Chapter 2

Concluded matters

2.1 This chapter considers responses to matters raised previously by the committee. The committee has concluded its examination of these matters on the basis of the responses received.

2.2 Correspondence relating to these matters is available on the committee's website.[1]

Bills

Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021[2]

Purpose	This bill seeks to amend various Acts relating to aged care, health and aged care pricing, and information sharing in relation to veterans and military rehabilitation and compensation Schedule 1 would enable the introduction of the Australian National Aged Care Classification, to replace the Aged Care Funding Instrument as the residential aged care subsidy calculation model from 1 October 2022 Schedule 2 would establish nationally consistent pre-employment screening for aged care workers of approved providers to replace existing police checking obligations Schedule 3 would allow the Aged Care Quality and Safety Commissioner (Commissioner) to make and enforce a Code of Conduct that applies to approved providers and their workers, including governing persons Schedule 4 would extend the Serious Incident Response Scheme from residential care to home care and flexible care delivered in a home or community setting from 1 July 2022 Schedule 5 would introduce new governance and reporting

1 See https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/Scrutiny_reports.

2 This entry can be cited as: Parliamentary Joint Committee on Human Rights, Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021, *Report 1 of 2022*; [2022] AUPJCHR 4.

	responsibilities for approved providers Schedule 6 would increase information sharing between Commonwealth bodies across the aged care, disability and veterans' affairs sectors in relation to non-compliance of providers and their workers Schedule 7 would enable the Secretary or Commissioner to request information or documents from a provider or borrower of a loan made using a refundable accommodation deposit or bond Schedule 8 would expand the functions of the Independent Health and Aged Care Pricing Authority to include the provision of advice on health and aged care pricing and costing matters, and the performance of certain functions
Portfolio	Health
Introduced	House of Representatives, 1 September 2021
Rights	Rights of persons with disabilities

2.3 The committee requested a response from the minister in relation to the bill in *Report 14 of 2021*.[3]

Background

2.4 This bill seeks to make numerous amendments to implement eight measures in response to recommendations of the Royal Commission into Aged Care Quality and Safety. The committee previously commented on the provisions in the bill which sought to require the Aged Care Quality and Safety Commissioner to establish and maintain a register of all individuals against whom a banning order has been made at any time.[4] On 25 October 2021 the government introduced amendments to the bill (which were agreed to in the House of Representatives). These included amendments in relation to the use of restrictive practices.[5] The committee has previously inquired into, and commented on, the regulation of the use of restrictive practices in aged care.[6]

3 Parliamentary Joint Committee on Human Rights, *Report 14 of 2021* (24 November 2021), pp. 2-8.

4 Parliamentary Joint Committee on Human Rights, *Report 11 of 2021* (16 September 2021) pp. 2–6.

5 House of Representatives, Government [sheet ZB120].

6 See Parliamentary Joint Committee on Human Rights, Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (13 November 2019), and most recently Parliamentary Joint Committee on Human Rights, *Report 10 of 2021* (25 August 2021) pp. 63–90.

Consent to restrictive practices and immunity from liability

2.5 The amendments seek to allow the Quality of Care Principles to make provision for persons or bodies who may give informed consent to the use of a restrictive practice on a person in aged care, if the care recipient lacks capacity to give consent. The amendments also provide that if such consent was given and the restrictive practice was used in approved circumstances, the aged care provider and staff member who used the restrictive practice are immune from any civil or criminal liability in relation to the use of the restrictive practice.[7]

Summary of initial assessment

International human rights legal advice

Rights of persons with disabilities

2.6 Setting out requirements relating to when restrictive practices can be used by aged care providers engages and may promote and limit a number of human rights, as set out by the committee in previous report entries.[8] Enabling consent to be given on behalf of a person who lacks capacity to give consent engages and limits the rights of persons with disabilities, including the right of persons with disabilities to consent to medical treatment. Article 12 of the Convention on the Rights of Persons with Disabilities provides that in all measures that relate to the exercise of legal capacity, there should be appropriate and effective safeguards to prevent abuse. Such safeguards must ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by an independent and impartial body.[9] The United Nations (UN) Committee on the Rights of Persons with Disabilities has confirmed that there can be no derogation from article 12, which describes the content of the general right to equality before the law under the International Covenant on Civil and Political Rights.[10] In other words, 'there are no permissible circumstances under international human rights law in which this right may be limited'.[11] The denial of legal capacity to care recipients by

7 House of Representatives, Government [sheet ZB120], amendment 14 to Schedule 9 of the bill.

8 See most recently Parliamentary Joint Committee on Human Rights, *Report 10 of 2021* (25 August 2021) pp. 63–90.

9 Convention on the Rights of Persons with Disabilities, article 12(4). See also article 17.

10 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [1], [5].

