The following Australian Health Complaints Commissioners provide this submission to the review of the National Registration and Accreditation Scheme (NRAS). We have confined our submission to the aspects of the scheme that relate to the handling of complaints and notifications about registered practitioners.

- Leon Atkinson-MacEwen, Health Ombudsman, Queensland
- Lisa Coffey, Health and Community Services Complaints Commissioner, Northern Territory
- Richard Connock, Health Complaints Commissioner, Tasmania
- Mary Durkin, Health Services Commissioner, Australian Capital Territory
- Kieran Pehm, Health Care Complaints Commissioner, New South Wales

Introduction

The NRAS was introduced in 2010 to ensure that health practitioners can practise anywhere in Australia under one registration. Commissioners welcomed this move and consider that the national scheme has been successful in achieving many of its stated aims.

While the legislation for the individual jurisdictions included provisions that were specific to States or Territories, the opinions expressed in the second reading speeches from the respective jurisdictions largely contained shared themes – stated objectives were to improve safeguards for the public, provide greater workforce flexibility, and recognition of the benefits associated with an independent and transparent system. Equally, the ability to ensure high standards of conduct and competency was represented in each speech.

Commissioners consider that while some of these objectives have been realised, further examination is warranted regarding the extent to which the National Law delivers on the aims of independence, transparency, and ensuring high standards of conduct and competency. We submit that Commissioners are central to achieving these objectives. Some clarification about the role of Commissioners is warranted in this respect.

Role of Health Complaints Commissioners

The consultation paper for the current review notes:

*National Boards (supported by AHPRA) are responsible for the investigation and management of notifications about the health, performance and conduct of regulated health practitioners. These concerns often relate to the practitioner’s health (the practitioner is believed to have an illness, mental impairment, addiction or substance abuse problem that impacts on their ability to do their job); conduct (inappropriate behaviour); or performance (poor knowledge, skill or care).*
Health Complaints Commissioners are noted as having the following responsibilities:

The Health Complaints Entities deal with issues relating to: health systems (such as hospitals or community health centres) and fees and charges. The focus of HCEs is to resolve complaints through a voluntary process that involves both the person making the complaint and the person or organisation subject to the complaint. The possible outcomes from this process are: an opportunity for the complainant to discuss their concerns in a face-to-face meeting with the provider; an apology; provision of remedial treatment; or payment of compensation.

While Commissioners’ legislative functions vary, we note that our roles are broader than the summary in the review paper. To greater and lesser degrees, Health Complaints Commissioners regularly consider the actions of health professionals, as well as systemic issues, thus providing consumers or notifyers with a seamless response to their concerns. This is particularly the case in Queensland, New South Wales and the ACT where the National Law has been amended and where Commissioners assume a central role in determining whether or not action is to be taken in relation to practitioners who fail to meet standards of performance or behaviour.

The national model

Under the National Law, complaints or notifications may be received by the Health Complaints Commissioners or by the national Boards. The Law requires the Boards and Commissioners to inform each other of notifications or complaints received where the subject matter would also be a ground for complaint to the other. They must then consult each other on the handling of a notification and attempt to reach agreement about how the matter should be handled, including which organisation should deal with it. If agreement cannot be reached, the National Law requires that “the most serious action proposed by either must be taken”. Once a matter has been referred to a national Board for action, the Commissioners have no right under the National Law to reports or other evidence obtained as part of any further action, or to be informed about outcomes of the process. Commissioners are generally not consulted on any action or sanction arising from AHPRA investigations.

Queensland

In Queensland the Health Ombudsman assesses all complaints and notifications about health services and health service providers, including registered and unregistered health practitioners. The Ombudsman decides what action to take in relation to those complaints and, in certain instances, can take immediate action to protect the safety of the public. The Ombudsman may refer matters to the National Boards in certain circumstances. The Ombudsman also has a role to monitor the health, conduct and performance functions of the Australian Health Practitioner Regulation Agency and national health practitioner boards.

New South Wales

In New South Wales the Health Care Complaints Commissioner receives and deals with complaints involving individual health practitioners and health services. The Commissioner decides what action to take in relation to complaints and formally investigates those that raise
serious issues of public health and safety, or would lead to disciplinary action against the health practitioner. The Commissioner can refer a complaint about a registered practitioner to the relevant professional Council to consider taking action such as counselling, performance management or action regarding impairment. The Commissioner also can refer a complaint about a registered practitioner to the Director of Proceedings (within the Commission) who determines whether or not it should be prosecuted before a disciplinary body.

