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Ana Margarida Pais Correia
Physical abuse against elderly
persons in institutional settings

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Physical abuse against elderly persons in institutional settings

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Abstract

INTRODUCTION: People over 65 years old are expected to be an increasing group exposed to abuse. Abuse affects mental, physical and psychological well-being, contributing to diminished quality of life, increased morbidity and mortality. Despite the well-studied intra-familial abuse, institutional abuse still lacks a better knowledge about its determinants and characteristics. Therefore, and in anticipation to the expected increased prevalence following the rapid ageing of the population, it is urgent to analyse and understand this emerging issue so that social policies and regulation may be developed, in an effort to protect the elderly, as well as to make improvements in the professional's skills.

AIM: The general objective of this study is to provide a better knowledge about physical abuse against elderly people in institutional settings, in order to contribute to the earlier detection and prevention of these cases.

METHODS: A retrospective study was conducted using 59 forensic medical reports performed in the North Services of the National Institute of Legal Medicine and Forensic Sciences of Portugal, between 2004 and 2013, to elders (≥ 65 years old) allegedly victims of physical abuse in an institutional setting by a caregiver.

RESULTS: All the alleged cases occurred in nursing homes and in most of them (93.2%) the complaints were against the institution and not focusing on a particular individual. The alleged victims were mostly female (79.7%), 75 years or older (75.9%), presenting a severe disability (55.9%) and 47.2% being unable to communicate. No injuries or pain phenomenon were found in 55.9% of the cases, to support the complaint of physical abuse. Only in 6.8% of the reports were the forensic medical findings highly suggestive of physical abuse; although this was not the object of the examination, 52.7% and 16.4% of the remaining cases were considered, respectively, highly suggestive or suggestive of neglect (mainly medication and medical care neglect). A statistically significant association was found between the alleged victim's degree of disability and the occurrence of neglect ($p = 0.003$).

DISCUSSION AND CONCLUSION: Our sample's size seems to be an underestimation of the reality, probably due to lack of detection and/or underreport of these cases. The condition of these elders, mainly related with their lack of ability to perceive abusive behaviours and to report (mostly by fear of reprisal or physical and/or mental disability), affects significantly the detection and diagnosis of physical abuse, particularly in those where injuries are not obvious.

Keywords: Forensic medicine; Abuse; Elder; Caregiver; Institutional abuse; Nursing home

Introduction

According to the World Health Organization (WHO), elder maltreatment is defined as “a single or repeated act or lack of appropriate action, occurring within any relationship in which there is an expectation of trust, that causes harm or distress to older people” ⁽¹⁾. Elder maltreatment comprises neglect, financial exploitation, mental abuse, psychological/emotional abuse and physical abuse ⁽²⁾. Physical abuse consists of “wilful infliction of physical pain or injury, including hitting, striking, pinching, slapping, shaking, pushing, grabbing, handling in a rough manner, or injuring someone in another way” ⁽³⁾. Physical coercion and sexual abuse are also included as a subset of physical abuse, as an “infliction of non-consensual sexual contact of any kind” (sexual coercion, sexual assault, sexual contact and sexual harassment) ^(2; 3).

With the progressive increase in life expectancy, people over 65 years are estimated to represent 25% of the European population by 2050, against the 14% in 2010 ⁽¹⁾. The same trend may be observed in Portugal, where, in 2011, the elderly represented 19.03% of the population ⁽⁴⁾, with 3.9% of these being in institutional care ⁽¹⁾. Also, the Portuguese National Institute of Statistics foresees that in 2060 there will be 307 elders for each 100 young people under 18, as opposed to the ratio of 131:100 in 2012 ⁽⁵⁾.

Following this is the arising of the “oldest old”, people older than 85 years, more susceptible to chronic and disabling diseases, cognitive impairment and even more dependent with greater needs of long-term care ^(2; 6; 7). As a result, families are resorting to institutional care more often, being these elders at higher risk of abuse related to caregivers’ burnout ^(2; 6; 8; 9; 10).

In the WHO European Region, it is estimated that physical abuse against people aged 60 years and older affects at least 4 million people every year, a prevalence of 2.7% ⁽¹⁾ which is expected to increase, as this population continues to grow, accentuating the stress on family and professional caregivers ⁽²⁾.

Abuse affects mental, physical and psychological well-being, contributing to diminished quality of life, increased morbidity, mortality and health costs, as well as functional and cognitive impairment ^(2; 10; 11). The consequences of this abuse create a vicious cycle of more dependency and deterioration of health, more need for long-term care, more caregivers’ burnout, hence more violence towards the elderly ⁽¹⁾.

On top of that, the ongoing economic crisis inflates the strain on the families and professional caregivers, also facilitating the occurrence of abuse ^(2; 9).

Despite the well-studied familial abuse, institutional abuse still lacks proper analysis of its risk factors, with low identification and reporting rates ^(2; 6; 7; 11; 12). Therefore, and in anticipation to the expected increased prevalence following the rapid ageing of the population, it is urgent to analyse and understand this emerging issue so that social policies and regulation may be developed, in an effort to protect the elderly, as well as to make improvements in staff's training ⁽¹³⁾.

The general objective of this study is to provide a better knowledge about physical abuse against elderly people in institutional settings, in order to contribute to the earlier detection and prevention of these cases. Specific aims are: (a) to determine the number of cases reported to the North Services of the National Institute of Legal Medicine and Forensic Sciences of Portugal in a ten years period; (b) to characterise the alleged victims and abusers; (c) to characterise the alleged abuse, regarding its mechanism, resultant injuries and consequences.

Methods

A retrospective study was conducted using forensic medical reports (FMR) selected from the databases of the North Services of the National Institute of Legal Medicine and Forensic Sciences of Portugal. From the retrieved reports, those who fulfilled the following inclusion criteria were selected ($n = 59$): (a) alleged victim being 65 years or older; (b) having been submitted to a forensic medical evaluation (FME); (c) at the North Services of the National Institute of Legal Medicine and Forensic Sciences of Portugal; (d) between 2004 and 2013; (e) due to a complaint of physical abuse in an institutional setting by a caregiver.

From each FMR, data was collected on: (a) the alleged victims' and abusers' socio-demographic characteristics; (b) the alleged abuse's (previous and current) characteristics; and (c) the FME findings.

Findings were statistically analysed using SPSS (Statistical Package for Social Science – SPSS INC, Chicago, Illinois, USA) version 22.0, for Windows. Continuous variables were described using mean, median and standard deviation and represented in the form of histogram. Age was categorised into two values (< 75 years and ≥ 75 years) according to previous evidence stating this cut point as a risk factor for elder abuse ⁽¹⁾. Concerning the same variable, 74 years old corresponded to the 25th percentile. Contingency tables were used to describe the categorical variables and Chi-Square test was performed to compare those variables, applying Fisher's correction when necessary. The significance level adopted was $p < 0.05$.

Results

Alleged victims' and abusers' socio-demographic characterisation

Most victims were female ($n = 47, 79.7\%$), 75 years or older ($n = 41, 75.9\%$), with a mean age of 79.7 (Min = 66, Max = 107), all retired, mostly without a partner (51.5% widowed or divorced and 39.4% single). The majority presented some degree of disability: mild/moderate ($n = 22, 37.3\%$) or severe ($n = 33, 55.9\%$). Twenty-six victims (47.2%) were unable to communicate and 1 (1.8%) experienced difficulties in doing so, just being able to answer simpler questions. Multiple disabilities were the most frequent (54.5%), followed by motor disability (21.8%), as shown on Table 1. Within the first, an association of mental and motor disabilities was mainly found ($n = 25, 83.3\%$). There was no information on the alleged victim's degree of education neither on previous familial history of abuse. As the distribution of the duration of stay in the nursing home was asymmetrical, the median was used to measure this variable and equals to 17 months (Min = 3 days, Max = 147 months). Most of the alleged victims were in the nursing home for a year or less ($n = 17, 45.9\%$).

