THE EVOLVING LANDSCAPE OF RESTRICTIVE PRACTICES IN AGED CARE: WHAT IS THE ROLE OF GUARDIANSHIP?[1]

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Introduction

1 The use and misuse of restrictive practices in aged care settings has gained increasing prominence in recent times.

2 The Royal Commission into Aged Care Quality and Safety's Final Report: Care, Dignity and Respect ("Royal Commission's Final Report")[2] (Vol 3A) notes that restrictive practices:[3]

> …impact the liberty and dignity of people receiving aged care. The right to personal autonomy is recognised in domestic laws and international human rights instruments. International human rights conventions, to which Australia is a signatory, recognise rights such as self-determination, liberty and security of the person, and recognition and equality before the law. The common law in Australia recognises that each person has the right to choose what occurs with respect to their own body. Providing care or treatment, or detaining someone without their consent, can be a civil wrong or a criminal offence.

3 The failure to obtain informed consent where required by law was also stated in the Commission's Interim Report to "ignore the rights of older Australians" (p 208).

4 The Royal Commission's Final Report makes recommendations that seek to increase oversight and regulation of the use of restraints in aged care through several mechanisms. These include making the proposed use of restrictive

[1] Paper presented to Australian Guardianship and Administration Council (AGAC), Hobart, 12 March 2021. I note that this paper refers to the legislative position as it existed at the time that this paper was given in March 2021. On 1 July 2021, amendments to the *Aged Care Act 1997* and Part 4A of the *Quality of Care Principles 2014* came into effect relating to the use of restrictive practices in residential aged care (see *Aged Care and Other Legislation Amendment (Royal Commission Response No.1) Act 2021* and the *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021*). Those changes will be noted in footnotes at relevant points in this paper.
[2] Tabled on 1 March 2021.
[3] P 110.

practices subject to independent expert assessment, accreditation and oversight of behaviour support practitioners, similar to the regime that exists under the National Disability Insurance Scheme (NDIS) Quality and Safeguarding framework.[4] The use of restrictive practices not in accordance with the new proposed statutory scheme would be reportable under an updated serious incident reporting scheme.[5] Breaches would expose providers to potential civil penalty at the suit of the regulator and an order for compensation may be sought for the person directly affected by the breach.[6]

5 It was also recommended that restrictive practices only be used in accordance with State or Territory laws and with documented informed consent of the person receiving care or someone authorised by law to give consent on that person's behalf.[7]

6 Also underway has been a review evaluating the effectiveness after one year of operation of Pt 4A of the *Quality of Care Principles 2014* (Cth)[8] ("Quality of Care Principles") in minimising the use of physical and chemical restraint in residential aged care. By way of background, on 1 July 2019 the Quality of Care Principles were amended by the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth) which introduced regulatory requirements in relation to the use of restraints by residential aged care providers. Following further amendment on 29 November 2019 by way of the *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019* (Cth), Pt 4A of the Quality of Care Principles specified the obligations placed on every "approved provider" of residential aged care in relation to the use of "physical restraint" and "chemical restraint" in order to ensure those measures are used only as a "last resort": ss 15F and 15G of the Principles.

7 The Final Report of the *Independent review of legislative provisions governing the use of restraint in residential aged care*[9] ("Independent Review's Final

[4] Recommendation 17.1(a)(i).
[5] Recommendation 17.3(a).
[6] Recommendation 17.3(b).
[7] Recommendation 17.1(b)(v).
[8] Made under s 96-1 of the *Aged Care Act*.
[9] Published in December 2020.

Report") recommended the strengthening and promotion of consent requirements under the Quality of Care Principles.[10] This included clarifying in the Quality of Care Principles that state and territory requirements regarding informed consent apply to both physical and chemical restraint.[11]

8 Significantly, the Independent Review's Final Report also recommended that instead of maintaining the two defined forms of restraint in the Principles (namely chemical and physical restraint), the adoption of the definition of the five types of restrictive practices described in the NDIS (Restrictive Practices and Behaviour Support) Rules 2018 (Cth) should be considered, that is, in addition to physical and chemical restraint, mechanical restraint, environmental restraint and seclusion should also be included.[12]

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[10] Recommendation 2.

[11] Recommendation 2a. This recommendation was adopted and since 1 July 2021, the "consumer representative" provision in Part 4A of the Quality of Care Principles was removed and replaced with the definition of a "restrictive practices substitute decision maker" defined (in amended s 4) as:

> 'a person or body that, under the law of the State or Territory in which the care recipient is provided with aged care, can give informed consent to:
>
> > (a) the use of the restrictive practice in relation to the care recipient; and
> > (b) if the restrictive practice is chemical restraint—the prescribing of medication for the purpose of using the chemical restraint; if the care recipient lacks the capacity to give that consent'.

