SUBMISSION TO THE PARLIAMENTARY JOINT COMMITTEE ON HUMAN RIGHTS

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UNLAWFUL RESTRAINT IN AGED CARE: A LEGAL PERSPECTIVE ON RESTRICTIVE PRACTICES AND ITS CONSEQUENCES FOR HUMAN RIGHTS IN AUSTRALIA

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INTRODUCTION

This is a submission directed to the following paragraphs issues in relation to which we understand the Committee is seeking evidence and to most of which this submission is directed:

- whether the restrictions in the instrument on the use of physical and chemical restraints by approved providers sufficiently protect the human rights of aged care consumers;
- how the regulation of the use of restraints in the instrument compares to the regulation of the use of restraints in comparable jurisdictions and sectors (i.e. state and territory jurisdictions, the disability sector and broader health care settings);
- whether it would be appropriate for the instrument to be amended to provide additional safeguards for the use of both physical and chemical restraints; and
- whether the substitute decision making arrangements set out in the instrument sufficiently protect the rights of aged care consumers.

We will argue that the Australian Government and the licensed aged care Providers have largely failed over many years, to contain the serious consequences for the rights of those of our people of the Australian Commonwealth who live their lives under the aegis of the Aged Care system, from the creeping and expanding unlawful restrictive practices seriously affecting scores of thousands of aged care residents and their right to liberty.

The consequences deny those who are affected by unlawful restraint, from enjoying the fundamental right to freedom of movement and self-determination, which the various forms of unlawful restraint removes.

By the use of the phrase 'unlawful restraint', or 'unlawful restrictive practices' we mean restraint [which includes common law assault and also battery] for which the person /s responsible for the restraint have no legal defence, or lawful consent.

We will attempt to show that over years, the approach by Providers [and through them their staff] and by the lead and with the support of the Commonwealth and its responsible Department, there has been a tendency to medicalise and approach restraint as a clinical issue with clinical guidelines, with little emphasis upon the legal issues of the balance between liberty and the lawful excuses for restraint.

The outcome of policies and practices minimising or even ignoring the legal effects of unlawful restraint must inevitably create a class of Australian of significant numbers who, for the most part because of their disability, are unable to defend themselves against such rude and egregious intrusions into their human rights.

The manner in which we intend to address the issues which Committee has expressed an interest in receiving submissions is set out in the table below.

ISSUE	**SUBMISSION**
whether the restrictions in the instrument on the use of physical and chemical restraints by approved providers sufficiently protect the human rights of aged care consumers	SEE 'A NEW REGULATION FOR RESTRAINT…' PP 26-29 ALSO SEE: 'EMPOWERING CONSUMERS WITH REMEDIES' at pp 30-42, for better and more accessible protections which are in the hands of the consumer
how the regulation of the use of restraints in the instrument compares to the regulation of the use of restraints in comparable jurisdictions and sectors (i.e. state and territory jurisdictions, the disability sector and broader health care settings);	SEE 'COMMON LAW' AND 'STATUTE LAW' pp 5 – 14 which describes the common law position which applies in every State and Territory, and references to Statute law in States and Territories in mental health and disability settings
whether it would be appropriate for the instrument to be amended to provide additional safeguards for the use of both physical and chemical restraints;	See 'OUR SUBMISSIONS FOR DRAFTING CHANGES' at p 27 and 'FURTHER SUBMISSIONS' AT PP 29-30
whether the substitute decision making arrangements set out in the instrument sufficiently protect the rights of aged care consumers.	SEE 'FURTHER SUBMISSIONS' ITEM 1, P.30

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WHAT DOES THE LAW SAY ABOUT UNLAWFUL RESTRAINT AND DETENTION?

COMMONWEALTH CONSTITUTIONAL POWER AND RESTRAINT IN THE AGED CARE ACT

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

> 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 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.[1]

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 –

[1] See History of the Criminal Law [Com], Australian Parliamentary Library at https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Browse_by_Topic/Crimlaw/Historycriminallaw accessed 02 April 2019

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. That is indeed what the Minister has now done by introducing amendments to the Quality of Care Principles[2].

COMMON LAW

The common law is clear about the rights and converse obligations which 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…[3]

…

> 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.[4]

[2] Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019

[3] 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]

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

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.[5]

This statement of Spigelman, C. J. 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 period. Once a plaintiff proves actual imprisonment the onus is on the defendant to establish lawful authority.[6]

The connection between the offences of assault, battery and false imprisonment is demonstrated by the following case references[7]:

- An assault is any act — and not a mere omission to act — by which a person intentionally — or recklessly — causes another to apprehend immediate and unlawful violence: *R v Burstow; R v Ireland* [1998] 1 AC 147. Thus it is the fear which is the gist of assault.
- Battery is the actual infliction of unlawful force on another. But the word "assault" has come to describe both offences: see *DPP v JWH* (unreptd NSWSC, 17 Oct 1997).
- An unlawful imprisonment is also an assault: *Hunter v Johnson* (1884) 13 QBD 225 (detention of a child after school hours by a master, without lawful authority)[8].

[5] Ibid at par 6.
[6] Ruddock v Taylor (2003) NSWCA 262 at [3]
[7] Judicial Commission of NSW, Criminal Trials Courts Bench Book, , https://www.judcom.nsw.gov.au/publications/benchbks/criminal/index.html , Assault, at 5020, accessed 16 April 2019.
[8] Op cit at [5-050] Examples of assault

What follows is a partial analysis of the common law regarding restraint, unlawful imprisonment and battery[9].

Some of the elements of false imprisonment are:

- there must be an absence of any reasonable means of escape;[10]
- restraint must be a total, not merely a partial, obstruction to freedom of movement;[11]
- physical detention is not required if a person's liberty is deprived by submitting to another's authority;[12]
- the claim is actionable without the need to prove damage;[13]
- if the trespass is negligent (such as carelessly locking someone inside a building), as opposed to intentional, it is necessary to prove actual injury or damage in order for damages to be awarded.[14] Damages are generally awarded for loss of dignity, mental suffering, disgrace, humiliation and any effect on the plaintiff's health.[15]

The House of Lords addressed issues of false imprisonment in a case involving a person, L, who had been a long-term resident under the care of the Public Guardian.[16] After an episode when he became agitated and was harming himself, L was transferred to the behavioural unit of a hospital, but without applying the provisions of the Mental Health Act 1983 (UK). Those procedures were not followed in his case because he seemed at the time 'to be fully compliant and did not resist admission'.

...

In the course of their judgment, the Court of Appeal stated:

> ... a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave those premises and have the ability to prevent him from leaving.

In the course of dealing with a claim for damages for false imprisonment consequent upon the High Court's first decision of *Re Patterson; Ex parte Taylor*, Meagher JA of the Court of Appeal said there is no place for innocence, ignorance or idealism:[17]

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[9] See generally *Butterworths Concise Australian Legal Dictionary*, 1997, for the definition of 'false imprisonment'. Also see Unlawful Restraint, in Lewis, R., Elder Law in Australia, 2nd edn, Lexis Nexis, Sydney, 2011, paras 7.34 – 7.50,which are substantially reproduced here.

[10] *Burton v Davies* [1953] St R Qd 26; (1952) ALJ 388.

[11] *Bird v Jones* (1845) 7 QB 742.

[12] *Symes v Mahon* [1922] SASR 447.

[13] *Myer Stores Ltd v Soo* [1991] 2 VR 597.

[14] Fleming, note ~~23~~ 24 above, p 30.

[15] *Myer Stores Ltd v Soo* [1991] 2 VR 597.

[16] *Re L* [1998] UKHL 24.

[17] *Ruddock v Taylor* (2003) 58 NSWLR 269; [2003] NSWCA 262 ~~Ibid~~ at [73].

> A second argument advanced on the Minister's behalf was the absence of 'fault' in them. In my view, in the absence of some statutory provision, if a defendant wrongfully imprisons a plaintiff he is guilty of the tort, no matter how innocent, ignorant or even idealistic he may be.