Only in 4 FMR an alleged abuser was identified. In the remaining cases ($n = 55, 93.2\%$) the complaints were against the nursing home and not focusing on a particular individual. From the identified alleged abusers, 2 were male employees in the nursing home and the other 2, both females, were the owners of the nursing home – 1 of the female presented a known deviant behaviour, namely previous complaints on offense to the physical integrity and maltreatment. No information on abuser's age, education, substance abuse, psychiatric disorders or previous familial history of abuse was available.

Alleged abuse characterisation

In most cases ($n = 55, 93.2\%$) there was no information concerning alleged previous episodes of abuse perpetrated by the same alleged abuser (institutional caregiver or the nursing home with no identification of a specific individual). Only 2 alleged victims denied the existence of such episodes, whereas 2 other living in the same nursing home mentioned previous abuse, both by the same institutional caregiver – a female employee

currently not working in that institution. In one of these, psychological abuse (threat of physical aggression or death threat) and physical abuse (with a blunt instrument – a belt), associated with hygiene neglect were described. The other case referred psychological abuse (threat of physical aggression or death threat) and physical abuse (grasping) and the victim pressed charges to the police. The frequency and duration of abuse, as well as its consequences were unknown in both cases.

Regarding the alleged physical abuse in an institutional setting by a caregiver, that justified the current complaint and respective FME (according to the defined inclusion criteria), all the cases occurred in nursing homes, with none reported in day centres or home care settings. In the majority of the suspected cases in which this information was available ($n = 29$), the report to the authorities was made by the Social Security Office ($n = 17$, 58.6%), often associated with the nursing home's lack of proper licensing; anonymous report represents 24.1% ($n = 7$) and familial report 6.8% ($n = 4$); the victim reported in only 13.8% of the cases ($n = 1$). The report considered a single abuser in 4 cases (6.8%) and an institution in the remaining cases ($n = 55$, 93.2% – corresponding to 10 different nursing homes). Allegation of physical abuse appeared isolated in 93.2% of the cases ($n = 55$) and associated with neglect in 3.4% ($n = 3$). The main recognised mechanism of aggression was grasping ($n = 10$, 83.3%) and, in 2 cases, multiple mechanisms were mentioned (pushing and punching; slapping and aggression with a sharp object – a scissors), although in most cases this information was unknown ($n = 47$), due to communication limitations during the FME. Only 4 alleged victims were taken by family members ($n = 3$) or an employee of the nursing home ($n = 1$) to seek for medical care, being then relocated to another nursing home or to a family-member's home.

Forensic medical findings

No injuries or pain phenomenon were found in 55.9% of the cases ($n = 33$); in the remaining cases, the resulting injuries were abrasions ($n = 4$, 6.8%), bruises ($n = 12$, 20.3%) and multiple injuries ($n = 10$, 16.9%), all of them in the skin and superficial. Within the 26 cases presenting injuries, 42.3% were in multiple locations ($n = 11$), followed by injuries located only on the upper limbs ($n = 8$, 30.8%), as displayed on

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Table 2. Injuries demanded a maximum of 9 days to heal. There were only 2 cases (8.3%) in which the patients presented permanent sequelae (scars) allegedly associated with the abuse in analysis. The FME concluded there was no compatibility between the forensic medical findings and the complaint in 93.2% of the cases, and just in 6.8% ($n = 4$) were the findings considered as highly suggestive of physical abuse. During the FME, 9 cases (15.3%) of decubiti sores were noticed. This finding, associated with victims' complaints and other medical observations, lead forensic physicians to conclude that 52.7% of the cases ($n = 29$) were highly suggestive of neglect and 16.4% ($n = 9$) were suggestive of neglect, with the medication and medical care neglect appearing as the main finding ($n = 32$, 84.2%), followed by medical care neglect ($n = 6$, 15.8%).

As described on Table 3, in physical abuse there was no significant relation between the conclusion of the FME and the alleged victim's characteristics, specifically sex ($p = 0.127$), age ($p = 0.964$), degree of disability ($p = 0.316$) or type of disability ($p = 0.837$). Likewise, no significant relation existed between the occurrence of neglect and the alleged victim's sex ($p = 0.394$), age ($p = 0.205$) or type of disability ($p = 0.865$). On the other hand, a statistically significant association was found between the alleged victim's degree of disability and the occurrence of neglect ($p = 0.003$).

Discussion

This is the first Portuguese study on this subject, concerning a forensic sample. FME in cases of suspected abuse, namely in elderly people, are mandatory in Portugal and are always performed by examiners of the National Institute of Legal Medicine and Forensic Sciences. Approximately 1479 FME were performed due to suspicion of elder abuse in the North of Portugal between 2004 and 2013, being 96% of these regarding intra-familial abuse and 4% ($n = 59$) perpetrated by a caregiver in an institutional setting. Considering we analysed forensic reports related to physical abuse in institutional settings during a ten years period, this sample's size seems to be an underestimation of the reality, probably due to underreport. Also, the FME due to institutional abuse was frequently demanded to the forensic medical services not referring to an individual but to a nursing home ($n = 55$, 93.2% – corresponding to 10 different nursing homes), which may include several alleged victims. Furthermore, as noticed in the results, the main motivation for the report was not the suspicion of physical abuse by itself, but administrative or legal issues, related to the lack of proper licensing (58.6%). In addition, it was not possible to use our data to estimate a prevalence of institutional elder abuse in the Portuguese northern region, since there are no available numbers by region of elders living in institutional settings. Difficulties in estimating prevalence and incidence of institutional elder abuse is concluded in various studies ^(6; 14; 15), with underreport being the justification found for this fact ^(1; 2; 16). Possible explanations for underreport have been proposed, such as elderly feeling of shame and fear of retaliation after reporting the abuse to the authorities ^(6; 14; 17; 18), lack of elderly knowledge on how to do it ⁽⁶⁾ or their inability to communicate, due to mental disability or other ^(6; 18), this corresponding to 47.2% of our sample. Another explanation would be fear of reprisal and criminal consequences experienced by staff when admitting an abusive behaviour or denouncing one perpetrated by their co-workers ⁽⁶⁾. At this level, it might be pertinent to ensure the existence of policies that guarantee staff's and elder's protection in case of report. Lack of specific training, resulting in uncertainty on defining criteria, low index of suspicion and/or divergent tolerance levels regarding what constitutes elder abuse by the victims, potential witnesses and abusers, might also explain the difficulty in recognising and reporting possible abusive situations ^(1; 14; 15; 16; 18). Furthermore, difficulty in discerning what is a risk factor, sign or symptom of abuse from predictable outcomes of the elder's disability also plays a role on

underreporting ^(1; 16). Therefore, investing in staff education and developing protocols to evaluate elders at risk, as well as to provide accurate information to the patients and their families regarding their rights, the identification of risk factors and on how to proceed in order to report potential cases of abuse, might prove to be important to reverse the current tendency ^(6; 15; 16). Other benefit of earlier identification of abuse/neglect is the prevention of its evolution and consequently of worse outcomes or escalation of violence, leading to greater treatment-related costs for the society ⁽¹⁴⁾. O'Brien also advocates that physicians' reluctance in getting involved with Adult Protective Services may explain the lower reporting rates in this professional category ⁽¹⁴⁾.