Under s15FA(1)(f) of the amended Quality of Care Principles, a restrictive practice in relation to a care recipient may only be used (amongst other requirements) if:

> 'informed consent to the use of the restrictive practice has been given by:
>
> > (i) the care recipient; or
> > (ii) if the care recipient lacks the capacity to give that consent—the restrictive practices substitute decision-maker for the restrictive practice'

(See Sch 1, *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021*).

[12] Recommendation 4a. This recommendation was adopted and since 1 July 2021, the language of "'restrictive practices" rather than "restraint" is used in the Aged Care Act and Quality of Care Principles (Sch 1, *Aged Care and Other Legislation Amendment (Royal Commission Response No.1) Act 2021*). In addition the definition of "restrictive practice" has been expanded to include chemical, environmental, mechanical and physical restraint as well as seclusion (Sch 1, the *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021*).See also amended s15E of the Quality of Care Principles for the definitions of each of these terms.

9 The enhancement of oversight mechanisms[13] and the requirement for behaviour support plans specific to the aged care (and dementia care) context[14] were also recommended.

10 It is clear from this that as members of the Australian Guardianship and Administration Council (AGAC), we are all working in areas subject to intense scrutiny and further legislative reform at a federal level in the near future.

11 My aim in this paper is to provide an overview of the matters raised in guardianship applications made to NCAT since the reform measures commenced at the federal level. This paper does not seek to assert that the cases determined by NCAT provide all of the answers to some of the very vexed questions raised by issues involving the use of restrictive practices, but seeks to provide an overview of some of the issues that we have been grappling with in the applications coming before this Tribunal.

12 I note that in all guardianship matters dealt with by the Guardianship Division of NCAT, the Tribunal must have regard to the general principles set out in s 4 of the *Guardianship Act 1987* (NSW) ("Guardianship Act") which provides as follows:

> It is the duty of everyone exercising functions under this Act with respect to persons who have disabilities to observe the following principles—
>
> (a) the welfare and interests of such persons should be given paramount consideration,
>
> (b) the freedom of decision and freedom of action of such persons should be restricted as little as possible,
>
> (c) such persons should be encouraged, as far as possible, to live a normal life in the community,
>
> (d) the views of such persons in relation to the exercise of those functions should be taken into consideration,
>
> (e) the importance of preserving the family relationships and the cultural and linguistic environments of such persons should be recognised,

[13] Recommendation 9.
[14] Recommendations 7 and 10c.

(f) such persons should be encouraged, as far as possible, to be self-reliant in matters relating to their personal, domestic and financial affairs,

(g) such persons should be protected from neglect, abuse and exploitation,

(h) the community should be encouraged to apply and promote these principles.

13 I also note also that the published decisions I discuss below consider these issues against the backdrop of the Quality of Care Principles as they exist at the current time, that is, as of March 2021 when this presentation was given.

Impact of new federal regulatory regime on work of NCAT

14 Prior to the changes first made to the Quality of Care Principles in July 2019, NCAT had received relatively few applications seeking the appointment of a guardian concerning the use of restrictive practices for people living in residential aged care. This was despite anecdotal evidence that restrictive practices have been utilised in aged care settings for a very long time.

15 Why is this a cause for concern?

16 Practices that would be likely to amount to assault, false imprisonment or detinue under the common law will be unlawful unless informed consent to the use of the practice is given by the affected person. However, if the affected person is unable to provide informed consent, consent must be sought from another person who has the legal authority to give or withhold consent to the use of the practice. In relation to adults living in NSW, that substitute decision maker may be a guardian appointed under the *Guardianship Act* who is appointed with the authority to make decisions as to whether or not restrictive practices should be used in relation to the person for whom they are the appointed guardian.[15]

[15] The use of restraint may be otherwise authorised, justified or excused by law, but is not the focus of discussion in this paper (see *Darcy (bht Diane Aldridge) v State of NSW* [2011] NSWCA 413, [2] (Allsop P); *State of New South Wales v McMaster* [2015] NSWCA 228, [216]-[225] (Beazley P, with

17 The relative trickle of applications received by the then Guardianship Tribunal and now Guardianship Division of NCAT over many years, despite the anecdotal evidence that various forms of restraint have been used for many years in aged care settings, is consistent with the following conclusion reached in the Royal Commission's Final Report:[16]

> Restrictive practices have been identified as a problem in aged care in Australia for more than 20 years. Their use has been considered in several reviews. Many recommendations for reform have been made but not fully implemented. Restrictive practices are activities or interventions, either physical or pharmacological, which restrict a person's free movement or ability to make decisions. Where this occurs without clear justification and clinical indication, we consider this to be abuse. Not only do restrictive practices have questionable success in minimising changed behaviours, they can result in serious physical and psychological harm, potentially increasing health complications and, in some cases, can cause death. Their inappropriate use is substandard care.