11 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [5].

enabling a substitute decision-maker to consent to the use of a restrictive practice would therefore engage this right.[12]

2.7 The UN Committee on the Rights of Persons with Disabilities has stated that substitute decision-making should be replaced by supported decision-making.[13] Supports may include peer support, advocacy, assistance with communication or advance planning, whereby a person can state their will and preferences in advance should they be unable to do so at a later point in time. The Committee on the Rights of Persons with Disabilities has noted that 'where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the "best interpretation of will and preferences" must replace the "best interests" determinations'.[14] States are also required to create appropriate and effective safeguards for the exercise of legal capacity to protect persons with disabilities from abuse.[15]

2.8 In addition, the Convention on the Rights of Persons with Disabilities requires health professionals to provide care of the same quality to persons with disabilities as to others including on the basis of free and informed consent.[16] It also provides persons with disabilities must be protected from all forms of exploitation, violence and abuse.[17]

2.9 Further, granting immunity from liability to aged care providers and their staff for the use of restrictive practices on those who lack the capacity to give consent, where consent is provided by a substitute decision-maker, engages and may

12 The Committee on the Rights of Persons with Disabilities has made clear that practices that deny the right of people with disabilities to legal capacity in a discriminatory manner, such as substitute decision-making regimes, must be 'abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others': *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [7]. For a discussion of the academic debate regarding the interpretation and application of article 12, particularly in relation to substitute decision-making, see, eg, Bernadette McSherry and Lisa Waddington, 'Treat with care: the right to informed consent for medical treatment of persons with mental impairments in Australia', *Australian Journal of Human Rights*, vol. 23, issue no. 1, pp. 109–129.

13 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [15]–[16], [21]. The features of a supported decision-making regime are detailed in paragraph [29].

14 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [21].

15 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [20]; Convention on the Rights of Persons with Disabilities, article 12(4).

16 Convention on the Rights of Persons with Disabilities, article 25(d).

17 Convention on the Rights of Persons with Disabilities, article 16.

limit the rights of persons with disabilities to equal recognition before the law and access to justice. The right to equal recognition before the law includes the right to enjoy legal capacity on an equal basis with others in all aspects of life, and the right to equal and effective legal protection against discrimination on all grounds.[18] The Convention on the Rights of Persons with Disabilities also provides that there should be effective access to justice for persons with disabilities on an equal basis with others.[19]

2.10 Further information was sought to assess the compatibility of this measure with the rights of persons with disabilities, including:

(a) how these proposed amendments are compatible with the rights of persons with disabilities, particularly the right of persons with disabilities to enjoy legal capacity on an equal basis with others;

(b) the necessity and appropriateness of providing immunity to aged care providers and their staff for *any* civil and criminal liability, including claims of negligence;

(c) noting that civil and criminal liability is not excluded when restrictive practices are used on a person with capacity who has given their consent, why is it appropriate that all civil or criminal action is excluded where the person against whom the restrictive practice is used lacks capacity to give consent, and how is this compatible with the right to effective access to justice for persons with disabilities on an equal basis with others; and

(d) why is there no legal requirement setting out a model of supported, rather than substituted, decision-making in relation to obtaining informed consent for the use of a restrictive practice.

Committee's initial view

2.11 The committee considered these measures engage and may limit the rights of persons with disabilities, in particular the requirement to obtain the free and informed consent of persons with disabilities prior to the provision of medical treatment or health care, and the right to effective access to justice for persons with disabilities on an equal basis with others.

