation	In so far as discrimination is concerned the existing laws which apply to disability discrimination are, in our view, reasonably sufficient to provide actionable relief for a resident who is treated differently to others of the same cohort. However, because the same criteria expressed in this right do not apply under discrimination laws, this right should not be omitted from any enforcement mechanism.
(f) to personal privacy	Where there is doubt about a right to privacy this "right" if it became actionable, would significantly elevate the resident's rights and the relative power imbalance which currently exists between resident and Provider.
(g) to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction	This right would permit a resident to argue for their right to self-determination ["move freely both within and outside"] with much more force or weight. Again, in cases of dispute, access to a binding decision making process would be helpful.
(h) to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect	This statement may be of utility to the resident if there is a need for personal preferences to be established or maintained [for example following a change of Provider] in matters of diet, clothing, healthy living environment [e.g. heating, cooling], and the many individual preferences which residents may wish to request. This is not a cause for expecting that litigation will occur about the color of paint on the walls, rather it may allow either party to seek and obtain a binding decision in the event that the residential care

	contract itself is unclear and has given rise to a dispute.
(i) to continue his or her cultural and religious practices, and to keep the language of his or her choice, without discrimination	These are rights which should rightly be accommodated in our society and again it is a matter which may be dealt with in the residential care contract – either excluding certain matters, or making a virtue of permitting them.
(j) to select and maintain social and personal relationships with anyone else without fear, criticism or restriction	These are similarly rights which may be assumed by residents and are likely to be subject to the law regarding discrimination, but it may be preferable if it be to the contract which both parties will look to establish whether or not these are matters of contention or agreement. Even though it may be that this 'right' applies to LGBTI issues, this 'right' to maintain personal relationships can also become important when there are conflicts which arise between the aged care home management and staff on the one hand and relatives friends or authorised delegates such as guardians, on the other. It happens not infrequently that conflict arises in relation to care and treatment which may not be perceived as satisfactory to a resident's family members or others concerned for the resident's welfare. It has been my experience that these cases can escalate to the stage of exclusion of the person who is accused of continual complaints about explicable incidents. When a person is excluded for the Home there is no recourse to an independent party who has the authority to make a decision binding upon both sides to the dispute. Elevating this particular 'right ' as enforceable by any party or associated party to the resident who has an interest may help to resolve disputes where otherwise there is nowhere to go for a binding outcome or decision. The drafting of a clause supporting this right in the contract would need to take account of whether the resident was able to advocate for themselves and if not, to permit an interested person to make an

	application under the contract clause for a decision. Other rights may also be involved in such a claim. The important issue is to have a dispute resolution mechanism, where none presently exists in many such cases.
(k) to freedom of speech	Residential care contracts will doubtless be amended [if this submission for enforceability is adopted] to make it clear that the resident is to have the same rights as all Australians, enjoy to freedom of speech.
(l) to maintain his or her personal independence	The terms of residential care contracts will likely be changed to accommodate the meaning of this provision and to elaborate upon it
(m) to accept personal responsibility for his or her own actions and choices, even though these may involve an element of risk, because the care recipient has the right to accept the risk and not to have the risk used as a ground for preventing or restricting his or her actions and choices	This is also a matter of self-determination balanced against risk of injury or harm. An example might be the assertion by a resident of the right to leave the aged care home at night, unaccompanied, for a stroll. These will be matters which will need to be elaborated upon and defined for each of the parties to the residential care contract, by its terms. Another important aspect is the role played by the guardian or person responsible for the resident if that is relevant to the making of the decision.
(n) to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions	This right is also a matter of self-determination and to the extent that the resident continues to manage their own affairs, there is no legal right reposing in the Aged Care Provider to require otherwise, subject to the terms of the residential care contract.
(o) to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service	Freedom of association is a fundamental right and is referred to in article 20 of the Universal Declaration of Human Rights [UDHR] and is a well understood right.
(p) to have access to services and activities available generally in the community	If this right is to be abridged in any way it must be by agreement and feature in the contract terms [subject always to existing law on this subject and the supply of services]

(q) to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service	This right should be the platform for requiring , in the residential care contract, a provision that resident committees may be formed by residents and their representatives, friends and supporters
(r) to have access to information about his or her rights, care, accommodation and any other information that relates to the care recipient personally	This right should be available to the resident and to their duly authorised delegate and that right should continue if the resident is deceased
(s) to complain and to take action to resolve disputes	The action should also include legal action and for that reason access to the resident's lawyer in the aged care setting should become a concurrent or parallel right to 'take action'
(t) to have access to advocates and other avenues of redress;	Advocates also include lawyers of the resident's choice and that should be made clear and should not be confined to a particular class of advocate as presently
(u) to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights	This is an important clause and because there are no apparent consequences to the low level at which this kind of reprisal for complaint making may take place, the person best able to take action is the resident or a member of their family or their authorised delegate.

