

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, 17 APRIL 2019**

SESSION FOUR

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**

Hearing commenced at 1.29 pm**Ms SARAH JANE COWIE****Director, Health and Disability Services Complaints Office, examined:**

The CHAIR: 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's inquiry into the monitoring and enforcing of child safety standards. My name is Sally Talbot. I am a member for South West and the chair of this committee. I will ask my colleagues to introduce themselves.

Hon DONNA FARAGHER: I am Donna Faragher, member for East Metro Region.

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

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

The Acting Principal Research Officer: Michele Chiasson, acting principal research officer.

The CHAIR: It is important to 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 you might say outside of today's proceedings. Before we begin with our questions, do you have any queries about your attendance here today?

Ms Cowie: No.

The CHAIR: Excellent. Would you like to start with an opening statement?

Ms Cowie: Certainly. First of all, thank you very much for the opportunity and the invitation to come and meet with you today—I do appreciate that—and to contribute to your work. I am the director/CEO of the Health and Disability Services Complaints Office. We are an independent statutory authority that provides a complaints resolution service for health, disability and mental health services in Western Australia.

The CHAIR: That is great. Thanks for coming in today. You will be aware of the nature of our inquiry; you have seen the terms of reference.

Ms Cowie: Yes.

The CHAIR: This issue of oversight has been around for a long time, probably starting with the Blaxell report. Then this committee in a previous iteration did a consideration of those recommendations and then the Commissioner for Children and Young People did his oversight mapping. Now, of course, we have the royal commission recommendations. We felt that HADSCO was particularly well-placed to talk to us about what works and what does not work, where the gaps are, and where the overlaps are, as we move into this period that is clearly going to see some quite significant change. Can I just start by asking you, in relation to HADSCO's operations—I notice we have some stats about who you service, the users of your service. Do you have a particular focus on relating to children and young people?

Ms Cowie: We provide a diverse service across many demographic groups. What I do find is that for children and young people, they are usually represented through their parents. It is normally the parents, because parents have responsibility for child health. Most of our complaints—68 per cent of them—are generally health-related; that is the biggest part of our jurisdiction. Here, children tend to be represented by their parents. With My Health Record and children now being able to have their own health record from 14, there is research around at what age children can start attending

a doctor's service by themselves; it could be a mental health service as well. The issue for us to focus on in particular is that time when you start to go to see a doctor by yourself; when you become more responsible for your own health service. It is before the age of 18—I know the definition of a child is zero to 18. There is that group when you are transitioning into managing your own health, between 14 and 18 years of age, they are not strongly represented in our jurisdiction, and that is an area we could focus on. But, mainly, it is parents who bring their complaints to us about the service. Obviously, if a child wanted to participate in that process, we would certainly engage with the child through that process.

The CHAIR: Do you have people who are trained to handle complaints by children?

Ms Cowie: As an organisation we are always very conscious of emerging issues. Under our strategic plan, one of our areas of focus is responding to our changing environments, and there are many changing environments that, as an office, we are facing at this point in time, just as any organisation is. One of those obviously is children—the responses to the royal commission as well. We triage all complaints and anything that involves a child is identified through that triage process. We look at other areas of changing environments for us, too. The National Disability Insurance Scheme is an area where our jurisdiction will change over time; the sustainable health review is as well. They are all areas that we focus on in dealing with our complaints.

The CHAIR: So the area of children and young people one of those areas of change, is that what you are suggesting?

Ms Cowie: Yes, it is in our triaging process. It is inherent in what we do. The training of staff can be very much on-the-job training. As a leader I like to pass on my learnings through my own experience. I have been in complaints management in various roles for over 17 years, so I am ever-mindful of things that change. For example, the royal commission and the focus on children is certainly something that I pass on and remind my staff all the time about—child safe principles, et cetera. Interestingly, one of our younger staff is under the age of 20, so we actually employ youth and are conscious to consult with that person. We are a small office; just to let you know, there are only 16 of us, and that covers everything we do. Including myself, only eight of those staff are actually hands-on complaint handlers. For example, we have a specialist in the medical area—we have a nurse engaged—but we do not necessarily have someone who is child-specific. It comes down to myself and my leadership to make sure that staff are conscious and aware of matters to triage; for example, where issues arise—and they do arise from time to time—of child safety and wellbeing, then those matters are brought to my attention and I will take appropriate steps to notify appropriate agencies.