**Australian Capital Territory**

The ACT model is seldom recognised as another regime with ‘co-regulatory’ aspects. The model will be outlined in further detail later. In summary, the Commissioner receives and deals with complaints involving individual health practitioners and health services. The Commissioner has the power to retain all complaints but in practice refers a number to the national Boards for assessment or investigation by AHPRA (primarily for resourcing reasons). Regardless of which agency assesses a particular complaint, the practitioner’s response and any other material that is obtained, must be shared with the other agency. All decisions about complaint outcomes are to be made jointly between the Commissioner and the relevant Board and, if there is disagreement, the strongest view prevails. AHPRA is then responsible for implementing joint consideration decisions.

**Issues associated with current complaint/notification mechanisms**

The review paper summarises some of the concerns with the current mechanisms in the National Law for dealing with complaints or notifications.

*Even in the earliest stages of the Review concerns have been expressed by members of the public, ombudsman, jurisdictions and professions about the management of notifications under the National Scheme. These concerns include:*

- lack of understanding about the notifications processes and its intersection with State and Territory Health Complaints Entities complaints processes
- lack of information provided to notifiers where the matter has been referred to AHPRA as a notification of professional misconduct
- no single entry point for notifications and complaints
- delays in the preliminary assessment or investigation of concerns raised by notifiers
- delays in the finalisation of notifications
- poor communication with notifiers and practitioners
- notifier issues are not resolved in accordance with notifier expectations.

As parties with a unique experience in these processes, we would endorse this list as representing concerns that have been raised with us over the time that the National Law has been in operation. We note that not every concern is necessarily a reality in each jurisdiction, (for example there is a single point of entry in some jurisdictions) but consider that the list broadly reflects areas for further analysis.
When considering the aims outlined in the second reading speeches, Commissioners would add further concerns about a lack of transparency in relation to Boards’ decision making, whether Boards are truly ‘independent’ in making such decisions, and whether there are sufficient checks and balances in the scheme for handling complaints about practitioners. When a complaint is allocated under the National Law to the Boards for assessment or investigation, Commissioners may hold significant concerns about the particular practitioner. As noted above, however, the National Law (with the exception of the co-regulatory jurisdictions) does not allow for Commissioners to be informed about the outcome of those inquiries.

In a number of jurisdictions, Commissioners and AHPRA have developed ways in which to ensure that Commissioners have greater levels of involvement, for example, in the Northern Territory the Commissioner is involved in decisions following the preliminary assessment of matters by AHPRA. This is not the situation universally, however, and in the ACT, NSW and Queensland, Commissioners have been legislatively given an independent or ongoing role in relation to action that might be taken.

**Questions asked in the review paper**

Before addressing the specific questions in the review paper, further clarification of the ACT model is appropriate, as this model has elements that are worthy of consideration.

**The ACT model**

Unlike Queensland and NSW, where Commissioners are responsible for implementing prosecution or disciplinary action, the ACT model does not provide the Commissioner with this responsibility. Implementation of such action remains with AHPRA to progress, although the Commissioner retains some oversight of such decisions.

In the ACT, the National Law was amended in a number of ways. Features of the system include:

- The Boards are required to provide copies of all notifications/complaints to the Commissioner and vice versa.
- The allocation of complaints is subject to joint consideration, which includes a legislative hierarchy of decision making. Unlike other jurisdictions where the National Law provides that certain categories of complaints are in the Boards’ domain, if the Commissioner decides that a complaint is better assessed or investigated by the Commission rather than by the Boards (AHPRA), the Commissioner’s view will prevail.
- Regardless of which agency assesses a particular complaint, the practitioner’s response and any other material that is obtained, must be shared with the other agency. Similarly, relevant material must be exchanged following a formal investigation process. If a complaint is allocated to the Boards to investigate, for example, the Commissioner must be provided with a copy of AHPRA’s investigation report and all associated paperwork.
• The outcome of any assessment or investigation process is further subject to joint consideration between the Commissioner and the relevant Board. In the event of disagreement, the strongest view prevails. If a Board, for example, decides that a matter should be closed and the Commissioner considers that further action is warranted, the Commissioner’s view must be implemented, and vice versa.

