Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

Royal Commission into Aged Care Quality and Safety

Public submissions

6 September 2019

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Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal of the Eora Nation.

[1] *Australians Lawyers Alliance* (Website). Accessed on 19 July 2019 <www.lawyersalliance.com.au>.

Introduction

1. The ALA welcomes the opportunity to provide a submission to the Royal Commission into Aged Care Quality and Safety (the Royal Commission).

2. This submission will focus on the following Terms of Reference (ToR):

    b. how best to deliver aged care services to:

        i. people with disabilities residing in aged care facilities, including younger people (ToR bi)

    d. what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe (ToR d)

ToR b: Delivery of aged care services to people with disabilities and people living with dementia

3. The ALA notes that a person must be aged under 65 years to apply for services under the National Disability Insurance Scheme (NDIS). Once a NDIS participant turns 65, the person is entitled to continue receiving services under the NDIS. However, the person will no longer be eligible to receive those services if they apply for and receive Commonwealth-supported home care or residential care services on a permanent basis.

4. The ALA submits that it is very difficult for a person in the position outlined above to obtain adequate information about the services they may be entitled to under the alternate schemes.

5. Under the *National Disability Insurance Scheme Act 2013* (the NDIS Act), there is a formalised system for NDIS participants to have an independent advocate to assist them to exercise choice and control, and to act as their spokesperson in matters affecting the person as they navigate the NDIS scheme. The NDIS Act acknowledges the important role of advocates (including independent advocates) and other representatives of persons with disability. It requires registered NDIS providers to have complaints management and resolution systems

in place that provide for co-operation with, and facilitation of arrangements with these advocates (including independent advocates) and other representatives.

6. Under current arrangements, the independent advocate is not funded once a person ceases to be a NDIS participant by transitioning to the aged-care system. The ALA submits that the advocate should be able to continue in their role in a seamless manner once the person starts receiving aged care services. After all, the need for an independent advocate will not have changed.

7. The ALA submits that some aged care providers appoint their own advocates for participants in the aged care system. The ALA submits that it is inappropriate for a person to have an advocate who is not independent, and who might prefer the interests of their employer, the aged care provider, over the interests of the person.

8. The ALA submits that the existing My Aged Care website and pathway are inappropriate for a person who has been a NDIS participant due to the complexity of the aged care system and the often lengthy delays in accessing services under it.

9. The ALA submits that it is inappropriate for most younger people under 65 who are participants in the NDIS to be accommodated in aged care facilities. The families of some of these people have given evidence at the Royal Commission about the factors leading to the deterioration of younger people living in aged care facilities. The ALA submits that the voices of those families should be heard. In the past, they have not been heard and nothing has been done.

10. The ALA submits that people living with dementia require dementia-specific as well as age-specific accommodation. A young person with dementia will require an inter-agency approach from the government in order for the care and support to be appropriate for that person, taking into account the considerations discussed in paragraph 9 above. Where there are private agencies and companies funded by the government, they should co-ordinate in the same way as allied healthcare teams currently do in hospitals. The ALA submits that the advice and assistance of allied healthcare teams should be sought by the government in the next year in relation to reform of the aged care system for people with disabilities.

Recommendation 1

That participants of the NDIS should continue to have a funded independent advocate when they transition to aged care.

Recommendation 2

That alternative accommodation should be provided to younger NDIS participants in the form of housing that is specific to their needs.

Recommendation 3

That the Australian Government should consult with allied healthcare teams at hospitals to create a pathway of a high standard for people with disabilities, including those who are young, those who are reaching 65, those over 65 and those with dementia. The age of persons with dementia should be taken into account as part of the NDIS plan so that care and support is age-specific.

ToR d: Strengthening the system of aged care services to ensure that the services provided are of high quality and safe

Regulation of staff and review of *Aged Care Act 1997*

11. The ALA submits that an underlying cause of the systemic problems in aged care is that the drafting and operation of the *Aged Care Act 1997* (Cth) (the Act) is weighted in favour of providers and large 'for-profit' healthcare groups. While the Act meant that the aged care sector became more heavily regulated, it also promoted privatised services and competition that led to the privatisation of the aged care sector. The ALA is concerned that these privatisation policies have resulted in an imbalance of power between provider and care recipient.

History of Aged Care Act 1997

12. The Act was introduced by the Howard government in 1997 and is the overarching legislation that outlines the obligations and responsibilities of aged care providers in order to receive funding from the Australian Government.[2] In effect, it is legislation written for aged care providers by aged care providers.[3]

13. The ALA submits that the Australian Government's reforms of 1997 have negatively contributed to the current situation in aged care. In 1997, control of oversight and regulation was taken away from the states and replaced by a federal accreditation and complaints system, which also became responsible for data collection and reporting about care.[4]

14. The ALA submits that the Act, which at the time represented the most significant reform of aged care services in over a decade, changed the context of care from smaller community-based and charity-run nursing homes and hostels to larger, often corporatised, residential aged care providers, which promote the interests of the aged care industry. An aged care 'consumer' now engages with multinational healthcare groups. The ALA notes that reliance on humanitarian motivation has been replaced by reliance on competition. According to Braithwaite, a reliance on a 'consumer choice' model to improve the quality of care in residential aged care facilities (RACFs) is naïve since the notion of depending on the rationality of the market does not work well to improve the quality of care.[5] The ALA submits that

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[2] Parliament of Australia, *Aged Care Bill Second Reading* (26 March 1997). Accessed on 19 July 2019 <https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22chamber/hansardr/1997-03-26/0105%22>.

[3] Aged Care Crisis, *Review: National Aged Care Quality Regulatory Processes and Framework* (Report, 7 June 2017) 11. Accessed on 19 July 2019 <https://www.pc.gov.au/__data/assets/pdf_file/0020/219620/subdr525-human-services-reform-attachment2.pdf>.

[4] Countries such as Australia, the UK and the United States with centrally controlled models of regulation have repeatedly and consistently failed some of their most vulnerable citizens, despite having different systems of regulation for aged care: Aged Care Crisis, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised* (Submission to Senate Inquiry, August 2017) 42. Accessed on 19 July 2019 <https://www.agedcarecrisis.com/images/pdf/sub41_ACC.pdf>.

[5] *Ibid*, 36.

residents are generally (but not always) too frail and vulnerable to 'vote with their feet', and in circumstances where available choices may be limited.[6]

15. The ALA submits that government policy to support the aged care sector requires an effective regulatory system, which encourages the participation of public and not-for-profit community-based providers. The ALA submits that substantive and structural reform is required to improve the culture, and the processes for the delivery of, aged care services in Australia, This is only possible if the existing overarching aged care legislation is redrafted.

Recommendation 4

That the Australian Government review and redraft the *Aged Care Act 1997* to incorporate clear safeguards that promote and protect the interests of aged care residents.

Residential aged care facilities

16. The ALA submits that the characteristics and services provided by, RACFs vary widely and that there may also be corresponding variance in the capacity of individual RACFs to follow best practice in the provision of specialised care, particularly in relation to end-of-life and dementia care.[7] A RACF provides residential care to a resident or 'care recipient' on a permanent or respite basis. Different facilities may specialise in the provision of a range of services — and have a variable composition of residents with various clinical and social needs. The ALA notes that the Act defines the meaning of residential aged care, but does not define the place in which this care is offered, other than as a 'residential facility'.[8]

[6] John Braithwaite, Toni Makki and Valerie Braithwaite, *Regulating Aged Care : Ritualism and the New Pyramid* (Edward Elgar Publishing Limited, 2007) 263. Accessed on 19 July 2019 <http://johnbraithwaite.com/wp-content/uploads/2016/06/Regulating-Aged-Care-Ritualis.pdf>.

[7] Coulton, Charles and Catherine Boekel, 'Research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice', *Department of Health* (31 March 2017). Accessed on 19 July 2019 <https://www.health.gov.au/internet/main/publishing.nsf/Content/EF57056BDB047E2FCA257BF000206168/$File/Palliative-care-and-end-of-life-care-within-gp-research.pdf>.

[8] *Aged Care Act 1997* (Cth) s41.3 (1).

