Legislative Council

Community Services Legislation Amendment Bill Hansard - Extract

18/06/2002

Second Reading

The Hon. CARMEL TEBBUTT (Minister for Juvenile Justice, Minister Assisting the Premier on Youth, and Minister Assisting the Minister for the Environment) [7.30 p.m.]: I move:

That this bill be now read a second time.

New South Wales has the most complex oversight arrangements of community service providers of any jurisdiction in Australia. The Community Services Legislation Amendment Bill represents a significant reform to these arrangements, whilst retaining and enhancing the protections for vulnerable people in our society. The bill provides for important changes to the roles of the Ombudsman, the Community Services Commissioner and the Coroner. It has been formulated on the basis of some fundamental principles: that the independence of oversighting agencies, the transparency and independence of the review and reporting process and the potential to share information should be strengthened wherever possible; that any gaps or uncertainties in the current system should be remedied; that client access and complaints handling are to be improved; and that none of the current protections in the review and monitoring systems of community services should be weakened. The Government has adhered to all these principles.

The bill simplifies, clarifies and strengthens the roles of the Coroner and the Ombudsman in the review and monitoring system. By amalgamating the Ombudsman and the Community Services Commission, it adopts the best and most effective powers currently available to those organisations. The bill has a number of other key benefits. It removes the jurisdictional uncertainty that currently exists for the Community Services Commission under the Community Services (Complaints, Review and Monitoring) Act 1993. It strengthens the independence of the monitoring, review and complaints handling functions. The Ombudsman can independently report to Parliament and is accountable to a joint parliamentary committee.

The bill creates a single responsible organisation with sufficient powers, skills and resources to undertake its functions. It reduces the chance of gaps in the investigation and handling of complaints. It provides clients with better access to the oversighting system through a single entry point. It enhances the capacity of the Coroner to provide the best system of investigating individual deaths of vulnerable children and people with disabilities. It also ensures the effective transfer of information about these deaths between agencies. The bill provides maximum opportunity for using information from individual deaths to target the monitoring and review of service providers, and to influence changes to systems and practices. It increases resources for improving services to the community by reducing corporate overheads and time spent on interagency duplication. Additional resources will be provided to the Coroner and the Ombudsman to deal with their expanded roles under this proposal.

The system established by the bill has been described by the Community Services Commissioner, Mr Robert Fitzgerald, as the most advanced scheme of its kind in Australia. I now turn to the substance of the bill. The bill will make significant amendments to the Community Services (Complaints, Review and Monitoring) Act 1993, the Coroners Act 1980 and the Ombudsman Act 1974. It will make minor consequential amendments to a number of Acts, including the Adoption Act 2000, the Children and Young Persons (Care and Protection) Act 1998, the Children (Care and Protection) Act 1987 and the Disability Services Act 1993. The bill makes some substantial structural changes to the system of oversight of community service providers.

The bill will amend the Community Services (Complaints, Review and Monitoring) Act 1993 to establish the Community Services Division in the Ombudsman's Office and to require the Ombudsman to appoint a Deputy Ombudsman as the Community Services Commissioner. The bill will also abolish the existing Community Services Commission and the office of the existing Commissioner of Community Services. The bill clarifies and streamlines the roles of agencies in regard to the investigation of individual deaths of children and people with disabilities in care, the systemic review of those deaths, the monitoring and review of community service providers, and complaints handling. I will deal with each of these roles in turn.

Currently, the investigation of individual deaths may be undertaken by a number of agencies, including the Coroner, the police, the Community Services Commissioner, the Ombudsman, the Disability Death Review Team, the Child Death Review Team and agencies conducting internal investigations. The bill streamlines responsibilities for the investigation of individual deaths. It significantly amends and enhances the functions and capacity of the Coroner. The bill inserts new provisions in the Coroners Act requiring the mandatory notification to the Coroner of the death of certain categories of children in care and people with disabilities in care. There is currently no legislative requirement to ensure that these deaths come to the notice of the Coroner. The bill also provides that the Coroner will be solely responsible for the investigation of these deaths.

The mandatory reporting of deaths is a significant enhancement to the powers and functions of the Coroner. It will ensure that the deaths of the most vulnerable members of our society are properly investigated. The

Government will provide the Coroner with additional resources to undertake the expanded role. The resources will include the appointment of an additional Deputy Coroner. Broadly, under new section 13AB of the Coroners Act, the deaths that must be notified to the Coroner include the deaths of a child or young person who has been notified to the Department of Community Services within two years of the child's death; whose death is or may be subject to abuse or neglect or due to suspicious circumstances; who is under the parental responsibility of the Minister for Community Services or under a care order of the Director-General of the Department of Community Services, pending court proceedings; who is in out-of-home care; and who is in juvenile detention.

The mandatory notification of deaths will also include the death of a person—other than a child in care—who is in a target group within the meaning of the Disability Services Act 1993 and who is in the care of a service provider within the meaning of the Community Services (Complaints, Review and Monitoring) Act or receives a service from a service provider that allows that person to live independently in the community. The Coroner will also receive notification of the death of people with a disability living in residential centres licensed under the Youth and Community Services Act 1973 and known as "licensed boarding houses".

