Submission No 9

INQUIRY INTO PROVISIONS OF THE AGEING AND DISABILITY COMMISSIONER BILL 2019

Organisation: NSW Ombudsman

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Ombudsman
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Legislative Council Standing Committee on Social Issues
Parliament of NSW
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Dear Committee

Inquiry into the provisions of the Ageing and Disability Commissioner Bill 2019

Thank you for the opportunity to contribute to this inquiry. As you are aware, we currently have a standing inquiry into allegations of abuse, neglect and exploitation of adults with disability in home and community settings, which will cease at the end of June 2019. In November 2018, I tabled a report to Parliament on our work in relation to the standing inquiry, which recommended that the NSW Government should implement the recommendations of the NSW Law Reform Commission to establish an independent statutory body to investigate and take appropriate action in relation to the suspected abuse and neglect of vulnerable adults in NSW.

We welcome the decision of the NSW Government to establish an Ageing and Disability Commission, and have provided input to the Department of Family and Community Services (FACS) to inform the drafting of the Bill. As a result, our comments on provisions relating to the Ageing and Disability Commissioner are limited to aspects that we believe require additional consideration.

The Bill also proposes amendment to The Community Services *(Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA). The intent of the amendment is to enable the Ombudsman to continue responsibility for reviewing the deaths of persons with disability in residential care, under part 6 of that Act. However, I have some concerns that as proposed, definitional issues will make the intended amendment unworkable. Further, even if the definitional issues are resolved, there is a lack of clarity as to the Ombudsman's role vis a vis the National Disability Insurance Scheme Quality and Safeguarding Commission (NDIS Commission), for which deaths of persons with disability who are NDIS recipients are reportable incidents.

I address these issues below.

The Ageing and Disability Commissioner

Information sharing provisions

My report to Parliament includes the recommendation that, as part of the establishment of the independent statutory body, the NSW Government should 'introduce legislative provisions to enable agencies that have responsibilities relating to the safety of vulnerable adults to be able to exchange information that promotes the safety of vulnerable adults.'

While the Bill includes powers for the Ageing and Disability Commissioner to exchange information with relevant agencies, this requires the Commissioner to be at the centre of any information exchange. It is vital that prescribed agencies are able to provide and receive information to promote and improve the safety of the adult at risk without the Commissioner having to facilitate all of the information exchange.

Given the focus is adults, we do not consider it appropriate or consistent with the rights of adults with disability to have provisions that are as broad as Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*. However, from our extensive experience and discussions with people with disability and their supporters, we are convinced that it is essential that agencies dealing with allegations of abuse or neglect have the ability to exchange information consistent with their legislative obligations and existing common law duty of care responsibilities. In our view, there is a need for a legislative provision to enable agencies that have responsibilities relating to the safety of vulnerable adults to be able to provide and receive information that promotes the safety of vulnerable adults.

Requiring parties to answer questions

The Bill provides for the Commissioner to make preliminary inquiries and to request further information from the reporter (13(7)), and to require any person to attend a meeting or produce a document or thing that is in their custody or control (16). However, the Commissioner should also have legislative provisions to require parties to answer questions.

We support the recommendation of the NSW Law Reform Commission in its review of the *Guardianship Act 1987* that the new legislation should provide that it is an offence to fail to produce documents, *answer questions* or attend a conference in response to a request from the independent statutory body. The inclusion of a requirement on parties to provide information to the Commissioner will be essential to enable the Commissioner to effectively investigate reports.

The Community Services (Complaints, Reviews and Monitoring) Act 1993

The Ageing and Disability Commissioner Bill (the Bill) proposes amendment to CS-CRAMA. The intent of the amendment is to enable the Ombudsman to continue his responsibility for reviewing the deaths of persons with disability in residential care, under part 6 of that Act. However, the Ombudsman is concerned that:

- As proposed, definitional issues will make the intended amendment unworkable;

- Even if the definitional issues are resolved, there remains a lack of clarity as to the Ombudsman's role vis a vis the NDIS Commission for which deaths of persons with disability who are NDIS recipients are reportable incidents.