The statement of Spigelman CJ in *Ruddock v Taylor* lends meaning and substance to the importance which the law attaches to freedom of movement of every person:[18]

> 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 period. Once a plaintiff proves actual imprisonment, the onus is on the defendant to establish lawful authority.

In the same case His Honour made the point that the tort of trespass requires a wilful or negligent act and that the defendant's intention was to detain the plaintiff. If however intentional conduct is shown then negligence or fault does not arise[19].

Knowledge — is it necessary?

Knowledge of restraint by the victim is not required as an element in a claim for false imprisonment.[20]

The point was made by Atkin LJ in *Meering v Grahame-White Aviation Co Ltd*[21] that imprisonment occurs in fact if the key to a door is turned and the person inside the room is therefore locked in, even if he or she is unaware the key has been turned because of sleep or other reason. The humiliation or distress of detention may not be reduced just because it is discovered after the event, since damages for false imprisonment encompass loss of dignity and reputation.

It follows [it is submitted] that a person who is in residential aged care and is in fact unable to leave the premises, even though he or she may be unaware, may be subjected to unlawful restraint or imprisonment; similarly, someone who is asleep but tied or secured to the bed. In such circumstances it may be necessary to consider what lawful excuse there may be.

Who can consent for the cognitively impaired?

[18] *Ruddock v Taylor* (2003) 58 NSWLR 269; [2003] NSWCA 262 ~~Ibid~~ at [3].
[19] *Cowell v Corrective Services Commission of New South Wales* (1988) 13 NSWLR 714 ~~Ibid~~ at 743
[20] *Murray v Ministry of Defence* [1998] 2 All ER 521.
[21] (1919) 122 LT 44 at 53.

Unless consent has been sought from the guardian appointed by the tribunal (or the Supreme Court whose jurisdiction it exercises under the Guardianship Act 1987), or by the person responsible in the limited circumstances described above, lawful excuse for the restraint must be sought elsewhere.

There is also a limitation to treatment which is resisted or refused by the person for whom such decisions are made. In such cases the matter of whether the best interests of the person are served by administering the treatment rests with the Guardianship Tribunal.[22]

There is a salutary caution from Retsas and Crabbe that should be carefully noted by all who are engaged in caring for elders:[23]

> The frequency of contact between carer and the cared for, creates a situation where consent is most often implied rather than expressly sought or stated. Irrespective of the way that consent is obtained, carers must not forget that they are unable to do anything to another person without that person's consent.

In New South Wales the guardian of a person has the custody of the person to the exclusion of others and has all functions of a guardian at law and in equity.[24] A decision made or consent given by a guardian has effect as if made or given by the person under guardianship (having legal capacity to do so).[25]

There is provision[26] for the same authority to be given to decisions and consents by a 'person responsible'. Such a person includes:[27]

- the guardian appointed by instrument under the Act as an enduring guardian appointed to consent to medical and dental treatment;
- the spouse of the person, if any, if the relationship between the person and the spouse is close and continuing, and the spouse is not a person under guardianship;
- a person who has the care of the person;
- a close friend or relative of the person.

The person responsible has authority in New South Wales under the Guardianship Act (s 40) to give consent for minor or major medical and dental treatment, for a person who lacks capacity to make decisions of that kind.

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22 In New South Wales see Guardianship Act 1987 ss 46(2), 46A.
23 A P Retsas and H Crabbe, 'Restraint: Legal Implications for Aged Care' (1996) *Australian Journal on Ageing* 15(1).
24 Guardianship Act 1987 (NSW) s 21.
25 Ibid s 21(c).
26 Ibid s 6G.
27 Ibid s 33A.

Medical treatment includes any medical or surgical procedure, operation or examination, including prophylactic, palliative or rehabilitative care normally carried out by a medical practitioner.[28] A person responsible may therefore consent to restraint, which is, for example, post-operative or assists in rehabilitation or is an incidental outcome of rehabilitation following a medical or surgical procedure. The restraint may also be an incidental part of treatment for psychiatric illness and this is especially so for chemical restraint achieved through prescription drugs.

A person responsible does not otherwise appear to have authority to consent to any form of restraint.

Necessity may be a defence

It may be necessary to apply restraint in order to protect a person from self-harm, or to protect others such as carers, health professionals or other residents in a residential aged care facility.

Necessity and best interests

There may be instances of manic behaviour manifesting in self-harm, such as head butting of a wall, picking at sores or similar activity which may lead to injury. There is a slight variation on the defence of necessity which focuses on the best interests of the person, in the context of their medical treatment and rehabilitation, which may be of a longer-term nature than confronting behaviour imminently causing self-harm.

In an Australian case[29] heard by Walsh J (whose decision was affirmed on appeal) in the High Court, the matter of necessity was addressed in the context of a claim that an action for false imprisonment and trespass to the person arose against the superintendent of a mental hospital who had failed to examine a patient without delay, in circumstances where the relevant statute required that the patient 'shall without delay be examined by the superintendent'

His Honour then went on to say that good faith and a belief that what he or she is doing is right will not save a person from infringing the legal rights of another:[30]

> For the reasons stated, I feel bound to come to the conclusion that the defendant has failed to show a legal justification for the restraint which he placed upon the plaintiff for the purpose of taking him to the hospital and that he must be held liable for it. I should have been glad to be able to hold that the law did justify his actions. I find he acted in good faith

[28] Guardianship Act 1987 (NSW) s 33(1)(a).
[29] *Watson v Marshall and Cade* (1971) 124 CLR 621.
[30] *Watson v Marshall and Cade* (1971) 124 CLR 621 ~~Ibid~~ at 630.

> and that he believed that he was entitled to do what he did and that it was right to do it. But this belief is irrelevant, in my opinion, to his responsibility in law for acts which were prima facie an infringement of the plaintiff's rights, although it is highly relevant to the question of the amount of damages which should be awarded.

In *Meering's* case[31] the following statement by Atkin LJ has been judicially approved in Australia:[32]

> The law attaches supreme importance to the liberty of the individual and if he suffers a wrongful interference with that liberty it should remain actionable without proof of special damage.[33]

The last word on this subject might be left to Justice Kirby of the High Court of Australia:[34]

> [T]he principal function of the tort is to provide a remedy for 'injury to liberty' … Damages are awarded to vindicate personal liberty rather than as a compensation for loss per se.

Consent by an adult with capacity

In relation to that other kind of trespass to the person which is battery, an adult of full mental capacity may waive the right to personal integrity. The right to do so is limited by the public interest in preventing grievous bodily harm or worse.[35]

It is unlikely that a mentally competent adult will agree in a residential aged care institution 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.

Moreover, it would be possible to secure consent to the restraints of the kind earlier referred to as 'environmental modification' provided they were clearly explained. In addition, the consent must not be affected by the kind of apparent compliance or consent to which Walsh J referred in *Watson v Marshall*,[36] namely that there is no 'justified apprehension' that if without submission to the request for restraint, there would be compulsion.

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31 *Meering v Grahame White Aviation Co* (1919) 122 LT 44 at~~Supra at pp~~ 174 and 179.

32 *Myer Stores v Soo* [1991] 2 VR 597 and see *Trevorrow v State of South Australia (no 5)* [2007] SASC 285.

33 *Meering v Grahame White Aviation Co* (1919) 122 LT 44 at 53–54.

34 *Ruddock v Taylor* [2005] HCA 48.

35 *Marion's* case (1992) 175 CLR 218 at [8] per Brennan J.

36 (1971) 124 CLR 621 at 626.

Accordingly, 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*[37] case, 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) 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.
[7-44]

Chemical restraint

The meaning of chemical restraint was formerly well explained in the New South Wales Department of Health Guidelines on Management of Challenging Behaviour in Residential Aged Care Facilities[38]:

> *Chemical Restraint* is the intentional use of medication to control a person's behaviour when no medically identified condition is being treated, where the treatment is not necessarily for the condition or amounts to over-treatment for the condition. Chemical Restraint includes the use of medication when the behaviour to be affected by the medication does not appear to have a medical cause and part of the intended pharmacologic effect of the drug is to sedate a person for convenience or disciplinary purposes.