Alleged victims' and abusers' socio-demographic characterisation

According to other studies, victims of elder abuse in general (in familial and extra-familial contexts) are women in 62% of the times ^(2; 14). A similar tendency was found in European statistics on maltreatment in nursing homes ⁽¹⁾ and in our study, with female representing 79.7% of the alleged victims in institutional settings. Nevertheless, further research would be recommended in order to consider sex as a risk factor for institutional abuse, since there are only a few studies on the matter and one of them establishing a higher percentage of male victims, 56.7% ⁽¹⁹⁾. Regarding victim's age, most of our subjects were 75 years or older (75.9%), a predisposition in harmony with European evidence that elder maltreatment rises after this age ⁽¹⁾. No data was found concerning such relation in institutional abuse. Another recognised risk factor (and a potential silencer) for victims in institutional settings in Europe is the social isolation of the elder, due to absence of family members or regular visitors ⁽¹⁾. However, in our sample there was no available information regarding this item in the FMR. In what concerns the victim's disability, 26 (47.2%) were unable to communicate and 1 (1.8%) experienced difficulties in doing so, just being able to answer simpler questions, being this higher than the 10% of the Portuguese elders reported to have daily difficulties in understanding others and making themselves understood ⁽⁴⁾. The latter experienced additional difficulties in daily living activities, such as walking (27%), bathing and dressing (14%), seeing (19%), hearing (15%), memory and concentration (15%) ⁽⁴⁾, consistent with our sample's more frequent disabilities: multiple (54.5%, with the

majority corresponding to an association of mental and motor disability), motor (21.8%) and mental (20%).

In most situations ($n = 55$, 93.2%), the complaint made was against the nursing home, so it was impossible to identify and describe most of the alleged abusers, hence the inability to draw conclusions in accordance to other studies, for instance, to find a connection between elder abuse and the abuser's personality traits, taking in consideration intergenerational transmission of violence ^(1; 6). Another known risk factor for abuse described in other studies is a scarce number of staff to attend the nursing home's needs, leading to excessive workload, stressful work environment and staff's burnout ^(1; 2; 15). In our sample, in spite of not having information on the number of employees, several reports ($n = 18$, 30.5%) suggested insufficient staff's training or experience in patient's handling techniques. This can justify the observed injuries, a finding corroborated by other authors ^(1; 6; 15).

Alleged abuse characterisation and Forensic medical findings

An absence of resulting injuries or pain phenomenon to support the complaint of physical abuse was verified in 55.9% of the times. This may be explained by the fact that when there is a complaint against a given nursing home, the medical-legal exam is not performed immediately. Legal constraints such as gathering in secrecy a team of medical-legal doctors, public health practitioner, district attorney, members of the police department and social workers determine a variable delay in the FME. During this time, alleged evidence might be lost with the cure of the alleged injuries. The referred multidisciplinary intervention was only verified in the major metropolitan areas and when requested by the General Prosecutor's Office. Even in these cases, not always was it possible to examine and elaborate the respective FMR of every elder attending that nursing home, because of the high occupancy rates. The criteria of choice in these cases are diverging: examination of patients with suggestive signs of abuse, or the ability to communicate set as an eligible criteria or even applying a random selection. For instance, from a complaint against a nursing home with 130 patients, only 7 FMR were elaborated and the remaining patients were submitted to a brief interview and inspection.

The resulting injuries verified in our sample were mainly present in multiple locations ($n = 11$, 42.3%), followed by the upper limbs ($n = 8$, 30.8%), a different finding from a literature review in which the distribution of injuries was upper limbs (43.98%), maxillofacial and neck (22.88%), skull and brain (12.28%), lower limbs (10.61%), and torso (10.25%)⁽²⁰⁾. This difference might be explained due to the review's focus not being institutional abuse and also to the exclusion of multiple locations for the statistical analysis.

In the USA, in a study that reviewed over than 20 000 reports of abuse and neglect, physical abuse was the most frequently found⁽¹⁴⁾ and, in Arizona, 63.6% of physical abuse complaints were substantiated⁽³⁾. However, in our study only 6.8% of the times was there compatibility between the clinical findings and the complaint and, within the remaining cases, 69.1% turned out to be highly suggestive or suggestive of neglect, opposing to an initial suspicion of 93.2% of isolated physical abuse and 3.4% of physical abuse associated with neglect motivating the FME. Neglect is “the refusal or failure to fulfil caretaking obligations and to meet the needs of the elder in order to punish or harm him/her, including behaviour such as deliberate abandonment or denial of food, medication, and health services”⁽²⁾ and when it happens in institutional settings, proof has been found that it usually derives from institutional problems⁽¹⁵⁾. According to the European Report on preventing elder maltreatment, the existence of dependence, any kind of physical or mental disability or cognitive impairment appear as a risk factor for maltreatment in institutional settings⁽¹⁾. Nevertheless, in our sample no significant relation was found between the diagnosis of physical abuse and the alleged victim's degree of disability ($p = 0.316$) or type of disability ($p = 0.837$). This was also documented by Schiamberg et al. (2012), stating that “older adults with a simple diagnosis of Alzheimer's disease or a diagnosis of cognitive impairment (e.g. failing memory, difficulty communicating, or difficulty concentrating) were not found to be at higher risk of physical abuse than patients without such diagnoses”⁽¹³⁾. Schiamberg et al. (2011) also states that “poor health and functional impairment predict neglect but not physical abuse”⁽²⁾. Similarly, in our study a statistically significant association was found between the alleged victim's degree of disability and occurrence of neglect ($p = 0.003$). This corroborates our deduction that the greater the degree of disability, the greater will be the predisposition to neglect.

Limitations

The total number of cases used in this study ($n = 59$) might underestimate the real prevalence of institutional abuse in the Portuguese northern region. Also, with data being retrieved from a limited region of Portugal, results may not be extrapolated to the general population, a common setback in several studies ⁽¹⁶⁾, as well as small sample sizes ⁽⁶⁾.

Other limitation is the amount of missing data – insufficient information on the caregivers, a similar problem to other articles ⁽³⁾, and incomplete reports due to elders' difficulty in communication (by mental and sensorial disability, such as confusion, dementia, aphasia, dysarthria or muteness).

Suggestions for the future

Despite the extensive study that has been done in domestic violence, little attention has been given or progress has been made regarding elder institutional abuse. This by itself presents as an opportunity and idea for future studies, but also as a major limitation, since little information exists on the matter. Its real prevalence, risk factors, best approach or outcomes, for instance, are still uncertain ^(1; 6; 14). However, it also comes as a challenge and a necessity to use the present knowledge to raise public awareness in hopes of inflating identification, report rates and actions to prevent elder maltreatment, a conclusion shared by numerous studies as the review of Oliveira AAV et al. stresses ⁽¹⁷⁾. Health care professionals play an essential role in identification of possible abusive scenarios, so their training should be seen as a necessity and good investment for the future. Cooper et al. also suggested the establishment of caregivers' education on mental illnesses, such as dementia, team work and management of challenging behaviours, as a preventive strategy at potential abuser's level ⁽¹⁸⁾.

It has been stated that understanding why institutional abuse occurs might prove to be more important than making out its prevalence, in order to elaborate preventive strategies ⁽⁶⁾. So, our suggestions for the future are to study the characteristics of the nursing homes, in a way to potentially promote modifications to the legislation and proposals on educational programs attended by institutional caregivers. For example,

the nursing home's tolerance level of abuse, if there are non-flexible routines and regimes, excessive programming or lack of socio cultural activities, the adequacy of the staff:patient rate and its employees' degree of education. Investigating protective factors of elder abuse in institutional settings also comes as an interesting approach, already suggested as may including enabling elders' independence and the existence of an emotionally supportive familial system ⁽²⁾. Finally, it might be useful to create pre-determined forms for forensic examination of alleged cases of elder maltreatment, to include information such as the risk factors already identified in elder abuse on other contexts, so as to facilitate future analyses on this subject.