• The hierarchy for decision making is outlined in the legislation. From most to least serious, it provides – immediate action; referral to the ACT Civil and Administrative Tribunal; Commission investigation or conciliation; AHPRA investigation; referral to a Performance and Professional Standards Panel; referral to a Health Panel; a decision to caution and/or impose conditions on a practitioner’s registration; no further action.

• When investigating complaints the Commission regularly seeks independent peer or expert reviews on clinical issues and issues around professional competence. These are generally sought from interstate so that there is no conflict of interest or perception of bias, as can inevitably be the case from time to time when local Boards are making decisions about their local peers.

• A range of oversight mechanisms are provided to the Commission in relation to Board processes, including the ability to appear and give evidence at Performance and Professional Standards Panel hearings. Boards are required to report back to the Commissioner on the outcomes of hearings.

These provisions provide the community with two separate reassurances.

First, the system is designed to ensure matters are appropriately investigated, and that the process is free of bias or perceptions of bias. The concept behind establishing the national Boards was to provide reassurances in this area but the idea is not necessarily realised in practice where local boards of the National Boards remain the decision makers in relation to their colleagues. This is particularly the case in the smaller jurisdictions. The office of the ACT Health Services Commissioner was originally established to address the shortcomings of past models, including the perception that there were repeated failures by boards to properly investigate complaints and take disciplinary action against negligent and incompetent practitioners. The amendments to the National Law in the ACT continue to provide independent scrutiny of Boards’ decision making.

Secondly, there is independent oversight of Boards/AHPRA’s processes. The Commissioner’s ongoing involvement in matters when a complaint has been allocated to the Boards, ensures that matters do not “fall through the cracks” and provides an additional level of oversight to ensure that decisions are implemented. Similarly, when a matter has been allocated to the Commission, the Boards/AHPRA are able to check on progress and reasons for any delays.

Some elements of the ACT Scheme have been implemented as working arrangements with AHPRA in State and Territory jurisdictions but there is no national consistency in this area. Some improvements to this regime are also required to address issues that have arisen in implementation. These will be discussed later.
**Question 9:** What changes are required to improve the existing complaints and notifications system under the National Scheme?

In our view, Commissioners are well placed to ensure greater accountability for public health and safety in relation to concerns about health practitioners. A scheme that provides an enhanced role for Commissioners when the Boards are dealing with complaints about practitioners, would address a number of the concerns raised in the review paper. It would also provide additional confidence that Boards are not making decisions without input from an independent body. This might be achieved through establishing a sole independent complaints handling body, as in Queensland or NSW. It can also be achieved to a significant extent by further developing an equal partnership with the registration Boards along the lines of the ACT model.

If any of the co-regulatory models were to be adopted nationally, resourcing issues for Commissions must be addressed. We note that the Health Ombudsman Act in Queensland includes provision for the redirection of registrants funds from AHPRA to the office of the Health Ombudsman to fund that portion of the Ombudsman’s work that otherwise would have been done by AHPRA and the Boards.

The Queensland model may be the most easily adapted model for other jurisdictions (while recognising that the New South Wales model also provides the desired outcomes of independence and impartiality in complaint handling). The Queensland model has not, however, been tested over any lengthy period of time and it would be useful to obtain some evaluation of its success in due course. We believe, however, that the current review should head in the direction of co-regulation. Introducing essential elements of the co-regulatory models, in particular by providing for Commissioners’ involvement in decision-making about actions to be taken following investigations, provides the best opportunity to achieve greater transparency and accountability.

**Question 10:** Should the co-regulatory approach in Queensland, where complaints are managed by an independent Commissioner, be adopted across all States and Territories?

The Queensland model certainly provides a single point of entry for complainants and notifiers, as well as addressing concerns about perceptions of bias or conflicts of interest when Boards deal with notifications. The Queensland model (as with NSW) goes a further step than in other jurisdictions, however, and places prosecution action in the Ombudsman’s domain. The Queensland legislation also provides that the national Boards retain their powers to take immediate action if necessary.

