A BILL FOR AN ACT OF ASTOUNDING DISCRIMINATION AND CONFISCATION OF LEGAL RIGHTS

THE AGED CARE AND OTHER LEGISLATION AMENDMENT (ROYAL COMMISSION RESPONSE NO.2) BILL 2021 [COM]

EXECUTIVE SUMMARY

- The Commonwealth government referred serious problems occurring in the aged care system to a Royal Commission into the aged care system in December 2018;
- One of the tasks of the Commissioners was to examine claims of neglect and poor treatment;
- The Commissioners found enough evidence of poor care that they issued an Interim report in October 2019;
- In their Interim Report they recommended that the Commonwealth should act urgently upon the evidence they discovered about neglect, abuse and especially about restrictive practices;
- The government acted with alacrity and initiated legislation designed to quickly raise the quality of care in residential aged care. That legislation was the **Aged Care And Other Legislation Amendment (Royal Commission Response No. 1) Act 2021 (No. 57, 2021);**
- Upon the delivery of the Royal Commissioner's final report the Commonwealth in April 2021 introduced another Bill which was intended to further amend the Aged Care Act.
- The Bill passed the House of Representatives on 25 October 2021 and was entitled the **Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021** .
- After the Bill was passed the government, within a few hours, presented a further bundle of amendments which included a proposal for legal immunity for aged care Providers.
- The precondition to the immunity was that the Provider, in applying restrictive practices upon an aged care resident, had complied with the aged care legislation including subordinate legislation known as the

Quality of Care Principles 2014;

- The proposal is objectionable because it ignores, in relation to persons unable to provide consent because of a disability;

[a] that the matters of lawful consent required for compliance, including who is qualified to give it, what information has been provided to the consentor, to what restraint does it apply [chemical, environmental, physical], how often and in what circumstances the required review will occur, are all matters which would need to be canvassed and are subjected to proof in litigation in any event, under State and Territory law;

[b] that the consent, if it is to be otherwise lawful, must be obtained before imposing restraint, except if there is imminent harm to the person or to others – a matter not entirely clear from the amending legislation in Part 4A of the [Aged Care] Quality of Care Principles;

[c] it is open ended as to the time required to achieve uniform legislation among the States and Territories on the complex issue of who may lawfully give consent allowing that the apparent interim nature of the measure might actually take years [see the government's rationale for the measure at pp 10,11 infra] ;

[d] the vulnerable or frail aged who are subject to the Bill are the only cohort subject to the removal of the civil and criminal protections which protect all other Australians [although regrettably there is already similar legislation in S.A., W.A. and a proposal in NSW applying to the NDIS sector],

[e] In the event of a person [or their legal representative] wishing to bring a civil claim or make a criminal charge they will be confronted with the need to show that the QOC Principles have not been complied with, thus in effect, nullifying the entitlement of a Provider to a grant of statutory immunity. The result is a need to confront a serious obstacle in the way to seeking redress and justice, probably as interlocutory litigation at the outset of proceedings, not required of any other litigant for the same or similar legal issues.

INTRODUCTION[1]

Problems with the Aged Care Act and Principles as regards restrictive practices and immunity

The recent amendments to the Quality of Care [QOC] Principles 2014 which is one of the subordinate regulations to the Aged Care Act 1997 contain detailed directions to Providers of their obligations when restrictive practices are applied to a resident. The amendments form Part 4A to the QOC Principles and are found in the attachment A to this paper together with relevant parts of the Aged Care Act 1997.

There are two issues which arise. Firstly there is some ambiguity about the requirement for consent in s.15FA[1][f]. A close reading of the provision gives rise to doubt as to whether the consent must be obtained prior to the restraint. Since restraint, if it is unlawful, cannot be excused by retrospective consent, the need for prior consent is essential. That requirement should be made explicit.

The second issue is the circularity of the application of consent requirements in s.15FA[1][j] which states:

> *(j) the use of the restrictive practice meets the requirements (if any) of the law of the State or Territory in which the restrictive practice is used.*

If indeed the law of the State/s are to be observed, then by definition, if that requirement is followed by aged care providers, the grant of immunity is itself defeated by becoming redundant.

That only leaves the Commonwealth law/s themselves which may require immunity for the Provider, but it is difficult to nominate a Commonwealth law which may apply and even more difficult to imagine how the Commonwealth can grant immunity in such a general manner, against offences which are precisely proscribed in most other Commonwealth laws.

Common law and the intentional torts

The common law is clear about the rights and converse obligations which

[1] The author of this submission to the International Commission of Jurists Australia ICJA is Rodney Lewis solicitor, of Elderlaw Legal Services, 32 Martin Place Sydney. Mr Lewis is the author of Elder Law in Australia 2nd edn 2011, Lexis Nexis, Chatswood NSW, seminar presenter and member of the Elder Law capacity & Succession Committee of the Law Society of NSW and a former Secretary General of the ICJA.

people owe to each other, regarding their fundamental right to freedom. This is what the High Court said in 1992:

> As we have indicated, the conclusion [upon sterilisation of a minor-ed] relies on a fundamental right to personal inviolability existing in the common law, a right which underscores the principles of assault, both criminal and civil…[2]

> 4. At common law, therefore, every surgical procedure is an assault unless it is authorised, justified or excused by law. The law draws no lines between different degrees of violence, "every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner"(261) Blackstone, Commentaries, 17th ed. (1830), vol 3, p 120. A person who inflicts harm upon another must justify the doing of the harm. He or she may do so by proving that the harm was lawfully consented to or that the harm occurred in circumstances which the law recognises as a justification or excuse(262) Collins v. Wilcock (1984) 1 WLR 1172, at p 1177.[3]

Relevantly, if there were any doubts, Brennan J. expressly included the disabled and the frail aged:

> 6. Blackstone declared the right to personal security to be an absolute, or individual, right vested in each person by "the immutable laws of nature"(128) Blackstone, ibid., vol 1, pp 124, 129; vol 3, p 119. Blackstone's reason for the rule which forbids any form of molestation, namely, that "every man's person (is) sacred", points to the value which underlies and informs the law: each person has a unique dignity which the law respects and which it will protect The law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the intellectually disabled.[4]

This statement of Spigelman, C. J. [SCNSW] lends meaning and substance to the importance which the law attaches to the personal integrity and the freedom of movement of every person:

> The protection of the personal liberty of individuals has been a fundamental purpose of the common law for centuries. The tort of trespass in the form of false imprisonment has been one of the ways in which that protection has been provided throughout that

[2] Department of Health & Community Services v JWB & SMB ("Marion's Case") [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992) Per Mason C.J., Dawson, Toohey and Gaudron JJ. At [55]

[3] Op. cit., Per Brennan,J, at par 4

[4] Ibid at par 6.

period. Once a plaintiff proves actual imprisonment the onus is on the defendant to establish lawful authority.[5]

Relevant Findings of the Royal Commission into Aged Care and Safety

This is a case study published by the Royal Commission into Aged Care and Safety, direct from the hearings in Sydney. It illustrates the application of several kinds of restraint well, and the serious effects upon the victim[6].

'He never came back 100 per cent'

Mr Terance Reeves was diagnosed with Alzheimer's disease in 2010. As Mr Reeves's condition declined, he continued to live in his own home cared for by his wife, Lillian Reeves. The decision in 2018 to seek respite care for Mr Reeves was a difficult one for Mrs Reeves and her family.

Mr Reeves was in respite care at Garden View Aged Care from 1 May 2018 to 7 July 2018. Mr Reeves's care plan at the time of his admission did not include strategies for addressing his care needs relating to behaviours associated with his dementia.

At the request of a nurse at the facility, a general practitioner prescribed Mr Reeves the antipsychotic drug risperidone, to be taken three times a day as required for unsettled behaviour. Although risperidone can have severe adverse side effects,

Mr Reeves was given the antipsychotic drug without the informed consent of either Mr Reeves or his wife, Mrs Reeves.

Mr Reeves's daughter, Michelle McCulla, was 'shocked' and 'confused' when she visited her father on 8 May 2019 and found him physically restrained by a belt across his lap. Ms McCulla recalled Garden View's explanation that the restraints had been used because Mr Reeves had been aggressive and that he was not being cooperative. Mrs Reeves recalled she was later asked to give her consent to Mr Reeves being physically restrained so that he did not walk around during shift changes. As Ms McCulla recalled, 'every single time I visited he was in a restraint except for one day when he was completely unconscious in a bed'. Describing one such visit, she said she 'found him in the East Wing, sitting in a lap belt, head hanging in his chest, drooling'. Describing another occasion, Ms McCulla told us:

We went through a keypad locked door. I found a small room, perhaps 11m by 5m or 6m. I found several patients across from me. There was a line of chairs and everyone was restrained in lap belts along that side of the wall. My father was in a chair with

[5] Ruddock v Taylor (2003) NSWCA 262 at [3]
[6] RCAC Interim Report at P 197

his back towards me restrained in the chair. He had another resident next to him restrained in a chair and there were…maybe two or three in tub beds also restrained.