To control a person's behaviour may or may not include confinement. To administer or direct the administration of drugs as a chemical restraint may amount to a battery, if not to unlawful restraint, in the absence of consent from the resident, her/ his lawful delegate, or absence of necessity.

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[37] Balmain New Ferry Co. v Robertson [1906] HCA 83

[38] Not found – but see generally Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD) A Handbook for NSW Health Clinicians accessed at https://www.ranzcp.org/files/resources/reports/a-handbook-for-nsw-health-clinicians-bpsd_june13_w.aspx

If a person who is being considered for restraint is unable to consent because he or she lacks the capacity to do so, caution must be exercised.

Part V of the Guardianship Act 1987 (NSW) provides a mechanism for the administration of medication for medical and dental treatment and includes treatment for psychiatric conditions or illnesses. If a competent consent is not available, the resident's 'person responsible' may give consent, unless the resident is objecting to the treatment. In that event application must be made to the Guardianship Tribunal.

Consent from the Guardianship Tribunal can only be forthcoming if the treatment promotes the person's health and wellbeing. An application can be made to the tribunal to appoint a guardian with discretion to consent or refuse consent to the chemical restraint of the person.

STATUTE

State & Territory legislation

The various States of the Commonwealth have, in some cases, adopted legislation concerning restrictive practices and they fall into the following categories[39]:

status	**Statutes**
No legislation	*Mental Health Act 2007* (NSW); *Disability Inclusion Act 2014* (NSW); *Disability Services Act 1991* (ACT); *Disability Services Act 1993* (WA).
Legislation excludes conditions related to ageing	*Disability Act 2006 (Vic)* s 3 (definition of 'disability'
Cover for specific disability and mental health services only	*Disability Services Act 1993* (SA) s 3A; *Disability Services Act 2012* (NT) s 41; *Mental Health and Related Services Act 1998* (NT); *Mental Health Act 2015* (ACT); *Mental Health Act 2014* (WA) pt 14 divs 5-6; *Mental Health Act 2009* (SA) s 7; *Mental Health Act 2014* (Vic) pt 6; *Disability Services Act 2011* (Tas) pt 6; *Mental Health Act 2013* (Tas).

[39] Office of the Public Advocate (Qld), Legal frameworks for the use of restrictive practices in residential aged care: An Australian and international comparative analysis (2017), State and territory legislation: Disability and mental health legislation, p.5, fn 30,31 & 32

In this submission we have not attempted an analysis of the various disability and Mental Health laws. We have referred to State criminal law statutes which contain restraint offences and they are dealt with later in this submission[40].

Aged Care Act – Reportable Assaults

The *Aged Care Act 1997* (Cth), which is the legislation under which the aged care in Australia is regulated and funded, formerly did not regulate[41] the use of restrictive practices. Consequently, the use of restrictive practices in aged care settings, without legal justification or excuse, was, and is after the commencement of the Quality of Care Amendment [Minimising the Use of Restraint] Principles, 2019, unlawful and amounts to elder abuse[42].

In this submission we seek to show that there are other, more accessible, remedies and potentially far more people concerned to report and perhaps even to enforce, the rights of aged care residents to their liberty. Self evidently the system has failed its "consumers", so the consumers, once informed, should be empowered to supervise and to regulate, through the application of law, the use of restraint and to seek redress where it is unlawful.

This is how the Queensland Public Advocate sees it:

> There is a growing body of research indicating that dementia-related behaviours are often being managed by unregulated restrictive practices, and that restrictive interventions are in widespread use in both formal and informal aged care settings. This is particularly problematic given that more than half of people in residential aged care in Australia have a diagnosis of dementia. Evidence also suggests that some residential aged care staff do not have the knowledge and skills to manage behaviours appropriately, and that the wellbeing of the person being restrained may be negatively affected as a result. It is

[40] See the section heading 'Empowering consumers with remedies: the criminal law'
[41] That is, prior to the commencement of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 on 1 July 2019
[42] Michael Williams, John Chesterman and Richard Laufer, 'Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria' (2014) 21(3) *Journal of Law and Medicine* 641, 644; Judy Allen and Tamara Tulich, ''I want to go home now': Restraint decisions for dementia patients in Western Australia' (2015) 33(2) *Law in Context* 1, 4.

> concerning that the inappropriate use of restraints in aged care facilities in Australia has been a factor in the deaths of some people upon whom the restraints were applied.[43]

Reportable assaults were inserted in the Aged Care Act[44] by the Aged Care Amendment (Security and Protection) Act 2007 and with earnest debate about the utility of the measure propounded by the then Minister, Senator Santoro. This was among the press releases by the Minister at the time[45]:

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

When the Bill was introduced to the House in 2007, the then Minister Christopher Pyne announced that[46]

> 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.
>
> …Failure to have the necessary systems and protocols in place, and failure to report incidents, will indicate regulatory noncompliance, leading to the possible imposition of sanctions.

The Minister described the reforms thus:

- it establishes a scheme for compulsory reporting of abuse;
- it includes protection for people who make disclosures about abuse; and
- it establishes a new and independent Aged Care Commissioner.
- this is one component of several very broad reforms that enhance the department's capacity to respond to complaints about aged-care services.

The Amendment required that:

[43] Office of the Public Advocate (Qld), Legal frameworks for the use of restrictive practices in residential aged care, Op cit, P.ii

[44] S 63.1AA Aged Care Act 1997

[45] <https://www.health.gov.au/internet/budget/publishing.nsf/Content/F5E0FB56F14AD5CACA257CA0003FF424/$File/amedia1.pdf>

[46] https://parlinfo.aph.gov.au/parlInfo/genpdf/chamber/hansardr/2007-0208/0013/hansard_frag.pdf;fileType=application%2Fpdf

- Upon receiving a report of 'reportable assault' – or if the Provider 'starts to suspect on reasonable grounds that such an incident has occurred, the approved provider is responsible for reporting the allegation or suspicion within 24 hours, to:
    - a police officer …; and
    - the Secretary.
- The obligation does not apply in the circumstances (if any) specified in the Accountability Principles;
- The obligation is not to be taken as affecting any requirement of a State or Territory law;
- The amendment would not otherwise prevent reporting of the matter to the police or to the Secretary of the responsible Department [Health]
- Staff also have a responsibility to report the incident to one or more of the Provider, the police and the Secretary, and the Provider has a responsibility to require staff to do so.
- The disclosure and the staff member are protected.

The definition of "reportable assault" means:

- unlawful sexual contact,
- unreasonable use of force, or
- assault specified in the Accountability Principles [i.e. assault by another resident] and
- constituting an offence against a law of the Commonwealth or a State or Territory, that is inflicted on a person when:

    (a) the person is receiving residential care in respect of which the provider is approved; and

    (b) either:

    (i) * subsidy is payable for provision of the care to the person; or

    (ii) the person is approved under Part 2.3 as the recipient of that type of residential care.

As to when the circumstances do not apply, the Accountability Principles stipulate that the Provider is not required to make a report –

> the approved provider forms an opinion that the assault was committed by a care recipient to whom the approved provider provides residential care[47]

[47] Part 7, Accountability Principles, s 53

The definition of reportable assault relevantly requires "an unreasonable use of force" which is, effect, creating a new offence of the application of force coupled with the qualification "unreasonable".

There are various terms used to qualify force in assault including 'immediate', 'unlawful', 'intentional', 'reckless', but 'unreasonable' is not commonly among them. That is probably so because any amount of force can constitute an assault as well as a battery, at common law. The term appears to serve no useful purpose. Its use complicates the further requirement that it must be combined with a breach of state law in order to conform with the requirements of the Aged Care Act amendment.

Moreover, who is to make the determination that there has been a breach of State or Commonwealth law? Is it the care staff, the Director of Nursing, the Provider, their legal advisors? A breach of State law occurs after a trial and a decision on the case. An accused is innocent until proven guilty. The requirements o the amendment on reportable assaults do not seem to be susceptible of easy answers. Perhaps these are the gaps through which unlawful assaults have been passing until now.

