AGED CARE AMENDMENT (SECURITY AND PROTECTION) BILL 2007

THE INQUIRY

1.1 The Aged Care Amendment (Security and Protection) Bill 2007 was introduced into the House of Representatives on 8 February 2007, passed the House on 15 February and was introduced into the Senate on 26 February 2007. On 8 February 2007, the Senate, on the recommendation of the Selection of Bills Committee (Report No. 2 of 2007), referred the Bill to the Community Affairs Committee (the Committee) for report.

1.2 The Committee received 15 submissions relating to the Bill and these are listed at Appendix 1. The Committee considered the Bill at a public hearing in Canberra on 1 March 2007. Details of the public hearing are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca .

THE BILL

1.3 The purpose of the Bill is to amend the *Aged Care Act 1997* to provide new measures to protect aged care residents, including:

- a regime for compulsory reporting of physical and sexual assaults of people in aged care;
- protections for approved providers and staff who report assaults of people in aged care;
- establishment of complaints investigation arrangements through new Investigation Principles; and
- establishment of the Aged Care Commissioner to replace the existing Commissioner of Complaints.

Compulsory reporting

1.4 In the Bill a 'reportable assault' is unlawful sexual contact, unreasonable use of force, or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory that is inflicted on a person receiving Commonwealth funded residential aged care services. If an approved provider receives an allegation of, or starts to suspect on reasonable grounds, a reportable assault, the approved provider is responsible for reporting the allegation or suspicion as soon as reasonably practicable and in any case within 24 hours. The report must be made to a relevant police officer and to the Secretary.

1.5 The proposed provisions outline an exception to this responsibility on approved providers in the circumstances (if any) specified in the Accountability Principles. The Department of Health and Ageing's Explanatory Guide to the Bill states that this exception 'is intended to deal with very specific and sensitive circumstances – such as assaults carried out by residents with a mental impairment'.[1]

1.6 The proposed amendments define 'staff member' as an individual who is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruiting agency) to provide care or other services. Approved providers are responsible for taking reasonable measures to require each of their staff members, who suspects on reasonable grounds that a reportable assault has occurred, report the suspicion as soon as reasonably practicable to one or more of the following: the approved provider; one of approved the provider's key personnel; another person authorised by the provider to receive reports of suspected reportable assaults; a police officer; or the Secretary.

Protections for those who report

1.7 A disclosure of information by a person qualifies for protection under proposed sub-section 96-8(1) if:

- the discloser is an approved provider or a staff member of an approved provider;
- the disclosure is made to: a police officer, the Secretary, the approved provider, one of the approved provider's key personnel or another person authorised by the provider to receive reports of alleged or suspected reportable assaults; and
- the discloser reveals their name and the disclosure is made in good faith.

1.8 If a person makes a protected disclosure they are not subject to any civil or criminal liability for making the disclosure and no contractual or other remedy may be enforced against the person on the basis of the disclosure. The person making a protected disclosure has qualified privilege in proceedings for defamation and is not liable to an action for defamation relating to the disclosure. A contract to which the person is party may not be terminated on the basis that the disclosure constitutes a breach of contract.

1.9 If a court is satisfied that a person has made a protected disclosure and that person's contract of employment has been terminated on the basis of the disclosure, the court may order that the person be reinstated or paid an amount by the employer.

1.10 A person must not cause detriment (by act or omission) to, or make a threat (whether express or implied or conditional or unconditional) to cause any detriment to, another person because they have made a protected disclosure.

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1 *Submission* 13, Attachment A, p.6 (Department of Health and Ageing).

1.11 Approved providers are also responsible for ensuring, as far as reasonably practicable, the protection of staff members who make a protected disclosure. In particular the approved provider must ensure, as far as reasonably practicable:

- that any staff member who makes a disclosure does not have contractual or other remedies enforced or exercised against them, because they made a protected disclosure;
- that any contract with a staff member who makes a protected disclosure is not terminated on the grounds that the staff member made the protected disclosure;
- that any staff member who makes a protected disclosure does not suffer a detriment because they made a protected disclosure; and
- that any staff member who makes a protected disclosure does not suffer a threat because they made a protected disclosure.

1.12 This covers not only compliance by the approved provider itself but extends to the ensuring as far as reasonably practicable that there is also compliance by others, such as other staff members of the approved provider and other parties with whom the approved provider contracts (for example an employment agency).

1.13 If a person reports a suspected reportable assault to the approved provider, the provider is responsible for taking reasonable measures to ensure that the fact that the person was the maker of the report is not disclosed, except to police, the Secretary, the approved provider's key personnel or when required by law.

Investigation Principles

1.14 The Investigation Principles (to be made by the Minister) may make provision relating to the investigation of matters (including complaints) relating to the Act or the Principles including: which matters are investigated; how investigations are to be conducted; considerations in making decisions relating to investigations; and procedures for reconsideration or examination of decisions in relation to investigations.

1.15 The Investigation Principles may make provision relating to actions which must be taken if it is found in an investigation that an approved provider has not complied with its responsibilities.

The Aged Care Commissioner

1.16 The new role of Aged Care Commissioner has a number of functions, including:

- to examine certain decisions made by the Secretary under the Investigation Principles and make recommendations to the Secretary arising from examinations;

- to examine complaints made to the Aged Care Commissioner about the Secretary's processes for handling matters under the Investigation Principles and make recommendations arising from examinations;
- to examine complaints made to the Aged Care Commissioner about the conduction of an accreditation body (currently the Aged Care Standards and Accreditation Agency) relating to its responsibilities under the Accreditation Grant Principles; or the conduct of a person carrying out an audit, or making a support contact under those principles. Examinations of conduct may also be initiated by the Aged Care Commissioner. The functions of the Aged Care Commissioner expressly exclude examination about the merits of a decision;
- to advise the Minister, at the Minister's request, about matters relating to any of the Aged Care Commissioner's functions; and
- other functions (if any) specified in the Investigation Principles.