2.12 The committee noted that the statement of compatibility with human rights that accompanied these government amendments does not acknowledge that the rights of persons with disabilities are engaged by this measure, and as such provides no information as to the compatibility of these measures with these rights. As such,

18 Convention on the Rights of Persons with Disabilities, articles 5(2) and 12.

19 Convention on the Rights of Persons with Disabilities, article 13.

the committee sought the minister's advice as to the matters set out at paragraph [2.10].

2.13 The full initial analysis is set out in *Report 14 of 2021*.

Minister's response[20]

2.14 The minister advised:

> It is important to highlight that these amendments follow the significant legislative reform which introduced strengthened legislation on the use of restrictive practices from 1 July 2021. These amendments are a part of the continued commitment from the Commonwealth to lead work on this matter and follow subsequent identification of gaps in state and territory legislation. These amendments are only to provide an interim solution to allow time for states and territories to amend their legislation and address any gaps that exist.
>
> ***Compatibility with the right of persons with disabilities to enjoy legal capacity***
>
> As confirmed by the United Nations Committee on the Rights of Persons with Disabilities there can be no derogation from article 12. The amendments to Schedule 9 do not limit the right of persons with a disability to equal recognition before the law.
>
> It is important to note that ageing is not a disability and not every care recipient in residential aged care has a disability. As such the protections offered through the legislation are afforded to care recipient's regardless of the presence of a disability.
>
> There are significant safeguards in place in the proposed legislation, the provisions in the *Aged Care Act 1997* (Act) will be supported by amendments to the Quality of Care Principles which will stipulate that a restrictive practice may only be used in accordance with the terms of the consent that has been provided. To further protect the care recipient, a restrictive practices substitute decision-maker is only deemed necessary when the care recipient is unable to consent themselves.
>
> The person who is given the power to consent on behalf of the care recipient as the restrictive practices substitute decision-maker, will include individuals nominated by the care recipient (when they had capacity) or otherwise must have a personal interest in the health and wellbeing of the care recipient and therefore would have an understanding of the care recipient's preference. They are also able to decline the request to be the restrictive practices substitute decision-maker if they wish.

20 The minister's response to the committee's inquiries was received on 13 January 2022. This is an extract of the response. The response is available in full on the committee's website at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/Scrutiny_reports.

While consent is one requirement of the use of restrictive practices, there are several additional criteria, as outlined in the Quality of Care Principles, that must be adhered to. These include:

- that the restrictive practice is only used as a last resort to prevent harm to the care recipient or others, and after consideration of the likely impact of the use of the restrictive practice on the care recipient;
- to the extent possible, best practice alternative strategies have been used before the restrictive practice on the care recipient;
- the alternative strategies have been documented in the behaviour support plan;
- it is only used to the extent necessary and in proportion to the risk of harm to the care recipient or others;
- the use of the restrictive practice complies with any provisions outlined in the care recipient's behaviour support plan;
- the use of the restrictive practice complies with the Aged Care Quality Standards;
- the use of the restrictive practice is not inconsistent with the Charter of Aged Care rights set out in the User Rights Principles 2014; and
- that the use of the restrictive practices meets requirements (if any) of the law of the state or territory the restrictive practice is used.

Necessity and appropriateness of providing immunity

The immunity provision (proposed new section 54-11 of the Act) which provides immunity from civil or criminal liability only applies where consent was given to the use by a person authorised to provide consent under the Commonwealth laws, and the use was in alignment with all other requirements under the Quality of Care Principles.

To ensure the immunity applies appropriately, these provisions will be supported by amendments to the Quality of Care Principles, stipulating that a restrictive practice may only be used in accordance with the terms of the consent that has been provided (such as the particular type of restrictive practice, for the time specified). This will mean that if, for example, consent is given to the use of a nominated restrictive practice for a particular period of time and it is used for longer than that specified period, it will not have been used in the circumstances set out in the Quality of Care Principles, and therefore those involved will not be able to rely on the immunity in this provision.

Appropriateness of immunity for the use of restrictive practices on persons without capacity

If a jurisdiction's laws provide authority for a person or body to consent to the use of restrictive practices, this immunity does not apply. The immunity will only apply in circumstances where the Commonwealth law

authorises a person or body to consent to the use of restrictive practices, because the state and territory arrangements do not otherwise provide for this consent to be given.

