THE COGNITIVE MECHANICS OF ELDER ABUSE

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Abstract

Whilst the link between cognitive impairment, undue influence, elder abuse and testamentary capacity is well established, the details of this relationship are not. The focus of this paper is around the *mechanics* of elder abuse. It examines the question: What is going on cognitively speaking, when the wishes and intents of an elderly client are overborne by another person in a manner amounting to unconscionable conduct or undue influence?

It is suggested that although the law treats the concepts of legal capacity and undue influence as separate entities, in so far as undue influence presupposes that the individual had capacity, in reality, the two rarely operate in isolation and are all but inseparable in a clinical setting. That is to say, whilst the law requires that capacity must exist for undue influence to occur, undue influence almost always occurs in the context of diminished capacity. An understanding of the relationship between cognitive impairment and elder abuse is required to differentiate undue influence from supported decision making, to devise and apply preventative strategies around elder abuse and to facilitate the selection of appropriate forms of decision-making support in cognitively impaired elderly clients.

I INTRODUCTION

Legal capacity involves decision making. Modern theories of decision making delineate three phases. The first phase is the generation of options; the second phase is the selection of options; and the third phase is the initiation of action[1]. Cognitive impairment can impede any one or more of these phases of decision making, increasing an individual's vulnerability to financial and emotional harm.

In a recent High Court Judgment around binding financial agreements (BFAs), undue influence was said to occur when 'a party is deprived of *free agency* in entering into an arrangement'. Unconscionable conduct is defined as a special disadvantage that 'seriously affects the weaker

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[1] A. Kalis, A. Mojzisch, T.S. Schweizer & S. Kaiser 'Weakness of will, akrasia and the neuropsychiatry of decision making: An interdisciplinary perspective' (2008) 8(4) *Cognitive, Affective, & Behavioural Neuroscience* 402.

party's ability to safeguard their interests'. Six factors were noted to be of relevance in assessing whether undue influence has occurred. Two of these reference the opportunity for *reflecting* (on advice received, for example, and available options or facts relevant to the decision).

Cognitive impairment in a number of different domains, including those of memory and executive function can adversely impact or prevent the person's ability to reflect in the process of decision making. For example, how might an individual reflect upon facts, advice, and different options if he/she is unable to retain such information for long enough to do so? How might an individual reflect upon the potential future impacts of a decision if he/she is not capable of thinking in abstract terms or is unable to consider future hypothetical scenarios? How may an individual safeguard his/her own interests when they are no longer able to remember what happened yesterday, judge or appraise the intentions of others, detect errors of an incongruous nature, or reason in an autonomous manner?

Cognitive impairment is a well-established risk factor for elder abuse[2] and financial exploitation.[3] It is a primary contributory factor in cases of undue influence[4] and disputed testamentary capacity.[5] Whilst the link between cognitive impairment, undue influence, elder abuse and testamentary capacity is well established, the details of this relationship, including our understanding of the risk factors, are not. It has been suggested that 'many Australians are likely to be affected by elder abuse if our understanding of this issue does not improve, as this prevents the establishment of evidence-based prevention and response programs'.[6]

The focus of this paper is around the *mechanics* of elder abuse. It examines the question; What is

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[2] X Dong et al 'Association of cognitive function and risk for elder abuse in a community-dwelling population'(2011) 32(2) *Dementia and Geriatric Cognitive Disorders* 209-215.
[3] P.A. Boyle et al, 'Poor decision making is a consequence of cognitive decline among older persons without Alzheimer's disease or mild cognitive impairment' (2012) 7(8) *PLOS One* 1; P.A. Lichtenberg et al, 'The Lichtenberg Financial Decision Screening Scale. A new tool for assessing financial decision making and preventing financial exploitation' (2016) 28(3) *J of Elder Abuse & Neglect* 134-151.
[4] Darryl Brown, 'Undue influence and coercion in wills' (2018) 5th Annual Melbourne Wills and Estates Conference.
[5] J.A. Lonie & K. Purser, 'Assessing testamentary capacity from a medical perspective' (2017) 44 *Australian Bar Review* 297.
[6] J Chesterman & L Bedson. (2017). *Are national elder abuse prevalence studies inclusive of the experiences of people with cognitive impairment? Findings and recommendations for future research.* Melbourne: Office of the Public Advocate.

going on cognitively speaking, when the wishes and intents of an elderly client are overborne by another person in a manner amounting to unconscionable conduct or undue influence?

