Inquiry into Abuse in Disability Services
Committee functions

Extract from the *Parliamentary Committees Act 2003 (Vic)*

S.11 The functions of the Family and Community Development Committee are, if so required or permitted under this Act, to inquire into, consider and report to the Parliament on—

(a) any proposal, matter or thing concerned with—

   (i) the family or the welfare of the family

   (ii) community development or the welfare of the community

(b) the role of Government in community development and welfare, including the welfare of the family.
Committee membership

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Ms Cindy McLeish MP
Deputy Chair
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Terms of reference

To the Family and Community Development Committee — for inquiry, consideration and completion of an interim report no later than 31 July 2015 and a final report by no later than 1 March 2016 an inquiry into abuse in disability services and —

(a) in particular the inquiry will include but not be limited to:

(i) why abuse is not reported or acted upon; and

(ii) how it can be prevented;

(b) the Committee should note that the Victorian Ombudsman is currently conducting an investigation into how allegations of abuse in the disability sector are reported and investigated, including the effectiveness of the statutory oversight mechanisms in reviewing incidents and reporting on deficiencies (Ombudsman’s investigation) and that this investigation will cover services which include residential, respite and day programs funded by the Victorian Government;

(c) in undertaking the inquiry, the Committee should:

(i) seek not to prejudice any investigations being undertaken by the Ombudsman or any Victorian Government agencies or any legal proceedings; and

(ii) work cooperatively with the Ombudsman to avoid unnecessary duplication;

(d) the inquiry will be conducted in two stages:

(i) Stage 1:

(A) the Committee should consider the strengths and weaknesses of Victoria’s regulation of the disability service system with a view to informing Victoria’s position on appropriate quality and safeguards for the National Disability Insurance Scheme, this may include issues being considered for the quality and safeguards framework including:

(I) workforce recruitment, screening, induction, training and supervision;

(II) provider registration requirements;

(III) systems for handling complaints; and

(IV) the impact of current systemic safeguards on the rights and protections of people accessing disability services;
(B) the Committee should have regard to any preliminary findings, recommendations or advice from the Ombudsman’s investigation, and any other evidence that the Committee considers appropriate;

(C) the Committee is requested to provide an interim report to the Parliament (on the matters set out in paragraph (d)(i)(A)) no later than 31 July 2015;

(ii) Stage 2:

(A) the Committee should consider any further systemic issues that impact on why abuse of people accessing services provided by disability service providers within the meaning of the Disability Act 2006 are not reported or acted upon and this should include:

(I) any interim measures to strengthen the disability services system prior to transition to the National Disability Insurance Scheme;

(II) any measures to strengthen the capacity of providers to prevent, report and act upon abuse to enhance the capability of service providers to transition to the National Disability Insurance Scheme; and

(III) any measures to support people with a disability, their families and informal supports to identify, report and respond to abuse;

(B) the Committee should undertake research to determine best practice approaches to how abuse of people accessing services provided by disability service providers within the meaning of the Disability Act 2006 can be prevented and this should include:

(I) identifying early indications of abuse;

(II) strategies to prevent abuse occurring;

(III) consideration of needs specific to particular cohorts;

(C) the Committee should examine the powers and processes of Victorian investigation and oversight bodies with jurisdiction over abuse of people with a disability, with particular focus on the ongoing role of these bodies in the context of the National Disability Insurance Scheme; and

(D) the Committee should have regard to the final report, findings and recommendations of the Ombudsman’s investigation, and any other evidence that the Committee considers appropriate.
The abuse of people who access disability services is a disturbing violation of the trust placed in organisations whose primary role is to support people with disability to engage and participate in the community.

In view of recent revelations of abuse that have shocked the community, the safeguarding mechanisms and watchdogs that operate in Victoria have come under considerable scrutiny. Evidence to the Inquiry suggested that these revelations are the ‘tip of the iceberg’. Evidence from the Inquiry suggests that there is a significant level of underreporting of abuse, and in some cases a failure to report abuse.

With the transition to the National Disability Insurance Scheme (NDIS) to commence in 2016 during a three year rollout period, this is a timely Inquiry. It provides a valuable opportunity to assess what safeguards are currently in place and to inquire into their effectiveness for future prevention of abuse in disability services.

It is also timely to consider what needs to happen in Victoria, both during the transition and beyond the transition.

Our Inquiry has been separated into two stages. Stage 1 has asked us to inform Victoria’s position on the proposed NDIS quality and safeguarding framework. We are mindful that while it has made recommendations to this effect, the Disability Reform Council may choose an approach that differs from these recommendations.

In view of this, Stage 2 of our Inquiry is an important opportunity to consider what safeguarding measures need to be in place in Victoria. We heard a firm view that while improvements can be made in the Victorian system, in the transition to the NDIS there should be no weakening of the safeguards that currently exist.

We have recommended a quality and safeguarding framework that takes into account the existing strengths of the Victorian system, but that also proposes improvements to overcome its limitations.

In reviewing the evidence provided to the Inquiry in written submissions and oral presentations, as well as other information the Committee sought, it is evident there are many concerns about the current system of oversight in Victoria.

In light of this, we have identified some questions to inform Stage 2 of our Inquiry. These questions are not intended to be exhaustive and further questions will emerge in Stage 2.

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1 The Council of Australian Governments Disability Reform Council oversees the trial and implementation of the NDIS. The Council consists of Commonwealth, State and Territory Ministers with responsibility for disability policy and supports.
On behalf of the Committee, I thank everyone who has contributed to this Stage of our Inquiry despite its tight timelines. We have valued the contributions of those who provided written and oral evidence to our Inquiry, often with short notice.

I also express my appreciation to the staff of the Secretariat for their hard work in short timelines and their support to the Committee in producing our interim report — Janine Bush (Executive Officer), Vicky Finn (Research Officer), Patrick O’Brien (Research Officer) and Helen Ross-Soden (Administrative Officer).

And finally, I would personally like to express my appreciation to the Committee Members for their commitment and collaborative approach — Cindy McLeish MP (Deputy Chair), Chris Couzens MP, Paul Edbrooke MP, Bernie Finn MLC, Emma Kealy MP, and Suzanna Sheed MP.

Maree Edwards, MP
Chair
## Glossary

**Community Visitors**

Community Visitors are volunteers appointed by the Governor in Council to visit accommodation facilities operating under the Disability Act. They can inquire into various matters relating to service delivery, including whether the rights of people with disability are being upheld and cases of suspected abuse or neglect of people with disability.

**Complaint**

A complaint is the expression of dissatisfaction with a decision, service or product.

**Compulsory treatment**

Compulsory treatment is treatment of a person who is admitted to a residential treatment facility, under direction of a court order as specified in section 152(2) of the Disability Act 2006 (Vic) or who is subject to a supervised treatment order issued by VCAT as specified in section 191 of the Act.

**Critical incident**

The term used by Department of Health and Human Services in Victoria to describe a reportable incident that relates to a serious outcome (severe trauma or death), or a threat to the health, safety or wellbeing of people who access disability services. See also ‘reportable incident’ and ‘serious incident’.

**Department of Health and Human Services (DHHS)**

The Department has a multifaceted and complex role, including responsibility under the Disability Act 2006 (Vic) to promote the rights of people accessing disability services and to support the provision of quality disability support services. In order to meet these responsibilities, the Department has a range of functions.

**Dignity of risk**

The right of people to choose to take some risk in engaging in life experiences.

**Disability Act 2006 (Vic)**

The Act sets out principles for people with disability and for disability service providers. The Act aims to provide a stronger whole of government, whole of community response to the rights and needs of people with disability, and a framework for the provision of high quality services and supports for people with disability.

**Disability Reform Council**

The Council of Australian Governments Disability Reform Council oversees the trial and implementation of the NDIS. The Council consists of Commonwealth, State and Territory Ministers with responsibility for disability policy and supports.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Disability Service Provider</td>
<td>A person or body (for example a community service organisation) that provides disability services under the Disability Act 2006 (Vic) and is registered on the register of disability service providers. The Department of Health and Human Services is also a disability service provider.</td>
</tr>
<tr>
<td>Disability Services Commissioner</td>
<td>The Disability Services Commissioner was established on 1 July 2007 under the Disability Act 2006 (Vic) to improve services for people with disability in Victoria through assisting in the resolution of complaints raised by or on behalf of people who receive services. The Commissioner is a statutory body that functions independent of government, the Department of Health and Human Services and Victorian disability services to provide a free, confidential and supportive complaints resolution process.</td>
</tr>
<tr>
<td>Disability Worker Exclusion List (DWEL)</td>
<td>The Disability Worker Exclusion List details people who pose a threat to the health, safety or welfare of people with a disability living in disability residential services.</td>
</tr>
<tr>
<td>Disability Worker Exclusion Scheme (DWES)</td>
<td>The Disability Worker Exclusion Scheme was introduced in Victoria in September 2014. It seeks to ensure that people who pose a threat to the health, safety or welfare of people with a disability are excluded from working in disability residential services in Victoria.</td>
</tr>
<tr>
<td>Guardianship</td>
<td>The appointment of a person to make decisions for an adult with a disability when they are unable to do so.</td>
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<tr>
<td>IGUANA</td>
<td>The Interagency Guideline for Addressing Violence, Neglect and Abuse is a good practice guideline for organisations, staff members and volunteers working with adults who are at risk of violence, neglect or abuse. The guideline states what action should be taken if a situation involving violence, neglect or abuse is reported to, witnessed by, or suspected by a staff member or volunteer.</td>
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<tr>
<td>Individualised or self-directed funding</td>
<td>Where government funds can be given directly to service users to then purchase services. This would mean service providers receive funding only after being approached (chosen) by the service user.</td>
</tr>
<tr>
<td>Individual Support Package (ISP)</td>
<td>An ISP enables a person to provide direction for the identification and implementation of supports that are most appropriate to their individual needs and circumstances. It enables the person to exercise choice in obtaining support that will assist them to achieve their goals and pursue their own lifestyle.</td>
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<tr>
<th>Glossary Item</th>
<th>Definition</th>
<th>Sources</th>
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<tr>
<td>Individual Support Plan</td>
<td>The <em>Disability Act 2006 (Vic)</em> requires that a person has a support plan in place if they are in receipt of an ongoing disability support such as an Individual Support Package (ISP). The support plan outlines the person's goals and the strategies and resources required to achieve those goals. If the supports require disability funding, these need to be written in a funding proposal.iv</td>
<td></td>
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<tr>
<td>National Disability Insurance Agency (NDIA)</td>
<td>An independent statutory agency whose role is to implement the National Disability Insurance Scheme (NDIS).vi</td>
<td></td>
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<tr>
<td>National Disability Insurance Scheme (NDIS)</td>
<td>The new way of providing individualised support for eligible people with permanent and significant disability, their families and carers.vi</td>
<td></td>
</tr>
<tr>
<td>National Disability Services (NDS) Victoria</td>
<td>The Victorian state office of the national peak body for non-government disability service organisations. Its purpose is to promote quality service provision and life opportunities for Victorians with disability.vi</td>
<td></td>
</tr>
<tr>
<td>Office of the Public Advocate</td>
<td>A statutory body established under the <em>Guardianship and Administration Act 1986 (Vic)</em> with the primary function as a guardian of last resort. Functions and powers include being appointed as a statutory guardian, providing advice and assistance, investigating complaints and advocating behalf of people with disability.</td>
<td></td>
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<tr>
<td>Productivity Commission Report</td>
<td>In February 2010 the Australian Government requested the Productivity Commission undertake an inquiry into a national disability long-term care and support scheme. The inquiry assessed the costs, cost effectiveness, benefits, and feasibility of the scheme. On 31 July 2011, the Productivity Commission provided the <em>Disability care and support report</em> to the Australian Government, which was released on 10 August 2011.</td>
<td></td>
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<tr>
<td>Quality of Support reviews</td>
<td>Quality of Support reviews are undertaken to ensure appropriate action has been taken to support a client’s health, safety and wellbeing following an incident. They are undertaken for all allegations of physical or sexual assault of a client by a staff member in disability services. A quality of support review may also be undertaken for patterns of unexplained injuries.</td>
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### Glossary

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<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Reportable incident</td>
<td>A ‘serious’ or ‘critical’ incident, such as abuse or neglect, which is required to be reported and investigated and results in appropriate actions being undertaken in response to the incident. See also ‘critical incident’ and ‘serious incident’.</td>
</tr>
<tr>
<td>Restrictive intervention</td>
<td>A restrictive intervention includes any intervention used to restrict the rights and freedom of movement of a person with a disability and can include the use of chemical, physical or mechanical restraint or seclusion. Restrictive interventions can only be used to prevent the person hurting themself or others and require an approved Behaviour Support Plan to be in place before an intervention is used.</td>
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<tr>
<td>Self-directed funding</td>
<td>see Individualised funding.</td>
</tr>
<tr>
<td>Senior Practitioner (Disability)</td>
<td>The Senior Practitioner (Disability) was established in 2007 by the Disability Act 2006 (Vic). Its remit is to ensure the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to these practices are complied with.</td>
</tr>
</tbody>
</table>
| Serious incident            | A serious incident is:  
                          • the death of, or serious injury to, a participant  
                          • allegations of, or actual, sexual or physical assault of a participant  
                          • significant damage to property or serious injury to another person by a participant. |
| Zero Tolerance Framework    | The Zero Tolerance Framework was developed by National Disability Services in 2013. Its aim is to help the non-government sector provide safeguarding approaches for people with disability. It also aims to identify specific strategies for service providers to improve prevention, early intervention and responses to abuse, neglect and violence experienced by people with disability. |
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABI</td>
<td>Acquired Brain Injury</td>
</tr>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>AMIDA</td>
<td>Action for More Independence and Dignity in Accommodation</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CRA</td>
<td>Communication Rights Australia</td>
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<tr>
<td>CSO</td>
<td>Community Service Organisations</td>
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<tr>
<td>Cth</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>CV</td>
<td>Community Visitor</td>
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<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>DHS</td>
<td>the former Department of Human Services (now DHHS)</td>
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<tr>
<td>DSC</td>
<td>Victorian Disability Services Commissioner</td>
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<tr>
<td>DSS</td>
<td>Department of Social Services</td>
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<tr>
<td>DWEL</td>
<td>Disability Worker Exclusion List</td>
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<tr>
<td>DWES</td>
<td>Disability Worker Exclusion Scheme</td>
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<tr>
<td>HACC</td>
<td>Home and Community Care</td>
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<tr>
<td>HACSU</td>
<td>Health and Community Services Union</td>
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<tr>
<td>IGUANA</td>
<td>Interagency Guideline for Addressing Violence, Neglect and Abuse</td>
</tr>
<tr>
<td>IR</td>
<td>Incident Reporting</td>
</tr>
<tr>
<td>ISP</td>
<td>Individual Support Package</td>
</tr>
<tr>
<td>LISA</td>
<td>Lifestyle in Supported Accommodation</td>
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<tr>
<td>NDIA</td>
<td>National Disability Insurance Agency</td>
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<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
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<tr>
<td>NDS</td>
<td>National Disability Services</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>NT</td>
<td>Northern Territory</td>
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<td>OPA</td>
<td>Office of the Public Advocate</td>
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<tr>
<td>OSP(D)</td>
<td>Office of the Senior Practitioner (Disability)</td>
</tr>
<tr>
<td>QoSR</td>
<td>Quality of Support Review</td>
</tr>
<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>TAC</td>
<td>Transport Accident Commission</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>TAS</td>
<td>Tasmania</td>
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<tr>
<td>VALID</td>
<td>Victorian Advocacy League for Individuals with Disability Inc</td>
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<tr>
<td>VCAT</td>
<td>Victorian Civil and Administrative Tribunal</td>
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<tr>
<td>VDSC</td>
<td>Victorian Disability Services Commissioner</td>
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<tr>
<td>VEOHRC</td>
<td>Victorian Equal Opportunity and Human Rights Commission</td>
</tr>
<tr>
<td>VIT</td>
<td>Victorian Institute of Teaching</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
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<tr>
<td>WDV</td>
<td>Women with Disabilities Victoria</td>
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<tr>
<td>YDAS</td>
<td>Youth Disability Advocacy Service</td>
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</table>
Executive summary

The introduction of the National Disability Insurance Scheme (NDIS) provides a valuable opportunity to consider what safeguarding mechanisms need to be in place to ensure the rights and dignity of people with disability are upheld.

It is a chance to look beyond the boundaries of what is currently in place in various states and territories and to consider what would be the most effective and appropriate quality and safeguarding system for service providers in Australia operating in the context of the NDIS.

It also provides an opportunity to learn from the strengths and weaknesses of existing systems, while considering an entirely new framework with relevant functions and adequate powers.

Scope—Stage 1 of the Inquiry

The terms of reference for the Inquiry ask the Committee to consider the safeguarding arrangements for people with disability in two Stages:

• Stage 1
  – to inform Victoria's position on appropriate quality and safeguards for the NDIS.

• Stage 2
  – to consider systemic issues and any interim measures to strengthen the disability services system prior to transition to the NDIS
  – to examine the powers and processes of Victorian investigation and oversight bodies with a particular focus on the ongoing role of these bodies in the context of the NDIS.

The Committee considered the current safeguarding mechanisms to inform Victoria’s position on appropriate quality and safeguards for the NDIS. In doing this, it also raised a number of questions that are relevant to Stage 2 of the Inquiry and the nature of the interim arrangements that may need to be in place during the transition to the NDIS.

People and organisations interested in informing the Committee’s final report and its recommendations will have the opportunity to participate in Stage 2 of the Inquiry. Stage 2 will provide further opportunity for people to express their views and opinions about the interim arrangements in Victoria alongside a number of other relevant issues contained within the terms of reference.
The national quality and safeguarding framework

In the terms of reference for Stage 1 of the Inquiry, the Committee is required to inform Victoria’s position on the national quality and safeguarding framework.

In February 2015, the Australian Government issued a Consultation Paper on a Proposal for an NDIS Quality and Safeguarding Framework (NDIS Consultation Paper). The Disability Reform Council will hold discussions and intends to agree on a national framework in early 2016.\textsuperscript{viii}

The NDIS Consultation Paper proposes three domains in a national quality and safeguarding framework. These domains are—developmental, preventative and corrective. More specifically it consulted on five elements that relate to the preventative and corrective domains:

- NDIA provider registration
- safeguards for participants who manage their own plans
- systems for handling complaints
- ensuring staff are safe to work with participants
- reducing and eliminating restrictive practices in NDIS funded supports.

A number of sources of information and evidence have assisted the Committee in reaching its recommendations for Stage 1 and identifying emerging questions for Stage 2 of the Inquiry. In addition to evidence from Inquiry participants, this also includes the Victorian Ombudsman’s report tabled in June 2015 on Reporting and investigation of allegations of abuse in the disability sector: Phase 1—the effectiveness of statutory oversight (Phase 1 Report). It also includes other submissions that have been provided to the NDIS Consultation Paper and the Senate Community Affairs References Committee Inquiry into the abuse of people in institutional and residential settings.

Limitations—NDIS Consultation Paper

The Committee identified limitations in the scope of the NDIS Consultation Paper. Specifically, it does not provide options for:

- oversight functions required for monitoring quality and safeguarding across the NDIS
- serious incident reporting and gathering information on dangerous situations.

These are two areas that the Committee identified were of particular concern in the evidence it received in Stage 1 of its Inquiry. The Committee determined that the consultation process has limitations given there are no detailed options for these components of the NDIS Safeguarding Framework for consideration.

\textsuperscript{viii} The Council of Australian Governments Disability Reform Council oversees the trial and implementation of the NDIS. The Council consists of Commonwealth, State and Territory Ministers with responsibility for disability policy and supports.
In addition, the Committee identified that two key related areas of work are not reflected in the NDIS Consultation Paper:

- Integrated Market, Sector and Workforce Strategy—the strategy and roadmap for a sustainable workforce is not a component of the NDIS Consultation Paper, despite the Paper indicating that workforce will be a key issue for the disability sector.ix
- National Framework for Advocacy provision—the current review into the National Disability Advocacy Program and the role of advocacy is not addressed in the NDIS Consultation Paper.

**Informing Victoria's position—NDIS quality and safeguarding framework**

The Committee makes recommendations in this Interim Report to inform Victoria’s position on the development of a quality and safeguarding framework to ensure the safety of people who access disability services.

In evidence to the Inquiry there was a clear message that the existing quality and safeguarding measures in Victoria should be built on and improved but not reduced. The Committee recommends that the Victorian Government ensures that in the transition to the NDIS that the existing elements of the system in Victoria are not diminished.

The Committee determined that there is a need for an oversight framework with a key oversight body. As one inquiry participant observed that the critical missing element is:

… a single point of responsibility to assess and respond to incidents in a timely and decisive manner.x

In considering the evidence it received, the Committee determined that responsibility for quality assurance, screening and registration (of providers and individual disability workers) needs to sit separately from an independent oversight body.

In addition, there is a role for advocacy services in supporting and advocating for some people with disability and carers. There is also a need to ensure people with disability and their families have access to relevant information and resources to manage their plans and access to support to further build their capacity in navigating the NDIS.

While the Committee also identified the importance of an ongoing role for a guardian of last resort, consideration of its powers is outside the scope of its Inquiry given the role is largely focused on the abuse and neglect of people with disability in the community. The guardian of last resort is currently a state responsibility.

ix This was agreed by the Disability Reform Council on 24 April 2015 and released in June 2015.
x Submission S025, P. Thomas, p.3.
The Committee considered that when the NDIS is fully rolled out there will be responsibilities for both national and state/territory bodies in the context of ensuring quality and safeguards are in place for people who access disability services.

In developing its recommendations, the Committee is conscious that oversight, advocacy and guardianship powers administered by state/territory governments have benefits over a centralised nationally administered scheme.

On the other hand, the Committee considers that in the context of quality assurance, screening and registration (of providers and individual disability workers) a national agency would need to have responsibility to ensure the effectiveness of cross-jurisdictional screening and national standards for registration.

The Committee recommends that Victoria advises the Disability Reform Council of the importance of a quality and safeguarding framework that compromises the following entities:

- a single, independent oversight body with powers and responsibility for:
  - handling complaints
  - managing and investigating reportable serious incidents
  - oversight of restrictive practices
  - voluntary community visitors
  - the option of an official inspector scheme with paid inspectors or visitors

- an independent advocacy and capacity building body with powers and responsibility for:
  - administering funds for individual and community advocacy
  - systemic advocacy
  - capacity building through information, education and resources, including how to spot abuse and report it.

- a guardian of last resort with responsibility for:
  - guardianship and supported decision making
  - investigation of guardianship matters

- a national quality assurance agency with responsibility for:
  - screening and clearance checks—administering a working with vulnerable persons check
  - provider registration
  - individual registration of disability workers.
In addition, the Committee recommends that Victoria advises the Disability Reform Council of the need to:

- conduct a national evaluation of the community visitor program with a view to determining how it will function in the NDIS environment.
- establish a mandatory reporting scheme for specified individuals and organisations to report incidents of abuse, neglect or exploitation to an independent oversight body with responsibility for managing and investigating the handling of reportable incidents.
- ensure that there are consequences for those who are responsible for abuse of people accessing disability services and that service providers take steps to learn from the incident to prevent its recurrence.

Quality and safeguarding mechanisms in Victoria

The effectiveness of Victoria’s quality and safeguarding mechanisms are essential to ensuring that people who access disability services are not exposed to abuse, neglect or exploitation.

Despite preventative efforts, it is known that abuse and neglect can occur when people access disability services. In such circumstances, it is essential that oversight mechanisms ensure that people’s experiences are responded to appropriately and reported to the relevant authorities. It is also critical that there are consequences for those who are responsible and that steps are taken to learn from the incident to prevent its recurrence.

The Committee’s preliminary observation is that there are both strengths and limitations in Victoria’s safeguarding system for disability services. The strengths lie in the functions and powers that are legislated within the Disability Act 2006 (Vic) and regulative oversight of disability services. These relate to five key elements:

- standards, provider registration and staff screening
- legislated visiting of services
- responding to and investigating complaints
- managing reportable or ‘critical’ incidents
- monitoring restrictive practices.

The weaknesses and limitations of the safeguarding system identified by the Committee largely relate to the implementation of the regulatory functions that are delivered by the Department of Health and Human Services (the Department) and the use of legislated powers of other statutory entities.

In addition, many Inquiry participants emphasised the need to build on what has already been established through increased independence relating to some functions, clarification of roles or introducing new powers where there are identified gaps.
Ombudsman’s recommendations

The Committee considered the recommendations contained in the Ombudsman’s Phase 1 Report and received additional evidence following the tabling of the Report.

In regard to Recommendation 1, evidence provided to the Inquiry indicates strong support for the establishment of a single independent oversight body assuming responsibility for the multitude of safeguarding functions and powers in Victoria.

In the context of Recommendation 2, a number of disability advocacy organisations expressed to the Inquiry that while they support the recommendation for additional funding for advocacy, they do not support the recommendation that the administration and funding provision be transferred to the Office of the Public Advocate.

The Committee concluded that there is merit in the Ombudsman’s recommendation to conduct a comprehensive assessment of advocacy needs in Victoria.

It determined that there needs to be caution in recommending a specific body to assume responsibility for administering the funds for advocacy without further consultation. It sought the views of the Public Advocate, who agreed there is a need for further consultation.

Prevention of abuse in disability services

People with disability have a right to be safe from abuse, neglect and exploitation when accessing disability services.

A key factor in prevention is the risk management strategies that government and organisations establish in the workplace to ensure that suitable people are working in disability services and that the workplace itself has zero tolerance for abuse or neglect.

The Committee heard that the key forms of preventative and risk management strategies relate to:

- provider registration and standards
- disability worker registration
- recruitment and screening
- minimum qualifications and professional development
- workforce culture.

xi Submission S028, Disability Advocacy Victoria; Submission S020A, Communication Rights Australia; Submission S008A, AMIDA (Action for More Independence and Dignity in Accommodation); Submission S003G, JacksonRyan Partners.
While the Committee identified strengths in the Victorian systems that relate to preventative safeguards, it also heard that there are weaknesses and limitations in the system. These largely relate to workforce practices, such as training and supervision. In addition, workforce culture is emerging as a theme that the Committee will consider in greater depth in Stage 2 of the Inquiry.

The Committee also heard there is scope to strengthen the quality and assurance schemes through considering the possibility of disability worker registration and strengthening screening processes by introducing a Working with Vulnerable Persons Check.

Responding to abuse in disability services

The Committee's preliminary view is that while there are sophisticated policies and processes in place in Victoria for complaint handling and responding to disclosures or allegations of abuse in disability services, the pathways for making complaints and reporting abuse or neglect are complicated and often confusing.

In particular, the Committee observed there is confusion between the policies and processes for handling and escalating complaints, and for the management of reportable incidents. It is important to note that complaints are not the same as reportable incidents and to distinguish the differences.

Complaints handling in Victoria

In the context of complaint handling, the Committee considered the role of the Victorian Disability Services Commissioner. The Commissioner has powers to receive, resolve, and investigate complaints about disability service providers. The nature of the matters the Commissioner responds to are diverse.

In the context of complaints about abuse, neglect and exploitation, the Commissioner informed the Inquiry that between 2007 and 2015 these account for approximately 12 per cent of all complaints received.

The complaints process involves the following components:

• assessment—undertake a preliminary assessment to determine whether to consider the complaint
• conciliation—consider if the complaint is suitable for conciliation and if it is, make all reasonable endeavours to conciliate it
• investigation—must investigate a complaint which the Commissioner considers is not suitable for conciliation with minimal formality.

Inquiry evidence suggests that the Commissioner has a strong focus on conciliation over investigation and that in some cases this approach failed to achieve an acceptable resolution to complaints. A number of Inquiry participants told the Inquiry that conciliation is not an appropriate response for certain complaints and expressed their frustration with inadequate outcomes achieved
by the Disability Services Commissioner. Chapter 5 (Section 5.2.1) discusses in further detail the circumstances in which conciliation is not considered appropriate.

The Committee found that there is an expectation that there should be consequences for service providers that fail to address complaints or incidents relating to abuse, neglect or exploitation in disability services.

**Management of critical incidents in Victoria**

Funded agencies are expected to meet certain requirements as part of their service agreement with the Department. The Department has a range of policies and guidelines in place to deal with critical incidents in disability services.

In general, there is a view that incident reporting is important with Inquiry participants highlighting that ‘Incident Reporting is vital because people with a disability usually don’t or can’t complain.’

A strong view was expressed that while essential, the system in Victoria needs considerable improvement.

The Department’s critical incident management processes have come under criticism through a number of inquiries and are currently being reviewed by the Department, following recommendations made in a KPMG report commissioned by the Department last year.

Incidents can be categorised as either Category One or Category Two. The categorisation of incidents as either Category One or Category Two affects the urgency with which matters are dealt with.

The Victorian Equal Opportunity and Human Rights Commission’s submission suggests that the Department’s critical incident reporting process is not consistently followed and that incidents are sometimes incorrectly classified. The Committee’s preliminary examinations of the issue and the evidence it received indicate similar findings to the Ombudsman’s report.

Since 2012, the Commissioner has been providing independent review and advice to the Department on Category One incident reports relating to allegations of staff-to-client assault and unexplained client injuries.

**Mandatory reporting**

Evidence to the Inquiry referred to the value of mandatory reporting in the context of abuse and neglect of people with disability.

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A critical consideration in any system of mandatory reporting is who should be mandated to report and what types of incidents are reportable. In addition, which authority should mandated reports be made to and for what purpose? For example:

- criminal investigation—compulsory reporting by specified professionals to police to instigate a criminal investigation?
- investigation into handling of allegations—mandatory reporting by specified professionals to an oversight body for allegations of abuse in a disability service to initiate an investigation into handling of the allegation by the organisation?
- guardianship investigation—mandatory reporting by specified professionals to an oversight body relating to concerns about the health and safety of a person with disability to initiate a guardianship investigation?

Currently disability service providers are required to report incidents to the Department. Yet there is no mandatory legal requirement for disability services or individuals to report allegations of abuse involving people who access disability services to an independent body.

Some Inquiry participants advocated for the introduction of mandatory reporting of abuse and neglect involving vulnerable people to an independent body. The Committee considers this is an option worth considering, particularly in the case of people with severe or profound disability, in order to legitimise reporting of abuse and provide clarity around the obligation to report. However it determined the pathways for reporting would need careful consideration.

Both the Disability Services Commissioner and the Ombudsman raised the possibility of mandatory reporting to an independent body. The Commissioner suggested lessons could be drawn from the Western Australian model of mandatory reporting.

The Victorian Ombudsman’s Phase 1 Report identified that a transformation of Victoria’s system for handling allegations of abuse should include mandatory reporting to an independent oversight body of serious incidents by service providers. The Ombudsman observed that mandatory reporting to an independent body would help to ‘minimise confusion, ensure consistency and build confidence in the disability sector.’

The Committee also notes that parallels could be drawn between the handling of abuse in disability services and in child protection services. In child protection, the legislated requirement of mandatory reporting by certain professionals to the Department did not require individuals to report instances of abuse in services

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to police. This gap led to a new offence being introduced in 2014 for failure to disclose child sexual abuse to police. Such an approach places an onus on individuals within organisations to report suspicions and instances of abuse and could aid in legitimising reporting of suspicions to police or, alternatively, to an independent body.
Summary of recommendations and questions

Recommendations

In developing its recommendations, the Committee is conscious that oversight, advocacy and guardianship powers administered by the state have benefits over a centralised nationally administered scheme.

