JOINT STANDING COMMITTEE ON THE COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

INQUIRY INTO THE MONITORING AND ENFORCING OF CHILD SAFE STANDARDS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 3 APRIL 2019

SESSION ONE

Members

Hon Dr Sally Talbot, MLC (Chair)
Mr K.M. O'Donnell, MLA (Deputy Chair)
Hon Donna Faragher, MLC
Mrs J.M.C. Stojkovski, MLA

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Hearing commenced at 9.56 am

Dr MEI-LING AUDREY KOAY
Executive Director, Patient Safety and Clinical Quality, Department of Health, examined:

The CHAIR: Thanks for coming in today. I have some formalities that I need to go through before we start so I will do that and then we will pursue some of the questions that we have.

On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the Joint Standing Committee on the Commissioner for Children and Young People Inquiry into the Monitoring and Enforcing of Child Safe Standards. I am Sally Talbot; I am a member for South West Region and I am the Chair of this committee. I will ask my colleagues to introduce themselves.

Hon DONNA FARAGHER: Donna Faragher, member for East Metropolitan Region.

Mr K.M. O'DONNELL: Kyran O'Donnell, member for Kalgoorlie.

Mrs J.M.C. STOJKOVSKI: Jessica Stojkovski, member for Kingsley.

The CHAIR: It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything that you might say outside today's proceedings. Do you have any questions about your attendance here this morning?

Dr Koay: No.

The CHAIR: Excellent. Please proceed if you have got an opening statement.

Dr Koay: The portfolio of my directorate supports hospitals in the provision of safe and quality health care. We do this through the surveillance of adverse events where people come to harm and also from near miss incidents where harm could have occurred but was averted. We monitor the outcomes—for example, outcomes to surgeries—and we also look at indicators for safety and quality. We then benchmark this and we provide feedback to the hospitals so that they can do quality improvement work. My area often supports hospitals by developing policies—for example, around mental health, around reproductive technologies—and works to address national accreditation standards and other esoteric things which are equally important, such as ensuring safe use of medications and so on. Finally, my portfolio covers the licensing of private hospitals and day hospitals as defined by the Private Hospitals and Health Services Act. I am providing you this background because my portfolio does not actually cover child protection or the implementation of the royal commission recommendations. Since receiving the correspondence last week, I have had opportunity to seek input into some of the things that you may be interested in, but I will forewarn you that I will have to seek your indulgence and probably take questions on notice.

The CHAIR: That is fine. We have a mechanism for doing that. We were a little puzzled as to why your unit had been singled out to come and testify today. You will be aware that our current inquiry is partly focused on the oversight report of the Commissioner for Children and Young People in 2017.

Dr Koay: Yes.

The CHAIR: One of the reasons we wrote to the Department of Health is because mental health service provision for children and young people was one of the six foci of the commissioner so that

is what we are particularly interested in. Have you got some more that you would like to lay out to us before we start?

Dr Koay: No. I am happy to start.

The CHAIR: Okay. Maybe I can start by taking you straight to the commissioner's recommendation on mental health.

Dr Koay: In relation to oversighting the outcomes for children?

The CHAIR: Yes. The second recommendation is —

> That strategies to improve the oversight for children and young people in relation to mental health services are considered including:

He has three dot points —

- Systematic inspection of facilities and review of practices such as restraint and seclusion.
- Proactive engagement of independent advocacy with voluntary patients.
- Independent monitoring of the outcomes for children and young people's mental health and the adequacy of treatment provision in WA.

How do you respond to that recommendation and has the department taken action since the report was released in 2017 to address that recommendation?

Dr Koay: In relation to the first one, the inspection of facilities and the review of practices, particularly around restraint and seclusion, that is one which is actually undertaken in WA by the Chief Psychiatrist under powers afforded to him under the Mental Health Act. The Chief Psychiatrist has an established program of work which basically looks at a review of clinical standards and services, and under that umbrella of work he visits different health services and basically monitors oversight, generates the report, which goes back to the board, with areas of commendations and then areas of improvement, which are required. In addition to that, one of his standards is around seclusion and bodily restraint, particularly in authorised institutions—so patients who are involuntary. Under that, he is able to require reporting by health services to his office and he does also undertake visits and inspects mental health services where he considers this appropriate. Any questions about that?

The CHAIR: Yes, I do, and I invite my colleagues to join me as well if they would like to.