As the proposed consent arrangements will result in an approved provider relying on consent by a person or body authorised to give that consent under the Commonwealth's aged care laws, rather than under the laws of the relevant state or territory, this will ensure that approved providers and relevant individuals working with them (such as staff members, volunteers and medical practitioners) are not open to any civil or criminal liability when restrictive practices are used. A condition of the immunity is that the use must also be used in compliance with all the additional criteria introduced through the strengthened requirements on the use of restrictive practices (listed on previous page).

As noted in the Bill's revised explanatory memorandum, it is also proposed that as part of the planned amendments to the Quality of Care Principles, clarifications will also be made to ensure that a restrictive practice may only be used in accordance with the consent that has been provided (such as the particular type of restrictive practice and for the time specified). This will mean that if, for example, the restrictive practices substitute decision-maker has consented to the use of bed rails between 10:00pm and 7:00am on weekdays, and the approved provider uses the bedrails outside the specified period, the restrictive practices will not have been used in accordance with the consent, and therefore in compliance with the requirements under the Quality of Care Principles, meaning those involved will not be able to rely on the immunity in this provision.

In the situation where a care recipient is unable to consent to the use of restrictive practices themselves and the provider is relying on the consent from a restrictive practices substitute decision-maker as set out by Commonwealth law, it is important that they are protected from liability should the decision be taken to court. Providing that the aged care provider and or staff meet all the requirements as set out in the Quality of Care Principles they should be able to rely on the consent of the substitute decision maker without fear of persecution. If an individual can consent themselves there is no requirement of immunity for the provider or staff as they will be relying on the direct consent from the individual and should not be exempt from criminal and civil liability should they use a restrictive practice inconsistently with the consent and the requirements as set out in the Quality of Care Principles.

Substitute or supported decision maker

It is acknowledged that supported decision-making is a best practice approach and would provide greater protections for consumers. However, the Australian Government is implementing this interim solution as quickly as possible, in acknowledgment of the time it may take state and territory governments to be able to address limitations in their laws.

As such, the Government acknowledges that the interim solution is the most practical approach and will continue to encourage state and territory governments to ensure there are rigorous protections at the jurisdictional level across the nation.

The interim solution will only apply in circumstances where a consumer does not have capacity to be able to provide consent. In these circumstances a supported decision-making model would not be appropriate. When a care recipient has capacity, they will be able to provide consent to the use of restrictive practices.

It is also proposed that the interim solution will involve arrangements where, while a consumer has capacity to do so, they would be able to nominate a person or body in writing who would be able to provide consent to restrictive practices on their behalf, if they later did not have capacity.

Concluding comments

International human rights legal advice

Right of persons with disabilities to equal recognition before the law

2.15 As noted in the initial assessment, enabling consent to be given in relation to the use of a restrictive practice on behalf of a person who is deemed to lack capacity to give consent engages and limits the rights of persons with disabilities, including the right to equal recognition before the law and the right to consent to medical treatment. It is noted that while not all aged care recipients are people with disability, those who are deemed to lack capacity are invariably those with cognitive impairment and thus in effect, the measure exclusively applies to people with disability.[21] The right to equal recognition before the law includes the right to enjoy legal capacity on an equal basis with others in all aspects of life and in all measures that relate to the exercise of legal capacity, there should be appropriate and effective safeguards to prevent abuse.[22] As acknowledged by the minister, there can be no derogation from article 12, which describes the content of the general right to equality before the law under the International Covenant on Civil and Political

21 The Committee on the Rights of Persons with Disabilities has stated that 'persons with cognitive or psychosocial disabilities have been, and still are, disproportionately affected by substitute decision-making regimes and denial of legal capacity. The Committee reaffirms that a person's status as a person with a disability or the existence of an impairment (including a physical or sensory impairment) must never be grounds for denying legal capacity or any of the rights provided for in article 12. All practices that in purpose or effect violate article 12 must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others': *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [5].