With this question in mind, the tightly related concepts of capacity, unconscionable conduct and undue influence are examined in their roles as vehicles for elder financial abuse using the recent judgment of *Fisher-Pollard v Piers Fisher-Pollard*[7] as a basis for discussion.

It is suggested that although the law treats the concepts of legal capacity and undue influence as separate entities, in so far as undue influence presupposes that the individual had capacity, in reality the two rarely operate in isolation and are all but inseparable in a clinical setting. That is to say, whilst the law requires that capacity must exist for undue influence to occur, undue influence almost always occurs in the context of diminished capacity. An understanding of the relationship between cognitive impairment and elder abuse is required to differentiate undue influence from supported decision making and to facilitate the selection of appropriate forms of decision-making support in cognitively impaired elderly clients.

II CONTEXTUAL FACTORS IN ELDER ABUSE

There are a number of key factors setting the medical context for the problems of diminished capacity, undue influence and elder abuse. One relates to the prevalence of cognitive impairment among the elderly. The Australian Bureau of Statistics suggests that by 2050 1/5 of the population will be greater than 65 years of age[8] and just under one million Australians will be living with a diagnosis of dementia. One in every ten persons aged 65 years or older live with dementia. The figure rises to 3/10 by 80 years.[9]

A second key factor relates to the manner in which the dementias manifest themselves. The cellular changes within the brain that accumulate and eventually result in dementia begin 20

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[7] *Fisher-Pollard v Piers Fisher-Pollard* [2018] NSWSC 500.
[8] Australian Bureau of Statistics, *Australian Social Trends 4102.0 – Future Population Growth and Ageing* (2009) 2–3; Access Economics, *Keeping Dementia Front of Mind: Incidence and Prevalence 2009–2050* (Alzheimer's Australia, August 2009).
[9] https://www.dementia.org.au/statistics

years prior to the point at which the first symptom appears (during the period that we refer to as 'normal aging').[10] Cognitive impairment does not begin suddenly but rather develops in an insidious manner and deteriorates slowly and progressively over time. As a result, individuals who go on to develop dementia pass through a prolonged phase of cognitive impairment prior to coming to the attention of the medical profession. This pre-diagnostic phase was formerly referred to as mild cognitive impairment [11] and now mild neurocognitive disorder[12].

A *The Interval of Legal Mayhem*

The final piece of the puzzle relates to the difficulties and delays that exist around diagnosing mild neurocognitive disorder and dementia. The detection of mild neurocognitive disorder is reliant upon the administration of appropriately sensitive formal neuropsychological measures.[13] Individuals with mild neurocognitive disorder often perform normally on cognitive screening tests. GP's are notoriously poor at detecting and diagnosing dementia, missing up to 90% of early stage cases in clinical practice.[14] As a result, there are extensive periods of time across which elderly individuals are significantly cognitively impaired as a result of an underlying or emerging dementia that is yet to be diagnosed or investigated.

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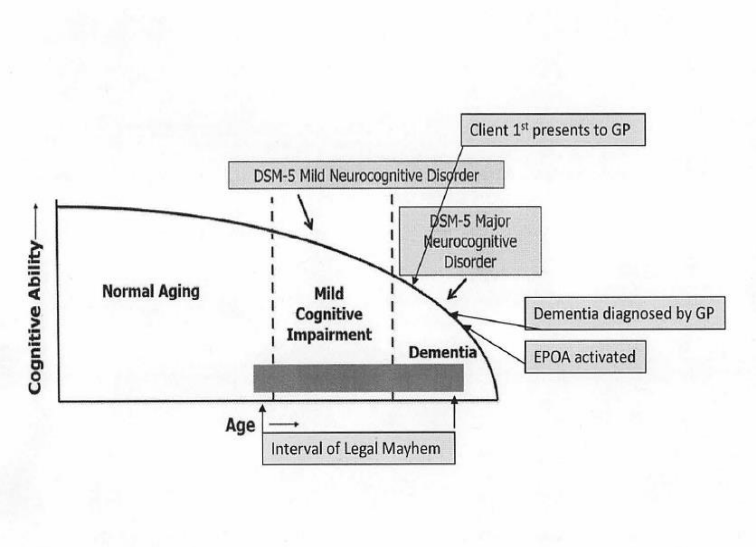
[10] Gary Small, 'Detection and prevention of cognitive decline' (2016) 24 *American Journal of Geriatric Psychiatry* 1142.
[11] R.C. Petersen et al 'Mild cognitive impairment: clinical characterization and outcome' (1999) 56 *Archives of Neurology* 303.
[12] American Psychiatric Association, *Diagnostic and statistical manual of mental disorders, 5th ed.* (Washington DC: American Psychiatric Association Publishing, 2013).
[13] Ibid.
[14] A. Bradford et al 'Missed and delayed diagnosis of dementia in primary care: prevalence and contributing factors' (2009) 23(4) *Alzheimer's Disease and Associated Disorders* 306.