The commissioner makes a point specifically about the Chief Psychiatrist, that while he has that power, what he calls broad inspectorial powers, he is actually not an inspectorial body. Is it your view that the Chief Psychiatrist should be deemed to be that body?

Dr Koay: I think there is benefit in it being an independent body. I think that the department, although under the Health Services Act it is separated from health services at present, there is still a fairly close working relationship and so in practice that independence may not be as real as you would want it to be if it was a proper oversight body. Whether the Chief Psychiatrist is that body is probably a question that has to be put to his office as well.

The CHAIR: Yes, we will be speaking to the Chief Psychiatrist. Just on the same dot point, has the Chief Psychiatrist made recommendations to the board about services for children and young people?

Dr Koay: Yes, so he did inspect the child and adolescent mental health service. In his report, he noted areas of good practice in particular around planning of the care provided and the involvement of families. But he did also note areas where improvements could be made and these were the

involvement of carers and families in medication safety in particular, understanding what medications patients were on and patients understanding the consequences of the risk of some these medications and that we could improve in the communication with patients' GPs around physical aspects of the care provided.

The CHAIR: Is that report a public document?

Dr Koay: The Chief Psychiatrist undertook in beginning the series of service reviews that the first report would not be a public document other than under an FOI act. However, subsequent reports would be publicly reported. Having said that, I understand that the chief executive of the child and adolescent service is also due to present here as well as, I imagine, the Chief Psychiatrist, so you could probably ask them for it as well.

The CHAIR: Would you be able to supply the committee with a copy of that report? We can keep it a private document. We might make that the first question on notice just to keep things nice and simple so the first question on notice is: could you provide a private or confidential copy of that report? Have there been subsequent reports yet?

Dr Koay: No.

The CHAIR: When did the Chief Psychiatrist start this review process?

Dr Koay: In May 2017.

The CHAIR: Thank you. Did you want to move on to the second point?

Dr Koay: The proactive engagement of independent advocacy with voluntary patients is something we would support, but generally speaking that is something that would be done by the Mental Health Advocacy Service and Debora Colvin.

The CHAIR: Yes, and we did have Ms Colvin in a hearing last week, which, again, it was public hearing so you would be interested in her comments on that. She is certainly very much in favour of it. So you would support that as well?

Dr Koay: Absolutely.

The CHAIR: And the third dot point?

Dr Koay: Around the monitoring of outcomes, again, we would support the Chief Psychiatrist's independent oversight role. We also emphasise that by having a mental health policy framework, so under the Health Services Act there are several instruments made available to the director general under which he could essentially compel work to be done by health services, and one of those was a policy framework. So if a policy appears in there, it is mandatory. Under our policy framework there are elements in there which cover seclusion and bodily restraint and there are also bits which reference the Chief Psychiatrist's standards. That is how we support his work. In addition to that, there is a Mental Health Complaints Partnership Agreement, which engages HADSCO, the Chief Psychiatrist's office, the Mental Health Commission and MHAS and ourselves. Under that agreement, it allows information sharing between the different agencies so that together we can get a more complete picture of what is going on at any site. There are components in there which do specifically touch on complaints—patient or family complaints—particularly where there is alleged significant harm which may be physical, sexual or emotional abuse, maltreatment and neglect. On those occasions, the different agencies do come together and come up with a plan of how we might manage that and who is responsible for which components.

The CHAIR: The whole question of data collection and sharing is obviously something that is engaging people's energy across the public sector. It sounds as if you have embarked on a process of improving data collection and sharing. Do you have a program with an end date?

Dr Koay: No. There is a couple of components to that, I guess. One is around collecting data so that you can monitor outcomes or the quality of the service being provided. The other component of information sharing, which is in a way a retrospective view, is around what needs to be told to who right now for the patient or their families. I will cover them separately. In relation to the first one, which is the data for retrospective views, probably mid of last year the Office of the Chief Psychiatrist, the Mental Health Commission and the Department of Health started a piece of work where we looked at what data was collected by each agency of the health service, and this is only the publicly funded health services so it does not touch on private agencies and it does not touch on non-government organisations. The ambition there is to recognise that there is a lot of data and there is a lot of reporting but we do not always make sense of what is coming through and we do not always use the information well. The idea of that piece of work is to try to work with families, carers association, so CoMHWA and also with MHAS in particular to try to come up with some metrics that tell us a little bit more about the quality of care that they are providing. That does not have an end date and it is very much a work in progress where we are currently just mapping out what data exists.