22 Convention on the Rights of Persons with Disabilities, article 12.

Rights.[23] This means 'there are no permissible circumstances under international human rights law in which this right may be limited'.[24]

2.16 The denial of legal capacity to care recipients who are deemed to lack capacity by enabling a substitute decision-maker to consent to the use of a restrictive practice would therefore engage this right. By denying legal capacity in these circumstances, care recipients are also deprived of their right to give consent to medical treatment and healthcare, noting that restrictive practices may include chemical and physical restraints.[25] While the minister has stated that this right is not limited, the UN Committee on the Rights of Persons with Disabilities has made clear that practices that deny the right of people with disabilities to legal capacity in a discriminatory manner, such as substitute decision-making regimes, are contrary to article 12 and must be 'abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others'.[26]

2.17 Additionally, States parties are required to take appropriate measures to provide access to support for persons with disabilities in exercising their legal capacity. Support in this context may include peer support, advocacy, assistance with communication or advance planning, whereby a person can state their will and

23 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [1], [5].

24 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [5].

25 With respect to persons with disability, the UN Committee on the Rights of Persons with Disabilities has held that 'forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention': *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [42]. More generally under international human rights law, the use of physical and chemical restraints against a person without their consent may engage and limit the right to privacy, which includes the right to personal autonomy and physical and psychological integrity, and protects against compulsory procedures: see, *MG v Germany*, UN Human Rights Committee Communication No. 1428/06 (2008) [10.1]. Note also that article 7 of the International Covenant on Civil and Political Rights expressly prohibits medical or scientific experimentation without the free consent of the person concerned. Article 7 may not be engaged, however, in relation to non-experimental medical treatment, even when given without consent, unless it reaches a certain level of severity: see *Brough v Australia*, UN Human Rights Committee Communication No. 1184/03 (2006) [9.5].

26 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [7]. For a discussion of the academic debate regarding the interpretation and application of article 12, particularly in relation to substitute decision-making, see, eg, Bernadette McSherry and Lisa Waddington, 'Treat with care: the right to informed consent for medical treatment of persons with mental impairments in Australia', *Australian Journal of Human Rights*, vol. 23, issue no. 1, pp. 109–129.

preferences in advance should they be unable to do so at a later point in time. The UN Committee on the Rights of Persons with Disabilities has stated that substitute decision-making should be replaced by supported decision-making and noted that '[s]upport in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making'.[27] It noted that 'where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the "best interpretation of will and preferences" must replace the "best interests" determinations'.[28] The minister acknowledged that supported decision-making is best practice and would provide greater protections for care recipients. However, the minister stated that substitute decision-making is an 'interim solution' that is the 'most practical approach', noting that it will only apply in circumstances where the person does not have capacity to consent to a restrictive practice themselves. The minister noted that supported decision-making is not appropriate in these circumstances.

2.18 Under the Convention on the Rights of Persons with Disabilities, a person's impairment (including cognitive or sensory) must never be grounds for denying legal capacity.[29] Yet, the minister's response did not make clear how it is determined that a person lacks capacity to consent to a restrictive practice, and when a substitute decision-maker would be provided. Further, there is no legislative requirement that the care recipient be supported or assisted to make their own decisions. This substitute decision-making model, even if an interim solution, appears contrary to

27 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [15]–[17], [21]. The features of a supported decision-making regime are detailed in paragraph [29].

28 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [21].

29 Committee on the Rights of Persons with Disabilities, *General comment No. 1 – Article 12: Equal recognition before the law* (2014) [5].

the requirements in article 12 of the Convention on the Rights of Persons with Disabilities as set out above.[30]

Rights of persons with disabilities to equality and non-discrimination and access to justice

2.19 As noted in the initial assessment, granting immunity from liability to aged care providers and their staff for the use of restrictive practices on those who are deemed to lack the capacity to give consent, where consent is provided by a substitute decision-maker, engages and may limit the rights of persons with disabilities to equal recognition before the law (as discussed above), equality and non-discrimination, and access to justice.[31] The measure differentially treats care recipients on the basis of disability by only granting immunity from liability for the use of a restrictive practice on a person who is deemed to lack capacity to consent, whereas those care recipients who are deemed to have capacity to consent are afforded greater protection under the law. In this way, the measure limits the right to both equality *before* the law and equality *under* the law.[32] As noted in the initial assessment, this differential treatment limits the rights of persons with disabilities to be treated equally and the right to effective access to justice for persons with disabilities on an equal basis with others.