CONSUMER RIGHTS ARE BEST PROTECTED BY CONSUMERS – NOT BY GOVERNMENT – PROVIDED THEY ARE EMPOWERED BY THE LAW

To illustrate the point and to draw some lines between what is endemic to the complaints system and what differences a consumer action oriented system may hold, let us examine a case example taken from the recent report of the Complaints Commissioner[3].

> *The daughter's main concern was that the service provider did not act quickly enough to get a doctor to review her father's deteriorating condition, despite his being short of breath and presenting with low oxygen levels. During our investigation, we requested and reviewed the resident's clinical records and found that it was reasonable to expect the service provider to have escalated his condition to a medical practitioner earlier.*

[3] Aged Care Complaints Commissioner Annual Report for the period 1 July 2016 to 30 June 2017, at page 30

> *When these findings were discussed with the service provider, they committed to improving the management of deteriorating residents by developing a number of best practice training resources for clinical and care staff. A service policy about detecting and managing deteriorating residents was also developed.*
>
> *The service provider agreed to discuss these actions and the outstanding issues with the daughter during a conciliation meeting which we facilitated.*
>
> *At the meeting, the service provider acknowledged that the resident's condition should have been escalated earlier and apologised to the daughter for this mistake. The service provider also advised that as well as developing training resources, they had appointed a clinical care coordinator and were recruiting more registered nurses.*

The writer is unsure whether any member of the HOR Committee has experienced breathing difficulties, but the tenor of this reported case indicates [with no opprobrium intended for the Commissioner of her officers] that the gentleman referred to was in a state of serious distress. His distress was not alleviated by anything done by the provider and the outcome was firstly an apology and secondly the addition of more staff. The circumstances indicate that this kind of incident can occur at any time to residents in the process of deteriorating health. The availability of oxygen in such circumstances may have been very important in ameliorating the pain, distress and suffering from which, indeed, this gentleman may well have died.

If death in this case had occurred what would have been the legal outcome?

How could a Provider claim to be providing 'adequate standard' of service to residents when this kind of incident occurs?

Firstly the administrator of the resident's estate may have been motivated to bring a claim for breach of service obligations. That much may be assumed in retrospect because the Provider made apology.

Secondly if the immediate cause of death was lack of attention by his carers to the man's oxygen / air supply which was an avoidable circumstance, the case may have attracted the attention of the Coroner.

Whether or not death followed the incident giving rise to the complaint, the resident will have needlessly suffered great pain and distress which may have given rise to the complaint to the Aged Care Complaints Commissioner.

In each of the variables the aged care system offers only advice about complaints. There is no redress for the individual, no improvement of the level of attention to their health needs, no overt recognition of harm and causation.

Compare for example, as may be the case for someone under the same circumstances in a hospital where recovery often leads to discharge and then to consideration of recourse to compensation or other means to restore the person to their former health, but for the incident complained about. Clearly the aged care resident is at a severe disadvantage. That is not tolerable.

THE VIRTUE OF MAKING RESIDENT'S RIGHTS ENFORCEABLE – EMPOWERMENT

If implemented as a package of enforceable rights, the current 'Rights and Responsibilities' or some improved and better drafted iteration of them, could render the complaints system as it presently exists, one of at least two alternatives for residents. At one stroke of the pen [see below the suggestions on implementation] residents or their family or supporters could themselves initiate action and reduce the burden of complaints upon the existing scheme. Moreover, if the 'Rights and Responsibilities' were made actionable, there would be, at the end of the process, a decision, binding upon both parties to the complaint or dispute.

If residents were empowered in this way, the possibility that serious and harmful lapses of care and treatment could escape attention [for example the Oakden matters], would be reduced.

Action could be taken or initiated by the resident through her/his representative by way of breach of contract at the nearest Local Court. The jurisdiction could also be shared with the various Administrative Tribunals around the country. In that way the risk of loss and costs would be reduced for those who wished to make that choice.