Records provided to the Royal Commission by the facility revealed that Mr Reeves had been physically restrained most days and sometimes for as long as 13 hours a day.

When Mrs Reeves made the decision to remove Mr Reeves from Garden View earlier than planned, she observed that he was less capable of walking and speaking than he was when he had arrived at the facility and that he had become completely incontinent.

Mrs Reeves described the facility where Mr Reeves now resides as a 'wonderful' place where Mr Reeves is not restrained and is free to walk around, having recovered his ability to walk very well. She added, however, that 'he never came back 100 per cent after being at Garden View; never came back'

Upon the prevalence of restraint, the Royal Commission observed:

The prevalence of physical restraint in residential aged care in Australia is very poorly documented and there is a lack of recent empirical data. However, the Royal Commission received substantial anecdotal evidence during the Sydney Hearing of the continuing use of physical restraint in residential aged care. In particular, Associate Professor Stephen Macfarlane, Head of Clinical Services, Dementia Centre at HammondCare, who also leads the team of Clinical Associates who work with the Severe Behaviour 'Response Team and the Dementia Behaviour Management Advisory Service, gave evidence about the experience of the team and service, both of which deliver specialist dementia services to aged care facilities to manage changed behaviours. Associate Professor Macfarlane said that he hears anecdotally and on a weekly basis from consultants of stories where restraint has been inappropriately applied. Witnesses with experience working in residential care described having seen physical restraint being used often in the care homes where they have worked.

The Commissioner's relevant recommendations regarding restraint

See attachment B to this submission.

The Australian government responses

This is the response from the Commonwealth to the Restraint recommendations of the Royal Commission. Obviously enough, there was no mention of the proposal for immunity.

The Government accepts this recommendation and is responding through the measure Residential Aged Care Quality and Safety - Aged Care Immediate Priorities - Strengthening Providers.

Strengthened restraint legislative provisions will commence from 1 July 2021. These provisions will:

- *Clearly define restraint*
- *Clarify consent arrangements*
- *Ensure that restraint is used only as a last resort following deployment of alternative behaviour management strategies.*

A Senior Practitioner will be appointed to the Aged Care Quality and Safety Commission (ACQSC) in 2021-22 to lead an education campaign for the sector and general practitioners, and provide independent oversight for aged care consumers to minimise the use of restraint.

In addition, the Government will fund training and support services to support aged care providers in better management of behavioural and psychological symptoms of dementia.

The ACQSC, the Australian Commission on Safety and Quality in Health Care and the NDIS Quality and Safeguards Commission are also collaborating to align regulatory approaches to the use of restraints.

THE BILL

The Minister's second reading speech in the House of Representatives

The second reading speech of the Minister for Health and Aged Care Mr Hunt, delivered to the House on 1 September 2021, was straightforward and dealt with a number of issues with which the bill was concerned. These matters included replacing the Aged Care Funding Instrument with a new model for calculating aged care subsidies. There was a measure which establishes an Authority for nationally consistent pre-employment screening for aged care workers and governing persons of approved providers. It also establishes a code of conduct.

The Bill also extends the Serious Incident Response Scheme to home-care and

flexible care which are delivered in a home or community care setting, commencing from 1 July 2022.

The Bill introduced a number of new governance responsibilities for approved providers and their governing bodies as well as new reporting requirements. For example, approved providers will be required to notify changes to their key personnel.

The Bill also represents according to the Minister, a first step towards aligning the regulation of providers across the broader care and support sector, including aged care, disability support and veterans care.

Further measures included increased and financial Prudential oversight and the establishment of an Independent Health and Aged Care Price and Authority which will provide advice on health which is intended to provide advice on health care and aged care pricing and costing.

Debate on the second reading of the Bill

Contributions to the debate on the second reading in the House were made by 10 members and there was nothing out of the ordinary about the matters which were raised. Members on both sides of the house contributed including the independent member for Warringah and the member for Goldstein, Mr Wilson, Assistant Minister to the Minister for Industry, Energy and Emissions Reduction) .

An amendment is proposed

After the vote was taken and the debate concluded, Mr Wilson introduced a raft of further amendments, with a supplementary explanatory memorandum[7]. The part which is relevant to the proposed schedule 9 [the immunity provision] is set out below:

> *New Schedule 9*
>
> *The amendments in new Schedule 9 of the Bill revise the strengthened arrangements on the use of restrictive practices that commenced on 1 July 2021, to address unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws.*

[7] The full terms of the amendments are found in the attachment to this paper.

In response to Recommendation 17(1)(b)(v) of the Royal Commission's final report, the strengthened arrangements require that prior to the use of restrictive practices [emphasis added-ed], the care recipient or a person who is authorised by law to consent on the care recipient's behalf has consented to the use of restrictive practices in accordance with relevant State or Territory laws. Specifically, if the care recipient themselves lacks the capacity, consent must be given by the 'restrictive practices substitute decision-maker'. Restrictive practices substitute decision-maker is defined as a person or body that can give informed consent to the use of restrictive practices under the law of the State or Territory in which the care recipient is provided with aged care.

The strengthened arrangements were not intended to affect the operation of any State or Territory laws, and instead are intended to provide clarification on how the laws, intended to protect individuals from interference with their personal rights and liberties, intersect with the arrangements for restrictive practices.

Since the commencement of the strengthened arrangements the Australian Government has received advice from States and Territories that in many jurisdictions, the relevant laws that authorise persons to consent on another's behalf do not allow, and in some cases prevent, persons being recognised as a restrictive practices substitute decision-maker under the Commonwealth aged care legislation. Without clear consent arrangements in place across all jurisdictions, restrictive practices cannot be used in certain circumstances where it may otherwise be appropriate. This may result in harm to care recipients and others. This issue may also result in providers refusing to take care recipients with complex needs into their care and increased hospital admissions where providers believe they have no other workable options.

The amendments introduce interim arrangements to address this issue until State and Territory laws can be amended. The amendments would allow for the Quality of Care Principles 2014 to make further provision for informed consent to the use of restrictive practices to be given in circumstances where a care recipient does not have capacity to consent. This would include the authorisation of a person to consent to the use of a restrictive practice on a care recipient's behalf, where State and Territory laws do not clearly provide for a

person to consent to the use of restrictive practices. In order to support these interim arrangements, the amendments also insert an immunity provision where approved providers have relied on the consent given by the restrictive practices substitute decision maker.[emphasis added-ed]

Introducing these arrangements will ensure that approved providers will be able to meet the strengthened requirements on the use of restrictive practices in jurisdictions where legal limitations with consent and guardianship laws exist.

The Ninth schedule and issues arising

The House apparently chose not to have a further debate on the 9th Schedule. The amendment was accepted without demur and was included in the Third Reading.

The manner of putting this part of the Bill [the ninth schedule] has had the effect of submerging the objectionable measure in the other lengthy and complex schedules in the apparently innocuous and intricate amendments.

To whom does the immunity apply?

A fair question may arise in any litigation which follows this proposed measure for immunity, seeking an answer to whether the measure applies to claims of immunity made after the commencement of the Act, in respect of incidents occurring before the commencement. That is not made clear and it may be implied, but since the offer of immunity by the Commonwealth in relation to criminal and civil charges and claims is rare, this is not a matter to be left unresolved by the lawmakers responsible for the proposal.

When is consent required?

Any request for acknowledgment, or voluntary agreement to any form of restraint by a competent person must be carefully prepared in order to demonstrate the absence of any kind of implied threat or even an inflexible policy, unable to respond to individual cases. For example, an inflexible policy that no resident may leave the nursing home after dark, with no exceptions, would likely be courting criticism if not a claim, especially as regards those who were already resident there when the policy was introduced. For those

entering the home later, it may be said that, like Mr Robertson in the *Balmain New Ferry* case[8], they were bound by the terms of their admission or, as the Privy Council indicated, they were bound by reasonable conditions upon entry For competent adults, however, it is tolerably clear that there must be a reasonable limit to compliance with conditions of entry.

Consent must surely be capable of being withdrawn in cases involving freedom of movement, and if a competent resident demanded the right, for example, to have dinner with family several times weekly, it is hard to see how the stated (example) Provider policy could prevail. Because the imposition and application of restraint in the case of competent persons rests upon their consent, the withdrawal of consent or later objection to the restraint, in reasonable circumstances at least, must terminate it[9].