18 Whilst neither the *Aged Care Act 1997* (Cth) nor the Quality of Care Principles bind NCAT (*VZM* [2020] NSWCATGD 25 ("VZM") at [57(1)]; *HZC* [2019] NSWCATGD 8("HZC") at [44]), there are nevertheless two particular issues relevant to the guardianship jurisdiction exercised by the Guardianship Division of NCAT that have arisen from the regulatory changes made at the federal level and the increased attention given to these matters by the Royal Commission into Aged Care Quality and Safety.

Practical impact

19 The first issue is the practical impact of these changes. The regulatory focus on the use of restraints in aged care, and in particular the related material published Aged Care Quality and Safety Commission, has led to an increase in applications before NCAT concerning the use of restrictive practices in aged care facilities. This has not been the avalanche of applications from facilities that we were anticipating, but certainly a steady stream of

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whom McColl and Meagher JJA agreed); *State of New South Wales v Riley*, [84]-[85] (Hodgson JA, with whom Sheller JA and Nicholas J agreed; SZH [2020] NSWCATGD 28, [140]-[150]; Chandler, K, White, B, & Willmott, L (2016) The doctrine of necessity and the detention and restraint of people with intellectual impairment: Is there any justification? *Psychiatry, Psychology and Law*, 23(3), pp. 361-387.

[16] Volume 2, p 97.

applications and significantly more than before the changes were first made in 2019.

20 The increase in applications led the Guardianship Division to take similar steps to those it took when the rate of applications prompted by the NDIS started increasing in the early days of the roll out of that scheme in NSW. These steps have included the following:

- The Guardianship Division Registry alerts the executive team to all applications received involving a resident in aged care and the use or proposed use of a restrictive practice/s.

- A watching brief is maintained for potential "test cases". We were particularly concerned to identify those applications for guardianship that suggested that the issue of whether a practice amounts to chemical restraint or medical treatment would be contentious. We were also alert to those matters in which the formulation of conditions in a guardianship order that were attached to use of restraint in aged care would need to be considered given the absence of the kind of behaviour support planning present in NDIS matters.

- Applications raising similar, potentially significant issues, have been carefully case managed. This is what occurred in relation to guardianship applications for six residents of two different residential aged care facilities. These applications concerned, amongst other things, consideration of whether a locked facility (*SZH* [2020] NSWCATGD 28 ("SZH")) and a locked dementia ward within an aged care facility (*JFL* [2020] NSWCATGD 32 ("JFL")) for the particular residents could constitute the tort of false imprisonment and a restrictive practice that may lead to the appointment of a guardian. These were contested matters in which a separate representative was appointed for all six individuals, none of whom had family or friends involved in their lives; the Public Guardian as a statutory party was granted leave to be represented by the Crown Solicitor's Office and

Counsel at the hearings; and detailed written and oral submissions were made.

- At least one day a month, applications are listed for hearing involving individuals living in residential aged care and the proposed use of restrictive practices. A specially selected three member panel is listed to hear these matters.[17] Along with an experienced Senior (Legal) member, these panels are constituted by members with appropriate expertise in the aged care sector including Senior (Professional) members who are geriatricians, psychogeriatricians or who otherwise have professional expertise in the area of behaviour support and restrictive practices and General (Community) members with expertise in this area.

- As many decisions as possible on these issues are published on NSW Caselaw. This ensures that all of those involved in this area, including prospective applicants, can understand how NCAT has determined other cases in accordance with the object that NCAT's processes are open and transparent.[18]

Do the Quality of Care Principles provide an alternative decision-making pathway to guardianship orders in NSW?

21 The second significant issue that has arisen for consideration is whether the Quality of Care Principles provide an alternative pathway, in NSW, for substitute decision making that could avoid the need for a guardianship order to be made. This is highly relevant to NCAT's jurisdiction as one of the mandatory considerations that the Guardianship Division of NCAT must consider when deciding whether or not to make a guardianship order is "the practicability of services being provided to the person without the need for the making of such an order": Guardianship Act, s 14(2)(d).