CONTRACTING FOR SERVICES REASONABLY FIT FOR PURPOSE

Just as there is merit to require incorporation of the resident's rights into the residential care contract, there is if anything a stronger case for requiring an enforceable clause incorporating the right to a reasonable standard of care. That is firstly because it is not uncommon for a reasonable standard of care to fail, and secondly, the standard of care is such an obvious candidate for becoming enforceable under the contract.

There are two kinds of residential care contracts in the experience of the writer. The first makes it clear that adherence to the standard of care required under the Quality of Care Principles is intended to be part of the obligation of the Provider. The second merely refers to the Quality of Care Principles and where they may be found. The latter leaves the resident with recourse to the complaints system, and without an enforceable claim for breach.

The second kind of contract – which is quite common – has the following potential shortcomings:

1. It may be misleading and deceptive by allowing the resident to believe that upon entry the standard of care which is available to them is clear and enforceable in their contract but which does not do so;

2. A failure to explain that omission in the contract is an example of why the requirement of the User Rights Principles for the Provider to 'help [the resident to understand] is so plainly ill designed.

The standard of care required by the QOC Principle should also be included in the additional clause which in our view is required and may be inserted by the Minister in the User Rights Principles [see below].

IMPLEMENTING THE REFORM PROPOSAL

There is no need to accommodate these proposed reforms in the Budget. There is no cost to the taxpayer.

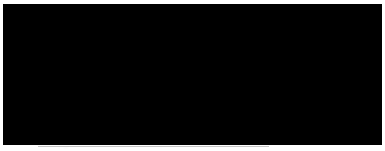
If such a proposed reform to the rights of residents is to be implemented, it is our submission that it may be done by Regulatory amendment. All this is required is an appropriate addition to the User Rights Principles [Part 2, Division 4, section 15], in the following general manner [not intended to be exhaustive of the possibilities]:

> *5A. [1] A resident agreement must provide that the care recipient shall have the rights described in the second schedule to the User Rights Principles and that they may be enforceable at law.*
>
> *[2] A resident agreement must provide that the Provider shall make all necessary arrangements for and submit at the request of a resident or their representative to arbitration of a dispute arising under the residential care agreement including if appropriate permitting the hearing to occur within a suitable place within or nearby to the aged care place; maintaining a list of not less than 2 suitable arbitrators for the resident to select one from the list or nominate their own choice; that the agreement shall incorporate at least by reference the usual or commonly used provisions of the Australian Disputes Centre guidelines and rules altered as the case may require for an arbitration of an aged care dispute but always providing for fairness and the situation of power imbalance [if that be the case] of the vulnerable resident.*
>
> *[3] A resident agreement must also include a promise to provide care and treatment which is to the required standard Part 2 Schedule 2 referred to in the Quality of Care Principles and that is always reasonably fit and appropriate for the resident and their circumstances and needs.*

Another consequential amendment should be to remove the allowance [if not a positive direction] for Aged Care Providers to see to it that the resident "must be informed of, and helped to understand, the terms of the resident agreement" which is, simply stated, a statutory permit for engaging in a blatant conflict of interest. If residents wish to take advice on their position they should be informed of their right to independent legal advice, like all other Australians.[4]

If there be doubt about a conflict between the Aged Care Act s.56.4 [see the reference above] and the proposed amendment to the User Rights Principles, an amendment by way of exception to the Act may be necessary.

[4] User Rights Principles, part 2, division 4, section 14[2]



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About the firm – Elderlaw

Following a recent merger, Elderlaw- the legal firm – is now a part of Foulsham & Geddes, solicitors of 32 Martin Place, Sydney. Our team comprising Dougal Geddes, Will Geddes, and support staff are ready to assist in all elder law issues. They are the legal issues associated with ageing including aged care, guardianship and financial management, retirement village law, accommodation agreements and disputes, and including family conflicts over powers of attorney, loans, guarantees, and will making.

The Senior solicitor is Rodney Lewis. He is Author of the text: Elder Law in Australia, 2nd edn, Lexis Nexis, Sydney 2012 and has practised in Elder Law since 1999 and before that in wills and estates legal issues. He has been delivering elder law education by way of talks and seminars to his colleagues in the legal profession and to the community, in elder law, for many years.