It is unlikely that a mentally competent adult in a residential aged care institution will agree to being restrained unless it be for some medical purpose which is clearly understood by the resident; for example, a person with neurological tremor who may be prone to injury through involuntary movement.

The consent must not be affected by the kind of apparent compliance or consent to which Walsh J referred in *Watson v Marshall*,[10] namely that there is no 'justified apprehension' that, if without submission to the request for restraint, there would be compulsion.

For persons who may be mentally incompetent which is what the Bill addresses, the issue of consent is different, in the sense that consent must be obtained vicariously and by other means. However, that consent is required, (unless lawful excuse is present) must not be doubted[11].

Who may give consent if there is impaired cognition?

In New South Wales, the Guardianship Division of the NSW Civil and Administrative Tribunal recently adverted to the process of providing consent for restrictive practices. It goes almost without saying that the Tribunal cannot

[8] Balmain New Ferry Co. v Robertson, [1906] 4 CLR 379
[9] Lewis, R., Elder Law in Australia, 2n edition, Lexis Nexis, Sydney, 2011, p.235, 7.40
[10] (1971) 124 CLR 621 at 626.
[11] Op.cit. at p 235, 7.41

authorise any imposition of restraint which is or becomes unlawful[12]. For example, all persons for whom a lawful consent is given, still require continual observation and review of their status, especially as regards the risk of imminent harm to themselves or to others. The decision in HZC[13] referred to the legal basis for its authority and other relevant matters :

> 100. Both the Tribunal and the former Guardianship Tribunal of NSW have had a long held practice of placing conditions upon an appointed guardian's ability to authorise the use of restrictive practices. The power to do so is granted in s 16(1)(d) of the Act. The condition has usually been framed such that an appointed guardian may only consent to the use of restrictive practices to address challenging behaviours within the context of a comprehensive positive behaviour plan. Such condition strikes an appropriate balance upon the obligation on the Tribunal to ensure that the welfare and interests of a person under guardianship are given paramount consideration (s 4 (a) of the Act) and the obligation to ensure that their freedom of decision and freedom of action should be restricted as little as possible (s 4 (b) of the Act).

There is neither time nor resources within the limited span of this submission to look at every other State and Territory jurisdiction. It suffices that all decisions of the various Tribunals must be in harmony with the basic common law requirements for lawful restraint.

Immunity was not a recommendation of the RCAC

Although the debate is upon the Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill of 2021, which conveys the context as being within the bounds of the Royal Commission's recommendations and the Commonwealth response, there is no such recommendation of the Commissioners which suggests that Providers and their staff should have immunity for some of the things which attracted their most vocal disapprobation.

SOME LEGAL ISSUES

Some recent cases from some Civil and Administrative Tribunals

[12] For a full discussion of guardianship legislation in Australia in relation to restrictive practices see: Chandler, Kim; White, Ben; Willmott, Lindy --- "What Role for Adult Guardianship in Authorising Restrictive Practices?" [2017] MonashULawRw 14; (2017) 43(2) Monash University Law Review 492

[13] [2019] NSWCATGD 8

There are a variety of cases which have come before some of the State Tribunals in recent times. Some of the references are provided in this paper[14], in the event the reader finds them useful. The utility of the cases is to demonstrate that the various Civil and Administrative Tribunals have been already involved in cases associated with the issues raised in this submission, and will continue to be so.

Policy makers will doubtless review the cases when considering what issues are actually involved in the coalescing of the various Tribunal statutory powers and the expressed objective of the Commonwealth government to seek uniformity among the States and Territories. Indeed the proposal for immunity appears to have been offered by the government only for so long as the desired uniformity escapes the grip of the responsible Federal and State bureaucrats.

What is the reason for the need for and lack of immunity for Providers and others?

There may be a reason in addition to the one put forward during the second reading debate being the complicated regime of State and Territory consent laws**.** but that has been already referred to above. However, one may suppose that there is another practical and financial motivation for this measure.

Ordinarily, an aged care provider will be insured for negligent liability of staff, directors liability, and the usual property and personnel insurances. However the question of whether they have or can secure insurance for liability for intentional torts is another matter.

It is generally the case that because an incident involving unlawful restrictive practices is an intentional tort, insurers will not provide cover against liability arising from harm or injury of the victim. If that be so, then there is a clear pecuniary advantage which has significant financial outcomes for Providers. If claims are brought against them arising from unlawful restrictive practices, then that claim will be critically compromised by this Bill, having relieved the Provider of the risk, against which insurance may be difficult to obtain.

What are the civil and criminal claims and offences to which the immunity may apply?

[14] JFL [2020] NSWCATGD 32; MZC [2018] NSWCATGD 34**;** [2020] NSWCATGD 28 (24 November 2020) **;** Darcy (bht Diane Aldridge) v State of New South Wales [2011] NSWCA 413

It is well understood that assault includes an apprehension of violence and whether that apprehension can be proven in any particular case will turn on its own facts. However the offence also includes battery:

> Battery is the actual infliction of unlawful force on another. But the word "assault" has come to describe both offences.[15]

It appears entirely possible that the imposition of restraint wlll render those who have unlawfully imposed physical restraint upon a resident, criminally liable for the common law offence of assault at least, for which a term of imprisonment is available upon sentence. The same applies to all forms of unlawful restraint. It follows that those who are accessories and those who have directed the offence to occur, that is, not only staff but management also may be liable. If that be so, the Department of Health, the health workers unions and the Provider organisations have a duty to the aged care workers who may have been unwittingly exposing themselves to this serious liability.

CRIMINAL CHARGES

There are other similar apposite provisions including:

> NSW – *Criminal Procedure Act 1986* NSW Schedule 1 Table 1 s 16C (the common law offence of false imprisonment) (Indictable offences that are to be dealt with summarily unless prosecutor or person charged elects otherwise)
>
> Victoria – *Crimes Act 1958* Vic s 320 – maximum term of imprisonment for certain common law offences – False imprisonment 10 years maximum
>
> Queensland – *Criminal Code 1899* QLD s 355 – deprivation of liberty (liable to imprisonment for 3 years):
>
> *s.355 Deprivation of liberty*
>
> Any person who unlawfully confines or detains another in any place against the other person's will, or otherwise unlawfully deprives another of the other person's personal liberty, is guilty of a misdemeanour, and is liable to imprisonment for 3 years.

[15] see *DPP v JWH* (unreptd NSWSC, 17 Oct 1997).

> A.C.T. Crimes (Offences Against Vulnerable People) Legislation Amendment Act 2020, sec. 36A (5)(b)(i)(D) – elder abuse of a vulnerable person resulting in serious harm: (D) deprive or restrict the vulnerable person's freedom of action; imprisonment 5 years.

There are also prosecutions under Workplace Health and Safety laws, especially in New South Wales and Victoria which impose criminal and civil penalties for a breach of the obligation to maintain a safe work place and a breach of the duty to ensure the safety of all persons in the work place.

THE CIVIL CLAIMS

- Habeas corpus- an ancient prerogative writ and an irreplaceable foundation to our claims to freedom;
- Tortious claims – battery and false imprisonment; negligence;
- Arbitration and alternate dispute resolution claims included in the care contract;
- Australian consumer law ss 21,22 [unconscionable conduct]; s34 [misleading conduct] s50 [no force to be used in delivery of services], s60 [due care and skill] s61 [services fit for purpose] s62 reasonable time for supply].
- Breach of contract.

All of these legal claims and criminal charges could be in contemplation by legal advisors advising a resident or their representative, in the event of harm or injury. The provisions of schedule 9 to the Bill would operate to prevent all or any of these claims, to which all Australians are entitled as recourse except those vulnerable residents in aged care liable to meet with immunity, proceeding with their claim.

Is the offer of immunity clear enough?

In the case of Coco v The Queen[16], the High Court expressed some definitive views on the interpretation of that part of a statute which

[16] Coco v the Queen [1994] HCA 15 (13 April 1994) (Mason CJ, Brennan, Deane, Dawson, Toohey, Gaudron and McHugh JJ)

affected basic rights. The court's views are persuasive and should be seen by the lawmakers as a deterrent to the substance of schedule 9 of the Bill.

10. The insistence on express authorization of an abrogation or curtailment of a fundamental right, freedom or immunity must be understood as a requirement for some manifestation or indication that the legislature has not only directed its attention to the question of the abrogation or curtailment of such basic rights, freedoms or immunities but has also determined upon abrogation or curtailment of them. The courts should not impute to the legislature an intention to interfere with fundamental rights. Such an intention must be clearly manifested by unmistakable and unambiguous language. General words will rarely be sufficient for that purpose if they do not specifically deal with the question because, in the context in which they appear, they will often be ambiguous on the aspect of interference with fundamental rights ((8) See Chu Kheng Lim v. Minister for Immigration (1992) 176 CLR 1 at 12 per Mason CJ).