The Committee considers that in the context of quality assurance, screening and registration (of providers and individual disability workers) a national agency would need to have responsibility to ensure the effectiveness of cross-jurisdictional screening and national standards for registration.

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td>That the Victorian Government advises the Disability Reform Council that in the transition to the NDIS the existing elements of the quality and safeguarding system in Victoria should not be diminished.</td>
</tr>
</tbody>
</table>
| **2**  | That the Victorian Government advises the Disability Reform Council to establish a single, independent oversight body with powers and responsibility for:  
  - handling complaints  
  - managing and investigating reportable serious incidents  
  - oversight of restrictive practices  
  - voluntary community visitors  
  - the option of an official inspector scheme with paid inspectors or visitors. |
| **3**  | That the Victorian Government advises the Disability Reform Council to ensure the establishment of an independent advocacy and capacity building body with powers and responsibility for:  
  - administering funds for individual and community advocacy  
  - systemic advocacy  
  - capacity building through information, education and resources, including how to spot abuse and report it. |
| **4**  | That the Victorian Government advises the Disability Reform Council to ensure that a guardian of last resort is maintained with responsibility for:  
  - guardianship and supported decision making  
  - investigation of guardianship matters. |
Summary of recommendations and questions

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendation</th>
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</table>
| 5      | That the Victorian Government advises the Disability Reform Council to ensure the establishment of a national quality assurance agency with responsibility for:  
  • screening and clearance checks—administering a working with vulnerable persons check  
  • provider registration  
  • individual registration of disability workers. |
| 6      | That the Victorian Government recommend to the Disability Reform Council that a national evaluation is conducted of the community visitor program with a view to determining how it will function in the NDIS environment. |
| 7      | That the Victorian Government recommend to the Disability Reform Council that it establishes a mandatory reporting scheme for specified individuals and organisations to report incidents of abuse, neglect or exploitation to an independent oversight body with responsibility for managing and investigating the handling of reportable incidents. |
| 8      | That the Victorian Government recommend to the Disability Reform Council that it ensures there are consequences for those who are responsible for abuse of people accessing disability services and that service providers take steps to learn from the incident to prevent its recurrence. |

Questions for stage 2

During Stage 1 of the Inquiry, the Committee identified a number of questions that are likely to inform Stage 2 of its Inquiry and the interim arrangements that need to be in place during transition to the NDIS. The Committee emphasises that this is not an exhaustive list of questions for Stage 2.

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions for Stage 2</th>
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<tbody>
<tr>
<td></td>
<td>Experiences of disclosing or reporting abuse</td>
</tr>
<tr>
<td>1.1</td>
<td>What experiences have people with disability, families and carers had when disclosing or reporting abuse?</td>
</tr>
<tr>
<td>1.2</td>
<td>What systems and processes do disability service providers have in place to prevent abuse occurring in their organisation or to respond to any allegations of abuse or neglect of people accessing their disability services?</td>
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<tr>
<td></td>
<td>Human rights and safeguards</td>
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<tr>
<td>3.1</td>
<td>How can the rights provided under the Charter of Human Rights in Victoria be maintained for people accessing disability services in the transition to the NDIS once it has been fully rolled out?</td>
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</table>
## Summary of recommendations and questions

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions for Stage 2</th>
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</thead>
<tbody>
<tr>
<td><strong>Independent oversight body</strong></td>
<td></td>
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<tr>
<td>3.2</td>
<td>During the interim period of transition to the NDIS from 2016 to 2020, should the Victorian Government:</td>
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<td></td>
<td>• create a new body under new legislation</td>
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<td></td>
<td>• allocate the responsibilities to a single existing body</td>
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<td></td>
<td>• improve the integration of existing bodies to fill the gaps and address overlaps on the boundaries?</td>
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<tr>
<td>3.3</td>
<td>If the current safeguarding responsibilities were allocated to a single existing body, should this body be:</td>
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<tr>
<td></td>
<td>• Disability Services Commissioner</td>
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<td></td>
<td>• Victorian Equal Opportunity and Human Rights Commissioner.</td>
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<td></td>
<td>• Victorian Ombudsman</td>
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<tr>
<td></td>
<td>• another existing body?</td>
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<tr>
<td>3.4</td>
<td>Should the state maintain responsibility for some elements of the safeguarding system during and after the transition to the NDIS?</td>
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<tr>
<td>3.5</td>
<td>If a single oversight body were established in Victoria what governance, accountability and oversight arrangements would need to be established to ensure it is accountable in safeguarding people who access disability services?</td>
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<tr>
<td><strong>Disability advocacy services</strong></td>
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<tr>
<td>3.6</td>
<td>What would be the most appropriate approach to the administration of funding disability and advocacy services, bearing in mind there are both state and federal funding streams?</td>
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<td></td>
<td>• Should an existing or new body have responsibility for this role?</td>
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<tr>
<td>3.7</td>
<td>In undertaking a comprehensive assessment of advocacy needs, what components of the advocacy system need to be evaluated or reviewed?</td>
</tr>
<tr>
<td><strong>Prevention, screening and accreditation</strong></td>
<td></td>
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<tr>
<td>4.1</td>
<td>Should the Victorian Government develop a prevention and risk management strategy for the Victorian disability workforce from 2016 to 2019?</td>
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<tr>
<td></td>
<td>• If so, what specific components would comprise such a strategy?</td>
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<tr>
<td>4.2</td>
<td>In Victoria, what would be the most preferable screening system to establish:</td>
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<tr>
<td></td>
<td>• a legislated disability worker exclusion scheme</td>
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<tr>
<td></td>
<td>• a legislated working with vulnerable persons check</td>
</tr>
<tr>
<td></td>
<td>• a combined version of an exclusion scheme and a working with vulnerable persons check?</td>
</tr>
<tr>
<td>4.3</td>
<td>Should a disability worker registration scheme be established, similar to the Australian Health Practitioner Regulation Agency (AHPRA)?</td>
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<td></td>
<td>• If so, should this be a national or state agency?</td>
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</tbody>
</table>
### Summary of recommendations and questions

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions for Stage 2</th>
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</thead>
</table>
| **4.4** | Should an independent body be established to oversee service standards, accreditation and registration?  
  • If so, should this be a national or state agency? |
| **Professional development** | |
| **4.5** | Should minimum qualifications be introduced for all disability workers?  
  • If so, what should be the minimum qualification?  
  • Should this be a state or national requirement? |
| **4.6** | Should there be compulsory requirements for professional development for disability workers?  
  • If so, what core components of ongoing professional development would be required? |
| **Workforce culture** | |
| **4.7** | What does the Victorian Government need to do to support a disability workforce culture that does not tolerate abuse, neglect or exploitation? |
| **4.8** | What do Victorian disability service providers need to do to promote and achieve a workforce culture that does not tolerate abuse, neglect or exploitation? |
| **Complaints handling** | |
| **5.1** | If the Victorian Government introduces an independent oversight body, should it have responsibility for handling general complaints about disability service providers, as the Disability Services Commissioner currently does? |
| **5.2** | If there is a new independent oversight body with responsibility for complaints handling and responding to serious incidents, should it have the power to conduct own-motion investigations?  
  • Should these powers relate to both complaints and the investigation of allegations of abuse and neglect? |
| **Guidelines for responding to abuse** | |
| **5.3** | If an independent oversight body is established in Victoria, should that body have responsibility for developing a standard set of guidelines for responding to allegations of abuse and neglect in disability services? |
| **Visiting schemes** | |
| **5.4** | In view of the skills necessary in identifying and responding to abuse and neglect, should consideration be given to paid inspectors or paid official visitors in Victoria? |
| **5.5** | If a paid inspector or paid official visitor role is introduced in Victoria, should they be located with an independent oversight body or other entity? |
| **5.6** | In relation to visiting schemes and the existing Community Visitor scheme:  
  • Should volunteer Community Visitors continue to be part of the safeguarding framework in Victoria?  
  • If Community Visitors continue to be part of a safeguarding framework in Victoria, should they be located within the Office of the Public Advocate, a new independent oversight entity or another body? |
### Questions for Stage 2

#### Mandatory reporting

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
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</table>
| 5.7    | Should the Victorian Government introduce mandatory reporting of serious or critical incidents to a new independent oversight body? If so:  
  - What individuals and organisations should be mandated to make such reports?  
  - What current functions of the Department of Health and Human Services regarding the management of critical incidents should be transferred to the new body? And should the Department retain any functions relating to critical incident management? |

#### Oversight of restrictive practices

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
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</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Should the Senior Practitioner be independent from the Department of Health and Human Services in its role in oversight of restrictive practices?</td>
</tr>
</tbody>
</table>
| 6.2    | If the view is that the Senior Practitioner should be independent, what option would be most appropriate for the nature of that independence:  
  - a specific entity with independent statutory powers and its own office  
  - a new single independent oversight body? |
| 6.3    | Should Authorised Program Officers in disability services have minimum qualifications for making decisions in relation to emergency restrictive practices, such as restraint? |
Inquiry scope and process

On 5 May 2015, the Parliament of Victoria’s Legislative Assembly asked the Family and Community Development Committee to inquire into abuse in disability services. The Committee was asked to conduct the Inquiry in two stages. The Terms of Reference for both stages of the Inquiry can be found on page viii.

Inquiry method—Stage 1

The Committee undertook a comprehensive range of methods to gather evidence to inform its findings and recommendations. These included:

- reviewing legislation
- reviewing policies and guidance from the Department of Health and Human Services and relevant oversight bodies
- calling for written submissions
- holding public hearings
- seeking further information from organisations.

Submissions

On 19 May 2015 the Committee issued a call for submissions to Stage 1 of the Inquiry. The Committee extended its invitation for submissions through an extensive database comprising a range of individuals and organisations, such as service providers, Australian disability enterprises, peak and advocacy bodies, community groups, research institutes and academics.

To assist those who wanted to make a written submission to the Inquiry, the Committee released a Submission Guide. This was published on the Committee’s website and circulated to those who expressed an interest in submitting to the Inquiry.

The Submission Guide outlined the scope of the Inquiry and the process for making a written submission. It provided an outline on the types of issues about which the Committee was seeking evidence. It posed questions for individuals and organisations to consider when preparing their submissions. A copy of the Submission Guide is provided in Appendix 1.

On 28 May 2015, the call for submissions was advertised in The Age, the Herald Sun, the Ballarat Courier, the Bendigo Advertiser and the Geelong Advertiser.

The Committee received 28 written submissions and 11 supplementary submissions from a range of individuals and organisations. The authors of these submissions included:
Inquiry scope and process

- professional carers
- family members of people with disabilities
- people with disabilities
- service providers
- advocacy organisations
- peak bodies
- statutory bodies.

**Figure Submissions received**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Advocacy organisations</td>
<td>32%</td>
</tr>
<tr>
<td>Family members of people with disabilities</td>
<td>18%</td>
</tr>
<tr>
<td>Professional carers</td>
<td>14%</td>
</tr>
<tr>
<td>Service providers</td>
<td>14%</td>
</tr>
<tr>
<td>Statutory bodies</td>
<td>11%</td>
</tr>
<tr>
<td>Peak bodies</td>
<td>7%</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>4%</td>
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</tbody>
</table>

**Submissions—Stage 2**

To assist with its Inquiry, the Committee will call for further submissions in Stage 2 of the Inquiry in regard to the terms of reference and questions raised in this Interim Report.

**Briefings**

On 25 May 2015, the Committee requested the Department of Health and Human Services and the Victorian Ombudsman attend separate meetings to brief the Committee on matters relating to Stage 1 of its Inquiry.

**Public hearings**

The Committee held hearings in June 2015. It heard from the Senior Practitioner (Disability), the Office of the Public Advocate, the Victorian Advocacy League for Individuals with Disability (VALID), National Disability Services (NDS), the Disability Services Commissioner, Community Visitors, the Department of Health and Human Services, and the Victorian Ombudsman.

**Public hearings—Stage 2**

The Committee will hold further public hearings during Stage 2 of the Inquiry.
Additional information

Throughout the Inquiry, the Committee requested information via correspondence from organisations, statutory bodies, experts and government departments. This additional information related to queries about evidence or information provided, or concerned newly emerging issues.

Scope—Stage 1 of the Inquiry

The terms of reference for the Inquiry ask the Committee to consider the safeguarding arrangements for people in disability in two Stages. The first stage asks the Committee to inform Victoria’s position on appropriate quality and safeguards for the NDIS.

In Stage 2, the Committee will further consider the quality and safeguarding systems in Victoria. In particular it is asked to:

• consider systemic issues and any interim measures to strengthen the disability services system prior to transition to the NDIS
• examine the powers and processes of Victorian investigation and oversight bodies with a particular focus on the ongoing role of these bodies in the context of the NDIS.

For Stage 1, the Committee examined the current safeguarding mechanisms operating in Victoria to inform Victoria’s position on appropriate quality and safeguards for the NDIS. In doing this, it also raised a number of questions that are relevant to Stage 2 of the Inquiry and the nature of the interim arrangements that may need to be in place during the transition to the NDIS.

Those people and organisations interested in informing the Committee’s final report and its recommendations will have the opportunity to participate in Stage 2 of the Inquiry to express their views and opinions about the interim arrangements in Victoria alongside a number of other relevant issues contained within the terms of reference.

Notably, outside the scope of the Inquiry are matters relating to the justice system, such as police responses and the criminal and civil law systems. Some evidence to the Inquiry raised concerns about how the justice system handles abuse and neglect of people with disability.

Definitions

People with disability

The Disability Act 2006 (Vic) (the Disability Act) defines disability as an impairment that may be sensory, physical, neurological or an acquired brain injury, which results in substantially reduced capacity in at least one of the areas
Inquiry scope and process

of self-care, self-management, mobility or communication. The definition of disability also includes an intellectual disability or developmental delay but does not include ageing.

Disability services

In Victoria, legislation governing disability services is provided by the Disability Act.

The Department of Health and Human Services provides and funds services for people with disability. It also funds a range of specialist disability supports that are available to people with disability and their families, to help the person with disability participate actively in the community and reach their full potential.

The support provided by disability services fall into two categories:

- short-term supports—such as respite services, behaviour supports, case management and therapy
- ongoing supports—such as Individual Support Packages and supported accommodation.

Individuals can request disability support if they have a disability and:

- the disability impacts on their mobility, communication, self-care or self-management
- the support request meets specific requirements related to the service they are seeking.

The Disability Act says a person with disability, or a person on their behalf, may request services from a disability service provider. This may be the Department of Health and Human Services or another disability service provider.

The Commonwealth also provides funding for some disability support services, including Disability Employment Services and Australian Disability Enterprises.

Abuse of people with disability

In the context of abuse of people with disability, abuse can include:

- physical, emotional abuse and/or neglect
- financial abuse
- sexual abuse offences, such as rape or indecent assault under the Crimes Act 1958 (Vic)
- an incident that has resulted in a serious outcome, such as a client death or severe trauma
- forced treatments and interventions
- violations of privacy and wilful deprivation.
Safeguards

Within the NDIS, safeguards are defined as including:

... natural safeguards such as personal relationships and community connections, and formal safeguards such as service standards, regulations and quality assurance systems that apply to individuals and organisations providing supports.\textsuperscript{viii}

Victorian Ombudsman investigation and report

On 8 December 2014 the Victorian Ombudsman announced an investigation into how allegations of abuse in the disability sector are reported and investigated.

The Terms of Reference for this Inquiry require that the Committee ‘work cooperatively with the Ombudsman to avoid unnecessary duplication’. The Committee sought to do this to the extent possible.

The Committee’s Inquiry differs particularly in its emphasis on the prevention of abuse and neglect in disability services. In addition, the Committee’s terms of reference are specific to abuse in disability services as defined under the Disability Act.

The focus of the Ombudsman’s investigation is on the reporting of allegations of abuse. It is investigating:

- services which include residential, respite and day programs funded by the Victorian Government
- the oversight responsibilities of agencies including the Department of Health and Human Services and the Disability Services Commissioner.

While there are some overlaps with the Committee's inquiry, the Ombudsman has chosen to focus on reporting specifically rather than prevention.

Phase 1 Report recommendations

The Ombudsman’s Phase 1 Report tabled on 25 June 2014 contained two recommendations in relation to the effectiveness of statutory oversight in the context of reporting and investigation of abuse in the disability sector. These recommendations are outlined in the Boxes on the following pages.

In considering the findings of this report, in particular the lack of consistent mandatory reporting, complex oversight arrangements and gaps in oversight, I recommend that:

a. the Victorian Government either establish, or transfer responsibility to an existing agency, for a single independent oversight body.

   This body could become part of, inform, or eventually be replaced by a national quality framework which ensures Victorians with disability are not provided with less protection under a national scheme.

b. that the Victorian Parliament Family and Community Development Committee further examine the logistics of a single independent oversight body, as it considers interim measures to strengthen the disability system prior to the introduction of the NDIS.


In recommending the establishment of a single, independent oversight body (or transferring responsibility to an existing agency), the Ombudsman has recommended that the following functions and powers are encompassed:

- independent oversight
- responsibility for mandatory and voluntary reporting of incidents and concerns
- interface with police regarding investigations
- consultation with the Senior Practitioner
- powers to investigate complaints and systemic issues, including own motion powers
- referral powers
- responsibility for reviewing incident reports and identifying lessons
- awareness raising
- education and training
- reporting on trends and issues in connection with incidents/allegations
- development and promotion of best practice guides for complaint handling
- information sharing about incidents/allegations with other bodies
- Disability Worker Exclusion Scheme.
Inquiry scope and process

BOX: Ombudsman Phase 1 report—Recommendation 2

The findings of this investigation support an increase in the funding for advocacy, which should be informed by a comprehensive assessment of the need. This is particularly critical in the transition to the NDIS. I recommend the government:

a. undertake a comprehensive assessment of the advocacy needs of people with disability

b. transfer sufficient funding provision from DHHS, and responsibility for administering advocacy services, to the Office of the Public Advocate, including:

(i) ensuring access to advocates to assist people with allegations of abuse, and to support them through the process

(ii) providing oversight for advocacy services to ensure consistency and best practice.

Background and context

AT A GLANCE

Background

To understand the context in which abuse in disability services is understood, this Chapter outlines the experiences of people with disability and the scale of abuse in disability services. It also provides an overview of the key bodies within Victoria’s safeguarding system and the transition of the National Disability Insurance Scheme.

Questions for Stage 2

• What experiences have people with disability, families and carers had when disclosing or reporting abuse?

• What systems and processes do disability service providers have in place to prevent abuse occurring in their organisation or to respond to any allegations of abuse or neglect of people accessing their disability services?
In Victoria disability services operate within the context of the *Disability Act 2006* (Vic) (the Disability Act), which establishes the current framework of quality and safeguarding mechanisms.

The provision of disability services is undergoing major reform with the introduction of the National Disability Insurance Scheme (NDIS), which has consequences for approaches to safeguarding people who access these services. In May 2013, the Victorian and Commonwealth Governments agreed to transition from trial to full scheme over three years commencing in 2016-17. By 2019-20, the NDIS is intended to provide individualised supports to over 100,000 Victorians with significant and permanent disability.

This Chapter provides a brief outline of the Disability Act, the experiences of people with disability and the scale of abuse in disability services. It also outlines the key bodies within Victoria’s safeguarding system and provides an overview of the NDIS.

### 1.1 *Disability Act 2006* (Vic)

The *Disability Act 2006* (Vic) commenced on 1 July 2007 and provides for:

- a stronger whole-of-government, whole-of-community response to the rights and needs of people with disability
- a framework for the provision of high-quality services and supports for people with disability.

It has a number of objectives including:

- promoting and protecting the rights of people accessing disability services
- advancing the inclusion and participation in the community of people with disability
- making disability service providers accountable to people accessing their services.

The Disability Act is supported by the *Disability Regulations 2007* (Vic), which provide additional requirements for disability service providers in relation to the management of money, approvals to use restrictive interventions and compulsory treatment and visits by community visitors.

The Disability Act establishes principles for people with disability and for disability service providers. It also provides a range of functions and powers for safeguarding people who access disability services and a number of statutory bodies to assume responsibility for those functions.

The Department of Health and Human Services (the Department) provides and funds services for people with disability. It also funds a range of specialist disability supports that are available to people with disability and their families, to help the person with disability participate actively in the community and reach their full potential.
Chapter 1 Background and context

1.2 People who use disability services

In Victoria, there are approximately 1.1 million people with disability, 364 000 of whom are living with profound or severe disability.1

The disability service system provides supports for people with disability that complements those supports available to all members of the community through the generic service system, such as includes hospitals, housing, recreation, leisure and general community services.

In some circumstances, a person with disability may have needs that could be better supported in the community through the mainstream service system.

To access disability services a person must:

• have a disability as defined by the Disability Act
• be considered a priority for access to services
• meet program-specific needs (where required).

Individuals can request disability support if they have a disability and:

• the disability impacts on their mobility, communication, self-care or self-management
• the support request meets specific requirements related to the service they are seeking.

The Disability Act states that a person with disability, or a person on their behalf, may request services from a disability service provider. This may be the Department of Health and Human Services or another disability service provider.

In Victoria, around 14 500 people in Victoria receive individual support packages under the Disability Act and just over 5000 people are living in supported accommodation. Of all the funding for supported accommodation, 52 per cent goes to services delivered by the Department and 48 per cent to services delivered by community services and funded by the Department.2

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1 Australian Bureau of Statistics (2014) Disability, ageing and carers, Australia. State tables for Victoria (2012 data), cat no 4420.0, Canberra, ABS. Referred to in Supplementary evidence, Information provided at briefing of Committee, Department of Health and Human Services, 1 June 2015.

2 Victorian Ombudsman (2015) Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight. p.13. The Victorian Ombudsman also noted that there are 141 privately owned residential services (SRSs) which house 5,400 people, 91 per cent of who are residents with disability. In addition there are approximately 1,400 severely injured clients of the TAC and WorkSafe Victoria. People with disability accessing services through SRSs, TAC and WorkSafe are beyond the scope of this Inquiry.
At 15 June 2015, there were 313 organisations in Victoria registered as disability service providers under the Disability Act.  

1.3 Experiences of people with disability and their families

People with disability have the same right as other members of the community to:

- participate actively in the decisions that affect their lives and be provided the information and support necessary to enable this to occur
- access information and communicate in a manner appropriate to their communication and cultural needs.

For those people who need support for day to day activities and to participate in society, disability services are provided to meet the individual needs of people with disability. They are intended to:

- maximise the choice and independence of people with disability
- enable people with disability to access services as part of their local community and foster collaboration, coordination and integration with local services.

1.3.1 Impact on carers of people with disability

Carers of people with disability told the Inquiry of their experiences in seeking to ensure safe and caring environments for their children. The Committee heard there are often protracted dealings with disability services, the Department and safeguarding bodies.

For example, one parent of a son with disability, Ms Julie Pianto, told the Inquiry that after 15 months of trying to achieve quality care for her son she felt she had no alternative but to resign from her job in order to care for him to ensure his safety. Ms Pianto explained that she believed the service provider had failed to address health, safety and care concerns she raised on multiple occasions. She also told the Inquiry she considered the Disability Services Commissioner had failed to make the service provider accountable despite making five separate complaints about her concerns.  

Another parent of a son with disability, Ms Sandra Guy, explained in her submission to the Inquiry:

Given my personal experiences over recent years, I fully understand why so many families, exhausted, exasperated, tired of being patronised and brickwalled, either remove their loved ones from supported accommodation and take them home, or walk away from their loved ones.  

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3 Supplementary evidence, Response to request for information, Department of Health and Human Services, 19 June 2015, p.1.
4 Submission S001, J. Pianto, p.15.
5 Submission S013, S. Guy, p.11.
1.3.2 Perception of attitudes towards people with disability

People with disability and their families often perceive a power imbalance between themselves and service providers. Women with Disabilities Victoria, for example, told the Inquiry that it had heard ‘story after story demonstrating how [people with disability] can be discredited and have their rights ignored or simply never be given the opportunity to speak up.’

Examples include:

If people do the wrong thing by a client you’re usually there by yourself and it’s your word against theirs.

The most frustrating thing was not being believed, being told I was making a mountain [out of] a molehill and staff believing staff.

There is a perception when you have an ABI — that the ABI accounts for everything — it’s the ABI’s fault that you have made these things up…we would need an independent specialist service to be believed.

Another Inquiry participant stated that:

You are more likely to receive unwarranted scrutiny if you are a known complainer, than if you are a known abuser.

Mr Tony and Ms Heather Tregale from Lifestyle in Supported Accommodation (LISA) provided some insight about how people with disability and their parents perceive staff relate to them:

Residents and their families are pests we could well do without.

Residents and their families are bludging on the government, and we staff are doing them a big favour, for which they should be very grateful and not complaining.

If we have to suffer them, we don’t have to respect them.

There must be no dobbing (whistleblowing).

The work is ‘appearance’ — we are paid just to be here, where our main concern must be the end of our shift.

We certainly do not do active support (engagement and interaction with the residents).

Any staff who comes here to do active support and good work, must be discouraged, or we all might be expected to do similar.

If we consider all domestic, personal care and administration has been done before the end of our shift, we can go home, as we do not do active support (engagement and interaction) with the residents.

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7 Acquired Brain Injury.

8 Submission S004, Women With Disabilities Victoria, p.17.

9 Submission S007, Name withheld, p.1. See also Submission S013, S. Guy, p.7.

Some Inquiry participants spoke of people who access disability services being afraid of reprisals for disclosing or reporting abuse. Action for More Independence and Dignity in Accommodation (AMIDA) told the Inquiry that reprisals can include:

Further abuse, restrictive practices, lack of choice in the house or lack of involvement in decision making over matters affecting the person. Other negative reprisals may be withdrawal of favoured activities, lack of support in a timely way, restriction of meals etc. Reprisals can also be quite subtle such as unpleasant mood or tone of voice of the carer or lack of attention in general given by the carer to the client (cold shoulder treatment).\(^{11}\)

### 1.3.3 Desire for action

The carers and parents of people who access disability services expressed their views that they are exhausted by continuing consultation and are seeking action. Ms Pianto, whose son has a severe intellectual and multiple physical disabilities, told the Inquiry that:

> I am desperately hoping that someone will finally try and FIX the system — not just inquire on it.\(^{12}\)

Ms Guy recently appeared before the Senate Community Affairs References Committee Inquiry.\(^{13}\) She explained her frustration at the inability of the current Victorian safeguarding system to achieve change. For example:

> The problem is that I cannot tell you how many times I have called the community visitors in relation to the concerns at my son’s house, which have been going on now for six long years, and what happens is that they might go to my son’s house but you have no idea what went on. They might lodge a report with the department and that is as far as it goes—end of story. What you do not see is any change.\(^{14}\)

In her submission, Ms Guy also told the Inquiry that she felt the system ‘brick walls families who have loved ones with disability, particularly those who do not effectively communicate.’\(^{15}\)

**QUESTION 1.1:** What experiences have people with disability, families and carers had when disclosing or reporting abuse?

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\(^{12}\) Submission S001, J. Pianto, p.1.

\(^{13}\) Senate Community Affairs References Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability.

\(^{14}\) S. Guy, Transcript of evidence, Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, Melbourne, 30 June 2015, p.15.

\(^{15}\) Submission S013, S. Guy, p.1.
Chapter 1 Background and context

1.4 Instances of abuse and neglect in disability services

While disability services are intended to support people with disability to participate in the community with the dignity and respect that all community members are entitled to, some people have experienced abuse or neglect while accessing disability services.

The Committee identified case studies that highlight the gaps in Victoria’s safeguarding system and failure to achieve a satisfactory outcome for people with disability.

1.4.1 Physical abuse and neglect

Although there is significant public attention on sexual abuse in disability services that comes to light through the media, the Committee heard that the majority of abuse relates to physical abuse and neglect of people with disability. The Committee acknowledges there is a huge impact on the quality of life of people with disability who have been subjected to such abuse. Abuse and neglect of people accessing disability services also has a significant impact on their families and carers.

Ms Tregale from LISA told the Inquiry about abuse and neglect she witnessed while working as a direct care worker, including:

- A bucket of water thrown over a resident by a staff member
- A resident tipped out of his wheelchair by a staff member
- A resident forced to stand in the corner for 30 mins
- Residents provided with food the staff would not eat themselves
- Residents given pizza as their main meal most days
- Residents having to wear poor clothing and shoes, as staff considered it was not their problem, yet the residents had plenty of finance
- Residents do few activities, as staff can’t be bothered to take them out or do activities with them, yet the residents have plenty of finance and department policy is for active support to frequently occur in contrast to minder-care.16

1.4.2 Case study—Yooralla

A major reason for the establishment of this Inquiry relates to the revelations of the abuse of residents in Yooralla disability services between 2011 and 2014. In view of this, the Committee considered it is necessary to review the factors that led to the failure of Victoria’s safeguarding system to prevent and respond effectively to these incidents of criminal abuse of several people with severe disability who require assistance for daily tasks.

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The Committee wants to emphasise that it has no intention of targeting any particular organisation. The facts relating to Yooralla have been widely publicised.

There are multiple lessons to be learnt when considering the Yooralla circumstances that resulted in abuse in its disability services. These relate to inadequacies of the response by the service provider, but they also relate to weaknesses of the broader safeguarding system that operates in Victoria.

The facts from this case study are drawn from evidence to the Inquiry, documents provided by Yooralla and publicly available materials.

**Overview**

Between 2011 and 2014, a number of people accessing Yooralla disability services were subjected to criminal abuse. This led to criminal investigations and a number of organisational reviews of Yooralla’s management of the abuse allegations and approach to preventing further abuse from occurring.

An independent review was undertaken by Mr Brian Joyce (the Joyce Report). It was jointly commissioned by the Department of Human Services and Yooralla. This Report identified that Yooralla did not meet its responsibilities to safeguard clients at two services from abuse or to properly investigate the allegations at one of the services.

Criminal investigations have led to the conviction of former Yooralla workers.

In the criminal trial, the victims provided victim impact statements. They explained that by reason of their disability they were unable to escape, to vocalise their lack of consent or to call for help. They articulated their sense of violation and powerlessness and their ongoing suffering as a consequence of the abuse they were subjected to.

**Prevention**

In reviewing the abuse that happened in Yooralla disability services, the Joyce Report identified that there were inadequacies in workplace practices that are central to preventing abuse. These relate to the need for improvement in a number of areas:

- recruitment of suitable personnel—particularly reference checking and adequate supervision of inexperienced staff
- formal supervision—particularly formal supervision of casual staff, but also ensuring staff properly understand and practice their person centred responsibilities to people who access their services

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17 In January 2015 the Department of Human Services merged with the Department of Health to become the Department of Health and Human Services.