Conclusion

From this study, we can conclude:

1. Our sample's size ($n = 59$) in a 10 years period (4% of the FME due to suspicion of elder abuse) seems to be an underestimation of the reality, probably due to underreport;
2. The alleged victims were mostly female (79.7%), 75 years or older (75.9%);
3. The majority presented a severe disability (55.9%), additionally 47.2% were unable to communicate and 1 (1.8%) experienced difficulties in doing so, which might explain the low reporting rates and why, when a complaint is made, it is usually anonymous or comes from a family member or the Social Security Office;
4. All the alleged cases of abuse occurred in nursing homes;
5. In most cases (93.2%) the complaints were against the nursing home and not focusing on a particular individual;
6. No injuries or pain phenomenon were found in 55.9% of the times, to support the complaint of physical abuse, a fact that may be explained by the legal constraints, determining a variable period of time between the presentation of complaint and the medical-legal examination;
7. Only in 6.8% of the reports were the forensic medical findings highly suggestive of physical abuse. Among the non-confirmed complaints, 52.7% were considered as highly suggestive of neglect and 16.4% as suggestive of neglect, with the medication and medical care neglect appearing as the main finding ($n = 32$, 84.2%), followed by medical care neglect ($n = 6$, 15.8%);
8. A statistically significant association was found between the alleged victim's degree of disability and the occurrence of neglect ($p = 0.003$). Therefore, we can conclude that the greater the degree of disability, the greater will be the predisposition to neglect.

Caution is advised in the generalisation of our results to the overall population of elders in institutional settings, since a retrospective analysis of FMR was performed.

Declaration of Conflicting Interests

There were no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Ethical approval

This study was carried out in accordance with ethical rules. It has not been submitted to Ethical Approval since it was a retrospective review in which no invasive studies were carried out nor identification of the individuals was given.

References

1. **Sethi D, Wood S, Mitis F, Bellis M, Penhale B, Marmolejo II et al.** *European report on preventing elder maltreatment*. s.l. : World Health Organization, 2011.
2. **Schiamberg LB, Barboza GG, Oehmke J, Zhang Z, Griffore RJ, Weatherill RP et al.** Elder abuse in nursing homes: an ecological perspective. *J Elder Abuse Negl.* **23**(2):190-211, Apr 2011.
3. **Phillips LR, Guo G, Kim H.** Elder mistreatment in U.S. residential care facilities: the scope of the problem. *J Elder Abuse Negl.* **25**(1):19-39, 2013.
4. **Instituto Nacional de Estatística, IP.** *Censos 2011 Resultados Definitivos - Portugal*. Lisboa : Instituto Nacional de Estatística, IP, 2012.
5. **Instituto Nacional de Estatística, IP.** *Projeções de população residente 2012-2060*. Lisboa : Unidade de Comunicação e Imagem do Instituto Nacional de Estatística, IP, March 2014.

6. **McDonald L, Beaulieu M, Harbison J, Hirst S, Lowenstein A, Podnieks E et al.** Institutional abuse of older adults: what we know, what we need to know. *J Elder Abuse Negl.* **24**(2):138-60, Apr 2012.
7. **Buzgová R, Ivanová K.** Elder abuse and mistreatment in residential settings. *Nurs Ethics.* **16**(1):110-26, Jan 2009.
8. **Phillips LR, Guo G.** Mistreatment in assisted living facilities: complaints, substantiations, and risk factors. *Gerontologist.* **51**(3):343-53, Jun 2011.
9. **Magalhães, Teresa.** *Violência e Abuso - Respostas simples para questões complexas.* s.l. : Imprensa da Universidade de Coimbra, March 2000. 978-989-26-0025-3.
10. **Frazão SL, Silva MS, Norton P, Magalhães T.** Domestic violence against elderly with disability. *J Forensic Leg Med.* **28**:19-24, Nov 2014.
11. **Cohen M.** The process of validation of a three-dimensional model for the identification of abuse in older adults. *Arch Gerontol Geriatr.* **57**(3):243-9, Nov-Dec 2013.
12. **Burns D, Hyde P, Killett A.** Wicked problems or wicked people? Reconceptualising institutional abuse. *Sociol Health Illn.* **35**(4):514-28, May 2013.
13. **Schiamberg LB, Oehmke J, Zhang Z, Barboza GE, Griffore RJ, Von Heydrich L et al.** Physical abuse of older adults in nursing homes: a random sample survey of adults with an elderly family member in a nursing home. *J Elder Abuse Negl.* **24**(1):65-83, 2012.
14. **O'Brien JG.** A physician's perspective: elder abuse and neglect over 25 years. *J Elder Abuse Negl.* **22**(1-2):94-104, Jan 2010 Jan.
15. **Natan MB, Lowenstein A.** Study of factors that affect abuse of older people in nursing homes. *Nurs Manag (Harrow).* **17**(8):20-4, Dec 2010.
16. **Daly J, Coffey A.** Staff perceptions of elder abuse. *Nurs Older People.* **22**(4):33-7, May 2010.

17. **Oliveira AA, Trigueiro DR, Fernandes MG, Silva AO.** [Elderly maltreatment: integrative review of the literature]. *Rev Bras Enferm.* **66**(1):128-33, Jan-Feb 2013.
18. **Cooper C, Dow B, Hay S, Livingston D, Livingston G.** Care workers' abusive behavior to residents in care homes: a qualitative study of types of abuse, barriers, and facilitators to good care and development of an instrument for reporting of abuse anonymously. *Int Psychogeriatr.* **25**(5):733-41, May 2013.
19. **Payne BK, Cikovic R.** An Empirical Examination of the Characteristics, Consequences, and Causes of Elder Abuse in Nursing Homes. *J Elder Abuse Negl.* **7**(4):61-74, 1995.
20. **Murphy K, Waa S, Jaffer H, Sauter A, Chan A.** A literature review of findings in physical elder abuse. *Can Assoc Radiol J.* **64**(1):10-4, Feb 2013.

Table 1: Alleged victim's disability characterisation

Type of disability	
<i>Mental</i> (<i>n</i> = 11, 20%)	NSD (<i>n</i> = 4); NSD with inability to communicate (<i>n</i> = 3); NSD with inability to communicate and epilepsy (<i>n</i> = 1); Mixed aphasia with ITC (<i>n</i> = 1); Schizophrenia and difficulty in communication (<i>n</i> = 1)
<i>Motor</i> (<i>n</i> = 12, 21.8%)	Paraparesis (<i>n</i> = 4); Monoparesis (<i>n</i> = 2); Loss of sphincter continence (<i>n</i> = 1); Hemiparesis and NSOAP (<i>n</i> = 1); Hemiparesis, NSOAP and loss of sphincter continence (<i>n</i> = 1); Paraparesis and loss of sphincter continence (<i>n</i> = 1); Tetraparesis, loss of sphincter continence and dysarthria with ITC (<i>n</i> = 1); Triplegia and loss of sphincter continence (<i>n</i> = 1)
<i>Sensorial</i> (<i>n</i> = 2, 3.6%)	Unilateral decreased visual acuity (<i>n</i> = 1); Deaf-mute (<i>n</i> = 1)
<i>Multiple</i> (<i>n</i> = 30, 54.5%)	Mental and Motor (<i>n</i> = 25, 83.3%)
	Alzheimer's disease with ITC, NSOAP, tetraparesis (<i>n</i> = 2); Alzheimer's disease with ITC, tetraparesis and loss of sphincter continence (<i>n</i> = 2); Alzheimer's disease with ITC and apraxia (<i>n</i> = 1); Alzheimer's disease with ITC and loss of sphincter continence (<i>n</i> = 1); Aphasia with ITC and hemiparesis (<i>n</i> = 1); Aphasia with ITC, hemiparesis and loss of sphincter continence (<i>n</i> = 1); Aphasia and tetraparesis (<i>n</i> = 1); NSPP with ITC, tetraparesis and loss of sphincter continence (<i>n</i> = 1); NSD and hemiparesis (<i>n</i> = 1); NSD and paraparesis (<i>n</i> = 1); NSD and tetraparesis (<i>n</i> = 1); NSD with ITC, NSOAP and tetraparesis (<i>n</i> = 2); NSD with ITC and loss of sphincter continence (<i>n</i> = 1); NSD with ITC and paraparesis (<i>n</i> = 1); NSD with ITC and tetraparesis (<i>n</i> = 1); NSD with ITC, epilepsy, tetraparesis and loss of sphincter continence (<i>n</i> = 1); NSD with ITC, hemiparesis and loss of sphincter continence (<i>n</i> = 1); NSD, depression and tetraparesis (<i>n</i> = 1); NSD, depression, hemiparesis and dysarthria (<i>n</i> = 1); NSD, epilepsy, tetraparesis and loss of sphincter continence (<i>n</i> = 1); Parkinson's disease with dementia (<i>n</i> = 1)
	Mental and Sensorial (<i>n</i> = 2, 6.7%)
	NSD and bilateral decreased hearing acuity (<i>n</i> = 1); NSPP and decreased visual acuity (<i>n</i> = 1)
	Motor and Sensorial (<i>n</i> = 1, 3.3%)
	NSD, anxiety disorder and albinism (<i>n</i> = 1)
	Mental and Other (<i>n</i> = 1, 3.3%)
	NSD and muteness (<i>n</i> = 1)
	Mental, Motor and Sensorial (<i>n</i> = 1, 3.3%)
	NSPP with ITC, NSOAP, blindness, deafness (<i>n</i> = 1)