17. A RACF may provide accommodation and geriatric health-care services and other types of support to frail and aged residents, including assistance with day-to-day living, as well as to a range of people with a very wide spectrum of care needs, including:

- homes for ambulant aged people with mild to moderate dementia, chronic anxiety or a stable physical disability who are unable to live independently
- medical and nursing facilities for people with multiple comorbidities
- specialist dementia care units managing the full range of challenging behaviours
- long-term accommodation for younger people with brain damage from trauma or younger onset neurodegenerative disease
- hospices for end-of-life care
- long-stay care for older people with chronic mental illness, and
- rehabilitation/recuperation units for people who have been discharged from hospital but who have not yet recovered sufficiently to go home.

18. The ALA submits that there is a need for a greater range of options in residential aged care. Aged care services are delivered by providers that are either large for-profit companies or not-for-profit, faith-based or government-operated organisations. In particular there is a need for government to encourage community-based, small group options such as the Abbeyfield model of supported housing.[9]

19. RACFs may have differing care objectives; for example, dementia care. The ALA recognises that a significant number of residents of RACFs have dementia.[10] The ALA is concerned that some residents are cared for in environments totally unsuited to this health issue, and by staff with limited specialised training.[11]

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[9] Abbeyfield website, Providing housing, residential care and supporting the needs of older people. Accessed on 19 July 2019 <https://www.abbeyfield.com/; Abbeyfield Australia website, *The Abbeyfield model.* Accessed on 19 July 2019 <http://www.abbeyfield.org.au/>.

[10] Aged Care Guide, *Information: Dementia.* Accessed on 19 July 2019 <https://www.agedcareguide.com.au/information/dementia>.

[11] Coulton and Boekel, above n 7.

20. The ALA submits that variability in service delivery by RACFs also leads to variability in knowledge of best practice in dementia and end-of-life care and that to improve the quality of care, RACFs must engage with the latest evidence-based clinical practice and models of care and have access to a specialised and skilled workforce.[12]

Recommendation 5

That the Australian Government encourage community-based small group options such as the Abbeyfield model of supported housing.

Recommendation 6

That the Australian Government support RACFs to engage with evidence-based clinical practice and models of care and utilise a specialised and skilled workforce.

RACFs require a skilled workforce: complex chronic health conditions, dementia and palliative care

21. The ALA submits that the aged care workforce provides care for people with long-term, sub-acute, and complex chronic health conditions. The ALA submits that RACFs require skilled palliative care nurses. The average life expectancy of an aged care resident is two and a half years; 30% of residents die each year; and 80% of exits from permanent residential care is due to death.[13] The ALA is concerned that some residents suffer from complicated medical problems, but are being cared for in RACFs that lack skilled nurses, including registered nurse (RN) expertise. The ALA notes that most people in residential care will be there until the end of their lives and many RACFs lack both a suitable environment and trained staff to facilitate a good death.[14] The ALA submits that it is vital that RACFs engage with evidence-based, end-

[12] End of Life Directions for Aged Care (ELDAC), *Residential Aged Care Toolkit*. Accessed on 19 July 2019 <https://www.eldac.com.au/tabid/4901/Default.aspx>.

[13] Australian Government, Australian Institute of Health and Welfare, *Aged Care Data: Factsheet 2015-16: People leaving aged care*. Accessed on 19 July 2019 <https://www.gen-agedcaredata.gov.au/Resources/Factsheets-and-infographics/Exits_factsheet.pdf?ext=; Australian Government, Australian Institute of Health and Welfare, *People leaving aged care*. Accessed on 19 July 2019 <https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care>.

[14] Palliative Care Australia, *Palliative Care in Aged Care*, Accessed on 19 July 2019 <https://palliativecare.org.au/palliative-care-in-aged-care>.

of-life organisational and clinical support and resources.[15] The ALA is concerned that the Act is silent on this issue.

22. More than half of residents in RACFs have dementia.[16] The ALA submits that each RACF with 60 residents or more should have a trained dementia nurse, skilled to assess and manage challenging behaviours associated with dementia.[17]

23. The ALA submits that as RACFs find it difficult to attract GPs, each RACF with 100 residents or more must have a nurse practitioner to manage standard medical issues such as urinary tract infections, respiratory infections, cellulitis, leg ulcers, diabetes, hypertension, etc.[18] The ALA recognises that this would allow visiting GPs to concentrate on the more complicated medical issues that arise.[19]

Recommendation 7

That the Australian Government legislate that RACFs engage with evidence-based end-of-life organisational and clinical support and resources.

Recommendation 8

That the Australian Government legislate that RACFs require additional nursing staff, such as Nurse Practitioners, to manage standard medical issues as well as other specialised staff to manage the needs of dementia patients and palliative care patients.

[15] End of Life Directions for Aged Care (ELDAC), *Organisational Support*: *Residential Aged Care Toolkit*. Accessed on 19 July 2019 <https://www.eldac.com.au/Portals/12/Documents/Factsheet/RAC-HC/Residential%20Aged%20Care_Organisational%20Factsheet_Web.pdf>.

[16] Health Direct, *Dementia Statistics*. Accessed on 19 July 2019 <https://www.healthdirect.gov.au/dementia-statistics>.

[17] Ward, Dr John, Senior Staff Specialist Geriatrician, Conjoint Assoc. Professor, University of Newcastle, *Submission to the Aged Care Royal Commission on Quality and Safety in Aged Care* (November 2018) 3.

[18] Australian Nursing and Midwifery Federation, *Nurse Practitioners: The answer for aged care*. Accessed on 19 July 2019 <https://anmf.org.au/pages/professional-november-2016>.

[19] Above n 17, 3.

Staffing requirements under the Act

24. Staffing requirements are not mentioned in the Act. The Act fails to mandate a minimum safe staffing standard or skill mix of workers required to meet the care needs of residents. The Act states that providers are to 'maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met'.[20] The Act does not specify what constitutes 'appropriately skilled and qualified staff' for the purpose of providing care. The ALA notes that as the Act does not specify a minimum staffing mix, a provider cannot be in breach of this obligation by providing a substandard level of experienced and skilled workers. The ALA submits that there is a compelling need for greater transparency and public accountability of staffing ratios in RACFs. The Aged Care Quality and Safety Commission (the Commission) does not have direct oversight of staffing – its functions are more indirect and relate to accreditation.

25. On 20 August 2018, Rebekha Sharkie MP introduced a Private Member's Bill, the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018* (the Bill), which required quarterly disclosure by RACFs of staffing ratios by category, namely: numbers of RNs, enrolled nurses (ENs), nurses with a certificate IV or equivalent qualification, personal care attendants, allied health staff and other staff members. Submissions to the Inquiry into the Bill demonstrated providers' opposition to the Bill. The Bill lapsed at dissolution on 11 April 2019.[21]

26. International research suggests that higher RN staffing levels, higher total staffing levels and a high skills mix (ratio of RNs to other nursing staff) is associated with better quality care.[22] The ALA submits that improved care in the aged care sector could be achieved by mandating an appropriate number and mix of skilled and experienced staff; a nursing skill mix requiring the compulsory physical presence of a RN at all times in all RACFs.

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[20] *Aged Care Act 1997* s 54.1 (1)(b); s 41.3 (1) (i).

[21] Parliament of Australia, Parliamentary Business, Bills Legislation. Accessed on 19 July 2019 <https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r6157>.

[22] Spilsbury, Karen, Catherine Hewitt, Lisa Stirk and Clive Bowman, 'The Relationship Between Nurse Staffing And Quality Of Care In Nursing Homes: A Systematic Review' (2011) 48(6) *International Journal of Nursing Studies*.

Recommendation 9

That legislation is required to mandate an evidence-based approach that sets minimum staff-to-resident ratios; a nursing skill mix and staff training requirements; and the compulsory physical presence of a Registered Nurse at all times in all RACFs.

Aged Care Act 1997: Regulation of aged care facilities

27. Aged care services are funded and regulated under the Act and associated Principles.[23]

28. The ALA submits that regulation is effective when:

    - accreditation standards empower residents
    - records are audited on site
    - intermittent inspections occur without notice
    - sanctions exist to deter negligent care without punishing residents
    - there is full data transparency and detailed reports are being made publicly available, which can be discussed with committees of residents and their relatives, and
    - innovation and excellence in providing quality care is recognised and honoured.