It is during this time period, which I have referred to as the interval of 'legal mayhem', where problems around legal capacity in elderly clients typically arise. During this interval the foundations are laid for multiple tribunal hearings in the years that follow and costly contested estate matters further down the track. I will return to discuss this interval within the context of the recent judgment of *Fisher-Pollard*.[15]

Current dementia prevalence estimates do not account for cognitive impairment arising at the Mild Neurocognitive Disorder phase of a neurodegenerative (dementia) process and can therefore be expected to underestimate the true prevalence of cognitive impairment among elderly Australians. Data from the University of Michigan, Health and Retirement Study indicates the incidence of Mild Cognitive Impairment is at least double that of dementia in older adults between 70-84 years of age and just under double from the age of 85 years onwards.[16]Mild Cognitive Impairment has been shown to exert a significant adverse impact on the financial management capacity of an individual[17] and as noted above, is a well-established primary risk factor in elder financial abuse.

The incidence and prevalence of elder abuse is alarming. American figures suggest one in 10

[15] *Fisher-Pollard v Piers Fisher-Pollard* [2018] NSWSC 500.
[16] A Belbase and G T Sanzenbacher, 'Cognitive aging and the capacity to manage money' (2017) 17 Centre for Retirement Research at Boston College 1.
[17] L M Niccolai et al, 'Neurocognitive predictors of declining financial capacity in persons with mild cognitive impairment' (2017) 40 *Clinical Gerontologist* 14; K L Triebel et al, 'Declining financial capacity in mild cognitive impairment. A 1-year longitudinal study' (2009) 73(12) *Neurology* 928-934.

seniors over the age of 60 living at home are subject to abuse,[18] and one in five over the age of 65 are subject to elder financial exploitation. For every one case of elder financial exploitation that is reported a further 43 cases never come to light.[19]

The literature suggests that we, as solicitors, financial advisors, wills and estates practitioners and clinicians, are encountering a minority of these people - seeing the tip of an iceberg. There are good reasons why this may be the case. Individuals who experience loss of cognitive and financial management capacity, are often unaware it is happening and remain confident in their capabilities.[20] Undue influence only comes to our attention when there is a third party, typically another sibling or relative, who ultimately loses out as a result of the undue influence and therefore objects to and challenges the decision. When such a party is not present, the decision goes uncontested, there is no family conflict and nothing to bring the situation to our attention.

III SUPPORTED DECISION MAKING OR UNDUE INFLUENCE?

The vast majority of decisions (testamentary, financial or otherwise) undertaken by cognitively impaired older adults are being made in this manner, that is, with the support or influence of one or more family members, without the involvement of legal or medical practitioners. That is to say informal supported decision making if you like is, in practical terms, the status quo. When the decision made is agreed upon by all stakeholders, typically siblings, supported decision making and/or undue influence operating within a supported decision-making context, go unnoticed and unchallenged.

How then do we ascertain the difference between informal or formal supported/assisted decision making and undue influence? At what point does a decision move from one that has been

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[18] National Council on Aging, https://www.ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/#intraPageNav1; Mark S Lachs and Karl A Pillemer 'Elder Abuse' (2015) 373 *New England J of Medicine* 1947-1956.

