

CORRECTED VERSION

LAW REFORM COMMITTEE

Inquiry into powers of attorney

Melbourne — 14 December 2009

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Witnesses

Mr P. Zanatta, Manager, Community Care, Policy and Small Rural Health; and

Ms J. Hadgraft, Manager, Residential Services, Aged and Community Care Victoria.

The CHAIR — Thank you, Janice Hadgraft and Paul Zanatta, for coming this morning and for your submission. Hansard will be recording our conversation this morning and you will receive a copy of the transcript later. You can make some slight editorial changes but obviously no changes to the substance. Our discussion this morning is also covered by parliamentary privilege. This basically means that if you say things that are actionable by somebody else they will not be able to take action against you for any comments or observations you make but if you make those same observations outside this hearing you will not be afforded that protection.

We have just under half an hour now, I am afraid, but we will be quick. We will hand it over to you for 10 minutes or so and then we might have a few matters to raise with you that come out of your comments and out of your submission.

Mr ZANATTA — Thank you. Kerryn Riseley kindly gave a briefing as to the nature of the Committee and this has given me an opportunity to consolidate my thinking around the recommendations we have made. I suppose probably one of the most primary considerations is that there is a need for general public education, both with the general public and with health and legal professionals. That is largely because there still tends to be in the community quite a degree of misunderstanding or confusion about what the instruments are and what people are authorised to do when they have been appointed as a power of attorney under those various instruments.

We particularly make the point that it would probably be very good to try and bring the three instruments together into one instrument, in a sense making the instrument into three distinct modules so that people have those modules — the enduring power of attorney for administrative and financial matters, the enduring power of guardianship and the enduring power of attorney, medical, side-by-side so that when people make such powers of attorney they can be very clear about the fact that there are three different types of instruments which have three different purposes.

We believe in the first instance that people often misunderstand those purposes. The most common instrument one tends to see in the aged care industry with regard to people who are residents of residential aged care facilities or are clients being supported in the community by community aged care services would be an enduring power of attorney for administrative and financial matters.

Less commonly does one see an enduring power of guardianship or an enduring power of attorney, medical. Having the three instruments side by side would enable people to see that they are three quite distinct types of power authority. I will hand over to Janice to make some comment about that.

Ms HADGRAFT — My background is working from the residential sector, so a lot of what I see is how it plays out in a practical sense. Probably one of the big issues that happens is that someone comes in, hopefully with some sort of power of attorney. It is most likely to be financial but a lot of the decisions that end up being made after that are often towards the medical point of view.

What will then happen is that there is confusion on both sides. There is confusion from the facility's point of view in trying to work out who they should be speaking to. The other thing that will happen is that the person with the power of attorney will tend to assume responsibility for all decision making. It obviously becomes potentially problematic when there are multiple viewpoints within the family and the person with the enduring power of attorney will say, 'No, you cannot talk to Mary about this because I am making all those decisions'. It then becomes very muddy as to who exactly should be consulted about various things. Probably that is the biggest concern we have.

The other thing that tends to happen as part of that is that someone may well come into a facility who has a reasonable amount of competency, and their idea of having the power of attorney, financial, is so that they do not have to be bothered with a lot of the financial things, whether it be paying the bills or whatever. But then what tends to happen is that a lot of the conversations on a practical level from then on can easily end up being between the power of attorney and the facility, and even if the resident has a reasonable ability to participate in those conversations, it is very easy for them to get isolated.

Mr ZANATTA — What is very interesting is that guardianship and administration orders that used to be made under GAB and are now made under VCAT become executable immediately upon that order being made. There is no known trigger point for a power of attorney, so one has to pass tests of having some form of

testamentary capacity. You have to be able to know that you are appointing someone to potentially make decisions on your behalf, and you have to have the capacity to be able to do that when you make a power of attorney. However, at some point that power of attorney is executed and it comes into play, and yet there is no process for asking, ‘When does that happen?’, unlike going to a hearing of VCAT with regard to guardianship administration, because the two questions at a guardianship administration hearing are, firstly, the person is not capable of managing their affairs independently, and secondly, they are not capable of appointing someone to do that; hence the order is made. But that does not happen.

It can come to the point where, as Janice pointed out, perhaps someone has mild dementia, physically they are quite frail and they end up in a residential care facility. Someone has a power of attorney for managing their financial affairs, but the person might still want to be consulted on some of the bigger picture issues of their finances — for example, whether or not their house is sold, whether or not the share portfolio they have had for 20 years is sold, or they might want to give money away to family members. Just because they might not be able to very easily execute the day-to-day machinations of managing their finances does not mean that they do not know in a broad sense what is going on and where they would like their money to be. On the broader issue of their intent and their consent in relation to their intentions, how the power of attorney works with the person possibly needs greater clarity.