[17] When hearing an application for guardianship (a 'substantive Guardianship Division function'), NCAT must be constituted by three Division members: *Civil and Administrative Tribunal act 2013* (NSW) ('CAT Act'), Schedule 6, clause 4(1).
[18] CAT Act, s 3(f).

22 Under the Quality of Care Principles in their current form,[19] if the person living in residential aged care (called the "consumer") is unable to give their own informed consent to the use of a restraint, then the aged care provider may seek consent from the person's "consumer representative". These terms are defined in s 5 of the Quality of Care Principles as follows:

> (1) Representative, of a consumer, means:
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> (a) a person nominated by the consumer as a person to be told about matters affecting the consumer; or
>
> (b) a person:
>
> (i) who nominates themselves as a person to be told about matters affecting a consumer; and
>
> (ii) who the relevant organisation is satisfied has a connection with the consumer and is concerned for the safety, health and well-being of the consumer.
>
> (2) Without limiting subparagraph (1)(b)(ii), a person has a connection with a consumer if:
>
> (a) the person is a partner, close relation or other relative of the consumer; or
>
> (b) the person holds an enduring power of attorney given by the consumer; or
>
> (c) the person has been appointed by a State or Territory guardianship board (however described) to deal with the consumer's affairs; or
>
> (d) the person represents the consumer in dealings with the organisation.
>
> (3) Nothing in this section is intended to affect the powers of a substitute decision-maker appointed for a person under a law of a State or Territory.

[19] As noted in FN 11, as a result of the amendments introduced by the *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021*, the definition of "consumer representative was replaced on 1 July 2021 with the definition of "restrictive practices substitute decision maker". Along with the new "informed consent" requirement in s 15FA(1) of the amended Quality of Care Principles, the effect is that if a care recipient lacks capacity to give their own informed consent to the use of a restrictive practice, then only their "restrictive practices substitute decision maker" will be able to do so. This is a person or body that has the authority to give informed consent to the use of a restrictive practice under the applicable State or Territory regime (see ss 4 and 15FA(1)(f) of the amended Quality of Care Principles).

23 Put simply, if the Principles set out a pathway for substitute consent to be provided for physical restraint, then why does a guardian under the Guardianship Act need to be appointed?

24 The answer to this question was addressed in VZM, that is, that a guardian *does* need to be appointed for a person in residential aged care in NSW in relation to the use of a restrictive practice if the person is incapable of giving their own consent. This is because only a guardian appointed with the appropriate authority can make lawful that which would otherwise be unlawful (VZM, [60(4)]). Unless a person's "consumer representative" under the Quality of Care Principles is also the person's appointed guardian with appropriate authority, consent given by a "consumer's representative" under the Principles to the use of a restrictive practice or restraint on a person is unlikely to amount to a defence under the common law applied in NSW to actions that could amount to assault, battery and unlawful imprisonment.

25 The decision sets out the Tribunal panel's consideration of this issue as follows:

> [47] Whilst there is no statutory definition of restrictive practices and/or physical or chemical restraint under NSW legislation, it has been long recognised in the jurisprudence developed by the Tribunal that the use of restrictive practices for a person who is unable to provide their own informed consent potentially leads to some of the most serious infringement of rights to personal autonomy and freedom of movement. This jurisprudence has also developed to ensure that practices used in relation to a person that would otherwise be unlawful under the common law (such as assault, false imprisonment and detinue) could be utilised in certain specified circumstances if consented to by a guardian with the authority to do so.

26 After providing an analysis of the consumer representative provisions, the Tribunal noted as follows (at [60(4)]:

> [60(4)] Therefore, whilst a provider may comply with the Principles by seeking the consent of a "consumer's representative" in order to meet its reporting obligations under the *Aged Care Act* in relation to the use of physical restraint, only a guardian appointed pursuant to the *Guardianship Act* with the appropriate decision making authority will have the legal authority to consent to the restraint if the person is

> incapable of giving their own consent. The inclusion of s 15E in the Principles (Pt 4A "does not affect the operation of any law of a State or Territory in relation to restraint") appears to acknowledge as much noting however, as previously discussed, that the *Guardianship Act* does not make reference to restraint or restrictive practices in the text of the legislation. The role of a substitute decision maker appointed under State or Territory law is also expressly acknowledged in ss 5(2)(c) and (3) of the Principles dealing with the definition of "representative".

What types of restraints are being raised in guardianship applications?

27 So far, NCAT has received applications seeking the appointment of a guardian to address the following practices:

- Chemical restraint[20]
- Bed rails[21]
- Low lying beds[22]
- Beds being pushed up against a wall[23]
- Facilities locked by way of coded keypads on the front door and front gate[24]
- Locked dementia specific units within a locked aged care facility[25]

28 Whether or not these practices have in fact been found to constitute a restrictive practice has required consideration of the evidence provided in each matter including in relation to the subject person's individual circumstances.