Hon DONNA FARAGHER: Can I just ask, what is your remit with respect to complaints from a disability services perspective? I ask that in the context that I will probably ask you a question on the NDIS in a moment. I just want to get an understanding of what your role is in terms of disability services.

Ms Cowie: The current landscape, as we are in transition, is that from 1 July 2020, for the disability jurisdiction, which is three to four per cent of our work, we expect to transition to the national quality and safeguards commission. Our remit is in relation to service delivery, so the way I explain it—and sorry, but sometimes I am a bit visual—the NDIA is responsible for the planning and the funding components, and that happens at this point. Once the plan is issued and the person starts taking those services through the plan, that is when we become involved, during this transition period. Previously, when it was a state-funded scheme, it was much the same. We would always do the service delivery component, so about the service provider. We would expect at transition that the disability jurisdiction for registered practitioners—people who will be registered through the quality and safeguards commission—will transition to the quality and safeguards commission. The

gap potentially will be where people lose their registration or are unregistered, so that is something we will need to resolve as a complaints jurisdiction going forward, for the state.

Hon DONNA FARAGHER: So at this stage, come July 2020—albeit that you have mentioned that there might be a gap there that you will need to look further into—do you see your role from a disability services perspective will effectively fall away and will be taken over by the quality and safeguards commission?

Ms Cowie: At the national level, yes. My counterparts across Australia have already rolled in—New South Wales and South Australia. The balance will roll in on 1 July this year and then in Western Australia after that.

Hon DONNA FARAGHER: Okay, thank you.

The CHAIR: I will ask Michele to put recommendation 2 up on the screen. This is the recommendation of the commissioner's oversight mapping report, specifically in relation to mental health services for children and young people. While he notes that, largely through the role of HADSCO and other agencies, there is a deal of independent oversight going on in mental health—that was his recommendation, that inspection of facilities and review of practices such as restraint and seclusion be improved through increased regular, systematic and independent oversight—do you have any comments to make about that or the other two dot points in that recommendation 2?

[1.40 pm]

Ms Cowie: The inspection component?

The CHAIR: Yes.

Ms Cowie: My role is complaint handling as opposed to inspection. The obvious one that comes to mind there is the Inspector of Custodial Services, who has an inspection role. We can provide information that would assist to feed into an inspection per se. Complaints about children: according to the recent data I collected to come to see you today, it is five per cent—zero to 18 years—of year to date in jurisdiction complaints. We would not have significant data to provide for an inspection of a facility involving children at this point in time, because it is a small component, and most of that is about the specialties, as in general practice or accident and emergency, for example. It is less in the areas like prison inspections.

The CHAIR: Can you give us an idea about what the actual number would be? You said five per cent of your complaints.

Ms Cowie: Yes, so 93 complaints involving a child.

The CHAIR: There are 93 from children and young people.

Ms Cowie: Yes, involving a child.

The CHAIR: I see, not complaints by children, but involving a child.

Ms Cowie: A child.

The CHAIR: Without anything that identifies people, can you give us a bit of an idea about what those complaints consist of?

Ms Cowie: As I said, they generally are about general practice or accident and emergency. They can be about psychiatric services as well.

The CHAIR: Somebody being sent home when they should not have been sent home—that sort of thing?

Ms Cowie: That level of information? I can look that up if you would like me to or I can provide it to you afterwards.

The CHAIR: I just wanted you to share, I just want you to give us a broadbrush idea about what the nature of those complaints might be.

Ms Cowie: Sure. If we look, for example, in the health sector, there are complaint issues concerning access to facilities; they could include also waiting lists; refusal to admit or treat and service availability—that might be in a regional context; communication and information, including the attitude and manner of the health practitioner; whether or not sufficient information was provided in relation to the procedure to be undertaken et cetera, or incorrect or misleading information; fees and costs have come up, and that is more in the private space, because we deal with both the public and private sectors; and treatment, so coordination of treatment, diagnosis, unexpected outcomes or complications. They are the types of things that have come up this financial year for children in the health sector. In the disability sector there are service management, staff competence and coordinated service delivery issues; staff conduct or inadequate service or service delays. In the mental health sector—they are a small component, mental health—there are issues around psychiatric services.

The CHAIR: With the same sorts of things—access, waiting lists?

Ms Cowie: Yes, that is right, but they are very small.