Effectiveness of the regulatory framework

29. The ALA submits that the current regulatory framework is clearly ineffective. The ALA is concerned, for example, the *Oakden Report*,[24] The Australian Law Reform Commission report *Elder Abuse: A National Legal Response* (ALRC Report 131) and the work of the Aged Care

[23] *Quality Agency Principles 2013* made under s 53 of the *Australian Aged Care Quality Agency Act 2013* (Cth) sets out the obligations that aged care providers must comply with in order to be approved providers.

[24] A Groves, D Thomson, D McKellar and N Procter (2017) The Oakden Report. Adelaide, South Australia: SA Health, Department for Health and Ageing.

Royal Commission bear this out; an inquiry would not have been needed otherwise.[25] The Aged Care Royal Commission has heard many revelations of mistreatment occurring in RACFs.

30. The ALA notes that there is a tension between commercial imperatives and public interest imperatives. Aged care providers are generally competitive commercial operations seeking to increase profit margins, which inevitably conflict with the interests of aged care residents.[26]

31. The ALA submits that evidence concerning the standard of aged care in Australia as heard by the Aged Care Royal Commission indicates that the current regulatory system serves the interests of the aged care industry rather than the recipients of care. The ALA submits that the systemic issues plaguing the aged care system require decisive structural reform.

32. The ALA submits that the regulation of aged care services and facilities needs to be overseen by a dedicated Minister rather than the current combined ministerial portfolio of Aged Care and Senior Australians/Youth and Sport. Considering our ageing population, aged care should not be de-prioritised to the extent it was in the 2019 election policies, with the major parties failing to focus on the needs identified by older Australians, including action on elder abuse and access to quality palliative care.[27] The ALA is concerned that significant failures in the provision of residential aged care involve governance, staffing, models of care, infrastructure and resources, and the collection, evaluation and use of data.

Is the legislation that underpins Australia's residential aged care system adequate?

33. The Act does not use the terms 'regulation' or 'regulatory system' in relation to compliance systems.[28] The ALA submits that the terminology used in the Act to describe the regulations

[25] See also, Australian Department of Health, *Aged Care Regulation in Quality: Activity and Actions* (Report 2017-2018): 3773 'reportable assaults'.

[26] Ian Ayres and John Braithwaite, *Responsive Regulation* (Oxford University Press, 1995) 28.

[27] COTA Australia, *COTA 2019 Older Australians Federal Election Survey* (Media Release, 12 May 2019). Accessed on 19 July 2019 <https://www.cota.org.au/wp-content/uploads/2019/05/COTA_1905_MR_COTA_2019_Older_Australians_Federal_Election_Survey.pdf>.

[28] Approved providers have certain responsibilities: *Aged Care Act 1997*, Chapter 4. These responsibilities relate to: (a) the quality of care they provide; and (b) user rights for the people to whom care is provided; and (c) accountability for the care that is provided, and the basic suitability of their key personnel. Failure to meet these responsibilities can lead to the imposition of sanctions that affect the status of approvals and similar decisions under Chapter 2 (and therefore may affect amounts of subsidy payable to an approved provider).

and requirements of providers is not effective in the context of privatised healthcare as it effectively reduces the impact of the regulatory system and implicitly promotes the ideals of self-regulation, which the ALA does not support in light of the systemic issues facing aged care in Australia. The ALA again submits that a revision of the aged care legislation is required to ensure transparency rather than legislation that preserves the status quo of 'commercial in-confidence' and the secrecy that surrounds accreditation and self-regulation.

A lack of data

34. The ALA submits that national, standardised, clinical data needs to be collected from the aged care sector and reported to the government. Other industries and sectors are required to provide this kind of information to the Australian Government. This information is essential to guide government decision-making and policy areas such as health insurance, life insurance and education. The Government could provide a similar portal to 'OneSchool' as used by Education Queensland in its administration processes.[29] The ALA submits that the 'consumer' has a right to this information.

35. The lack of available data on unreported complaints, pressure injuries, dehydration, malnutrition, medication errors, falls, and adverse events, including physical restraint, elder abuse, resident-to-resident aggression, suicide, choking, and unexplained absences occurring in RACFs. The ALA notes that shared knowledge leads to preventive interventions and well-co-ordinated policies, as well as informed choice for potential residents and their families.

36. The ALA submits that information needs to be available from regulatory authorities about deaths, quality of care, quality indicators, accreditation outcomes, complaints and police reports.

37. The ALA submits that published information needs to be user-friendly and easily accessible to recipients of care and their families, aged care advocacy organisations, policy-makers, legislators and the media.

[29] Queensland Government, Department of Education, OneSchool and QParents. Accessed on 19 July 2019 <https://education.qld.gov.au/parents-and-carers/school-information/oneschool-qparents>.

Recommendation 10

That the Australian Government introduce legislation to mandate annual public disclosure of each RACF's performance data and a governmental portal to facilitate the publishing of comparative data.

Aged Care Quality and Safety Commission

38. The stated role of the Commission[30] is to:

- protect and enhance the safety, health, well-being and quality of life of aged care consumers
- promote confidence and trust in the provision of aged care, and
- promote engagement with aged care consumers about the quality of care and services.

39. The Explanatory Memorandum to the *Aged Care Quality And Safety Commission Bill 2018* also speaks of 'aged care consumers', who are at the 'heart of the reform' which is marked by the new establishment of the Commission.[31]

40. The ALA submits that genuinely seeking to 'promote engagement' with aged care consumers about the quality of care and services is difficult. Many frail and vulnerable older persons have dementia or are unable to speak out. More than half of all people in permanent residential aged care have a diagnosis of dementia and are not easily able to access information online. They almost always rely on friends and family to advocate on their behalf.[32] Genuinely

[30] Australian Government, Aged Care and Quality Safety Commission, *About us.* Accessed on 19 July 2019 <https://www.agedcarequality.gov.au/about-us>.

[31] The Parliament of the Commonwealth of Australia, House of Representatives, Aged Care Quality and Safety Commission Bill 2018, Explanatory Memorandum, Minister for Senior Australians and Aged Care, and Minister for Indigenous Health, Ken Wyatt (12 September 2019). Accessed on 19 July 2019 <https://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r6180_ems_74c70007-05dd-46b8-9979-10dd9a48be3a/upload_pdf/684437.pdf;fileType=application%2Fpdf#search=%22legislation/ems/r6180_ems_74c70007-05dd-46b8-9979-10dd9a48be3a%22>.

[32] Health Direct, Dementia Statistics. Accessed on 19 July 2019 <https://www.healthdirect.gov.au/dementia-statistics>.

engaging with this group of people is not easy. The ALA submits that all persons regardless of disability deserve recognition of their human rights.

41. The Commission was formed following the amalgamation of two agencies: the Australian Aged Care Quality Agency (ACQA) and the Aged Care Complaints Commissioner (ACCC). The ALA submits that many reports issued by the former ACCC conclude that a facility failed to provide satisfactory care, but the decision did not lead to sanctions, disciplinary action, or any significant impact on a facility's approved accreditation status.

42. The Commission can now receive complaints about aged care abuse. The ALA submits that the abuse of the elderly is more than an issue of failing to meet aged care standards or accreditation requirements. The essential matter of protecting a person's human rights is at stake in extreme cases. The ALA submits that safeguarding the human rights of vulnerable people with dementia should be a priority for the aged care sector. Independent safeguards are sadly lacking and, thus, it submits that improvements to the way aged care is provided in Australia are essential. The ALA submits that the issue of remedies is important. There needs to be power to award compensation for breaches of human rights rather than simply powers to conduct an investigation or revoke accreditation.

43. The ALA submits that the Commission does not significantly expand the powers of the former quality agency: the ACCC. The Commission's functions and powers are largely analogous to that of its predecessor. The evidence of current Commissioner, Janet Anderson, at the Royal Commission into Aged Care Quality and Safety on 18 February 2019, described the Commission's complaints and regulatory function as a particular power to do with accreditation and quality assessment monitoring. The Commissioner stated that when undertaking its quality assessment and monitoring role 'ready access to timely information about active or recent complaints in relation to a provider is another information input to assist us in planning the visit and what we might ask about when they get to the aged care home'.[33] The ALA submits that having the complaints function tied so closely to the regulatory function highlights the fundamental conflict between the Commission's regulatory role in monitoring the accreditation of approved providers while simultaneously investigating

[33] Royal Commission into Aged Care Quality and Safety (Transcript, 18 February 2019). Accessed on 19 July 2019 <https://agedcare.royalcommission.gov.au/hearings/Documents/transcripts-2019/transcript-18-february-2019.pdf>.

complaints and failures. This reflects an inherent lack of governance over the Commission's functions by an independent auditor.