11. So long as the requirement for express statutory authorization is understood in the sense explained above, we would accept the requirement as a correct statement of principle. At the same time, in our view, the principle was expressed more simply by Brennan J in Re Bolton; Ex parte Beane ((9) (1987) 162 CLR 514 at 523.) in these terms:

"Unless the Parliament makes unmistakably clear its intention to abrogate or suspend a fundamental freedom, the courts will not construe a statute as having that operation."

12. In Bropho v. Western Australia ((10) (1990) 171 CLR 1 at 18.), Mason CJ, Deane, Dawson, Toohey, Gaudron and McHugh JJ pointed out that the rationale against the presumption against the modification or abrogation of fundamental rights is to be found in the assumption that it is:

"…in the last degree improbable that the legislature would overthrow fundamental principles, infringe rights, or depart from the general system of law, without expressing its intention with irresistible clearness; and to give any such effect to general words, simply because they have that meaning in their widest, or usual, or natural sense, would be to give them a meaning in which they were not really used' ((11) Potter v. Minahan (1908) 7 CLR 277 at 304.) ".

At the same time, curial insistence on a clear expression of an unmistakable and unambiguous intention to abrogate or curtail a fundamental freedom will enhance the parliamentary process by securing a greater measure of attention to the impact of legislative proposals on fundamental rights.

13. The need for a clear expression of an unmistakable and unambiguous intention does not exclude the possibility that the presumption against statutory interference with fundamental rights may be displaced by implication. Sometimes it is said that a presumption about legislative intention can be displaced only by necessary

implication but that statement does little more than emphasize that the test is a very stringent one ((12) See the discussion in Bropho (1990) 171 CLR at 16-17.). As we remarked earlier, in some circumstances the presumption may be displaced by an implication if it is necessary to prevent the statutory provisions from becoming inoperative or meaningless. However, it would be very rare for general words in a statute to be rendered inoperative or meaningless if no implication of interference with fundamental rights were made, as general words will almost always be able to be given some operation, even if that operation is limited in scope.

Conflict of laws and Constitutional power in aged care

Here is a description of the limitations upon the Commonwealth government to make laws regarding criminal offences and its connection to State governments[17].

Constitutionally the Commonwealth Parliament has no general power to legislate in relation to crime. State and Territory governments are mandated by their Constitutions to legislate for the peace, order and good government of their jurisdictions. They have a general power to maintain public order and to protect individuals who reside within their State and their property.

The constitutional basis for the Crimes Act 1914, the Criminal Code Act 1995 and offence provisions in other Commonwealth legislation is found in the express incidental power in section 51 (xxxix) of the Constitution or in the implied incidental powers contained in the heads of power in sections 51 and 52 and in the executive power in section 61. The majority of Commonwealth criminal offences and penalties are to be found in various Commonwealth statutes dealing with widely differing subjects, eg customs and excise, taxation, insurance, social security, broadcasting and the Internet.

The Commonwealth's powers to legislate have been greatly expanded through the external affairs power (section 51 (xxix)). The Tasmanian Dams case in the High Court confirmed that the Commonwealth is able to enact legislation to fulfil obligations incurred through its ratification of treaties covering areas otherwise outside its constitutional capacity.

Another area of Commonwealth expansion into the area of criminal law has been the few occasions where the States have considered that a national law is preferable to a set of State laws and have referred their constitutional powers to

[17] see https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Browse_by_Topic/Crimlaw/Historycriminallaw accessed on 29 October 2021

> legislate to the Commonwealth. This has happened, for example, in the areas of corporations regulation (2001) and anti-terrorism legislation (2002).

Commonwealth criminal legislation, therefore, began mainly covering offences against the Commonwealth and its institutions, or against Commonwealth officers, property or revenue. It has expanded, through the reasons mentioned above, to cover other areas of national concern.

The Aged Care Act 1997 which is the foundation legislation for the aged care system in Australia, provides for the application of the Commonwealth Criminal Code –

AGED CARE ACT 1997 - SECT 96.9

Application of the Criminal Code

Chapter 2 of the *Criminal Code* applies to all offences against this Act.

> The Section notes that *"The Criminal Code creates offences which can apply in relation to the regulation of providers of aged care. For example, under section 137.1 of the Code it would generally be an offence to give false or misleading information to the Secretary in purported compliance with this Act."*

Other offences such as making false claims in relation to Commonwealth funding would also fit the definition.

There appears no constitutional barrier for the Commonwealth to legislate upon unlawful restraint, so long as there is a connection by regulating the conduct of Approved Providers of aged care. There has been no regulation of the conduct of residents or 'consumers' of aged care, under the Act. However, because there is no international treaty which is open to subscribe and thus legislate under the Foreign Affairs power, that makes it even more unlikely there will be any constitutional foundation to secure the proposed immunity.

How curious then, that only now the Commonwealth has decided, not to

impose a raft of criminal offences upon Providers and their staff, for serious unlawful behaviour, but rather, in the face of evidence [Royal Commission and many previous inquiries] that many are prone to offend the law and render themselves liable in civil and criminal proceedings, they reward the industry with immunity. This is the only criminal manifestation in the legislation so far introduced by the Minister for Health as a result of the Royal Commission, but it is immunity, not the creation of further offences which have been - proposed.

It seems a far cry from the Minister's second reading speech on the first law to emerge after the Royal Commission's report,

THE BIG PICTURE

The aged care system – can it be trusted with granting immunity?

Reliance on the aged care system regulatory oversight Is problematic. The complaints system, for example, has been unresponsive to the particular complaints of residents insofar as they may require recovery, redress, or restorative justice for harm and injury. The system of compliance is oriented to regulatory oversight of Providers, not to directly assist individual residents . These are some insightful comments from the Carnell Paterson Report[18] :

> The Department does not directly monitor the use of restrictive practices, although if approved providers are found not to be compliant with the expected outcomes the Department may take compliance action.

…

> The evidence available to this Review suggests that the regulatory framework is not sufficient to protect the rights of residents.

The authors of the Report identified what they saw as inhibiting factors for minimising or eliminating restrictive practices in aged care:

- Lack of knowledge of guidelines, and guidelines not promoted or easily accessible or tailored.
- Residential service characteristics such as nursing and care skills, staffing levels, staff turnover and time pressure that work against implementing

[18] Review of National Aged Care Quality Regulatory Processes, Ms Kate Carnell AO Professor Ron Paterson ONZM, October 2017

person-centred care.

- Funding and care models and organisational culture.
- Constraints on the residential aged care facility workforce, including lack of time and awareness of guidelines, complex patient population and pressure from family members and / or other residential care staff.
- Limited collaboration among general practitioners, residential care staff and pharmacists.
- Lack of access to mental health and allied health professionals' expertise for assessment, guidance on behavioural interventions and appropriate use of medicines, particularly in rural and remote areas.
- Lack of assessment skills, including pain assessment.
- View of medication as a first and quick response to behavioural issues, along with a lack of awareness of the risks of harm and the limited benefits of antipsychotics.
- Lack of the knowledge, skills and time to implement non-pharmacological interventions.

To those factors we would add the need for education and training in the legal issues and especially the absence of legal deterrent risks to staff and management in the use of restrictive practices and their lack of knowledge and awareness of criminal and civil law liabilities.

The Bill represents an astounding discrimination

If this proposal for immunity is carefully considered, it becomes apparent that what is in fact occurring is the removal of basic legal rights of those Australians who happen to be confined by restrictive practices in the aged care system.

Consider for example, the immunity which this bill offers to aged care providers, from the issue of the prerogative writ of Habeas Corpus. This is one of the fundamentally important pillars of our common law system which, in the absence of a written and enforceable Bill of Rights, underpins the basic legal and democratic rights which every Australian is entitled to enjoy.

Habeas Corpus is one of the very freedoms referred to and used in arguments against the bneed for a written 'Bill of Rights'.

Other causes of action, in particular claims which might be brought arising from harm or injury suffered by a resident as a result of poor care and neglect, will be seriously undermined by this provision for immunity.

For example, the whole litigious process which is required in relation to civil claims which will be barred and for which immunity is offered, will first need to be contested on the question of whether or not immunity is applicable in that case. For example, if the immunity is offered for the reason that the aged care provider has complied with all the necessary standards and the requirements of the Quality of Care Principles, a great deal of expense and time will be wasted on that preliminary issue.