ITC = Inability to communicate; NSD = Non-specified dementia; NSOAP = Non-specified osteoarticular pathology; NSPP = Non-specified psychiatric pathology.

Table 2: Location of the resulting injuries

	n (%)	Location of injury (n)	
<i>Face</i>	2 (7.7)	Oral region (<i>n</i> = 1); Zygomatic region (<i>n</i> = 1)	
<i>Torso</i>	3 (11.5)	Abdomen and buttock region (<i>n</i> = 2); Abdomen (<i>n</i> = 1); Buttock region (<i>n</i> = 1)	
<i>Upper limbs</i>	8 (30.8)	Arm (<i>n</i> = 4); Forearm (<i>n</i> = 2); Arm and forearm (<i>n</i> = 1); Hands and fingers (<i>n</i> = 1)	
<i>Lower limbs</i>	2 (7.7)	Thigh (<i>n</i> = 1); Knee (<i>n</i> = 1)	
<i>Multiple</i>	11 (42.3)	Head and Upper limbs (<i>n</i> = 1)	Scalp, hands and fingers (<i>n</i> = 1)
		Head, Face and Upper limbs (<i>n</i> = 2)	Auricular region, infra-orbital region, zygomatic region, preauricular region, elbow, hands and fingers (<i>n</i> = 1); Scalp, zygomatic region, preauricular region, arm, elbow, forearm, wrist, hands and fingers (<i>n</i> = 1)
		Torso and Upper limbs (<i>n</i> = 1)	Thorax, arm and forearm (<i>n</i> = 1)
		Torso and Lower limbs (<i>n</i> = 1)	Buttock region and hip (<i>n</i> = 1)
		Torso, Upper and Lower limbs (<i>n</i> = 1)	Abdomen, shoulder, arm, elbow, forearm, thigh, knee and leg (1);
		Upper and Lower Limbs (<i>n</i> = 5)	Shoulder and knee (<i>n</i> = 1); Forearm and leg (<i>n</i> = 1); Arm, knee and leg (<i>n</i> = 1); Arm, forearm, hands and fingers, leg (<i>n</i> = 1); Arm, forearm, thigh, knee and leg (<i>n</i> = 1)

Table 3: Compatibility between the forensic medical findings and the complaint according to the alleged victim's characteristics.

		Physical Abuse			Neglect			
		Diagnostic of physical abuse <i>n</i> (%)	Nonspecific of physical abuse <i>n</i> (%)	<i>p</i>	Nonspecific of neglect <i>n</i> (%)	Suggestive of neglect <i>n</i> (%)	Highly suggestive of neglect <i>n</i> (%)	<i>p</i>
<i>Sex</i>	Male	2 (16.7)	10 (83.3)	0.127	5 (41.7)	3 (25)	4 (33.3)	0.394
	Female	2 (4.3)	45 (95.7)		16 (34)	6 (12.8)	25 (53.2)	
<i>Age</i>	[65;75 years[1 (7.7)	12 (92.3)	0.964	7 (53.8)	3 (23.1)	3 (23.1)	0.205
	≥ 75 years	3 (7.3)	38 (92.7)		14 (34.1)	6 (14.6)	21 (51.2)	
<i>Degree of disability</i>	None	1 (25)	3 (75)	0.316	1 (25)	2 (50)	1 (25)	0.003
	Mild/Moderate	1 (4.5)	21 (95.5)		14 (63.6)	2 (9.1)	6 (27.3)	
	Severe	2 (6.1)	31 (93.9)		6 (18.2)	5 (15.2)	22 (66.7)	
<i>Type of disability</i>	Mental	1 (9.1)	10 (90.9)	0.837	5 (45.5)	2 (18.2)	4 (36.4)	0.865
	Motor	1 (8.3)	11 (91.7)		3 (25)	1 (8.3)	8 (66.7)	
	Sensorial	0	2 (100)		1 (50)	0	1 (50)	
	Multiple	1 (3.3)	29 (96.7)		11 (36.7)	4 (13.3)	15 (50)	

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ANEXOS



JOURNAL OF FORENSIC AND LEGAL MEDICINE

An International journal of Forensic and Legal Medicine

AUTHOR INFORMATION PACK

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Reference to a book:

2. Strunk Jr W, White EB. *The elements of style*. 4th ed. New York: Longman; 2000.

Reference to a chapter in an edited book:

3. Mettam GR, Adams LB. How to prepare an electronic version of your article. In: Jones BS, Smith RZ, editors. *Introduction to the electronic age*, New York: E-Publishing Inc; 2009, p. 281–304.

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FICHA RESUMO DE PROJETOS DE INVESTIGAÇÃO CIENTÍFICA OU DE ARTIGOS CIENTÍFICOS
– A DECORRER OU A DESENVOLVER –

• **TÍTULO DO PROJETO/ARTIGO CIENTÍFICO** (se inexistente, indicar 3 palavras-chave que exprimam o tema):
Physical offenses against elderly persons in institutional settings

• **SERVIÇO/UNIDADE RESPONSÁVEL PELA EXECUÇÃO/ORIENTAÇÃO:** Departamento de Medicina Legal e Ciências Forenses da FMUP

• **ELEMENTO(S) RESPONSÁVEL(EIS) PELA ORIENTAÇÃO DO PROJETO/ARTIGO:** Professora Doutora Teresa Magalhães, Mestre Sofia Frazão

• **ELEMENTO(S) QUE VAI(VÃO) DESENVOLVER O PROJETO/ARTIGO:** Ana Margarida Correia, Sofia Frazão

• **EMAIL INSTITUCIONAL** (dos elementos atrás mencionados): tmaga@med.up.pt, lalanda77@hotmail.com, ambbpc@gmail.com

• **OUTRAS INSTITUIÇÕES ASSOCIADAS/COLABORADORAS** (se aplicável): Serviço de Clínica e Patologia Forenses da Delegação do Norte do INMLCF, I.P.