44. The ALA submits that if the regulator is to remain responsive to community concerns it must take a stricter enforcement approach – this means more legal action, including greater criminal and civil enforcement measures. Commissioner Janet Anderson has acknowledged in evidence to this Commission the need for a 'risk-based regulatory approach'.[34] Braithewaite's regulatory pyramid provides a model for regulation, with education and softer measures at the base and criminal sanctions in the courts at the apex.

45. The ALA submits that the Commission will be unable to bring necessary reform to aged care complaints processes without significant changes to overarching values relevant to the aged care system and legislative framework. The ALA submits that the Commission needs more powers akin to Australian Competition and Consumer Commission (ACCC) and the Australian Securities and Investments Commission (ASIC), which take a stronger regulatory approach in the courts. The Commission is an independent statutory agency.

46. The Commission is a single point of contact for both consumers and RACFS and that it is also responsible for the accreditation, assessment and monitoring of, and complaints handling of, aged care services and Commonwealth-funded aged care services. The new Commission absorbed both the Aged Care Quality Agency and the Aged Care Complaints Commission.[35] The ALA understands that it is intended that the Commission will be responsible for the approval of providers of aged care, compliance and compulsory reporting of assaults from 1 January 2020.[36] The ALA submits that some aspects of these responsibilities require a greater degree of separation between the delivery of these responsibilities and services. The ALA submits that an independent watchdog, such as an independent aged care ombudsman, is

[34] Ibid.

[35] *Community Affairs Legislation Committee, Aged Care Quality and Safety Commission Bill 2018* [Provisions]; *Aged Care Quality and Safety Commission (Consequential Amendments and Transitional Provisions) Bill 2018*, October 2018, 1.

[36] Australian Government, Federal Register of Legislation, *Aged Care Quality and Safety Commission Act 2018* [and] Aged Care Quality and Safety Commission Rules 2018, Explanatory Memorandum, Minister for Senior Australians and Aged Care, and Minister for Indigenous Health, Ken Wyatt (12 September 2019). Accessed on 19 July 2019 from <https://www.legislation.gov.au/Details/F2018L01837/Explanatory%20Statement/Text>.

necessary to ensure the transparency, objectivity and independence of all functions of the Commission.

Single Aged Care quality framework

47. From 1 July 2019, the new single set of standards, the Aged Care Quality Standards, apply to aged care services, including residential care. The ALA submits that compliance with the standards must be measured uniformly and objectively. Accreditation standards are open to interpretation by the quality agency. The ALA submits that uniform and objective compliance measurement must be built into aged care standards.

48. Each of the eight standards includes a statement of outcome for the consumer, a statement of expectation for the organisation and a number of organisational requirements to demonstrate that the standard has been met. The Aged Care Quality Standards were developed through significant consultation and co-designed with the aged-care sector. The ALA submits that the single quality framework's eight standards are malleable and not objectively measurable standards as the criteria are not based on clinical outcomes.

Aged Care Quality and Safety Commission's Consumer Experience Reports

49. The Commission refers to its 'Consumer Experience Reports'. Note is made of the Commissioner's use of the terms 'consumer voice' and the 'consumer experience'. The ALA further notes that in her evidence to the Royal Commission the Commissioner stated: 'What we are trying to do is empower the consumer.' [37]

50. The ALA submits that relying on the 'consumer voice' does not accurately reflect the culture and experience of being a RACF resident. The ALA submits that an independent body is required to monitor the experience of recipients of care through unannounced visits and speaking directly to the residents or people who are directly involved in advocating on their behalf.

[37] Royal Commission into Aged Care Quality and Safety Commission (Transcript, 18 February 2019). Accessed on 19 July 2019 from <https://agedcare.royalcommission.gov.au/hearings/Documents/transcripts-2019/transcript-18-february-2019.pdf>.

A lack of independent safeguards

51. The ALA submits that independent safeguards are lacking in the current system. The ALA submits that public information for RACFs include clearly visible sanctions and conditions on registration, if applicable. The ALA is concerned that results are currently inaccessible as detailed accreditation reports and complaints are not published, nor are there outcomes, and the Act exempts facilities from the operation of the *Freedom of Information Act 1982* (Cth) (FOI Act). It is of concern that the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) (ACQSC Act) are exempt from the operation of the FOI Act under the secrecy provisions. There is limited, if any, public policy rationale for this.

52. The ALA submits that the Australian Government should establish an independent aged care ombudsman with powers to inspect RACFs.

53. The ALA submits that valuable lessons can be learned from the recent accomplishments of the Care Quality Commission (CQC): the independent regulator of health and social care in England where, for example, where all providers are inspected and graded and the results and detailed inspection and accreditation reports are publicly available.

Recommendation 11

That the Australian Government should establish an independent aged care ombudsman with inspection powers in RACFs.

An unsatisfactory complaints mechanism

54. The ALA submits that the Commission's effectiveness should be under the spotlight. Rule 11 of the *Aged Care Quality and Safety Commission Rules 2018* (Cth) defines a complaint as follows:

> *A person may make a complaint to the Commissioner raising an issue or issues about (a) the responsibilities of the approved provider of an aged care service under the Aged Care Act or the Aged Care Principles or the responsibilities of a service provider of a Commonwealth-funded aged care service under the funding agreement that relates to that service.*

55. In the 2017–18 financial year, there was an exponential increase in complaints to the former Aged Care Complaints Commission, said to be a 400% increase in complaints after Oakden (whether a result of publicity or otherwise is immaterial).[38] There were 5,779 complaints to the Commission, an increase of 23% from 4,711 complaints in 2016/–17.[39] Of these, 3,253 complaints (56%) came from family members or representatives of people receiving care, and 1,083 (19%) were from care recipients. The remaining complaints (25%) were from anonymous sources, other interested parties and referrals from other agencies. There were 4,315 complaints about residential care, which accounted for 75% of all complaints, compared with 78% last year. This year, 18% of complaints were about home care packages (1,014) and 7% were about Commonwealth Home Support Programme (406), compared with 15% and 7% respectively last year. There were also 44 complaints about Flexible Care.[40]

56. According to the 2017–18 Annual Report, there can be many issues in a complaint that may be resolved in different ways. The most common issues raised in complaints about residential aged care were about medication administration and management (706), personal and oral hygiene (473) and personnel numbers/ratios (452). Medication administration and management was also one of the most common issues in residential care complaints in 2016–17. In 2017–18, 452 issues were raised about staff numbers and ratios, making it one of the top three issues in residential care complaints for the first time. In home care, the most common issues complained about were fees and charges (336), lack of consultation and communication (167) and communication about fees and charges (144). These were also the top three issues in complaints about home care in 2016-17.[41]

57. The current Commissioner, Janet Anderson, in her evidence at the Royal Commission into Aged Care Quality and Safety on 18 February 2019, stated that the Commission complaints function was 'largely unchanged' and it had not made any significant changes in relation to

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[38] Aged Care Royal Commission, *Statement of Paul Versteege to Royal Commission into Aged Care Quality and Safety* (7 February 2019). Accessed on 19 July 2019 from <https://agedcare.royalcommission.gov.au/hearings/Documents/exhibits-2019/12-february/WIT.0009.0001.0001.pdf>.

[39] Australian Government, Aged Care Quality and Safety Commission, *Australian Aged Care Quality Agency*, Historical publications. Accessed on 19 July 2019 from <https://www.agedcarequality.gov.au/about-us/corporate-publications/australian-aged-care-quality-agency>.

[40] Australian Government, Aged Care Quality and Safety Commission, above n 38.

[41] Australian Government, Aged Care Quality and Safety Commission, above n 38.

the operation of the complaints function, compared with what was happening previously.[42] The ALA submits that the Commission's complaints function is not radically different from its predecessors.

58. The ALA submits that the new Commission's complaint's process is not sufficiently independent and does not provide a transparent outcome-focused mechanism in its approach to the resolution of complaints. The ALA submits that the Commission is essentially a toothless tiger – and even if it has teeth it is not (at least not yet) using them effectively.