30 It is noted that Australia has made an interpretive declaration in relation to article 12, which most relevantly states, 'Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards'. The Australian Government has stated that it does not propose to withdraw this declaration and it does not purport to exclude or modify the legal effects of the Convention, but clarify Australia's understanding: see Committee on the Rights of Persons with Disabilities, *Combined second and third periodic reports submitted by Australia under article 35 of the Convention, due in 2018*, CRPD/C/AUS/2-3 (2019) [15]. The Committee on the Rights of Persons with Disabilities has recommended that Australia urgently withdraw this declaration: see Committee on the Rights of Persons with Disabilities, *Concluding observations on the combined second and third periodic reports of Australia*, CRPD/C/AUS/CO/2-3 (2019) [5], [6], [63].

31 International Covenant on Civil and Political Rights, articles 2 and 26; Convention on the Rights of Persons with Disabilities, articles 5, 12 and 13.

32 Convention on the Rights of Persons with Disabilities, article 5(1). See Committee on the Rights of Persons with Disabilities, *General comment No. 6 (2018) on equality and non-discrimination* (2018) at [14] where the Committee explained: '"Equality under the law" is unique to the Convention. It refers to the possibility to engage in legal relationships. While equality before the law refers to the right to be protected by the law, equality under the law refers to the right to use the law for personal benefit. Persons with disabilities have the right to be effectively protected and to positively engage…Thus, the recognition that all persons with disabilities are equal under the law means that there should be no laws that allow for specific denial, restriction or limitation of the rights of persons with disabilities, and that disability should be mainstreamed in all legislation and policies'.

2.20 While article 12 is absolute, the rights to equality and non-discrimination and access to justice may be subject to permissible limitations. Under international human rights law, differential treatment (including the differential effect of a measure that is neutral on its face) will not constitute unlawful discrimination if it is based on reasonable and objective criteria such that it serves a legitimate objective, is rationally connected to that objective and is a proportionate means of achieving that objective.[33] However, as the right to legal capacity and equal recognition before the law is a 'threshold right', were the measure to violate article 12, it is likely that it will impermissibly limit associated rights. In this regard, the UN Committee on the Rights of Persons with Disabilities has stated:

> The right to legal capacity is a threshold right, that is, it is required for the enjoyment of almost all other rights in the Convention, including the right to equality and non-discrimination. Articles 5 and 12 are fundamentally connected, because equality before the law must include the enjoyment of legal capacity by all persons with disabilities on an equal basis with others. Discrimination through denial of legal capacity may be present in different ways, including status-based, functional and outcome-based systems. Denial of decision-making on the basis of disability through any of these systems is discriminatory.[34]

2.21 As noted in the initial assessment, the stated aim of these amendments is to address 'unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws'.[35] The minister further stated that the amendments are intended to provide an interim solution to allow time for states and territories to amend their legislation and address any gaps. The minister noted that the immunity applies in circumstances where the Commonwealth law authorises a person or body to consent to the use of restrictive practices (as a substitute decision-maker), because the state and territory arrangements do not otherwise provide for this consent to be given. The supplementary explanatory memorandum states that without clear consent arrangements in place across all jurisdictions, restrictive practices cannot be used in certain circumstances where it might otherwise be appropriate, which could result in harm to care recipients and others.[36] The purpose

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33 UN Human Rights Committee, *General Comment 18: Non-Discrimination* (1989) [13]; see also *Althammer v Austria*, UN Human Rights Committee Communication No. 998/01 (2003) [10.2]. It is noted that while the Convention on the Rights of Persons with Disabilities contains no general limitation provision, the general limitation test under international human rights law is applicable, noting that many rights in the Convention on the Rights of Persons with Disabilities are drawn from the International Covenant on Economic, Social and Cultural Rights and International Covenant on Civil and Political Rights.

34 Committee on the Rights of Persons with Disabilities, *General comment No. 6 (2018) on equality and non-discrimination* (2018) [47].