• **PROJETO SUBSIDIADO? SE SIM: INDICAR ENTIDADE FINANCIADORA & MONTANTE:**

Não

Sim

Entidade Financiadora: ; Montante €

• **ENCONTRA-SE INSERIDO EM ALGUM CURSO? SE SIM INDIQUE QUAL:**

DE Pré-GRADUAÇÃO

Faculdade de , Universidade de



Departamento de Investigação, Formação e Documentação

Outra:

DE PÓS - GRADUAÇÃO:

Mestrado (Pré-Bolonha)

Mestrado em _____, pela Faculdade/Universidade:

Mestrado Integrado (Processo Bolonha)

Faculdade de Medicina, Universidade de Porto

Doutoramento/Programa Doutoral

Doutoramento em Ciências Forenses, pela Faculdade/Universidade: Porto

Pós-Doc

Pela Faculdade/Universidade:

Outra:

• PERÍODO (DATAS) EM QUE DECORRE (início e fim): julho de 2014 e maio de 2015

• RECURSOS ESPECÍFICOS | MATERIAL E MÉTODOS A USAR:

Instalações: consulta de relatórios periciais de Clínica Forense

Consumíveis:

Pessoal:

Amostras Biológicas*:

Outros:



*** Obrigatório o preenchimento do Formulário MOD 005 - DIFD (Pedido de Colheita e/ou Utilização de Amostras Biológicas para Investigação e/ou Treino Cirúrgico)**



• RESUMO DO PROJETO/ARTIGO (máximo uma página):

Introduction: According to WHO, elder maltreatment is defined as “a single or repeated act or lack of appropriate action, occurring within any relationship in which there is an expectation of trust, that causes harm or distress to older people”. With the progressive increase in life expectancy, people over 65 years are estimated to represent 25% of the European population by 2050, against the 14% in 2010. The same trend may be observed in Portugal. As a result, families are resorting to institutional care more often and these more challenging patients are at higher risk for abuse, following, among others, the caregivers’ burnout associated with providing care for elders with cognitive and physical impairment augmented needs. Abuse affects mental, physical and psychological well-being, contributing to diminished quality of life, increased morbidity and health costs, reduced survival, functional and cognitive impairment. The consequences of this abuse create a vicious cycle of more dependency and deterioration of health, more need for long term care, more caregivers’ burnout, hence more violence towards the elderly. On top of that, the ongoing crisis inflates the strain on the families and professional caregivers, also facilitating the occurrence of abuse. Despite the well-studied familial abuse, institutional abuse still lacks proper analysis of its risk factors, with low identification and reporting rates (limited analysis). Therefore and in anticipation to the expected increased prevalence following the rapid ageing of the population, it is urgent to analyse and understand this emerging issue so that social policies and regulation may be developed in an effort to protect the elderly. Aim: To promote a better knowledge about physical offenses perpetrated against elderly people in institutional settings, in order to promote the detection and prevention of these cases. It will focus on physical abuse towards people aged 65 years and older in institutional settings, perpetrated by family members, other residents and/or institutional caregivers (“person who undertake the fiduciary responsibility to provide residents with care and protections, and include paid caregivers, accessory staff and other professionals”). Material and methods: A retrospective analysis of clinical forensic medical reports will be performed. Cases’ inclusion criteria are: (a) alleged victim 65 years of age or older; (b) allegedly abused in an institutional setting by a family member, another resident or institutional caregiver; (c) having been submitted to a forensic medical evaluation in the scope of criminal law; (d) at the north branch of the National Institute of Legal Medicine and Forensic Sciences of Portugal, in Porto; (e) between 2003 and 2013. Data extracted from reports included characterization of: (a) the alleged victim’s and abuser’s socio-demographics; (b) the relationship between alleged victim and abuser; (c) the type of disability presented by the victim; (d) previous episodes of violence perpetrated by the same alleged abuser; and (e) the episode of abuse that motivated the report and consequent forensic medical examination, namely its type, the resultant lesions, the need for medical treatment and the existence of permanent physical consequences.

Departamento de Investigação, Formação e Documentação

11/06/2014

Fernando da Silva
(Assinatura do Responsável)

Parecer do Diretor/Coordenador de Serviço:

Concordo.
13/06/2014
[Assinatura]

Parecer do DIFD:
 Favorável Não favorável
Data: 30 Junho 2014

[Assinatura]
Parecer DIFD n.º 08/2014

Despacho RAI:
 Autorizado ^(*)
 Indeferido
Data: 25.06.2014

^(*) Parecer n.º 23/2014

Despacho do Diretor da Delegação:
 Deferido Indeferido
Data: 30/6/14 S. Janeiro

Vice-Presidente
Conselho Diretivo do INMLCF, I.P.

Parecer do Departamento de Investigação, Formação & Documentação (DIFD)

Atividade de Investigação Científica - PARECER nº08/2014

1. Pedido de **ANA MARGARIDA CORREIA E SOFIA FRAZÃO**, subscrito pela Prof^a. Doutora Teresa Magalhães, para consultar e recolher dados dos relatórios periciais de clínica forense relativos a casos de maus tratos a idosos.
2. O pedido surge no âmbito do Mestrado Integrado e do Doutoramento em Ciências Forenses da Faculdade de Medicina da Universidade do Porto (FMUP) com o tema intitulado "*Physical offenses against elderly persons in institutional settings*", sendo orientada pela Senhora Prof^a. Doutora Teresa Magalhães e Dr^a. Sofia Frazão.
3. MOD 004 - DIFD devidamente preenchido.
4. Com parecer positivo por parte do Responsável pela respetiva Unidade Funcional.
5. Com parecer (Parecer nº 23/2014) do Responsável pelo Acesso à Informação deferindo o pedido, desde que salvaguardadas as condições expostas.

Face à posição do RAI sobre a apreciação de legalidade dos pedidos de acesso a relatórios periciais, entende-se que no âmbito da atividade de investigação científica do INMLCF, I.P. protocolada com instituições de ensino universitário ou de investigação em que o investigador tenha aquele enquadramento institucional, o condicionamento do acesso à informação constante dos relatórios periciais implica a proibição do registo, em qualquer tipo de suporte, dos elementos identificativos do processo judicial, designadamente, os elementos identificativos do examinado, o número do processo judicial e o tribunal respetivo.

Face ao exposto, sou de parecer favorável ao pedido efetuado, sendo da opinião de que competirá ao diretor da respetiva unidade funcional velar pela observância dos procedimentos que garantam o mencionado condicionamento.

30 de Junho de 2014

A Diretora do DIFD


(Helena M. Teixeira)

Parecer do Responsável pelo Acesso à Informação (*)

PARECER N.º 23/2014

ASSUNTO: Pedido de colaboração para realização do trabalho científico “Physical offenses against elderly persons in institutional settings”, no âmbito da realização de mestrado integrado da Faculdade de Medicina da Universidade do Porto e de Doutoramento em Ciências Forenses pela mesma Universidade (Ana Margarida Correia, Sofia Frazão).

SUMÁRIO

I - A atividade de investigação científica, designadamente a colaboração na realização de estudos científicos, inclui-se no conjunto das legais atribuições dos serviços médico-legais.

II - A atividade estruturante e fundamental dos serviços médico-legais é a atividade pericial, pelo que o acesso à informação processual no desenvolvimento da atividade científica toma como pressuposto a necessidade da adequação desta atividade ao ambiente processual (ao contexto normativo) no qual se insere a atividade pericial.

III – O estatuto processual dos serviços médico-legais implica que estes garantam, no desenvolvimento da atividade científica e designadamente na consulta da informação pericial para tanto necessária, a devida preservação do acesso aos dados que são de natureza confidencial.

IV - O pedido de consulta vai deferido, no pressuposto de que o serviço técnico competente assegura que o requerente não identificará os casos concretos vertidos em cada processo médico-legal e judiciário.

(*) O Parecer do Responsável pelo Acesso à Informação (RAI) é um parecer sobre a legalidade do requerido acesso à informação (pericial, designadamente), e respetiva reutilização. O parecer do RAI sobre pedidos visando finalidades de ensino, formação e, ou, investigação científica, é, pois, distinto e independente da apreciação que o DIFD - Departamento de Investigação, Formação e Documentação, em articulação com os Serviços Técnicos, faça quanto ao interesse (para o INMLCF), à oportunidade e à viabilidade de execução do(s) pedido(s).