The CHAIR: That is very useful, thank you for that.

Ms Cowie: In relation to the other dot points—the proactive engagement of independent advocacy and voluntary patients—we work closely with the Mental Health Advocacy Service. It is possible that we will get on to those measures of good advocacy later, but it is very important that we remain absolutely independent in this process.

The CHAIR: Let us take that point now, because it is absolutely crucial. Talk to us about that view.

Ms Cowie: Sure. We are an independent statutory authority, and, again, if I can be visual, the way I describe it to staff is that we have an individual here who has a complaint and we have a service provider here and we are right in the middle. We must not move from that independence; we must gather the evidence.

The CHAIR: So you are impartial?

Ms Cowie: Absolutely, yes, thank you. As I have said, I have been in complaint handling 17 or 18 years now—15 years in the state ombudsman's office, so independence is critical to the work I do. In this very specialised area of disability and mental health there is a very strong advocacy component to the work that we do. Look, anecdotally a lot of the disability work I think is managed through advocacy. Advocates, albeit we have a strong professional relationship, say the Mental Health Advocacy Service, they will represent people in complaints to our office, hence the reason that we need to have a really professional relationship, but maintain an independence from them, because they have a different role to what we do.

The CHAIR: You do not provide the advocacy.

Ms Cowie: No, we do not at all.

The CHAIR: Who provides the advocacy, did you say?

Ms Cowie: For the mental health space the Mental Health Advocacy Service do; for disabilities its People with Disabilities WA, to name one; and Health Consumers Council are very strong in that

field in the health space. Again, I say we have really good relationships with those organisations, but we all respect our roles—we are clear about our roles and responsibilities.

The CHAIR: Do you see yourself as a systemic advocate?

Ms Cowie: Interesting question.

The CHAIR: Does that question make sense?

Ms Cowie: It does make sense. What I have always thought: from one complaint you can have change for many, and we see that all the time, because we are a complaint-driven organisation. My functions are set out in the Health and Disability Services (Complaints) Act, as well as in the Disability Services Act and the Mental Health Act, I might add. With the approval of the minister, I can look at systemic issues. I can gather all my complaints data together and look at systemic issues. As I said there are 16 of us—16 to 18, depending on adding in staff who might work part time. It is certainly an area we could focus on, but we are slightly constrained because of our size and resourcing. It is somewhere I would like to take the office. We have a lot of information, a lot of complaints data. I just described the types of issues that have come up here, for example, like treatment coordination or delay of treatment or inadequate treatment. We could look at those types of things. We could look at discharge issues. I think in the mental health space, I talked about respecting and responding to our changing environments, and I think that is something we could look at. We could look at issues associated with the NDIS space now—people presenting in hospital with disability. We are very tuned into these issues and mindful. Yes, we could go ahead and look at that, but at this point in time I do not think we have the capacity.

The CHAIR: It is a resourcing issue.

Ms Cowie: It is, and there is only so much I can really ask my staff to do, but I would like to take the office into that space. To help others with that though we prepare each year a disability—maybe I just need to go a step back. In addition to all our data on the complaints we receive, there are 25 health service providers and 20 disability providers who are prescribed under the regulations to provide us their complaints data at the end of every financial year. We take that data, we analyse it, we put a high level summary in our annual report and then we produce a health trends report and a disability trends report. We just released the two of them in March. That analyses all the data that has come from those prescribed providers. That, again, identifies issues that could be looked at from a systemic perspective. What we also do to help others is for the five public health service providers and Ramsay Health Care, St John of God and Corrections—because nearly 20 per cent of our health complaints work is from people in prisons—we do a summary of the complaints received for those providers and give them report cards each year as well now. We have not yet made them public. This is the second year we have done this and we will start to do that. Where we are not actually filling that space because of capacity at the moment, we are providing information to assist others as well, so trying to add value to the system in that way. I turn to the third dot point—is that okay?

The CHAIR: Yes.

Ms Cowie: I turn to the third dot point: “independent monitoring of the outcome for children and young people’s mental health and the adequacy of treatment provision for them across Western Australia”. I recently presented to the Mental Health Clinical Governance Review Panel and talked to them about a number of similar things I am talking about today. We have done a lot of work in the mental health space. We have just released some guidelines for complaint handling for mental health service providers.