35 Statement of compatibility in the Supplementary Explanatory Memorandum, p. 8.

36 Supplementary Explanatory Memorandum, p. 4.

of the immunity is to ensure that approved providers and individuals who rely on the consent of a substitute decision-maker to use a restrictive practice are not open to any civil or criminal liability. The minister stated that it is important that those using the restrictive practice are protected from liability so that they can rely on the consent of the substitute decision-maker without fear of prosecution. Whereas the minister stated that those using a restrictive practice on the basis of direct consent from the care recipient should not be exempt from liability should they use the restrictive practice inconsistently with that consent or the requirements set out in the Quality of Care Principles.

2.22 Any limitation on a right must be shown to be aimed at achieving a legitimate objective. A legitimate objective is one that is necessary and addresses an issue of public or social concern that is pressing and substantial enough to warrant limiting the rights in question. While addressing gaps in legislation and ensuring consistency in consent arrangements would appear to be an important aim, it is not clear that the measure addresses a pressing and substantial concern as required to constitute a legitimate objective for the purposes of international human rights law. It is not clear why providing a blanket immunity is necessary, noting that seeking an outcome regarded as desirable or convenient, such as alleviating fears of prosecution, is, in and of itself, unlikely to be sufficient to constitute a legitimate objective.

2.23 As to proportionality, the minister stated that there are safeguards contained in the proposed legislation, notably that a restrictive practice may only be used in accordance with the terms of the consent that has been provided. For example, the minister stated that if consent is given to the use of a nominated restrictive practice for a particular period of time and it is used for longer than that specified period, it will not have been used in the circumstances set out in the Quality of Care Principles, and therefore those involved will not be able to rely on the immunity in this provision. However, this does not appear to be an adequate safeguard as the consent is that of a substitute decision-maker, not that of the individual whose rights may be affected. If the terms of consent were broad and contrary to the will and preferences of the care recipient, then it may have limited safeguard value in practice.

2.24 Additionally, the minister noted that the use of a restrictive practice must comply with criteria set out in the Quality of Care Principles, including that the restrictive practice be used as a last resort to prevent harm and only used to the extent necessary and in proportion to the risk of harm to the care recipient. The committee has previously considered these criteria, noting that while these safeguards are important, their strength will depend on how they are applied in practice.[37] In particular, there are concerns regarding the use of restraints in an

37 Parliamentary Joint Committee on Human Rights, *Report 10 of 2021* (25 August 2021) pp. 63–90.

emergency, noting that certain criteria in the Quality of Care Principles do not apply to such use.

2.25 The minister also identified as a safeguard the fact that a restrictive practices substitute decision-maker will only be used where a person is unable to consent to the restrictive practice themselves. The minister stated that the substitute decision-maker will include individuals nominated by the care recipient or those who have a personal interest in the health and wellbeing of the care recipient. While in some circumstances the substitute decision-maker will act in accordance with the best interpretation of the care recipient's will and preferences, it is not clear that this requirement would operate as an effective safeguard in all instances. Further, as noted above, it is not clear in what circumstances a person would be considered to be unable to provide consent, and the denial of legal capacity and provision of a substitute decision-maker would, in itself, be contrary to article 12 and would likely limit other human rights.

Right to an effective remedy

2.26 Furthermore, by depriving care recipients who are deemed to lack capacity the ability to pursue a remedy for any violation of their human rights arising from the use of restrictive practices, the measure has implications on the right to an effective remedy. As noted in the initial assessment, it appears that if a restrictive practice was used in accordance with the Quality of Care Principles and after consent had been provided by the substitute decision-maker, but due to negligence the care recipient was injured, it would appear that a care recipient who lacked capacity to consent would not be able to bring an action for negligence, whereas a care recipient with capacity may be able to. It would also appear that even if a care recipient could successfully challenge the lawfulness of the consent provided on their behalf, no action could be brought against the provider or their staff if they used the restrictive practice after gaining informed consent by one of the listed substitute decision-makers.

2.27 The right to an effective remedy requires the availability of a remedy which is effective with respect to any violation of recognised rights and freedoms.[38] It includes the right to have such a remedy determined by competent judicial, administrative or legislative authorities or by any other competent authority provided for by the legal system of the state. This may take a variety of forms, such as prosecutions of suspected perpetrators or compensation to victims of abuse.