BACKGROUND

1.17 On 27 July 2006 the Minister for Ageing, Senator the Hon Santo Santoro announced a $90.2 million package of reforms to take effect from 1 April 2007 aimed at further safeguarding residents in aged care homes from sexual and serious physical assault.[2] This followed an earlier announcement of compulsory police background checks for aged care staff and volunteers and an increase in random unannounced inspections of aged care homes. These measures formed part of the Government's response to incidents which came to light in 2006 involving the alleged serious assaults and mistreatment of people in residential aged care.

1.18 The Minister for Ageing and the Department of Health and Ageing undertook consultation in the development of Bill, in part through the Minister's Aged Care Advisory Committee which met four times in 2006. The Minister also invited members of the public, including care recipients and their families, to write to him through the Residential Aged Care Taskforce established in February 2006.[3]

1.19 The Aged Care Amendment (Security and Protection) Bill 2007 was introduced into the House of Representatives on 8 February 2007 with a commencement date of 1 April 2007.

ISSUES

1.20 Amongst the submissions which the Committee received there was broad support for the reforms in the Bill to increase protections for elderly people in residential care from physical and sexual assaults. However, a number of significant issues of concern were also raised.

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2 Minister for Ageing, Senator the Hon Santo Santoro, *Howard Government delivers major new safeguards against abuse*, Media Release SS68/06, 27 July 2006.

3 *Submission* 13, p.4 (Department of Health and Ageing).

Commencement

1.21 The Bill provides that the new procedures commence on 1 April 2007 as was the intention when the Minister announced the reforms in July 2006. As the explanatory memorandum states 'this means that approved providers will be expected to start complying with the new responsibilities imposed by this legislation (including new responsibilities to compulsorily report certain assaults) from 1 April 2007'. The Explanatory Guide outlines the requirements for providers:

> From 1 April 2007, the approved provider must also have in place systems to alert staff to the reporting requirements. The approved provider must also have systems in place to protect the identity of staff that make disclosures and also to protect such staff from victimisation.[4]

1.22 Provider and staff representatives claimed that with the Bill still before Parliament and the Principles containing all the operational detail not to be finalised before the Bill has passed, it was not feasible to have all these new systems in place by the 1 April commencement date. They argued that to develop materials for and organise training so that staff can be appraised of and actually trained in their new responsibilities required a longer timeframe. Some proposed a delay of eight weeks to enable full and thorough implementation of the new arrangements.[5]

Investigation Principles

1.23 The amendments proposed in the Bill set the general framework for the reforms. Much of the operational detail about the practices and processes that will give effect to the reforms will be included in subordinate legislation, Aged Care Principles made under the Aged Care Act 1997. Proposed Division 94A provides for Investigation Principles that will detail the processes and procedures for complaint handling and investigation. However, while the Department has advised that the Principles cannot be finalised until the Bill has passed it has prepared an Explanatory Guide 'setting out the proposed content of the Principles in order to provide stakeholders with information about the totality of the proposed arrangements'. The Department has undertaken 'to consult on the content of the proposed Principles as they are developed and welcomes input from stakeholders'.[6]

1.24 The Principles are fundamental to the operation of the new measures dealing as they do with issues including the matters to be investigated and how investigations are to be conducted. A number of groups could only provide general comment without access to draft Principles. As the Elder Rights Advocacy commented:

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4 *Submission* 13, Attachment A, p.9 (Department of Health and Ageing).

5 *Committee Hansard* 1.3.07, p.14 (Australian Unity); p.17 (LHMU); p.21 (Aged and Community Services Australia and Aged Care Association Australia). Also *Submission* 10, p.3 (Aged Care Association Australia).

6 *Submission* 13, pp.2-3 (Department of Health and Ageing).

> Overall we believe that the measures are good. We have a problem, though, in that we have not seen the principles…We would like to see the rest of the detail—the devil is always in the detail. We hope it is not; we hope that some of the measures that people are suggesting can be included in the principles to make this very workable.[7]

1.25 The Committee received a number of suggestions about what should be included in the Principles and how the procedures they provide should operate, including what would trigger an investigation, managing vexatious complaints, anonymous complaints, training requirements for staff, level and form of evidence, procedural fairness and appeal processes.[8]

1.26 A number of submissions highlighted the need to ensure that principles of natural justice and administrative fairness were reflected in the Investigation Principles and investigation procedures. The COTA over 50s Alliance commented:

> The amendments, along with the Investigation Principles, must ensure that, whilst they provide the appropriate mechanisms to achieve thorough and comprehensive investigations of reportable assaults, at all times natural justice is afforded all relevant parties. By the very nature of these offences, often presented as allegations and suspicions, there needs to be ample opportunities for all relevant parties to be able to answer or provide further explanations without fear of reprisal.[9]

1.27 Catholic Health Australia noted there was 'no provision for a complainant to be informed of the Commissioner's recommendations or have recourse should the complainant be dissatisfied with these recommendations.'[10] Similarly Aged and Community Services Australia commented:

> The Bill does not adequately address the issue of informing both the complainant and the party complained about on the outcomes of an investigation. The legislation should specify that both parties are informed of the outcomes of an investigation.[11]

1.28 The Department gave a commitment that 'all relevant parties, including approved providers, will be afforded natural justice and procedural fairness during the course of investigations (and this will be expressly provided for in the Principles)'.[12]

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7 *Committee Hansard* 1.3.07, p.2 (Elder Rights Advocacy). Also *Submission* 12, p.3 (Health Services Union).

8 *Submission* 8, pp.2-3 (Elder Rights Advocacy); *Submission* 9, pp.1-2 (Aged and Community Services Australia); *Submission* 5, p.1 (Liquor Hospitality and Miscellaneous Union).

9 *Submission* 3, p.2 (COTA over 50s Alliance).