[1.50 pm]

In March, they were on our website. That is a big area of work that we have done. They can then be used to help develop training. We have two service delivery areas—one is complaints handling and one is education and training. You may be familiar, from just gleaning from our annual report, that not only do we do complaint handling, we have that other side of our work—educating and training in the prevention and resolution of complaints. We do that in the mental health space. Leading into the new Mental Health Act 2014 that was implemented in November 2015, my predecessor had developed a mental health complaints partnership agreement and there was an action plan in there. That partnership agreement was with the Department of Health, the Mental Health Commission, the Mental Health Advocacy Service, the Office of the Chief Psychiatrist and the Health and Disability Services Complaints Office, and it had an action plan. Although the action plan expired 12 months after implementation in August 2016, we have continued to work with those organisations; for example, in developing the complaint handling guidelines, and we use them in training. One of the things we do there, too, for mental health is that we have a direct referral line from the Office of the Chief Psychiatrist, so they will deal with any urgent clinical issues that might arise on a phone call to them, and if it is a complaint-related matter, the matter will get transferred automatically to us. Sometimes things can be incremental—small, little steps—and then we will be able to move forward.

The CHAIR: It is very interesting listening to your description of the annual reporting that you do and the collation of complaints from different agencies and organisations. Do you have a relationship with the Commissioner for Children and Young People in terms of sharing information and requesting assistance from the commissioner? The commissioner has a statutory brief to listen to the voices of children.

Ms Cowie: Yes. My staff have met with the commissioner's staff. I write to the commissioner from time to time, letting him know that he is more than welcome to contact me. I talked very early on about that gap when people are transitioning from childhood to adulthood in terms of managing your own health. We just prepared an information sheet and put information on our website and did a poster for children and young people particularly for that area—the 14-year-olds to 18 group. I have sent that over to him. As I said, I am more than happy to talk with him about that.

The CHAIR: Are you yet in a position to measure any outcomes from your attempt to engage better with that age group? I ask you because the commissioner made the observation in his submission to this inquiry, which is a public document, that agencies are pretty good at fulfilling their statutory obligations, they are very good at producing reports and recommendations, but they are not so good at implementing anything, and they are very, very bad at measuring outcomes in terms of material benefits for children. People set up sometimes quite elaborate complaints handling systems or education systems to teach people how to work with children, but they have no way of measuring the outcome.

Ms Cowie: What comes to mind there is that I mentioned our report cards for the five public health service providers—using that report card to meet with the chief executive and the chair of the Child and Adolescent Health Service and talking about outcomes and change. As I was saying, from one complaint, you can see significant change that happens across an organisation, and sometimes across a sector actually. The ongoing measure of that? Well, in a complaints space, if you continue to get complaints about something that has been put in place, that is an indication that it has not worked. That does happen. Sometimes we have seen a commitment to change. Complaints will drop off for a while and then start emerging again. We would always look at any themes that would arise as well, and if we were making inroads to minimise the complaints in that space, are they tracking, coming up again? As an organisation, for example, since I have been in this role, I have not produced a report on systemic issues and made recommendations that I would then be wanting to follow up.

My view is that any report that is produced in that way that has recommendations should be followed up to see the change. Sometimes change can be small, little steps as well. In our annual report, you probably have noticed that our statistics are done to the age group of the mark of 24. I have given you statistics today for zero to 18. But having looked back over the last three years, because I know the statistics were quoted in the commissioner's report that you have referred to, the number of complaints involving a child has remained reasonably static. There could be a couple of things there—people do not know about us, complaints are getting managed at the local level, or things are plateauing and change is happening.

The CHAIR: It is interesting that you identified that cohort who are just beginning to seek their own medical services or seek medical services alone. How would they know about you?