29 The challenges involved with identifying whether something is a restrictive practice was recognised in the Royal Commission's Final Report (Vol 3A) (p 112):

[20] NBT [2021] NSWCATGD 2; BZW [2020] NSWCATGD 3 ("BZW"); JFL [2020] NSWCATGD 32 ("JFL").
[21] VZM; OZS [2021] NSWCATGD 1 ("OZS"); OZQ [2020] NSWCATGD 40 ("OZQ").
[22] FNX [2021] NSWCATGD 4.
[23] SZH.
[24] SZH.
[25] JFL; OZQ [2020] NSWCATGD 40; NBT [2021] NSWCATGD 2; BZW.

> Whether something is a restrictive practice that requires regulation often depends on the circumstances. Placing a person in a deep chair from which they are unable to stand may be appropriate because it is done for the person's comfort and with their informed consent. However, placing a person in a deep chair to prevent their free movement, or without regard to the effect of this on their free movement, is restrictive and should be regulated. However 'restraint' is defined, identification of whether a practice is a restraint should focus on whether the practice restricts free movement or capacity to make choices. This should not be confused with any purpose or justification for the practice.

30 Highlighted below are some of the issues that have arisen in several NCAT decisions that may be of interest.

Definitions of restraint in Quality of Care Principles

31 As noted earlier, under the current form of the Quality of Care Principles, only two types of restraint are defined – chemical and physical restraint.[26]

32 The terms "restraint", "physical restraint" and "chemical restraint" are defined in s 4 of the Principles as follows:

> ***restraint*** means any practice, device or action that interferes with a consumer's ability to make a decision or restricts a consumer's free movement.
>
> ***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 prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.

[26] As noted in FN 12, as a result of the amendments introduced by the *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021*, the definition of "restrictive practice" has been expanded to include chemical, environmental, mechanical and physical restraint as well as seclusion (Sch 1, the *Aged Care Legislation Amendment (Royal Commission Response No.1) Principles 2021.* See also amended s15E of the Quality of Care Principles for the definitions of each of these terms.

33 In VZM, the Tribunal considered these definitions, considered whether they were consistent with NCAT's use and understanding of these restrictive practices and concluded that it is the best interests of people to whom the Principles apply that the Tribunal adopt those descriptions of restraints when dealing with applications concerning residents of aged care. The reasoning for this is set out as follows:

> [52] In HZC the Tribunal adopted these definitions [ie under the NDIS] on the basis that it "would be in the best interests of people with whom restrictive practices are being used in NSW, for there to be some consistency in the way definitions are applied throughout the quality and safeguards arena and within the Tribunal" (at [45]).
>
> [57(2)] There would, however, seem to be equally sound reasons as those expressed in *HZC* as to why it would promote the welfare and interests of people in relation to whom restrictive practices are being used in residential aged care facilities in NSW for there to be some consistency in the way definitions are applied in the aged care arena and within the Tribunal: s 4(a) of the *Guardianship Act*.

34 It was acknowledged in VZM (at [57(3)]) that by adopting this approach two different sets of definitions of restrictive practices would be created, depending on whether a person was living in residential aged care and subject to the Principles, or was an NDIS participant. The Tribunal noted that this was "a reality created by the two different federal regulatory regimes" (ibid).

Chemical restraint

35 The issue of whether medication is being used to chemically restrain a person in aged care or whether it is being used to treat a medical condition is probably the most vexed issue in the matters dealt with so far.

36 The line between these two findings is not always a bright or clear one. As noted in JFL (at [59]):

> [59] The resolution of this issue requires consideration of a person's individual circumstances and the evidence provided to the Tribunal about the reason for the administration of the medication. Wherever possible, this should involve evidence directly from the prescribing specialist and if no specialist, the person's general practitioner.

37 Unfortunately, the prescribing medical practitioner is not always available to give oral evidence and NCAT has had to make findings based on the written evidence before it and oral evidence of the applicant/care provider.