Chapter 1 Background and context

- disciplinary procedures—particularly the investigation of allegations of abuse and the instigation of disciplinary procedures and intersections with police investigations
- performance management—adequate coordination of any performance concerns across all services, including casual staff
- training—ensuring that staff can understand and recognise the risks and nature of abuse
- minimum qualifications—disability support workers may be required to provide personalised services and in this context Yooralla should consider requiring staff to have a Certificate IV with disability worker competencies.\\(^{19}\)

Response to disclosures of abuse

The Joyce Report identified a number of inadequacies in how Yooralla responded to disclosures of abuse by residents. These relate to:

- support to a person who discloses abuse—inadequate procedures in the context of any police involvement and ensuring the person disclosing abuse has the option of a support person
- awareness of responsibilities for reporting serious incidents—insufficient staff awareness of the requirement to report all serious incidents in line with the relevant practice manual and departmental instructions
- procedures for dealing with police—no procedures for dealing with police when reporting allegations of assault
- responsibilities of management—lack of clarity regarding the need to report staff to client assaults to the CEO and other responsible managers
- Board responsibility—inadequate processes to ensure that the Board has relevant information to be sure that client rights are protected.\\(^{20}\)

Oversight responses

Given the extended period in which abuse continued to occur in specific services provided by Yooralla, the Committee considered not only were there inadequacies by the provider, but that the case highlighted inadequacies in the safeguarding system in Victoria and the role of oversight bodies in cases of abuse in disability services.

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19 Supplementary evidence, Response to request for information, Yooralla, 21 June 2015.
20 Supplementary evidence, Response to request for information, Yooralla, 21 June 2015.


Chapter 1 Background and context

Department of Health and Human Services

In the context of the Department’s oversight and management of the critical incident reporting, the Committee identified there was:

- poor clarity about its role and the extent to which it might question the incident reports and for what purpose
- lack of guidance for agency staff on reporting allegations—particularly how they should engage with police when advising them of allegations of physical and sexual assault of clients

In its agency monitoring role the Department explained that the following actions were undertaken:

- after the initial allegations in 2011, in 2012 Mr Brian Joyce was jointly commissioned by the Department and Yooralla to undertake a review of Yooralla’s management of allegations of assault
- in August 2013, an independent audit was commissioned to determine the extent to which Yooralla had implemented actions emerging from the recommendations in the Joyce Report
- in February 2015, the Department contracted KPMG to undertake a Service Review to consider the duration of Yooralla’s change program and the extent to which practice improvements have been embedded
- the Department informed the Inquiry it has maintained a ‘very close and ongoing agency monitoring role’ with Yooralla.

In the context of its authority to deregister providers, the Department advised the Committee that:

- while there are a number of options available to the Secretary ranging from a Service Review to the appointment of an Administrator through to deregistration of providers, in this case Yooralla was not deregistered
- it determined that a comprehensive Service Review by an independent reviewer was the most appropriate mechanism to determine Yooralla’s capacity to deliver support services that ensure the safety and wellbeing of clients.

Victorian Disability Services Commissioner

The Committee questioned whether the Victorian Disability Services Commissioner (the Commissioner) received complaints relating to the Yooralla allegations. The Commissioner informed the Inquiry that any such complaints received would be a matter for the police, not for any investigation he might undertake.

21 Supplementary evidence, Response to request for information, Department of Health and Human Services, 19 June 2015.
22 Supplementary evidence, Response to request for information, Department of Health and Human Services, 19 June 2015.
If the Commissioner received a complaint, he did not investigate the concerns. The Commissioner told the Inquiry that between 2010 and 2014 he did not undertake any investigations. The Commissioner’s approach in the past has been focused on conciliation. In contrast, since December 2014, the Commissioner has commenced four investigations, two of which relate to alleged abuse or assault in disability services.  

In the absence of complaints, the Disability Services Commissioner does not have own motion investigation powers. Yet even if the Commissioner were to investigate, it is not clear what outcomes the Commissioner could provide. Inquiry participants likened the Commissioner’s approach to unwittingly stepping onto a ‘meeting treadmill’.  

**Community visitors**

Despite their extensive reporting powers, the Community Visitors informed the Inquiry that they notify serious matters to the Public Advocate and do not report matters to the Minister, the Commissioner, or the Ombudsman.

In turn, the Public Advocate has a process for notifying the Department.

As outlined above, the Department was actively involved in monitoring Yooralla’s management of the allegations and it made a decision to undertake a Service Review of the organisation.

**Victorian Ombudsman**

While the Ombudsman ‘has a clear jurisdiction to deal with allegations in state-run facilities, the jurisdiction to deal with allegations elsewhere, for example funded providers, is far less clear and needs to be considered on a case-by-case basis.’

**Lessons and improvements**

Yooralla made a written submission to the Committee’s Inquiry. It states that ‘Yooralla has undertaken an extensive program of reform to embed a safeguards and rights framework to better protect the rights and well-being of customers from abuse, harm and neglect.’

In regard to the incident that occurred in 2014, Yooralla stated that:

> Yooralla has responded more promptly to disclosures of abuse and ensures therapeutic supports are provided to the person making a disclosure. For example, Yooralla responded quickly and decisively in the 2014 sexual assault incident.

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23 Supplementary evidence, Response to request for information, Disability Services Commissioner, 20 July 2015, p.2.

24 Submission S013, S. Guy, p.4.


26 Submission S006, Yooralla, p.1.
When the disclosure was first made late on Friday afternoon, Yooralla immediately instigated the required protocols of ensuring the person was safe and informing the family, and the Police. By Monday morning, the perpetrator was dismissed from employment and charged by the Police.27

The CEO of Yooralla informed the Senate Inquiry that Yooralla has developed safeguarding actions that are built on the three pillars of primary, secondary and tertiary pillars of prevention:

1. primary—changing social attitudes so that people with disability are valued as equal citizens, promoting self-advocacy, promoting choice and control, and promoting inclusion
2. secondary—addressing systems
3. tertiary—responding to and learning from incidents

### 1.4.3 Case Study – EW Tipping Foundation

The experiences of Mr Christopher Heenan in supported accommodation provided by EW Tipping have been widely publicised in the media. As emphasised in the previous case study, the Committee has no intention of targeting any particular organisation.

Like the Yooralla case study, in reviewing the EW Tipping case, there are multiple lessons for service improvement that can be identified, but also improvements required in the broader safeguarding system that operates in Victoria.

The facts from this case study are drawn from evidence to the Inquiry and publicly available materials.

#### Overview

Mr Heenan is in his early twenties and has a severe intellectual disability and no communication. He also has multiple physical disabilities, including being born with no pituitary gland which puts him at risk of hypoglycaemia, requiring careful monitoring and care management.

Ms Julie Pianto is Mr Heenan’s mother and she cared for him at home until the age of 21. Concerned that there would be nobody to take care of Mr Heenan if something happened to her, in March 2011 Ms Pianto decided to move Christopher into supported accommodation.

By May 2013 after trying to ensure that Mr Heenan had quality care where he would be safe, Ms Pianto moved her son back to her home. The Department allocated a new Individual Support Package with funding of approximately $60,000. An emergency care plan was put in place and will be invoked in the event of something happening suddenly to Ms Pianto and resulting in her inability to care for her son.

27 Submission S006, Yooralla, p.1.
Prevention

Ms Pianto stated that she provided extensive written and video guidance to EW Tipping regarding Mr Heenan’s medical history and how to manage his health issues. She explained that this is critical to prevent dangerous seizures and hypoglycemic episodes.

By June 2011, Ms Pianto started to have concerns about Mr Heenan’s care. In particular she considered that the staff did not have the expertise to manage her son’s health and disability needs. She suggested that some staff shared her concerns.

Response

In October 2011, Ms Pianto wrote a formal complaint to EW Tipping about the level and quality of care provided to her son after observing bruises on his body, including around his anus, and noting her son’s agitated mood.

EW Tipping arranged meetings between Ms Pianto, staff and management in an attempt to resolve the issues. Yet Ms Pianto stated that she considered the issues remained unresolved. The Committee is not aware to what extent critical incident processes were followed.

Despite multiple occasions when complaints were highlighted, Mr Heenan’s care did not improve. Ms Pianto stated that she made complaints to multiple members of management at EW Tipping. These included the:

- CEO
- Services Co-ordinator
- Executive Officer - Services
- Regional Services Manager Gippsland
- Services Co-ordinator
- Regional Services Manager Gippsland (acting),
- Services Manager, Regional Services Manager Gippsland.

Oversight

Screening

In her submission, Ms Pianto suggested that EW Tipping employed a convicted sex offender without adequate screening checks and she has concerns that her Mr Heenan may have been sexually abused while living in supported accommodation.

The worker with prior convictions was later charged and at the time of the arrest, the CEO of EW Tipping stated that in its police check, it failed to identify ‘any disclosable offences’. Since that time, the CEO explained that the organisation has been screening staff via a national police check.
Disability Services Commissioner

Ms Pianto contacted the Commissioner and was encouraged to lodge a complaint. In June 2012, Ms Pianto made a formal complaint to the Commissioner.

In August, Mr Heenan was hospitalised with hypoglycaemia and Ms Pianto identified that that EW Tipping had been recording incorrect blood glucose levels on incident reports to the Department.

In her submission, Ms Pianto explained that the Commissioner arranged a conference in November to discuss ‘issues that require attention and remain unresolved’. She stated that at this meeting, EW Tipping admitted that Mr Heenan had not been properly looked after and agreed to create an Action Plan for her son. However, by January 2013, Ms Pianto considered there was continuing unsafe treatment of her son, which EW Tipping attributed to staffing shortages.

Despite conciliation facilitated by the Commissioner between Ms Pianto, EW Tipping and the Department, Ms Pianto stated that her relationship with EW Tipping broke down irretrievably. She explained that the organisation would no longer accept her son as a client. The Commissioner advised Ms Pianto:

> Our office was established to provide an independent complaints resolution process, and does not have a broader compliance monitoring role that might be expected of a ‘watchdog’ type organisation. We can however provide a Notice of Advice to a service provider under section 17 (1)(d) of the Act on actions required to address issues identified through a complaint and request confirmation that the advice has been accepted and will be acted upon.

The Commissioner provided such a Notice of Advice to EW Tipping regarding support planning on 11 July 2013 and received confirmation that EW Tipping have acted on this advice and put in place improved processes to ensure appropriate support planning is completed for all new clients. However, this did not address the care concerns.

Department of Health and Human Services

Ms Pianto told the Inquiry that she had some difficulty obtaining critical incident reports relating to her son’s treatment. She sought to access incident reports from the Commissioner but was advised to obtain these from EW Tipping. Redacted incident reports were finally provided by EW Tipping. Ms Pianto stated that these reports revealed that EW Tipping deliberately misstated the blood glucose levels.

In addition, the evidence suggests that EW Tipping had received part of her son’s ISP for a service that he did in fact not access, and sought to argue this was bulk funding and not refundable to Mr Heenan.

Ms Pianto indicated that the Department took no action to reprimand the behaviour.
Community Visitors

Ms Pianto also contacted the Office of the Public Advocate and was advised that Community Visitors were aware of concerns with Mr Heenan’s facility and would visit the house. Despite assurances that she should notice a ‘definite improvement in the service soon’, Ms Pianto told the Inquiry her son’s care did not improve.

Lessons and improvements

EW Tipping has acknowledged its failings in relation to this case. It told the Senate Inquiry on disability that Ms Pianto’s submission has assisted them in ‘focussing attention’ on improvements to their service delivery. It provided the following examples of the improvements in process and systems implemented as a result:

- improvements to Client Intake and Access process
- introduction of a new complaints management system that ensures consistent management of complaints and response in a timely manner
- review and update of the Client Welcome Information Booklet
- a greater investment in training and development of Occupational Health and Safety Practices
- collaboration with the Office of the Disability Services Commissioner to tailor the Customer Service Focus for clients and families who are accessing external care support for the first time.

In addition, the organisation has improved its governance and review systems in the following ways:

- introduced a specific Board level sub-committee with oversight of service delivery chaired by a member of the Board
- committed to involvement in the La Trobe University Person Centred Active Support research and training program
- undertaken an independent client satisfaction survey and committed to implementing recommendations
- committed to a zero tolerance approach to abuse.

QUESTION 1.2: What systems and processes do disability service providers have in place to prevent abuse occurring in their organisation or to respond to any allegations of abuse or neglect of people accessing their disability services?

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28 Response to submission #9, EW Tipping Foundation, Submission to the Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, p.2.

29 Response to submission #9, EW Tipping Foundation, Submission to the Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, p.3.
1.5 The scale of abuse in disability services

A key question for the Committee during this Inquiry was determining the scale of abuse in disability services. However, the Committee found there was no reliable source of information and it was unable to determine the extent of abuse in disability service providers.

The Victorian Ombudsman recently reached a similar conclusion, stating that because there is ‘no single source of information or common framework for the reporting of abuse in the disability sector’ it is ‘impossible to say with any certainty what the scope of the problem is.’

It is not surprising that there is no single source of data about reported abuse in the disability sector, in light of the number of agencies with responsibility for dealing with abuse against people with disability in Victoria. Agencies have different responsibilities in relation to the types of abuse they can deal with, different approaches to dealing with abuse allegations they receive, and different approaches by the same agency, depending on where the abuse occurred or which service provider was providing services to the victim of abuse at the time it occurred.

The Committee shared the view of the Ombudsman that it is not possible to identify the scale of abuse in disability services. This underlies its recommendation in Chapter 2 that there needs to be a single, independent oversight body.

The different sources that might be considered in reviewing the extent of abuse and neglect in disability services include:

- Category One incidents—staff to client assaults and client to client assaults
- criminal statistics
- complaints to the Disability Services Commissioner
- complaints to Community Visitors.

There are shortcomings in all of these approaches. While staff to client assaults and client to client assaults can be captured, the groupings within Category One critical incidents reported to the Department will not necessarily capture all forms of abuse and neglect. Furthermore, as discussed in Chapter 5, there are issues with the reporting that might include underreporting or incorrect categorisation that make the data unreliable as an indicator of the extent of abuse and neglect in disability services.

The Committee has heard there are issues with reports of abuse and neglect in disability services that are made to police and the follow up investigations that police undertake. Again, this makes the data from police sources potentially unreliable in determining the extent of the problem.

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The Victorian Disability Services Commissioner takes complaints about a multitude of issues that occur within disability services. This includes staff to client assaults, client to client assaults and neglect. In evidence to the Inquiry, the Commissioner indicated that approximately 12 per cent of all complaints received between 2007 and 2012 related to abuse or neglect.

In recent evidence to the Senate Inquiry on abuse of people with disability, Disability Justice Advocacy Inc stated that about 16.75 per cent of its clients since 2010 were victims of violence, abuse or neglect.\footnote{32}{T. Carroll, Executive Officer, Disability Justice Advocacy Inc, \emph{Transcript of evidence}, Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, Melbourne, 30 June 2015, p.23.}

Evidence to the Inquiry suggested that the issue of under-reporting of abuse and neglect potentially obscures the extent of the problem. For example, in the 2014 Community Visitors Annual Report, the comment was made that what Community Visitors see is ‘only the tip of the iceberg.’\footnote{33}{Office of the Public Advocate (2014) \emph{Community Visitors Annual Report 2013-2014}, p.6.} In that Report, the Community Visitors suggested that almost 20 per cent of the issues they identify in their visits relate to abuse and neglect.\footnote{34}{Office of the Public Advocate (2014) \emph{Community Visitors Annual Report 2013-2014}, p.69.}

### 1.6 Victoria’s safeguarding framework

Victoria’s current safeguarding entities have a range of functions and powers that have been in effect since the commencement of the Disability Act in 2007, and some that have a longer history. This section provides an outline of the functions and powers of the relevant bodies. Chapters 3-6 discuss the evidence relating to these bodies and their effectiveness in carrying out their safeguarding functions.

Table 1.1 outlines the relevant bodies and their responsibilities.

<table>
<thead>
<tr>
<th>Key organisations</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health and Human Services</td>
<td>The Department has a multifaceted and complex role, including responsibility under the Disability Act to promote the rights of people accessing disability services and to support the provision of quality disability support services. In order to meet these responsibilities, the Department has a range of functions.</td>
</tr>
<tr>
<td>Disability Services Commissioner</td>
<td>The Commissioner is established under the Disability Act and is appointed by the Governor in Council to resolve complaints raised by or on behalf of people who receive disability services about their providers.</td>
</tr>
<tr>
<td>Senior Practitioner (Disability)</td>
<td>The Senior Practitioner is appointed by the Secretary of the Department under the Disability Act and is responsible for protecting the rights of people subject to restrictive interventions and compulsory treatment, and to ensure that the relevant standards are met.</td>
</tr>
<tr>
<td>Community Visitors</td>
<td>Community Visitors are volunteers appointed by the Governor in Council to visit accommodation facilities operating under the Disability Act. They can inquire into various matters relating to service delivery, including whether the rights of people with disability are being upheld.</td>
</tr>
</tbody>
</table>

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\footnote{32}{T. Carroll, Executive Officer, Disability Justice Advocacy Inc, \emph{Transcript of evidence}, Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, Melbourne, 30 June 2015, p.23.}

\footnote{33}{Office of the Public Advocate (2014) \emph{Community Visitors Annual Report 2013-2014}, p.6.}

\footnote{34}{Office of the Public Advocate (2014) \emph{Community Visitors Annual Report 2013-2014}, p.69.}
1.6.1 Department of Health and Human Services

State-funded disability service providers are overseen and regulated by the Department under the Disability Act 2006 (Vic). Until the full transition to the NDIS, the Department has responsibility for the provision of funding to community service organisations to deliver services on behalf of the Department to people with disability. These include:

- individual support (including services direct to a person’s home)
- residential accommodation services
- information, planning and capacity building
- targeted services, including behaviour intervention and advocacy services.

In addition the Department is a provider of disability services, specifically disability accommodation services, two residential institutions (Colanda Residential Services and Sandhurst Residential Services), and two forensic facilities (Disability Forensic Assessment and Treatment Service).

The Department is responsible for administering the Disability Act in accordance with the objectives and principles of the Act. Section 1.1 outlines these principles. The Department has key regulatory responsibilities that include:

- registering all disability service providers
- monitoring standards as determined by the Minister
- setting and monitoring performance measures
- independently monitoring compliance.

The Secretary of the Department is responsible for overseeing the Department’s responsibilities and has extensive powers under the Disability Act.

Chapter 4 reviews the role of the Secretary as a regulator of standards of service delivery and in registering disability service providers. When the NDIS has been fully rolled out, the Secretary will no longer hold responsibility for these functions.

One of the key functions of the Department in its performance monitoring of services is in the context of critical incident management. Critical incidents relate to serious outcomes (severe trauma or death), or threats to health, safety or wellbeing of people who access disability services. All disability service providers are required to comply with the Department’s instructions in regard to responding to critical incidents. Critical incident reporting is discussed in further detail in Chapter 5.
1.6.2 Disability Services Commissioner

The Victorian Disability Services Commissioner has responsibility for responding to complaints about issues raised about disability services. Most other states and territories have a Commissioner with only Queensland and Tasmania not having appointed such a body. They have differing powers.

The Victorian Commissioner’s role is essentially focused on complaints resolution. As emphasised in Chapter 5, complaints are different from reportable incidents.

Division 6 of the Disability Act outlines the process for dealing with complaints and the Commissioner’s related powers. The complaints process involves the following components:

- assessment—undertake a preliminary assessment to determine whether to consider the complaint.
- conciliation—consider if the complaint is suitable for conciliation and if it is, make all reasonable endeavours to conciliate it.
- investigation—must investigate a complaint which the Commissioner considers is not suitable for conciliation with minimal formality.

The Commissioner’s related powers include powers to compel attendance and call for evidence and documents. The Commissioner can also apply to a magistrate for a warrant to enter premises.

The Commissioner general powers are stipulated in Section 17 of the Disability Act and are intended to assist in the resolution of complaints. They are based on consultation, suggestion, the provision of advice, encouragement, and seeking information. Box 1.1 outlines these powers.
Chapter 1 Background and context

BOX 1.1: Powers of the Victorian Disability Services Commissioner

- consult with any person or body as the Commissioner considers appropriate
- develop and suggest ways of implementing procedures for:
  - dealing with complaints relating to disability services
  - making existing procedures more effective
- provide advice to complainants of alternative means for dealing with complaints
- provide advice generally on any matter in respect of complaints relating to disability services to
  - disability service providers
  - complainants
  - the Minister
  - the Secretary
- encourage disability service providers to distribute, display or make available material and information produced by the Commissioner about the resolution of complaints relating to disability services
- seek information from disability service users and disability service providers about the working of the disability services complaint system.

Source: Disability Act 2006 (Vic), Section 17.

1.6.3 Senior Practitioner (Disability)

The Senior Practitioner (Disability) was established in 2007 by the Disability Act 2006. Its remit is to ensure the rights of people subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to these practices are complied with. Evidence received relating to restrictive practices is discussed in Section 6.1 of Chapter 6.

The Senior Practitioner aims to create an inclusive and safe community that supports people to achieve dignity without restraints. The work of the Senior Practitioner is guided by the underlying principles from the Charter of Human Rights and Responsibilities Act 2006 (Vic) and United Nations Convention on Rights of Persons with Disabilities. These principles include: human rights and citizenship; quality of life and wellbeing; community inclusion; and promotion of individualised positive behaviour support.
Chapter 1 Background and context

The role of the Senior Practitioner is to:

- evaluate and monitor the use of restrictive interventions in disability services
- develop guidelines and standards
- provide education and information to disability service providers
- develop links to professionals and academic institutions to facilitate knowledge and training in clinical practice
- research restrictive interventions and compulsory treatment.

The Senior Practitioner has powers to:

- visit, talk to and inspect any disability service
- see any person who is subject to any restrictive intervention or compulsory treatment
- investigate, audit and monitor the use of any restrictive interventions or compulsory treatment
- direct a disability service provider to discontinue a restrictive practice.

The Senior Practitioner also has the capacity to undertake joint reviews with the Disability Services Commissioner of critical incident reports that relate to restrictive practices.

1.6.4 Community Visitors

In Victoria, Community Visitors are independent, statutory appointments who safeguard the interests of people with disability. In addition to Community Visitors that visit disability service providers, there are also Community Visitors that visit mental health facilities and supported residential services. Community Visitors are discussed in Section 5.6 of Chapter 5.

Community Visitors have an important function and responsibility in the community. The role of Community Visitors is to observe, listen, question and monitor. In the words of the Community Visitors Combined Board, they are intended as an ‘early warning system’ about quality failures.35

More specifically, the legislation stipulates that their functions are to visit any premises where a disability service provider is providing residential services and to inquire into a number of different aspects of the provision of services. Box 1.2 outlines these functions.

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BOX 1.2: Functions of the Community Visitors

To visit any premises where a disability service provider is providing residential services and to inquire into:

- the appropriateness and standard of premises for the accommodation of residents
- the adequacy of opportunities for inclusion and participation by residents in the community
- whether the residential services are being provided in accordance with the principles specified in Section 5
- whether information is being provided to residents as required by the Act
- any case of suspected abuse or neglect of a resident
- the use of restrictive interventions and compulsory treatment
- any failure to comply with the provisions of this Act
- any complaint made to a community visitor by a resident.

Source: Disability Act 2006 (Vic), Section 30.

Specifically relevant to this Inquiry is the legislated powers to visit residential facilities at any time, unannounced, for the purpose of inquiring into any case of suspected abuse or neglect of a resident, stipulated in Section 30(e). Yet, like the Disability Services Commissioner, the role of the Community Visitors is not limited to inquiring into suspected cases of abuse, neglect and exploitation.

Under Section 130, Community Visitors have powers of inspection and disability service providers are expected to reasonably assist Community Visitors to fulfil their functions. There are considerable penalties for failing to do this (up to 60 penalty units—that is, $9,10036). Community Visitors can speak with residents, identify concerns about the care being provided and liaise with staff and management to resolve these matters.

There is also a Community Visitors Board whose functions are to:

- represent Community Visitors
- prepare and circulate publications explaining the role of Community Visitors
- supervise the training of Community Visitors
- report a matter to the Public Advocate or the Minister
- refer a matter under relevant sections of the Disability Act
- prepare an annual report.

36 The penalty unit rate for 1 July 2015 to 30 June 2016 is $151.67.
Without limiting the discretion of the Community Visitors Board to refer a matter to any other person, the Community Visitors Board may refer a matter reported by a Community Visitor to whichever of the following the Community Visitors Board considers is the appropriate person to deal with that matter—

• the Secretary
• the Disability Services Commissioner
• the Senior Practitioner
• the Ombudsman.

There are 278 Community Visitors across Victoria that visit, inquire and report on residential disability services. Each visit involves the Community Visitors preparing a report. If they identify any matters that require attention in their inquiries, they indicate the nature of the action required, which are referred to as ‘issues’. A copy of the report is provided to the most senior staff member. If the Community Visitors cannot resolve issues at a facility level, the matter is referred to the Department’s regional office. In the instance of serious matters, these are referred to the Public Advocate.37

1.6.5 Office of the Public Advocate

The Office of the Public Advocate is an independent statutory body that works to protect and promote the interests, rights and dignity of people with disability.

The Public Advocate is appointed by the Governor in Council under the Guardianship and Administration Act 1986 (Vic) to promote and protect the rights of people with disability in Victoria. The Public Advocate reports to the Victorian Parliament but sits within the Department of Justice and Regulation. The Office of the Public Advocate is discussed further in Section 6.2 of Chapter 6.

The Public Advocate is the guardian of last resort. This function has parallels with statutory guardianship in the context of children who are taken into the care of the state. The Public Advocate has an extremely important function and role in safeguarding people who are unable to make decisions. The Guardianship and Administration Act emphasises the desirability of preserving existing family relationships.

Sections 15 and 16 of the Guardianship and Administration Act 1986 (Vic) outline the functions and powers of the Public Advocate.

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37 Transcript of evidence, Community Visitors, Melbourne, 29 June 2015, p.2.

Guardianship—
means the appointment of a person to make decisions for an adult with disability when they are unable to do so.
The Advocate Guardian Program provides services across three areas:

- guardianship
- investigation
- advocacy.

Guardianship of people with disability is the main component of the work conducted by the Office of the Public Advocate. The Guardian makes decisions such as where the person will live and who will have contact with them according to the terms of a Guardianship Order made by the Victorian Civil and Administration Tribunal (the Tribunal).

The Public Advocate investigates matters at the request of the Tribunal or in response to a complaint. The Public Advocate can investigate any complaint or allegation that a person is under inappropriate guardianship or is being exploited or abused or in need of guardianship.

The Office of the Public Advocate provides advocacy that focuses on the best interests of a person with disability. The advocacy services provided by the Office of the Public Advocate have developed from its understanding of the Guardianship and Administration Act.

The Office also has responsibility for the administration of the Community Visitor program.

### 1.7 The National Disability Insurance Scheme (NDIS)

The NDIS is a new way of providing individualised support for eligible people with permanent and significant disability, their families and carers. It will progressively replace the existing disability arrangements in the states and territories participating in the NDIS and the Commonwealth.

The Productivity Commission’s report, *Disability Care and Support*, was released in August 2011. The Commission found that existing systems for people with disability were not working and recommended an NDIS be created to provide all Australians with insurance for the cost of support if they or a family member acquired a disability.

In April 2012, Australian governments agreed to fund the NDIS. The *National Disability Insurance Scheme Act 2013* (Cth) establishes the scheme, including the National Disability Insurance Agency (NDIA) to administer the NDIS. The NDIS is designed to give people choice and control over the supports they receive, including the ability to manage their own funding, if that is approved by the NDIA. Under the NDIS, funding for disability supports is allocated to individuals based on an individual support plan, rather than to service providers. This approach is similar to the allocation of funding under Victoria’s individualised support packages.
In May 2013, the Victorian and Commonwealth Governments agreed to transition from trial to full scheme over three years commencing in 2016-17. By 2019-20, the NDIS is intended to provide individualised supports to over 100 000 Victorians with significant and permanent disability.

In the full scheme Victoria will contribute $2.5 billion per annum, and the Commonwealth around $2.6 billion per annum.

Victoria is currently working with all governments and the National Disability Insurance Agency on this major reform of the disability services sector, including how and when existing eligible clients of state funded services will transition to the NDIS.

1.7.1 NDIS trial

A three year trial of the NDIS commenced operating in 2013-14 in the Barwon area of Victoria. The trial is providing valuable lessons for the design and implementation of full scheme coverage.

Other jurisdictions involved in the initial trial included the Hunter region in New South Wales, South Australia (for children aged 0–5) and Tasmania (for young people aged 15–24).

There are now trials in all states and territories except Queensland.

1.7.2 NDIS and eligibility

About 10 per cent of people with disability in Victoria will receive funding as participants of the NDIS. In 2012 about 6.4 per cent of Victorians with disability received specialist disability supports. In 2013, about 1.5 per cent received an Individual Support Package. The NDIS will contribute to a substantial increase in support for people with a profound disability.

1.7.3 NDIS and safeguarding

The Disability Reform Council has recognised that in this context of rapid change, governments need to reconsider protections for people with disability and arrangements to ensure supports are of a high quality.

A national quality and safeguarding framework for the NDIS is currently in development. This is discussed in further detail in Chapter 2.

The NDIS quality and safeguarding framework is intended to replace existing state-based arrangements and is designed to give participants choice and control over their supports and allow people to take reasonable risks to achieve their goals.
Informing Victoria’s position—NDIS quality and safeguarding framework

AT A GLANCE

Background

The introduction of the National Disability Insurance Scheme (NDIS) provides a valuable opportunity to consider the most appropriate safeguarding mechanisms to have in place to ensure the rights and dignity of people with disability are upheld.

Recommendations

That the Victorian Government advises the Disability Reform Council:

• That in the transition to the NDIS the existing elements of the quality and safeguarding system in Victoria should not be diminished.

• To establish a single, independent oversight body with powers and responsibility for:
  – handling complaints
  – managing and investigating reportable serious incidents
  – oversight of restrictive practices
  – voluntary community visitors
  – the option of an official inspector scheme with paid inspectors or visitors.

• To ensure the establishment of an independent advocacy and capacity building body with powers and responsibility for:
  – administering funds for individual and community advocacy
  – systemic advocacy
  – capacity building through information, education and resources, including how to spot abuse and report it.

• To ensure that a guardian of last resort is maintained with responsibility for:
  – guardianship and supported decision making
  – investigation of guardianship matters.

• To ensure the establishment of a national quality assurance agency with responsibility for:
  – screening and clearance checks—administering a working with vulnerable persons check
  – provider registration
  – individual registration of disability workers.
With the transition to the National Disability Insurance Scheme (NDIS), the intention of the Disability Reform Council is that an NDIS quality and safeguarding framework will replace existing state-based arrangements.¹

The NDIS is a major reform and will fundamentally change disability service delivery in Victoria. The introduction of the NDIS provides a valuable opportunity to consider the most appropriate safeguarding mechanisms to have in place to ensure the rights and dignity of people with disability are upheld.

It is a chance to look beyond what is currently in place in various states and territories and to consider what would be the most effective and appropriate quality and safeguarding system Australia can put in place. There is also an opportunity to learn from the strengths and weaknesses of existing systems, while considering an entirely new framework with relevant functions and adequate powers.

Having given preliminary consideration to the safeguarding system in Victoria and identified its strengths and weaknesses (as outlined in Chapters 3-6, the Committee reviewed the proposed national framework and developed recommendations for an approach to safeguarding people who access disability services. This is intended to inform Victoria’s position in discussions to be held by the Disability Reform Council and agreed on by the end of 2015.

The Committee determined that in considering a nationally consistent scheme for quality and safeguards of people who access disability services, there is scope to introduce elements that go beyond the current system in Victoria.