The astounding discrimination which is inherent in the bill and the nullity provision, is made manifest in its outcome, which is to deprive the most vulnerable, frail and disabled people in our community from the fundamental rights which they formerly enjoyed under the Rule of Law, before they entered the aged care system.

Put another way, The age care system will be unique as removing fundamental legal and human rights from its own "consumers". Moreover, they will be the only consumers within the Commonwealth who are or will be disentitled from seeking access to justice through the application of the Australian Consumer Law, if this measure is allowed to pass.

The aged care system and permanent detention

Our residential aged care system which houses residents in locked wards, is populated by those who have become innocently separated from the Australian community by succumbing to dementia and for them, being locked in, is their way of life.

When properly accommodated and overseen, they mostly offer no imminent harm either to themselves or others, thus after occupying a place in a locked ward, lawful and informed prior consent is the only possible lawful excuse for detaining them.

However, having regard to general experience, recent official inquiries and the well documented history of care and safety breaches by some [not all] Providers, it is a reasonable supposition that consents , if they exist at all, and are in writing, for those residents already in a locked dementia specific ward, will very likely fall short of what is required for 'informed consent'.

Some of the reasons which may render consent forms invalid may include:

- Poor knowledge or training of the Provider's staff responsible for documenting a transfer to a dementia ward including a valid consent,

either upon entry or later;

- Failure to anticipate the other kinds of restraint which may subsequently be used, including chemical restraint;
- Consent is sought and given by someone who, in ignorance of State or Territory law, has no legal status for granting consent, such as in some cases a 'next of kin';
- Where a person who is a guardian with authority for medical decision making, appointed either under an instrument authorised by State/ Territory statute [such as an Enduring Guardianship Appointment -NSW] or by an order made by a Tribunal under a State statute governing guardianship, the authority to give such a consent must be granted in the order, or the instrument, specifically.

Thus it is entirely possible[19] that there are tens of thousands of Australians detained unlawfully in dementia wards around the country. That this issue has not been the subject of any action or even any attempt to properly audit consent forms, by the relevant Minister and successive Australian governments is appalling.

The relevant part of the Bill under discussion which grants immunity to those who may impose this blight upon the right to freedom of movement and action of our fellow Australians in aged care places, must be rejected.

In its Report delivered in 2015[20] this Committee stated :

> **Committee view**
>
> 8.69 It is clear from the evidence provided that indefinite detention of people with cognitive or psychiatric impairment is a significant problem within the aged care context, occurring both within external facilities and private homes. It is also clear this detention is often informal, unregulated and unlawful.
>
> 8.70 The evidence presented to this inquiry further supports the views formed by the committee during its 2015 abuse inquiry that action needs to be taken in the aged care setting to protect vulnerable people from abuse.

[19] There are no statistics available or published audit results or regulatory reports on the making of valid and invalid consents for people who are presently in a dementia specific place or a locked ward.

[20] Senate Standing Committees on Community Affairs; Indefinite detention of people with cognitive and psychiatric impairment in Australia 29 November 2016

This submission has sought to focus on the legal issues which arise from this particular response by the Commonwealth government. It is submitted that the measure offering immunity is entirely inappropriate. It is for this committee to consider whether its recommendations and conclusions in the 2015 report have yet been taken seriously by the governments which have followed.

RODNEY LEWIS

ELDERLAW LEGAL SERVICES

SOLICITORS, SYDNEY

08 November 2021

ATTACHMENT A

A. Relevant provisions of the Aged Care Act 1997

AGED CARE ACT 1997 - SECT 54.3

Reportable incidents

(1) When making provision in relation to an incident management system for the purposes of subparagraph 54-1(1)(e)(i), the Quality of Care Principles must make provision for dealing with * reportable incidents.

(2) A ***reportable incident*** is any of the following incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the provision of residential care, or flexible care provided in a residential setting, to a * residential care recipient of an approved provider:

(a) unreasonable use of force against the residential care recipient;

(b) unlawful sexual contact, or inappropriate sexual conduct, inflicted on the residential care recipient;

(c) psychological or emotional abuse of the residential care recipient;

(d) unexpected death of the residential care recipient;

(e) stealing from, or financial coercion of, the residential care recipient by a * staff member of the provider;

(f) neglect of the residential care recipient;

(g) use of a * restrictive practice in relation to the residential care recipient (other than in circumstances set out in the Quality of Care Principles);

(h) unexplained absence of the residential care recipient from the residential care services of the provider.

.....

AGED CARE ACT 1997 - SECT 54.9

Restrictive practice in relation to a care recipient

(1) A ***restrictive practice*** in relation to a care recipient is any practice or intervention that has the effect of restricting the rights or freedom of movement of the care recipient.

(2) Without limiting subsection (1), the Quality of Care Principles may provide that a practice or intervention is a ***restrictive practice*** in relation to a care recipient.

.....

AGED CARE ACT 1997 - SECT 54.10

Matters that Quality of Care Principles must require etc.

(1) The Quality of Care Principles made for the purposes of paragraph 54-1(1)(f) must:

(a) require that a * restrictive practice in relation to a care recipient is used only:

(i) as a last resort to prevent harm to the care recipient or other persons; and

(ii) after consideration of the likely impact of the use of the practice on the care recipient; and

(b) require that, to the extent possible, alternative strategies are used before a restrictive practice in relation to a care recipient is used; and

(c) require that alternative strategies that have been considered or used in relation to a care recipient are documented; and

(d) require that a restrictive practice in relation to a care recipient is used only to the extent that it is necessary and in proportion to the risk of harm to the care recipient or other persons; and

(e) require that, if a restrictive practice in relation to a care recipient is used, it is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the care recipient or other persons; and

(f) require that informed consent is given to the use of a restrictive practice in relation to a care recipient; and

(g) require that the use of a restrictive practice in relation to a care recipient is not inconsistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles made for the purposes of paragraph 56-1(m); and

(h) make provision for, or in relation to, the monitoring and review of the use of a restrictive practice in relation to a care recipient.

(2) The Quality of Care Principles made for the purposes of paragraph 54-1(1)(f) may provide that a requirement specified in those Principles does not apply if the use of a * restrictive practice in relation to a care recipient is necessary in an emergency.

(3) Subsections (1) and (2) do not limit the matters that may be specified in the Quality of Care Principles made for the purposes of paragraph 54-1(1)(f).

.....

Quality of Care Principles 2014

made under section 96-1 of the *Aged Care Act 1997*

...

Part 4A—Behaviour support and restrictive practices—residential care and certain flexible care

Division 1—Preliminary

15D Purpose of this Part

This Part:

(a) specifies kinds of aged care; and

(b) provides that certain practices or interventions are restrictive practices; and

(c) sets out circumstances for the use of restrictive practices in relation to care recipients; and

(d) specifies other responsibilities of approved providers.

15DA Kinds of aged care for the purposes of paragraph 54-1(1)(f) of the Act

For the purposes of paragraph 54-1(1)(f) of the Act, the following kinds of aged care are specified:

(a) residential care;

(b) flexible care in the form of short-term restorative care provided in a residential care setting.

Division 2—Restrictive practices

15E Practices or interventions that are restrictive practices

(1) For the purposes of subsection 54-9(2) of the Act, each of the following is a restrictive practice in relation to a care recipient:

(a) chemical restraint;

(b) environmental restraint;

(c) mechanical restraint;

(d) physical restraint;

(e) seclusion.

(2) ***Chemical restraint*** is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing a care recipient's behaviour, but does not include the use of medication prescribed for:

(a) the treatment of, or to enable treatment of, the care recipient for:

(i) a diagnosed mental disorder; or

(ii) a physical illness; or

(iii) a physical condition; or

(b) end of life care for the care recipient.

(3) ***Environmental restraint*** is a practice or intervention that restricts, or that involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour.

(4) ***Mechanical restraint*** is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient's movement for the primary purpose of influencing the care recipient's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient.

(5) ***Physical restraint*** is a practice or intervention that:

(a) is or involves the use of physical force to prevent, restrict or subdue movement of a care recipient's body, or part of a care recipient's body, for the primary purpose of influencing the care recipient's behaviour; but

(b) does not include the use of a hands-on technique in a reflexive way to guide or redirect the care recipient away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the care recipient.

(6) ***Seclusion*** is a practice or intervention that is, or that involves, the solitary confinement of a care recipient in a room or a physical space at any hour of the day or night where:

(a) voluntary exit is prevented or not facilitated; or

(b) it is implied that voluntary exit is not permitted;

for the primary purpose of influencing the care recipient's behaviour.