38 An example of some of the practical difficulties faced by the Tribunal depending on the nature of the written evidence and availability of witnesses to give oral evidence is explained in BZW (at [33]-[35]):

> [33] Ms Z [the care manager at the aged care facility] told us that BZW had settled well into that aged care facility and anti-psychotic medication that was initially prescribed for him had been ceased. However over the past 8 to 12 months, BZW had become increasingly agitated and aggressive. After a number of incidents of aggression he was seen by Dr Y, a psychogeriatrician who had prescribed Risperidone on a regular basis to control his behaviour.
>
> [34] HAW said that she had been consulted as BZW's 'person responsible' and had consented to the use of medication to calm BZW as he had been refusing to be showered and had been attempting to leave the facility.
>
> [35] We note that BZW's medication chart lists Rixadone (risperidone) for treatment of "psychotic aggression". We were unable to speak to Dr Y or Dr X, who is BZW's General Practitioner, to obtain further evidence as to whether that treatment should be characterised as treatment of a medical condition as opposed to chemical restraint of behaviour. However taking into account the evidence of Ms Z we were satisfied, on balance, that the primary purpose of the medication is to control BZW's behaviours of concern that include aggression, and that, therefore, its purpose is to control his behaviour by chemical means.

Is the person being physically restrained?

39 Applications for guardianship have been received seeking the appointment of a guardian in relation to the use of a low-lying bed, bedrails and having the person's bed pushed up against the wall of their bedroom.

40 These are all practices that in material published by the Aged Care Quality and Safety Commission are described as physical restraint for the purposes of regulatory oversight provided by the Commission.

41 But are they necessarily restrictive practices that may lead to the appointment of a guardian?

42 In the following cases, after examination of the evidence about the use of the practice and the circumstances of the individual, the conclusion was reached that the practice in question does not amount to a restrictive practice.

Bed pushed against bedroom wall

43 In SZH, the applicant for the guardianship order, a manager of an aged care facility, sought the appointment of a guardian for, amongst other things, the practice of pushing the bed of the person concerned against a wall of his bedroom. The applicant relied upon the information contained within a Regulatory Bulletin issued by the Aged Care Quality and Safety Commission[27] that "advise[s] that a bed against the wall or use of bed rails is "in general … restricting the free movement of the person using that bed and is therefore considered a restraint" (at [50]).

44 The Tribunal found on the basis of the particular facts of that case, however, that person was not being physically restrained because "although one side of SZH's bed is placed against a wall, he is not prevented from getting into and out of the other side of his bed. He is physically able to do so of his own accord" (at [55]).

Low lying bed

45 In FNX, the Tribunal had to consider whether the use of a low-lying bed constituted physical restraint. The evidence given about the use of the low-lying bed was set out as follows:

> [47] LZT gave evidence that FNX's bed is operated as a "low low" bed, meaning her bed is raised when she wishes to get into bed, and then lowered immediately once she is in bed, for safety reasons – to mitigate the risk of harm if she were to roll or fall out of bed. She has crash mats placed around her bed whenever she is in bed, to soften

[27] Entitled "Regulation of physical and chemical restraint" (Issue No.2019-8.1 Issue Date: 11 December 2019).

her fall if she were to roll or fall out. LZT indicated that this happens "very very frequently and [FNX] consistently rolls out of bed" creating a risk of injury. LZT could not recall exactly when the low low bed was instituted for FNX, however, said it was sometime in March 2020 after her stroke.

[48] LZT told the Tribunal the low low bed was not being used to prevent FNX from getting out of bed, but was for her safety to reduce the height at which she might roll out. At both heights at which the bed is placed, that is, both the high setting when FNX goes to bed, and when the bed is lowered once she is in bed, she is unable to leave her bed without "lots of assistance" from staff. LZT said that if FNX tried to leave her bed by herself when on the high setting, she would likely fall. She is unable to leave her bed of her own accord, other than rolling out, when it is on the low setting.

46 The Tribunal concluded that the use of the low-lying bed, on the particular facts of this case, did not amount to a restrictive practice. The Tribunal stated:

[51] On the facts available to us, we find that although FNX is unable to purposefully leave her bed when it is on the low-lying setting, this is also the case when it is on the high setting, that is, she requires assistance to leave her bed no matter the height of the bed. On that basis, we conclude that the use of a low-lying bed for FNX, when on its low-lying setting, does not amount to a physical restraint as that term is defined under s 4 of the Quality of Care Principles. Nor does it constitute a restrictive practice not otherwise captured by that definition as it is not a practice that would otherwise be unlawful under the common law (VZM, [47]). We note that the purpose of the low-lying bed is to ensure FNX's safety should she accidentally roll out of bed.