59. The ALA submits that aged care residents are among the most vulnerable people in our society and also face significant barriers to accessing justice – which is why the inadequacies of the complaints mechanism must be evaluated.[43] The ALA submits that the Commission's complaints system is an ineffective advocate for the vulnerable aged care residents and is unlikely to satisfy the public call for greater accountability and transparency from a privatised aged care sector. The ALA submits that complaints mechanism processes continue to unduly favour the aged care providers, and that a more robust complaints process with increased powers, accountability and transparency is urgently required.

60. The ALA submits that the greatest barrier to making a complaint is the fear of reprisals: punishment of residents and fear of termination of employment for staff members.[44] The ALA submits that there is a lack of protection for vulnerable private sector whistleblower aged care staff.

61. The ALA submits that members of the public are entitled to know the reasons for an administrative decision such as the outcome of a complaint that affects them. The ALA submits that providing reasons promotes fairness, transparency and accountability. This gives the person affected by the decision the opportunity to have the decision explained and to seek review if they wish. The ALA submits that the public expects agencies and ministers to

[42] Royal Commission into Aged Care Quality and Safety (transcript, 18 February 2019). Accessed on 19 July 2019 from <https://agedcare.royalcommission.gov.au/hearings/Documents/transcripts-2019/transcript-18-february-2019.pdf>.

[43] Blumer, Noor, 'President's Page: The coming of age', *Precedent* (2018) 148, 3.

[44] Carnell, Kate and Professor Ron Paterson, *Review of the National Aged Care Quality Regulatory Processes*, (*Carnell Patterson Review*) October 2017.

act fairly, transparently and consistently in their administrative decision-making and to be accountable for the decisions they make.

Recommendation 12

That the Australian Government establish a stronger regulatory model for the Aged Care Quality and Safety Commission, and an effective complaints mechanism that is transparent, consumer-oriented and outcome-based.

Advocating on behalf of residents in RACFs: a frail and vulnerable population

62. The ALA submits that the current system places undue focus on internal complaint mechanisms which have been proven to be ineffective. Internal reviews conducted by providers do not take into account the power discrepancy between aged care consumers and aged care facilities. The Commission and Older Persons Advocacy Network still direct complainants back to their service providers, which fails to properly recognise the implicit threat of reprisal following the making of a complaint.[45]

63. The ALA submits that an effective complaints mechanism must take into account the practical difficulties facing people in aged care facilities, including limited access to and understanding of computers; the impact of dementia and other cognitive difficulties; vulnerability (including fear of reprisals); and reliance on others to assist with the process.

64. The ALA submits that the aged care regime would do very well to substantially fortify its regulatory and complaints process through an aged care ombudsman program like the 'California State Long-Term Care Ombudsman Program' in California, in the United States, which involves California's State Certified Ombudsman representatives, nearly 80% of whom are volunteers.[46] The stated goal of the State Long-Term Care Ombudsman Program is to advocate for the rights of all residents of long-term care facilities.[47]

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[45] Australian Government, *Aged Care Quality and Safety Commission, Making a complaint.* Accessed on 19 July 2019 from <https://www.agedcarequality.gov.au/making-complaint>.

[46] State of California, Department of Aging website, Programs and Services, Long-Term Care Ombudsman. Accessed on 19 July 2019 from <https://www.aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/>.

[47] Ibid.

Recommendation 13

That the Australian Government provide strong and accessible advocacy services to aged care residents with a volunteer program of independent certified representatives.

Openness, transparency and accountability: linking complaints to regulatory action and compensation

65. The ALA submits that openness, transparency and accountability are key attributes of an effective aged care complaints mechanism. The complaints function needs to be more closely connected to the regulatory function. As Commissioner Janet Anderson said in evidence, the Commission needs information from both sources (accreditation data and complaints) to 'sharpen its regulatory gaze'.

66. The ALA submits that there is a lack of public scrutiny and effective sanctions for demonstrably poor care in the current system. Serious incidents should lead to escalation of complaints. There is little action taken in relation to the administration of inappropriate medications; the use of restraints; or neglect — even where incidents involving negligence lead to death.

67. The ALA submits that disciplinary hearings should be implemented, especially where a complaint shows a pattern or a practice of poor care. The ALA submits that hearings in relation to RACFs should be conducted in a similar framework to hearings and decisions of the Health Care Complaints Commission (HCCC).

The need for an independent tribunal

68. The ALA submits that the mistreatment of people in RACFs is a breach of human rights and should be treated as such. There needs to be a power to award compensation for breaches of human rights. The ALA submits that an independent tribunal is required to hear complaints with powers to issue fines; cancel accreditation; publicly reprimand providers; and order monetary compensation. Currently consumers are not provided compensation unless they undertake litigation privately.

69. The power to refer complaints to the Department of Health for compliance action is insufficient and does not adequately protect the rights of aggrieved persons. Even if the Commission assumed the Department's roles, there are problems with having the same

agency exercise all the functions — as judge, jury and executioner. This conflict of interest was not adequately considered when the ACQSC Act was passed. [48]

70. Further, the ALA submits that the cost of litigation is prohibitive for many complainants. Aged care litigation, such as common law action in negligence (often the only form of monetary redress available to victims and complainants), can be a lengthy process.

71. The ALA submits that an independent tribunal with the power to hear aged care complaints and fine/sanction providers in breach and award compensation to victims should be established. The ALA submits that such a tribunal should have the power to investigate alleged breaches without reliance on the consent of the victim or the need to obtain direct evidence from a victim. The NSW Health Care Complaints Commission (HCCC) provides a model upon which to base such a Tribunal.[49] The HCCC has full powers to receive and investigate complaints, conciliate complaints, resolve complaints, and refer complaints for further action. Judicial and/or quasi-judicial hearings can be conducted before the NSW Civil and Administrative Tribunal.

72. The ALA submits that the fundamental principle is that offenders should pay. Aged care providers are making significant profit from their commercial operations and receiving government funding. The ALA submits that it is not enough to rely on the accreditation mechanisms to revoke accreditation on breach. The closure of aged care facilities has an adverse effect on all persons involved, but particularly innocent aged care residents who may be forced to relocate.

73. The ALA submits that managers and boards of RACFs should be held personally accountable when standards are not met.[50] It is not sufficient to revoke accreditation only to have it re-conferred in a subsequent accreditation inspection (as this Commission has heard in

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[48] Parliament of Australia, *Aged Care Quality and Safety Commission Bill 2018*, Second Reading Speech, Minister for Aged Care, Ken Wyatt (12 September 2018). Accessed on 19 July 2019 from <https://parlinfo.aph.gov.au/parlInfo/genpdf/chamber/hansardr/e9910ead-7240-49bf-bdec-3741da5331b9/0018/hansard_frag.pdf;fileType=application%2Fpdf>.

[49] *Health Care Complaints Act 1993 (*NSW).

[50] Coroner's Court of South Australia, *Inquest into the death of Dorothy Mavis Baum on 31 May 2012*, *Inquest by Mark Frederick Johns, State Coroner* (59/2016 (0853/2012) 28. Accessed on 19 July 2019 from <http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/763/BAUM%20Dorothy%20Mavis.pdf>.

evidence). The ALA submits that persons who suffer wrongs and losses should be entitled to claim compensation.

Recommendation 14

That an equitable and accessible independent tribunal be established with an outcome-based complaints system with power to hear aged care complaints; fine/sanction providers in breach; hold RACF management personally liable for breaches and award compensation to victims for serious breaches – offenders in breach should pay.

Place of common law and tort law in driving high-quality aged care services

The place of common law

74. The ALA submits that the common law provides an important role in improving the safety of aged care services care in residential aged care facilities (RACFs) and promotes justice for elderly people who have suffered harm in aged care.

Why is it a useful vehicle?

75. The ALA submits that the common law tort of negligence is a valuable tool in the struggle for justice to protect some of Australia's most vulnerable, frail and aged citizens as it sets and upholds an appropriate standard of care. The ALA submits that litigation has the potential to promote quality and safety by imposing sanctions where there are breaches of protocols and guidelines. Litigation provides effective deterrents; it can expose poor practice and encourage good practice.

76. The ALA submits that very few complaints about the provision of substandard care in RACFs result in sanctions or disciplinary action. The ALA submits that complaints about aged care are often managed either internally or externally with a view to conciliation or to conceal problems.