Ms Cowie: A lot of it would be through our website. We would hope that with organisations that do exist, like the Commissioner for Children and Young People, the Mental Health Advocacy Service and the Office of the Chief Psychiatrist, that we would rely on those relationships and that their clients would be informed about us. I do not have a social media presence. Social media, in a complaints environment, can be a little difficult—staff can be defamed through a process like that, and I obviously want to protect staff. The other thing about it is that I have a duty of care to them. The other thing is that there is a lot of work involved in that space. I do not want to emphasise how small we are, but I did try to put everything in perspective and context. There is word of mouth as well. When we go out to organisations, we would talk about the role that we have with this emerging space. In responding to the focus on children that is present at the moment, we produce these products. Now it is like: how do we engage with people who are not ordinarily in our space to get that information out? For example, the boarding schools association is one area I would like to contact about it, because children at boarding school sometimes have to go to the doctor by themselves. It is making sure that I now have that outreach to people whom we would not necessarily outreach with at the moment. As I said, we have the big five health service providers and we have the disability service providers, who are larger than most et cetera. We went to regional visits. We accompany the Ombudsman's office. We are very privileged to be invited on their regional visits, so we hold complaint clinics. They are just small, little ways that are all incremental to help raise awareness. Interestingly, we also have a service delivery agreement with the Commonwealth of Australia to provide services in the Indian Ocean territories. Two of my staff are just returning home from a visit. We are required, under that agreement, to visit the Indian Ocean territories every two years. There would have been opportunities there for my staff to meet with youth as well. Where we can, we will always outreach to whoever we can. We can do more—there is no doubt that we could do more.

The CHAIR: The committee has been inviting witnesses to comment on this list of dot points that you can see on the screen now. These are referred to as the Paris principles. They are from an old Australian Law Reform Commission report, but they seem to have a lot of contemporary relevance and the Commissioner for Children and Young People certainly refers to them. You have covered a number of those. You have talked about regional and local representation, active participation by children and accessibility to all children. Is there anything else there that you think is worth commenting on in relation to HADSCO's activities?

[2.00 pm]

Ms Cowie: I do think, yes, I have covered statutory independence. The other point I would just note there is that I do have a reporting relationship to the Minister for Health through my legislation; nonetheless, that relationship is, I consider, a good relationship. You do not want to ever compromise your independence at all. There are certain things in the legislation that I am required

to do to fulfil my responsibilities towards the minister, but also there are certain things that a minister cannot do. For example, he cannot direct that I undertake an investigation about a particular matter unless certain provisions apply and in relation to the provision of information, it has to be with the consent of parties. Even though it is a model that is slightly different from an Ombudsman model because there is a minister involved, nonetheless I think that there are strong safeguards in place in the legislation to maintain that statutory independence.

The CHAIR: What about your investigative powers?

Ms Cowie: Yes, I have investigative powers. They are set out under the legislation that operates. I do not have royal commission powers like an Ombudsman does but I do have powers. I can apply for a warrant et cetera, so they are reasonably strong powers. The model that we operate under is very alternative dispute resolution based. A lot of matters are resolved through a negotiated settlement or conciliation. We can investigate, but the interesting thing about the investigation powers is that, in some ways, we might more likely use them in the disability sector, because what happens in the health and mental health sectors is there is the national registration and accreditation scheme. There are 15 registered health professional groups that are registered through what is called NRAS. You may have heard of NRAS. For example, a doctor, a nurse and a midwife are all registered. We are required by law that is set for registered practitioners—it is called the national law—to consult with the Australian Health Practitioner Regulation Agency for any matter that concerns the conduct of a registered health practitioner. So where a health practitioner is named, we are required by law to consult in relation to their performance and conduct. We do that once a week through a consultation meeting, normally by teleconference. It is determined which organisation then manages the complaint. Where I am coming to is that, for investigations in relation to performance and conduct, they are more likely to be done by the Australian Health Practitioner Regulation Agency.

The CHAIR: So if you get a complaint that involves Dr X, that is likely to be taken up by a body other than HADSCO?

Ms Cowie: Say, for example, it was about sexual misconduct, or if it was something that went wrong during surgery, a sentinel event et cetera, yes, it is most likely. Therefore, you can see how we do fit into that alternative dispute resolution space.

The CHAIR: Yes; I was just going to say because those complaints, by their very nature, would not be amenable to alternative dispute resolution.

Ms Cowie: Yes.

The CHAIR: Yes, I understand.

Ms Cowie: What I will say in relation to investigative powers is that there is what is called a national code of conduct for health practitioners, healthcare workers, basically, the unregistered health practitioner—so, anybody who does not fall within those 15 groups, for example. A massage therapist is not registered. They may belong to their own association, but they are not registered. The COAG Health Council decided in 2015 that health complaints commissions across Australia, including HADSCO, would be responsible for dealing with breaches against the national code of conduct. It is a self-regulating type system. You do not need to belong, but you need to make sure you comply with the code. The drafting instructions are with parliamentary counsel to amend our legislation to introduce the national code in Western Australia. That will very much change the role and functions of HADSCO though, because more than not we will investigate those types of matters for breaches of the code. They would include things like making false claims for cures—for example, a naturopath. It could involve sexual misconduct allegations for an unregistered practitioner that

ordinarily would be at AHPRA. That will change and will provide powers to the position that I hold to issue conditions on their practice or prohibition orders to stop them from practising, with appropriate appeal provisions to the State Administrative Tribunal.