### 2.1 Existing safeguarding mechanisms in Victoria

A clear message in the evidence to the Inquiry was that while there are weaknesses in the existing safeguarding mechanisms in Victoria, these should not be diminished in the transition to the NDIS. That is, at a bare minimum Victoria should retain the functions and powers that exist in Victoria’s safeguarding system for disability services.

The Committee heard that the Victorian safeguarding system includes the following essential functions and powers that should not be lost in the transition:

- prevention of abuse
  - standards and registration for disability service providers
  - screening of new workers
  - exclusion of unsuitable workers.

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¹ National Disability Insurance Scheme (2015) Consultation paper: Proposal for a National Disability Insurance Scheme Quality and Safeguarding framework, p.10. WA has not committed to the full rollout of the NDIS. The Framework will apply to those states and territories that participate in the full NDIS.
• responding to abuse
  – a complaints handling system
  – a visitors scheme
  – a critical incident management system
  – oversight of restrictive practices.

As outlined in Chapters 3-6, there were mixed views about the effectiveness of Victoria’s safeguarding system. Some service providers and bodies with oversight responsibilities, suggested Victoria’s safeguarding system ‘has all the elements of a robust system’ and that ‘Victoria has one of the country’s most comprehensive and extensive safeguarding rights systems’.

Others suggested that the Victorian safeguarding systems have failed and there is a need to move beyond what currently exists in Victoria. For example, one participant suggested that ‘given the system that has been in vogue now for many years has clearly not worked, then a more innovative approach is required.’

RECOMMENDATION 1: That the Victorian Government advises the Disability Reform Council that in the transition to the NDIS the existing elements of the quality and safeguarding system in Victoria should not be diminished.

2.2 The NDIS and the proposed quality and safeguarding framework

The introduction of the NDIS will fundamentally change disability service delivery in Victoria. The regulatory role of the Victorian Government and current Victorian safeguarding mechanisms have been designed for a disability system delivered or funded at the state level. With disability services instead being funded federally, state-based regulatory and safeguarding mechanisms will increasingly play a smaller role.

A national quality and safeguarding framework for the NDIS is currently in development. Consultation and online discussion on a proposed framework closed on 30 April 2015. As illustrated in Box 2.1, the proposed framework identifies ten elements across three domains—developmental, preventative and corrective.

2 Submission S006, Yooralla, p.5.
3 Submission S003, JacksonRyan Partners, p.35.

It goes into detail about five of the ten elements identified across the three domains, mostly relating to the prevention domain (see Table 2.1). For these five elements of the NDIS Safeguarding Framework, the Consultation Paper outlines a number of detailed options for consideration.
Table 2.1 Elements of the NDIS Consultation Paper aligned to the NDIS Safeguarding Framework

<table>
<thead>
<tr>
<th>All domains</th>
<th>Preventative domain</th>
<th>Corrective domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguards for participants who manage their own plans (discussed in Section 2.3.3)</td>
<td>NDIA provider registration (discussed in Section 2.3.1)</td>
<td>Systems for handling complaints (discussed in Section 2.4.2)</td>
</tr>
<tr>
<td>Ensuring staff are safe to work with participants (discussed in Section 2.3.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing and eliminating restrictive practices in NDIS funded supports (discussed in Section 2.3.4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


This chapter considers each of the five elements in the context of the evidence it received for Stage 1 of the Inquiry. In addition, this chapter discusses other aspects relevant to the National Quality and Safeguarding Framework that are not flagged for detailed consideration in the Consultation Paper:

- national workforce strategy (see Section 2.3.5).
- serious incident reporting (see Section 2.4.2).
- oversight functions (see Section 2.4.3).

### 2.2.1 Limitations of the Consultation Paper on the Proposal for an NDIS Quality and Safeguarding Framework

In reviewing the NDIS Consultation Paper, the Committee identified limitations in the elements for consultation.

In detailing these five specific elements of the proposed quality and safeguarding framework, the NDIS Consultation Paper states that ‘these are challenging issues’ and ‘a number of options have been developed for them which warrant more detailed discussion’. It goes on to outline that:

> These five elements also potentially have a significant regulatory impact for participants, other family members, the not-for-profit sector and businesses. Any new policy work of this nature being developed for Ministerial Councils must meet the requirements of the Council of Australian Governments’ guide to best practice regulation.⁴

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The Committee determined the NDIS Consultation Paper is limited in that it does not provide specific options for consideration regarding the following two elements of the NDIS Safeguarding Framework:

- oversight functions required for monitoring quality and safeguarding across the NDIS.
- serious incident reporting and gathering information on dangerous situations.

These are two areas that the Committee identified were of particular concern in the evidence it received in Stage 1 of its Inquiry. It is unclear why there are no options provided for either of these elements of the NDIS Safeguarding Framework.

In addition, the Committee identified that two related areas of work are not reflected in the NDIS Consultation Paper:

- Integrated Market, Sector and Workforce Strategy—the strategy and roadmap for a sustainable workforce is not a component of the NDIS Consultation Paper, despite the Paper indicating that workforce will be a key issue for the disability sector.
- National Framework for Advocacy provision—the current review into the National Disability Advocacy Program is not a component of the NDIS Consultation Paper.

### 2.3 Preventative domain

The preventative domain of the NDIS Safeguarding Framework focuses on three levels of safeguards:

1. Formal individual safeguards—for example, individual supports provided by the NDIA, risk assessment and management strategies as individual plans are developed and monitored.
2. Service level safeguards—ensuring safe and high quality provision of support by disability service providers, for example good management practices, staff training and development, and formal background checks for staff.
3. System level quality measures—the NDIA will ensure that providers are suitable to provide supports in the NDIS.

Four of the five elements on which the NDIS Consultation Paper seeks detailed views relate to the Preventative Domain. They are:

- NDIS provider registration
- ensuring staff are safe to work with participants
- safeguards for people who manage their own plans (the Consultation Paper identifies this as an element that spans all domains, however the options relate mainly to the preventative domain)
Chapter 2 Informing Victoria’s position—NDIS quality and safeguarding framework

2.3.1 NDIS provider registration

The NDIS Consultation Paper explains that quality and safeguarding arrangements for providers of disability supports are currently managed by the ‘terms and conditions’ in contractual agreements between providers and the government agencies that provide funding. These agreements can also refer to additional requirements in state and territory legislation that providers need to meet.5

As part of the transition to the NDIS, new providers not registered under existing state arrangements are expected to emerge in the disability sector. The NDIS Consultation Paper explains that:

... once the NDIS is fully rolled out, the Chief Executive Officer of the National Disability Insurance Agency (as the registrar of providers) will have primary responsibility for deciding whether individuals and organisations proposing to provide supports meet the quality and safeguards standards for the NDIS.6

The National Disability Insurance Scheme Act 2013 (Cth) provides for the making of rules and requirements for registered providers of support. These are known as the ‘Terms of Business for Registered Support Providers’.7

The NDIS also plans a risk-based approach to provider registration, meaning higher risk supports will face more stringent regulations than low-risk supports. It aims to establish a registration system that should:

• support the goal of choice and control for participants, including confidence that the providers they choose are safe and competent
• minimise the red tape burden on providers, including the elimination of unnecessary duplication of quality, compliance and reporting systems.8

For those providers who choose to be registered with the NDIS, the Consultation Paper offers four options of registration requirements. Table 2.2 outlines the options.

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Table 2.2 Options for registration requirements for providers

<table>
<thead>
<tr>
<th>Option</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>Basic registration requirements</td>
</tr>
<tr>
<td>Option 2</td>
<td>Additional registration conditions</td>
</tr>
<tr>
<td>Option 3</td>
<td>Mandated independent quality evaluation requirements for certain providers of supports</td>
</tr>
<tr>
<td>Option 4</td>
<td>Mandated participation in an external quality assurance system for certain providers of supports</td>
</tr>
</tbody>
</table>

Source: NDIS Consultation Paper

The NDIS Consultation Paper explains that these options are not designed to be mutually exclusive. For example, a low-risk provider would only be required to meet only Option 1, whereas a service provider operating in a high-risk environment would be expected to meet all four options.

At the very minimum, Option 1 establishes an NDIS Code of Conduct.

Evidence to the Inquiry

The Committee heard a range of views about how a registration scheme should be designed at the national level as part of the NDIS. These views included:

- registration and quality accreditation should apply to all providers, that is, the same standard of quality and rigor should apply to all providers so as to ensure and maintain a high level of quality and service delivery\(^9\)
- mandated participation in an external quality assurance system for providers of supports\(^10\)
- creation of a risk-based registration and accreditation scheme, including creation of legislated screening system\(^11\)
- the need for workers to be registered as professionals, in line with a number of other sectors\(^12\)

National Disability Services and the Health and Community Services Union suggested there is some room for a risk-based approach yet still recommended a mandated independent quality evaluation requirement. However, it was open to this being a requirement for certain providers of supports.\(^13\)

Section 2.4.3 discusses the nature of an oversight body that Inquiry participants proposed and outlines the Committee’s recommended approach.

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9  Submission S006, Yooralla, p.7.
11  Submission S015, Health and Community Services Union, p.3.
12  Submission S003, JacksonRyan Partners, p.33; Submission S021, Victorian Equal Opportunity and Human Rights Commission, p.9; Submission S015, Health and Community Services Union, p.7.
13  Submission S023, National Disability Services; Submission S015, Health and Community Services Union.
National consultations on the introduction of the NDIS indicated support for strong regulation of disability service providers, in particular for staff vetting.\textsuperscript{14}

In addition to the evidence it received, the Committee reviewed submissions to the NDIS Consultation Paper. It noted that the Commonwealth Ombudsman recommended a ‘mixed’ model that enables registration requirements to vary according to the type, frequency and location of the support. More specifically it outlined a ‘tiered registration arrangement’, stating that this:

... arrangement would provide a sensible approach to balancing risk minimisation against the desire to maintain choice and competition.

All providers – regardless of the level of registration – should be required to:

• indicate their awareness of, and compliance with all relevant state, territory and federal laws relating to their industry
• provide details of their internal complaint handling arrangements, and
• subscribe to, and abide by an NDIS Code of Conduct.

Consideration might also be given to requiring that providers and/or their staff be members of any relevant professional bodies applying to their industry.\textsuperscript{15}

The Committee considered there is value in the proposal made by the Commonwealth Ombudsman in the context of evidence received from Inquiry participants.

\subsection*{2.3.2 Ensuring staff are safe to work with participants}

The NDIS Consultation Paper explains that there are currently different requirements for employee recruitment in each state and territory. It indicates that most states and territories require checks for those who are working with children and some have specific requirements for those who are working with vulnerable people, such as people with disability.

The NDIS Consultation Paper also acknowledges that ‘people with disability are at an increased risk of abuse, harm, exploitation and neglect due to a range of factors, including reliance on others for support, social isolation, fear of retribution and difficulties with communication.’\textsuperscript{16}

\begin{footnotesize}
\begin{itemize}
\item[14] Supplementary evidence, Information provided at briefing of Committee, Department of Health and Human Services, 1 June 2015.
\end{itemize}
\end{footnotesize}
It goes on to state that the aim under the NDIS is to:

- reduce the potential for people who pose a risk to participants being employed in supports funded through the NDIS
- remove those proven to pose a risk to participants
- send a strong signal about the priority placed on the right of people with disability to be safe.17

In considering the possible approach to ensuring staff are safe to work with participants, the NDIS Consultation Paper proposed four options. It states that they could be adopted individually or a combination of options could be considered. Critically, it highlights that the options should also be read in conjunction with the options for registration arrangements for providers. The options are outlined in Table 2.3.

<table>
<thead>
<tr>
<th>Table 2.3</th>
<th>Options for ensuring staff are safe to work with participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option</strong></td>
<td><strong>Explanation</strong></td>
</tr>
<tr>
<td>Option 1</td>
<td>Risk management by employers</td>
</tr>
<tr>
<td>Option 2</td>
<td>Requirement for referee checks for all roles and police checks for certain employee roles</td>
</tr>
<tr>
<td>Option 3</td>
<td>Working with vulnerable people clearances</td>
</tr>
<tr>
<td>Option 4</td>
<td>Create a barred persons list</td>
</tr>
</tbody>
</table>

Source: NDIS Consultation Paper

In outlining the four options and associated considerations, the NDIS Consultation Paper states that in the context of Option 3:

... a screening agency would be established, either nationally or in each jurisdiction, to assess the risk a person poses. Employees or potential employees working with particularly vulnerable people would be required to obtain a clearance through this screening agency.18

**Evidence to the Inquiry**

In the evidence received by the Committee, many submissions emphasised their support for a working with vulnerable persons check. Some proposed this in addition to the existing Disability Worker Exclusion Scheme in Victoria.

For example, in its submission Life Without Barriers explained its support for increased employee screening, stating that:

... a comprehensive strategy that looks at a wider range of information about a person's history and put in place a national system to assess the risk a person poses. Employees or potential employees working with particularly vulnerable people


would be required to obtain a clearance through this screening agency. This would be similar to the Working with Vulnerable People central clearances systems used in several jurisdictions.\footnote{Submission S010, Life Without Barriers, p.5.}

HACSU also supported a Working with Vulnerable People Check, stating that:

\begin{quote}
It is our view that legislation, such as the Australian Capital Territory’s \textit{Working with Vulnerable People (Background Checking) Act 2011} should be applied in Victoria. This would ensure the rights of people with disability and the rights of workers to privacy and natural justice are met.\footnote{Submission S015, Health and Community Services Union, pp.8-9.}
\end{quote}

As noted in the NDIS Consultation Paper, a barred persons list (such as the DWES) is more limited in its scope than a screening clearance. A system of centralised checks would enable clearances to capture a wider range of information than police checks, including spent convictions and non-conviction information such as civil cases, intervention orders, work history and child protection information and orders.

In addition, a further benefit is that it is the screening agency making the judgement about the risk a person might pose, not the employer.\footnote{National Disability Insurance Scheme (2015) \textit{Consultation paper: Proposal for a National Disability Insurance Scheme Quality and Safeguarding framework}, pp.62-63, 65.} Section 2.5 discusses the evidence received in regard to an agency that would hold such responsibility and then outlines the Committee’s recommendation.

In its submission, Women with Disabilities Victoria (WWDV) suggested that the wording needs to change away from the use of ‘vulnerable’, stating that is disempowering. However, WWDV did not suggest an alternative title or form of wording for the clearance check.\footnote{Submission S004, Women With Disabilities Victoria, p.5}

### 2.3.3 Safeguards for participants who manage their own plans

The NDIS Consultation Paper states that a key aim of the NDIS is to ensure that to the full extent of their capacity, participants are able to determine their own best interests, have choice and control, and be equal partners in the decisions that affect their lives.

The NDIS aims to get the right balance of risk and safety for people participating in the scheme. It distinguishes between those who choose (where they can choose) to have the NDIA manage their plans and those participants who self-manage their plans. The NDIS Consultation Paper explains that:

\begin{quote}
People who choose to have the NDIA manage their plans for them will have the protection of using registered providers, including any staff vetting requirements, complaints processes, controls on the use of restrictive practices and other measures
\end{quote}
agreed by governments. Under the NDIS Act, self-managing participants can choose to receive their supports from anyone they wish, whether or not they are a registered provider of NDIS supports.23

This approach reflects a number of the core principles at the heart of the NDIS, including choice and control and a risk-based and person-centred approach.

The NDIS Consultation Paper offers several options as a way of negating this risk. Table 2.4 outlines these options.

### Table 2.4 Options for safeguarding participants who self-manage their plans

<table>
<thead>
<tr>
<th>Option</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>Building the capacity of participants to manage their own risks</td>
</tr>
<tr>
<td>Option 2</td>
<td>Prohibiting certain providers from offering supports</td>
</tr>
<tr>
<td></td>
<td>2a—Negative licensing scheme</td>
</tr>
<tr>
<td></td>
<td>2b—Creation of an excluded persons or barred persons scheme</td>
</tr>
<tr>
<td>Option 3</td>
<td>Self-managed participants would be required to use a provider who has been approved or screened by the NDIA</td>
</tr>
<tr>
<td></td>
<td>3a—Separate registration process with limited conditions</td>
</tr>
<tr>
<td></td>
<td>3b—Registration</td>
</tr>
<tr>
<td></td>
<td>3c—Individuals to be employed have been screened</td>
</tr>
</tbody>
</table>

Source: NDIS Consultation Paper

### Evidence to the Inquiry

The majority of evidence to the Inquiry related to people who do not have the capacity to self-manage their NDIS plan, yet some views about self-management were provided.

For example, AMIDA expressed its view that:

Ideally everyone wanting to provide services can register with NDIS in future. People with disability are vulnerable, and therefore, even if managing their own plans, people with disability must be protected.

We do agree to providing people with support to build capacity to manage staff selection.

Resources, for example on risks and checklists to ask about and the pros and cons of choosing a registered provider must be available.24

It is important to note that the ability to self-manage funds is directly proportional to the person’s capacity – allowing people to choose their own providers makes it very hard to manage risk. It also means being unregistered is no longer a disincentive for service providers.25

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25 Submission S011, Disability Services Commissioner, p.19.
Essentially there is a choice between two beliefs: that people who manage their own plans and choose unregistered providers of supports do so on an ‘at your own risk’ basis; or that the NDIS has a duty of care to ensure that all providers are safe and competent.\(^{26}\)

### 2.3.4 Reducing and eliminating restrictive practices in NDIS funded supports

The NDIS Consultation Paper defines a restrictive practice as ‘any intervention which restricts the rights or freedom of movement of a person with disability who displays challenging behaviours, where the primary purpose of that intervention is to protect that person or others from harm.’\(^{27}\)

The Paper outlines the significant variations across states and territories in regard to the regulation of the use of restrictive practice in the context of people with disability.

It states that its aim is to continue to work towards the reduction and elimination of restrictive practices in services for people with disability, and that the NDIS Safeguarding Framework should ensure:

- any use of restrictive practice in an NDIS funded support is always a last resort and it must be the least restrictive option
- individuals are involved in developing and agreeing their behaviour support plans
- families and others who know the person well should be used to help ensure the person understands and, to the greatest extent possible, agrees with the behaviour support plan
- decisions to include restrictive practices in a behaviour support plan are well informed and decision makers are accountable and authorised to make such decisions
- there are effective systems in place for monitoring the use of restrictive practices in NDIS funded supports, at both the individual and system levels
- appropriate linkages are made for individuals, where appropriate and necessary, with other systems, including the mental health system.

The NDIS Consultation Paper outlines a number of options that distinguish between authorisation of practices and the monitoring and reporting of restrictive practices. Table 2.5 outlines these options.

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Table 2.5 Options for reducing and eliminating restrictive practices

<table>
<thead>
<tr>
<th>Option</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorisation</strong></td>
<td></td>
</tr>
<tr>
<td>Option 1</td>
<td>A voluntary code of practice</td>
</tr>
<tr>
<td>Option 2</td>
<td>Substitute decision makers must be formally appointed guardians</td>
</tr>
<tr>
<td>Option 3</td>
<td>Providers would be authorised to make decisions under specific conditions</td>
</tr>
<tr>
<td><strong>Monitoring and reporting</strong></td>
<td></td>
</tr>
<tr>
<td>Option 1</td>
<td>Reporting would be mandatory for emergency use only</td>
</tr>
<tr>
<td>Option 2</td>
<td>All positive behaviour plans which include a restrictive practice must be reported</td>
</tr>
<tr>
<td>Option 3</td>
<td>Providers must report on each occasion where a restrictive practice is used (for physical, chemical, mechanical restraint and seclusion)</td>
</tr>
</tbody>
</table>

Source: NDIS Consultation Paper

Evidence to the Inquiry

Chapter 6 discusses the system of oversight for restrictive practices in Victoria, noting that the legislated model of the Senior Practitioner is highly regarded nationally and internationally.

The majority of Inquiry participants indicated that a model of oversight of the use of restrictive practices should continue to operate in the NDIS.

On the whole, most participants considered the legislated model in Victoria should be adopted within the National Quality and Safeguarding Framework. For example, Yooralla stated that 'The Victorian Senior Practitioner model is a very good model to emulate.' Similarly AMIDA stated that 'In Victoria the Senior Practitioners Office is a worthy model for overseeing restrictive practices'.

A key message from Inquiry participants is that the role needs to be independent of any funding bodies.

2.3.5 National workforce strategy

In December 2014 the Disability Reform Council agreed to the development of an Integrated Market, Sector and Workforce Strategy (the Strategy) in preparation for the full roll out of the NDIS.

The Australian Government, together with states and territories and the NDIA, developed the Strategy to provide a roadmap for activities that can be implemented to foster and advance market, sector and workforce maturity.

28 Submission S006, Yooralla, p.29 of Submission to NDIS Consultation Paper.
On 24 April 2015, the Disability Reform Council agreed to the Strategy, which was publicly released in July 2015. The Strategy focuses on ensuring a sustainable disability workforce, and does not discuss the role of the workforce strategy in ensuring effective safeguards for disability services. It proposes funding support for training and skill development to ensure the workforce has adaptable and relevant skills, including skills relating to quality and safeguards. The Council identifies the necessity of balancing 'low barriers for entry to the workforce with appropriate levels of workforce screening through the development of the National Quality and Safeguarding Framework.'

The Australian Government (through the Department of Social Services) contracted the national peak organisation, National Disability Services (NDS), to provide advice on this strategy. Box 2.2 outlines the issues that NDS identified in its consultations about the workforce and transitioning to the NDIS.

**BOX 2.2: The disability workforce challenge**

The challenge for the strategy is to support a flexible workforce that also has the depth and breadth of skills needed to facilitate and complement the social and economic participation and inclusion outcomes required by the NDIS. Jobs in the sector also need to be attractive enough to draw a sufficient and appropriately diverse workforce.

Anticipated workforce risks associated with the introduction of the NDIS have been widely reported and are well known. They include:

- **Workforce shortages:** Estimates vary of how many workers will be required in the future; however, support is labour-intensive, and some estimate the demand for workforce will grow in line with the market – it may double in size. The sector also competes for workforce with other rapidly expanding industries such as aged care and health.

- **Increased fragmentation of jobs:** Already the most common form of employment for non-professional disability workers is permanent part-time, and there is also a relatively high proportion of casual employment. About 26 per cent of workers want to work more hours and 24 per cent have more than one job.

- **Lack of appropriately skilled workers will undermine choice and quality:** As participant choice and new technology shifts the provision of support to the home, the skills and associated job roles will need to change. There are widely diverging views about skills required and who should provide them.

- **Uneven access:** People from Indigenous or minority ethnic communities currently lack access to appropriate support. The distribution of the available workforce does not match the geographic spread of current and future NDIS participants.

- **The number of informal carers is expected to decline:** This is anticipated as a result of ageing, the changing roles of women and changing family structures.


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30 Disability Reform Council (2015) *Integrated Market, Sector and Workforce Strategy*. National Disability Insurance Scheme, p.21. The Sector Development Fund is a pool of funds dedicated to support NDIS transition and is complemented by activity funded by jurisdictions and initiated by the disability sector.
Evidence to the Inquiry

The Committee heard that disability support work is complex and challenging.\textsuperscript{31} A number of inquiry participants identified workforce issues as contributing to abuse and neglect in disability services, including concerns regarding the high casualization of staff, high levels of part-time work and low rates of pay.\textsuperscript{32} HACSU warned of an ‘increased reliance on the use of short-term contract and casual staff, which will be exacerbated by the NDIS.’\textsuperscript{33} The Office of the Public Advocate identified that residents are placed at risk as staffing shortages often result in ‘minimally trained, casual and inexperienced staff working night shifts unsupervised with vulnerable residents.’\textsuperscript{34} HACSU referred to its research which shows that ‘casual workers are much less likely to report abuse than those in secure employment as they believe this may potentially put them in direct conflict with both co-workers and management, making their employment more tenuous.’\textsuperscript{35}

Inquiry participants identified the following workforce concerns:

\begin{itemize}
  \item No sector-wide entry level qualification or mandatory qualifications.\textsuperscript{36}
  \item No mandated continuing professional development.\textsuperscript{37}
  \item Over-reliance on casual and contracted workers.\textsuperscript{38}
\end{itemize}

Chapter 4 discusses the issues in Victoria regarding the workforce and prevention of abuse in greater depth.

2.4 Corrective domain

The corrective domain focuses on responses to incidents after they have occurred (eg. independent complaints system, oversight and compliance), including:

\begin{enumerate}
  \item universal safeguards—such as legal protections
    \begin{enumerate}
      \item complaints handling—identification of best practice such as timely resolution of complaints, independent investigation, seamless referral to other complaints bodies where appropriate, emphasis on continuous improvement for providers based on the complaints received. Three approaches being considered are:
      \begin{enumerate}
        \item internal complaints processes and external dispute resolution mechanism.
      \end{enumerate}
    \end{enumerate}
\end{enumerate}

\textsuperscript{31} See for example Submission S015, Health and Community Services Union, p.2.
\textsuperscript{32} See for example, Submission S013, S. Guy, p.20.
\textsuperscript{33} Submission S015, Health and Community Services Union, p.2.
\textsuperscript{34} Submission S018, Office of the Public Advocate, p.15.
\textsuperscript{35} Submission S015, Health and Community Services Union, p.15.
\textsuperscript{36} Submission S015, Health and Community Services Union, p.2.
\textsuperscript{37} Submission S015, Health and Community Services Union, p.4.
\textsuperscript{38} Submission S015, Health and Community Services Union, p.5.
Chapter 2 Informing Victoria’s position—NDIS quality and safeguarding framework

(c) internal complaints process as a requirement for registration, agreement to abide by decisions of an approved external disputes resolution agency.

2. formal external complaints handling body that assists providers to manage complaints and supports participants to have their complaints resolved quickly and effectively

3. serious incident reporting—NDIA to ensure that providers are suitable to provide supports in the NDIS. In addition to NDIA’s oversight role, potential to establish an independent body, with potential additional powers to oversee the market, and have an educative role.\(^{39}\)

As emphasised in Section 2.2.1, the Committee is concerned that the NDIS Consultation Paper has not provided an opportunity for further discussion and consideration of identified options for the following two elements of the Corrective Domain of the NDIS Safeguarding Framework:

- oversight functions required for monitoring quality and safeguarding across the NDIS
- serious incident reporting and gathering information on dangerous situations.

These are two areas that the Committee identified were of particular concern in the evidence it received in Stage 1 of its Inquiry.

Given the intersections across complaints handling and the management of reportable incidents, it is unclear in the NDIS Consultation Paper why it did not include options for consideration in the context of serious incident reporting that warrant further discussion.

In addition, while the Committee acknowledges the challenges in considering options for oversight bodies in the absence of clear indications of the required safeguarding mechanisms, it determined that the nature of the safeguarding entities that will oversee the NDIS Safeguarding Framework appears to warrant further discussion and consideration of some early options.

### 2.4.1 Systems for handling complaints

The NDIS Consultation Paper states that in considering a complaints scheme its aim is to achieve ‘an effective and nationally consistent complaints mechanism’ that should ensure:

- providers of supports have adequate internal complaints handling mechanisms in place
- effective, fast and accessible external dispute resolution mechanisms are available to consumers
- serious and systematic concerns are able to be identified and addressed.

Complaints can relate to any aspect of the provision of services in the context of the NDIS. They are different from reportable or serious incidents.

The proposed approach takes into consideration what jurisdiction the complaints scheme will need to have. For example, are all funded supports included, or a subset of supports funded by the NDIA, or only those supports that specifically target people with disability.

It asks the question as to whether there is an ongoing role for a community visitor scheme, or whether there is a need to redesign a visiting scheme, or if the functions are no longer necessary in the context of an NDIS Safeguarding Framework.

As outlined in Table 2.6, there are three options for the establishment of a complaints scheme.

### Table 2.6 Options for handling complaints

<table>
<thead>
<tr>
<th>Option</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>Self-regulation</td>
</tr>
<tr>
<td>Option 2</td>
<td>Internal and external complaints handling requirements</td>
</tr>
<tr>
<td>Option 3</td>
<td>Independent statutory complaints function</td>
</tr>
<tr>
<td></td>
<td>3a— Complaints office in the NDIS</td>
</tr>
<tr>
<td></td>
<td>3b— Disability complaints office</td>
</tr>
</tbody>
</table>

Source: NDIS Consultation Paper

### Evidence to the Inquiry

As outlined in Chapter 5, in the context of a complaints handling scheme and considering safeguards to prevent and respond to abuse in disability services, there is some blurring of the line between complaints and reportable incidents.

One of the major shortcomings of the Victorian system was considered to be the inability of the Victorian Disability Services Commissioner to initiate own-motion investigations. However, as outlined in Chapters 5, the Victorian Ombudsman identified a reluctance of the VDSC to undertake investigations when matters were not considered suitable for conciliation.\(^{40}\)

In the context of the NDIS, most Inquiry participants indicated that the complaints scheme should apply to all supports, even if there is another complaints body that may have the jurisdiction to manage the complaint.

In addition, the evidence received by the Inquiry pointed to the need for an independent statutory complaints function that is separate from the NDIA. There was strong opposition to Options 1 and 2 that are limited to self-regulation and internal complaints handling.

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2.4.2 Serious incident reporting

The NDIS Consultation Paper explicitly states that:

A complaint is not the same as a serious incident, which is an event which threatens the safety of people and property and must always be reported...

Serious incidents, such as a criminal offence or safety issue, could be reported initially through a complaints system, but these matters would require investigation and/or other action by police and/or other authorities.\(^{41}\)

It defines serious incidents as events that threaten the safety of people or property.

The NDIS Consultation Paper emphasises that in most states and territories, ‘serious incidents in funded disability services are required to be reported to the funding agency.’ It goes on to explain that:

However, in some cases there are requirements to report some or all incidents to independent agencies such as police or complaints commissioners.\(^{42}\)

There is an identified need to determine how serious incidents will be handled in the context of the NDIS. The NDIS Consultation Paper states that there could be a number of different approaches:

- a requirement that all providers have effective internal systems in place to deal with serious incidents (this approach would not, however, provide a mechanism for external monitoring of the effectiveness with which incidents are managed, or provide early warning of systemic issues with a provider or support)
- a requirement for registered providers to report serious incidents to the NDIA (as there is now under the NDIA’s terms of business)
- incidents could also be reported to an independent oversight body.\(^{43}\)

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Evidence to the Inquiry

Chapter 5 highlights the serious shortcomings of the Victorian system of critical incident management. One of the critical issues identified with the Victorian system related to the government having responsibility for the process through the Department of Health and Human Services (DHHS). Disability Advocacy Victoria told the Inquiry that:

...there is an inherent conflict of interest between DHHS, its own services and its funded services. It is not in the interest of DHHS to find fault with itself due to concern about liability, or to find fault with its service providers, for the same reason. In addition, if DHHS believed one of its major providers’ quality of service was fatally flawed, this would require an inordinate amount of work on the part of DHHS to find a replacement service. That is a driving force, we submit, behind their lack of a stringent response to the many failures of service providers.  

Life Without Barriers suggested that there is a need for external oversight to adequately understand where the limitations or weaknesses are occurring in the provision of services:

Life Without Barriers suggests that external oversight of critical incidents, to include root cause analysis as is undertaken in the health system would highlight areas of deficiency and/or areas for improvement.