[10.10 am]

In terms of the second bit around information sharing, I think one of the observations that I have from my work particularly looking at coronial inquests is that there are many instances at which different agencies or different parts of different government bodies may have been privy to some information and that there may have been value in passing some of that on. One of the tensions is balancing the need to share to protect versus the perception perhaps of the patient's rights to confidentiality and privacy. There has been a fair bit of work done between some of my units, particularly in response to coronials, with child protection and family services and also with the Ombudsman to better understand how we currently share information, how it can be improved. So as a consequence of those communications, which were had in 2017–18, we then wrote to hospitals to basically provide some of this feedback and suggest that hospitals might want to proactively contact the Ombudsman, child protection agencies, so that some of those linkages could actually happen at the ground level rather than in a head office.

The CHAIR: Can you just give me an idea about what that process might consist of? As you have just described it, a letter from the health department to a local hospital saying you might want to consider doing X, Y and Z.

Dr Koay: Is not the same as —

The CHAIR: It would be a question, in my mind at least, about whether it would actually do anything.

Dr Koay: I am afraid I cannot. I will have to take that one on notice. Essentially what happened was in 2016 we liaised with child protection and family services to look at the current, or the then, rates of information sharing. There was an MOU that was in place at the time. However, child protection did allude to the fact that perhaps not all staff in Health were aware of the MOU and what that allowed them to do. As a consequence of that, we liaised with health services to bring their attention to the MOU. There were some bilateral schedules that were developed and also some local procedures put in place by health services so that they could actually have some of the information sharing, and actually in fact put life to the MOU. The feedback from the health services was that in some quarters that was difficult because of staff turnover, so there was a constant need to basically keep staff trained up. I think there was also feedback that some of our ICT processes did not facilitate it as much as it could have, but I understand from some of the inputs that I have had for today that the Department of Communities has since developed an e-referral system that might assist with that.

The CHAIR: They have developed a new referral system?

Dr Koay: That is my understanding, but I do not know very much about it.

The CHAIR: I think that might be your second question on notice: exactly what that directive consisted of and the work that has been done subsequently to try to drive some kind of practical outcome. I guess the sort of thing we are talking about here is a spike in the number of children with sexually transmitted diseases, for example. Is that your understanding, with the subject matter that we might be dealing with here: where that information has not been shared with other agencies, it has made it very, very difficult for child protection to take action? When I say "child protection", I do not necessarily mean the department; I mean preventing child sexual abuse.

Dr Koay: My understanding was that it was more than just when a child has been diagnosed with an STI; it was also around at-risk cases. If I look back through coronials—I guess that is with the benefit of hindsight—often the child comes to our attention when they arrive at PMH, for example. But if one goes back through the child's personal history, there will be multiple incidents in the past where, in retrospect, it is possible to find a story and to identify that one could have intervened earlier. I guess that is what I was thinking of in terms of that.

The CHAIR: You are thinking about internal processes within the Department of Health so that you could —

Dr Koay: And between agencies, because often Health is the last port of call.

The CHAIR: Perhaps if we take that question on notice, we will see where we go from there. Thank you for that.

Let us get right back to the provision of mental health services. What mechanisms do you have in place for actually engaging children and young people?

Dr Koay: The department does not—not directly. We do have, on a variety of different committees, consumer representatives. We have a clinical policy committee, for example, which does have input from consumers. There is also, through the Mental Health Commission, a Mental Health Network which does have different subnetworks; I think one of which does allow for consumer input. Whether it is specific to children, I do not know.

The CHAIR: It does not specifically include consumer input from people under the age of 18, for example?

Dr Koay: I do not know. That is a committee that is established by the Mental Health Commission. The Mental Health Network has different subgroups.

The CHAIR: You are speaking solely for the Department of Health?

Dr Koay: That is right.

The CHAIR: Would you be able to let us know whether any of your consumer advisory bodies include people under the age of 18?

Hon DONNA FARAGHER: Further to that, I think it would be helpful to know the committees where there is consumer representation—if we could have the names of those committees or whatever they are referred to, and from that, the consumer representative; on what basis they are there and whether or not it does cover 18 or under or what is their purpose and remit.

Dr Koay: Yes.