Ms HADGRAFT — The other thing that happens is that they will often have that financial power of attorney organised, and then as they become more frail and perhaps unable to participate in decision making at all you end up with a potential gap in the decision making for the person’s care needs. I have traditionally seen it quite a bit where you have either a dysfunctional family where no-one wants to have anything to do with the relative, or else when they have no family members and you may well have someone like, potentially, their longstanding accountant or somebody who may be covering that financial part quite well, but then you have a gap in their care needs. Decisions being made about their care and medical decisions end up coming down to a combination of the GP and the health professionals within the facility who do not necessarily have a longstanding history with the family and do not necessarily really know what their intentions may be.

I am not sure that it is necessarily the best outcome for anyone; for this proxy to be happening, for the responsibility to need to be taken by the people in the facility. That is not to say they may necessarily be making bad judgements, but it should not be part of their role; their role should be a result, generally, of the care rather than decision-making primacy for the patient.

Mr ZANATTA — I will further cover some of the main points, and we might come back to that issue a bit more. We have also made a point here about having enduring powers of attorney registered such that when people enter a health-care institution or an aged residential-care facility, or they come into the purview of an aged community-care service, that certain groups or classes of organisation, such as approved providers of aged residential-care facilities, might be able to then look up and actually establish that there is someone who has an enduring power of attorney. That would allay a lot of confusion.

If you consider the situation, for example, of a person who might be fairly isolated, however, they have actually appointed someone as a power of attorney at some stage in their lives either for administrative, financial or guardianship purposes or medical treatment purposes. They present to an emergency department because, for example, they have collapsed and perhaps had a stroke, and they are not in a very high state of consciousness. It would be very good if the power of attorney could actually be looked up on some sort of register and established.

At the same time with the Commonwealth potentially moving as part of the recommendations of the National Hospitals and Health Reform Commission towards actually having universal e-health medical records, people could even opt in to have that information added to their e-health record, and that would give people greater safety, knowing that in some sort of emergency people would actually be contacting the right decision-makers to act on their behalf.

Ms HADGRAFT — And that also sometimes happens when the power of attorney that you are given when the person comes into the facility is not necessarily the latest one. You have been liaising with one particular person and then all of a sudden three months later or six months later someone pops out of the woodwork with another power of attorney. That certainly has happened.

Mr ZANATTA — You end up with a rock, paper, scissors type of arrangement — ‘I have the most recent version’.

In our submission we also suggested broadening who else can assess competency. There are obviously general practitioners who can, but there are a range of other professionals, particularly the likes of neuropsychologists who work extensively in dementia clinics, nurse practitioners, nurse practitioners who specialise in the area of aged-care work or dementia-care work, or nurse practitioners in the mental health setting who would probably be fairly appropriate people as far as the types of health professionals who might be able to assess competency.

I think there is a bit of work that needs to go on in terms of redefining what we mean by competency in a testamentary capacity, because even I am not too clear about the differences between the two regarding the testamentary capacity in relation to the making of a will versus the test of competency in terms of someone being able to themselves establish the appointment of someone as their power of attorney. I think that would be quite worthwhile.

We have actually suggested that there should be a shelf life for enduring powers of attorney, so that we do not end up in potential situations such as where someone at the same time that they made a will have decided to appoint a person — possibly the person who is going to be the executor of their will — as their power of attorney for some sort of future purpose, and then perhaps what happens down the track is that they revise their will arrangements but neglect to revise their power of attorney arrangements, or in some way that person has become disenfranchised from their life.

You may have situations where people who are disenfranchised in such a way attempt to come back on the scene, wield some sort of authority, and they could perhaps abuse or misuse that authority if they do not have a close relationship with the person. For example, they might take it upon themselves to misappropriate people’s assets or simply appropriate people’s assets not maliciously but in a way that is perhaps precocious to their circumstances, or even in a way that is malicious and is simply an exploitation of their rights. By having at least a shelf life of something like three or five years one would have a greater surety that the person who has made the power of attorney has contemplated it reasonably recently in their lives; it is not something from the dim past.

We have also made a suggestion here regarding the matter of determining when an EPA becomes executable. We have also suggested greater attention be paid to who has right of access to personal and health information. Oftentimes in aged-care facilities, as happens in hospitals, relatives come in and say, ‘How is mum or dad today?’ et cetera. I think what people sometimes do not appreciate is that, technically speaking, even giving away information about someone’s health to a son or daughter is a breach of the person’s privacy. In a facility or a health-care setting one would normally establish with the patient or a resident, as far as possible, ‘Is it okay if I talk to your son and daughter? They rang up’, and the person may say, ‘Yes’.