While many Inquiry participants identified weaknesses in the Victorian system of managing critical incidents, at the very minimum they indicated that there needs to be a system of managing critical or serious incidents in the NDIS. AMIDA stated that:

DHHS has a thorough process of incident reporting and handling. Improvement can and should be made and the Victorian Ombudsman is currently reviewing this system. It is different from complaints handling but equally as vital and has been neglected in the consultation paper on a Quality Safeguards System under the NDIS by DSS. The Victorian approach to incident reporting is worth highlighting and should be emphasized in any negotiations around the NDIS.

As outlined in Section 2.5, the Committee determined that this needs to be the responsibility of a body independent from any funding responsibilities.

2.4.3 Oversight functions

In the context of oversight functions, the NDIS Consultation Paper briefly outlines some of the key factors for consideration. It outlines the ongoing operational responsibility of the NDIA. That is:

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44 Submission S028A, Disability Advocacy Victoria, p.4.
45 Submission S010, Life Without Barriers, p.6.
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The NDIA will oversee operation of the NDIS. It will be responsible for monitoring whether the goals in individual plans have been achieved and will gather information about which supports are most effective. It will also need to have its own complaints system for participants who are not happy with the NDIA’s service.47

Given the breadth of service providers in the scheme, the NDIS also emphasises that ‘there are potential roles for industry and, consistent with their responsibilities, for universal safeguarding bodies such as consumer protection agencies.’48 Table 2.7 outlines the nature of the providers that were registered with the NDIA at August 2014.

**Table 2.7 Active providers registered with the NDIA (August 2014)**

<table>
<thead>
<tr>
<th>Provider category</th>
<th>Number of providers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional disability sector</td>
<td>193</td>
<td>27</td>
</tr>
<tr>
<td>Transport — taxis, etc.</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Equipment suppliers</td>
<td>62</td>
<td>2</td>
</tr>
<tr>
<td>Early intervention</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Household tasks – cleaning, gardening</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>Interpreting</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Plan managers</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Registered or accredited health professionals</td>
<td>377</td>
<td>53</td>
</tr>
<tr>
<td>Vehicle modifications (only)</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Registered building trades</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>710</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


The NDIS Consultation Paper highlights that ‘A key issue for the scheme is whether there is also a case for establishing a body with an independent oversight function to provide an additional level of assurance for the NDIS.’49 It outlines some possible different functions that such an independent oversight body might be expected to perform. These include:

- providing a leadership role across the NDIS to ensure that registered organisations hear and respond to complaints and other feedback in positive ways
- providing information, education, training and advice about matters relating to complaints and complaints handling and monitor and report publicly on the effectiveness of complaints handling in the sector

having powers to make binding decisions which providers would be legally obliged to implement and award compensation up to a specified dollar value (the model that is used by the Telecommunications Industry Ombudsman)

- independently monitoring and assessing the NDIS market, such as proactively monitoring, reviewing and reporting on the effectiveness of the NDIS market.

The NDIS Consultation Paper does not map out any specific options or models for an independent oversight body.

It does give consideration to the anticipated oversight of the NDIA, explaining that the measures include the Board of the NDIA, the NDIS Independent Advisory Council, the Disability Reform Council and the scheme actuary. Its work will be overseen by bodies such as the Administrative Appeals Tribunal, the Commonwealth Privacy Commissioner and the Commonwealth Ombudsman.

**Evidence and submissions**

The Committee reviewed evidence to the Inquiry and submissions made to the NDIS Consultation Paper. It identified that there are a number of different options for establishing an independent oversight body (see Section 3.3 of Chapter 3). It also determined that there are important preventative and corrective functions and powers that are required in the context of a national quality and safeguarding framework.

On reviewing the available evidence, the Committee considered that there is a need for two different roles that can be broadly (but not exclusively) considered to perform the prevention and corrective functions:

- prevention of abuse
  - standards and registration for disability service providers
  - screening of new workers
  - exclusion of unsuitable workers.

- responding to abuse
  - a complaints handling system
  - an official visitors/inspectorate scheme
  - a critical incident management system
  - oversight of restrictive practices.

The Committee considered the views of the Victorian Disability Services Commissioner in regard to separating the role of registration and accreditation from any oversight body that has responsibility for managing reportable incidents and handling complaints. The Commissioner stated that:
Chapter 2 Informing Victoria’s position—NDIS quality and safeguarding framework

Separation from resource and provider registration decisions will go some way to alleviate the concerns of conflict of interest and over time aspire to normalising complaints in the provision of disability services.\(^5\)

While this comment is made in the context of an assumed role of the NDIA in overseeing registration of providers, the Committee considered there is value in considering two separate bodies—1) oversight and 2) quality assurance.

Professional quality assurance bodies that were proposed to the Committee for its consideration included the Australian Health Practitioners Regulation Agency (AHPRA) and the Victorian Institute of Teaching (VIT). The Committee is aware that both bodies have had some issues in their operations and effectiveness and it proposed that any system introduced to the NDIS learn from both professional associations.

The NDIS Consulting Paper clearly questioned the value of an ongoing community visitor scheme. The Committee considered that on the basis of the evidence it received and other submissions to the NDIS Safeguarding Framework that there is value in considering the establishment of an official inspector scheme with paid officials who have the appropriate skills and experience. For example, the Commonwealth Ombudsman stated that it:

... would strongly support the implementation of a national scheme with a suitably trained and paid staff that is authorised to work closely with the independent oversight agency to decide the locations, providers and types of supports that might be targeted in their visits, and to make complaints and refer other matters to the independent body as required.\(^5\)

The Committee considered that similar to the WorkSafe scheme in Victoria, there would be value in these official inspectors being located with an independent oversight body.

Victoria’s community visitor scheme is discussed in detail in Chapter 5.

2.5 The Committee’s position—Proposed oversight framework

Based on the evidence it received regarding the Victorian safeguarding system and views on the NDIA Safeguarding Framework, alongside the recommendations contained in the Victorian Ombudsman’s report on Reporting and investigation of allegations of abuse in the disability sector: Phase 1—the effectiveness of statutory oversight, and its review of submissions to the NDIS Consultation Paper, the Committee determined that there is a need for an oversight framework with a key oversight body.

\(^{50}\) Submission S011, Disability Services Commissioner, p.9 of Attachment 2.

In considering the evidence provided, the Committee determined that the regulation of quality and assurance of service providers needs to sit separately from an independent oversight body. In addition, there is a need for advocacy services for some people with disability and some carers. There is also a need to ensure people with disability and their families have the information, resources and support to manage plans and can build their capacity.

In addition, there is an ongoing role for a guardian of last resort, which is currently a state responsibility.

The Committee also considered that there will be an ongoing role for both the national and state/territory bodies in the context of ensuring quality and safeguards are in place for people who access disability services.

In developing its recommendations, the Committee is conscious that oversight, advocacy and guardianship powers administered by the state have benefits over a centralised nationally administered scheme.

The Committee considers that in the context of quality assurance, screening and registration (of providers and individual disability workers) a national agency would need to have responsibility to ensure the effectiveness of cross-jurisdictional screening and national standards for registration.

The oversight framework proposed in the Committee's recommendations is outlined in Figure 2.1.

### Figure 2.1 Proposed quality and safeguarding framework

<table>
<thead>
<tr>
<th>Independent oversight body</th>
<th>Screening and quality assurance body</th>
<th>Advocacy and capacity building</th>
<th>Guardian of last resort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints handling</td>
<td>Working with vulnerable persons check</td>
<td>Advocacy</td>
<td>Guardianship</td>
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<td>Management and investigation of reportable incidents</td>
<td>Provider registration</td>
<td>• individual</td>
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<td>Oversight of restrictive practices</td>
<td>Disability worker registration</td>
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<td>Voluntary community visitors</td>
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<td>Option of official inspector scheme with paid inspectors and visitors</td>
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<td>• education</td>
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Chapter 2 Informing Victoria’s position—NDIS quality and safeguarding framework

RECOMMENDATION 2: That the Victorian Government advises the Disability Reform Council to establish a single, independent oversight body with powers and responsibility for:

- handling complaints
- managing and investigating reportable serious incidents
- oversight of restrictive practices
- voluntary community visitors
- the option of an official inspector scheme with paid inspectors or visitors.

RECOMMENDATION 3: That the Victorian Government advises the Disability Reform Council to ensure the establishment of an independent advocacy and capacity building body with powers and responsibility for:

- administering funds for individual and community advocacy
- systemic advocacy
- capacity building through information, education and resources, including how to spot abuse and report it.

RECOMMENDATION 4: That the Victorian Government advises the Disability Reform Council to ensure that a guardian of last resort is maintained with responsibility for:

- guardianship and supported decision making
- investigation of guardianship matters.

RECOMMENDATION 5: That the Victorian Government advises the Disability Reform Council to ensure the establishment of a national quality assurance agency with responsibility for:

- screening and clearance checks—administering a working with vulnerable persons check
- provider registration
- individual registration of disability workers.
3 Current safeguarding measures in Victoria

AT A GLANCE

Background
The effectiveness of Victoria’s quality and safeguarding mechanisms are essential to ensuring that people who access disability services are not exposed to abuse, neglect or exploitation. The Disability Act 2006 (Vic) was important in establishing the safeguarding system in Victoria through new and legislated functions and powers.

Questions for Stage 2

• How can the rights provided under the Charter of Human Rights in Victoria be maintained for people accessing disability services in the transition to the NDIS once it has been fully rolled out?

• During the interim period of transition to the NDIS from 2016 to 2020, should the Victorian Government:
  – create a new body under new legislation
  – allocate the responsibilities to a single existing body
  – improve the integration of existing bodies to fill the gaps and address overlaps on the boundaries?

• If the current safeguarding responsibilities were allocated to a single existing body, should this body be:
  – Disability Services Commissioner
  – Victorian Ombudsman
  – Another existing body?

• Should the state maintain responsibility for some elements of the safeguarding system during and after the transition to the NDIS?

• If a single oversight body were established in Victoria what governance, accountability and oversight arrangements would need to be established to ensure it is accountable in safeguarding people who access disability services?

• What would be the most appropriate approach to the administration of funding disability and advocacy services, bearing in mind there are both state and federal funding streams?
  – Should an existing or new body have responsibility for this role?

• in undertaking a comprehensive assessment of advocacy needs, what components of the advocacy system need to be evaluated or reviewed?
The effectiveness of Victoria’s quality and safeguarding mechanisms are essential to ensuring that people who access disability services are not exposed to abuse, neglect or exploitation.

Despite preventative efforts, it is known that abuse and neglect can occur when people access disability services. In such circumstances, it is essential that oversight mechanisms ensure that their experiences are responded to appropriately and reported to the relevant authorities.

Critical also is that there are consequences for those who are responsible and that steps are taken to learn from the abuse, neglect or exploitation that occurred to prevent it from occurring again.

This chapter provides an overview of the current safeguarding mechanisms operating in Victoria. It does this in the context of the Victorian Ombudsman’s report on *Reporting and investigation of allegations of abuse in the disability sector: Phase 1—the effectiveness of statutory oversight* (Phase 1 Report) and recommendations. These functions outlined in this Chapter are discussed in greater detail in Chapters 4-6.

This overview has assisted the Inquiry to inform the development of recommendations for a national safeguarding framework as required in Stage 1 of this Inquiry (see Chapter 2). It has also allowed the Committee to identify issues that will need to be considered in Stage 2 of its Inquiry. This Chapter outlines questions that have arisen out of Stage 1 for further consideration in Stage 2.

### 3.1 Rights and safeguards

Stage 1 of the Inquiry requests the Committee consider ‘the impact of current systemic safeguards on the rights and protections of people accessing disability services’.

As a signatory to the United Nations (UN) *Convention on the Rights of Persons with Disabilities* (the Convention), Australia is expected to actively pursue the objectives of the Convention. Specifically, Article 16 stipulates that signatories are responsible for taking:

> … all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects. ¹

The Australian Government’s Consultation Paper titled *Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework* (Consultation Paper) emphasises that principles relating to the rights and dignity of people with

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¹ *Convention on the Rights of Persons with Disabilities* s. Article 16.
disability need to be reflected in any such framework. It identifies a number of principles to this effect, including choice and control, presumption of capacity, and a risk-based and person-centred approach.

In its submission to the Inquiry, Women with Disabilities Victoria recommended ‘That the principles for the Quality and Safeguarding Framework are expanded to include ease of use of the system, that no person be subject to a lesser standard of safeguard or quality through nationalisation, that persons with disabilities are entitled to risks within the law and that empowerment underpins all policies and strategies’.

In Victoria, the government and service providers are required to abide by the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter). The Charter requires public authorities to consider and protect human rights when they make decisions. According to the Victorian Equal Opportunity and Human Rights Commission:

Service providers have further legal obligations under the Charter to provide an abuse-free environment and to observe human rights when responding to allegations and conducting investigations. The Disability Services Commissioner, Office of the Public Advocate, the Mental Health Complaints Commissioner, and DHHS must also comply with the Charter when responding to complaints and investigating allegations.

The Victorian Ombudsman made the following point in her recently tabled Phase 1 Report on the effectiveness of statutory oversight:

Victoria is the only state in Australia with a legislative charter of human rights...

The obligation to act compatibly with the Charter does not extend to Commonwealth authorities; therefore, moving to a national system may result in people with disability in Victoria losing the protections of the Charter. Given this, safeguards for fundamental human rights must be at the core of the national system.

In its submission to the Inquiry, the Office of the Public Advocate ‘strongly suggests the Charter inform the Victorian Government’s position on appropriate quality and safeguards for the NDIS.’

A number of Inquiry participants also made reference to the importance of government and service providers having a duty of care to people with disability who access disability services. That is, a ‘duty or responsibility required of

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4 Department of Health and Human Services
one person caring for or responsible for another, being legally responsible to ensure that the person being cared for is protected from abuse, neglect, abuse exploitation and violence.8

**QUESTION 3.1:** How can the rights provided under the Charter of Human Rights in Victoria be maintained for people accessing disability services in the transition to the NDIS once it has been fully rolled out?

### 3.2 Ombudsman’s Recommendation 1—A single independent oversight body

The Stage 1 terms of reference ask the Committee to have regard to any preliminary findings, recommendations or advice from the Ombudsman’s investigation. It also states that the Committee should have regard to any other evidence it considers appropriate.

In view of this, the Committee considered the two recommendations made in the Ombudsman’s Phase 1 Report. Recommendation 2 is considered in further depth in Section 3.4.

As outlined in the Inquiry Process, Recommendation 1 of the Ombudsman’s Phase 1 Report recommended that a single independent oversight body should be established or responsibilities should be transferred to an existing agency for oversight.

Evidence provided to the Inquiry indicates strong support for the establishment of a single independent oversight body assuming responsibility for the multitude of safeguarding functions and powers in Victoria. Inquiry participants provided numerous suggestions about the most appropriate body to assume this responsibility, such as:

- an entirely new statutory entity
- Disability Services Commissioner
- Victorian Equal Opportunity and Human Rights Commissioner
- Victorian Ombudsman.

At a public hearing, the Committee asked the Ombudsman to explain her views on the body that the Phase 1 Report recommended. The Ombudsman replied, stating that the options she envisaged were to:

1. create a new body
2. allocate the responsibilities to a single existing body
3. improve the integration of existing bodies to fill the gaps and address the overlaps on the boundaries.9

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8 Submission S003, JacksonRyan Partners, p.9.
9 Transcript of evidence, Victorian Ombudsman, Melbourne, 29 June 2015, p.5.
The Ombudsman expressed the view that the third option was ‘probably the least desirable option but is certainly an option’\(^\text{10}\).

In Chapter 2, the Committee outlines a proposal to inform Victoria’s position on the national quality and safeguarding framework. There is the possibility that this could be considered for the Victorian system in the transition period and beyond. The remainder of this chapter considers the existing functions and powers in the Victorian safeguarding system and the bodies with responsibility for exercising those functions and powers.

**QUESTION 3.2:** During the interim period of transition to the NDIS from 2016 to 2020, should the Victorian Government:
- create a new body under new legislation
- allocate the responsibilities to a single existing body
- improve the integration of existing bodies to fill the gaps and address overlaps on the boundaries?

**QUESTION 3.3:** If the current safeguarding responsibilities are allocated to a single existing body, should this body be:
- Disability Services Commissioner
- Victorian Equal Opportunity and Human Rights Commissioner
- Victorian Ombudsman
- another existing body?

**QUESTION 3.4:** Should the state maintain responsibility for some elements of the safeguarding system during and after the transition to the NDIS?

### 3.2.1 Accountability of the new safeguarding entity

One of the most significant challenges in establishing or reviewing existing oversight bodies is who oversees these types of ‘watchdogs’? This is the subject of considerable public, academic and political debate.

Given the nature of an oversight body with responsibility for safeguarding people who access disability services, it is critical to consider the governance arrangements of such a body. The two accountability and oversight mechanisms generally adopted for statutory bodies are:
- a board of governance—appointed by the relevant Minister
- a Parliamentary Committee.

In some instances there are no specific governance arrangements and the statutory entity reports directly to Parliament, such as the Public Advocate which has no governing board or Parliamentary Committee overseeing the

\(^{10}\) Transcript of evidence, Victorian Ombudsman, p.5.
activities of the Office. Or the Disability Services Commissioner which has a Disability Services Board that operates more as an advisory body than a board of governance.

In addition to the appropriate governance arrangements of departmental and statutory bodies in the disability sector, the Ombudsman has the jurisdiction to receive complaints about the administration of their roles. For example, the Public Advocate told the Inquiry that “the Ombudsman investigates complaints about OPA [which] are almost entirely in relation to guardianship and administration.”

The Committee heard some views, but very few, about the appropriate oversight and governance mechanisms for entities with safeguarding responsibilities. For example, JacksonRyan Partners stated that they ‘question the effectiveness of any scrutiny of the performance that may be made by Parliament of these two roles [the Public Advocate and the Disability Services Commissioner].’ They also went on to comment that:

Other than VCAT being the complaint agent of last resort for some decisions such as residential, the Ombudsman in effect acts in that capacity for many of the actions that cause conflict in the disability sector, as the entity of last resort to raise complaints.

The Committee identified that there is a need to consider what body will have jurisdiction to hear any complaints about an oversight body that is responsible for the oversight of the safeguarding mechanisms for people who access disability services.

**QUESTION 3.5:** If a single oversight body were established in Victoria what governance, accountability and oversight arrangements would need to be established to ensure a single, independent oversight body is accountable in its role in safeguarding people who access disability services?

### 3.3 Elements of the current safeguarding system in Victoria

There are multiple components that form the current quality and safeguarding systems for people who access disability services in Victoria. These are illustrated in Figure 3.1.

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11 Transcript of evidence, Office of the Public Advocate, Melbourne, 15 June 2015, p.4.
12 Submission S003, JacksonRyan Partners, p.45.
13 Submission S003G, JacksonRyan Partners, p.4.
In undertaking this examination, the Committee began to identify emerging themes and questions that need to be considered in Stage 2 of the Inquiry. In view of this, many of these emerging themes and questions are highlighted throughout this section of the chapter.

Essentially, Victoria’s safeguarding system includes six key elements:

- standards, provider registration and staff screening—these are administrative elements currently used to monitor the quality of services and also to prevent or minimise the risk of abuse, neglect or exploitation of people in disability services (discussed in Chapter 4)
- responding to and investigating complaints—a legislated requirement to ensure that any person can make a complaint about a disability service provider relating to the provision of service, including complaints relating to suspected abuse or neglect of a person using a disability service (discussed in Chapter 5)
- managing reportable or ‘critical’ incidents—an administrative oversight function that ensures any serious incident, such as abuse or neglect, is reported, investigated and results in appropriate actions being undertaken in response to the incident (discussed in Chapter 5)
- authorised visiting of services—a legislated power to empower members of the community to visit the premises of residential services of disability providers to inquire into a range of matters that relate to the quality and provision of services, including any case of suspected abuse or neglect of a resident (discussed in Chapter 5)
- monitoring restrictive practices—a legislated requirement to ensure that the rights of people subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to such practices are complied with (discussed in Chapter 6)
- guardian of last resort—although this is an important function for people with disability who are unable to make reasonable judgment relating to matter/s about themselves or their circumstances, this function extends
beyond disability services into the community and has a key role in safeguarding people with disability who are unable to make decisions on their own behalf (discussed in Chapter 6).

It is important to note that complaints are not the same as reportable incidents and to distinguish the differences. This is discussed further in Section 5.1 of Chapter 5.

The Committee considers that while oversight of reportable incidents is largely the responsibility of the Department of Health and Human Services (the Department), the responsibility does not stop there. It rests with other statutory entities and disability services themselves. The Committee concurs with the view expressed by the Disability Services Commissioner at a public hearing:

> It is lamentable that people find themselves in the circumstances that they do. I, like you, am a citizen of the state. We have a shared responsibility, in my view, to our fellow Victorians with a disability, to do a lot better than what we collectively do as citizens of this state, in my view.\(^\text{14}\)

Chapters 4, 5 and 6 explore in detail the way in which the elements of safeguarding operate in Victoria.

### 3.3.1 Strengths and limitations

In evidence received by the Inquiry, it is evident that participants considered there are strengths and limitations in the current safeguarding system that operates in Victoria for people using disability services. Many expressed the view that the *Disability Act 2006 (Vic)* had been an important turning point in improving the safeguard mechanisms through new and legislated functions and powers. Yet a number also expressed concern about the effectiveness of the implementation of the legislation.

Regardless of views about the implementation of safeguarding measures, a resounding message from the evidence the Committee received was that in moving to a national quality and safeguarding framework, Victoria should not lose any of its existing safeguards. Most of the features that participants emphasised need to be retained relate specifically to the powers and functions defined under the Disability Act:

- registration of providers
- complaints system and investigation
- reporting critical incidents
- system of visiting services.

\(^\text{14}\) Transcript of evidence, Disability Services Commissioner, Melbourne, 22 June 2015, p.9.
Many Inquiry participants emphasised the importance of building on what has already been established by identifying areas that could be improved and resolving them through a range of methods, such as increasing independence, clarifying roles or introducing new powers.

The broad system level issues that Inquiry participants raised with the Committee were similar to those outlined in the Ombudsman’s Phase 1 Report. These include:

- overlaps in functions and powers resulting in confusion and inconsistency
- gaps in functions or powers resulting in statutory bodies or organisations stepping in to fill an identified need
- failure to fully implement the functions and powers provided under the Disability Act
- bodies with safeguarding responsibilities failing to take responsibility for issues with the system.

The overlaps and gaps relate to legislative and regulatory functions and powers under the Disability Act and funding and administrative requirements of service providers. Table 3.1 highlights that there is overlap across areas of the system.

<table>
<thead>
<tr>
<th>Powers and bodies in the disability sector</th>
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<tbody>
<tr>
<td>Department of Health and Human Services</td>
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<tr>
<td>Registration and screening</td>
</tr>
<tr>
<td>Visiting services</td>
</tr>
<tr>
<td>Responding to complaints</td>
</tr>
<tr>
<td>Managing reportable incidents</td>
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<tr>
<td>Overseeing restrictive practices</td>
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</table>

Source: Family and Community Development Committee

### 3.4 Ombudsman’s Recommendation 2—Advocacy

As outlined in the Inquiry Process Recommendation 2 of the Ombudsman’s Phase 1 Report relates to the provision of advocacy in Victoria and the Ombudsman’s view that the funding is inadequate.

The recommendation also considers the most suitable entity to locate the administration of funds for advocacy services in Victoria, and recommends that responsibility for advocacy be transferred to the Office of the Public Advocate.
In considering the need for advocacy for people with disability accessing disability services, the Ombudsman’s Phase 1 Report refers to the intention underlying both the Disability Act and the Productivity Commission’s report that led to the NDIS, *Disability care and support*. The Productivity Commission emphasised that ‘advocacy plays an important role in the disability system’, further stating that:

Systemic advocacy pushes for broad policy and social change, while individual advocacy promotes the interests of particular individuals by acting on their behalf to resolve specific issues.  

In considering advocacy in Victoria, the Ombudsman stated that ‘there is currently limited funding for advocacy’. The Phase 1 Report quoted correspondence from the Department of Health and Human Services that:

> Of the $4.8 million provided for advocacy, only $1.59 million is allocated to supporting individuals.

The Report goes on to state that ‘as there is no systemic understanding of the actual demand for advocacy, there is an unquantified gap between those who would appear to need advocacy and those who receive it.’

In addition, the Ombudsman makes the point that there is ‘a question about whether there is an inherent conflict in the department funding advocacy for people who are reliant on the services of the department itself.’

The Report states that the Office of the Public Advocate ‘also provides some advocacy services to people with disability, limited by its funding arrangements.’ The Ombudsman concludes that while the Public Advocate is an ‘advocate of last resort’ that ‘this advocacy role should be further enhanced.’

As noted earlier, the Ombudsman recommended that the funding for advocacy should be increased and that the funding provision and administration of advocacy services should be transferred from the Department to the Office of the Public Advocate.

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3.4.1 Evidence to Inquiry—issues raised

The Committee received a number of additional written submissions and supplementary submissions in relation to the Ombudsman’s recommendation relating to advocacy in its Phase 1 Report.

A number of disability advocacy organisations expressed to the Inquiry that while they support the recommendation for additional funding for advocacy, they do not support the recommendation that the administration and funding provision be transferred to the Office of the Public Advocate. Box 3.1 outlines these views.

BOX 3.1: Examples of evidence regarding Recommendation 2(b)(i)

• We do not support transferring funding provision and administering of advocacy services to the Office of the Public Advocate (‘OPA’). The OPA Guardianship Program represents a conflict for some people with disabilities and their advocates. OPA’s role in acting as Guardians against the wishes of people with disabilities and their families is problematic and has at times resulted in complaints by people with disabilities and their advocates against OPA.

  Source: Disability Advocacy Victoria, Submission S028, p.4

• We do not support part b) of recommendation 2. The recommendation that OPA manage advocacy funding and provision did not appear to be well justified. The main reasons appear to be to ensure all people with disability have access to advocacy and to provide freedom from conflict of interest.

  Office of the Public Advocate is also a service provider in that it provides guardians appointed by VCAT. Advocates have at times supported people with disability to challenge guardian’s decisions including at VCAT. For OPA to administer advocacy would not remove conflict of interest.

  Source: AMIDA, Supplementary submission S008A, pp.1-8

• We agree that advocacy responsibility and administration should not sit within DHHS but equally we do not support the transfer to the Office of the Public Advocate (‘OPA’). OPA’s model of advocacy is sometimes in conflict with that of a person with disability and the independent advocate who is supporting the individual. This can be quiet distressing for people with disabilities and their families.

  ... often we find ourselves standing with the individual who wishes to remain independent and rejects been subjected to Guardianship or Administration Orders...

  In summary, while DHHS is in a position of conflict of interest in relation to funding disability advocacy agencies, we believe that OPA are in the same position.

  Source: Communication Rights Australia, Supplementary submission S020A, p.6
Advocacy groups indicated that they were firmly of the view that the body that administers the funds needs to be independent of any conflict of interest. In regard to the current arrangements, AMIDA stated that funding and administration through the Office for Disability probably represented less of a conflict of interest than the responsibility resting with the Office of the Public Advocate:

Conflict of interest is at least minimized by advocacy funding currently being administered within the Office for Disability which, while now part of DHHS, is separate from the part of DHHS responsible for provision of funding and administration of disability services. The Office for Disability has funded the Disability Advocacy Resource Unit and the Self Advocacy Resource Unit so that training, resourcing and development of advocacy and self advocacy services is independent of government or DHHS.  

Communication Rights Australia made the point that “To ensure that advocates can act without fear or favour, a body without conflict must administer funding.”

In a joint submission, both CRA and Disability Discrimination Legal Service emphasised that:

The Community Visitors Program, while providing an additional layer of monitoring, is not a substitute for advocacy, and does not generally provide staff members with specialised skills in communicating with people with disabilities (e.g. Deaf, Deaf/Blind, Complex Communication Needs Etc).

The Committee also received some evidence suggesting that because advocacy organisations are currently funded and administered by the Department of Health and Human Services they have been less effective than they need to be.

3.4.2 Emerging themes and questions

The Committee concluded that there is confusion between ‘best interest’ advocacy, individual advocacy and other forms of advocacy.

On its website, the Office of the Public Advocate clearly explains the role of best interest advocacy, noting that it is different from individual or community advocacy:

Last resort means we only provide advocacy to people who have no other advocacy options. Our role is to advocate when all other advocacy options have failed.

23 Submission S020A, Communication Rights Australia, p.6.
25 Submission S003, JacksonRyan Partners, p.31.
The principle of best interest means our advocacy focuses on solutions that are in the best interest of the person with a disability. This is different to individual or client advocacy, which supports the person with a disability to achieve their preferred outcomes.\textsuperscript{26}

Its advocacy services can be distinguished from other forms of advocacy in that the principles which underlie it are contained within the \textit{Guardianship and Administration Act 1986} (Vic). The Public Advocate advised the Committee that ‘in both guardianship and investigation matters, advocacy will be subordinate to the principal roles of the office in those matters.’\textsuperscript{27}

Communication Rights Australia also emphasised the differences in the nature of the advocacy. In addition to noting that ‘OPA’s model of advocacy is sometimes in conflict with that of a person with disability and the independent advocate who is supporting the individual’, CRA stated that:

\begin{quote}
Although OPA has power to investigate it also has a Guardianship and Administration responsibility and regularly provides direction under ‘the best interest of a person with disability’ rather than what the individual may request, or what is their human right.\textsuperscript{28}
\end{quote}

In evidence to the Inquiry, participants made suggestions of alternative bodies to the Office of the Public Advocate, such as Disability Advocacy Victoria. The Committee also noted that other jurisdictions, such as Queensland, have models that separate the role of the Public Advocate from the Public Guardian.

The Committee concluded that there is merit in the Ombudsman’s recommendation to conduct a comprehensive assessment of advocacy needs in Victoria.

It determined that there needs to be caution in recommending a specific body to assume responsibility for administering the funds for advocacy without further consultation. The Committee sought the views of the Office of the Public Advocate regarding Recommendation 2 of the Ombudsman’s Phase 1 Report:

\begin{quote}
In relation to recommendation 2, the Public Advocate supports the transfer of advocacy from DHHS to an independent, non-government agency and supports further research being conducted on which agency might be best placed to take on this role.\textsuperscript{29}
\end{quote}

In addition, advocacy organisations indicated that any assessment of advocacy needs and funding needs to take place in the context of reviews that are currently being conducted, such as the federal government’s current review of the National


\textsuperscript{27} \textit{Supplementary evidence}, Response to request for information, Office of the Public Advocate, 20 July 2015.

\textsuperscript{28} Submission S020A, Communication Rights Australia.

\textsuperscript{29} \textit{Supplementary evidence}, Response to request for information, Office of the Public Advocate, 20 July 2015.
Framework for Advocacy provision. The federal government has announced it will be reviewing the National Disability Advocacy Program with results to be fed into the Disability Reform Group at COAG by December 2015.

Notably, the disability advocacy sector is not solely funded by the Victorian Government. In addition to state funding, a number of advocacy groups receive both state and federal funding, while others are specifically funded by the Australian Government.

**QUESTION 3.6:** What would be most appropriate approach to the administration of funding disability and advocacy services, bearing in mind there are both state and federal funding streams?

• Should an existing or new body have responsibility for this role?