The CHAIR: We had a look at your website and there are six dot points about aims and objectives. I do not know whether Michele can get that on the screen. I refer to —

- Robust information systems
- Continuous process of safety and quality improvement

We were wondering how you measure the outcomes against those criteria.

Dr Koay: Do you mind bringing up my website?

The CHAIR: There we go. We can probably make it a bit bigger for you as well.

Dr Koay: A lot of what we do is currently based on audit. Generally speaking, the process would be that we identify an area that may perhaps have been the focus of a previous review or a previous report. We identify recommendations which might be particularly pertinent or of particular priority to us. We work with health services to nut out how we will measure those recommendations and their implementation. We then expect them to do a clinical audit. That might be based on going back to paper copies, if necessary. They then provide those reports to us. We tend to collate them, provide the data in the context of how other health services are doing, and that report goes up to the director general, to the board chair and then back to the health service.

The CHAIR: Is there anything in those six objects that you can see that relates specifically to children and young people?

Dr Koay: Not specifically. Most of our work would be done for any patient who uses one of our public health services. We do not tend to focus specifically on children only.

The CHAIR: Even when this service is delivering services for children and young people?

Dr Koay: That would be the Child and Adolescent Health Service. Some of the other health services do have paediatric units and we do ask for data from them. To my recollection—not just in mental health but in any others—we have never asked just for the paediatric component.

The CHAIR: Okay. There is another set of dot points that the committee has gleaned from quite an old report now; it is the Australian Law Reform Commission. It pulled out nine dot points about the functions of an agency with oversight responsibility. You have already said, I think, that your unit is not actually an oversight body. Some of these clearly will not relate to your activities, but if you could just have a look at what is now on the board. The second dot point is “adequate resources”. Leaving out the first dot point, if you could just address the others, that would be good.

[10.20 am]

Dr Koay: If I just answer that question by going back a little bit. Under the Health Services Act, health services are a statutory, autonomous, independent body separate from the Department of Health, but I think in practice we are yet to fully devolve those components, so we still do work with them, for example, on implementation of some recommendations or some mandatory requirements of work.

One of the things that the department has been doing, as part of the change in governance of health services, is trying to define different buckets of work. One could be regulation, another one is assurance and the last is around facilitation. We view regulation as the black and white—what is in the law—and our place is complying with that. The only area of my work that covers anything related to that would probably be licensing of private hospitals. The other bit is assurance. I think of it very simplistically as: how does the minister or the director general know that there is not something awful happening? The last is facilitation, which is very much around policy and other hands-on work that might be done to help health services meet particular criteria or a standard.

Much of what I will say covers the assurance function rather than the black-and-white oversight or independent function. I do not know if any area in the public sector would claim to have adequate resources, so I might pass that one.

The CHAIR: We found one last week.

Dr Koay: Did you? They better not talk to me then!

Investigative powers: the Health Services Act does allow the director general the ability to instigate a review or an audit or an investigation into a particular situation that might be happening in a health service. We have on occasion exercised that within my directorate, but not in relation to anything relating to children. Again, it is very much one that is blurred with some of the facilitation functions because not being an oversight body, we do tend to still work with health services because they will need to continue the work once we are no longer there.

Active participation by children is one that I have taken on notice from the previous question. Accessibility to all children is not something that my unit would have. If we did hear from children, it would be indirectly, usually through a minister, by a concerned parent or through an advocacy service. Regional and local representation is not something that we would do. Access to research and statistics is something that we have to some extent. As I described earlier, it is something that we probably need to improve on in terms of the quality of that data but also how we use it. Again, that is generally not specific to children.

The CHAIR: I am sure you will be aware that there is some discussion around the appropriateness of combining advocacy in the individual sense with systemic advocacy and then who handles the complaints function is woven into that. I think Blaxell was one of the first people to raise that question when he did the report into St Andrew's Hostel in Katanning. Do you have a view about how those mechanisms are appropriately set up?

Dr Koay: Not personally. I do think, however, that in mental health, particularly if we are talking about children, these are vulnerable groups that often do not have a voice. I think that support for the advocacy services that are provided is something that we would not question. You would probably have to ask the actual patients and their families about the extent to which they can access adequate services. I think that often while the individual advocacy and the systemic advocacy might be in tension, systemic advocacy ideally should also be informed by what is happening to individuals, otherwise you get a vacuum. I do not see them as being at odds. I see that as more about how you divvy up limited resources to be able to capture the whole bucket really.

The CHAIR: That is an interesting point.