Commissioners note that if the Queensland model were to be adopted, this would significantly change the current roles and workloads for Commissions. Resourcing issues would need to be addressed as many Commissioners do not currently have the responsibility or expertise in implementing prosecution decisions or other disciplinary processes. This is a role undertaken by AHPRA.
Providing Commissioners with oversight responsibilities in relation to AHPRA’s implementation of prosecution decisions or decisions to place restrictions on a practitioner’s registration, may also be a cost-effective solution (while recognising that this also will have resourcing implications for Commissioners). In the ACT, for example, the Commissioner’s right to be provided with reports on the outcomes of Panel hearings, and to attend Panel hearings, provides a level of oversight that ensures decisions are properly implemented.

**Impact of unregistered practitioner/Code of Conduct measures**

We also note that the Australian Health Ministers Advisory Council (AHMAC) has already determined that Commissioners will assume a new function to take enforcement action in relation to unregistered practitioners based on a National Code of Conduct. This would involve Commissioners issuing prohibition orders that prevent unregistered practitioners from practising or placing restrictions on their scope of practice. This is already a role for Commissioners in New South Wales, Queensland and South Australia. Legislation in the Victorian parliament also anticipates this role for the Victorian Commissioner.

While the arrangements for implementing this function is a policy decision for each State and Territory, its potential implementation in each jurisdiction will necessarily require Commissioners to develop greater legal expertise and face possible involvement in court proceedings if practitioners seek to appeal Commissioners’ decisions. Those jurisdictions that already have this responsibility have noted that this function has necessitated a significant increase in the need to take a more legalistic approach to handling matters related to the health, conduct or performance of unregistered practitioners, in comparison to the less formal processes resolution processes currently adopted by Commissioners.

Implementation of the AHMAC decision would see Commissioners increase capacity and expertise in an area that could indicate a greater ability to undertake prosecution functions in the longer term.

**Question 11:** Should there be a single entry point for complaints and notifications in each State and Territory?

A single entry point for complaints and notifications in each State and Territory would address frustrations currently experienced by complainants and notifiers, and would lead to a better understanding of processes by providers. From a consumer’s perspective, they do not understand why their complaint would be split into parts and dealt with by different entities. If Commissioners have the ability to take on matters that involve a range of complaints including professional and systemic issues, this confusion could be resolved.

A single point of entry is not necessarily the only model that would reduce complainants’ confusion. The ACT model allows for the agency that receives the complaint or notification to deal with it, as the Commissioner has the power to direct which organisation will deal with matters. This is achieved through the legislative hierarchy that enables the Commissioner to
retain all matters, or allow matters to be handled by AHPRA. Complainants are then satisfied that the agency they have approached is the agency with which they will have ongoing contact. At the end of either agency’s investigation, action in relation to registered practitioners is jointly considered with the respective Boards and AHPRA implements those decisions. Liaison with the complainant or notifier remains with the receiving agency. Resourcing constraints have, however, necessitated the referral by the Commissioner of most matters received by the Commission to the Boards/AHPRA for assessment or investigation. This has precluded the Commissioner from providing complainants with a “one stop shop”.

The undersigned Commissioners believe that a single point of entry is the optimal approach. In our view, that point of entry should be the Commissions. Health Complaints Commissioners are able to provide a more comprehensive service, providing outcomes for complainants as well as addressing practitioner issues. A move towards a model that places decision making with Commissioners about how complaints will be handled, would provide an effective single point of entry.

**Question 12:** Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

**Legislative timeframes**

Commissioners note that if a single point of entry were to be progressed (and with Commissions undertaking that role), local legislation would require amendment as well as the National Law in relations to timeframes. Currently each State and Territory’s legislation deals with timeliness in different ways.

Delays in complaint handling are clearly a matter for concern, for complainants, providers and complaint handling authorities. Legislative timeframes are a useful pressure for complaint handling authorities to seek to resolve matters as quickly as possible. They can also, however, be an impediment to thorough investigation processes and can provide a perverse incentive for complaints handling authorities to close matters when further investigation may be warranted in the circumstances. Legislative timeframes may prompt complaint handling authorities (not just in the health complaints jurisdiction) to explore methods to ‘stop the clock’ in complaint processes to ensure that statistics and public accountability are achieved.

Delays can be experienced for a range of reasons, including personal elements preventing complainants or respondents from meeting deadlines; the involvement of lawyers representing either party, with continuous challenges around issues of procedure or legal technicalities; the need to source unbiased expert opinions from busy health practitioners; the time required to establish the full extent of a complainant’s ongoing injuries as a result of negligence or substandard care; and for a host of other reasons.