10 *Submission* 6, p.5 (Catholic Health Australia).

11 *Submission* 9, p.2 (Aged and Community Services Australia).

12 *Submission* 13, Additional information dated 7.3.07, p.9 (Department of Health and Ageing).

1.29 The Committee expects that all these issues relating to the Principles will be considered during the process being undertaken by the Department in the development of the Principles. The Committee does note that consultation drafts of the Private Health Insurance Rules were available for public comment while the Private Health Insurance Bill 2006 was progressing through Parliament and that this assisted in an understanding of many aspects of that Bill.

Compulsory reporting

Scope

1.30 Under the provisions of the Bill if an approved provider receives an allegation or starts to suspect on reasonable grounds a reportable assault the approved provider is responsible for reporting to the relevant police force and the Department of Health and Ageing. There were significant concerns expressed to the Committee about the details of the operation and scope of the compulsory reporting requirements, particularly the requirement to report to police. The undesirability of reporting resident-on-resident and resident-on-staff assault was a common theme among submissions. There was much commentary on the practicality of a system of otherwise compulsory reporting and a number of possible alternatives to the proposed model were proffered.

1.31 Aged and Community Services Australia noted that 'an allegation must be reported whether it is based on reasonable grounds or not, but suspicions have to be on reasonable grounds…wouldn't the same test of reasonableness apply to both allegations and suspicions?'.[13] Australian Unity argued for a higher threshold before approved providers were required to report allegations or suspicions:

> Section 63-1AA (2) states
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> "If the approved provider receives an allegation of, or starts to suspect on reasonable grounds etc…"
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> Our recommendation is that the word 'or' should be replaced with 'and' so that aged care providers may assess the situation and establish that on reasonable grounds a particular incident is a case of suspected abuse.[14]

1.32 Australian Unity fully supported mandatory recording of all allegations, even when there were no reasonable grounds to suspect a reportable assault. They also noted that requiring reasonable grounds before requiring reporting would limit the number of mistaken or vexatious claims.[15]

1.33 In evidence Australian Unity offered an alternative position. In some cases, it was suggested, police involvement is unnecessary. Excessive police involvement would over-burden the system. It argued that care-providers should report only where

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13 *Committee Hansard* 1.3.07, p.20 (Aged and Community Services Australia).

14 *Submission* 7, p.3 (Australian Unity).

15 *Committee Hansard* 1.3.07, p.11 (Australian Unity).

there were 'reasonable grounds to suspect…assault'. They felt a parallel set of obligations, one based on reasonable reporting, and one based on the mandatory recording of all incidents, would be sufficient. All records could be reviewed by the Department of Health and Ageing at their convenience. Family members, dissatisfied with the actions of health-providers, could demand that incidents be reported.[16]

1.34 The Australian Medical Association argued that the scope of the compulsory reporting responsibilities was too broad and should be focused on the abuse of elderly residents by staff. They commented:

> The AMA has maintained that while abuse between residents needs to be addressed, extending the focus of compulsory reporting to resident-on-resident and resident-on-staff interactions is inappropriate, and will have significant resource implications. The AMA strongly believes that the core focus of compulsory reporting should be on preventing elder abuse by health care workers.[17]

1.35 During the hearing the issue was raised that the compulsory reporting measures in the Bill could lead to police and Department resources being diluted or diverted, so that serious cases of abuse by staff members or others were not adequately investigated. Dr Ford of the Australian Medical Association stated that resident on resident assaults in aged care facilities were very common:

> If the staff or the providers take a defensive approach to this and basically see that they cannot define it and will report everything, then it could become unworkable and the element that we wish to really pursue would fail to be addressed.[18]

1.36 However the Department commented that in developing the legislation a blanket exemption for all aged care residents did not seem defensible.

> There are 170,000 people every night in residential aged care. They consist of a complete slice of the human community in Australia. There are people there that have been in the past perpetrators of very serious crimes. There are people there who are bullies. There are people there who are predators. There have been also, in the past, for people who have worked in aged care for a long time, some really very grievous examples of resident-on-resident abuse.[19]

1.37 There was concern that the language of the Bill in relation to compulsory reporting requirements for approved providers and staff members lacked clarity. Aged and Community Services Australia noted that:

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16 *Committee Hansard* 1.3.07, pp.9,10,13 (Australian Unity).

17 *Submission* 14, p.1 (Australian Medical Association).

18 *Committee Hansard* 1.3.07, p.30 (Australian Medical Association).

19 *Committee Hansard* 1.3.07, pp.36-37 (Department of Health and Ageing).

> The use of terms "unreasonable" and "start to suspect" are vague and open to interpretation. A tighter definition of these terms is required. Providers should not be required to report on the basis of suspicion - this is likely to waste time and resources of both the providers and the police forces.[20]

1.38 Australian Unity sought 'clarification on the obligations of other health professionals involved with our residents, such as GPs and allied health professionals in advising us as the approved provider of a suspected abuse'.[21] The Department noted that:

> There are existing mechanisms in place which encourage health professionals to report abuse. The Aged Care Act currently requires approved providers to comply with relevant state and territory laws…
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> Regardless of any legislative requirements to report, it is important to note that:
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> - any person (including health professionals) may at anytime make a report to the Department and this will be investigated;
> - the Department (including through approved providers) encourages any reporting of abuse or other issues of concern regarding the treatment and safety of residents;
> - the Department's communications strategy for the new arrangements will target GPs and hospitals; and
> - approved providers can also encourage health professionals to report any abuse to the approved provider (who plays a crucial role in relation to the care and safety of residents) or to the police or Department. [22]

Compulsory reporting and police

1.39 A number of submissions and witnesses stressed the need for sensitivity in investigating assaults in residential aged care facilities. Australian Unity noted:

> Where police are required to investigate, we believe that community policing squads or sexual assault units are the most appropriate police to intervene in these cases…Consideration of the gender of the investigating police officer will also be paramount to the victim and their family.[23]

1.40 Aged and Community Services Australia also noted that the definition of 'reportable assault' in the Bill may require approved providers to report non-criminal conduct to police.