Division 3—Circumstances for the use of restrictive practices

15F Circumstances for the use of restrictive practices

For the purposes of paragraph 54-1(1)(f) of the Act, the circumstances in which an approved provider may use a restrictive practice in relation to a care recipient are that the requirements set out in this Division that apply to the restrictive practice in relation to the care recipient are satisfied.

Note: The use of a restrictive practice in relation to a residential care recipient of an approved provider other than in these circumstances is a reportable incident (see paragraph 54-3(2)(g) of the Act).

15FA Requirements for the use of any restrictive practice

(1) The following requirements apply to the use of any restrictive practice in relation to a care recipient:

(a) the restrictive practice is used only:

(i) as a last resort to prevent harm to the care recipient or other persons; and

(ii) after consideration of the likely impact of the use of the restrictive practice on the care recipient;

(b) to the extent possible, best practice alternative strategies have been used before the restrictive practice is used;

(c) the alternative strategies that have been considered or used have been documented in the behaviour support plan for the care recipient;

(d) the restrictive practice is used only to the extent that it is necessary and in proportion to the risk of harm to the care recipient or other persons;

(e) the restrictive practice is used in the least restrictive form, and for the shortest time, necessary to prevent harm to the care recipient or other persons;

(f) informed consent to the use of the restrictive practice has been given by:

(i) the care recipient; or

(ii) if the care recipient lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice;

(g) the use of the restrictive practice complies with any provisions of the behaviour support plan for the care recipient that relate to the use of the restrictive practice;

(h) the use of the restrictive practice complies with the Aged Care Quality Standards set out in Schedule 2;

(i) the use of the restrictive practice is not inconsistent with the Charter of Aged Care Rights set out in Schedule 1 to the *User Rights Principles 2014*;

(j) the use of the restrictive practice meets the requirements (if any) of the law of the State or Territory in which the restrictive practice is used.

(2) However, the requirements set out in paragraphs (1)(a), (b), (c), (f) and (g) do not apply to the use of a restrictive practice in relation to a care recipient if the use of the restrictive practice in relation to the care recipient is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 15GB for other responsibilities of approved providers that apply if the use of a restrictive practice in relation to a care recipient is necessary in an emergency.

15FB Additional requirements for the use of restrictive practices other than chemical restraint

(1) The following requirements apply to the use of a restrictive practice in relation to a care recipient that is not chemical restraint:

(a) an approved health practitioner who has day-to-day knowledge of the care recipient has:

(i) assessed the care recipient as posing a risk of harm to the care recipient or any other person; and

(ii) assessed that the use of the restrictive practice is necessary;

(b) the following matters have been documented in the behaviour support plan for the care recipient:

(i) the assessments;

(ii) a description of any engagement with persons other than the approved health practitioner in relation to the assessments;

(iii) a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments.

(2) However, the requirement set out in paragraph (1)(b) does not apply to the use of a restrictive practice in relation to a care recipient if the use of the restrictive practice in relation to the care recipient is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 15GB for other responsibilities of approved providers that apply if the use of a restrictive practice in relation to a care recipient is necessary in an emergency.

15FC Additional requirements for the use of restrictive practices that are chemical restraint

(1) The following requirements apply to the use of a restrictive practice in relation to a care recipient that is chemical restraint:

(a) the approved provider is satisfied that a medical practitioner or nurse practitioner has:

(i) assessed the care recipient as posing a risk of harm to the care recipient or any other person; and

(ii) assessed that the use of the chemical restraint is necessary; and

(iii) prescribed medication for the purpose of using the chemical restraint;

(b) the following matters have been documented in the behaviour support plan for the care recipient:

(i) the assessments;

(ii) the practitioner's decision to use the chemical restraint;

(iii) the care recipient's behaviours that are relevant to the need for the chemical restraint;

(iv) the reasons the chemical restraint is necessary;

(v) the information (if any) provided to the practitioner that informed the decision to prescribe the medication;

(vi) a description of any engagement with persons other than the practitioner in relation to the use of the chemical restraint;

(vii) a description of any engagement with external support services (for example, dementia support specialists) in relation to the assessments;

(c) the approved provider is satisfied that informed consent to the prescribing of the medication has been given by:

(i) the care recipient; or

(ii) if the care recipient lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

Note: Codes of appropriate professional practice for medical practitioners and nurse practitioners provide for the practitioners to obtain informed consent before prescribing medications. Those codes are approved under the Health Practitioner Regulation National Law and are:

(a) for medical practitioners—*Good medical practice: a code of conduct for doctors in Australia* (which in 2021 could be viewed on the website of the Medical Board of Australia (https://www.medicalboard.gov.au)); and

(b) for nurse practitioners—*Code of conduct for nurses* (which in 2021 could be viewed on the website of the Nursing and Midwifery Board of Australia (https://www.nursingmidwiferyboard.gov.au)).

(2) However, the requirements set out in paragraphs (1)(b) and (c) do not apply to the use of a restrictive practice in relation to a care recipient if the use of the restrictive practice in relation to the care recipient is necessary in an emergency.

(3) Subsection (2) applies only while the emergency exists.

Note: See section 15GB for other responsibilities of approved providers that apply if the use of a restrictive practice in relation to a care recipient is necessary in an emergency.

Division 4—Other responsibilities of approved providers relating to restrictive practices

15G Purpose of this Division

For the purposes of paragraph 54-1(1)(h) of the Act, this Division specifies other responsibilities of an approved provider that provides aged care of a kind specified in section 15DA of this instrument to a care recipient.

15GA Responsibilities while restrictive practice being used

If an approved provider uses a restrictive practice in relation to a care recipient, the approved provider must ensure that while the restrictive practice is being used:

(a) the care recipient is monitored for the following:

(i) signs of distress or harm;

(ii) side effects and adverse events;

(iii) changes in mood or behaviour;

(iv) changes in well-being, including the care recipient's ability to engage in activities that enhance quality of life and are meaningful and pleasurable;

(v) changes in the care recipient's ability to maintain independent function (to the extent possible);

(vi) changes in the care recipient's ability to engage in activities of daily living (to the extent possible); and

(b) the necessity for the use of the restrictive practice is regularly monitored, reviewed and documented; and

(c) the effectiveness of the use of the restrictive practice, and the effect of changes in the use of the restrictive practice, are monitored; and

(d) to the extent possible, changes are made to the care recipient's environment to reduce or remove the need for the use of the restrictive practice; and

(e) if the restrictive practice is chemical restraint—information about the effects and use of the chemical restraint is provided to the medical practitioner or nurse practitioner who prescribed the medication for the purpose of using the chemical restraint as mentioned in paragraph 15FC(1)(a).

15GB Responsibilities following emergency use of restrictive practice

If an approved provider uses a restrictive practice in relation to a care recipient and the use of the restrictive practice in relation to the care recipient is necessary in an emergency, the approved provider must, as soon as practicable after the restrictive practice starts to be used:

(a) if the care recipient lacked capacity to consent to the use of the restrictive practice—inform the restrictive practices substitute decision-maker for the restrictive practice about the use of the restrictive practice; and

(b) ensure that the following matters are documented in the behaviour support plan for the care recipient:

(i) the care recipient's behaviours that were relevant to the need for the use of the restrictive practice;

(ii) the alternative strategies that were considered or used (if any) before the use of the restrictive practice;

(iii) the reasons the use of the restrictive practice was necessary;

(iv) the care to be provided to the care recipient in relation to the care recipient's behaviour;

(v) if the restrictive practices substitute decision-maker for the restrictive practice was informed about the use of the restrictive practice under paragraph (a)—a record of the restrictive practices substitute decision-maker being so informed; and

(c) if the restrictive practice is not chemical restraint—ensure that the assessments mentioned in paragraph 15FB(1)(a) are documented in the behaviour support plan for the care recipient; and

(d) if the restrictive practice is chemical restraint—ensure that the matters mentioned in paragraph 15FC(1)(b) are documented in the behaviour support plan for the care recipient.

Division 5—Other responsibilities of approved providers relating to behaviour support plans

15H Purpose of this Division

For the purposes of paragraph 54-1(1)(h) of the Act, this Division specifies other responsibilities of an approved provider that provides aged care of a kind specified in section 15DA of this instrument to a care recipient.

15HA Responsibilities relating to behaviour support plans

(1) If:

(a) an approved provider provides aged care to a care recipient; and

(b) behaviour support is needed for the care recipient;

the approved provider must ensure that a behaviour support plan for the care recipient is included in the care and services plan for the care recipient.

(2) The approved provider must ensure that the behaviour support plan:

(a) is prepared, reviewed and revised in accordance with this Division; and

(b) sets out the matters required by this Division and Divisions 3 and 4.

(3) In preparing the behaviour support plan, the approved provider must take into account any previous assessment relating to the care recipient that is available to the approved provider.