The CHAIR: And the link, presumably, is that most of those investigations arise out of complaints rather than inspections.

Ms Cowie: Yes. But, interestingly, they will introduce own-motion powers. If we saw something in the media—a classic example—where we considered that somebody was acting not in accordance with the code, we could actually then investigate that without a complaint, whereas at the moment, I do not have those powers for the space we are in. Were there any others there?

The CHAIR: That is up to you, if you see anything there that you would like to address.

Ms Cowie: I think I have covered the good relationship with the decision-making bodies concerned with issues affecting children, because that does cover, as I say, both service providers and the relationships we have with other independent statutory authorities and oversight bodies as well. On active participation by children and accessibility to children, we have talked about accessibility. As I say, there is probably more we can do in that space. There is more we can do in a lot of spaces. We cover all demographics. I would like to have a stronger focus on Aboriginal health, Aboriginal disability and Aboriginal mental health. They are all areas for my term I would like to focus on as well. We have talked about regional and local representation. On access to research and statistics relevant to children, that covers what I was talking about in relation to what we do to provide those report cards of statistics of complaint trends. There are our annual reports and there is our external data collection report. More and more we have been asked, I think as many people are, for data and statistics that will assist. I hope some of those statistics that I have given to you today help assist with the work that you are doing.

The CHAIR: I want to finish, and then I will throw the questions to my colleagues, just by asking you about the recommendations of the royal commission. The state government has talked about a whole-of-government approach and they have a process being led by DPC. Is HADSCO part of that process?

Ms Cowie: No.

The CHAIR: Do you think HADSCO should be part of that process? Can we perhaps put the organisational charts up there, Michele? This is how DPC is organising the working groups.

Ms Cowie: No, I am not part of that. The oversight working group is there.

The CHAIR: Some of those groups are quite specific—redress, for example.

Ms Cowie: Yes, of course.

The CHAIR: The Department of Communities implementation working group is looking at things like harmful sexual behaviours. The criminal justice working group and police and justice—it is interesting that you are not represented on the oversight working group. You would have something to contribute in that discussion, I would have thought.

Ms Cowie: Yes. With the Department of the Premier and Cabinet, I am involved with the disability area for the transition to the NDIS, but I am not involved with this. I suppose as a question sometimes—I do not know if I am permitted to ask you questions, but —

The CHAIR: You can try!

Ms Cowie: It is a rhetorical question: do people know about my office? You may or may not have heard of my office before the invitations were issued to come along. Obviously, my office is referred

to in the commissioner's report. I do everything possible to raise the profile of my office. It is possible we have slipped under the radar.

The CHAIR: You are a unique part of the structure, because almost always we are talking to agencies who have a complaints function tacked onto the side. That is not to be disrespectful about some complaints mechanisms that are working quite well, but a lot of agencies have not really given very much thought to it. But clearly, in health and disability, we have you.

Ms Cowie: Yes; thank you.

The CHAIR: You are quite unique. Yes, we did know about you.

Ms Cowie: Thank you very much. I will be at whatever table people think I can add value to, because I do think my office can add value to many areas that we look at from a policy perspective.

[2.10 pm]

The CHAIR: Thank you for clarifying that. I had to ask you because you may have said, "Look, we were invited, but we decided that we weren't interested." But that is clearly not the case.

That brings us to the end. I do not think you have taken any questions on notice. If you have, Michelle will write to you. With that, I will formally close the hearing. Was there anything else you wanted to share with the committee? Was there anything else you think might be of use to us?

Ms Cowie: I think in preparing for today I have covered off much of what I would have wanted to let you know, and I thank you for your questions. They have helped me to contribute.

The CHAIR: Thank you. It has been a most enlightening hour.

Ms Cowie: Thank you.

The CHAIR: We appreciate it very much. 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 the period, it will be deemed to be correct. New material cannot be added by 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.

Thank you very much. It was very interesting.

Ms Cowie: Thank you.

Hearing concluded at 2.10 pm