Litigation: an empowering medium to improve quality

77. The ALA submits that litigation holds the potential to hold providers to account for wrongdoing, serving to raise the standard of care in RACFs for aged care residents. Litigation in medical law, for example, has frequently served as an effective deterrent to poor practice in health. Similarly, litigation in aged care is an effective mechanism to force compliance within the aged care regulatory framework. Financial deterrence is a strong incentive to improve systems; litigation brought against aged care providers discourages substandard care.

78. The ALA submits that if the standard of reasonable care in a RACF is to improve over time and not remain static and hindered by outdated practices, it is necessary to bring new cases that challenge the status quo. The ALA submits that the tort system permits various positions to be tested in court.

Litigation: an empowering medium for aged care complainants

79. The ALA submits that tort law offers more than a compensatory regime: it is potentially an empowering medium for residents of aged care who have suffered insult, injury, humiliation, distress and a loss of dignity, or had their life unnecessarily shortened in aged care.

80. The ALA submits that the harm suffered by an aged person injured due to negligence should be acknowledged and apologised for. Tort law gives injured persons the power to choose whether to assert their rights and how to frame their claims. Injured parties may be empowered through their access to a public forum to call the harm-causing defendants to account.

Recommendation 15

That the power of the common law to as a tool to improve safety and drive high quality aged care services be recognised by the Australian Government.

Australia's tort system: increasing its efficacy

81. The ALA submits that there is a need to have mechanisms in place to ensure that tort law plays an effective role in regulating the aged care industry.

82. The system of tort law in Australia contains some barriers for the aged care complainant and their relatives and advocates. Firstly, the ALA recognises that victims of negligence in aged care rely on families, friends and other advocates to assist them to achieve a remedy in law. Secondly, the victims of negligence arising from substandard practice in aged care are often in the advanced stages of an illness or their lives, and there is a risk that some will not live long enough to achieve a satisfactory and timely outcome due to lengthy delays in the court system. Thirdly, there are statutory limitations on the award of damages. The ALA submits that this should not be an excuse not to act to achieve justice on behalf of aged care residents when wrongdoing has occurred.

83. A lack of economic compensation may be awarded under tort law due to no loss of 'future earnings' of aged victims.

Recommendation 16

That statutory limitations that operate as prohibitive barriers to litigation are reduced for aged care complainants.

84. The ALA submits that compensation for abuse is required that goes beyond a trail of paperwork. Monetary remedies can restore some aspects of damaged dignity when there are physical injuries although money is not a substitute for being treated with respect and dignity, particularly in the face of social inequalities. The ALA submits that the system must be reviewed to ensure effective remedies for victims of negligence. [51]

85. The ALA submits that introducing specific torts and developing new causes of action may result in aged care providers being held accountable for negligent care – which in turn improves the quality of care.

Recommendation 17

That the tort system in Australia is modified by legislation to refine existing torts and develop new causes of action.

[51] Blumer, Noor, 'President's Page: The coming of age', *Precedent* (2018) 148, 3.

86. The ALA submits that an aged care claim requires expedited processes like the Dust Diseases Tribunal of New South Wales (DDT). The DDT is a legal court that hears claims for damages from sufferers of dust-related diseases, including those linked to asbestos exposure and dependants of sufferers who have died. The special purpose of the DDT is to serve the interests of justice by expediting claims without undue delay, a factor also potentially relevant to a claimant in an aged care matter. The ALA submits that as time is often a critical factor in aged care litigation these matters should be expedited in a similar manner.

Recommendation 18

That legal rights of aged persons who have suffered harm are protected and expedited through a regulatory process like the Dust Diseases Tribunal of New South Wales (DDT).

Legislative reform: a new Act

87. The ALA submits that this Commission has uncovered many instances where an elderly person's human rights have not been protected in aged care, and where substandard care has caused injury, neglect, and other forms of harm to residents of RACFs. The ALA submits that effective protection of human rights should include viable access to a judicial process resulting in a legal remedy or legal consequence.[52] Currently, access to justice for elderly persons is lacking. The ALA submits that a specific Act that deals with RACFs is required.

88. This Act should state a series of civil obligations which, if breached, may be remedied through a civil process initiated in the Federal Court.[53] The ALA submits that such an Act would be constitutionally valid since the establishment of a regulatory scheme for aged care was

[52] Barnett, Michael and Robert Hayes, 'Not seen and not heard: protecting elder human rights in aged care' (2010) 14(1) *University Of Western Sydney Law Review* 45-83, at 83. Accessed on 19 July 2019 from <http://ezproxy.uws.edu.au/login?url=http://www.austlii.edu.au/au/journals/UWSLRev/2010/2.html>.

[53] Ibid 79.

recognised by the High Court of Australia in *Alexandra Private Geriatric Hospital Pty Ltd v The Commonwealth*.[54]

Recommendation 19

That the Australian Government legislate to provide for a series of civil obligations which, if breached, may be remedied through a civil process initiated in the Federal Court.

Commissioner for Older Persons within the Australian Human Rights Commission

89. In addition, the ALA submits that the current Commissioner for Aged Discrimination within the Australian Human Rights Commission (AHRC) should be renamed the Commissioner for Older Persons, and be given additional responsibilities under the Act.[55] The Commission should be given standing to initiate or intervene in any proceedings, prosecutions and administrative decision-making relating to breaches of Australian law. The ALA submits that the Commission would have the power of oversight and to intervene in any complaint's investigation under the *Aged Care Act*. A comparable model would be the Ombudsman's power and role in relation to complaints made against the police.[56]

Legal advocacy in aged care

90. The ALA submits that this Commission has heard many accounts where substandard care has caused injury, neglect, and other forms of harm to residents of RACFs. The ALA submits that there is a lack of access to justice for elderly persons.

91. The ALA submits that it is important for elderly people and their relatives to be able to discuss an aged care complaint with a lawyer who can provide advice and referral where appropriate. The ALA submits that advocacy services should exist outside the aged care facilities and should be face-to-face and provide regular contacts. Legal Aid prisoner advice services visit jails and

[54] (1987) 162 CLR 271.

[55] Barnett and Hayes, above n 52, 80.

[56] Barnett and Hayes, above n 52, 80.

may offer a useful comparator.[57] The ALA submits that a specific form of human rights advocacy is needed for the elderly due to their inherent vulnerabilities.

A human rights approach to the delivery of aged care services

92. The ALA submits that a key strategy in ensuring that aged care services are safe and of high quality is strengthening the human rights protections within Australia and ensuring that these protections have direct application to the provision of aged care services. Two strategies for achieving this are:

    a. ensuring that aged care services are included within the definition of 'place of detention' and thereby covered by Australia's obligations under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT); and

    b. enacting a federal legislative human rights charter that follows a dialogue model of human rights protection requiring public authorities, including aged care services, to comply with human rights. The charter should reflect the recommendations of the Chair's Report of the United Nations Open-Ended Working Group on Ageing (OEWG) in relation to a proposed United Nations Convention on the Rights of Older People. The OEWGA was established in 2011.

Australia's obligations under OPCAT extending to aged care services

93. The ALA submits that under the recently ratified Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), Australia will have obligations to provide for independent, regular and preventive oversight visits to aged care facilities. The purpose of these visits will be to identify and analyse factors that may increase the risk of ill-treatment to residents of such facilities and aim to eliminate the risk factors of such ill-treatment.

94. Australia ratified the OPCAT in December 2017. The OPCAT requires States to establish and maintain a body or framework to visit places of detention to undertake 'preventive inspections' (a National Preventive Mechanism (NPM)). At the time of ratification, the

[57] Barnett and Hayes, above n 52, 81.

Australian Government exercised its right under Article 24 of the OPCAT to delay the formal establishment of the Australian NPM for three years. In addition, the Australian Government has indicated that the NPM will focus on what it deems 'primary places of detention' such as prisons, youth justice, immigration detention, military detention, closed psychiatric facilities and police custody.

95. The ALA submits that there should be no limit or restriction regarding the categories of 'place of detention' that should be subject to visits by Australia's NPM bodies. Article 4 of OPCAT does not place any limitations or restrictions on the definition of 'places of detention.' The open-ended scope of the OPCAT provides the benefit of ensuring that places not traditionally seen as detention, but showing evidence of mistreatment, can be subject to the same rigorous monitoring as would be expected of a correctional facility or immigration detention. This includes aged care facilities.