[19] Lifespan of Greater Rochester Inc and Weill Cornell Medical Centre, Cornell University *Under the Radar: New York State Elder Abuse Prevalence Study; Self-Reported Prevalence and Documented Case Surveys,* Final Report, May 2011 available at https://nyceac.org/wp-content/uploads/2011/05/UndertheRadar051211.pdf

[20] O C Okonkwo et al , 'Awareness of deficits in financial abilities in patients with mild cognitive impairment: Going beyond self-informant discrepancy' (2008) 16 *American Journal of Geriatric Psychiatry* 650.

supported to one that has been influenced? What level of legal and cognitive capacity (and what cognitive skills) are required to support an impaired decision maker without influencing their decision? These questions and the practical conundrums to which they give rise, should ideally be explored and addressed *prior* to the implementation of models of supported decision making for elderly persons living with cognitive impairment.

In everyday clinical and legal practice, when dealing with elderly clients and patients, we are regularly faced with the task of differentiating between influence and support. We may revert to our own moral compass, our own beliefs around what appears to be a reasonable and just course of action or decision. In doing so, we are differentiating between undue influence and supported decision making on the basis of what we perceive to be ethically permissible. Indeed, the equity of the result is recognised in Californian law[21] as a factor determining the operation of undue influence, together with victim vulnerability, (including the presence of any cognitive impairment), influencer authority and conduct.

Another way we might seek to differentiate between undue influence and supported decision-making on the part of an elderly client's son or daughter, for example, is to look for the presence of 'red flags'. The International Psychogeriatric Association Task Force on Testamentary Capacity and Undue Influence[22] identified three areas of risk: (1) social or environmental risk factors such as dependency, isolation, family conflict, and recent bereavement; (2) psychological and physical risk factors such as physical disability, deathbed wills, personality disorders, substance abuse, and mental / cognitive disorders including dementia, delirium, and mood and paranoid disorders; and (3) legal risk factors such as unnatural provisions in a will, or provisions not in keeping with the previous wishes of the person making the will, and the instigation or procurement of a will by a beneficiary.

Each of the above factors have been identified as risk factors for susceptibility to undue

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[21] Cal *Welfare and Institutions Code, Ch 11 Elder Abuse and Dependent Adult Civil Protection Act* §15610.70(a)(4) available at http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=15610.70.

[22] C Peisah et al., 'The wills of older people: risk factors for undue influence' (2009) 21(1) *International Psychogeriatrics* 7.

influence. However, their effects, if present, can only be inferred. That is to say, the presence of one or more of these risk factors for undue influence, does not, in and of itself, provide for any tangible mechanism by which undue influence can be said to have occurred. It may therefore be the case that red flags are present when the decision-making process is being supported *not* influenced.

At a practical level, the distinction between assisting an elderly person with cognitive impairment to decide and unduly influencing their decision is a subtle one, that should not be overlooked in our rush to conform with disability rights through legislating the process of supported decision making. The mechanics of cognitive impairment, undue influence and elder abuse must be understood to enable their practical differentiation from supported decision making. What types of cognitive ability are required for supported decision making? At what point, cognitively speaking, does the decision move from being supported to being influenced?

IV BEYOND RED FLAGS

If we were to conceptualise undue influence in an emotionally neutral manner, that is with the potential to operate for or against the will and preference of the elderly client, and focus instead on whether the elderly client retains the requisite cognitive mechanics to make the decision *without reliance* on the input and the potential influence of another, we arrive at a more tangible and direct means of evaluating both undue influence and the scope for supported decision making.

For example, if an elderly client; a) no longer retains the insight to form an accurate view of their situation i.e. has no awareness of their cognitive and associated functional loss and arising support needs, or b) has lost the cognitive ability to independently appraise a family member, or c) to remember information that is relevant to decision making and retain this for long enough to be able to reason through the various options and outcomes available to them, or d) to generate a range of options of their own accord as part of the decision making process, they become reliant on the potentially influential input of others to complete one or more aspect(s) of the decision making process on their behalf.

When we understand the cognitive abilities and limitations of elderly clients, we can appreciate when and how undue influence might occur and when and what form(s) of appropriate support could be provided to ensure their own will and preference is upheld.

V CASE ILLUSTRATION - *FISHER-POLLARD* [2018]

Turning now to the recent Judgment in *Fisher-Pollard* [2018][23], a judgement around unconscionable conduct and undue influence in the context of a series of property and financial transactions.