15HB Matters to be set out in behaviour support plans—alternative strategies for addressing behaviours of concern

A behaviour support plan for a care recipient must set out the following matters:

(a) information about the care recipient that helps the approved provider to understand the care recipient and the care recipient's behaviour (such as information about the care recipient's past experience and background);

(b) any assessment of the care recipient that is relevant to understanding the care recipient's behaviour;

(c) information about behaviours of concern for which the care recipient may need support;

(d) the following information about each occurrence of behaviours of concern for which the care recipient has needed support:

(i) the date, time and duration of the occurrence;

(ii) any adverse consequences for the care recipient or other persons;

(iii) any related incidents;

(iv) any warning signs for, or triggers or causes of, the occurrence (including trauma, injury, illness or unmet needs such as pain, boredom or loneliness);

(e) alternative strategies for addressing the behaviours of concern that:

(i) are best practice alternatives to the use of restrictive practices in relation to the care recipient; and

(ii) take into account the care recipient's preferences (including preferences in relation to care delivery) and matters that might be meaningful or of interest to the care recipient; and

(iii) aim to improve the care recipient's quality of life and engagement;

(f) any alternative strategies that have been considered for use, or have been used, in relation to the care recipient;

(g) for any alternative strategy that has been used in relation to the care recipient:

(i) the effectiveness of the strategy in addressing the behaviours of concern; and

(ii) records of the monitoring and evaluation of the strategies;

(h) a description of the approved provider's consultation about the use of alternative strategies in relation to the care recipient with the care recipient or the care recipient's representative.

15HC Matters to be set out in behaviour support plans—if use of restrictive practice assessed as necessary

If the use of a restrictive practice in relation to a care recipient is assessed as necessary as mentioned in section 15FB or 15FC, the behaviour support plan for the care recipient must set out the following matters:

(a) the care recipient's behaviours of concern that are relevant to the need for the use of the restrictive practice;

(b) the restrictive practice and how it is to be used, including its duration, frequency and intended outcome;

(c) the best practice alternative strategies that must be used (to the extent possible) before using the restrictive practice;

(d) how the use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;

(e) how the use of the restrictive practice is to be reviewed, including consideration of the following:

(i) the outcome of its use and whether the intended outcome was achieved;

(ii) whether an alternative strategy could be used to address the care recipient's behaviours of concern;

(iii) whether a less restrictive form of the restrictive practice could be used to address the care recipient's behaviours of concern;

(iv) whether there is an ongoing need for its use;

(v) if the restrictive practice is chemical restraint—whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;

(f) a description of the approved provider's consultation about the use of the restrictive practice with:

(i) the care recipient; or

(ii) if the care recipient lacks the capacity to give informed consent to the use of the restrictive practice—the restrictive practices substitute decision-maker for the restrictive practice;

(g) a record of the giving of informed consent to the use of the restrictive practice by:

(i) the care recipient; or

(ii) if the care recipient lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

Note: Assessments mentioned in sections 15FB and 15FC must also be documented in the behaviour support plan (see paragraphs 15FB(1)(b) and 15FC(1)(b)).

15HD Matters to be set out in behaviour support plans—if restrictive practice used

If a restrictive practice in relation to a care recipient is used in relation to the care recipient, the behaviour support plan for the care recipient must set out the following matters:

(a) the restrictive practice and how it was used, including the following:

(i) when it began to be used;

(ii) the duration of each use;

(iii) the frequency of its use;

(iv) the outcome of its use and whether the intended outcome was achieved;

(b) if, under the plan, the restrictive practice is to be used only on an as-needed basis in response to particular behaviour, or in particular circumstances:

(i) the care recipient's behaviours of concern that led to the use of the restrictive practice; and

(ii) the actions (if any) taken leading up to the use of the restrictive practice, including any alternative strategies that were used before the restrictive practice was used;

(c) the details of the persons involved in the use of the restrictive practice;

(d) a description of any engagement with external support services (for example, dementia support specialists) in relation to the use of the restrictive practice;

(e) details of the monitoring of the use of the restrictive practice as required by the plan;

(f) the outcome of the review of the use of the restrictive practice as required by the plan.

Note 1: For paragraphs (e) and (f), see paragraphs 15HC(d) and (e) for the requirements for a behaviour support plan for a care recipient to require monitoring and review of the use of a restrictive practice in relation to the care recipient.

Note 2: If the use of a restrictive practice in relation to a care recipient is necessary in an emergency, other matters must also be documented in the behaviour support plan for the care recipient (see section 15GB).

15HE Matters to be set out in behaviour support plans—if need for ongoing use of restrictive practice indicated

If a review of the use of a restrictive practice in relation to a care recipient (as required by the behaviour support plan for the care recipient) indicates a need for the ongoing use of the restrictive practice, the behaviour support plan for the care recipient must set out the following matters:

(a) the restrictive practice and how it is to be used, including its duration, frequency and intended outcome;

(b) how the ongoing use of the restrictive practice is to be monitored, including how the monitoring will be escalated if required, taking into account the nature of the restrictive practice and any care needs that arise from the use of the restrictive practice;

(c) how the ongoing use of the restrictive practice is to be reviewed, including consideration of the following:

(i) the outcome of the ongoing use of the restrictive practice and whether the intended outcome is being achieved;

(ii) whether an alternative strategy could be used to address the care recipient's behaviours of concern;

(iii) whether a less restrictive form of the restrictive practice could be used to address the care recipient's behaviours of concern;

(iv) whether there continues to be need for the ongoing use of the restrictive practice;

(v) if the restrictive practice is chemical restraint—whether the medication prescribed for the purpose of using the chemical restraint can or should be reduced or stopped;

(d) a description of the approved provider's consultation about the ongoing use of the restrictive practice with:

(i) the care recipient; or

(ii) if the care recipient lacks the capacity to give informed consent to the ongoing use of the restrictive practice—the restrictive practices substitute decision-maker for the restrictive practice;

(e) a record of the giving of informed consent to the ongoing use of the restrictive practice by:

(i) the care recipient; or

(ii) if the care recipient lacks capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice.

15HF Reviewing and revising behaviour support plans

An approved provider must review a behaviour support plan for a care recipient and make any necessary revisions:

(a) on a regular basis; and

(b) as soon as practicable after any change in the care recipient's circumstances.

15HG Consulting on behaviour support plans

(1) In preparing, reviewing or revising a behaviour support plan for a care recipient, an approved provider must consult the following:

(a) the care recipient and any other person nominated by the care recipient (unless the care recipient lacks the capacity to be consulted);

(b) if the care recipient lacks the capacity to be consulted—a person or body who, under the law of the State or Territory in which the care recipient is provided with aged care, can make decisions about that care;

(c) health practitioners with expertise relevant to the care recipient's behaviours of concern.

(2) If the use of a restrictive practice in relation to the care recipient is assessed as necessary as mentioned in section 15FB or 15FC, the approved provider must also consult the following in preparing, reviewing or revising the behaviour support plan:

(a) the approved health practitioner who made the assessment;

(b) if the care recipient lacks the capacity to be consulted—the restrictive practices substitute decision-maker for the restrictive practice.

(3) In consulting under this section, the approved provider must provide the plan or revised plan, and any associated information, in an appropriately accessible format.

Also see sec 15NA as regards reportable incidents:

Note 2: The use of a restrictive practice in relation to the residential care recipient (other than in circumstances set out in this instrument) is also a reportable incident: see paragraph 54-3(2)(g) of the Act and Part 4A of this instrument.

ATTACHMENT B

The Commissioner's relevant recommendations

Recommendation 17: Regulation of restraints

1. The Quality of Care Principles 2014 (Cth) should be amended by 1 January 2022 to provide that the use of restrictive practices in aged care must be based on an independent expert assessment and subject to ongoing reporting and monitoring. The amendments should reflect the overall principle that people receiving aged care should be equally protected from restrictive practices as other members of the community. In particular, restrictive practices should:

a. be prohibited unless:

i. recommended by an independent expert, accredited for the purpose by the Quality Regulator, as part of a behaviour support plan lodged with the Quality Regulator and reviewed quarterly by the expert, with reports on implementation of the behaviour support plan being provided to the Quality Regulator on a monthly basis, or

ii. when necessary in an emergency to avert the risk of immediate physical harm, with any further use subject to recommendation by an independent expert under Recommendation 17(1)(a)(i), and with a report of the restraint to be provided with reference to the matters in Recommendation 17(1)(b) as soon as practicable after the restraint starts to be used; and

b. only be used:

i. as a last resort to prevent serious harm after the approved service provider has explored, applied and documented alternative, evidence based strategies to mitigate the risk of harm

ii. to the extent necessary and proportionate to the risk of harm

iii. for the shortest time possible to ensure the safety of the person or

others

iv. subject to monitoring and regular review (to be stipulated in the behaviour support plan) by an approved health practitioner

v. in accordance with relevant State or Territory laws and with the documented informed consent of the person receiving care or someone authorised by law to give consent on that person's behalf

vi. in the case of chemical restraint, if prescribed by a doctor who has documented the purpose of the prescription.