The commissioner has made a submission to this inquiry. In that submission, he says that despite the best efforts of the current oversight agencies, where they do operate, there have not been any discernible improvements in quality of care or wellbeing outcomes of these children and young people overall, with many oversight reports repeatedly highlighting the same concerns and recommendations over significant periods of time. Is that an observation that you would share?

Dr Koay: I think it would be wrong for me to dismiss it. I would probably have to go through and understand a little bit more of where that comes from.

The CHAIR: It has been interesting listening to your response about recommendation 2. I guess the commissioner's point is drawing our attention to the difficulty of turning good ideas into practice that make material benefits in the lives of children and young people.

Let us go specifically to the recommendations of the royal commission. The royal commission talked about a whole-of-government approach and you will undoubtedly be aware of the mechanisms that

are set within DPC as the lead agency to put the recommendations of the royal commission into effect. Do you see your part of the health department as having any direct role in that?

Dr Koay: We do not have within my directorate a direct role in it, apart from the work that was done a few years ago to help information sharing between agencies, which I have also taken on notice. We do have within the department and prior to the royal commission report coming out, a variety of policies that might potentially address action area 1 around prevention of abuse and action area 2 around the timely and effective response. I have to state up-front that these are not policies that my directorate own but they are certainly mandatory policies that are held by the department. Some of these include things like a policy on the special referral to child health services. The aim of that is to ensure the effective transfer of information from maternity hospitals and neonatal services to child health services for a newborn who might be in a family where there are risk factors identified in the antenatal or the postnatal period. That is just to ensure that they have adequate support. There is also a public health policy on the management of children aged under 14 who are diagnosed with a sexually transmitted infection and the process that needs to be stepped through in terms of child protection and also the police. Then there are also child protection guidelines which have been in place since 2005 and which I understand are being updated this year. That is some of the background work.

I have also had some advice over the course of the week around some of the work that the department is doing with the Department of Communities around implementation or progressing with the child safe standards. There is a working group with health services that has been convened and, essentially, there are a couple of different pieces of work involved there.

The CHAIR: Is that an internal working group to the Department of Health?

Dr Koay: It is the Department of Health and health services, looking at the alignment between the child safe standards and other regulatory mechanisms that might exist. Another is to map the services that are funded by the Department of Health which are aligned to recommendations related to advocacy and harmful sexual behaviours. The third is to look at options to embed those standards into existing contracting work that is happening.

The CHAIR: Do you include the Commissioner for Children and Young People in any of those working groups?

Dr Koay: I would have to find out.

The CHAIR: If you can take that on notice, that would be good. If you do not include the commissioner or anybody from the office in those working groups, could you also find out what contact there is by way of seeking advice and guidance or looking at papers and policies that the commissioner has devised in your directorate, and if you can go further than your directorate to include the Department of Health, that would be great, but whatever you can do.

[10.30 am]

Dr Koay: I will have to go outside my directorate, because the work around the royal commission is actually led by another group.

The CHAIR: Right, okay. What is that group called? Is that the one you just referred to?

Dr Koay: Yes.

The CHAIR: So that is the one with the working group with Health and Health Services?

Dr Koay: That is right, yes.

The CHAIR: So they are specifically focused on the royal commission recommendations?

Dr Koay: The Department of Health work on the royal commission recommendations is closely aligned with both the Child and Adolescent Health Service and the Department of Communities, and that work is being done by a different directorate within the same division as mine.

The CHAIR: Could you include that directorate in your feedback to us? Thank you.

My final question is about the recommendations made by the royal commission relating to the independent oversight across four areas where children are clearly vulnerable. As far as your service provision goes, do you have a way of identifying children who are in out-of-home care when they have contact with your services, or children who are in youth detention?

Dr Koay: I will have to find out in terms of both.

The CHAIR: Thank you, on both those counts. That would be most useful. If you do identify those groups, could you also describe for us what independent oversight there is of service provision to those two groups of vulnerable children?

Dr Koay: Yes.

The CHAIR: Thank you. I will open up now to my colleagues. No? I think we may be at the end. Is there anything you would like to add or anything you feel you would like to tell us that I have not asked you?

Dr Koay: No, thank you.

The CHAIR: Okay, thank you very much. Let me just go through the formalities of closing. Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary document for the committee's consideration when you return your corrected transcript of evidence. Thanks very much for coming in today.

Hearing concluded at 10.32 am

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