At times, again when no-one has been appointed to the position, for example, of having an enduring power of guardianship, it may be that inappropriate health information is being divulged — for example, to enduring powers of attorney or even to other people who do not have any power of attorney. I am having some further discussions about that, and I am a little bit thin on the strategic way to pursue that, but I think that we have to be careful. The concept of being a guardian is someone who is actually acting for the person, and one would argue that includes protecting their information privacy as well.

Ms HADGRAFT — Also, on a practical level it is being able to at least have some level of conversation with relatives. On the one hand, there is a lot of talk about pushing that the facility is the resident’s home and it is a home-like environment, and you may well have three or four main people who come in and out all the time visiting, and to not be able to say anything puts a lot of pressure back onto the facility.

Mrs Jones is being visited by her next-door neighbour every week for five years, and then all of a sudden Mrs Jones is unwell and the neighbour rings up and says, ‘Is it okay if I come and visit today?’. Poor Mrs Jones is acutely, terribly unwell, so what does the facility say? ‘No, it is not a very good idea’; ‘Why not?’ ‘It is just not a very good idea, but we cannot tell you why’. It is a really difficult sort of situation that facilities often find themselves in the middle of, and trying to be clearer so that facilities know exactly who they can and cannot talk to is all part of the power of attorney and it is all part of that health information privacy.

Mr ZANATTA — And there may be a greater role for guardians — —

The CHAIR — I am sorry, I am just conscious that we have got 5 minutes left or a little bit more. Please conclude what you were saying.

Mr ZANATTA — I suppose I will say three things. Perhaps we need to pay attention to the role of guardians in terms of giving permission for information like that to be released. The other couple of things is that perhaps the powers of attorney document should be a scheduled instrument to a set of regulations, so that in fact it is a universal document in the same way that a statutory declaration is referenced to the appropriate legislative framework, to avoid people, for instance, buying these instruments or acquiring them online from other jurisdictions when they might not be technically correct. We also need to pay attention to having multilingual versions, because we have a culturally diverse community. Over 35 per cent of the over-65 population by 2013 will be from non-English-speaking backgrounds, so we need to make sure these instruments are also available in non-English versions.

The CHAIR — Just quickly on that last point, you did mention on the outset about developing a single instrument and the value of that, and we are also aware that jurisdictions like New South Wales and Queensland have got a consolidated act as well. Have you had time to have a look at the act and the single instrument in the other jurisdictions at all?

Mr ZANATTA — No.

The CHAIR — You are not able to throw any light on that for us, as to what might be the best model to pursue?

Mr ZANATTA — At face value that sounds like a good idea.

Mr CLARK — I want to follow on from that in a sense. At pages 4 and 5 of your submission you list examples of powers that a holder of an enduring power of attorney seeks to exercise. Your submission suggests that those are examples of powers that the holder is empowered to exercise. Is that in fact not the correct wording of your submission?

Mr ZANATTA — Yes, so what is sometimes happening is that the person with enduring power of attorney, financial, is actually de facto assuming a whole lot of other things that are really in the space of an enduring guardian. We are actually saying that really sometimes people only have one single authority because they have neglected to make any other type of authority, and hence what is happening is that the power of attorney, financial, is receiving reports about the person's health. They are making other decisions about the person and about their physical needs. They are acting as an informal clinical coordinator sometimes, which is really well beyond the scope of — —

Mr CLARK — Can I take you up on that? What is your source for making that statement that those examples there are outside their power?

Mr ZANATTA — Real-life experience.

Mr CLARK — No, I am sorry, it is matter of law; you are saying that they do not have the legal capacity to make those decisions. What is the source of your legal justification? Are you acting on what the OPA — the Office of the Public Advocate — has told you? Has the association had independent advice?

Mr ZANATTA — No, we are acting upon our understanding of what an enduring power of attorney, financial, is.

Ms HADGRAFT — The other thing is that if you see that list, it is more just the general range of things that a facility may need to contact somebody about.

Mr CLARK — I think it is arguable that with the exception of medical treatment decisions all of those items are within the authority of the holder of an enduring power of attorney under the Instruments Act.

Mr ZANATTA — Putting that up against an enduring power of guardianship, and looking at the information that is contained in it, I went back and looked at the source material on the OPA website, where one can download the instruments. The guidelines for those instruments on the OPA website would suggest that in fact the authority for a person who has an EPA financial is narrow, as I suppose I have implied there. These

things are beyond the scope, because that is actually what the guidelines say on the OPA website. If you read the guidelines for all three instruments, and you compare what each instrument is there to do, you would come to the same analysis here as I have arrived at. We treat the information on the website as authoritative.