Parecer do Responsável pelo Acesso à Informação

PARECER N.º 23/2014

ASSUNTO: Pedido de colaboração para realização do trabalho científico “Physical offenses against elderly persons in institutional settings”, no âmbito da realização de mestrado integrado da Faculdade de Medicina da Universidade do Porto e de Doutoramento em Ciências Forenses pela mesma Universidade (Ana Margarida Correia, Sofia Frazão).

1. Descrição do Pedido

Subscrito pela Senhora Prof. Doutora TERESA MAGALHÃES, foi recebido no Instituto Nacional de Medicina Legal e Ciências Forenses (INMLCF), requerimento de pedido de afetação de recursos deste Instituto à realização de investigação, no âmbito de cursos de pós-graduação, a desenvolver por ANA MARGARIDA CORREIA, e por SOFIA FRAZÃO.

No âmbito do(s) trabalho(s) a realizar (sob orientação de docentes que são médicos da carreira médica de medicina legal), pretende-se, pois, permitir a consulta de relatórios periciais de clínica forense relativos a casos de *maus tratos em idosos* (o requerimento, porém, não especifica o tipo de suporte dos relatórios a consultar, nem especifica os critérios de determinação do conjunto de relatórios a consultar, isto é, não diz se a consulta abrange relatórios de perícias que não tenham sido realizadas na Delegação do Norte, muito menos qual o período temporal a que respeitam as perícias realizadas).

2. Enquadramento do pedido à luz das legais atribuições do INMLCF

2.1. O pronunciamento sobre a colaboração solicitada implica o prévio enquadramento da atividade de investigação científica no INMLCF.

Nos termos do n.º 1 do artigo 3.º do Decreto-Lei n.º 166/2012, de 31 de julho, diploma que define as missões e atribuições do INMLCF, este Instituto «tem por missão assegurar a formação e coordenação científicas da atividade no âmbito da medicina legal e de outras ciências forenses, superintendendo e orientando a atividade dos seus serviços médico-legais e dos peritos contratados para o exercício de funções periciais.».

É, aliás, expressa atribuição do INMLCF «desenvolver atividades de investigação e divulgação científicas, de formação e de ensino, no âmbito da medicina legal e de outras ciências forenses e desenvolver formas de colaboração científica e pedagógica com outras instituições» (cf. a alínea c do n.º 2 do mencionado artigo 3.º).

Consequentemente, e nos termos do n.º 1 do artigo 20.º Decreto-Lei n.º 166/20012, de 31 de julho, «o INMLCF, I.P., prossegue as suas atribuições e exerce as suas competências em colaboração com os estabelecimentos de ensino superior, especialmente escolas médicas, nomeadamente de investigação, públicas ou privadas, mediante a celebração de protocolos nas áreas do ensino, da formação e da investigação científica.».

Deve ainda referir-se - como reforço do mencionado interesse público na atividade de investigação científica por parte dos serviços médico-legais - que uma das finalidades da existência, nos serviços médico-legais, de «ficheiros de dados informatizados nas áreas de tanatologia forense, clínica médico-legal, biologia forense, toxicologia forense, psiquiatria forense, anatomia patológica e

histopatologia forense, e criminalística» (n.º 1 do artigo 1.º do Decreto-Lei n.º 395/99, de 13 de Outubro, que autoriza e regula os mencionados ficheiros de dados informatizados) é a «elaboração de trabalhos de investigação científica, desde que não sejam identificáveis as pessoas a que respeitam» (alínea *h* do n.º 4 do referido artigo 1.º).

Temos, pois, que a atividade de investigação científica é uma atividade que o legislador desejou para o INMLCF entendendo-se que a colaboração com os estabelecimentos de ensino universitários é fundamental para a constante atualização do conhecimento científico, seja o que pode diretamente constituir suporte óbvio da continuidade e melhoria da qualidade das perícias médico-legais e forenses e, em geral, da intervenção pericial dos serviços médico-legais, seja o que se traduza, mesmo que indiretamente, na adoção de medidas de intervenção nas problemáticas relacionadas com as situações de vitimação que justificam a intervenção pericial do INMLCF.

2.2. Feito este enquadramento prévio, cabe explicitar a natureza jurídica e processual da intervenção pericial dos serviços médico-legais.

Para tanto, recorre-se à análise dos fundamentos legais da intervenção processual dos serviços médico-legais, como segue.

Os serviços médico-legais, administrativamente organizados no INMLCF, são (os) serviços de apoio técnico aos tribunais e ao Ministério Público, na área da Medicina Legal e de outras Ciências Forenses, conforme definido no Decreto-Lei n.º 166/2012, de 31 de julho.

A atividade fundamental e estruturante do INMLCF é a atividade pericial de apoio técnico à administração da justiça, conforme se pode diretamente liquidar das várias disposições relativas às atribuições e competências dos distintos

órgãos e serviços médico-legais, constantes do sua lei orgânica (Decreto-Lei n.º 166/2012, de 31 de julho) e dos seus Estatutos, aprovados pela Portaria n.º 19/2013, de 21 de janeiro, quer ainda, obviamente e sobretudo, de todo o conteúdo normativo do regime jurídico da realização das perícias médico-legais e forenses (Lei n.º 45/2004, de 19 de Agosto).

Nos termos da sua lei orgânica e da lei das perícias médico-legais e forenses, e de acordo com as leis de processo nos tribunais, os serviços médico-legais atuam no âmbito dos processos judiciais como auxiliares (serviços de apoio técnico pericial) do Ministério Público (ou do Tribunal), estando por isso obrigados a respeitar as regras processuais que dispõem sobre a produção da prova pericial. Com efeito, existem regras para o surgimento da perícia médico-legal no processo, consoante a área do Direito em questão, fixadas, designadamente, no Código de Processo Civil (cf., especialmente, quanto à realização das perícias médico-legais, o artigo 467.º, n.º 3), no Código de Processo Penal (cf., especialmente, quanto à realização das perícias médico-legais, o artigo 159.º), no Código de Processo do Trabalho (cf., em processo especial, os artigos 101.º e 102.º, artigo 105.º, n.º 2, 117.º, 134.º, 138.º, 139.º, e 145.º), e também na Lei n.º 45/2004, de 19 de Agosto (especialmente os artigos 2.º a 6.º, e 9.º a 26.º).

Encontramos, assim, uma clara conexão entre as perícias médico-legais e o processo a que se destinam, daqui resultando uma dependência processual da intervenção pericial médico-legal, dependência que se reporta à fixação do objeto da perícia, ao momento e ao tempo processual da intervenção pericial, e ao tratamento e disposição da informação pericial.

Precisamente, e como se colhe do Parecer n.º 30/2005, de 2-6-2005, do Conselho Consultivo da Procuradoria-Geral da República (PGR), a perícia tem uma função exclusivamente processual. Conforme aí se refere, «o regime processual relativo à prova pericial apresenta-se, assim, suficientemente

determinado em termos de assinalar à perícia a natureza de meio de prova organizada e produzida no próprio processo que a utiliza, quer porque se destina a fazer a prova de factos processualmente relevantes na relação discutida ou na situação averiguada, quer porque a lei estabelece por quem e em que condições é determinada ou solicitada (requisitada) às entidades que têm por funções ou atribuições realizá-la.».

Em conformidade com o enquadramento processual da atividade dos serviços médico-legais, existe entre estes e as autoridades judiciárias uma relação funcional no âmbito da qual estas autoridades definem os casos a submeter à intervenção dos serviços médico-legais e determinam o objeto da perícia, cabendo aos serviços médico-legais exercer a sua função de serviços auxiliares da administração da justiça mediante a realização de exames e perícias, estando excluída da competência destes serviços a prática de quaisquer outros atos processuais que não tenham a prévia indicação ou autorização da autoridade judiciária competente, ou sejam solicitados por autoridade policial ou administrativa a que faleça a devida competência legal (processual), própria ou delegada (ressalvada a exceção prevista no artigo 4º da Lei n.º 45/2004, de 19 de Agosto, quanto à competência dos serviços médico-legais para a prática de atos urgentes e recebimento de denúncias de crimes).