While Commissioners recognise that complaint handling agencies should be subject to an imperative to deal with complaints as efficiently and as expeditiously as possible, the nuances of complaint handling need to be recognised in any system. Legislative imperatives should not
encourage the early closure of complaints that require further investigation or where delays are experienced for objectively justifiable reasons.

Commissioners recognise that they have a responsibility to ensure that their processes and procedures are efficient, that they have adequately trained staff, and that there is adequate supervision of complaint handling. Commissioners would caution, however, against having time constraints that are too restrictive when considering the realities of complaint handling. A legislative imperative to handle complaints expeditiously and update complainants or notifiers about progress in dealing with a matter, and providing reasons for delays, is appropriate. An obligation to report against performance would also provide reassurances about the timeframes in which complaints are handled.

The approach adopted in Queensland, whereby the Health Ombudsman can take a number of “relevant actions” (including resolution, conciliation and investigation) concurrently, with each action subject to a separate legislative timeframe, is one potential solution to the need for Commissioners to have flexibility to deal with matters with clear legislative guidance on expected timeframes.

If national legislative timeframes are to be implemented, however, complaints handling authorities must be adequately resourced to deliver on such imperatives.

**Administrative solutions to current delays**

Commissioners note that a reduction in delays in current processes could be achieved by some simple changes to how the Boards and AHPRA operate. Initial joint consideration processes to determine which body will assess a complaint would be improved if all Boards were to delegate this decision to AHPRA in all jurisdictions so that there no delays in progressing a complaint/notification. This already occurs in some jurisdictions.

Delays would also be mitigated if joint consideration were to be conducted directly between Commissioners and Boards. Again, this already occurs in some jurisdictions, such as the Northern Territory where certain matters have been resolved directly with Boards.

The majority of complaints are in relation to registrants of the Medical Board and Nursing and Midwifery Board, where local Boards exist in each jurisdiction. Direct joint consideration would significantly reduce delays that can currently be experienced because of AHPRA’s need to wait for meetings of Boards to ratify joint consideration decisions, and then refer back to Complaints Commissioners in relation to implementation of decisions. This is particularly the case in the ACT jurisdiction where joint consideration occurs at the end of assessment and investigation processes. Delays are experienced when either agency queries the position taken by the other and clarification cannot occur until the next meeting of a Board. These delays would be obviated by direct discussions in one joint meeting. Direct joint consideration would address communication misunderstandings and enable any differences of opinion to be resolved immediately.
**Question 13:** Is there sufficient transparency for the public and notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?

**Transparency of processes**

Commissioners recognise that it is appropriate for complaints to be handled in a way that ensures confidentiality for practitioners who are subject to complaints. There are many reasons why practitioners might be subject to complaints that do not have substance. The public do, however, need to be confident that complaints handling processes are impartial and that independent oversight of Boards’ decision making has ensured a lack of bias. Commissioners are not criticising Boards in this respect but note that a perception of bias is a reality in many consumers’ minds.

The ACT model, where joint consideration between Boards and Commissioners occurs at the end of any assessment or investigation process, can provide such assurances. It has been the ACT Commissioner’s experience that complainants and notifiers take comfort from reassurances that the Commissioner has endorsed decisions made by Boards. For joint consideration to be most effective, the current model could be improved by legislating that joint consideration is to occur following ‘show cause’ processes and following health and performance assessments, as well as after other processes. In the ACT a number of the Commissioner’s ‘stronger view’ decisions have been overturned following ‘show cause’ processes, apparently based on the same reasoning that was initially proposed by Boards.

In the last financial year, for example, the Commissioner took the stronger view on seven occasions, while Boards took the stronger view on five occasions. The Commissioner decided to impose two cautions, refer one matter to a Performance and Professional Standards Panel, require further investigation by AHPRA in relation to two matters, and to undertake a Commission investigation in two matters. The two cautions were not progressed as the respective Boards decided not to proceed with the cautions following ‘show cause’ processes. The five occasions when a Board decided to take the stronger view occurred when Boards decided to impose conditions in one case, to progress three investigations, and to issue one caution. It is to be noted that the ACT is a small jurisdiction with relatively low complaint numbers and it is likely that Commissioners’ involvement in larger jurisdictions would see a greater proportion of matters being subjected to ‘stronger’ views. This represents an invaluable check and balance in the system.