Mrs Fisher-Pollard was a widower with three sons, one of whom lived in Sydney and the other two lived abroad. Her husband died on 30 August 2011, leaving his estate to her. Mrs Fisher-Pollard was 78 years of age at this time. She had developed dementia prior to her husband's passing. Her friends had noted cognitive decline since 2009. Four days prior to Mr Fisher-Pollard's passing, Mrs Fisher-Pollard revoked the EPOA in favour of her husband and appointed her son (later the defendant). Her estate comprised of two residential properties at Tuross Head and Queens Park.

Over the two months that followed her husband's passing, her son (later the defendant) took out mortgages on both properties in order to purchase a further property at Bondi Junction in his own name. The Tuross and Queen street properties were sold in February 2012 and the proceeds of the two sales were used to pay off the loan for the Bondi Junction property.

On 10 May 2012 Mrs Fisher-Pollard signed a statutory declaration prepared by a barrister and witnessed by solicitor stating;

> I am of sound mind and body, except for some osteopathic problems relating to both knees and my right hip. On 25/11/2011 I transferred my title in the two-bedroom apartment with harbour views at Grafton St Bondi Junction, NSW, 2022 to my third son Piers Hugh Fisher-Pollard … he received unencumbered free-hold title over the said property…. The gift of the Bondi Junction apartment reflects my heartfelt, total and true

[23] *Fisher-Pollard v Piers Fisher-Pollard* [2018] NSWSC 500.

> desire. It was and is my own decision made of my own accord. It is Piers' home whereas my other sons have their own independent homes elsewhere……. No threat, promise or inducement was held out to me to make this statutory declaration. I have not been coerced by anybody or anything and make this sworn statement of my own free will and volition.

In 2014, her son (the defendant) purchased a property in Tyagarah in his own name and sold the Bondi Junction property for 1 million which went into his own account to pay off Tyagarah. At some point after this, Mrs Fisher-Pollard's other sons learned the Tyagarah property was in their brother, the defendant's name.

In the 6 months that followed the purchase of Tyagarah, Mrs Fisher-Pollard signed a living testament saying:

> I was not in control of my thoughts and life when my husband died and I was unaware that my properties at Tuross Head and at Queens Park were sold and my former home at Bondi Junction was purchased not in my name. The proceeds from the sale of my Bondi Junction home were used to purchase my current home at … Tyagarah, which also was purchased not in my name. I need my Tyagarah house to be owned in my name'.

A caveat was lodged on the Tyagarah property and her other two sons as EPOA's were appointed in place of the defendant son.

The judge concluded that the defendant had engaged in unconscionable conduct and that further and in the alternative, the facts of the matter supported a finding of undue influence.

A *Fisher-Pollard [2018] – The Medical Evidence*

The financial and legal transactions in question took place across the time period 2011 – 2014 and are considered below within the context of the medical evidence within the judgement itself and the wider neuroscientific knowledge referencing the nature and course of cognitive decline in Alzheimer's disease.

Mrs Fisher-Pollard's memory problems had been noted by her friends from 2009 onwards who described poor short-term memory, forgetfulness and repetitiveness (i.e. for three years prior to

her husband's death). Her husband wrote to their GP in 2009, describing his wife's severe loss of recent memory and the fact she had no insight into her memory problems. In August 2011, her son (later the defendant) gave a long history of dementia symptoms. Mrs Fisher-Pollard is likely to have been suffering with a clinically diagnosable dementia from at least 2009 onwards and it is probable that the condition would have been identified one-two years prior to this with the relevant specialist clinical investigations.

Cognitively speaking, this meant that Mrs Fisher-Pollard's memory is likely to have been impaired from at least 2007 onwards (see Figure 1). On 25 August 2009 she scored 28/30 and it was incorrectly concluded: 'the score of 28 indicates no significant cognitive impairment has been identified'.

By February 2010 she was described as confused and phoning in a repetitive manner as a result of her memory loss. By April 2010 she was unable to recall the places she had visited on holiday. By August 2011 (at the time of her husband's passing) hospital staff described her as confused, emotional with repetitive questioning and conversations. In November 2011, the defendant son emailed his brother the following; 'Bit fatigued by looking after mum. Dementia is a horrible, cruel thing; rationality and common-sense count for nothing'.