Assim, encontram-se os relatórios periciais médico-legais numa situação de dependência processual relativamente aos procedimentos judiciais para que são produzidos (isto é, pertencem *ao processo*) pelo que o acesso de terceiros a essas peças processuais está subordinado aos poderes de direção intraprocessual da respetiva autoridade judiciária competente. No âmbito Processual Penal (aquele em que ora nos situamos) estão os serviços médico-legais por isso obrigados a respeitar as regras processuais relativas ao acesso aos documentos do processo (designadamente as constantes dos artigos 86.º, n.ºs 9 e 11, 89.º, n.ºs 1, 4 e 6, e 90.º, n.º 1, todos do Código de Processo

Penal), obrigação que se estende aos próprios documentos (os relatórios periciais) produzidos por aqueles serviços, incluindo qualquer informação relativa ao diagnóstico médico-legal do facto em apreciação, ou surgida ou recolhida durante e por causa da intervenção pericial.

Cabe, pois, ao INMLCF, no processo penal e fundamentalmente em fase de inquérito, realizar os exames e as perícias na qualidade de auxiliar do Ministério Público, agindo na dependência funcional da autoridade judiciária competente que determinou a realização de tais exames e perícias, devendo o acesso ao relatório pericial ou a qualquer informação resultante da perícia - para fins processuais, do mesmo processo no qual a perícia se integra, ou de diferente processo, judiciário ou judicial, ou de outro a que se apliquem, ainda que subsidiariamente, as leis de processo nos tribunais, ou para qualquer outra finalidade que não a investigação científica - ser direta e unicamente solicitado à autoridade judiciária titular do processo no âmbito do qual foi realizada a perícia, ou que nele tiver proferido a última decisão.

3. Viabilidade do acesso à informação pretendida

A apreciação da viabilidade do acesso à informação pretendida toma como pressuposto a necessidade da adequação da atividade científica do INMLCF ao ambiente processual no qual se insere a atividade fundamental e prioritária deste Instituto, que é, como é sabido, a atividade pericial.

Para o desenvolvimento da atividade de investigação científica que estatutariamente lhe compete e conforme as concretas competências que lhe são atribuídas, o INMLCF observa as pertinentes disposições legais aplicáveis, a saber, a norma do n.º 1 do artigo 20.º do Decreto-Lei n.º 166/2012, de 31 de julho, quanto à legitimidade das entidades e utilizadores que pretendam aceder

à informação, bem como a norma da alínea *h* do n.º 4 do artigo 1.º do Decreto-Lei n.º 395/99, de 13 de Outubro, quanto às condições desse acesso.

A eficaz concretização da legal atribuição de desenvolver atividade científica (mesmo que em colaboração com instituições terceiras) admite que o INMLCF possa decidir sobre pedidos de consulta de relatórios periciais para os exclusivos fins de produção de conhecimento científico, desde que esteja previamente garantido o devido condicionamento do acesso à informação por parte dos utilizadores estranhos ao INMLCF (que, em regra, são os requerentes dos pedidos de consulta), de modo a impedir que aqueles identifiquem e registem os processos judiciais concretos a que respeitem os relatórios periciais, ou os respetivos ficheiros informáticos, consultados.

A preservação do acesso aos dados periciais - que são processuais e de natureza confidencial - assume especial relevância quanto aos processos que eventualmente¹ se encontrem em segredo de justiça, cujo regime, em princípio, impedirá que qualquer terceiro não interveniente processual aceda ao processo. Ora, o INMLCF não sabe se os processos em que intervém se encontram em segredo de justiça, sendo que um processo relativamente ao qual vigore a regra da publicidade pode ser sujeito a qualquer momento ao segredo de justiça (e vice-versa, aliás) sem que disso seja o INMLCF notificado.

Daí que a permissão de consulta (seja de relatórios periciais, seja de bases de dados de perícias, ou de qualquer outro suporte documental que contenha informação pericial) concedida pelo INMLCF implique os adequados orientação e acompanhamento do acedente, visando assegurar que se respeitam as implícitas e necessárias restrições no acesso concedido.

¹ O segredo de justiça tem, por definição legal, natureza excepcional. A regra é a publicidade, nos termos do disposto no n.º 1 do artigo 86.º do CPP, podendo ser sujeito a segredo, nos termos do disposto nos n.ºs 2 e 3 do mesmo artigo.

3.1. No caso vertente

Apesar de não tal não vir invocado no requerimento, a instituição que enquadra o estudo científico que justifica o pedido formulado (FMUP) estabeleceu Protocolo de Cooperação Pedagógica e Científica com o INMLCF, estando, assim, reunido o requisito referido no artigo 20.º, n.º 1, da lei orgânica do INMLCF (a articulação interinstitucional prévia e específica no domínio pedagógico e científico entre o INMLCF e uma instituição terceira).

A profissão e o estatuto médico-legais dos orientadores do trabalho científico demonstram a efetividade daquele requisito legal.

4. Conclusão

Em razão, nos pressupostos e nos termos do supra exposto,

DEFERE-SE O PEDIDO,

devendo o Serviço de Clínica e Patologia Forenses da Delegação do Norte do INMLCF assegurar as condições de observância da necessária confidencialidade.

25 de junho de 2014

O Responsável pelo Acesso à Informação



(Diogo Pinto da Costa)

Autorização de acesso
aos respetivos Gabinetes Médico-Legais e
Forenses.
4.12.13

Exma. Senhora

Prof. Doutora Teresa Magalhães

Directora da Delegação do Norte do INMLCF, I.P.

REQUERIMENTO

Eu, **Sofia Manuela Lalanda Maia Frazão**, enquanto estudante do 3º ciclo de estudos em Ciências Forenses da Universidade do Porto, a realizar o trabalho de tese sob orientação da Professora Doutora Teresa Magalhães, com o título **"O abuso físico no idoso. Contributo para a sua caracterização e intervenção médico-legal"**, venho solicitar autorização, na sequência de alterações que foram introduzidas ao projeto, para ter acesso aos relatórios de Clínica Forense e Patologia Forense relativos a idosos vítimas de violência (mortal e não mortal) observados nesses serviços da Delegação Norte do INMLCF, I.P. e respetivos Gabinetes Médico-Legais e Forenses.

Os dados destinam-se à realização dos seguintes trabalhos científicos:

1. **Physical offenses against elderly people. A comparative study of intra and extra-familial cases.**
2. **Physical offenses against elderly people under foster care.**
3. **Elderly abuse and disabled people.**
4. **Judicial outcomes in elderly abuse cases. The impact of the new Portuguese Penal Code and of the forensic medical reports.**
5. **Fatal abuse against elderly people. A study in the north of Portugal.**
6. **Elderly abuse. Detection and report by medical practitioners.**

Garanto a segurança, confidencialidade e anonimato dos dados a consultar, de acordo com a legislação vigente no que respeita ao acesso a relatórios periciais médico-legais para fins de investigação científica, sendo que os mesmos apenas serão utilizados para fins de investigação científica.

Com os mais respeitosos cumprimentos, peço deferimento.

Porto, 4 de Dezembro de 2013


(Sofia Manuela Lalanda Maia Frazão)

INSTITUTO NACIONAL DE MEDICINA LEGAL, I.P.
DELEGAÇÃO DO NORTE
N.º de Entrada 39832
Recabido em 5 de 12 de 2013
Respondido em 00 de
Processo n.º