Bedrails

47 In the case of VZM, the Tribunal found that the use of bedrails in the circumstances of VZM's situation did not amount to a restrictive practice. VZM has lived in a residential aged care facility for many years following a brain haemorrhage. As a result, VZM requires high-level, 24-hour-a-day care, has quadriplegia, no free movement, and has significant cognitive impairment. VZM's husband and sister are very close to her and for many years had agreed to the use of bedrails to prevent the risk of VZM accidentally falling out of bed. Cushions were also used to support VZM when she was positioned on either side of her body and the bedrails allowed the cushions to be used in this manner. Since January 2020 bedrails had not been used based on the care provider's understanding of the amended Quality of Care Principles and

that only an appointed guardian could consent to their use. Since the use of the bedrails were ceased, evidence was given that VZM's bed was lowered to reduce possible injury if she were to accidentally fall out of bed.[28] As a consequence she was deprived of any view through a single window into the garden as she was too low to see out, and her family was concerned that she experienced colder temperatures because her bed was closer to the ground.[29]

48 The Tribunal concluded that the use of bed rails does not constitute a restriction on VZM's free movement as it is her physical condition that restricts her movement. In her particular case, the use of bed rails prevent her rolling out of bed by accident which, if it occurred, would cause her serious harm; they allow her to be positioned in ways other than on her back; and they allow her to have better access to a view out of her window.[30] The guardianship application was dismissed.

49 Similar findings were made in other published decisions.[31]

Locked aged care facilities

50 As noted earlier in this paper, NCAT has recently considered the issue of locked aged care facilities.

51 Academic consideration and policy discussion of this issue is not new.[32] The Royal Commission's Final Report specifically noted that:[33]

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[28] VZM, [28].
[29] VZM, [28].
[30] VZM, [63].
[31] OZS, OZQ.
[32] See, for example, Steele L, Swaffer K, Phillipson L, Fleming R. Questioning Segregation of People Living with Dementia in Australia: An International Human Rights Approach to Care Homes. *Laws*. 2019; 8(3):18. https://doi.org/10.3390/laws8030018; Allen J, Tulich T. 'I Want to Go Home Now': Restraint Decisions for Dementia Patients in Western Australia. LiC [Internet]. 2018Dec.22 [cited 2021Aug.9];33(2). Available from: https://journals.latrobe.edu.au/index.php/law-in-context/article/view/53; Chandler,K, White, B, & Willmott, L (2017) What role for adult guardianship in authorising restrictive practices? *Monash University Law Review*, *43*(2), pp. 492-529; Senate Standing Committee on Community Affairs, Report Indefinite detention of people with cognitive and psychiatric impairment in Australia, 29 November 2016 (https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/IndefiniteDetention45/Report).

> Inconsistencies in the definition of 'restraint' contribute to uncertainty about its prevalence and lawful justification for its use. For example, secluding a person in a residential unit or confining a person to a place where they are not free to leave is restrictive and may deprive the person of their liberty. A national approach should clarify definitions of restrictive practices, as well as the circumstances in which a person may be detained and the legal safeguards that apply.

52 In the matter of SZH, the Tribunal considered the situation of a man living in the general area of an aged care facility that used coded keypads at all exits, none of which SZH could utilise due to the extent of his cognitive impairment.

53 The applicant, who was the manager of the aged care facility in which SZH lives, applied for a guardian to be appointed on the basis that SZH was being restrained by the use of the coded keypads.

54 The applicant gave evidence that she based her understanding of this issue on the information contained in a Regulatory Bulletin issued by the Aged Care Quality and Safety Commission[34] as follows:

> **7. Is the use of a coded key pad on doors to exit the facility considered a restraint?**
>
> Yes. Aged care providers may require consumers to use a PIN-code to exit the home. If the PIN code is not provided to the consumer, or if they are unable to use the PIN-code for other reasons (such as poor memory, vision impairment, out of reach), this restricts their ability to leave the home. A physical environment that restricts consumers' free movement is a physical restraint. The organisation must take the steps set out in the Principles for consumers who are subject to this form of restraint.
>
> The Commission would be looking for evidence that physical restraints of an environmental nature are based on the least restrictive option. For example, for consumers who have been assessed by an approved health practitioner as requiring this type of restraint due to a risk of harm to themselves or others, has the basis for this decision been noted in their care and services plan, is the decision for this restraint transparent and is it reviewed as circumstances change.
>
> Under the Quality Standards, the service environment is expected to promote the free movement of consumers including access to outdoor areas even if for safety reasons some consumers' access or egress is restricted.

[33] Volume 2, p 112.
[34] Entitled "Regulation of physical and chemical restraint" (Issue No. 2019-8.1 Issue Date: 11 December 2019).

> Arrangements to protect consumers need to be in line with their assessed care and services plan and the least restrictive option for them.