The converse case that an assault was committed upon a care recipient by any other person, including care staff, is the outcome obviously intended. The problem has been that it has not often occurred to providers (if ever) that as referred to in this submission, assault includes battery and unlawful detention.

Thus it is our submission that the very legislation which might have been effective in detecting, correcting and curbing restraint has been a failure.

The statistics published by the Department of health (below) refer to "unreasonable use of force", one only of the defined "results". We can only guess what the recorded number of assaults actually means. If, as the Act requires, each of those assaults also represented and offence "against a law of the Commonwealth or a state", where is the record of reports to Police and of prosecutions?

In 2016-2017, 2853 notifications of reportable assaults were made to the Department of Health. Of those:

- 2463 were recorded as alleged or suspected unreasonable use of force;
- 348 as alleged or suspected unlawful sexual contact;
- 42 as both; and
- 130 incidents were referred to the Quality Agency[48].

Plainly, this amendment to the Act has and was intended to have, far reaching outcomes and effects. That might have been so, if it had been interpreted by the Department of

[48]<https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/AgedCareFacilities/Report/section?id=committees%2Freportrep%2F024167%2F26039>

Health, the Providers and perhaps by the Complaints Commissioner, as applying to the most vulnerable residents with cognitive impairment, who have been assaulted by the imposition of unlawful restraints.

We have earlier in this submission made the connection between unlawful restraint, battery and assault. It appears to us however, that the requirement to report what is arguably a criminal offence committed by staff, and committed vicariously by management personnel of aged care Providers, has obviously been too much to ask of them, or has been unreported because of ignorance of the law.

Furthermore, it appears that in circumstances where a staff member or a manager for an aged care facility is both implicated in an assault and also has an obligation to report it, there is a serious conflict between the right to silence, the presumption of innocence and the obligation to report.

The apparent failure of the Department to enforce this part of the legislation, introduced with so much fanfare, is egregious. It is very concerning to consider what pain and suffering might have been avoided, had the amendment to the law been given its full and intended effect.

THE CONNECTION BETWEEN UNLAWFUL RESTRAINT AND AGED CARE PRACTICE

There has been a great deal of public comment upon the prevalence, effects and public claims of excessive, unlawful restraint. We note, for example, the following:

- There has been suggestion that there is a high prevalence restraint incidents in Australian aged care facilities between 15-30%[49] ;
- Evidence cited in a report by Alzheimer's Australia 2014 cites evidence that the prevalence of physical restraint use in residential care has a range of estimates between 12% to 49%[50],
- A Report in journal of *Age and Ageing* found that examining deaths reported to Coroners in Australia between 1 July 2000 and 30 June 2013, 5 deaths in nursing homes were due to physical restraint [51].

[49] (Johnson S, Ostaszkiewicz J and O'Connell B 2009, 'Moving beyond resistance to restraint minimization: a case study to change management in aged care', Worldviews on Evidence-Based Nursing, 4th quarter, 210)

[50] Alzheimer's Australia 2014, The use of restraints and psychotropic medications in people with dementia Alzheimer's Australia, Melbourne– https://www.dementia.org.au/files/NATIONAL/documents/Alzheimers-Australia-Numbered-Publication-38.pdf

[51] Bellenger, E., et al., 2017, 'Physical restraint deaths in a 13-year national cohort of nursing home residents', Age and Ageing, Vol. 46(4), pp. 688–693.

The House of Representatives Committee on Health and Ageing recently addressed restraint issues in the course of their inquiry and their findings included the following[52]:

> 3.58 One inquiry participant, who did not wish to be named, stated that in one facility, 'many unfortunate residents are restrained for the entire day and on an ongoing basis. The only time they are unrestrained is for the purpose of using the bathroom'.75 Further, the inquiry participant stated that family members who had consented to the use of restraints for the resident were unaware of the 'negative effects of using restraints'.76
>
> 3.59 G W Hitchen stated that her late mother had been administered a chemical restraint 'because staff handling my mother failed to take into account she was profoundly deaf and was disturbed by their inappropriate physical handling', and suggested that staff could have approached her mother using auditory equipment instead.77
>
> 3.60 Dementia Australia set out a number of consumer stories about the use of restrictive practices for residents with dementia. These included:
>
> - A family member whose husband was tied to a chair after wandering into other residents' rooms;
> - A family member whose husband was placed onto antipsychotic medication after wandering into other residents' rooms, and who was given a higher dosage of antipsychotic medication against the family member's wishes;
> - A family member or carer of a resident who was prescribed antipsychotic medication because staff 'wanted her to be manageable';
> - Sedatives being prescribed without the resident or family member's knowledge and wishes; and
> - Residents with dementia being sedated and left in front of televisions all day

Use of Restrictive Practices – the decision making tool

The **Department of Health** produced the *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (Decision-Making Tool), which sets out that in a person-centred, restraint-free approach, 'the use of any restraint must always be the last resort after exhausting all reasonable alternative management options'.[53]

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[52] Health, Aged Care and Sport Committee of the House of Representatives *Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*. 2018

[53] Department of Health, *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care*, https://agedcare.health.gov.au/publications-articles/resources-learning-training/decision-making-tool-responding-to-issues-of-restraint-in-aged-care/decision-making-tool-supporting-a-restraint-free-environment-in-residential-aged-care, Accessed 7 June 2018.

The Office of Public Advocate [OPA] Queensland has pointed out that there is no reference to the Decision-Making Tool in aged care legislation or the Quality of Care Principles. The OPA Queensland stated that although the document is available online, 'there is no requirement that residential aged care facilities train their staff in these matters to meet legislative or accreditation requirements'.[54]

Also see the comments made by the QLD OPA on their website:

> The use of restrictive practices to manage challenging behaviours in the aged care and disability sectors is a key human rights issue in Australia. Different types of restrictive practices are used in disability accommodation and support services, residential aged care services, mental health services and prisons.
>
> Common types of restrictive practices include:
>
> - detention (e.g. locking a person in a room indefinitely)
> - seclusion (e.g. locking a person in a room for a limited period of time)
> - physical restraint (e.g. clasping a person's hands or feet to stop them from moving)
> - mechanical restraint (e.g. tying a person to a chair or bed)
> - chemical restraint (e.g. giving a person a sedative)
> - electronic restraint (e.g. using tracking bracelets, camera surveillance, restrictions on media devices).
>
> The inappropriate use of restrictive practices is concerning because it can cause physical and psychological harm to the person being restricted. It can constitute a breach of law and human rights.

Similarly, the Townsville Community Legal Service [TCLS] stated that the absence of regulatory frameworks for the use of restrictive practices is 'concerning', as the Aged Care Act 'does not prohibit, legislate for, or regulate the use of restrictive practices to manage the challenging behaviours of some aged care residents'.[55]

WHAT RECENT SOLUTIONS HAVE BEEN PROPOSED?

SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE REPORT 2016

[54] Office of the Public Advocate (Queensland), *Submission 60*, p. 7
[55] Townsville Community Legal Service, *Submission 55*, pp 8-9

In their report in 2016, the Senate Standing Committee on Community Affairs left no doubt where the members stood on restraint in aged care[56]:

> 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.
>
> 8.71 It is clear there is a prevalence of indefinite detention of Australians with cognitive or psychiatric impairment within the mental health, disability, guardianship and aged-care contexts. This detention takes place in a number of location types and comes in many forms. It can stem from formal orders under mental health, disability or guardianship legislation. It can stem from restrictive practice or seclusion that creates a de facto form of indefinite detention. It can also be informal and unregulated, as a result of practices within the disability or aged-care, and in some cases in private homes.
>
> 8.72 It is also clear to the committee that evidence for this problem has been well-known to states and territories, and the Commonwealth, for some time. Although there have been some moves to address this form of indefinite detention, they have been patchy at best, and significantly underfunded.
>
> 8.73 As with the forensic mental health regimes, changes to these sectors will require effort from the states and territories, as well as coordination and leadership from the Commonwealth.

So the relevantly important findings of this Committee were:

- The detention of people with a cognitive impairment is often informal, unregulated and unlawful;
- Evidence of this problem is well known to authorities.