We also submit that any legislative impediments to the complete sharing of information between the Boards/AHPRA and Commissioners be removed. As noted above, this will assist Commissioners in undertaking resolution activity. It will also assist Commissioners in progressing systemic concerns that may be related to the actions of individual practitioners.

**Feedback on outcomes**

As noted above, Commissioners agree with the observations made by the reviewer in the consultation paper that complainants are regularly frustrated by the lack of information when a
matter has been referred to AHPRA, that there is poor communication with notifiers and providers, and that notifier issues are not resolved in accordance with notifier expectations.

We submit that transparency should be increased by providing a legislative obligation on all complaint agencies, whether this be Commissions or Boards/AHPRA, to provide complainants or notifiers with reasons for decisions at the completion of complaint processes. The extent and nature of the information provided will vary in appropriate circumstances. Discretion would need to be applied for example in circumstances where a practitioner has an impairment and their personal health information should remain private. Only limited assurances should be provided to complainants in such circumstances. Further, it would not be appropriate to provide all individual notifiers with extensive feedback if they have not been the recipient of the health service or they have no genuine interest in the complaint matter. We would also encourage greater sharing with employers, as they have a responsibility to ensure that the practitioners they employ meet the standards of practice expected of their particular profession.

On the other hand, we believe that files held by Commissions and Boards/AHPRA in relation to complaint and notification matters should be exempt from Freedom of Information (FOI) legislation to provide appropriate protection for information that should not be publicly available during the course of investigations. Considerable effort is currently expended across jurisdictions in responding to FOI requests, particularly from the media, when the outcome is generally that the material sought is exempt from release on personal information grounds. We submit that an exemption from FOI legislation would prevent the unnecessary diversion of resources to undertake FOI processes. The parties should, of course, be provided with access to their own information.

**Question 14:** Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

Providing the National Boards with alternative dispute resolution mechanisms would introduce an additional level of confusion for consumers and depart further from the ‘one stop shop’ concept.

Alternative dispute resolution expertise has traditionally rested with Commissioners and there does not appear to be a strong rationale for moving this role to the Boards. The ability for Commissioners to settle matters by consent would be enhanced if Board decisions and reasons for decisions were available to all Commissions at the end of assessment or investigation processes. If Commissions concurrently proceed with conciliations while Boards investigate conduct or competence issues, Commissions lose the ability to look at individual culpability when conciliating and, more importantly, assess vicarious liability issues. Access to Boards’ expertise would assist in addressing consumer concerns during conciliation processes. An early opinion from Boards when it is agreed that Commissions will conciliate would be useful.
If Commissions are able to effectively conciliate matters following the completion of Board processes in relation to the actions of individual practitioners, the provision of Board decisions and the reasons for decisions, and any expert opinions that have been obtained, should be provided to Commissioners. Similarly, performance and professional standards panel decisions, and health panel decisions, should be provided to Commissioners so that all relevant material is available to Commissions in determining the scope and approach to conciliations.
We note that this material is currently available to the ACT Commissioner and to the Queensland Health Ombudsman, and is invaluable in making decisions whether or not to conciliate. For example, the Commissioner/Ombudsman does not proceed with conciliations where it would impact negatively on the health of an impaired practitioner.

Conclusion
We consider that transparency, accountability, and achieving a fair balance of rights between complainants and practitioners in the handling of complaints, are essential to public confidence. All of these attributes would, in our view, be strengthened by providing independent complaints Commissioners with an increased role in the procedures for handling complaints against practitioners.

While Queensland and NSW legislation has given a substantial role to the independent Ombudsman and Commissioner, a model along the lines of that currently in the ACT, is also worthy of consideration in achieving these outcomes.

If the current review recommends a co-regulatory approach in relation to complaint handling, we recommend that further consultation be undertaken with all Commissioners regarding the aspects of the current co-regulatory models that should be adopted, how implementation should occur, and what funding is required to deliver on co-regulation.

Signed on behalf of the following Commissioners by Mary Durkin:

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Lisa Coffey, Northern Territory

Richard Connock, Tasmania

Mary Durkin, Australian Capital Territory

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