In December 2011 Mrs Fisher-Pollard donned the well-polished social façade that accompanies the early and moderately advanced stages of an Alzheimer-type dementia and attended the War Memorial Hospital, where she informed the attending Doctor that her memory had only been poor over the past 3-4 weeks and attributed the changes to the loss of her husband. As noted by her husband several years prior, Mrs Fisher-Pollard did not retain insight into her memory impairment, which is entirely understandable if we consider her inability to remember she was forgetting.

Mrs Fischer-Pollard's loss of insight into her dementia illness (anosognosia) and cognitive impairment was further documented on 20 Dec 2011 in a letter to her son overseas, in which she writes, 'Not being an idiot, mentally challenged, unable to function normally or take care of myself I find it offensive that you think otherwise.'

In April 2012, Mrs Fischer-Pollard once again obtained a score of 28/30 on the MMSE. In May and June 2012, Mrs Fischer-Pollard saw a mental health nurse and a psychiatrist, both of whom obtained an independent history of her functional capabilities. The mental health nurse took a history from Mrs Fisher-Pollard's son (the defendant) with whom she was living. It read as follows:

> Lives with son. Son reports mother's dementia is worse. Loses things, leaves herself notes. Not cooking anymore, can't live alone. Soils her underwear and washes it in the bathroom sink.

The Psychiatrist took a history from Mrs Fisher-Pollard. It read as follows:

> Scored 30/30 on MMSE. She manages her own money day to day. She is mostly independent. No depressive cognitions. Memory attributed to age and grieving.

These are two very different pictures of Mrs Fisher-Pollard's level of functioning and cognitive abilities at that point in time, underscoring the insensitivity of the MMSE to Mrs Fischer-Pollard's cognitive impairment as well as the loss of awareness that typically accompanies dementia related cognitive decline.

In May 2013, one year later, Mrs Fisher-Pollard signed a statutory declaration prepared by a barrister saying: 'I am of sound mind and body, except for some osteopathic problems relating to both knees and my right hip', further attesting to her loss of insight. In an email to his brother, the defendant son wrote:

> As far as the sale of the Mum's properties, Mum decided that's what she wanted, Mum signed all the paperwork at the bank, real estate and conveyance; I had nothing to do with any of those sales.

The above statement from the defendant son raises the complicating factor of the failure of family and professionals who do not have specialist training and knowledge in brain-behaviour relationships, to recognise the manner in which dementia related cognitive impairment may impact upon decision-making. As a result, we end up with situations in which both parties believe that they have acted in accordance with the elderly persons wishes. The often-ill-

informed steadfast viewpoints in turn fuel the veracity of the legal battle that ensues. This situation is, to a large extent, a reflection of the unsatisfactory state of medical services around the under investigation of cognitive complaints among the elderly, the delays around dementia diagnosis and a failure to deliver education and support to the family at the time a dementia diagnosis is made.

In Mrs Fisher-Pollard's case, a number of red flags were present. She was isolated, with the exception of the defendant son. She was dependent on the defendant son for care. She was, at times, depressed and grieving following the loss of her husband and we know that in this case, as in a vast majority of others, undue influence and unconscionable conduct occurred on a backdrop of dementia related cognitive impairment.

What aspects of Mrs Fischer-Pollard's cognitive state facilitated the operation of undue influence and unconscionable conduct? How is it, that her wishes and intents were overborne? What can the cognitive state of a victim of financial elder abuse in a wider sense, tell us about the probability of undue influence having taken place when we are forced to consider this from a retrospective perspective?

B *Fisher-Pollard [2018] – The Cognitive Context*

Mrs Fisher-Pollard's cognitive abilities across the relevant time period 2011-2014 are examined in detail below for the purposes of elucidating the cognitive mechanisms of undue influence and financial exploitation.