55 Following consideration of the written and oral submissions made on behalf of the Public Guardian, the applicant and the separate representative for SZH, and after undertaking an analysis of the common law authorities relevant to the tort of false imprisonment, the Tribunal set out its understanding of the relevant legal principles, summarised as follows:

> [127] Having regard to the authorities discussed above we have identified the following principles as being relevant to our consideration of this matter:
>
> (1) whether a person is restrained is a question of fact to be determined on all of the available evidence as to the person's circumstances and the nature and extent of the restraint said to be imposed upon the person's freedom of movement and liberty (*Re: EUY* [2019] SACAT 51 at [82]);
>
> (2) the placing of "total restraint" on the person's movement is required in order to constitute false imprisonment. That "total restraint" need bear no similarity to what might normally be described as imprisonment. Compulsion, even of the mildest kind, to remain in a place, leave only with permission and to return to the place, may nevertheless be sufficient (*Darcy (bht Diane Aldridge) v State of NSW* [2011] NSWCA 413, [153]). Any "restraint within defined bounds which is a restraint **in fact** may be imprisonment": (*Meering v Grahame-White Aviation Co. Ltd* (1920) 122 L.T. 44 at 53-54) (emphasis added);
>
> (3) the use of force or direct physical contact is not necessary in order to establish that a person is restrained;
>
> (4) lack of fault, in the sense of absence of bad faith, is irrelevant to whether a fact finding of detention may be made;
>
> (5) it is not necessary to find that the alleged restraint is against the person's will. A finding that restraint has occurred is possible even though the person is unaware that they are being restrained;
>
> (6) it is not necessary to find that the person has expressed a desire to end the detention, has taken active steps to do so or is physically able to do so.

56 The Tribunal concluded that the conditions under which SZH lives at his aged care facility involve a total restraint on his freedom of movement. This is because SZH is unable to unlock the front door and gate of the facility, is unable to leave the facility unless he is accompanied and must be returned to the facility if he leaves.[35] This finding was made even though the Tribunal was satisfied that SZH was unaware of being restrained, has never asked to leave the facility or attempted to leave of his own accord.[36]

57 The Tribunal went on to consider whether to appoint a guardian for SZH having regard to the principles set out in s 4 of the Guardianship Act and ultimately determined to do so. In arriving at this decision, the Tribunal referred to the obligation on the Tribunal to observe the principle set out in s 4(c) that a person who is the subject of proceedings under the Act "should be encouraged, as far as possible, to live a normal life in the community". The Tribunal noted that it "does not promote SZH's right to live a normal life in the community … if his living arrangements constitute false imprisonment [as] other members of the community do not expect to be restrained in this manner".[37] The Tribunal concluded:

> [160] In our view, it would promote SZH's welfare and interests (s 4(a) of the *Guardianship Act*) for a guardian to be appointed to decide upon the circumstances of his restraint. Due to the impact of SZH's cognitive impairment, he is unable to give or withhold consent to the circumstances in which he is living. It is appropriate and in his interests for a guardian to have the authority to do so in his stead. Providing a guardian with this authority recognises not only the fundamental importance of SZH's right to freedom of movement and liberty, but also ensures that any restriction on those rights (ss 4(b) and (c) of the *Guardianship Act*) is properly considered by someone with the legal authority to do so in circumstances where SZH is unable to do so on his own behalf.
>
> [161] After careful consideration of all matters relevant to SZH, a decision may be made to consent to the restraint. Alternatively the decision may be to withhold consent. What may flow from the latter decision would be a matter for the appointed guardian taking into account all of SZH's circumstances.

[35] SZH, [135].
[36] SZH, [137].
[37] SZH, [155].

58 The reasoning in SZH has been adopted in other cases involving the circumstances of a person living in a secure dementia-specific unit within an aged care facility.[38]

Conclusion

59 Different legislative regimes exist in each of the states and territories as to the regulation of restrictive practices. As previously noted, in NSW there is currently no legislation dealing with restrictive practices.[39] Jurisprudence has developed over time within the then Guardianship Tribunal and now Guardianship Division of NCAT to deal with these important matters.

60 The issues and cases discussed in this paper aim to demonstrate some of the complexities of this area given the interaction of federal regulatory processes on the state-based guardianship jurisdiction exercised by NCAT.

61 In conclusion, I hope that the experience to date of the Guardianship Division of NCAT as outlined in this paper is of interest and may be of assistance to other Boards and Tribunals in the context of ongoing federal reform processes in aged care.

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[38] JFL [2020] NSWCATGD 32; BZW [2020] NSWCATGD 38; NBT [2021] NSWCATGD 2.
[39] Note, however, the Persons with Disability (Regulation of Restrictive Practices) Bill 2021.