I turn now to systemic review of deaths in care. Currently, the Child Death Review Team and the Disability Death Review Team undertake the systemic review of deaths. The bill amends the Community Services (Complaints, Review and Monitoring) Act to make the Ombudsman, through the Community Services Division, responsible for this function. The Ombudsman will be responsible for the review of all deaths of children and people with disabilities in care. These terms have the same meaning as in the Coroners Act outlined previously. This will include the deaths of people in licensed boarding houses and the deaths of children in juvenile detention centres.

The Ombudsman will look at the circumstances of, and the potential for, preventing these deaths. He will also undertake detailed reviews of information relating to these deaths and make recommendations aiming to improve systems and prevent or reduce such deaths where possible. The Community Services (Complaints, Review and Monitoring) Act 1993 will be amended to provide the Ombudsman with such unrestricted access to the records of the Coroner and other service providers as is necessary to fulfil the functions I have just referred to. Linked to the mandatory reporting of deaths to the Coroner, this proposal provides a powerful tool for focusing investigations and improving services.

Also, as part of these changes, the Child Death Review Team will be retained with some amended functions. The Child Death Review Team will continue to keep a register of child deaths. It will continue to have a role in formulating recommendations regarding policies and practices to be implemented by government, private agencies and the community for the prevention or reduction of child deaths. For that purpose, the Child Death Review Team will continue to review information concerning deaths of children, except for children in the categories to be reviewed by the Ombudsman. The Child Death Review Team would seek to identify patterns and trends relating to those deaths and would undertake detailed research as appropriate. In this respect, specific information powers are contained in the bill to allow information to be shared by the Child Death Review Team and the Ombudsman.

The proposals in the bill regarding the Child Death Review Team have been developed after extensive consultation with all members of the team. The Ombudsman has undertaken to use the independent members of the existing Child Death Review Team as expert advisers for at least the first 12 months of his expanded role. This recognises the valuable skills and experience of those members. In relation to monitoring and review of community service providers, the bill will insert a new part 3 into the Community Services (Complaints, Review and Monitoring) Act that makes the Ombudsman responsible for the monitoring and review of community service providers.

This function will include the review of statutory functions of government agencies. Under this part, the Ombudsman may, on his own initiative, review the situation of a child in care or a person with a disability in care. Importantly, this power has been extended to allow the Ombudsman to review the situation of a group of children or people in care, not just individual cases. The Ombudsman may review such aspects of the child or person's care as he thinks fit. The Ombudsman will have extensive information-gathering powers to undertake this task, powers not available to the existing Community Services Commission.

Part 3 requires the Ombudsman to provide a report of his findings to the relevant Minister and the service provider. Importantly, however, the Ombudsman has a general power to report independently to Parliament. I note that the important Community Visitors Scheme will be retained in its entirety. Appointments of Community Visitors will be made by the Minister for Community Services, as is currently the case. However, such appointments will be made on the recommendation of the Ombudsman. The Ombudsman will be responsible for the co-ordination of the Community Visitors Scheme. I further note that the Ombudsman will be responsible for the existing powers in the Community Services (Complaints, Review and Monitoring) Act relating to the promotion, and assisting in the development of standards, for the delivery of community services, and the education of service providers about those standards.

Currently, both the Ombudsman and the Community Services Commission handle complaints. The bill will insert a new part 4 into the Community Services (Complaints, Review and Monitoring) Act to make the Ombudsman responsible for complaints handling. Under that part, a person can make a complaint to the Ombudsman about the conduct of a service provider with respect to the provision, or failure to provide, of a service, or the withdrawal, variation or administration of a community service. The complaint can be made in respect of a service provided to a person or a group of people.

These new powers are in addition to the existing rights to complain under the Ombudsman Act. The bill ensures that complaints can be made about the statutory functions of agencies. To ensure appropriate access to the complaints handling system for all people, the bill provides that a complaint may be made personally or on behalf of another person. It also provides that complaints may be made orally or in writing. The Ombudsman will have

extensive powers to investigate and conciliate a complaint. The Ombudsman will also have the power to review the internal complaints handling systems of service providers and make recommendations about those systems.

The bill addresses potential or perceived conflict between the investigatory and advocacy functions currently contained in the Community Services (Complaints, Review and Monitoring) Act. Under part 3, division 1, the Ombudsman will explicitly promote access to advocacy support for people receiving community services, make recommendations for improvements in the delivery of community services, assist in the making of complaints, provide information, education and training, and consult with persons and groups with an interest in the provision of community services.

This bill increases the accountability of community service providers and government. It strengthens the complaints handling process. It strengthens the review powers under the Community Services (Complaints, Review and Monitoring) Act. It subjects community service providers to the transparent and independent scrutiny of the Ombudsman's Office. The proposals in the bill have been the subject of extensive consultation. We have worked closely with both government and non-government agencies to develop a proposal which protects the rights of vulnerable people, strengthens the accountability of service providers, and clarifies and refocuses the roles of oversight agencies. The Government is committed to effective reform of the system for oversighting of community service providers. This bill is strongly supported by the Ombudsman, the Community Services Commissioner, the Commissioner for Children and Young People and the Coroner. It represents significant and sensible reform. I commend the bill to the House.