**QUESTION 3.7:** In undertaking a comprehensive assessment of advocacy needs, what components of the advocacy system need to be evaluated or reviewed?
Prevention and registration

AT A GLANCE

Background

This chapter focuses on preventative measures that address abuse in the disability sector and covers issues relating to: the sector as a whole; organisations and leadership; and individual workers. It reflects the evidence the Committee has heard to date on provider and worker registration, recruitment practices and staff training needs. The final section of the chapter addresses organisational culture in the disability sector.

Questions for Stage 2

• Should the Victorian Government develop a prevention and risk management strategy for the Victorian disability workforce from 2016 to 2019?
  – If so, what specific components should comprise such a strategy?

• In Victoria, what would be the most preferable screening system to establish:
  – a legislated disability worker exclusion scheme
  – a legislated working with vulnerable persons check
  – a combined version of an exclusion scheme and a working with vulnerable persons check?

• Should a disability worker registration scheme be established, similar to the Australian Health Practitioner Regulation Agency (AHPRA)?
  – If so, should this be a national or state agency?

• Should an independent body be established to oversee service standards, accreditation and registration?
  – If so, should this be a national or state agency?

• Should minimum qualifications be introduced for all disability workers?
  – If so, what should be the minimum qualification?
  – Should this be a state or national requirement?

• Should there be compulsory requirements for professional development for disability workers?
  – If so, what core components of ongoing professional development would be required?

• What does the Victorian Government need to do to support a disability workforce culture that does not tolerate abuse, neglect or exploitation?

• What do Victorian disability service providers need to do to promote and achieve a workforce culture that does not tolerate abuse, neglect or exploitation?
People with disability have a right to be safe from abuse, neglect and exploitation when accessing disability services.

A key factor in prevention is the risk management strategies that government and organisations establish in the workplace to ensure that suitable people are working in disability services and that the workplace itself has zero tolerance for abuse.

The Committee heard that the key forms of preventative and risk management strategies relate to:

- provider registration and standards
- recruitment and screening
- qualifications and professional development
- workforce culture.

While the Committee identified strengths in the Victorian systems that relate to preventative safeguards, it also heard that there are weaknesses and limitations in the system.

### 4.1 A strategy for prevention

This Inquiry’s Terms of Reference ask the Committee to consider the extent to which employee screening, professional development and other workforce issues are effective safeguards against abuse in disability services. In Victoria, the Department of Health and Human Services requires disability services to undertake employment safety screening, in particular through its *Disability services employment safety screening compliance policy*.¹

Evidence received by the Committee supports the notion that although it is important for service providers to have strong processes for reporting instances of abuse, the prevention of abuse must have a higher priority.² As JacksonRyan Partners point out, it is simply not possible to completely prevent abuse in any area in society, nonetheless ‘... as with any risk management approach, while the intent must be prevention, there is also the objective of minimising the potential’.³

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² For example, see Submission S003, JacksonRyan Partners, pp.17-18; Submission S015, Health and Community Services Union, p.2.

³ Submission S003, JacksonRyan Partners, p.17.
In evidence to this Inquiry Karingal states:

...standards in themselves cannot prevent abuse. Rather, it is staff selection, staff training and staff culture, in combination with client voice and empowerment that ensures a safe environment for people with a disability.4

There are a range of risk management strategies that regulators and service providers can establish to decrease the opportunities for abuse to occur and ultimately work towards its elimination. These include provider registration, pre-employment checks and organisational culture (including governance of organisations)5 and together comprise a suite of options to be used in conjunction with each other.

In its submission to the Inquiry, the Office of the Public Advocate recommended that:

The Victorian Government should introduce a comprehensive abuse prevention program aimed at changing workplace culture and better equipping staff in disability residential settings to identify and respond to abuse or potential abuse.6

The Committee did not receive any details about what the specific components of such a prevention program might look like. It determined that there would be value in further exploring the components of a statewide prevention and risk management strategy.

**QUESTION 4.1:** Should the Victorian Government develop a prevention and risk management strategy for the Victorian disability workforce from 2016 to 2019?

- If so, what specific components would comprise such a strategy?

### 4.2 Provider registration

The Committee heard that it is essential for any safety framework in the disability sector to contain a rigorous process overseeing the registering of service providers. It is at this first stage that governments determine expected behaviour, including the requirement that providers must outline how they intend to prevent abuse as well as the processes they will put in place to respond properly to abuse when it does occur.

In Victoria, the sections of the *Disability Act 2006* (Vic) relevant to provider registration cover the following areas:

- application for registration as a disability service provider7

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4 Submission S012, Karingal Inc, p.2.
6 Submission S018, Office of the Public Advocate, p.4.
7 *Disability Act 2006* s.40.
Chapter 4 Prevention and registration

- registration
- renewal of registration
- revocation of registration
- notice before refusal or revocation.

Under the Disability Act, service providers must register with the Department of Health and Human Services as a disability service provider. Entities that apply for registration must then demonstrate their capacity to comply with the Department’s Human Services Standards. Providers are required to complete a self-assessment report and quality improvement plan and undertake an independent review within 12 months of registration. The exception to this is when the Department determines either the provider is exempt from an independent review or accreditation against the Standards has already been achieved.

The Department maintains a register of disability service providers, which is a public list of disability service providers that are registered and funded by the Department to provide services specifically for the support of people with disability. The Department’s Standards and Regulation Unit has endorsed a number of independent review bodies to conduct reviews of funded service providers against the Standards. Renewal of a provider’s registration requires an independent review, self-assessment or accreditation, as determined by the Department. Service providers are required to review their registration every three years.

In Stage 1, the Committee did not receive evidence suggesting that the process of registering service providers in Victoria needs strengthening. Rather, the evidence is that Victoria’s standards must not be weakened on transition to the National Disability Insurance Scheme (NDIS).

However, the Committee noted the comments by Mr David Bowen, Chief Executive Officer of the National Disability Insurance Agency, that many provider registration systems focus on processes at the expense of the individual. Mr Bowen told the Senate’s Inquiry into abuse in the disability sector, ‘My very strong suggestion for quality and safeguards is to move away from those service provider accreditation systems to a risk based one around the individuals.’

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8 Disability Act 2006 s.41.
9 Disability Act 2006 s.42.
10 Disability Act 2006 s.43.
11 Disability Act 2006 s.44.
4.3 Prevention of abuse—the workforce

The Committee heard that a safety framework must ensure that workers in the sector are appropriately qualified and suitable to work with people with disability. This includes screening to ensure new workers do not have a background or history that could affect their appropriateness to work in the sector.

The Committee recognises that recruitment and screening standards are an integral part of a safeguarding framework in the disability sector. This includes identifying suitable staff as well as excluding people who are unsuitable to work with vulnerable people, most frequently because of a past history of abusing people with disability or having a criminal record.15

The Disability Reform Council has recently released its *Integrated Market Sector and Workforce Strategy June 2015* in preparation for the full roll-out of the NDIS. That document proposes that the Sector Development Fund be used to support the disability sector through funding analysis of training and skill requirements to enable the sector to develop methods and approaches to ensure the workforce has adaptable and relevant skills, including skills relating to quality and safeguards.16 The Council identifies the necessity of balancing ‘low barriers for entry to the workforce with appropriate levels of workforce screening through the development of the National Quality and Safeguarding Framework.’17

4.3.1 Disability Worker Exclusion Scheme

The Disability Worker Exclusion Scheme (DWES) was introduced in Victoria in September 2014. It seeks to ensure that people who pose a threat to the health, safety or welfare of people with disability are excluded from working in disability residential services in Victoria. Workers must also pass referee and police checks as well as working with children checks for some service types.

DWES currently applies to disability workers who provide direct support to clients of disability residential services delivered or funded by the Department. It includes direct employees and contractors, those hired via labour hire agencies, volunteers and students.

The Disability Worker Exclusion Scheme consists of:

- a permanent Disability Worker Exclusion List (DWEL) detailing people who pose a threat to the health, safety or welfare of people with disability living in disability residential services

- a temporary provisional list for people who are currently under investigation and excluded from client contact by their employer.

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15 Submission S021, Victorian Equal Opportunity and Human Rights Commission, p.9; Submission S023, National Disability Services, p.4.

16 Disability Reform Council (2015) *Integrated Market, Sector and Workforce Strategy*. National Disability Insurance Scheme, p.21. The Sector Development Fund is a pool of funds dedicated to support NDIS transition and is complemented by activity funded by jurisdictions and initiated by the disability sector.

Under the DWES, disability residential service providers are required to:

- check that an individual is not listed on the DWEL prior to making an offer of employment
- not employ people on the DWEL in roles with direct client contact
- provide relevant information about employees to the Disability Worker Exclusion Scheme Unit.

### 4.3.2 How the Disability Worker Exclusion List is compiled

Aside from directly preventing unsuitable people from working with vulnerable people, the DWES also acts as a disincentive for such workers attempting to find employment in the disability sector.  

Disability service providers are required to notify the Disability Worker Exclusion Scheme Unit at the following points:

- if a pre-employment screening conducted by the disability service provider, for example a police check, has raised issues that may qualify the worker for placement on the DWEL
- at the commencement of an investigation process where a worker has been stood-down from working with clients because of alleged behaviour that poses a risk to the health, safety or welfare of people with disability. This notification (referred to as a preliminary notification) should occur following preliminary assessment of the allegation by the disability service provider. A preliminary notification to the Disability Worker Exclusion Scheme Unit must be made within five days of the commencement of the investigation process. However, no notification will be required if a worker is immediately cleared of all wrongdoing before the conclusion of this five day period (for instance because it has been established that there has been a vexatious complaint)
- following the outcome of a formal investigation of a worker. This notification should occur within five working days of a decision being made
- where it has been determined that an investigation is required because of alleged behaviour that poses a risk to the health, safety or welfare of people with disability but the worker resigns before the investigation can be completed.

To be placed on the DWEL, a disability residential services worker must have been found to pose a threat to the health, safety or welfare of people with disability living in a disability residential service. This includes any person that has been found guilty of an offence that:

- involves bodily harm, violence or threats of violence
- is of a sexual nature

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• involves dishonesty
• involves neglect of a person living in a disability residential service.

A person does not need to be convicted of an offence prior to being placed on the DWEL. A worker may be considered for placement on the DWEL if on the balance of probability an allegation is substantiated and their employment has been terminated or if they resign and refuse to participate in an investigation.

To date the Department of Health and Human Services has received around 5500 requests by disability service providers to check workers against the list out of which 22 workers were found to be on the exclusion list and excluded from working within residential services. Around 60 people are currently on the DWEL.\(^\text{19}\)

**QUESTION 4.2:** In Victoria, what would be the most preferable screening system to establish:
• a legislated disability worker exclusion scheme
• a legislated working with vulnerable persons check
• a combined version of an exclusion scheme and a working with vulnerable persons check?

### 4.3.3 Strengths and limitations

There is broad support in the disability sector for the DWES (and exclusion or barring lists in general). In particular, the DWES is considered an important way of excluding people who pose a threat to people who access disability services.

However, the Committee did hear concerns about limitations of the DWES with many Inquiry participants suggesting that the current scheme needs strengthening. For example, the Victorian Ombudsman’s report on *Reporting and investigation of allegations of abuse in the disability sector: Phase 1—the effectiveness of statutory oversight* (Phase 1 Report) into the effectiveness of statutory oversight in the disability sector identifies a number of weaknesses in the DWES. These include:
• the scheme has limited reach by only applying to residential services registered under the *Disability Act 2006* (Vic)
• lacking power by not being backed by legislation
• only being able to refer employees where it has been proven that serious misconduct occurred
• a clash between the Department’s industrial relations obligations and its obligations under the *Protected Disclosure Act 2012* (Vic).\(^\text{20}\)

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\(^{19}\) *Transcript of evidence, Department of Health and Human Services, Melbourne, 29 June 2015*, p.9.

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The Ombudsman’s report reflects a wider view presented to the Committee that the DWES is a good ‘first start’ but needs to be strengthened.

In arguing for the DWES to be backed by legislation, the Victorian Ombudsman, Ms Deborah Glass, told the Committee that ‘It does need some teeth’.21 This need for legislation was also supported by several submissions to this Inquiry.22 The Committee did not receive any detailed views on what a legislated scheme would look like.

Inquiry participants also supported extending the DWES beyond residential services registered under the Disability Act.23 For example, in its submission, the Victorian Equal Opportunity and Human Rights Commission recommends:

The Victorian Government should expand the Disability Worker Exclusion Scheme to include all persons who have been found to have abused, assaulted or neglected a client of a disability, mental health and other service for people with disability. Subject to evaluation, this could be the next step toward a comprehensive registration scheme for persons delivering direct services to people with disability.24

The Department’s Mr Arthur Rogers, Deputy Secretary, Social Housing and NDIS Reform, told the Committee that the DWES initially applied to residential services because of their high risk profile and that it was always envisaged that the Scheme might be extended to other services after an initial review.25

4.3.4 Worker registration

While the Disability Worker Exclusion Scheme is a way of excluding people considered unsuitable for working in the disability sector, another option is to require NDIS workers to be registered before they can be employed. A comparison can be found in the education system. For example, in Victoria teachers must be registered with the Victorian Institute of Teaching before they can be employed by a school.

An additional idea came from Mr Peter Cross, President, United Voices for People with Disabilities. He told the Senate’s Inquiry into abuse in the disability sector that accredited workers should be required to report abuse to an accrediting body as this would ‘... take [reporting abuse] out of the system of taking it up through the management system—only to have it not heard or not dealt with’.26

22 Submission S018, Office of the Public Advocate; Submission S023, National Disability Services. HACSU argued for a different format but still backed by legislation. See Submission S015, Health and Community Services Union, p.9. for its suggested recruitment and screening process for workers in the disability sector.
25 Transcript of evidence, Department of Health and Human Services, p.9.
26 P. Cross, President, United Voices for People with Disabilities, Transcript of evidence, Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, Melbourne, 30 June 2015, p.48.
The Committee heard that registering workers is potentially a more preventative option than something like the DWES, which is by nature reactive. As with service providers, though, the NDIS plans to allow people to choose workers based on their own judgement. Again, this reduces the control that the system can have when it comes to addressing risk posed by workers.

In its submission to this Inquiry, the Victoria Equal Opportunity and Human Rights Commission refers to the Australian Capital Territory, which is currently phasing in a registration scheme for disability workers.\(^{27}\) The Commission states that such a scheme must balance the rights of workers and volunteers with those of clients:

> The ACT Explanatory Statement balanced the rights of perspective staff and volunteers of disability services against those of service users. If Victoria were to introduce a similar scheme, the same process of assessing competing rights would be required under section 7(2) of the [Human Rights] Charter. The ACT found that the requirement for an applicant to provide the Commissioner with their criminal history, non-conviction information and additional information was the least restrictive way of minimising risks for vulnerable people who access regulated activities or services.\(^{28}\)

The Health and Community Services Union recommends that Victoria should implement a risk-based worker registration and accreditation scheme overseen by an independent registration body, similar to that of the Australian Health Practitioner Regulation Agency (AHPRA) in Victoria.\(^{29}\)

**QUESTION 4.3:** Should a disability worker registration scheme be established, similar to the Australian Health Practitioner Regulation Agency (AHPRA)?
- If so, should this be a national or state agency?

**QUESTION 4.4:** Should an independent body be established to oversee service standards, accreditation and registration?
- If so, should this be a national or state agency?

### 4.4 Staff training and minimum qualifications

As with registration, staff training and qualifications are considered an important part of quality safeguards in the disability sector. Staff must be able to understand:
- the rights of people with disability
- how to care for them properly
- how to spot abuse and report it.

\(^{27}\) See Disability Services (Disability Service Providers) Amendment Bill 2014 (ACT).
\(^{29}\) *Submission S015*, Health and Community Services Union, p.3.
Evidence provided to the Committee suggests that more training is currently needed both to improve standards across the sector and to prepare for the expected growth in workforce numbers with the transition to the NDIS (some predict a doubling of the workforce over the next few years\textsuperscript{30}). For example, Ms Naomi Anderson, a lawyer at Villamanta Disability Rights Legal Service Inc, made an analogy between training, which she believes is lacking in the sector, and other safety procedures such as fire and evacuation drills. She said, ‘If everybody is working together and everybody knows how the situation will be handled there is actually a deterrent to that kind of behaviour simply because you know what the protective mechanisms are.’\textsuperscript{31}

The Committee heard that training should be viewed by the sector as a way to increase the professionalisation of the disability sector, thereby raising the standards of the workforce. Professionalisation, however, is a two-way street. If the sector decides it requires a more professional workforce, it must provide for staff to be trained in a professional manner.

Inquiry participants told the Committee that there are differences in qualification requirements for disability support workers in Department-provided services and community service organisations.

The Department of Health and Human Services requires those disability support workers it employs to have a Certificate IV in Disability or higher.\textsuperscript{32} Regarding minimum qualifications, evidence received by the Committee suggests Certificate IV in Disability (or equivalent) as being adequate.\textsuperscript{33} However, Distinctive Options states that in its experience some staff holding a Certificate IV in Disability Services are not prepared for the complex demands of working with people with disability, a problem exacerbated when service providers offer little support.\textsuperscript{34}

The Office of the Public Advocate went on to state that ‘Some workers in residential services require no minimum level of training.’\textsuperscript{35}

Several submissions to this Inquiry argue for compulsory training or professional development for staff working in the disability sector.\textsuperscript{36} The Office of the Public Advocate states: ‘Training and minimum qualifications of staff should be mandatory, in addition to system-wide requirements that fall under the NDIS provider registration elements of a national framework.’\textsuperscript{37}

\textsuperscript{30} For example, see Transcript of evidence, National Disability Services, p.5.
\textsuperscript{31} N. Anderson, Casework lawyer, Villamanta Disability Rights Legal Service Inc., Transcript of evidence, Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, Melbourne, 30 June 2015, p.27.
\textsuperscript{32} Transcript of evidence, Department of Health and Human Services, p.5.
\textsuperscript{33} Submission S015, Health and Community Services Union, p.4.
\textsuperscript{34} Submission S019, Distinctive Options, p.4.
\textsuperscript{35} Submission S018, Office of the Public Advocate, p.15.
\textsuperscript{36} Submission S012, Karingal Inc, p.1; Submission S015, Health and Community Services Union, p.3.
\textsuperscript{37} Submission S018, Office of the Public Advocate, p.16.
The Senior Practitioner (Disability) told the Inquiry that there is no specific qualification or training linked to authorised program officers. Any organisation using restrictive practices must have an authorised program officer, a role the Senior Practitioner believes is best filled by a senior staff member removed from the daily care of patients. An example in a residential service would be an operations manager.38

Mr David Bowen, Chief Executive Officer of the National Disability Insurance Agency (NDIA), suggested to the Senate’s Inquiry into abuse in the disability sector that training should be more values based than skills based. Mr Bowen said, ‘The critical elements required for a workforce—a predominant workforce; there are some elements that are highly specialised—should be around the aptitude and attitude of the people to have the appropriate values to take into account the interests of their clients ...’.39

The need for training has also been expressed in terms of continuing or ongoing professional development.40 For example, Distinctive Options argues that service providers need to know that staff are adequately trained prior to employment and then address any shortfalls through continuing professional development.41

### 4.4.1 Cost of training

The Committee heard concerns about the proposed unit pricing for the NDIS and whether it is sufficient to allow ongoing professional development for disability workers. Ms Sarah Fordyce of National Disability Services told the Committee:

> We know that NDIS prices do not allow for extensive training — they are very lean prices — and organisations are going to have to think cleverly about how they will embed their workers in terms of the knowledge but also the culture of the organisation.42

In its submission to this Inquiry, Distinctive Options makes two recommendations related to pricing:

- unit pricing to recognise the importance of training and supervision in the prevention of abuse and ensure services are funded appropriately to supervise and support the professional development demands of staff43
- services be funded to provide opportunities for staff to participate in reflective practices, case conferencing and attend training and professional development programs to enhance skills44

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38 Transcript of evidence, Senior Practitioner (Disability), Melbourne, 15 June 2015, p.6.
39 D. Bowen, Transcript of evidence, p.39.
40 Submission S010, Life Without Barriers, p.4; Submission S018, Office of the Public Advocate, p.15; Submission S015, Health and Community Services Union, p.4.
41 Submission S019, Distinctive Options, p.9.
42 Transcript of evidence, National Disability Services, p.8.
43 Submission S019, Distinctive Options, p.5.
44 Submission S019, Distinctive Options, p.9.
4.4.2 Examples of training

The Committee was informed of several examples of training available to workers in the disability sector.

For example, the Senior Practitioner (Disability) told the Committee about the following training programs:

- behaviour support plan toolkit training: a four-hour course on developing high-quality behaviour support plans, including identifying the best positive behaviour support interventions
- chemical restraint reduction strategy: a protocol to guide collaborative medication review for adults with behaviours of concern which involved 14 projects based on the process of ongoing data collection and evaluation. This lead to the development of: online learning modules for psychiatrists on intellectual disability psychiatry; modules for disability support workers on dual disability; and modules on the prescription of psychotropic medications for behaviours of concern in people with an intellectual disability for general practitioners.45

Since 2007, the Disability Services Commissioner has delivered training to over 7800 workers in the disability sector.46 It has also produced a range of resources which are available on its website, including: ‘Good Practice Guide and Self-Audit Tool’; Information Sheets; and Occasional Papers.47 The Victorian Ombudsman described such preventative and educational work as ‘very effective’.48

Further, the Department’s Mr Arthur Rogers, Deputy Secretary, Social Housing and NDIS Reform, told the Committee:

> We have training targeted to induction, which includes competency around client safety and so on. There is a ready-for-work module that is available for the funded section which complements that and targets the prevention of abuse of people with a disability, and we have training in and reinforcement of reporting requirements.49

As a service provider the Department has developed many training resources. Examples include:

- the Critical Client Incident Management Instruction Technical Update 2014 and the Responding to Allegations of Physical or Sexual Assault Technical Update 2014 – these outline the responsibilities, management and reporting requirement of disability service providers and are a requirement of the Department’s funding and service agreements

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45 Transcript of evidence, Senior Practitioner (Disability).
46 Submission S011, Disability Services Commissioner.
48 Transcript of evidence, Victorian Ombudsman.
49 Transcript of evidence, Department of Health and Human Services.
Chapter 4 Prevention and registration

• the Department also provides a range of support materials on the Funded Agency Channel including the Incident Reporting Categorisation Table and practice advice.

• the Residential Services Practice Manual outlines the roles and responsibilities of disability services support staff working in residential services managed by the Department.

The Senior Practitioner also awards ‘Promoting dignity grants’ to encourage disability support workers to develop and implement alternative solutions for people with disability who are subject to restrictive interventions.

4.4.3 Supervision

Adequate supervision of staff is a key component of continuing professional development as it allows management to observe what support is needed for staff to improve the way they work. Supervision can take administrative, developmental, supportive and mediative forms. Critically, it also demonstrates accountability and that clients are being treated properly and with the dignity they deserve.

The Committee was presented with several examples of inadequate supervision in the disability sector. For example, in her submission to this Inquiry, Ms Julie Pianto revealed that staff were unqualified to work unsupervised with her son. JacksonRyan Partners also include examples of clients being put at risk because of inadequate supervision in their submission.

JacksonRyan Partners argue that a lack of supervision means ‘... incidents of abuse had great potential to go unnoticed’. In its submission, the Office of the Public Advocate states ‘The lack of supervision and monitoring enables acts of violence to be perpetrated because their actions are unseen.’

The Committee heard that supervision across the disability sector is currently inadequate and this is because of funding constraints and use of casual and agency staff. It also heard an argument that the unit pricing in the NDIS
should allow for adequate supervision of staff in a way that contributes to both continuing professional development for staff and prevention of abuse for clients.  

**QUESTION 4.5:** Should minimum qualifications be introduced for all disability workers?
- If so, what should be the minimum qualification?
- Should this be a state or national requirement?

**QUESTION 4.6:** Should there be compulsory requirements for professional development for disability workers?
- If so, what core components of ongoing professional development would be required?

## 4.5 Workforce culture

The workforce culture in the disability sector is emerging as a key theme in the Inquiry. In this case, the use of 'culture' refers to the attitude of organisations with regard to their staff, as well as that of staff towards other staff and towards clients.

Opinions on the relationship between workforce culture and abuse vary. For example, Distinctive Options, a disability service provider based in Sunbury, suggests that while organisations are responsible for setting standards it could be argued that '...in the vast majority of cases service user abuse is very much an individual staff action rather than as a result of organisational culture or limiting standards'.

However, most evidence received by the Committee identifies a strong relationship between organisational culture and abuse. The Office of the Public Advocate states: 'Workplace culture is a central determinant of the way staff treat people with disability.' And Mr Laurie Harkin, the Disability Services Commissioner, told the Committee 'I cannot emphasise more strongly that culture sits at the heart of what does not go well.'

In its submission to this Inquiry, National Disability Services says that '...while policies and procedures matter, organisational culture matters more.' Indeed, that agency’s National Senior Sector Development Officer, Mr James Bannister, told the Committee that organisational culture starts at the top and permeates down through the whole organisation.

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59 Submission S012, Karingal Inc, p.1; Submission S019, Distinctive Options, p.5.
60 Submission S019, Distinctive Options, p.11.
61 Submission S018, Office of the Public Advocate, p.16.
62 Transcript of evidence, Disability Services Commissioner, Melbourne, 22 June 2015, p.6.
63 Submission S023, National Disability Services, p.6.
64 Transcript of evidence, National Disability Services, p.10.
A strong message beginning to emerge in this Inquiry is that staff may fear losing their job if they report abuse to management.65 The Victorian Advocacy League for Individuals with Disability’s Project Coordinator, Mr David Craig, told the Committee ‘Even carers who have hands-on care roles who really do care — there are a lot of fantastic staff — often it is difficult for them to speak up at risk of losing a job and having to go somewhere else. But many have; they have taken that shot.’66

Both the Health and Community Services Union and Office of the Public Advocate recommend that the Victorian Government change workplace culture in the disability sector with regard to abuse.67

No specific suggestions were made as to how to achieve such change. The Committee recognises that changing culture is a long-term strategy that requires commitment at all levels of government and organisations (including at board level).

A related view regarding workplace culture is that the sector is more concerned with protecting its reputation than protecting its clients. The Department’s Mr Arthur Rogers, Deputy Secretary, Social Housing and NDIS Reform, told the Committee:

We had some feedback from staff and particularly from the disability services commissioner that our process was not focusing enough on the client experience and outcomes, so we have reviewed that practice and will shortly be releasing an amended practice guide on how the support is going to be carried out, particularly covering client experience and outcomes, timeliness and greater guidance on consistent and clear application.68

Ms Carmen Harris, who had worked at Yooralla between 2008 and 2014 as a trainer and assessor developing and delivering training relating to reporting of abuse, provided the following observation of services she visited as part of her work:

The many services I visited varied widely in the quality of service and client satisfaction, this seemed to depend on the attitude of staff and particularly the attitude fed down by service and regional managers.

Some services fostered a client centred explorative, responsive approach, while at others there seemed to be a culture of fear and harassment for both client and direct support staff.69

65 See, for example Submission S024, Youth Disability Advocacy Services (YDAS); Submission S018, Office of the Public Advocate; Submission S021, Victorian Equal Opportunity and Human Rights Commission; Transcript of evidence, Community Visitors, Melbourne, 29 June 2015.
66 Transcript of evidence, Victorian Advocacy League for Individuals with Disability (VALID), Melbourne, 22 June 2015, p.7.
67 Submission S015, Health and Community Services Union; Submission S018, Office of the Public Advocate.
68 Transcript of evidence, Department of Health and Human Services, p.3.
69 Submission S027, C. Harris, p.1.
Ms Harris observed that the training program was only sustained while ‘someone was watching’ and that once an audit of the service had finished, the program was ‘effectively shut down’.\(^{70}\)

### 4.5.1 ‘Normalisation’ of violence

The term ‘normalisation’ of violence was raised by a number of submissions to this Inquiry.\(^1\) It refers to a belief that it is natural for people with disability to act violently, or that ‘a person’s behaviour is their disability’.\(^2\)

An example of this ‘tacit acceptance’\(^3\) of violence was presented to the Committee by the Public Advocate, Ms Colleen Pearce. Ms Pearce quoted from a case study regarding a person with autism and said:

> ‘The guardian recalled on another occasion’ — this was about being bitten — ‘the risks posed to Ms G ... stating their clients with autism “all bite each other”’. And there is another comment in there. So it is this normalisation of violence in that they accept that people with autism might bite themselves, that you have got people with challenging behaviours living together and that that is okay. I think that really is a significant part of the culture that needs to change. There needs to be a much more respectful approach and an understanding that it is not okay for a person to be living in a situation where they are subjected to violence.’\(^4\)

As to who is ultimately responsible for determining workforce culture, Ms Pearce added, ‘I think there is a vacuum in leadership and it is the leadership that is really critical.’\(^5\)

### 4.5.2 Attempts at culture change

The Committee is aware of programs that aim to improve the workforce culture in the disability sector in context of abuse in services. Despite these efforts to add value the Committee is firmly of the view that the Disability Act needs to be the overarching legislative and regulatory framework that oversees the quality and safeguarding mechanisms in Victoria.

**QUESTION 4.7:** What does the Victorian Government need to do to support a disability workforce culture that does not tolerate abuse, neglect or exploitation?

**QUESTION 4.8:** What do Victorian disability service providers need to do to promote and achieve a workforce culture that does not tolerate abuse, neglect or exploitation?

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70 Submission S027, C. Harris, p.1.
71 See, for example Submission S018, Office of the Public Advocate; Submission S027, Victorian Equal Opportunity and Human Rights Commission; Submission S020, Communication Rights Australia & Disability Discrimination Legal Service Inc.
72 Transcript of evidence, Victorian Advocacy League for Individuals with Disability (VALID), p.10.
73 Transcript of evidence, Community Visitors, p.3.
74 Transcript of evidence, Office of the Public Advocate, p.7.
75 Transcript of evidence, Office of the Public Advocate, p.8.
**BOX 4.1: Zero Tolerance Framework**

The Zero Tolerance Framework was developed by National Disability Services in 2013. Its aim is to: help the non-government sector provide safeguarding approaches for people with disability; and identify specific strategies for service providers to improve prevention, early intervention and responses to abuse, neglect and violence experienced by people with disability.

The Framework addresses the following categories:

- understanding abuse
- practices and safeguards which can help prevent abuse
- addressing risk for specific groups and service settings
- responding to abuse
- analysis, learning and improvement.

The Zero Tolerance Framework was initially funded by National Disability Services but has recently received funding from the Victorian Government for it to be expanded across the sector.

In its submission to this Inquiry, National Disability Services states:

Zero Tolerance potentially addresses the gap in Victoria in terms of providing a rights based framework with practical resources to enhance responses to abuse and neglect at the preventative end, in particular improving people and culture practices in disability services.

Source: *Submission S023, National Disability Services, p.7*
Complaints handling and critical incident management

AT A GLANCE

Background

Responses to allegations of and complaints regarding abuse in disability services occur at a number of levels and via a range of mechanisms.

Recommendations

That the Victorian Government propose to the Disability Reform Council that:

• a national evaluation is conducted of the community visitor program with a view to determining how it will function in the NDIS environment

• it establishes a mandatory reporting scheme for specified individuals and organisations to report incidents of abuse, neglect or exploitation to an independent oversight body with responsibility for managing and investigating the handling of reportable incidents

• it ensures there are consequences for those who are responsible for abuse of people accessing disability services and that service providers take steps to learn from the incident to prevent its recurrence.