96. The ALA submits that all places where people are kept against their will require visits by Australia's NPM bodies under this treaty, including aged care facilities, disability institutions and youth detention facilities. The treaty does not restrict its attentions to specific places of detention but applies to all places under the 'jurisdiction and control' of the government, including non-traditional places of detention.

97. Accordingly, the ALA strongly submits that there should be no limit or restriction in legislation regarding the categories of 'place of detention' that should be subject to visits by Australia's NPM bodies. Article 4 of the OPCAT is expressed in broad terms and none of the 67 signatory States has placed restrictions on the categories of places of detention that NPMs can visit.

98. The ALA submits that aged care facilities should be considered closed environments in certain circumstances, as they are environments where individuals are often in need of a high level of care. Residents are often dependent on others for the basic necessities of life and their freedom of choice or movement can be restricted or removed altogether.

99. The aged care facilities are included within the definition of places of detention for the purposes of NPM preventive visits in Austria,[58] Germany[59] and New Zealand.[60] Both the German NPM and the NZ NPM inspect all places envisioned in the wide definition of detention, including aged-care facilities.[61]

100. The role of the NPMs is to monitor all closed environments regardless of whether they are owned and operated by the government or outsourced to the private sector. The ALA is concerned that by limiting or restricting the categories of 'place of detention' that should be subject to visits by Australia's NPM bodies, many closed environments owned and operated by non-state actors and private entities may escape appropriate scrutiny.

Recommendation 20

That the Australian Government designate aged care facilities as places of deprivation of liberty to be inspected by the OPCAT National Preventive Mechanism.

101. Article 18 (1) of the OPCAT stipulates that 'The States Parties shall guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel.' In implementing the NPM framework, the Australian Government must ensure that the NPM organisations are structurally independent and are seen to be independent by the community. The NPM must be transparent in all its activities and must report directly to Parliament.

102. The ALA is concerned that the Australian Aged Care Quality and Safety Commission in its current state does not meet the standard of independence required by the OPCAT for an NPM

[58] Austrian Ombudsman Board (2017). *Annual Report on the activities of the Austrian National Preventive Mechanism (NPM),* p23. Accessed on 6 March 2019 from <https://volksanwaltschaft.gv.at/downloads/ctjmf/aob-npm-report-2017.pdf>.

[59] National Agency for the Prevention of Torture (208). Annual Report 2017, Accessed on 6 March 2019 from <https://www.nationalestelle.de/fileadmin/dateiablage/Dokumente/Berichte/Jahresberichte/ANNUAL_REPORT_2017_National_Agency.pdf>.

[60] New Zealand Human Rights Commission (2016). *The OPCAT and what it can do for aged care in New Zealand.* Sourced on 6 March 2019 from <https://www.hrc.co.nz/news/opcat-and-what-it-can-do-aged-care-new-zealand/>.

[61] See n 2 above; New Zealand National Preventive Mechanism (2018). Submission to the Universal Periodic Review: Executive Summary. Accessed on 6 March 2019 from <https://www.hrc.co.nz/files/8215/4145/0979/NPM_submission_to_UPR.docx>.

oversight body. The Commission is not directly accountable to Parliament. Under its legislation it is only accountable to the Minister for Senior Australians and Aged Care.

103. Article 20 (c) of the OPCAT stipulates that States shall grant the NPM 'access to all places of detention and their installations and facilities'. While the Commission is required to visit and accredit all aged care facilities, ss68-69 of the ACQSC Act require the aged care facility to consent to the presence of assessors and can withdraw that consent at any time during an assessment or audit. Although it is not in the best interest of an aged care facility to do so, the very ability to withdraw consent indicates that the framework governing visits to facilities by the Commission is not compliant with the purposes of the OPCAT.

Recommendation 21

That the Australian Government urgently review the Australian Aged Care Quality and Safety Commission to assess the Commission's compliance with the principles of the OPCAT and Principles of Oversight, and undertake any necessary legislative, policy and procedural changes to ensure that the Commission is compliant.

Recommendation 22

That the Australian Aged Care Quality and Safety Commission, or other independent watchdog such as an independent aged care ombudsman, be a made a part of the National Preventive Mechanism for the purposes of the implementing the OPCAT.

A Federal Human Rights Charter that requires aged care services to comply with human rights

104. The ALA submits that it is necessary to strengthen the legislative framework that seeks to protect and promote human rights, in order to provide greater human rights protections for older Australians who rely on aged care services. In particular, the ALA submits that a federal legislative human rights charter that follows a dialogue model of human rights protection (similar to what exists in the United Kingdom, New Zealand, Victoria, the ACT and Queensland) which specifically requires public authorities to comply with human rights, would provide additional protections to people who are reliant on aged care services.

105. The ALA submits that the charter should reflect the recommendations of the Chair's Report of the United Nations Open-Ended Working Group on Ageing (OEWG) in relation to a proposed United Nations Convention on the Rights of Older People. The OEWGA was established in 2011.

106. The ALA submits that a federal human rights charter would be extremely useful in the aged care sector, and particularly in the practice of health law and aged care. From a practising perspective, a lawyer would likely welcome the ability to advance their client's causes legally and practically with a federal human rights charter.

107. A federal legislative human rights charter could provide additional human rights protections for people who are reliant on aged care services in four ways:

    a) A federal human rights charter would require the courts to interpret all existing legislation and regulations in a manner that is compatible with the protected human rights. This would include all legislation and regulations governing the provision and regulation of aged-care services in Australia, including the *Aged Care Act 1997* (Cth) and all relevant delegated legislation.

    b) A federal human rights charter would require that when new legislation and regulations are introduced into Parliament, they are to be accompanied by a Statement of Compatibility in which the relevant Minister is required to certify that the proposed legislation/regulations is compatible with human rights. This would include any new legislation and regulations governing the provision of aged care services in Australia.

    c) A federal human rights charter would require all public authorities to act in a manner that is consistent with the protected human rights, and to take into account the protected human rights when making decisions. The definition of a 'public authority' would include a public or private body whose functions include functions of a public nature. The phrase 'functions of a public nature' includes functions of a regulatory nature. This would mean that the regulatory body governing the provision of aged care services, currently the Australian Aged Care Quality and Safety Commission, would have obligations to act compatibly, and make decisions which are compatible, with the rights protected in the charter.

    d) A federal human rights charter would require all non-government organisations that perform functions of a public nature to comply with the human rights protected by the

charter. This would include non-government organisations that provide aged care services.

108. In relation to 107(c) above, the operation of government and statutory regulatory schemes that govern the licensing, accreditation or regulation of non-government service providers is a mechanism by which government can secure human rights compliance from non-government service providers undertaking contracted-out services. Where those schemes operate pursuant to legislation or are operated by a government department or agency as 'core' public authorities, they are required to comply with human rights obligations. Given the guidance that has been specified in the Victorian *Charter of Human Rights and Responsibilities Act 2006* (s4(2)c)), the Australian Capital Territory *Human Rights Act 2004* (s40A(1)c)) and the Queensland *Human Rights Act 2019* (s10(1)c)), it is likely that any statutory or private regulatory schemes are public authorities when performing functions of a regulatory nature.

109. A similar provision in a federal human rights charter would mean that the regulatory body governing the provision of aged care services, currently the Australian Aged Care Quality and Safety Commission, would have obligations to act compatibly, and make decisions which are compatible, with the rights protected in the charter. Accordingly, in fulfilling its own public authority human rights obligations, the Commission would need to include requirements for human rights compliance as a precondition for licensing or industry accreditation, including requirements for annual reporting of human rights compliance by organisations as part of them maintaining their licensing or accreditation status. A failure to adhere to required human rights standards would have adverse consequences for the organisations themselves, including possible cancellation of contracted arrangements or punitive responses from the regulator.

110. In relation 107(d) above, a critical element in ensuring that aged care services are aware of their statutory obligations to comply with human rights is ensuring that the phrase 'functions of a public nature' is adequately defined, and that the provision of aged care services is explicitly included within the definition of that phrase.