Mrs Fischer-Pollard was suffering with a dementia of the Alzheimer type when she entered into a range of financial, legal and property transactions involving her son, between 2011 - 2014. As a result of the dementia, her ability to learn and retain new information was impaired[24] and manifested itself in terms of Mrs Fisher-Pollard repeating herself and asking the same questions in a repetitive manner and forgetting that she was forgetting, (contributing to her lack of awareness of her condition). At the point in time when the Tuross Head and Queens Park

[24] S. Weintraub, A.H. Wicklund and D.P. Salmon, "The neuropsychological profile of Alzheimer disease" (2012) 2(4) *Cold Spring Harbor Perspectives in Medicine* a006171.

properties were mortgaged in order to purchase the Bondi Junction property, and were later sold, Mrs Fisher-Pollard would have consequently experienced considerable difficulty retaining the values of her respective properties, and evaluating the net loss in terms of any interest payable on the loan. She is unlikely to have been able to retain the detail of any discussion or advice received around the property transactions or the process of re-mortgaging in order to secure the loan. Mrs Fisher-Pollard's recent memory impairment would have made it difficult for her to keep track of her financial affairs in a wider sense, for example how much money she held in savings and her weekly outgoings. Decisions around property transactions and mortgages may have been made without full appreciation of her overall financial situation.

In arriving at a decision to sell two properties, raising a mortgage against them and purchasing another property, Mrs Fisher-Pollard would have been required to consider a number of matters simultaneously, including although not necessarily restricted to; the respective costs of each the properties in relation to the cost of the new property and the loan amount, as well as the overall cost of the mortgage in terms of the length of time that might be required to sell both properties and the means by which this would be funded (i.e. whether she had the savings to cover this amount and the future impact of dipping into those savings). Working memory capacity, or the ability to hold multiple strands of information in mind in order to consider these simultaneously, is reduced from early on in the course of Alzheimer's disease as well as a range of other dementia types.[25] Mrs Fisher-Pollard is not likely to have retained the working memory capacity to simultaneously consider the matters involved in the above property transactions. As a result, she would have experienced considerable difficulty holding the relevant information in her mind for long enough to reason through it in order to arrive at an informed decision, making her reliant on others to formulate and present a course of course of action.

Mrs Fisher-Pollard did not have insight into severity or significance of her cognitive impairment. Anosognosia is a common finding in Alzheimer's disease[26] and thought to be related to early

[25] C L Stopford et al, 'Working memory, attention and executive function in Alzheimer's disease and frontotemporal dementia' (2012) 48(4) *Cortex* 429.
[26] BB. Caiado de Castro Zilli and B.P. Damasceno, 'Anosognosia in Alzheimer's disease: A neuropsychological approach' (2007) 1(1) *Dementia & Neuropsychologia* 81.

medial temporal lobe atrophy.[27] It is unlikely therefore, that her decision making incorporated any consideration of her current or future health care and support needs, either from a financial or practical/care perspective.

Based on what we know of how Alzheimer's disease manifests cognitively speaking, Mrs Fischer-Pollard is unlikely to have been able to monitor herself or others in order to pick up on her own errors or errors of contradiction made by others.[28] This loss of monitoring ability, together with her recent memory impairment, would have impeded Mrs Fisher-Pollard's ability to detect and/or challenge any anomalies in withdrawals in her bank accounts, making her vulnerable to financial exploitation.

When the medial aspect of the temporal lobe is damaged, as it is early on in the course of Alzheimer's disease, deficits arise in a patient's ability to think into the future[29], as one is required to do in order to imagine and appreciate the future impact of decisions. In Mrs Fischer-Pollard's case, the relevant cognitive task was to consider the future testamentary impact of transferring her primary asset into her son's name.

A number of studies have demonstrated impairments in the ability to read intent, identify emotion, empathise and appreciate the emotional perspective of others in association with dementia[30]. These skills are collectively referred to as forms of social cognition. Impairments of social cognition can in turn (particularly in combination with a loss of insight) alter the manner in which a patient appraises a family member or judges their intent.