Questions for Stage 2

• If the Victorian Government introduces an independent oversight body, should it have responsibility for handling general complaints about disability service providers, as the Disability Services Commissioner currently does?

• If there is a new independent oversight body with responsibility for complaints handling and responding to serious incidents, should it have the power to conduct own-motion investigations?
  – Should these powers relate to both complaints and the investigation of allegations of abuse and neglect?

• If an independent oversight body is established in Victoria, should that body have responsibility for developing a standard set of guidelines for responding to allegations of abuse and neglect in disability services?

• In view of the skills necessary in identifying and responding to abuse and neglect, should consideration be given to paid inspectors or paid official visitors in Victoria?

• If a paid inspector or paid official visitor role is introduced in Victoria, should they be located with an independent oversight body or other entity?
• In relation to visiting schemes and the existing Community Visitor scheme:
  – Should volunteer Community Visitors continue to be part of the safeguarding framework in Victoria?
  – If Community Visitors continue to be part of a safeguarding framework in Victoria, should they be located within the Office of the Public Advocate, a new independent oversight entity or another body?
• Should the Victorian Government introduce mandatory reporting of serious or critical incidents to a new independent oversight body? If so:
  – What individuals and organisations should be mandated to make such reports?
  – What current functions of the Department of Health and Human Services regarding the management of critical incidents should be transferred to the new body? And should the Department retain any functions relating to critical incident management?
This Chapter discusses various channels for incident reporting and complaints in Victoria. These include channels provided through the Disability Services Commissioner, the Department of Health and Human Services (the Department), internal disability service processes and Community Visitors. Issues relating to the possible introduction of mandatory reporting to an independent body are also discussed.

The Committee’s preliminary view is that although there are sophisticated policies and processes in place in Victoria for complaint handling and responding to allegations of abuse in disability services, the pathways for making complaints and reporting abuse are complicated and confusing.

In particular, the Committee observed there is confusion between the policies and processes for handling and escalating complaints, and for the management of reportable incidents.

A critical inadequacy of the safeguarding system in Victoria relates to responses to disclosures or allegations of abuse, neglect and exploitation in disability services. Some Inquiry participants criticised approaches by the Department, service providers and the Disability Services Commissioner (the Commissioner), suggesting they have inadequacies in dealing with disclosures of allegations of abuse in disability services.

The Committee identified that a lack of authoritative guidance may hinder clarity and consistency in provider responses to abuse.

Some evidence also suggested a cultural acceptance of a level of abusive behaviour in services and negative attitudes towards those who raise complaints and concerns about inappropriate behaviour.

### 5.1 Distinguishing complaints and reportable incidents

It is important to note that complaints are not the same as reportable incidents and to distinguish the differences. The Committee identified that there can be some confusion in Victoria regarding the way in which general complaints and reportable critical incidents are dealt with and understood.

The Australian Government’s consultation paper on the proposed national quality and safeguarding framework (NDIS Consultation Paper) explains that complaints can take a variety of forms, including:

- dissatisfaction about the service or product and how it is being delivered that may be resolved through the provision of further information

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• disagreement with a decision made by the provider of the disability support, product or service that may require explanation and/or investigation
• a claim that a situation or decision should never have happened or been made, or an issue that requires explanation and/or resolution.²

In contrast, a reportable or ‘critical’ incident is a serious incident, such as abuse or neglect, which is required to be reported and investigated and results in appropriate actions being undertaken in response to the incident. As explicitly stated in the NDIS Consultation Paper:

A complaint is not the same as a serious incident, which is an event which threatens the safety of people and property and must always be reported...

Serious incidents, such as a criminal offence or safety issue, could be reported initially through a complaints system, but these matters would require investigation and/or other action by police and/or other authorities.³

A complaint might be made regarding an allegation or disclosure of abuse, neglect or exploitation. Such a complaint would be considered a reportable or serious incident and reported to the appropriate authorities, including police.

The pathways for reporting abuse in disability services in Victoria are complex and overlapping. Responses to allegations and complaints occur at a number of levels. Reportable incidents are handled at the service provider level, at the funder level (the Department) and are reviewed at the regulator level (the Commissioner). They are also reported to police.

The diagram in Figure 5.1 from the Victorian Ombudsman’s report on Reporting and investigation of allegations of abuse in the disability sector: Phase 1—the effectiveness of statutory oversight (Phase 1 Report) illustrates this complexity.⁴

This diagram does not clearly distinguish between processes for dealing with complaints and mandated processes for managing reportable incidents in disability services. However, as can be seen under the ‘tell staff’ pathway in the Ombudsman’s diagram, service providers are subject to multiple mandated reporting requirements, reviews and procedures for dealing with reportable incidents. In addition, there are a range of internal and external processes in place for responding to complaints received.

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The Committee identified that processes for handling complaints include:

- internal policies and procedures in disability services
- escalation of complaints to the Commissioner
- direct complaints to the Commissioner.

Processes for management of reportable incidents include:

- internal reporting processes in line with Departmental guidelines
- Departmental processes to respond to critical incidents
- the Commissioner’s oversight of critical incidents.

**Figure 5.1 Complaints pathways in Victoria**


The Committee had limited opportunity to systematically review protocols and guidance within disability services for responding to complaints and allegations. However, it notes that the Victorian Ombudsman’s report observed that ‘agencies have different responsibilities in relation to the types of abuse they can deal with, different approaches to dealing with abuse allegations they receive, and different
approaches by the same agency, depending on where the abuse occurred or which service provider was providing services to the victim of abuse at the time it occurred.\textsuperscript{5}

Some of the complexity shown in Figure 5.1 is due to the gaps within Victoria’s system of oversight and the overlapping roles of the safeguarding bodies.

### 5.2 Complaints through the Disability Services Commissioner

Evidence received by the Committee supported the existence of an external and impartial complaints body, however the Commissioner’s approach to some complaints was criticised by several inquiry participants.

As outlined in Chapter 1, the Disability Services Commissioner has powers to receive, assess, conciliate and investigate complaints about disability service providers. In addition, since 2012, the Commissioner has been providing independent review and advice to the Department of Category One incident reports relating to allegations of staff-to-client assault and unexplained client injuries.

The nature of the matters the Commissioner responds to include:

- service delivery and quality standards (49 per cent)—such as dissatisfaction with the quality of service provided, insufficient service or support
- communication and relationship (38 per cent)—such as insufficient communication from disability service providers or concerns about the quality of communication
- policies and procedures (30 per cent)—such as issues with fees or charges, internal complaint handling, or service providers’ policies and procedure
- service access and compatibility (27 per cent)—such as length of wait times to access services and cessation of services
- workforce and staff (16 per cent)—such as inappropriate behaviour or attitudes of staff.

In the context of complaints about abuse, neglect and exploitation, the Commissioner informed the Inquiry that between 2007 and 2015 these accounted for approximately 12 per cent of all complaints received (see Table 5.1).


\textsuperscript{6} Victorian Disability Services Commissioner (2014) Annual Report 2014, p.19. Multiple responses are possible, so figures relating to issues may not add up to 100 per cent.
Table 5.1  Abuse and neglect complaints, 2007-15

<table>
<thead>
<tr>
<th>Issue</th>
<th>No of complaints</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alleged assault / abuse by staff</td>
<td>40</td>
<td>3</td>
</tr>
<tr>
<td>Alleged assault/abuse by other service user</td>
<td>53</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
<td><strong>7</strong></td>
</tr>
<tr>
<td>Alleged neglect by service</td>
<td>71</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td><strong>Total no. of complaints received</strong></td>
<td><strong>1316</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Disability Services Commissioner, Information provided to Committee, on 10 July 2014, Attachment 4

The Committee observes that some aspects of the Commissioner’s approach were commended. For example, the Victorian Ombudsman’s Phase 1 Report considered the educational component of the Commissioner’s work is an area that has been particularly effective. Further, the Ombudsman concluded that the Commissioner’s assessment process is effective. It identified issues such as suitability for conciliation and it aims to resolve complaints informally, quickly and effectively. The report noted that in reviewing the assessment process there were a number of assessments that related to complaints about the handling of allegations of abuse, yet made no comment regarding how effectively these were handled in the assessment process.7

However, other aspects of the Commissioner’s approach to complaints was criticised by the Ombudsman and Inquiry participants. In particular, the Commissioner’s reliance on conciliation and apparent reluctance to conduct investigations was the subject of significant criticism.

5.2.1 Conciliation—Alternative resolution

The Commissioner promotes an alternative resolution approach, whereby complaints are resolved through conciliation. The Committee heard from a number of Inquiry participants that for complaints relating to abuse and neglect, an alternative resolution approach is inadequate or inappropriate. In such situations there is usually an imbalance of power. As noted by Women with Disabilities Victoria, the Dispute Settlement Centre of Victoria’s guidelines on mediation recognise that ‘mediation should not be conducted in cases where there is a power imbalance and/or where one party has been traumatised by the other’.8

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In her evidence, Ms Sandra Guy explained she had complained to the Commissioner regarding poor standards at her son’s disability service provider. She told the Inquiry she found it inappropriate for the Commissioner to insist on a ‘conciliation’ with the service provider without regard for the nature of the complaint.9

Similarly, Youth Disability Advocacy Service (YDAS) explained that young people with disability who report abuse and neglect to the Commissioner often see no improvement in their circumstances. YDAS suggested that there are many situations where conciliation is an ‘inappropriate and unacceptable approach’.10 YDAS provided an example of a complaint made on behalf of a 13-year-old boy living in out-of-home care who was subjected to mechanical restraints by a service provider and was only offered conciliation.11 Although out-of-home care is outside the Inquiry’s terms of reference, this illustrates that conciliation can be highly inappropriate in certain circumstances.

In considering the conciliation process, the Victorian Ombudsman reviewed a number of conciliation files that had been closed. In this review some questions were raised about the suitability of some of the matters referred for conciliation and the duration of conciliation.12 The Victorian Ombudsman’s report provided the following examples of matters that remained unresolved following the conciliation, indicating this was an inappropriate approach:

- Person A, a parent, complained about poor quality of care provided to her child in June 2012. The matter was closed, unresolved, on 7 January 2015. There was a high level of distrust between the family and the provider, which should have indicated from the outset that conciliation would not be effective
- Person B, a service user, was referred to conciliation after making a complaint that she was being verbally threatened and bullied by staff. The complaint was made in September 2011 and was closed, unresolved, in December 2013.13

5.2.2 Inadequate outcomes

Inquiry evidence suggests that the Commissioner in some cases failed to achieve an acceptable resolution to complaints. A number of Inquiry participants were frustrated with a perceived lack of action by the Disability Services Commissioner. Ms Sandra Guy related her experience upon lodging a complaint:

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9 Submission S013, S. Guy, p.4.
10 Submission S024, Youth Disability Advocacy Services (YDAS), p.2.
11 Submission S024, Youth Disability Advocacy Services (YDAS), p.2.
In lodging complaints with the DSC what we had naively and unwittingly stepped onto was what so many people with disability and their families describe as the ‘meeting treadmill.’ There are meetings, meetings and more meetings. They appear to spend much of their work time in meeting after meeting. What you don’t see is any action.14

When asked about the types of outcomes the Commissioner can achieve, the Commissioner informed the Inquiry that he ‘seeks to ensure better outcomes for people with disabilities and looks at the adequacy of supports and reviews by service providers and, where appropriate, directs the service providers to complete actions to remedy identified issues of concern.’15 Under the Disability Act 2006 (Vic) (Disability Act), if the Commissioner considers the complaint is justified, he can:

- require the service provider to remedy the complaint, and in doing so outline actions required to remedy the complaint (s119(1))
- conduct an inquiry into what actions the provider has taken (including to remedy the complaint) (s119(9))
- name a disability service provider in the Disability Services Commissioner Annual Report who has unreasonably failed to take action required by the Commissioner (s19(2)).16

However, the Commissioner explained that his power to resolve or appropriately deal with matters is ‘limited to outlining actions required to remedy the complaint in question.’17 Furthermore, in determining what action is required to remedy a complaint the Commissioner noted that he is ‘legislatively bound to have regard to the impact on the service provider and any other person accessing the services of the service provider who may be affected.’18

The Commissioner informed the Inquiry that ‘there have been no circumstances to date where a service provider has failed to comply with a direction by the office, thus there has not been a situation where a service provider could be named for non-compliance.’19 Furthermore, the Commissioner has not conducted investigations since 2010 (discussed further in section 5.2.3).

Some participants argued that the Commissioner’s approach and that of other safeguarding mechanisms does not hold service providers accountable. Lifestyle in Supported Accommodation, for example, told the Committee:

14 Submission S013, S. Guy, p.4.
15 Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.3.
16 Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.3.
17 Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.3.
18 Pursuant to Disability Act 2006 s.118(7). Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.3.
19 Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.3.
(a) the person making the complaint/s is wrong, (b) the service provider is right and, (c) no one is to blame for the matter occurring or not occurring. This complaint resolution philosophy is all about drawing a line-in-the-sand from which a reported problem may be considered resolved, whilst previous happenings which led to the complaint are ignored/dismissed...

Similarly, Ms Sandra Guy identified that the Commissioner does not require proof of any outcomes, stating that the disability service that was the subject of her complaint to the Commissioner:

... did not have to demonstrate to the DSC that they had actually addressed any of the issues ... raised, they simply had to inform the DSC they were conducting a review, and that’s all the DSC required. No actual outcomes were required.

Ms Sandra Guy expressed particular concern with the practice of referring complaints back to the organisation a person is complaining about.

The Committee considers that these concerns illustrate the current gaps and lack of clarity in Victoria’s oversight system, as discussed in Section 5.2.6.

### 5.2.3 Investigation powers

Some Inquiry participants suggested there is inadequate action by the Disability Services Commissioner in response to complaints about abuse, neglect or exploitation. The Committee heard that between 2010 and 2014, the Commissioner did not undertake any investigations in the context of the functions outlined in Section 16(a) or the complaints process outlined in Division 6 and more specifically Section 118 of the Disability Act. In the context of the approach to investigations used by the Commissioner, the Victorian Ombudsman reported that her investigation had ‘raised questions about the DSC’s reluctance to use investigation powers’ and noted that he uses his powers ‘sparingly’.

The Phase 1 Report identified that there are no internal policies, procedures or practice guidelines for investigations.

A number of Inquiry participants also expressed their concern about the extent to which the Commissioner undertakes investigations that relate to abuse, neglect and exploitation. For example, Action for More Independence and Dignity in Accommodation (AMIDA) stated that:

The Disability Services Commissioner has the power to investigate allegations and reports of abuse but has not conducted any investigations. They operate primarily as a mediator and educator and while this has value there is a desperate need for independent investigation of reports of abuse and they are empowered to do so yet choose not to.

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20 Submission S002, Lifestyle in Supported Accommodation Inc (L.I.S.A.), p.3.
21 Submission S013, S. Guy, p.10.
22 Submission S013, S. Guy, p.4.
Villamanta Disability Rights Service (Villamanta) expressed similar views in its evidence to the Senate hearings on 30 June 2015:

The Disability Services Commissioner is another point I would like to mention. The power to investigate is hardly ever used. There is no power to direct and people seldom go back a second time. Although we do encourage people initially, they often find that they achieve nothing and waste a lot of time going to the Disability Services Commissioner and do not go back again.25

JacksonRyan Partners also considered that there are issues relating to the extent to which the Commissioner receives complaints about abuse in disability services and the extent to which they can be resolved:

... despite the DSC having existed since 2007 and being required to operate as an independent entity for the receipt, review and investigation of reported complaints, the actual number of complaints reported to the DSC must be considered as a concern, this being particularly in light of the fact that the Public Advocate and Community Visitors, in the Community Visitors Annual Report 2014, indicate that they have reported abuse and neglect for years and it is systemic across Victoria’s disability sector.26

In explaining the reason for the lack of investigations conducted, the Commissioner told the Committee that this is due to the adoption of an alternative dispute resolution practice model. The Commissioner emphasised that the ‘exhaustive character of the assessment process’ undertaken through this practice allows the Commissioner to elicit all the facts about a complaint that it needs from service providers:

My view is that if I have not got a clear view of the facts of a matter, then it would be worthy of me to investigate. But through the process we have followed, and with the assessment process being as exhaustive as it is, we have always been able to elicit cooperation from parties as to what the facts of an issue were. It is useful to understand that if asked and/or pushed, organisations in particular tend to be more helpful than otherwise and less defensive than otherwise.27

This concurs with the findings of the Ombudsman’s Phase 1 investigation.

While acknowledging that the Commissioner is a complaints body, not an authority with powers to investigate reportable incidents, the Committee was interested to know when a complaint might be determined unsuitable for conciliation and should be investigated. In particular the Committee was interested to hear if the Commissioner had received any complaints about the allegations of sexual assault that occurred in Yooralla in 2011 and 2012.

26 Submission S003, JacksonRyan Partners, p.13.
27 Transcript of evidence, Disability Services Commissioner, Melbourne, 22 June 2015, p.4.
When questioned by the Committee regarding his use of his investigatory powers, despite their limitations, the Commissioner pointed out that he does not conduct criminal investigations. When responding to the Committee’s questions on notice relating to the scope of the Commissioner’s investigatory functions, the Commissioner distinguished investigations within the scope of the Disability Act from criminal investigations undertaken by police:

It is important to note that investigations pursuant to s118 are not criminal investigations and the Commissioner has no legislative remit to enforce punishments, convict anyone of a criminal offence or impose individual sanctions. These are powers reserved for law enforcement and the judicial system.

However the Committee observed that there is a role for non-criminal investigations to be carried out by the Commissioner. JacksonRyan Partners, for example, argued that a significant proportion of the abuse that is being perpetrated against people with disabilities might be called neglect, failure to meet duty of care or of a type that does not constitute a criminal action.

The Committee sought further information about the Commissioner’s approach to investigations that do not relate to matters that require criminal investigation. In the Winter 2015 Newsletter, in responding to the Ombudsman’s report, the Commissioner explained that:

In the past six months we have initiated three investigations. It is important to note that we do not have power to initiate our own actions, but can only act on a complaint.

The Committee asked the Commissioner for further information about the nature of the complaints that had resulted in these investigations. The Commissioner informed the Committee that since December 2014 it had commenced four investigations, two of which are related to alleged abuse or assault, and two related to quality of care and incident management.

5.2.4 Own motion investigations

As emphasised by the Commissioner, the Ombudsman also highlighted that the Commissioner does not have own motion powers.

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28 Transcript of evidence, Disability Services Commissioner, p.8.
29 Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.3.
30 Submission S003, JacksonRyan Partners, p.16.
32 Supplementary evidence, Response to request for information, Disability Services Commissioner, 20 July 2015, p.2.
There is limited power for the Commissioner to conduct own motion inquiries under the Disability Act. The Act allows the Commissioner to initiate inquiries into matters referred by the Disability Services Board and broader issues concerning services for persons with disability arising out of complaints received. However, this power still relies on people making a complaint.

In contrast, the Commissioner told the Committee that ‘six other jurisdictions within Australia with similar complaint resolutions functions have own motion capacity—NSW, SA, NT, TAS, ACT, WA.’ In his submission to the Inquiry, the Commissioner identified that this is of concern as ‘the power to conduct an own motion inquiry can have a direct and positive outcome on individuals in receipt of disability services who may or may not be empowered or have capacity to complain about conduct or service delivery of concern.’

Some Inquiry participants also argued that a singular reliance on people reporting abuse is not sufficient, and that an ‘effective complaints body should have the capacity and resourcing to undertake its own investigations.’

This concern was also raised by the Victorian Ombudsman in her recent report. The question of whether a complaints body should be investigating abuse or referring these to a separate investigative body with specific responsibility for responding to serious incidents is discussed in Chapter 2.

5.2.5 Reportable or critical incidents

While the Commissioner does not have a specific role that relates to the management of critical or reportable incidents, since June 2012 the Commissioner has had responsibility for providing independent review and advice to the Department on Category One incident reports relating to allegations of staff-to-client assault and unexplained client injuries. In August 2012, this arrangement was extended to include community service organisations.

The Commissioner monitors and identifies issues relating to critical incidents, and may question issues. In the submission to the NDIS Consultation Proposal, the Commissioner explains that the intention of this involvement is to:

... influence policy to improve prevention and responding to abuse; and provide advice on individual matters where the concern for the person with a disability is not apparent.

Notably, the Commissioner does not have responsibility for undertaking investigations into reportable or critical incidents.

33 Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.2.
34 Submission S011, Disability Services Commissioner, p.15.
35 Submission S010, Life Without Barriers, p.8.
36 Submission S011, Disability Services Commissioner, p.17 of Attachment 2.
37 Submission S011, Disability Services Commissioner, p.17 of Attachment 2.
5.2.6 Clarifying the role of the Commissioner

Although the evidence supports the need in the community for an independent body to handle complaints and incidents, the Committee identified that there is confusion about the role of the Commissioner in the broader safeguarding framework. As emphasised by the Commissioner in information provided to the Inquiry:

The Victorian Disability Services Commissioner was established in 2007 primarily as a complaints body.\(^\text{38}\)

At a public hearing on 22 June 2015, the Commissioner advised the Inquiry that:

I was always reasonably confident, without ever being overconfident about things, that the interpretation and application of the act that I had stewardship of was correct. I more recently sought advice from the Victorian government solicitor, in fact in the last two weeks, just to reassure myself, and indeed anybody else who might have had a question or two about this, as to the extent to which I have correctly applied the act and had appropriate regard for the history, the parliamentary documentation that is available and the explanatory memoranda that accompanied the introduction of the legislation. It is the case that the Victorian government solicitor holds the same view as I do in terms of the approach to be adopted and that has been adopted.\(^\text{39}\)

The Committee acknowledges that there is considerable frustration and for some, anger, at the manner in which the Commissioner has addressed their complaints of abuse, neglect and exploitation. JacksonRyan Partners capture the frustration that was unmistakeable in the evidence provided to the Inquiry:

... the reporting of incidents, including abuse in all its forms, is a significant weakness in the disability sector in Victoria. They further argue that underpinning this weakness is the failure of managers and the watchdog entities such as the DSC to adequately address as the significant issue it is reported cases of abuse in all its forms.\(^\text{40}\)

Currently the system does not allow for the external resolution of critical incidents. Instead, these are resolved through the critical incident system involving the service provider and the Department (as discussed in Section 5.3). Complainants who seek an independent resolution of critical incidents through the Commissioner find themselves back in a system that involves the service provider and the Department, which are often the bodies they are seeking to complain about in the first place.

The Committee considers the possibility that given the degree of frustration about how the Department manages critical incidents, an expectation has been placed on the Commissioner to assume responsibility for this gap in safeguarding mechanism.

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38 Supplementary evidence, Response to request for information, Disability Services Commissioner, 10 July 2015, p.Attachment 1.
39 Transcript of evidence, Disability Services Commissioner, p.3.
40 Submission s003, JacksonRyan Partners, p.14.
The blurring of responsibilities of the Department in the management of critical incidents with the complaints functions of the Commissioner adds to this frustration and has ultimately led to what the Ombudsman referred to as a ‘credibility problem’.  

As mentioned in Section 5.1, it is necessary to bear in mind that complaints are different from critical or reportable incidents. The Commissioner has interpreted his role as complaints resolution, not an investigator of reportable incidents. Yet confusing this issue further is the reality that since 2012 the Commissioner has had responsibility for reviewing critical incident reports and providing advice.

In view of the blurred lines of responsibility for investigations and complaints handling, the Committee considers there needs to be greater clarity about the purpose and functions of own motion investigations.

As discussed in Chapter 3, this evidence suggests there is a justification for an external independent body to address both complaints and critical incidents. The Commissioner pointed the Committee’s attention to the model that is currently operating in New South Wales in which the Ombudsman has direct responsibility for responding to reportable incidents. This is discussed further in Section 5.7.

The Committee determined that despite having investigatory powers, between 2010 and November 2014 the Victorian Disability Services Commissioner has not undertaken any investigations despite having identified complaint matters that are not suitable for conciliation.

It also identified that in Victoria, the lines across the resolution of complaints and management of reportable incidents are blurred and have consequently led to confusion in the community regarding responsibilities across the Department of Health and Human Services and the Disability Services Commissioner.

The Committee’s preliminary observations have led it to identify emerging themes and questions that it will consider in Stage 2.

**QUESTION 5.1:** If the Victorian Government introduces an independent oversight body, should it have responsibility for handling general complaints about disability service providers, as the Disability Services Commissioner currently does?

**QUESTION 5.2:** If there is a new independent oversight body with responsibility for complaints handling and responding to serious incidents, should it have the power to conduct own motion investigations?

- Should these powers relate to both complaints and the investigation of allegations of abuse and neglect?

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5.3 Department guidelines and policies for critical incident management

Funded agencies are expected to meet certain requirements as part of their agreement with the Department. The Department has a range of policies and guidelines in place to deal with critical incidents in disability services. These include the DHHS Standards, departmental instructions and critical client incident management instructions (outlined in Table 5.2).

Table 5.2 DHHS guidelines for funded agencies processes for responding to incidents

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Guideline</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegations of misconduct/abuse</td>
<td>DHHS Standards and evidence guide 2011</td>
<td>Requires funded disability services to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• have processes in place to respond to allegations of misconduct/abuse in ways that ensure people are protected from future harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• promote an environment where people are free from abuse, neglect, violence and preventable injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• have clearly documented policies and processes for responding to potential or actual harm, abuse, neglect, violence and/or preventable injury.</td>
</tr>
<tr>
<td>Allegations of physical or sexual assault</td>
<td>Responding to allegations of physical or sexual assault (DHHS instruction issued in 2005 and updated in 2014)</td>
<td>Provides a more detailed outline of the reporting and management requirements for allegations of physical or sexual assault that involves a client for all services directly delivered or funded by the Department. This includes reporting to police, initiating disciplinary procedures and reporting to the Department through its critical incident management process (discussed in section 5.3).</td>
</tr>
<tr>
<td>Critical client incidents</td>
<td>Critical client incident management instruction (issued in 2011 and updated in 2014)</td>
<td>Describes the requirements for funded service providers to submit client incident reports to the Department for all critical incidents that occur at the service or during service delivery which involve and/or impact upon clients.</td>
</tr>
<tr>
<td>Physical and sexual assault</td>
<td>DHHS residential services practice manual, 3rd edition</td>
<td>Outlines roles and responsibilities of disability services support staff working in residential services managed by the Department for responding to physical and sexual assault.</td>
</tr>
<tr>
<td>Not specified</td>
<td>Managing Performance and Conduct in Disability Services Policy</td>
<td>Focuses on disciplinary investigations.</td>
</tr>
<tr>
<td>Not specified</td>
<td>Promoting Better Outcomes - Systemic Improvement Policy: Managing and reviewing adverse events</td>
<td>Aims to assist in the effective management of all adverse events and promote a learning culture and continuous improvement in disability service delivery.</td>
</tr>
</tbody>
</table>

Source: Compiled by the Family and Community Development Committee from Department of Health and Human Services publications and supplementary evidence.42

42 Supplementary evidence, Response to request for information, Department of Health and Human Services, 23 July 2015.
Despite this extensive guidance from the Department, there appears to be inconsistencies between approaches adopted by disability service providers in responding to abuse. The Victorian Ombudsman’s report identified that ‘departmental guidance on serious misconduct does not apply to funded providers, which adopt a variety of separate approaches.’ Similarly, the Office of the Public Advocate identified lack of clear requirements relating to investigations and disciplinary action to be undertaken by disability services providers in response to abusive incidents perpetrated by staff:

The (DHHS) Residential services practice manual 3rd edition does not specify what action must be taken during an investigation of staff to resident violence.

In providing material to the Committee relating to guidance, the Department acknowledged two areas for improvement:

• There is a need to provide specific guidance for the investigation of allegations of staff to client assault within disability services.

• There is a need to strengthen disciplinary investigation practice for community sector organisations and build on an investigation framework being developed to respond to quality of care concerns for out-of-home care for children.

These enhancements are scheduled to be undertaken as part of its Strengthen safeguards for people with a disability work plan.

In addition to the guidelines and policies listed in Table 5.2, the Department conducts internal and external investigations of critical incidents occurring within funded disability service providers, and undertakes quality of care reviews.

The Department provided the Committee a diagram of these processes (Figure 5.2). The diagram shows the complexity of decision making required by Department and disability service providers to determine appropriate action.

In general, there is a view that incident reporting is important with participants noting that ‘Incident Reporting is vital because people with a disability usually don’t or can’t complain.’ A strong view was expressed that while essential, the system in Victoria needs considerable improvement. For example, Karingal made the point that the process is often the focus of the system rather than improving practices and quality of service:

Specific to incident reporting and quality of service reviews, Karingal’s view is that a shift in focus by DHHS to less on actual completion of the process and more on the quality of improved practices and outcomes would be of benefit to the sector.

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45 Supplementary evidence, Response to request for information, Department of Health and Human Services, 23 July 2015.
Figure 5.2  DHHS reporting and review types

<table>
<thead>
<tr>
<th>Incident identification disclosure and response</th>
<th>Reporting</th>
<th>Post incident response and investigation</th>
<th>Review</th>
<th>Organisational and system review</th>
</tr>
</thead>
<tbody>
<tr>
<td>INCIDENT OCCURS</td>
<td></td>
<td>Ensure safety of client and others (RAPSA)</td>
<td>Quality of support review</td>
<td>Division performance monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing support to client and others (RAPSA)</td>
<td>No further action</td>
<td>CSO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Internal investigation</td>
<td>Staff misconduct assessment</td>
<td>Agency monitoring and framework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>External investigation</td>
<td>Department services</td>
<td>Organisational learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assessment of action required</td>
<td>CSO</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>High level risk or issues of concern</td>
<td>Policies/Procedures and EBA</td>
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<tr>
<td></td>
<td></td>
<td>Unsatisfactory</td>
<td>Misconduct</td>
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<tr>
<td></td>
<td></td>
<td>Serious misconduct</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No further action</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LEGEND

- Policy and procedure
- Policy and procedure (CSO)
- Practice based decision making
As the funder and provider of disability services in Victoria, the Department of Health and Human Services has a central role in managing the reporting of critical incidents. There are five steps in critical incident reporting, as outlined in Table 5.3.

### Table 5.3: Critical incident management—five phases

<table>
<thead>
<tr>
<th>Phase</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1:</strong> Incident identification, notification and response</td>
<td>Ensure client and the staff member are safe and again that the police are notified if required. Ensure specific reporting requirements in the RAPSA are followed (i.e., responding to allegations of physical or sexual assault instruction) Report all allegations regarding physical or sexual assault to the police (no discretion).</td>
</tr>
</tbody>
</table>
| **Phase 2:** Reporting | Determine if it is a category 1 or category 2 incident:  
• Category 1—a serious outcome such as death or severe trauma to a client or person (service required to report to the department within 24 hours)  
• Category 2—a threat to client health, safety or wellbeing (service required to report to the department within two days).  
The agency or the Department staff member—the most senior person present—must complete the incident report, send it in and outline any immediate actions that have occurred. |
| **Phase 3:** Post incident response and investigation | • Ongoing support to ensure health and safety are attended to and referral to relevant support agencies and services, if necessary.  
• Senior manager to assess the incident, what happened, and make decisions—firstly, regarding the need for a formal investigation, and secondly, whether that investigation should be internal or external.  
• In this phase the senior manager will also assess whether there has been any alleged or likely misconduct by a staff member involved in the incident and start taking appropriate action if that is the case. |
| **Phase 4:** Review | Identify underlying causes of the incident—any lessons and practice implications that there might be—make recommendations for improvement and, if needed, develop some strategies and review the effectiveness of those strategies.  
Reviews might include:  
• Quality of Support Review  
• Practice review  
• Service review (whole of organisation review) |
| **Phase 5:** Organisation and systems learning | Review incident information over time, look at the pattern—the incidences—and look at the lessons and practice implications, make recommendations to improve, generate some improvement plans and monitor and review implementation of actions. |

Source: Department of Health and Human Services Transcript of evidence, p.2-3.