OAKDEN -CARNELL REPORT 2016

[56] Senate Standing Committee on Community Affairs, Indefinite detention of people with cognitive and psychiatric impairment in Australia, **29 November 2016,** Chapter 8, Disability, guardianship and aged-care detention

The report following an inquiry established by the Commonwealth government which is known as the Carnell & Paterson Report [the Oakden Inquiry], brought much media and public attention upon the very poor and unprofessional practices which had developed over time at a care facility which was operated by an aged care Provider, in South Australia. Among the issues addressed were restrictive practices.

These are their relevant recommendations[57]:

> Recommendation 7. Aged care standards will limit the use of restrictive practices in residential aged care.
>
> Actions
>
> (i) Any restrictive practice should be the least restrictive and used only:
>
> (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm
>
> (b) to the extent necessary and proportionate to the risk of harm
>
> (c) with the approval of a person authorised by statute to make this decision
>
> (d) as prescribed by a person's behaviour support plan
>
> (e) when subject to regular review.
>
> (ii) Approved providers must record and report the use of restrictive practices in residential aged care to the Commission.
>
> (iii) Accreditation assessments will review the use of psychotropic agents.
>
> (iv) Chief Clinical Advisor must approve the use of antipsychotic medications for aged care residents.

From the viewpoint of this submission, it is recommendation (i) (c) which is relevant. If anything, it is not given the prominence it deserves, from the vulnerable individual's perspective. Moreover, the approval should be properly informed, and must not become perfunctory.

One matter of significance however is the departmental practice regarding restraint[58]:

> 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.

…

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

[58] Carnell & Paterson, Op. cit. at p.120

> 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[59]:

- 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 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 risks to staff and management in the use of restrictive practices and the connection with criminal and civil law liabilities.

The Report also addresses the issue of consent in the following way[60]:

> *The lack of informed consent in current practice is potentially a key factor that contributes to the high levels of use of antipsychotics. This could be addressed by further tightening the PBS clinical criteria restrictions to include the need for documented informed consent.* It could also be included in compliance monitoring by the new Aged Care Quality Commissioner.
>
> While ideally, informed consent should be obtained from the resident, it is likely that in many cases where restraints are used, the resident lacks the capacity to consent. Consent should then be obtained from a substitute decision-maker. Enforcing the requirements for obtaining informed consent promotes shared decision-making and greater effort to explain benefits versus harm and possible alternatives.

[59] Ibid pages 120-121
[60] ibid

We support the proposal for improving the PBS clinical criteria as a welcome and practical positive step

ALRC REPORT NO.131 – REFERENCE ON ELDER ABUSE

Within the report which it published upon elder abuse[61] the Australian Law Reform Commission received submissions and made recommendations about restrictive practices of aged care. The Report made the observation that -

> 4.184 The key elements of regulation set out in Recommendation 4–10 are intended to discourage the use of restrictive practices and set a clear and high standard, so that the practices are subject to proper safeguards and only used when strictly necessary.
>
> 4.185 The ALRC also recommends that the Australian Government consider a number of additional oversight measures for the use of restrictive practices, as well as the merits of consistently regulating the use of restrictive practices in aged care and the NDIS.
>
> **Recommendation 4–10**
>
> Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:
>
> (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
>
> (b) to the extent necessary and proportionate to the risk of harm;
>
> (c) with the approval of a person authorised by statute to make this decision;
>
> (d) as prescribed by a person's behaviour support plan; and
>
> (e) when subject to regular review.
>
> **Recommendation 4–11**
>
> The Australian Government should consider further safeguards in relation to the use of restrictive practices in residential aged care, including:
>
> (a) establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices;

[61] Elder Abuse—A National Legal Response (ALRC Report 131), 4. Aged Care Restrictive practices, Regulating restrictive practices in aged care

(b) requiring aged care providers to record and report the use of restrictive practices in residential aged care; and

(c) consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme.

The recommendation that restraint be regulated in a way it has not since the introduction of the Aged Care Act 1997, is to be applauded. However, insofar as the issue of consent is concerned, mere approval is insufficient. The proposed provision must require the prior informed consent in writing, of the person who is entitled to give that consent, in the State or Territory which is relevant. It appears the ALRC recommendations have become redundant now, with the introduction of the new restraint Principles, by the Minister.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH & AGED CARE 2018 – ZIMMERMAN REPORT

The inquiry conducted by the House of Representatives committee on aged care elicited many submission concerning restraint and they make salutary reading[62]. In this submission however we also wish to comment upon the committee's recommendations, observing that the restraint matter should be clearer, for the avoidance of doubt. It would serve nobody's interests if legislation were to be introduced, which actually made the situation worse, having regard to the state of and the principled stand of the common law and the various statutes addressing assault and restraint associated offences.

On the matter of recording and collection of records, the substantive issue is not merely to be able to identify 'hot spots' or geographical patterns and other data outcomes. It is time for these matters to be not only recorded by the Department of Health, but investigated and followed through to serve the interests and the rights of residents.

Set out below is the relevant recommendation:

Recommendation 10

3.180 The Committee recommends that the Australian Government amend the *Aged Care Act 1997* to legislate that:

- the use of restrictive practices in residential aged care facilities be limited to the 'least restrictive' and be a measure of last resort only;

[62] House of Representatives Standing Committee on Health, Aged Care and Sport - report on the Quality of Care in Residential Aged Care Facilities in Australia, Canberra, 2018

- any use of restrictive practices within the legislated meaning be recorded by providers and collected by the Department of Health;

- restrictive practices are only to be used after a medical practitioner has prescribed/recommended such use; and

- the legal guardian and/or family member must be advised immediately.

Like the ALRC recommendation in relation to restraint, there appears no need to address any comments to this recommendation since the introduction of the new restraint Principles.

A NEW REGULATION FOR RESTRAINT - QUALITY OF CARE AMENDMENT (MINIMISING THE USE OF RESTRAINTS) PRINCIPLES 2019

The Minister for Aged Care has made amendments to the Quality of Care Principles which are to commence on 1 July 2019[63].

We submit for the consideration of the Committee, amendments to the instrument which make clearer the intention for effective regulation of the restrictive practices to which it is directed.

Our submissions for drafting changes

In our assessment of the definitions and the sections which follow, we have used CAPS to identify some changes and additions which we submit are required to make the meaning of the provisions clearer and focussed upon the right of the resident to his or her self determination. The all important definitions of the relevant terms include the following:

> ***approved health practitioner*** means a medical practitioner, nurse practitioner or registered nurse.
>
> ***chemical restraint*** means a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
>
> ***physical restraint*** means any restraint other than:
>
> (a) a chemical restraint; or
>
> (b) the use of medication AS prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

[63] Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019

restraint means any practice, device BARRIER or action OR OMISSION that interferes with a consumer's ability to make a decision or restricts a consumer's free movement.

The existing common law and Statute law of the States and Territories is not affected by the new Principles[64], a matter omitted from some of the Inquiries referred to above.

In the sections 15F [physical restraint] and 15G [chemical restraint] of the amendments we have indicated our suggestions for clarifying and improving the effectiveness of the new amendments. We have omitted those parts for which we have not proposed changes:

(1) An approved provider must not use a physical restraint in relation to a consumer unless, in relation to that use of the restraint:

(a) an approved health practitioner who has day-to-day knowledge AND RESPONSIBILITY FOR the HEALTH STATUS OF THE consumer has:

(i) assessed the ACTUAL OR APPREHENDED CONDUCT OF THE consumer as posing a risk of harm to the consumer or any other person, and as requiring the restraint AS THE APPROPRIATE MEANS FOR SIGNIFICANTLY MITIGATING THE RISK ; and

(ii) documented the assessment, unless the use of the restraint is necessary in an emergency; and

…

(e) the approved provider has the informed consent of the consumer or the consumer's representative IN WRITING IN ADVANCE to the use of the restraint, unless the use of the restraint is necessary in an emergency.