The Ombudsman's role in reviewing deaths

Under Part 6 of CS CRAMA, the Ombudsman has responsibility (separate to the Child Death Review Team) for reviewing the death of:

- a child in care
- a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances
- a child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place)
- a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider or an assisted boarding house (in this Part referred to as a person in residential care).

In relation to these deaths, the Ombudsman's functions are to:

- monitor and review reviewable deaths
- formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of these deaths
- maintain a register of reviewable deaths occurring in NSW, classifying the deaths according to cause, demographic criteria or other factors prescribed by the regulations
- undertake, alone or with others, research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with reviewable deaths that are preventable.

In exercising those functions the Ombudsman may form an advisory committee to assist in exercising these functions, keep under scrutiny systems for reporting reviewable deaths, undertake detailed reviews, analyze data with respect to the causes of reviewable deaths, and consult with and obtain advice from any person or body having appropriate expertise.

The Ombudsman must report to the NSW Parliament every two years on the work and activities under Part 6, including data and information collected, recommendations made and the extent of implementation of recommendations.

Deaths of persons with disability in residential care and the QSC

In regard to deaths of persons with disability in residential care, the Ombudsman's responsibility has changed since the establishment of the NDIS Commission. Since 1 July 2018, the deaths of persons with disability who are NDIS recipients became reportable incidents to the NDIS Commission instead of the Ombudsman. In reviewing deaths, the NDIS Commission is focused on the NDIS provider(s).

To ensure effective transition, the definition of 'service provider' in s 4(1) CS CRAMA was amended by way of an agreement between the relevant Commonwealth and State Ministers. This has provided for the NSW Ombudsman to continue to review deaths of persons with disability in residential care, whether or not the care is provided by FACS or an NDIS provider. In practice, this has enabled the Ombudsman to examine the involvement of state services with the people who died. We do not seek information or records from NDIS providers.

This Ministerial agreement ends on 1 July 2019. The arrangement has emphasized the need for our office and the NDIS Commission to work together to ensure that there is no duplication. In this regard, the NDIS Commission provides this office with the notification forms and related documents of the NDIS providers relating to reviewable deaths.

Effect of the Ageing and Disability Commissioner Bill

The draft Bill includes an amendment to s35 CS CRAMA that is intended to continue the Ombudsman's jurisdiction over the deaths of people with disability in supported accommodation in NSW, without the need for a further Ministerial arrangement.

There are two main issues arising from the Bill in relation to the Ombudsman's role in reviewing deaths:

1. Definition of persons with disability whose deaths are reviewable

The Bill amends section 35 (1) (f) CS CRAMA by replacing 'residential care provided by a service provider' to 'supported group accommodation', with supported group accommodation having the same meaning as it has in the *Disability Inclusion Act 2014*. The note to clause 3 Schedule 1 of the Bill states that the definition includes supported group accommodation provided by a registered provider under the *National Disability Insurance Scheme Act 2013* of the Commonwealth.

However, as proposed, definitional issues will make the intended amendment unworkable:

- Clause 9(1) of the *Disability Inclusion Regulation 2014* prescribes 'supported group accommodation' as premises in which support is provided by FACS or a FACS-funded entity. Contrary to the note in the Bill, NDIS providers are therefore excluded from the definition.
- The definition of 'supported group accommodation' in the *Disability Inclusion Act* is premised on shared living arrangements – it excludes people who live alone in residential care with staff support (Specialist Disability Accommodation).
- The definition of 'supported group accommodation' may include nursing homes.

2. Capacity to perform functions under Part 6 CS CRAMA

Should the definitional issues be resolved, there remains a question about the degree to which the functions under Part 6 can be performed effectively by the Ombudsman.

The NSW Ombudsman does not have jurisdiction over NDIS providers as they are Commonwealth funded. In that context, reviews of deaths would be limited to consideration of records from state funded services, in particular health services.

The Ministerial agreement described above will cease on 1 July 2019. It would be prudent to consider measures in the spirit of that agreement which enable the work of the Ombudsman and the NDIS Commission to continue in a complementary manner.

Thank you for the opportunity to contribute to this inquiry. If you require further information, please contact Kathryn McKenzie, Director Disability,

Yours sincerely

Michael Barnes
NSW Ombudsman