> The phrase "unreasonable use of force" encompasses criminal and non-criminal conduct. Given the reference to unlawful sexual contact and an

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20 *Submission* 9, p.3 (Aged and Community Services Australia).

21 *Submission* 7, p.4 (Australian Unity).

22 *Submission* 13, Additional information dated 7.3.07, p.5 (Department of Health and Ageing).

23 *Submission* 7, p.4 (Australian Unity).

> assault, it is unclear what this is referring to. To the extent that it covers non-criminal conduct, it seems inappropriate to require such a report to the police.[24]

1.41 The Department advised that:

> The guidelines to the industry will make it clear that if an approved provider is in any doubt as to whether unreasonable force has been used, the approved provider should err on the side of reporting to police and the Department. Approved providers are currently making similar assessments when they decide whether or not to report incidents to the Department or the police under existing voluntary reporting arrangements.
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> While each case will be judged on its merits, an example of reasonable use of force in the context of compulsory reporting of assaults would be where a staff member is genuinely trying to assist a care recipient, but despite their best intentions the care recipient is accidentally injured.
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> An example of unreasonable use of force would be where a staff member is violent towards a resident.[25]

1.42 The Committee is concerned that with the new reporting arrangements to commence on 1 April, the level of consultation undertaken with Commonwealth, State and Territory police forces in developing the terms of the Bill, and particularly in developing procedures to respond to the additional burdens compulsory reporting might put on police resources, has been inadequate. This was especially the case as the Department indicated there was no available data to even indicate approximately how many incidents would be reported to police as a result of the legislation.

1.43 The Department advised that members of the Australian Federal Police had attended meetings of the Aged Care Advisory Committee when the issue of compulsory reporting was being explored. While the Department's State and Territory offices have been meeting with relevant police forces, since January 2007 meetings have only been held in the ACT, Queensland and Victoria to discuss police check requirements and the issue of compulsory reporting. Meetings with other States are being arranged.[26]

1.44 As noted earlier, compulsory reporting has a dual reporting requirement – to the police and to the Department. The Department explained the purpose of this requirement:

> The purpose of the police involvement is to assess whether criminal activity has occurred and if charges need to be laid. The police are the best and most appropriate authorities to make that judgement. The purpose of reporting to

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24 *Submission* 9, Additional information 2.3.07, p.1 (Aged and Community Services Australia).

25 *Submission* 13, Additional information dated 7.3.07, p.3 (Department of Health and Ageing).

26 *Submission* 13, Additional information dated 7.3.07, p.13 (Department of Health and Ageing).

> the department is for us to consider whether the approved provider has actually met its responsibilities under the aged-care legislation.[27]

While the Investigation Principles will outline how the Department, through the new Office of Aged Care Quality and Compliance, should conduct investigations, the investigation procedures to be adopted by police in assessing whether criminal activity has occurred will continue to be determined by the relevant State/Territory police service.

The right not to report

1.45 A number of submissions expressed concerns about whether the Bill would respect a competent person's right not to have an assault disclosed or reported to police or others. Australian Unity commented:

> An aged care facility is the resident's home and we believe, where appropriate, victims should have a choice as to the level of disclosure of their situation to the wider community within their aged care facility, and that any intervention by officials, either police or departmental, must be respectful of the victim's right to privacy.[28]

1.46 Aged and Community Services Australia considered that without such an option 'we [would be] giving older people fewer rights than we would to anyone else, simply because they are residents in residential care'.[29] Similarly the Australian and New Zealand Society for Geriatric Medicine argued that 'Young rape victims have the option of treatment without police intervention. Cognitively intact elderly residents should be accorded the same right.'[30]

1.47 Aged and Community Services Australia expressed concern that aged care providers would be forced to act against the wishes of residents:

> ACSA is concerned that the introduction of compulsory reporting takes away the rights of competent older people to determine whether or not they wish to take any action on an assault. Under the provisions of this Bill, approved providers are required to make reports in the absence of the alleged victim’s consent and even in the face of their refusal to grant such consent.[31]

1.48 However during the hearing it was also noted that while the Bill required approved providers to report reportable assaults to the police, the individual could still decide their level of cooperation with the investigation. The Department indicated that

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27 *Committee Hansard* 1.3.07, p.37 (Department of Health and Ageing).

28 *Submission* 7, p 3 (Australian Unity).

29 *Committee Hansard* 1.3.07, p.19 (Aged and Community Services Australia).

30 *Submission* 1, p.2 (Australian and New Zealand Society for Geriatric Medicine).

31 *Submission* 9, p.2 (Aged and Community Services Australia).

if residents 'do not want the police to continue investigation or they do not want charges to be laid, they can have that discussion with the police.'[32]

1.49 The AMA argued strongly that the nature of the relationship between a resident and their provider mandated that there not be a discretion for the former not to report an assault:

> This is not an issue for that person alone. That is an indication of risk to everybody else in that residential care service and anywhere else that that casual worker might be working. The other thing I would have to say is that residents are sometimes frightened in that environment. They fear being thrown out. They fear not receiving the services. If you cannot walk and you are dependent on the people around you to stand you up so that you are not wet that day, it is very tough. I think that, irrespective of that, it will have to be worked through with the resident. Even if they have cognitive impairment, you would have to work through it with them, because it still has to be addressed. I do not think you can allow a situation where there has been a clear episode of abuse and the resident says, 'Don't take it any further,' because the alleged perpetrator of that abuse is a risk for everybody else in the residential care centre.[33]

1.50 The Department commented on the tension between compulsory reporting requirements and the responsibility to respect residents' wishes not to have the matter reported:

> In the context of residential aged care, approved providers (and the Government) have an obligation not only to protect the victims of abuse (and, as far possible, to respect their wishes) but also to protect others in the residential aged care service and ensure the safety of all.
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> Recognising the broader need to ensure the safety of others, the legislation adopts a cautious approach by requiring reporting of all allegations to police and the Department regardless of whether a resident agrees that such reporting should occur.
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> While this may sometimes mean that the wishes of a particular resident may not be met, it also ensures that:
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> - the safety of all residents is paramount; and
> - there can be no pressure on a resident to encourage them not to report because the approved provider will be required to report.[34]

Discretion not to report

1.51 The Explanatory Guide to the Bill provides for a discretion for approved providers not to report assaults in recognition that 'assaults by residents with mental

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32 *Committee Hansard* 1.3.07, p.41 (Department of Health and Ageing).