(2) If an approved provider uses a physical restraint in relation to a consumer, the approved provider must:

…

(b) if the restraint is used without the consent mentioned in paragraph (1)(e)—inform the consumer's representative as soon as practicable after the restraint starts to be used FOR THE PURPOSE OF SEEKING THEIR INFORMED CONSENT; and

…

(i) the consumer's behaviours that are relevant to the COMMENCEMENT AND CONTINUATION OF THE need for the restraint;

(ii) MAKE A RECORD OF THE MATTERS IN THIS SUB-PARAGRAPH IN WRITING AND CO-SIGNED BY THE CONSUMER OR REPRESENTATIVE AND IF NOT CO-SIGNED THE RECORD MUST HAVE ATTACHED TO IT THAT PERSON'S INFORMED CONSENT

…

(e) while the consumer is subject to the restraint:

(i) regularly AND IN A TIMELY MANNER monitor the consumer for signs of distress or harm; and

[64] S 15E

(ii) regularly AND IN A TIMELY MANNER monitor and review the necessity for the restraint.

15G Use of chemical restraint

(1) An approved provider must not use a chemical restraint in relation to a consumer unless:

…

(c) the consumer's representative is informed before the restraint is used if it is practicable to do so FOR THE PURPOSE OF SEEKING INFORMED CONSENT AND IF IT IS NOT PRACTICABLE TO DO SO THEN THE CHEMICAL RESTRAINT MUST BE USED ONLY IN AN EMERGENCY TO PREVENT IMMINENT HARM TO THE PERSON OR TO OTHERS .

(2) If an approved provider uses a chemical restraint in relation to a consumer, the approved provider must:

…

(b) ensure the care and services plan documented for the consumer in accordance with the Aged Care Quality Standards set out in Schedule 2 identifies the following:

(i) the consumer's behaviours that are relevant to the COMMENCEMENT AND CONTINUATION OF THE need for the restraint;

…

(iv) the information (if any) provided to the practitioner that informed the decision to prescribe the medication AND THE PERSON OR PERSONS WHO PROVIDED THE INFORMATION ;

(V) THE REASONS, ADVICE OR DIRECTIONS OF THE PRESCRIBING HEALTH PRACTITIONER FOR THE APPLICATION OF THE RESTRAINT

and

(c) while the consumer is subject to the restraint—regularly monitor the consumer IN A TIMELY MANNER for signs of distress or harm and provide information to the practitioner regarding use of the restraint.

As to the issue of what is meant by a timely manner, reference may be made to s.62 of the Australian Consumer Law which requires services for a consumer to be supplied within a reasonable time. Thus to review or monitor a restraint in a timely manner can mean nothing less than a 'reasonable time'.

The amendments apply to residential aged care and respite care[65].

Further Submissions

We propose to the Committee the following further changes :

[65] S 15D

1. The definition of "representative" of the resident should be included and carefully drafted to ensure that only those persons lawfully authorised in the relevant State or Territory may give consent at the relevant time on behalf of a cognitively impaired resident.

2. We suggest that the reference to the heading of Part 4A to 'Minimising the use of …Restraint" could easily be enhanced and the amendments made more useful and purposeful, if the heading included the words " AND PROHIBITING UNLAWFUL PHYSICAL ENVIRONMENTAL AND CHEMICAL RESTRAINT" were added, and

3. the Aged Care Act should be amended to provide that a breach of the Principles in Part 4A are explicitly made an offence against the Act for the Provider and for the persons who take part in the breach .

4. The definition of physical restraint should be expressed to include environmental restraint.

5. The term "environmental restraint" should be defined[66] as –

   a restrictive practice that restricts a person's free access to all parts of their environment, including items and activities including a place where the person is confined by but is not limited to, barriers and exits passable only by unlocking or other controlled means.

EMPOWERING CONSUMERS WITH REMEDIES

In this part of our submission we outline the various possible alternatives for recourse, redress and restorative justice which may be available in a particular case, for individuals as aged care residents, or their delegated representatives.

In recent times the term 'consumer' has displaced other terms which have been used by the Department responsible and in legislation. Those other terms include 'User', 'resident' and 'care recipient'. We have sought throughout this submission to use the term

[66] See the definition in Restrictive Practices Guidance Environmental Restraint, NSW Family & Community Services, at https://www.facs.nsw.gov.au/__data/assets/pdf_file/0010/636949/Restrictive-Practices-Resources-environmental-restraint-guidance.pdf accessed 29 August 2019 which has been extended by the author for this submission

'resident' as we believe it has more dignity and is more respectful, than the other descriptions.

AGED CARE QUALITY & SAFETY COMMISSION – COMPLAINTS

Here is how the Complaints process is described by the Department, a process which fails residents because nothing in it requires a final binding decision.[67]:

> To resolve your concern or complaint, we may:
>
> - resolve it quickly without a formal process that might take longer (*early resolution*)
> - refer your complaint back to the service to address within a set time frame (*service provider resolution)*
> - help you and the service provider discuss the issues and reach an agreement that resolves your complaint (*conciliation)*. This might involve a few phone calls, informal discussions or formal meetings. We will document the process and provide written feedback to you, the person receiving aged care (if you are raising the concern on behalf of someone else) and the service provider
> - investigate your complaint (*investigation)*. This might involve gathering information, discussing the issues with both parties, visits to the service or home, analysing records and conducting interviews. Feedback is provided to everyone except anonymous complainants; we will provide written advice about the outcome of the investigation.
>
> In cases where we are unable to achieve a resolution to your complaint, **we may ask you and the service provider to enter into a formal mediation process [emphasis added - ed.].** The mediation process is external to the Commission.

Evident from this description of the complaints process by the Aged Care Quality and Safety Commission is the absence of compulsion for a Provider to make any genuine attempts at settlement of a dispute. More importantly still and already noted, is the absence of any process which leads to a decision which is binding upon the parties. That is because the process ends at mediation. For residents without the financial resources to look at alternatives, incidents of harm and injury will go unaddressed by notions of restorative justice and in particular, no pathway to restoration of health, the cost of which may rightly be the responsibility of the provider.

How then might a system for a binding decision be achieved with minimum expense and minimal strict legal format which might otherwise be the cause for hesitation in bringing claims?

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67 The complaints process: What can the Aged Care Quality and Safety Commission do for you? https://www.agedcarequality.gov.au/making-complaint/complaints-process, accessed 23 April 2019

The aged care Provider is obliged to adopt a complaints resolution mechanism[68]. Furthermore the Provider must:

- use the complaints resolution mechanism to address any complaints made by or on behalf of a person to whom care is provided through the service; and
- advise the person of any other mechanisms that are available to address complaints, and provide such assistance as the person requires to use those mechanisms; and
- comply with any requirement made of the approved provider under rules made for the purposes of subsection 21(2) of the *Quality and Safety Commission Act[69].
- The complaints resolution mechanism must be provided for in the resident agreement

It is the Secretary who imposes sanctions for non- compliance with parts 4.1, 4.2 and 4.3 of the Aged Care Act. Those parts include quality of care and the User Rights Principles. Sanctions include financial penalties such as prohibiting new admissions, taking of further Refundable Accommodation Deposits, or withdrawing accreditation entirely from the Provider.

The problem is that no sanction actually makes any provision for redress, compensation, rehabilitation or any recourse for the "consumer".

It is of no comfort to the resident or their family, if their comfort, dignity or health have been adversely affected by unlawful restraint, to witness a sanction imposed upon the Provider, even assuming that the sanction arises from harm to just one individual.

Indeed, the occurrence of such an event as serious sanctions imposed for harming just one individual is unknown to us. The complaints system is unable to satisfactorily provide real redress to an individual complainant who may have suffered harm arising from unlawful restraint. This systemic failure is not of course confined only to instances of harm through restraint.

68 See Aged Care Act 1997 - Ss 56.4 and 59.1

[69] the rules may establish a scheme for dealing with complaints made, or information given, to the Commissioner about an approved provider's responsibilities under the Aged Care Act and the responsibilities of a service provider of a Commonwealth-funded aged care service under the funding agreement that relates to the service.

We are unaware of any residential care contract which includes more than their own system for complaint and review, and escalating the complaint process to include the Complaints Commissioner. There may also be reference to the various State advocacy services which provide advice and referral, but because of budget constraint, have aonly limited resources to take matters to a further stage.