111. Section 10(3) of the Queensland *Human Rights Act 2019* and s40A(3) of the Australian Capital Territory *Human Rights Act 2004* lists particular functions that are defined as being of a public nature. The statutory eight-year review of the Victorian *Charter of Human Rights and Responsibilities Act 2006* recommended that the Charter be amended to include a similar

provision.[62] The review noted that such a provision was necessary given the continuing uncertainty about whether several non-government organisations are functional public authorities. The review noted that this was a barrier to the incorporation of the Charter in the day-to-day work of these organisations and inhibited the development of a human rights culture.[63]

112. The clarification of the phrase 'function of a public nature' assists in providing greater certainty to non-government organisations that perform public functions as to their obligations under the legislation.

113. To ensure the application of statutory human rights obligations to providers of aged care services, a federal human rights charter should include a similar provision that lists particular functions that are defined as being of a public nature. This should explicitly include the provision of aged care services.

114. Such a provision would overcome the difficulty that was encountered with the United Kingdom *Human Rights Act 1999*, in which there was no definition or further clarification of the phrase 'functions of a public nature'. This resulted in the phrase being clarified by the courts, with the House of Lords deciding in 2007 by a 3-2 majority that the non-government owners and managers of a registered care home were not exercising functions of a public nature in providing accommodation and nursing care (*YL (by her litigation friend the Official Solicitor) (FC) v Birmingham City Council and Others*[64]).

115. Following the House of Lords decision in *YL*, the UK Government provided a legislative response that dealt with the specific case of residential care services arranged by local authorities, where the services are provided by a privately owned and operated facility. The following year the UK Parliament passed the *Health and Social Care Act 2008* which included a specific provision to deal with the gap in human rights protection for service users of private residential care homes that arose as a result of the decision in *YL*.[65]

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[62] See n 2 above, 62.

[63] Ibid, 58.

[64] *YL (by her litigation friend the Official Solicitor) (FC) v Birmingham City Council and Others* [2008] 1 AC 95.

[65] *Health and Social Care Act 2008* (UK), s145(1): A person (P) who provides accommodation, together with nursing or personal care, in a care home for an individual under arrangements made with P under the

116. In 2014 the UK Parliament passed the *Care Act 2014* which included a provision that made explicit that care providers are exercising a function of a public nature for the purposes of the *UK Human Rights Act 1998* when providing adults with nursing or personal care in their home or accommodation, arranged or funded by a public authority pursuant to specific duties and powers.

117. The principle that the provision of specialist care services for the aged is a function of a public nature that should give rise to obligations to comply with human rights was recognised by Baroness Hale, as she then was, in her minority judgment in *YL*:

> *In a state which cares about the welfare of the most vulnerable members of the community, there is a strong public interest in having people who are unable to look after themselves, whether because of old age, infirmity, mental or physical disability or youth, looked after properly. They must be provided with the specialist care, including the health care, that they need even if they are unable to arrange or pay for it themselves. No-one can doubt that providing health care can be a public function, even though it can also be provided purely privately.*[66]

118. The ALA submits that a statutory Bill of Rights may not create rights that cannot be struck down. The ALA notes that a Bill of Rights may provide no remedy in damages for breach of its provisions.

Recommendations 23

That the Australian Government implement the recommendation from the National Human Rights Committee's Consultation Final Report in 2009 that Australia adopt a federal Human Rights Act that is based on the 'dialogue' model, which sets out a list of human rights and accords the executive, the legislature and the judiciary specific roles in the protection and promotion of those rights, and imposes the obligation to act in accordance with those rights on federal public authorities.

relevant statutory provisions is to be taken for the purposes of subsec(3)(b) of s6 of the *Human Rights Act 1998* (cl 42) (acts of public authorities) to be exercising a function of a public nature in doing so.

[66] *YL (by her litigation friend the Official Solicitor) (FC) v Birmingham City Council and Others* [2008] 1 AC 95, per Baroness Hale of Richmond, [67].

Recommendation 24

That the federal Human Rights Act include a within the definition of 'federal public authorities' those entities that are performing functions of a public nature, and that the provision of a regulatory function be included within the definition of 'functions of a public nature.'

Recommendation 25

That the definition of the phrase 'functions of a public nature' in the federal Human Rights Act provide a list of particular functions, which includes the provision of aged care services, that are assumed to be of a public nature.

Conclusion

119. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into the Royal Commission into Aged Care Quality and Safety through the public submission process.

120. The ALA makes the following recommendations:

1. **Participants of the NDIS should continue to have a funded independent advocate when they transition to aged care.**

2. **Alternative accommodation should be provided to younger NDIS participants in the form of housing that is specific to their needs.**

3. **The Australian Government consult with allied health care teams at hospitals to create a pathway of a high standard for people with disabilities, including those who are young, those who are reaching 65, those over 65 and those with dementia. The age of persons with dementia should be taken into account as part of the NDIS plan so that care and support is age specific.**

4. **The Australian Government review and redraft the *Aged Care Act 1997* to incorporate clear safeguards that promote and protect the interests of aged care residents.**

5. **The Australian Government encourage community-based small group options such as the Abbeyfield model of supported housing.**

6. **The Australian Government support RACFs to engage with evidence-based clinical practice and models of care and utilise a specialised and skilled workforce.**

7. **The Australian Government legislate that RACFs engage with evidence-based end-of-life organisational and clinical support and resources.**

8. **The Australian Government legislate that RACFs require additional nursing staff, such as Nurse Practitioners, to manage standard medical issues as well as other specialised staff to manage the needs of dementia patients and palliative care patients.**

9. **Legislation is required to mandate an evidence-based approach that sets minimum staff-to-resident ratios; a nursing skill mix and staff training requirements; and the compulsory physical presence of a RNs at all times in all RACFs.**

10. **The Australian Government introduces legislation to mandate annual public disclosure of each RACFs performance data and a governmental portal to facilitate the publishing of comparative data.**

11. **The Australian Government establish an independent aged care ombudsman with inspection powers in RACFs.**

12. **The Australian Government establish a stronger regulatory model for the Aged Care Quality and Safety Commission, and an effective complaints mechanism that is transparent, consumer-oriented and outcome based.**

13. **The Australian Government provide strong and accessible advocacy services to aged care residents with a volunteer program of independent certified representatives.**

14. **An equitable and accessible independent tribunal be established with an outcome-based complaints system with power to hear aged care complaints; fine/sanction providers in breach; hold RACF management personally liable for breaches and award compensation to victims for serious breaches – offenders in breach should pay.**

15. **The power of the common law to as a tool to improve safety and drive high quality aged care services be recognised by the Australian Government.**

16. **Statutory limitations that operate as prohibitive barriers to litigation are reduced for aged care complainants.**

17. **The tort system in Australia is modified by legislation to refine existing torts and develop new causes of action.**

18. **Legal rights of aged persons who have suffered harm are protected and expedited through a regulatory process like the Dust Diseases Tribunal of New South Wales (DDT).**

19. **The Australian Government legislate to provide for a series of civil obligations which if breached, may be remedied through a civil process initiated in the Federal Court.**

20. **The Australian Government designate aged-care facilities as places of deprivation of liberty to be inspected by the OPCAT National Preventive Mechanism.**

21. **The Australian Government urgently review the Australian Aged Care Quality and Safety Commission to assess the Commission's compliance with the principles of the OPCAT and Principles of Oversight, and undertake any necessary legislative, policy and procedural changes to ensure that the Commission is compliant.**

22. **The Australian Aged Care Quality and Safety Commission, or other independent watchdog such as an independent aged care ombudsman, be**

made a part of the National Preventive Mechanism for the purposes of the implementing the OPCAT.

23. **The Australian Government implement the recommendation from the National Human Rights Committee's Consultation Final Report in 2009 that Australia adopt a federal Human Rights Act that is based on the 'dialogue' model, which sets out a list of human rights and accords the executive, the legislature and the judiciary specific roles in the protection and promotion of those rights, and imposes the obligation to act in accordance with those rights on federal public authorities.**

24. **The federal Human Rights Act include a within the definition of 'federal public authorities' those entities that are performing functions of a public nature, and that the provision of a regulatory function be included within the definition of 'functions of a public nature.'**

25. **The definition of the phrase 'functions of a public nature' in the federal Human Rights Act provide a list of particular functions, which includes the provision of aged-care services, that are assumed to be of a public nature.**

Andrew Christopoulos

President

Australian Lawyers Alliance