2. In making these amendments, the Australian Government should consider whether any adjustments or additions are warranted as a result of the statutory review of Part 4A of the Quality of Care Principles 2014 (Cth).

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3. The amendments should also provide that:

a. any use of restrictive practices that is not in accordance with the statutory scheme should be reportable under the updated serious incident reporting scheme, and

b. any breach of the statutory requirements should expose the approved provider to a civil penalty at the suit of the regulator. If a person directly affected by the breach wants to be compensated, the regulator or the person should have the power to seek an order for compensation.

4. In the interim, the repeal of Part 4A of the Quality of Care Principles 2014 (Cth) should be delayed until 31 December 2021.

5. Following the conclusion of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, the Australian Government should consider the applicability to aged care of any findings from that Royal Commission about restrictive practices and make further legislative

amendments required to ensure that the treatment of people receiving aged care services is consistent with the treatment of other members of the community.

ATTACHMENT C

Amendments moved by Minister Wilson

[schedule 9 - see page 30]

(1) Clause 2, page 2 (at the end of the table), add:

11. Schedule 9 The day after this Act receives the Royal Assent.

(2) Schedule 1, page 10 (after line 4), after item 37, insert:

37A Subsection 44-21(2) (Care subsidy reduction calculator, step 4, paragraphs (a) and (b))

Repeal the paragraphs, substitute:

*(a) the **adjusted basic subsidy amount** for the care recipient for the day (see subsection (6A));*

(b) any primary supplement amounts for the care recipient for the day.

37B Subsection 44-21(2) (Care subsidy reduction calculator, step 5, paragraphs (a) and (b))

Repeal the paragraphs, substitute:

*(a) the **adjusted basic subsidy amount** for the care recipient for the day (see subsection (6A));*

(b) any primary supplement amounts for the care recipient for the day.

37C Subsection 44-21(3)

*Omit all the words after "**care subsidy reduction**", substitute:*

for a day is the total of the following amounts:

(a) the adjusted basic subsidy amount for the care recipient for the day (see subsection (6A));

(b) any primary supplement amounts for the care recipient for the day.

37D After subsection 44-21(6)

Insert:

*(6A) The **adjusted basic subsidy amount** for a care recipient for a day is an amount:*

(a) determined by the Minister by legislative instrument; or

(b) worked out in accordance with a method determined by the Minister by legislative instrument.

(3) Schedule 1, items 40 and 41, page 10 (lines 11 to 25), omit the items.

(4) Schedule 1, item 71, page 14 (lines 22 to 25), omit the item, substitute:

71 Subsection 44-21(3) (Income tested reduction calculator, step 4, paragraph (c))

Repeal the paragraph (not including the note), substitute:

*(c) the **subsidy related amount** for a care recipient for a day (see subsection (4)).*

71A At the end of section 44-21

Add:

*(4) The **subsidy related amount** for a care recipient for a day is the total of the following amounts:*

(a) the adjusted basic subsidy amount for the care recipient for the day (see subsection (5));

(b) the amounts of any primary supplements worked out using Subdivision 44-C for the care recipient for the day;

less the amounts of any reductions in subsidy worked out using Subdivision 44-D for the care recipient for the day.

*(5) The **adjusted basic subsidy amount** for a care recipient for a day is an amount:*

(a) determined by the Minister by legislative instrument; or

(b) worked out in accordance with a method determined by the Minister by legislative instrument.

71B Paragraph 44-23(4)(b)

Repeal the paragraph, substitute:

(b) the subsidy related amount worked out under subsection 44-21(4) for the care recipient for that day.

(5) Schedule 1, items 80 and 81, page 16 (line 30) to page 17 (line 17), omit the items.

(6) Schedule 1, item 90, page 20 (after line 10), after paragraph (1)(c), insert:

(ca) section 44-21;

(7) Schedule 1, item 90, page 20 (line 24), omit paragraph (3)(f), substitute:

(f) section 44-21;

(fa) paragraph 44-23(4)(b);

(8) Schedule 1, page 25 (after line 15), after item 97, insert:

97A Saving — care subsidy reduction under the Aged Care Act

Despite the amendments of section 44-21 of the Aged Care Act made by the amending Part, that section, as in force immediately before the commencement day, continues to apply, on and after that day, in relation to a payment period that starts before that day.

97B Saving — daily income tested reduction under the Transitional Act

Despite the amendments of section 44-21 and paragraph 44-23(4)(b) of the Transitional Act made by the amending Part, those provisions, as in force immediately before the commencement day, continue to apply, on and after that day, in relation to a payment period that starts before that day.

(9) Schedule 1, items 99 and 100, page 25 (line 28) to page 26 (line 10), omit the items, substitute:

99 Application — maximum daily amount of resident fees on or after the commencement day under the Aged Care Act

Section 52C-5 of the Aged Care Act, as amended by the amending Part, applies in relation to a day that is on or after the commencement day.

100 Saving — maximum daily amount of resident fees for a day that is before the commencement day under the Aged Care Act

Despite the amendment of section 52C-5 of the Aged Care Act made by the amending Part, that section, as in force immediately before the commencement day, continues to apply, on and after that day, in relation to a day that is before the commencement day.

(10) Schedule 5, item 16, page 71 (lines 8 to 24), omit subsections 63-1D(3) and (4), substitute:

(3) Subsection (2) does not apply in relation to an approved provider at a particular time if both of the following apply at that time:

*(a) the *governing body of the provider has fewer than 5 members;*

*(b) the provider provides *aged care through one or more *aged care services to fewer than 40 care recipients.*

(4) Paragraph (2)(a) or (b) does not apply in relation to an approved provider at a particular time if a determination under section 63-1E that the responsibility set out in that paragraph does not apply in relation to the provider is in force at that time.

(11) Schedule 8, item 49, page 112 (line 15), omit "subsections (3) and (4)", substitute "subsection (4)".

(12) Schedule 8, item 49, page 112 (lines 25 to 29), omit all the words from and including "anyone" to the end of subsection 161(3), substitute "a member of the Pricing Authority".

(13) Schedule 8, item 124, page 137 (line 9), omit "subsection 161(3) of the National Health Reform Act 2011", substitute "subsection 161(1) or (2) of the National Health Reform Act 2011 (other than a member of the Pricing Authority (within the meaning of that Act))".

(14) Page 145 (after line 5), at the end of the Bill, add:

Schedule 9 — Restrictive practices

Aged Care Act 1997

1 After subsection 54-10(1)

Insert:

*(1A) The Quality of Care Principles made for the purposes of paragraph 54-1(1)(f) may make provision for, or in relation to, the persons or bodies who may give informed consent to the use of a *restrictive practice in relation to a care recipient if the care recipient lacks capacity to give that consent.*

2 Subsection 54-10(3)

After "Subsections (1)", insert ", (1A)".

3 At the end of Division 54

Add:

54-11 Immunity from civil or criminal liability in relation to the use of a restrictive practice in certain circumstances

(1) This section applies if:

(a) an approved provider provides aged care of a kind specified in the Quality of Care Principles made for the purposes of paragraph 54-1(1)(f) to a care recipient; and

*(b) a *restrictive practice is used in relation to the care recipient; and*

(c) the care recipient lacked capacity to give informed consent to the use of the restrictive practice.

*(2) A *protected entity is not subject to any civil or criminal liability for, or in relation to, the use of the *restrictive practice in relation to the care recipient if:*

(a) informed consent to the use of the restrictive practice was given by a person or body specified in the Quality of Care Principles made for the purposes of this paragraph; and

(b) the restrictive practice was used in the circumstances set out in the Quality of Care Principles made for the purposes of paragraph 54-1(1)(f).

*(3) Each of the following is a **protected entity**:*

(a) the approved provider referred to in paragraph (1)(a);

*(b) an individual who used, or assisted in the use of, the *restrictive practice in relation to the care recipient referred to in that paragraph.*

4 Clause 1 of Schedule 1

Insert:

***protected entity** has the meaning given by subsection 54-11(3).*

Question agreed to.

Bill, as amended, agreed to.

Third Reading

Mr TIM WILSON (Goldstein—Assistant Minister to the Minister for Industry, Energy and Emissions Reduction) (18:04): by leave—I move:

That this bill be now read a third time.