33 *Committee Hansard* 1.3.07, p.33 (Australian Medical Association).

34 *Submission* 13, Additional information dated 7.3.07, p.6 (Department of Health and Ageing).

impairments are not uncommon, and in such cases, the focus should be on behaviour management of the resident with the mental impairment and protection of residents, and not police involvement, which can be traumatic for all involved.' The Guide states:

> [I]t is proposed that the *Accountability Principles 1998* would provide approved providers with the discretion not to report a reportable assault to the police and the Office if the following three circumstances all exist:
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> - the approved provider must have reasonable grounds for believing that the person who carried out the reportable assault is a resident. The approved provider must form this view within the 24 hours after the allegation of the reportable assault or after starting to suspect on reasonable grounds that a reportable assault has occurred;
> - a medical diagnosis of mental impairment must have been made in respect of the resident and documentation must exist showing that the resident is mentally impaired. Both the diagnosis and the documentation must exist prior to the allegation of the reportable assault or the approved provider starting to suspect on reasonable grounds that the reportable assault occurred. If this is not the case, then a report must be made to the police and the Office, within 24 hours of the allegation or suspicion; and
> - the approved provider has a behaviour management plan in relation to the particular resident who is suspected to have carried out the assault.
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> It is also proposed that section 19.5 of the Records Principles 1997 be amended to require that the approved provider keeps a record of all such incidents where assaults are not reported because of reliance on these alternative requirements. [35]

1.52 The importance of the discretion for aged providers outlined in the Explanatory Guide was highlighted in evidence to the Committee indicating the high proportion of aged care residents with dementia or cognitive impairment. The Australian and New Zealand Society for Geriatric Medicine indicated that 'Dementia and cognitive impairment are very common conditions in residents of nursing homes (at least 50%) and hostels (at least 30%)', while the Australian Medical Association suggested that up to 60% of residents in low care and 80% in high care could have some form of cognitive impairment.[36] The AMA also noted the difficulties in the accurate diagnosis of dementia or mental impairment and the currency of a formal diagnosis (which is required in accordance with the procedure outlined in the Explanatory Guide):

> While a diagnosis of cognitive impairment often occurs upon admission to an aged care facility, this process is not always formalised at this stage, the

35 *Submission* 13, Attachment A, pp.6-7 (Department of Health and Ageing).

36 *Submission* 1, p.1 (Australian and New Zealand Society for Geriatric Medicine); *Submission* 14, p.1 (Australian Medical Association).

> diagnosis does not always remain current, and the current cognitive status of a previously competent resident might not be known.[37]

1.53 During the hearing there were concerns expressed about who would make a diagnosis of mental impairment for residents and whether it was possible for up-to-date medical records to be maintained. The Department indicated it expected that residents would be seen by a medical professional on a regular basis to assess their needs. The Department also indicated that it expected that for the purposes of the Bill a diagnosis of mental impairment would be made by a general practitioner or a geriatrician.[38]

1.54 There was concern that the discretion in relation to assaults by aged residents with mental impairments would detract from approved providers' obligations to provide a safe environment for all aged care residents. The Aged Care Crisis Team noted:

> We see here no requirement of the provider to exercise 'duty of care'. A frail elderly person, powerless to defend him/herself is not afforded protection and has no recourse when the provider does not adequately manage the resident with dementia.[39]

Training and Awareness

1.55 Staff training and awareness of the compulsory reporting requirements in relation to abuse of people in aged care were identified as crucial to the success of the Bill.[40] The Liquor Hospitality and Miscellaneous Union submitted that the Bill should include guidelines for training requirements for staff that are obligated to report suspected assault under compulsory reporting. The Union noted that:

> A compulsory reporting system will do nothing to stop the incidence of abuse against elders if aged care staff members are not trained to detect symptoms of abuse, and contend with the difficult discussions with residents, providers, staff and families that could follow detection of abuse.[41]

Retrospective effect?

1.56 The Explanatory Guide to the Bill notes that, subject to the passage of the legislation, approved providers will be expected to comply with these new requirements from 1 April 2007. It continues:

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37 *Submission* 14, p.1 (Australian Medical Association).

38 *Committee Hansard* 1.3.07, p.35 (Department of Health and Ageing).

39 *Submission* 11, p.3 (Aged Care Crisis Team).

40 *Submission* 12, p.12 (Health Services Union).

41 *Submission* 5, p.3 (Liquor Hospitality and Miscellaneous Union).