Mrs VICTORIA — I want to ask about the proposal you put forward about an expiry date of three years for non-active enduring powers of attorney. One of the things we have come across in some of our previous hearings is the cost, and that is why some people do not have these types of instruments in place. The fact is that it is not the cheapest thing to do if you get legal advice and do not do it online or whatever. The cost is prohibitive just to go and renew it, and you are then obviously lodging it again with a lawyer, or if there is a register developed, it would then need to be updated. Is that something you think is necessary, or on balance is it just fairly whimsical?

Ms HADGRAFT — I do not know about whimsical. It is more about trying to make sure that it reflects the person's needs. I understand what you are saying about the cost, but perhaps that should be considered as part of it — whether there is a less expensive way of doing it or of renewing it or something. It is more that if one is done, then nothing happens for absolutely ages. For example, if I was given a power of attorney of someone who was severely cognitively impaired but it was 10 years old, I have to take that at face value, but is it necessarily going to be in the person's best interests when an awful lot of things can happen in 10 years? It is more about that sort of thing, and trying to reflect that person's needs.

Mr CLARK — Going back to the issue of the scope of different powers, and leaving aside what the current legal position may be, in terms of what would be helpful for your centre it seems to me arguable that you do not need to draw a distinction between a medical authorisation and a lifestyle authorisation, because in a sense they almost merge into one. If you are designing these things from scratch, would you find it more helpful to have one set of powers that covers all the personal assistance and non-financial decision making, or contrary to that, do you think it would be better to have separate appointments for medical treatment and for lifestyle — —

Mr ZANATTA — For guardianship. In the same way as it works at the moment for guardianship orders made through VCAT — and I find it a little bit hard to understand the information that is on the OPA website — but I understand there is a distinction in terms of the scope of the order that can be made at VCAT for a guardianship order. You can make a guardianship order that covers lifestyle decisions and then put aside matters medical and make a separate guardianship order for medical. I think that to make a coherent system one would have a parallel process for powers of attorney, so that you may be able to appoint someone as a guardian either with limited or plenary powers, and that would seem to make sense.

The other issue that might come up is that if possible there should always be two guardians appointed rather than one just as a safeguard, particularly I think for medical matters, and in particular for serious medical conditions. It is better to have the wisdom of two people.

The CHAIR — Perhaps just to wrap up, the system in the UK of establishing interested persons — are you familiar with that?

Mr ZANATTA — Kerryn has briefed me.

The CHAIR — Okay. Do you have any views on it, and on how effective it has been?

Mr ZANATTA — The situation is that an interested person could be registered. It is a little bit like a community advocate, or even something like the community visitors scheme, to be if you like another force with a non-binding authority to see that the right decisions are being made. My comment about that is: how does that work if the person does not have an authority? What is the mechanism by which that person is empowered to see them? It might be one thing to observe that decisions are not being made in a person's best interests, but then what is the mechanism to remedy that situation? It could only be useful really if there is some sort of mechanism established so there is a right of appeal for some sort of veto over decision making. A person might perhaps go back to a board or to an ombudsman to say, 'I think the decision making going on here is not good decision making, and therefore we apply to have the decision making overturned' et cetera. Yes, but subject to giving it some teeth.

The CHAIR — The last thing just very quickly is that in your submission you talk about the need for community education, particularly in a sector such as the one you are working in. How might that be

conceived? How do you get a good community education program in this area that would have a positive impact on senior Victorians?

Mr ZANATTA — A model we see that works quite well in our sector is to have at least two if not three levels of education. One is very broad and general; so very simple messages that you get out through pamphlets, videos, CDs and website links to about 90 per cent of the working population of the sector. Then you have high-level education. It is a little bit like the Wisconsin model Respecting Patient Choices that is being used in some health institutions here in Victoria. You train specific people to be the champions of a particular issue or of that particular area of practice in the facility. You go for a broad approach — simple broad messages to the majority and then high-level information, so you bed-in change agents within various organisational settings and they become the go-to person on that particular issue. They have the ability then to resource the rest of their colleagues and peers about those matters.

Ms HADGRAFT — I think also having the ability to be able to call on someone who can give a talk on something. Aged-care facilities will often have residents' relatives meetings where you get someone along and give a talk on something, and that is another way of doing it too.

The CHAIR — We are out of time. On behalf of the Committee I thank you for your submission and also for coming along this morning and sharing some of your expertise with us. It has been very useful. You will receive a copy of the transcript, and it is possible that Kerryn or Kerry might be in touch with you to follow up on matters that we have not been able to canvas properly.

Witnesses withdrew.