In short there is presently no prospect of a final determination by the decision of an independent decision maker [such as an arbitrator] available either under contract or under the regime of the legislation.

HABEAS CORPUS

There have been a small number of cases in Australia dealing with restraint in aged care, involving applications for a writ of Habeas Corpus, and a Tribunal case in Victoria. In two of those cases, the Office of Public Guardian Queendland, has provided a short summary of the facts and decisions[70]:

> ***Skyllas v Retirement Care Australia (Preston) Pty Ltd*** After the son of a Victorian residential aged care resident submitted an affidavit evidencing his belief of his mother's unlawful detainment, the court invoked the writ of habeas corpus (the power of a court to review the lawfulness of an arrest or detainment[18]) and found it unlawful for a residential aged care facility to detain a resident against their will, regardless of their physical health. No further action was taken as the Public Advocate was appointed as the resident's legal guardian for accommodation matters. [71]
>
> ***Saitta Pty Ltd v Secretary, Department of Health and Ageing*** The Administrative Appeals Tribunal upheld the Department of Health and Ageing's imposition of severe sanctions that led to the closure of the Belvedere Park Nursing Home in Melbourne, following an assessment that residents' safety was at severe and immediate risk. The tribunal described an incident where an unattended resident had been restrained to a chair with a lap-belt an hour after it should have been removed. This was considered a breach of the principle for the right to dignity, for residents to be assisted to achieve maximum independence, and for management to actively work in providing a safe and comfortable environment consistent with the residents' needs. However, there was no further discussion of restrictive practices as the matter focussed on many other serious incidents that led to the finding of severe immediate risk, including poor infection control; poor sanitation; inadequate incontinence management etc.

[70] Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia, Senate Standing Committee on Health, Aged Care and Sport February 2018, Office of Public Guardian, Queensland, Submission 60

[71] [2006] VSC 409 (10 November 2006) (Byrne J)

In a recent case South Australian case[72] a claim for Habeas Corpus orders was made in circumstances where the plaintiff was an aged care resident in the dementia unit of the aged care home, having been placed there by a decision of his guardian, the Public Advocate of South Australia. The issue before the Court was whether the power exercised by the guardian had been lawful.

The Supreme Court found that the plaintiff had been detained by the acts both of the Public Advocate and the staff of the residential aged care facility. However the power to detain had not been properly exercised. In those circumstances the writ of habeas corpus was issued upon the finding of unlawful detention.

This discussion [following] of psychological control, which is connected to environmental restraint and the right to habeas corpus is of particular reference to Victoria, because it includes a reference to the Victorian Charter of Human Rights. However it is still very relevant to adding further understanding to the legal duties of persons who have the day to day control over residents in an aged care setting[73].

> While "psychological control" is seemingly less discussed in the Victorian context, the case of *Antunovic v Dawson* (2010) 30 VR 355 shows that it is relevant to people living with mental illness or certain intellectual impairments, where they may have no physical restraints on their movements but genuinely believe that they cannot leave a facility. In such cases, their treating doctors or carers have significant power over their freedom of movement. *Antunovic* was an action in habeas corpus by a woman with a mental illness whose community treatment order under the MHA 1986 did not require any residential arrangements (at [162], [164]). While she wished to live with her mother and was free to leave during the day of her own accord, the psychiatrist told her that she must reside at a treatment unit, a requirement with which the plaintiff complied. While the case was a successful action for habeas corpus relief on the basis that she was being restrained without lawful authority, it demonstrates the "Bournewood gap" in the context of mental or psychological control which leads to detention of those with impaired capacity.
>
> The core principle in *Antunovic*, as with *HL*, is that "personal liberty can only be restrained where this is authorised by law".[55] This applies equally to "paternalistic" or apparently benign restrictions.[56] Thus, unauthorised physical restraints on people with disabilities amount to criminal assault in certain circumstances.[57] Conduct restricting freedom (which *Antunovic* shows need not be "total restraint")[58] that lacks a legal basis would also give rise to a common law action in habeas corpus or for false imprisonment.[59] A person could also invoke a right under the *Victorian Charter of Human Rights and Responsibilities Act 2006* (Vic) although, unless a common law action were also available, any breach would not be actionable.[60] Section 12 of the Charter guarantees "freedom of movement". Section 21 protects the "right to liberty and security of person", including the right in s 21(2) against "arbitrary arrest or detention"

[72] BC v The Public Advocate & ors, [2018] SASC 193

[73] Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria Michael Williams, John Chesterman and Richard Laufer* (2014) 21 JLM 641

and in s 21(3) to only be detained pursuant to lawful procedures. A further relevant Charter right is "protection from torture and cruel, inhuman or degrading treatment".[61] Commenting in *Antunovic* (at [73]) on the distinction between ss 12 and 21 of the Charter, Bell J wrote that:

> The purpose of the right to liberty and security is to protect people from unlawful and arbitrary interference with their physical liberty, that is, deprivation of liberty in the classic sense. It is directed at all deprivations of liberty, but not mere restrictions on freedom of movement. It encompasses deprivations in criminal cases but also in cases of vagrancy, drug addiction, entry control, mental illness etc. The difference between a deprivation of liberty and a restriction on freedom movement is one of degree or intensity, not one of nature and substance.
>
> The fundamental value which the right to liberty and security expresses is freedom, which is a prerequisite for individual and social actuation and for equal and effective participation in democracy.[62]

PROFESSIONAL CONDUCT TRIBUNALS

There are many boards and Tribunals around the country which are established to hear and determine, and if necessary to discipline professionals when there has been professional misconduct. The outcome for the profession al may be fines, and in serious cases loss of the right to practice in the particular profession. To complain to the relevant professional tribunal for a health worker about whom a complaint may be made, is open to residents and their delegates. As an example in the particular issues which are discussed in this paper, the following case is apposite:

> *Nursing & Midwifery Board of Australia v Kiroff & Nyhan* [2016] SAHPT (South Australian Health and Practitioners Tribunal)

- Tribunal decision regarding the conduct of two nurses who had physically restrained the complainant to a chair by pelvic posey for about two hours, a second pelvic posey was used to restrain him for approximately nine hours
- The complainant at the time was a 75 year old male suffering from dementia
- Accepted by counsel for the complainant that there would be no orders as to costs
- Example of a professional tribunal being used to challenge restrictive practices as opposed to civil or criminal law

TORTIOUS CLAIMS

It has been truly said that "common law claims usually require professional legal advice, time, and considerable financial resources, as well as the mental capacity and knowledge to identify and progress a tort claim"[74]. Moreover, it is self-evident that a person who is aged, infirm and living in an aged care home will be disinterested in bringing a claim at

[74] Michael Barnett and Robert Hayes, 'Not seen and not heard: protecting elder human rights in aged care' (2010) 14(2010) *University of Western Sydney Law Review* 45, 72.

common law for negligence, battery, false imprisonment or assault. The will power, determination and energy required is exhausting, emotionally and financially.

However such a claim may be possible vicariously [instituted by a tutor, or other agent on their behalf], especially if the harm or injury has been serious, and the determination of the person's family and supporters is steadfast.

In such cases, there is little or no room for the kind of heads of damages which usually attend a claim for tortious jury. There is no loss of income, and no loss of future income, two of the main claims which produce significant damages, but which are related to past and future estimated earnings. There are two other main barriers to tortious claims.

Firstly, there is the threshold for personal injuries claims which is an amount of 15% of the maximum allowed for pain and suffering. In order to achieve a successful claim the risk of falling below the threshold is a hurdle which requires caution. There is no award of damages reported of which we are aware, and which shows the way for a common law injury claim in an aged care facility. The closest example may be that of Keys, brought in the Federal Court[75]. In the case of injury of an aged person, without pain and suffering damages, what is left is remedial damages for health care and similar consequential damages. We have set out below an argument that the Threshold for injury may not apply, at least in one instance of restraint. However, as suggested in the following paragraph, risk of loss and therefore costs awards, always attends common law claims.