38 International Covenant on Civil and Political Rights (ICCPR), article 2(3). See, *Kazantzis v Cyprus,* UN Human Rights Committee Communication No. 972/01 (2003) and *Faure v Australia,* UN Human Rights Committee Communication No. 1036/01 (2005), State parties must not only provide remedies for violations of the ICCPR, but must also provide forums in which a person can pursue arguable if unsuccessful claims of violations of the ICCPR. Per *C v Australia* UN Human Rights Committee Communication No. 900/99 (2002), remedies sufficient for the purposes of article 5(2)(b) of the ICCPR must have a binding obligatory effect.

While limitations may be placed in particular circumstances on the nature of the remedy provided (judicial or otherwise), state parties must comply with the fundamental obligation to provide a remedy that is effective.[39] This right must also be provided in a non-discriminatory way.[40] By granting immunity from *any* civil and criminal liability, care recipients who are denied legal capacity do not appear to have access to an effective remedy for any violation of their rights arising from the use of a restrictive practice against them.

2.28 In conclusion, the measure denies legal capacity to certain care recipients by enabling a substitute decision-maker to consent on their behalf to the use of a restrictive practice against them. The denial of legal capacity and the provision of a restrictive practices substitute decision-maker does not appear to be compatible with the right to equal recognition before the law and has the effect of limiting other human rights, including the right to consent to medical treatment, the right to equality and non-discrimination and the right to access to justice. It has not been established that these other human rights would be permissibly limited in practice. Further, by granting blanket immunity from liability, the measure has implications on the right to an effective remedy. As such, these amendments do not appear to be compatible with a number of human rights, particularly the rights of persons with disabilities.

Committee view

2.29 The committee thanks the minister for this response. The committee notes government amendments to this bill seek to enable the Quality of Care Principles to make provision for persons or bodies who may give informed consent to the use of a restrictive practice on a person in aged care, if the aged care recipient lacks capacity to give consent. The amendments also provide that if such consent is given and the restrictive practice was used in approved circumstances, the aged care provider and staff member who used the restrictive practice are immune from any civil or criminal liability in relation to the use of the restrictive practice.

2.30 The committee notes that by enabling consent to be given in relation to the use of a restrictive practice on behalf of a person who is deemed to lack capacity, the measure engages and limits the rights of persons with disabilities, including the

39 See UN Human Rights Committee, *General Comment 29: States of Emergency (Article 4)* (2001) [14].

40 For commentary on this right see, International Commission of Jurists, *The Right to a Remedy and Reparation for Gross Human Rights Violations: A Practitioners' Guide*, revised edition (2018). At pp. 53 and 58, the Guide stated: 'States have an obligation to make available effective remedies to people whose rights are violated. Universal and regional standards guarantee the right to an effective remedy to all persons who allege that their human rights have been violated…By requiring that human rights be enjoyed by all without discrimination, human rights law thereby obliges States to ensure that access to, and the provision of, effective remedies and reparation be without distinction of any kind'.

right to equal recognition before the law and the right to consent to medical treatment. The committee notes that the right to equal recognition before the law is absolute and may not be subject to permissible limitations. The committee notes the minister's advice that while supported decision-making is best practice, it is not appropriate in these circumstances as this measure is an interim solution to allow time for states and territories to amend their legislation regarding substitute decision-making, and that is the most practical approach. While the committee appreciates that this is a temporary measure and notes the minister's advice that the government will continue to encourage rigorous protections at state and territory levels, the committee considers that until such time there is a significant risk that the amendments are incompatible with the right to equal recognition before the law.

2.31 The committee also notes that granting immunity from liability to aged care providers and their staff for the use of restrictive practices on those who are deemed to lack the capacity to give consent, engages and may limit the rights of care recipients to equality and non-discrimination and access to justice. It is not clear that these rights would be permissibly limited in practice, noting that it has not been established that the measure pursues a legitimate objective or is proportionate in all circumstances. It also is not clear that this immunity would ensure an affected person would have access to an effective remedy. As such, the committee considers that the proposed amendments are unlikely to be compatible with a number of human rights, particularly the rights of persons with disability.

2.32 The committee draws these human rights concerns to the attention of the minister and the Parliament.

Dr Anne Webster MP

Chair