> From 1 April 2007, approved providers will have to report any reportable assaults that come to their attention.
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> This includes assaults that may have occurred before 1 April 2007, but were not reported to the approved provider until after 1 April 2007.[42]

1.57 Several submissions raised the status of past allegations and suspicions in relation to reportable assaults and the possible retrospective effect of the Bill's provisions. Aged and Community Services Australia commented:

> Given that a reportable assault may take place before or after the commencement of the legislation, there is a potential for pre-1 April 2007 reportable assaults which have already been dealt with by an approved provider, to be the subject of an allegation or suspicion post-1 April automatically invoking the requirements under section 63-1AA(2).[43]

1.58 Mr Brian Herd also suggested that ' providers will now need to pour over their records (or memory) to determine what past or existing allegations were received or suspicions arose.'[44]

1.59 The Department commented:

> The bill requires that if an issue comes to the provider's attention after 1 April, which is the proposed commencement date, then that must be reported… The incident may have occurred on 30 March and it comes to the provider's attention on 1 April. Because the bill is imposing a reporting obligation, there is a reporting obligation on the provider once they become aware of the incident.[45]

Whistleblower protections

Scope of protections

1.60 Previously the Committee has recommended that the Commonwealth examine the feasibility of 'introducing whistleblower legislation to provide protection for people, especially staff of aged care facilities, disclosing allegations of inadequate standards of care or other deficiencies in aged care facilities'.[46] However the Health Services Union noted that the protections in the Bill are limited to physical and sexual assaults and do not provide protections for staff or others who make disclosures regarding other deficiencies in relation to the services provided to those in aged care.[47]

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42 *Submission* 13, Attachment A, p.9 (Department of Health and Ageing).

43 *Submission* 9, Additional information 2.3.07, p.1 (Aged and Community Services Australia).

44 *Submission* 15, p.1 (Mr Brian Herd).

45 *Committee Hansard* 1.3.07, p.36 (Department of Health and Ageing).

46 Senate Community Affairs References Committee, *Quality and equity in aged care*, June 2005, p.65.

47 *Submission* 12, p.6 (Health Services Union).

1.61 This point was also addressed by the Aged Care Crisis Team in its submission:

> Only a small minority of cases of elder abuse involve breaking the law; so the vast majority of cases do not come under compulsory reporting. Thus, most cases of physical abuse, all emotional abuse, financial abuse and incidents of neglect are not covered…Whistleblowers are only protected if they report reportable offences. So, again, the whistleblower will have no protection if he/she reports the vast majority of cases of elder abuse as outlined above.[48]

1.62 Aged and Community Services Australia noted that the protection provisions in section 96-8 'do not extend to non-staff members who may make a complaint, such as residents, family members or visitors.'[49] This issue was also highlighted by Elder Rights Advocacy who reported instances of aged care advocates and families of residents being threatened with legal action for pursuing complaints.[50]

1.63 Catholic Health Australia indicated the scope of the protection for whistleblowers was limited by the Bill's focus on the role and responsibilities of approved providers:

> Whilst a person may not make a threat or cause any detriment to another person, the only action that the Australian Government can take to enforce these provisions is with respect to approved providers. Where an individual staff member or a relative victimises a discloser, the Commonwealth would be powerless to act.[51]

1.64 The Aged Care Association Australia argued that employers should also be protected where they comply with their responsibilities.

> ACAA is concerned that though there are specific provisions that obliges employers to protect employees who report a reportable assault there appears little protection for employers who undertake their obligations under the legislation but are still potentially liable for unfair dismissal action, defamation and slander where action is taken in response to an allegation or suspicion which subsequently proves erroneous or false.[52]

1.65 In addressing this issue the Department argued that:

> Family members, residents, visitors and funded advocates are not required by the proposed provisions to report abuse and therefore they do not have statutory protection.

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48 *Submission* 11, p.2 (Aged Care Crisis Team).

49 *Submission* 9, Additional information 2.3.07, p.1 (Aged and Community Services Australia).

50 *Committee Hansard* 1.3.07, pp.2-5 (Elder Rights Advocacy).

51 *Submission* 6, p.6 (Catholic Health Australia).

52 *Submission* 10, p.5 (Aged Care Association Australia).

> However, such people will be encouraged to report abuse and if they do so, they are able to report to the Department confidentially or anonymously (as they can currently). [53]

Responsibility of approved providers

1.66 Under the Bill approved providers are responsible to ensure staff members who make protected disclosers are not victimised. The Explanatory Guide noted that this responsibility 'covers not only compliance by the approved provider itself with the provision but extends to the approved provider ensuring as far as reasonably practicable that there is also compliance by others, such as other staff members of the approved provider and other parties with whom the approved provider contracts (for example, an employment agency)'.[54] However some doubted approved providers would be in a position to comply with this responsibility. Aged and Community Services Australia argued:

> It is difficult for a provider to be held responsible for the actions of a contractor once the contractor is off site or has completed their role. It is impossible for the provider to ensure protection once the person is no longer on site. The legislation should make the contractor responsible for the actions of their employees. The definition of a staff member needs to be narrowed to reflect this. A provider should not be held responsible for a third party.[55]

1.67 The Department advised that:

> …the legislation recognises that the approved provider cannot ultimately control the actions of individuals be they staff, external contractors or anyone else. This is why the legislation does not say that the approved provider must prevent any victimisation against a discloser (something for which the approved provider could not possibly exercise any control) but rather that the approved provider take reasonable measures to prevent victimisation – this could include, for example, limiting the number of people who are told the identity of the discloser and advising such people about responsibilities not to victimise. [56]

Protections for staff members

1.68 The Health Services Union proposed an amendment to the part of the Bill relating to reinstatement and compensation of staff members who have had their employment terminated because of a protected disclosure:

> The union is also concerned that there is very little detail in Section 96-8 (5) regarding how the clause would operate and apply and no assurance that

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53 *Submission* 13, Additional information dated 7.3.07, p.8 (Department of Health and Ageing).

54 *Submission* 13, Attachment A, p.8 (Department of Health and Ageing).

55 *Submission* 9, p. 3 (Aged and Community Services Australia).

56 *Submission* 13, Additional information dated 7.3.07, p.6 (Department of Health and Ageing).