Secondly, the risk of losing the case and the consequent liability for costs is another and it is submitted, the main barrier to bring claims for damages at common law. Again, this is especially so for someone of advanced age, probably little means and no income except the old age pension.[76]

ARBITRATION AND ALTERNATE DISPUTE RESOLUTION

For a dispute to be submitted to arbitration, the parties must first agree that will be so. Commonly an arbitration clause will be accompanied by an alternate resolution procedure which may require conciliation and mediation as necessary pre-cursors to the arbitration.

There are advantages for the aged care resident who may be frustrated by the complaints system, a failure to get results from mediation, and the intransigence of their provider

[75] John James Memorial Hospital v Keys [1999] FCA 678
[76] For further discussion on negligence claims and aged care, see Lewis, R., Elder Law in Australia, 2nd edn, Lexis Nexis, Sydney, 2011, at pp 200-215.

who may not be willing to admit to any liability for injury resulting from Unlawful restraint. In such a case, and always at the option of the resident, arbitration occurring under an arbitration agreement, as part of the residential care contract, will be perhaps the only way to obtain a binding decision on the dispute.

It appears also, that in the circumstances of, for example, chemical restraint, the threshold for personal injury damages, arguably may not apply, at least, in New South Wales[77]. That is so, because:

1. The administering of chemical restraint is usually intentional;

> ***3B CIVIL LIABILITY EXCLUDED FROM ACT***
>
> (1) The provisions of this Act do not apply to or in respect of civil liability (and awards of damages in those proceedings) as follows:
>
> (a) civil liability of a person in respect of an intentional act that is done by the person with intent to cause injury

2. The outcome is usually impairment of a person's mental or physical condition – and is should be noted that impairment is the intended and inevitable outcome of chemical restraint;

> **"injury"** means personal injury and includes the following:
>
> (a) impairment of a person's physical or mental condition,

In any event, arbitration may allow costs to be removed from the risks, if the Provider has been persuaded to agree that there will be no costs awarded regardless of the outcome. That is a matter of negotiations, but support from the Royal Commission for that proposition would be important.

THE CRIMINAL LAW

Each State and Territory has a statutory criminal law. In New South Wales it is the Crimes Act 1900.

> *59 ASSAULT OCCASIONING ACTUAL BODILY HARM*
>
> (1) Whosoever assaults any person, and thereby occasions actual bodily harm, shall be liable to imprisonment for five years.

And

[77] We have not attempted to compare the various Civil Liability Acts in Australia at the time of writing.

> *Section 61 of the Crimes Act 1900* provides:
>
> Whosoever assaults any person, although not occasioning actual bodily harm, shall be liable to imprisonment for two years

It is well understood that the 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[78]:

> Battery is the actual infliction of unlawful force on another. But the word "assault" has come to describe both offences: see *DPP v JWH* (unrep NSWSC, 17 Oct 1997).

It appears entirely possible that the imposition of restraint wlll render those who have imposed it criminally liable for the common law offence of assault at least, for which a term of imprisonment is applied. 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.

There are other similar apposite provisions including:

> NSW – *Criminal Procedure Act 1986* NSW Schedule 1 Table 1 s 16A (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)
>
> > *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.

[78] Judicial Commission of New South Wales, Criminal Trial Court Benchbook Offences, [5000] common assault prosecuted by indictment.

AUSTRALIAN CONSUMER LAW

There are at least five and possibly six sections we have identified in the Australian Consumer Law [ACL] as applying to breaches of quality of service on the part of the aged care Provider. Each give an opportunity for a 'consumer' to take action and seek remedies against the service provider who is in breach.

The five are as follows:

> **Unconscionable conduct**
>
> S 21(1)(a) – person must not, in trade or commerce, in connection with the supply or possible supply of goods or services to a person engage in conduct that is, in all circumstances, unconscionable

This section deals with what has been for many generations a remedy only found in the Equity divisions of the various State and Territory Supreme Courts. The term 'unconscionable' is not limited to its traditional legal meaning. Accordingly, if one contemplates a a consumer complaint which is to the effect that the service provider has imposed unlawful restraint upon the consumer, or customer, it is hardly a stretch to imagine the response of a Consumer Tribunal.

Along the same general lines and to similar effect is the following provision:

> sect 50 Harassment and coercion [part 3-1]
>
> (1) A person must not use physical force, or undue harassment or coercion, in connection with:
>
> (a) the supply or possible supply of goods or services;

Then there are the three implied guarantees which are included in every contract for services [**emphasis added in bold type]**:

> **60 Guarantee as to due care and skill**
>
> If a person supplies, in trade or commerce, services to a consumer, there is a guarantee that the services will be rendered **with due care and skill**.
>
> ……..

61 Guarantees as to fitness for a particular purpose etc.

(1) If:

(a) a person (the ***supplier***) supplies, in trade or commerce, services to a consumer; and

(b) the consumer, expressly or by implication, makes known to the supplier any particular purpose for which the services are being acquired by the consumer;

there is a guarantee that the services, and any product resulting from the services, **will be reasonably fit for that purpose.**

(2) If:

(a) a person (the ***supplier***) supplies, in trade or commerce, services to a consumer; and

(b) **the consumer makes known**, expressly or by implication, to:

(i) the supplier; or

(ii) a person by whom any prior negotiations or arrangements in relation to the acquisition of the services were conducted or made;

the result that the consumer wishes the services to achieve;

there is a guarantee that the services, and any product resulting from the services, **will be of such a nature, and quality, state or condition, that they might reasonably be expected to achieve that result.**

(3) This section does not apply if the circumstances show that the consumer did not rely on, or that it was unreasonable for the consumer to rely on, the skill or judgment of the supplier.

(4) This section does not apply to a supply of services of a professional nature by a qualified architect or engineer.

……..

62 Guarantee as to reasonable time for supply

If:

(a) a person (the ***supplier***) supplies, in trade or commerce, services to a consumer; and

(b) the **time within which the services are to be supplied:**

(i) is not fixed by the contract for the supply of the services; or

(ii) is not to be determined in a manner agreed to by the consumer and supplier;

there is a guarantee that the services will be supplied within a reasonable time.

The former sections speak for themselves, but the latter [s.62] applies, as regards restraint, to the regular reviews which are to be undertaken by the Provider to ensure that the lawful restraint does not become unlawful, by being unnecessarily extended beyond the time it is consented to.

The sixth of the sections of the ACL is one which is quite familiar to most lawyers:

> **34 Misleading conduct as to the nature etc. of services**
>
> A person must not, in trade or commerce, engage in conduct that is liable to mislead the public as to the nature, the characteristics, the suitability for their purpose or the quantity of any services.

There is an opportunity in these provisions, we would argue, that permit the aged care consumer making a claim under the very Act which is eponymous with the designation by statute of the status of the claimant. That is the Australian Consumer Law.

The advantages for the resident and their family include the following:

- Access to the law will be easier and less expensive if the claims are brought in the Civil and Administrative Tribunals of the States and Territories;

- The Tribunals are distributed widely among the rural and regional areas of Australia;

- The risk of costs being awarded against the consumer in the event of failing to prove their case is minimal;

- The Tribunals proceedings involve a minimum of formality;

If claims are brought and succeed, one of the likely outcomes is for a refund of some or all of the fees for service paid already to the Provider as is provided for by the ACL.

However, very many of the residents in aged care are funded wholly or partly by the Commonwealth through the Department of Health. What then if the orders are for refund of fees already paid? We suggest that in the event of concession residents whose fees are paid for them, the whole or a part of those fees should be directed to the resident claimant, rather than refund to the Department of Health.

It is only fair that the person who has been harmed by sub standard care, should receive the benefit of the order for refund. That is also reasonable if it is considered that the funds have already been allocated and paid in the name of the resident by the third party Commonwealth. The expense has been incurred and allocated in the Budget.

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Proposing then teaching the first course in Elder Law at Western Sydney University in 1999;

Authoring the first text in Elder Law called Elder Law in Australia, Lexis Nexis, Sydney 2011 and currently in its second edition;

Presenting at numerous seminars and conferences to lawyers and others in Sydney and throughout Australia in many aspects of Elder Law.