The early stages of dementia are typically accompanied by a decline in the patient's ability to

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[27] M. Tondelli et al, 'Neural correlates of anosognosia in Alzheimer's disease and mild cognitive impairment: a multi-method assessment' (2018) 12 *Frontiers in Behavioural Neuroscience* 100.
[28] S.J. Banks and S. Weintraub, 'Self-awareness and self-monitoring of cognitive and behavioural deficits in behavioural variant frontotemporal dementia, primary progressive aphasia and probable Alzheimer's disease' (2008) 67(1) *Brain and Cognition* 58.
[29] M. Verfaellie, E. Race and M. Keane, 'Medial temporal lobe contributions to future thinking: evidence from neuroimaging and amnesia' (2012) 52(2-3) *Psychologica Belgica* 77-94.
[30] S. Cosentino et al, 'Social cognition in Alzheimer's disease: a separate construct contributing to dependence' (2014) 10(6) *Alzheimer's Dementia* 818-826.

think about things in abstract terms[31]. The affidavit that was signed by Mrs Fischer-Pollard on 24 May 2012 states, 'It is Piers' home, whereas my other sons have their own independent homes elsewhere'. This of course is true, in the most concrete of senses, and without consideration of related abstract factors (such as how it was her sons came to have their own homes, whether or not she or her husband had assisted her sons in this regard and why it was that the defendant had not acquired his own home), this surface level of reasoning may suffice, within the mind of the cognitively impaired, in providing justification for unequal estate distribution or transfer of property.

Finally, to the extent that judging a situation requires the above cognitive abilities, that is remembering the relevant facts, retaining insight, reading the intent and emotions of others, considering multiple relevant fact simultaneously and appreciating the future impact of a decision, Mrs Fisher-Pollard's judgement is likely to have been affected by her dementia.

VI CONCLUDING REMARKS

This is the reality and complexity of the relationship between cognitive impairment, undue influence and legal capacity. Perhaps in recognition of the difficult task solicitors, financial advisors and wills and estates practitioners face in dealing with elderly patients at risk of undue influence or with diminished capacity, the Victorian Law Reform Commission[32] and the Australian Law Reform Commission,[33] in their reports on Elder Abuse, suggest practice guidelines for Undue Influence. The chief proposal in relation to wills specifically, was for best practice guidelines for legal practitioners.

There are multiple existing guidelines that centre around 'red flags', including the Californian legislation introduced in 2014, with its basis in Quinn's[34] identification of the four common

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[31] T. Yoshiura et al, 'Deterioration of abstract reasoning ability in mild cognitive impairment and Alzheimer's disease: correlation with regional grey matter volume loss revealed by diffeomorphic anatomical registration through exponentiated lie algebra analysis' (2011) 21(2) *European Radiology* 419.
[32] Victorian Law Reform Commission, *Succession Law: Report* 'Guidelines on Minimising Undue Influence' 2.57.
[33] Australian Law Reform Commission, *Elder Abuse – A National Legal Response* (ALRC Report 131) Wills: Recommendation 8-1.
[34] http://www.courts.ca.gov/documents/UndueInfluence.pdf; Quinn MJ et al, *Undue Influence: Definitions and Applications*. Salt Lake City, UT: The Borchard Foundation Center on Law and Aging, March 2010.

factors of 1) Susceptibility of the victim; 2) Opportunity for the influencer; 3) Disposition of the Influencer and 4) Result. Guidelines published by Peisah and colleagues, referenced above, further highlight a range of risk factors or vulnerability factors in relation to undue influence. Practice guidance that extends beyond the identification of risk factors is lacking.

Although the concepts of capacity and undue influence are treated separately by law, and in a minority of cases may exist independently, they rarely do so. Cognitive impairment is an established risk factor and important direct facilitating mechanism for, legal capacity, undue influence and elder abuse. It is helpful to understand the manners in which cognitive impairment can facilitate the operation of undue influence and elder abuse when evaluating a client's risk of financial exploitation, susceptibility to undue influence, and in a retrospective sense, the probability of this having occurred.

Identification of red flags alone does not enable us to differentiate between the practices of supported decision-making and undue influence. As a consequence, further consideration must be given to the *practical* realities of supported decision making, in particular, if and how it might be possible to differentiate between supported decision-making and undue influence, in protecting against elder abuse, and in determining when and how elderly individuals who are cognitively impaired can be supported to make important legal and financial decisions. An understanding of how cognitive impairment facilitates the process of undue influence coupled with an ability to recognise when higher-level cognitive functions, beyond those of simple communication and comprehension, such as, retention, reasoning, judgement, appraisal, problem-solving, and appreciation of consequences are compromised, is necessary to ensure the will and preference of clients with diminished capacity is upheld, and risks to professionals providing services to such individuals are minimised.