> employees would be sufficiently compensated including all financial and other costs involved in the victimisation such as legal costs and compensation for pain and suffering where applicable. The clause currently provides for reinstatement **or** "an amount instead of reinstating the employee". This should be amended so that employees who are reinstated also have access to compensation.[57]

1.69 The Liquor Hospitality and Miscellaneous Union also submitted that the protections for staff members should be 'extended to protect whistleblowers who have their hours cut or established work tasks altered as a result of reporting suspected abuse'.[58]

1.70 The Committee has noted in paragraph 1.11 that under the Explanatory Guide an approved provider must ensure, as far as reasonably practicable, any staff member who makes a protected disclosure does not suffer a detriment because they made a protected disclosure.

1.71 The Department confirmed that:

> If a staff member has their hours cut or work tasks changed by the approved provider, solely on the basis of making a report, then the approved provider would be in breach of its responsibilities not to cause detriment to a discloser. Compliance action could be taken against the approved provider by the Secretary, under the Aged Care Act. [59]

Vexatious or mistaken allegations and suspicions

1.72 The Bill requires that a protected disclosure must be made in good faith. However there was considerable concern expressed about situations where vexatious or mistaken allegations and suspicions about reportable assaults could be made. The Australian and New Zealand Society for Geriatric Medicine commented:

> The staff of residential care facilities may have concerns about their rights if they are thought to be behaving inappropriately. There must be safe guards for staff against false or mistaken accusations. This will need to be balanced against the requirement for reporting. While this is incorporated in the bill, there may be considerable disruption to the operation of the residential care facility if each complaint is reported.[60]

1.73 The Aged Care Association Australia was also concerned that approved providers may be left with staff on special leave, at considerable cost, for protracted periods of time while a matter is investigated.[61]

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57 *Submission* 12, p.5 (Health Services Union).

58 *Submission* 5, p.4 (Liquor Hospitality and Miscellaneous Union).

59 *Submission* 13, Additional information dated 7.3.07, p.8 (Department of Health and Ageing).

60 *Submission* 1, p.2 (Australian and New Zealand Society for Geriatric Medicine).

61 *Submission* 10, p.5 (Aged Care Association Australia).

Aged Care Commissioner

1.74 There was some criticism that the Aged Care Commissioner was not sufficiently separate from the Department of Health and Ageing to independently investigate complaints.[62] Elder Rights Advocacy noted that the 'perceived and actual independence and accountability of the Aged Care Commissioner's role in oversighting the scheme will be an important aspect of ensuring public confidence in the aged care system.'[63] Similarly the Liquor Hospitality and Miscellaneous Union commented that 'when the commissioner is internal to the Department, it seems that the perception of independence, for staff who are aware of the links between providers and the department, is what creates a lot of the difficulty around reporting'.[64]

1.75 Catholic Health Australia also noted that there was a risk that conflicts of interest could arise:

> The Commissioner may delegate all or any of his or her functions to an APS employee in the Department. This could result in the Department's own investigation officers from the Office of Quality and Compliance being asked by the Commissioner to examine matters handled by the Office.[65]

1.76 There were also some concerns about the limits on the Age Care Commissioner's functions. The Aged Care Association Australia commented:

> The Bill seems to confine the areas of possible investigation by the Commissioner to matters relating to the Investigation Principles and the Accreditation Grant Principles. ACAA believes that the Commissioner should be granted authority across all activities of the Aged Care Division, of the Department of Health and Ageing and not just the Investigation Principles and the Accreditation Grant Principles.[66]

1.77 The Aged Care Crisis Team noted that some limitations would make the Aged Care Commissioner less useful for complainants.

> The Aged Care Commissioner may only check that the Office for Aged Care Quality and Compliance and the Aged Care Standards and Accreditation Agency have followed the correct procedures; he/she is not permitted to deal with a complaint about the merits of a decision. For example, the Commissioner cannot indicate whether the investigation of a complaint resulted in a correct conclusion. A complainant, therefore, will have to go to the Administrative Appeals Tribunal (AAT), or even the Federal Court, for a full review of the complaint.[67]

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62 *Submission* 5, p.4 (Liquor Hospitality and Miscellaneous Union).

63 *Submission* 8, p.3 (Elder Right Advocacy).

64 *Committee Hansard* 1.3.07, p.16 (Liquor Hospitality and Miscellaneous Union).

65 *Submission* 6, p.5 (Catholic Health Australia).

66 *Submission* 10, p.5 (Aged Care Association Australia).

67 *Submission* 11, p.1 (Aged Care Crisis Team).

Other issues

Limits

1.78 A number of submissions pointed to the limits of the Bill in addressing all potential forms of abuse of people in aged care facilities. These included poor nutrition, hydration, hygiene, verbal and emotional abuse or financial fraud.[68] Australian Unity noted the scope of the protection in the Bill is limited to persons in Commonwealth funded aged care and noted that 'there are many older Australian who live in residential settings, such as Boarding Houses, Supported Residential Services in Victoria and Retirement Villages that could equally be at risk of abuse'.[69]

1.79 Staff training and staffing level were also raised as important factors in preventing elder abuse by some submissions. The Aged Care Lobby Group argued that the basic causes of abuse result 'from a pervading lack of properly trained and supervised staff in the majority of aged care facilities.'[70]

1.80 A number of submission and witnesses at the hearing were concerned the Bill did not clarify the position of aged care residents who have been accused or have been found to have committed a reportable assault. The Australia Medical Association called on the Government to 'consider what the fall back position might be for residents who are charged with assault in terms of the provision of appropriate care and accommodation thereafter.'[71] Aged and Community Services Australia noted:

> The legislation does not address what would happen to a resident accused of a reportable assault which is subsequently proven, and the resident may be convicted. This needs to be addressed in relation to the security of tenure provisions in the Aged Care Act.[72]

Sanctions

1.81 The new Office of Aged Care Quality and Compliance has responsibility for investigating information about possible non-compliance by approved providers under the Aged Care Act 1997. The Explanatory Guide notes that 'the Office will have the capacity to issue Notices of Required Action to providers who have breached their responsibilities, and take compliance action where the provider fails to remedy the issue'.[73] However Aged and Community Services Australia raised an issue regarding the legal status of the sanctions in the measures outlined in the Bill:

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68 *Submission* 11, p.2 (Aged Care Crisis Team).

69 *Submission* 7, p.2 (Australian Unity).

70 *Submission* 2, p.1 (Aged Care Lobby Group).

71 *Submission* 14, p.1 (Australian Medical Association).

72 *Submission* 9, p.3 (Aged and Community Care Services Australia).

73 *Submission* 13, Attachment A, p.13 (Department of Health and Ageing).

> In our opinion, the Department does not have the power to impose punitive sanctions or require compensatory payments. It seems to be contemplated that the Notice of Required Action may encompass a wide range of actions. Given that the AAT has in the past admonished the Department for imposing punitive sanctions, and we have seen in matters before the CRS settlements involving compensatory payments, this is a real concern.[74]

1.82 In relation to this issue the Department noted that:

> Notices of Required Action will require approved providers to address any breaches of their responsibilities under the Aged Care Act 1997 and to meet their responsibilities under that Act. If an approved provider does not comply with a Notice of Required Action then compliance action may be taken under the Aged Care Act – these are the same actions that can currently be taken by the Secretary for non-compliance with any of the approved provider's responsibilities.
>
> In the event that a breach of the approved provider's responsibilities relates to, for example, failure to repay a resident their full bond or over charging of a resident, then the Notice of Required Action could require the approve provider to repay the resident the appropriate amount – this is not a punitive penalty but rather seeks to restore the resident to the position they should have been in had they not been overcharged. [75]

Review of approach

1.83 The Department indicated there may be changes to the Principles to reflect the experience gained in implementing the measures in the Bill:

> I think an important reason for having these arrangements in the disallowable instrument is that we expect we are going to learn a great deal about this in the initial year or two. We are asking providers to keep registers of information and we are going to be asking the accreditation agency to make sure those registers are kept. I think we will all be a lot wiser in a year or two.[76]

1.84 The Health Services Union suggested that 'a comprehensive review of the changes occur in two years time to evaluate their effectiveness.'[77]

Financial Impact Statement

1.85 The Committee raised with the Department concerns at the lack of information contained in the explanatory memorandum's financial impact statement.[78]

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74 *Submission* 9, Additional information 2.3.07, p.2 (Aged and Community Services Australia).

75 *Submission* 13, Additional information dated 7.3.07, p.10 (Department of Health and Ageing).

76 *Committee Hansard* 1.3.07, p.37 (Department of Health and Ageing).

77 *Submission* 12, p.12 (Health Services Union).

78 *Committee Hansard* 1.3.07, pp.41-42.

The explanatory memorandum simply states that 'the new initiatives that are implemented through this Bill are part of a $90.2 million (over four years) package of reforms aimed at further safeguarding older people in Australian Government-subsidised aged care from sexual and serious physical assault'.

1.86 The Department subsequently provided a more detailed breakdown of the $90.2 million divided over the 4 years by departmental, capital and administered (offset) expenditure. An indication of the areas of expected expenditure for 2006-07 and future years was also provided.[79] The Committee considers that at least this level of information should have been provided in the explanatory memorandum.

Conclusion and recommendations

1.87 The Committee supports the measures being introduced in the Aged Care Amendment (Security and Protection) Bill 2007. However, the Committee considers that there are a few areas that could be improved or refined and has recommended accordingly.

1.88 The Committee recognises the broad support for the Bill which contains urgent reforms with the important aim of protecting vulnerable people in aged care. However the Committee also acknowledges the legitimate concerns expressed in relation to the period of time it will take for approved providers to adequately inform and train staff members of the requirements of the Bill.

Recommendation 1

1.89 That in recognition of the additional responsibilities the Bill places on approved providers especially in relation to training staff members and instituting new systems, the commencement date, particularly in relation to the reporting provisions, be deferred for a period of at least one month.

1.90 The Committee has carefully listened to the issues which have been raised in relation to the compulsory reporting requirements for reportable assaults. There are obviously difficult questions regarding the appropriate treatment of resident-on-resident abuse and residents who may have mental impairments. The Committee also acknowledges the broad consultation which the Minister and the Department of Health and Ageing have undertaken in the development of the Bill. Nonetheless the Committee has concerns the Bill is being implemented when there is currently no clear evidence or reliable data as to the volume of reports which may result.

Recommendation 2

1.91 That the Department of Health and Ageing carefully and closely monitor developments in relation to the compulsory reporting regime upon its commencement and that care is taken to ensure the reporting mechanism operates as intended.

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79 *Submission* 13, Additional information dated 7.3.07, p.12 (Department of Health and Ageing).

1.92 The Committee acknowledges that some concerns were raised that the implementation of the new measures may not fully achieve the desired goal of protecting vulnerable older people in residential care. The Committee notes that the Department has regular meetings with the Aged Care Advisory Committee and has undertaken to continue ongoing discussions with the sector in relation to the Principles and new measures after their introduction. The Committee considers that this process should provide appropriate opportunities for the sector to raise and have resolved any unforseen consequences arising from the implementation of the new measures. The Committee believes this process must be proactive and dynamic to address emerging issues of concern. The Committee leaves open the question of whether a more formal review of the legislation might be appropriate after, say, two years of operation.

1.93 As currently drafted the Bill only provides protections for approved providers and staff members who make protected disclosures. A number of submissions and witnesses to the inquiry suggested that some other persons should also be entitled to these protections where they make protected disclosures. The Committee agrees.

Recommendation 3

1.94 That the Bill be amended to extend the whistleblower protections to aged care residents, the families of residents and aged care advocates where they have reasonable grounds to suspect that the information indicates that a reportable assault has occurred and the disclosure is made in good faith.

Recommendation 4

1.95 That subject to the above recommendations, the Committee recommends that the Senate pass the Bill.

Senator Gary Humphries
Chairman

March 2007