The first three phases of the critical incident reporting process involve incident identification, reporting and response, and are discussed in Section 5.3.1.

Section 5.3.2 considers Phases 4 and 5 of the process. That is, the process of review and the process of organisation and systems learning. In a number of respects these two phases of the process are interlinked.
The Department’s critical incident management processes have come under criticism through a number of inquiries and are currently being reviewed by the Department, following recommendations made in a KPMG report commissioned by the Department in 2014 (discussed in Section 5.3.5).

### 5.3.1 Critical incident identification, reporting and response

All organisations that have a service agreement (or contract) with the Department, and are funded to provide disability services, are required to report critical incidents that involve, or impact, upon clients. This requirement forms part of the organisation’s service agreement with the Department.

Incidents can be categorised as either Category One or Category Two. As can be seen from Table 5.4, the categorisation of incidents as either Category One or Category Two affects the urgency with which matters are dealt with. The Committee received little evidence in relation to this issue, however, the Victorian Equal Opportunity and Human Rights Commission’s submission suggests that the Department’s Critical Incident reporting process is not consistently followed and that incidents are sometimes incorrectly classified. The Victorian Ombudsman’s report outlines case studies illustrating the implications of misclassification of incidents, including understatement of their seriousness and delay of response.

#### Table 5.4 Critical incident management – incident types

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category One</td>
<td>Event that has resulted in a serious outcome, such as a client death or severe trauma. All staff/carer to client sexual assaults.</td>
<td>Reports must be sent to the Department designated divisional office as soon as possible and at the latest within one working day of the incident or within one working day from first being told of the incident.</td>
</tr>
<tr>
<td>Category Two</td>
<td>Event that threatens the health, safety and/or wellbeing of clients or staff.</td>
<td>Reports must be sent to the Department designated divisional office as soon as possible and at the latest within two working days of the incident or two working days from first being told of the incident.</td>
</tr>
<tr>
<td>Critical incidents that are criminal child abuse</td>
<td>Critical incidents may also be criminal child sexual abuse and therefore must be reported to police. The offence for failure to disclose child sexual abuse to the police came into effect on 27 October 2014.</td>
<td></td>
</tr>
</tbody>
</table>


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48 This includes three reports by the Victorian Ombudsman, an inquiry by the Disability Services Commissioner and a report by the Victorian Auditor-General’s office.


As outlined in Figure 5.3, under the Departmental *Critical client incident management instruction*, all client incident forms are to be completed and faxed to the Department.\(^{51}\) Incident reports are recorded in a Department database and the data is intended to be systematically analysed to inform policy development, training and practice improvements.

All client incident reports are to be filed and be accessible to relevant staff and Community Visitors at all times. Service providers also must maintain a critical client incident register or database and conduct regular review and analysis of the information for trends and lessons.

**Figure 5.3** Critical incident reporting

Incident occurs

Respond to immediate needs of the individual’s involved

The most senior staff member records the incident using the DHS Client Incident Report form (parts 1-4)

The delegated management representative records a summary of the incident, the response to the incident and action taken to prevent recurrence (part 5)

The completed DHS Client Incident Report is faxed to the designated regional office

Assault is reported to police where appropriate

Refer to *Responding to Allegations of Physical and Sexual Assault Instruction*

Client incident report is entered into client incident register

Report is placed in client file


Although the Committee received little direct evidence about the differences between Department operated facilities and those run by community service organisations, it notes the Victorian Ombudsman’s report suggested that the former have a higher level of compliance with incident reporting requirements. The report highlights the difference between incident reporting in Department accommodation and accommodation run by funded community service providers, providing the following comment from the Public Advocate:

Incident reporting in DHS houses is of a higher standard than CSOs. In part that is due to having central command... when you have CSOs who have various sizes of organisation they may or may not have the same capacity... the weaknesses are definitely in CSOs and how those services are monitored...\(^{52}\)


The Office of the Public Advocate (OPA) provided a case study to the Inquiry related to threats and violence by one disability service resident towards another (See Box 5.1). This example highlights that even where incidents are reported, this does not always result in action to stop abuse and promote safety.

**BOX 5.1: Case study – Office of the Public Advocate**

OPA was providing advocacy for individuals who were transitioning from state funded services to NDIA. With a planner we met with one individual residing in this house. When he was asked if there was anything that he did not like, he said that he did not like being hit. Everyone was very surprised about this. Our advocate guardian, who was doing advocacy on his behalf, talked to the staff, and they confirmed that this gentleman was subject to ongoing physical abuse by a co resident. He had been threatened, assaulted and threatened to be killed on a regular basis. Because of OHS issues staff were not permitted to intervene during the assaults. Staff reported incidents themselves. In one case a staff member suffered a dislocated shoulder after being thrown over the sofa. Doors had been reinforced after the co resident smashed doors trying to get at Mr K. The house supervisor said that the co resident had moved in several years ago despite being told about the ongoing conflict between the two individuals.

OPA provided advice to Mr K about his right to be free from abuse and to access the same legal support as other members of the community. Mr K indicated that he did want to seek legal support, and he made an application for an intervention order. Before that happened, OPA had notified senior management of DHHS and NDIA, but no satisfactory response was forthcoming. When OPA referred the matter to Villamanta Disability Rights Service, they assisted Mr K to take out an interim intervention order. The court granted that intervention order and, not surprisingly, this prompted an immediate response from DHHS and NDIA and alternative interim accommodation was found for the co resident. This case study highlights that, despite numerous incidents being reported to senior management for more than two years, no action had been taken to stop the violence and to provide a safe home for Mr K.

Source: *Transcript of evidence, Office of the Public Advocate, p5.*

5.3.2 **Review and organisational learning from critical incidents**

This section considers Phases 4 and 5 of the process. That is, the process of review and the process of organisation and systems learning. In a number of respects these two phases of the process are interlinked.

As outlined in Table 5.3, there are three types of review that can occur that are geared to improving processes and outcomes following an incident. The main review used by the Department is the Quality of Support Review (QoSR). Quality of Support Reviews are undertaken to ensure appropriate action has been taken to support a client’s health, safety and wellbeing following an incident. They
are undertaken for all allegations of physical or sexual assault of a client by a staff member in disability services. A Quality of Support Review may also be undertaken for patterns of unexplained injuries.\textsuperscript{53}

The purpose of this review is to assess the steps taken by a disability service provider in instances of staff to client assaults or unexplained patterns of injury. These include the service’s response, its actions, any specific responses undertaken to the client’s health, safety and wellbeing, and finally its action plan for improvement.\textsuperscript{54}

The Department advised the Inquiry that the QoSR process has recently been reviewed following both staff and the Disability Services Commissioner indicating it needed a greater focus on the client outcomes and experience.\textsuperscript{55}

## 5.3.3 Delay and inconsistent categorisation of incidents

The key objective of the Victorian Ombudsman’s investigation relates to the reporting and investigation of allegations of abuse in the disability sector.

In this investigation the Ombudsman reviewed the management of critical incidents by the Department in detail. In regard to the initial phases of the critical incident reporting process, the Ombudsman specifically identified that the categorisation model is confusing and can result in incorrect categorisation.

In regard to Quality of Support Reviews, the Ombudsman’s report identified the following issues:

- significant time delays between the date an incident occurs and the completion of a QoSR
- areas of further action were not followed up to ensure completion, despite being necessary to address client safety and wellbeing
- inconsistency—the divisions were not using the same QoSR template.

The report noted the need for improved practice guidelines and the need to review compliance.\textsuperscript{56}

In regard to conducting external investigations in the context of service reviews, the Ombudsman reported that there are no guidelines and that this is a source of confusion. The Department informed the Ombudsman’s investigation that generally service reviews are conducted by the Department, but when resources are unavailable an external consultant may be appointed.\textsuperscript{57}

\textsuperscript{53} Supplementary evidence, Response to request for information, Department of Health and Human Services, 19 June 2015, p.3.
\textsuperscript{54} Transcript of evidence, Department of Health and Human Services, Melbourne, 29 June 2015, p.3.
\textsuperscript{55} Transcript of evidence, Department of Health and Human Services, p.3.
\textsuperscript{57} Victorian Ombudsman (2015) Reporting and investigation of allegations of abuse in the disability sector, p.35.
In its evidence to the Inquiry, JacksonRyan Partners provided a number of reasons it considers the critical incident reporting system is not effective in Victoria and results in underreporting of incidents of abuse, neglect or exploitation. These reasons related to the skill level of staff in services, an acceptance of abuse or that they are blocked by middle or senior management in many services.\textsuperscript{58}

### 5.3.4 Lack of clarity regarding role of disability services in DHHS reviews

Some disability services indicated that their role in Quality of Support Reviews was not sufficiently clear. For example, in its submission, Karingal commented on the lack of clarity provided by the Department about the aims of and processes for these reviews, and the role of service providers. It supported improved governance arrangements in Quality of Support Reviews. It also identified a lack of consistency across regions. Furthermore, it identified that the reviews may result in ‘vague and/or unhelpful recommendations that appear not to address the core of the critical incident.’\textsuperscript{59}

Life Without Barriers suggested that the Quality of Support Reviews have improved oversight, but that they need to be more timely:

> The implementation of the Quality of Care [sic] Reviews following all incidents of abuse in care and unexplained injuries has seen an improvement of external oversight following such incidents. The reviews often occur some months following the incident so a more timely response to assist inform some of the longer term follow up would improve these processes.\textsuperscript{60}

Communication Rights Australia suggested that advocacy is often essential if reporting is to be followed up and also outlined the consequences for people with disability who have been subjected to an incident of abuse, neglect or exploitation:

> Incident reporting (IR) of abuse to DHHS is not actioned or responded to urgently unless there is an external body lobbying for action. Despite DHHS having a fully documented process for these cases advocates have found that the machinery of government operates very slowly leaving individuals who have been a victim of a crime fearful as to their future and safety.\textsuperscript{61}

### 5.3.5 KPMG review of critical incidents

The Department engaged KPMG to undertake a review of the Critical Incident Management System. KPMG found that the system is ‘overly ambitious, ambiguous and difficult to measure’ and has a disproportionate focus on routine

\textsuperscript{58} Submission S003, JacksonRyan Partners, pp.11-12.
\textsuperscript{59} Submission S012, Karingal Inc, p.3.
\textsuperscript{60} Submission S010, Life Without Barriers, p.7.
\textsuperscript{61} Submission S020A, Communication Rights Australia, p.12.
matters and compliance rather than safety of clients. The review concluded that the Department is ‘failing to meet the stated aims of the CCIRM [client critical incident and response management] framework and to adequately mitigate risks from critical incidents.’

The KPMG review determined that:

... the risks, challenges and deficiencies arising from the CCIRM framework cannot be adequately mitigated without fundamental reform of the end-to-end system.

KPMG has recommended a change to the categorisation model, including ‘more clearly defining and differentiating incident types, removing duplication, minimising the capture of routine, non-critical incidents and reflecting a primary emphasis on significant harm or risk of harm.’

Table 5.5 outlines the specific KPMG concerns about the five phases. It is important to note that KPMG is concerned with all areas within the Department that are subject to the critical incident management processes, such as children, youth and families. In addition, the review was completed in December 2014, which was prior to the merging of the Department of Human Services with the Department of Health in January 2015.

### Table 5.5 KPMG concerns about the phases of the critical incident reporting process

<table>
<thead>
<tr>
<th>Phase</th>
<th>KPMG concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Incident identification,</td>
<td>At the current volume of 33,000 incident reports per year (about 15,300 relating to disability), the divisions cannot reasonably be expected to manage and ensure the adequacy of all incident responses.</td>
</tr>
<tr>
<td>notification and response</td>
<td></td>
</tr>
<tr>
<td>Phase 2: Reporting</td>
<td>Rigour and effectiveness of the system is compromised by the categorisation model, which currently captures a range of non-critical, routine service delivery and case management matters rather than risks to the safety of clients or staff.</td>
</tr>
<tr>
<td>Phase 3: Post incident response and</td>
<td>The current DHS policy framework for incident investigation and review can be described as a patchwork of processes with varying levels of detail and maturity.</td>
</tr>
<tr>
<td>investigation</td>
<td></td>
</tr>
<tr>
<td>Phase 4: Review</td>
<td>While quality of care and quality of support reviews provide the primary formal review mechanisms, they do not apply across all DHS services.</td>
</tr>
<tr>
<td>Phase 5: Organisation and systems learning</td>
<td>The analysis of incident data currently occurs in the absence of benchmarks and consideration of incident outcomes, which means that DHS is relying on unsubstantiated reports and unsophisticated analysis, thus limiting the usefulness of the information provided.</td>
</tr>
</tbody>
</table>

Source: DHHS information request, Attachment 15, KPMG report, pp.6-7.

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5.3.6 **Disability Services Commissioner and Senior Practitioner review of critical incident reports**

As discussed in Chapter 1, a protocol has been in place since 2012 for Category One incident reports relating to allegations of staff-to-client assault and unexplained injuries to be reported to the Disability Services Commissioner. There is also a provision in the protocol for a joint review of such incidents by the Commissioner and the Office of the Senior Practitioner.\(^{65}\)

In his submission to the Inquiry, the Commissioner identified that his office has reviewed 281 incident reports in the year ending June 2013 and 309 incident reports in the year ending June 2014.\(^{66}\)

The Senior Practitioner informed the Inquiry that, since 2012, forty incidents have involved a person subject to restrictive intervention or unreported restrictive intervention resulting in Senior Practitioner staff reviewing and providing advice or direction to service providers.\(^{67}\)

Through his reviews, the Commissioner informed the Inquiry that the following themes were consistently identified:

- a lack of focus on people’s outcomes and safeguarding people’s rights during investigations
- the need for proactive engagement with Victoria Police
- further clarification on the scope, conduct and guidelines for Quality of Support Reviews
- the requirement for advocacy organisations to report critical incidents
- a lack of clarity and shared understanding of the definition of ‘assault’ and ‘poor quality of care’
- the need to regulate the suitability of staff who work in disability services.\(^{68}\)

Although there are sophisticated policies and processes in place in Victoria for responding to allegations of abuse in disability services, the pathways for reporting abuse are complicated and confusing.

5.4 **Non-departmental guidelines for responding to allegations of abuse**

Over the past few years, guidelines have emerged outside the Department’s guidelines and policies for responding to allegations of abuse in disability services. An example is the Interagency Guideline for Addressing Violence,

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65 Transcript of evidence, Senior Practitioner (Disability), Melbourne, 15 June 2015, p.4.
66 Submission S011, Disability Services Commissioner, p.17 of Attachment 2.
67 Transcript of evidence, Senior Practitioner (Disability), p.4.
68 Submission S011, Disability Services Commissioner, p.17 of Attachment 2.
Neglect and Abuse (IGUANA) developed by the Office of the Public Advocate.69 Dr Chesterman from the Office of the Public Advocate explained that IGUANA was developed in 2013 as a response to inadequate Department guidelines:

We were concerned that there was not enough leadership being shown to guide people working in the disability services sector as to what they should do in that case in responding to a suspicion or allegation of abuse, exploitation or neglect.70

The Committee notes that only a small proportion of disability service providers are signatories to IGUANA. In response to a request for further clarification by the Committee, the Public Advocate advised that signatories include ‘three major disability residential service providers’ and a total of 27 ‘providers in the sector’ including mental health and disability day services, advocacy, employment and training services, some of which are not registered disability service providers.71 Given there are 313 registered disability service providers in Victoria as at 15 June 2015, this represents a small proportion of services.72

National Disability Services (NDS) Victoria is a signatory to IGUANA and emphasised the need to tailor approaches to front line workers in order to improve staff responses to abuse:

you need a version of IGUANA that is tailored for front-line workers so they have a ready reckoner and they can look and say, ‘It is two o’clock in the morning, Saturday night. Something has happened. What do we do?’ — because that is the thing. People need supporting from the moment something happens, and all of these tools and resources are useful and they can be refined, but you need to get runs on the board.73

In its evidence to the Inquiry, the Department provided the following view regarding IGUANA:

We think it is a very useful document as a clear guideline, but we have not said that is what we would apply to our internal services because, again, we want to be really unambiguous about what we expect from our internal staff and funding and service agreements.

We are very clear that all allegations around physical and sexual abuse must be reported to police. In addition, those related to sexual abuse must be reported to a centre against sexual assault. It is not as clear in the IGUANA around that, and I am happy to go into some detail about. So whilst we think we are consistent with IGUANA and it is consistent with us, we want to make sure we have a mandatory requirement around that reporting, which I think needs to happen.74

70 Transcript of evidence, Office of the Public Advocate, Melbourne, 15 June 2015, p.7.
71 Supplementary evidence, Response to request for information, Office of the Public Advocate, 20 July 2015, pp.4-5.
72 Supplementary evidence, Response to request for information, Department of Health and Human Services, 19 June 2015, p.1.
73 Transcript of evidence, National Disability Services, Melbourne, 22 June 2015, p.7.
74 Transcript of evidence, Department of Health and Human Services, pp.4-5.
Similarly, as part of her Phase 1 Report, the Ombudsman questioned whether the Department could adopt IGUANA. The Department’s response provided in the report indicates there are key elements of IGUANA that ‘do not meet departmental requirements and policies’, including:

- the process for removal of staff from the workplace
- reporting allegations of assault to police, reporting of sexual assaults to the Centre Against Sexual Assault
- existing departmental discipline procedures consistent with relevant industrial instruments.  

The Disability Services Commissioner has also developed a resource paper and practice guidance sheets for disability service providers undertaking investigations of staff to client assaults and unexplained injuries: *Investigations: Guidance for service providers*. In the preface to the resource paper, the Commissioner identified that the guidance emerged in response to a need to share lessons learned through the Commissioner’s complaints resolution work and reviews of Category One critical client incidents of alleged staff to client assault or unexplained injuries in disability services.

The Committee heard, however, that there is varying level of competence in the sector in responding to disclosures and suspicions of abuse. Karingal, for example, recognised that:

> there may be a differential understanding of and varied ability of staff to identify the early warning signs of possible abuse against clients including their role in responding to allegations of assault against a client by a staff member (family member, past carer, or unknown perpetrator).

In its appearance before the Inquiry, NDS Victoria identified that there is scope for improved education around the Department’s standards. Ms Sarah Fordyce of NDS Victoria told the Committee that a response to improving clarity should ensure that ‘the grassroots workers have a good understanding of the language and what the definitions are.’

Women’s Health West recommended the Committee consider lessons from the family violence sector to improve staff responses to disclosures and suspicions of abuse. The organisation recommended that the Victorian Government establish communication and risk assessment and management protocols and introduce compulsory training for staff in disability services.

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77 Submission S012, Karingal Inc, p.2.
78 Transcript of evidence, National Disability Services, p.11.
79 Submission S009, Women’s Health West, p.12.
Life Without Barriers made the point that managers need to be specifically trained to manage critical incidents. In her recent appearance before the Senate Community Affairs References Committee Inquiry, Ms Naomi Anderson from Villamanta told the Committee:

> There is the problem of service providers with staff not knowing what to do. They may have a feeling—may not feel confident with the situation—but just do not know what to do. Then there is the problem of applying processes and policies poorly. It is one thing to have a policy about what you would do, but practise it: what would you do if someone said a certain thing to you? Practise it with the people you are working with. What would you do if someone did a certain thing to you? Who would you speak to? What would you say? How would you get this information across? We only become good at these things by doing them. None of us knows how to report an assault until we have had to do it. None of us knowns how to understand that somebody is trying to report an assault until we have had to do it. Practise it, learn it, make it real.

Training is discussed in more detail in the context of prevention (see Chapter 4).

As can be seen from these examples, a lack of authoritative guidance for disability providers has prompted a range of alternative materials to be developed to fill the gap. The Committee observed, however, that additional guidance developed in parallel to Department processes has the potential to cause further confusion and lack of consistency in the sector. The Committee suggests that careful consideration should be given to developing a single authoritative guidance for disability service providers to ensure that incidents and allegations of abuse are consistently and appropriately acted upon by disability service staff and management.

**QUESTION 5.3:** If an independent oversight body is established in Victoria, should that body have responsibility for developing a standard set of guidelines for responding to allegations of abuse and neglect in disability services?

### 5.5 Attitudes and practices within disability service providers

In addition to inconsistent policies and procedures for responding to complaints, the Committee received evidence that some disability services have a culture of negative attitudes towards complainants and poor responsiveness to allegations of abuse.

The Health and Community Services Union, for example, asserted that the Department and disability service management are 'broadly risk averse and punitive in managing complaints of abuse and fail to take actions that prevent

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80 Submission S010, Life Without Barriers, p.7.
Referring to feedback from members, the Health and Community Services Union identified ‘a culture and practice within disability service providers that is, broadly, not responsive to complaints,’ and that complaints are often not appropriately acted upon.\(^{83}\)

In her evidence to the Inquiry, the Public Advocate referred to a ‘normalisation of violence’ in the disability sector and pointed to a culture ‘embedded’ in some disability services which results in the ‘implicit acceptance of behaviours that cause harm’ and prevents incidents from being identified and reported as abuse.\(^{84}\)

Attitudes and organisational culture are discussed in Chapter 4.

### 5.5.1 Attitude towards complainants and whistleblowers

Despite the Disability Services Commissioner’s long-standing campaign to encourage reporting of complaints (the ‘It’s OK to Complain’ campaign), the Committee identified that cultural attitudes towards complainants within disability service providers prevents concerns from being raised.

The Committee heard that some who try to complain are labelled ‘troublemakers’, ignored, patronised or threatened.\(^{85}\) For example, Women with Disabilities Victoria provided the following statement from a focus group participant:

> When you are dealing with the bigger institutions it can be even harder to report neglect. My friend has tried to complain and been told that she is just a troublemaker and complaints are not taken seriously.\(^{86}\)

Some Inquiry participants suggested that they were fearful of repercussions that might arise if they were to raise complaints. For example, Julio Pianto felt pressure to keep quiet about concerns relating to care of her son in a disability service ‘for the sole reason of being frightened that there would be repercussions if complaints were made.’\(^{87}\) Another Inquiry participant noted that:

> If you make a habit of reporting issues and “run the full gamut”... You will be bullied, you will be marginalised, you will be defamed, you will be targeted and you will be hated.\(^{88}\)

Similarly, AMIDA explained:

> There is legitimate fear of reprisals held by clients of disability services. The reprisals can include further abuse, restrictive practices, lack of choice in the house or lack of involvement in decision making over matters affecting the person. Other negative reprisals may be withdrawal of favoured activities, lack of support in a timely way,

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\(^{82}\) Submission S015, Health and Community Services Union, p.10.

\(^{83}\) Submission S015, Health and Community Services Union, p.10.


\(^{85}\) Submission S013, S. Guy, p.1; Submission S004, Women With Disabilities Victoria, p.17.

\(^{86}\) Submission S004, Women With Disabilities Victoria, p.17. See also Submission S011, Disability Services Commissioner, p.10 of Appendix 2.

\(^{87}\) Submission S001, J. Pianto, p.5.

\(^{88}\) Submission S007, Name withheld, p.1. See also Submission S013, S. Guy, p.7.
Chapter 5 Complaints handling and critical incident management

restriction of meals etc. Reprisals can also be quite subtle such as unpleasant mood or tone of voice of the carer or lack of attention in general given by the carer to the client (cold shoulder treatment). 89

The Inquiry also received evidence of adverse consequences for staff that speak up about concerns. This includes being inadequately supported, being stood down, or having no option but to resign. 90 The Public Advocate, for example, identified that there is a culture in some disability services of staff being unwilling to raise concerns due to bullying and fear of repercussion. 91

The Committee acknowledges that culture relating to complaints and whistleblowers varies across disability services. Some have sought to create a supportive reporting culture, as indicated by Karingal in their submission:

A Karingal commissioned independent review confirmed that there is a generally supportive culture towards staff raising quality of care concerns about colleagues. All clients interviewed reported they felt safe engaging with Karingal’s services and that they could raise any concerns or complaints, including allegations of abuse without fear of reprisal. 92

Further analysis is necessary to determine how pervasive the negative culture towards complaints and whistleblowers is in disability services and the Committee will consider this question at the second stage of this Inquiry.

5.5.2 Inadequate responsiveness to allegations of abuse

The Committee heard that when complaints are made to management within disability organisations, they can be inadequately addressed or even ignored.

For example, one Inquiry participant explained that they had observed instances where complaints had been ignored, ‘painted over’ or denied and allowed to continue. 93

Some Inquiry participants questioned the commitment of disability providers to the resolution of complaints. For example, some Inquiry participants noted that incidents are treated ‘singularly’ or ‘in isolation’ and often referred to as ‘spot fires’. 94

90 See, for example Submission S013, S. Guy, p.13; Submission S015, Health and Community Services Union, p.10.
92 Submission S012, Karingal Inc, p.3.
93 Submission S007, Name withheld, p.1. See also Submission S024, Youth Disability Advocacy Services (YDAS), p.2.
94 Submission S007, Name withheld, p.1; Submission S017, M. Potocnik, p.3.
The Public Advocate also identified as a critical issue the failure of disability services to investigate and undertake disciplinary action in response to abusive incidents perpetrated by staff:

... many cases fall well short of normative procedural expectations, with staff failing to be stood aside allowing continued contact with the complainant.95

The Department’s Standards do not compel staff to be stood down following allegations of abuse against them, however the Department’s *Responding to allegations of physical or sexual assault instruction* states:

Where an allegation is made against a staff member or volunteer carer of an organisation providing services funded by the department, the response should refer to program guidelines and the organisation’s disciplinary procedures, including redirecting the staff member to alternate duties that do not involve direct client care or support or standing the staff member down.96

The Committee did not receive sufficient evidence to enable an assessment of the disciplinary procedures in place in disability services nor how the issue is dealt with in practice. However, it is likely that the approach varies between providers. Life Without Barriers, for example, indicated that its response includes standing down staff who are the subject of any allegations or reports of abuse:

> Our response to any allegation or report of abuse includes standing down the perpetrator pending investigation. If the perpetrator is another client, we would have them supported at alternative location pending investigation and work with the Department about longer term arrangements.97

The Committee acknowledges that practices vary, and that some disability service providers adopt a more responsive approach. For example, Life Without Barriers, a disability service provider, told the Committee that it recognised ‘the need to reflect on serious incidents and ensure that all appropriate actions have been taken not only as part of the immediate response but also in the longer term.’ To this end, Life Without Barriers has established committees to ‘conduct root cause analysis to further strengthen safety, minimise risk for ... clients and staff and enhance organisational learning.’98

Nevertheless, the evidence before the Inquiry suggests that inappropriate responses to incidents of abuse in disability services are common practice.

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97 Submission S010, Life Without Barriers, p.7.
98 Submission S010, Life Without Barriers, p.7.
5.6 **Authorised visiting of services – Community Visitors**

As outlined in Chapter 1, Community Visitors play an important role in Victoria. Their function is to visit any premises where a disability service provider is providing residential services and to inquire into conditions and concerns. Mr David Roche from the Community Visitors Board explained to the Inquiry that:

> Serious abuse is defined as any incidents of abuse and involves police or admission to a hospital as a direct consequence. Most notifications — 67 per cent — to the public advocate from CVs were about assault, neglect, abuse and violence.99

The Community Visitors gave the Inquiry an indication of the nature of the work they do, stating that:

> Whilst the vast majority of visits are scheduled and unannounced, a significant number are in response to specific complaints. This includes referrals to the program via OPA's advice service. On occasion, repeated visits are necessary to certain facilities over a short period in response to serious issues identified and at the discretion of the CV.100

### 5.6.1 Strengths of the Community Visitor role

The Ombudsman considered that in a broad sense the Community Visitors do their job effectively, concluding that the Records of Visit reviewed in the investigation were generally consistent with the Community Visitors statutory functions, indicative of careful observations, and compliant with Community Visitor Scheme requirements. The Phase 1 Report stated that they consistently mention:

- the condition and mood of the house: eg if it is tidy, homely, bare or cold
- the standard of meals and nutrition
- building and maintenance issues
- the demeanour of residents seen and spoken with
- activities residents were undertaking
- whether incident reports and documents were available to view, noting an absence of documents, restricted access, incorrectly completed forms or out of date documents.101

Also in regard to the effectiveness of Community Visitors, the Ombudsman made reference to the Public Advocate’s views about the value that volunteers bring to the role.102

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99 Transcript of evidence, Community Visitors, Melbourne, 29 June 2015, p.2.
100 Transcript of evidence, Community Visitors, p.2.
The Committee acknowledged the important work of Community Visitors, as the Chair stated in her welcome to the board members at their public hearing:

... we acknowledge and thank the many community support volunteers because we know that the visits you do are not easy, and I know that you encounter many times very difficult situations. Your volunteering in this capacity is enormously appreciated.103

The Community Visitors emphasised to the Inquiry the savings and the value that they bring to the community, quoting from a letter sent to the Victorian Treasurer:

Our conservative calculation of the value of the community visitors’ contribution to the Victorian community is $3.6 million annually. However, we would also highlight the importance of community visitors as an early warning system about quality failures as well as in the prevention of abuse and neglect. These matters, once made public, have a high cost to government with investigations, inquiries, loss of public trust and the like.104

Evidence to the Inquiry also pointed to the valuable role that Community Visitors have in the community. For example, the Disability Services Commissioner stated that:

Community Visitors (CVs) have an important safeguarding function in Victoria... VDSC utilise referral to the CV requesting visits to particular group homes the Commissioner has concerns about arising from enquiries and complaints that have been received.105

In the context of the future safeguarding mechanisms in the NDIS, Communication Rights Australia expressed the view that ‘Information gathered by Community Visitors can also provide important information to inform investigations, remembering that Community Visitors do not take complaints.’106 Karingal stated that it ’strongly supports the retention of a Community Visitors type program with the transition to the NDIS as part of an integrated approach to monitoring quality and standards’.107 Similarly Yooralla expressed its high regard for the Community Visitors:

The CVs have, on many occasions advocated and brought matters of concern to service providers. They work at an individual and systemic level, and their insight has been pertinent in safeguarding rights in disability service delivery.108

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103 Transcript of evidence, Community Visitors, p.6.
104 Transcript of evidence, Community Visitors, p.4.
105 Submission S011, Disability Services Commissioner, p.18 of Submission to NDIS Consultation.
106 Submission S020A, Communication Rights Australia, p.6 of Attachment 2: Submission to NDIS Consultation.
107 Submission S012, Karingal Inc, p.3.
108 Submission S006, Yooralla, p.3.
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5.6.2 Limited capacity for action to address abuse in disability services

Yet despite the value that the Community Visitors bring to Victoria’s safeguarding mechanisms, the Committee heard that there are limitations to their role and their effectiveness. For example, Disability Advocacy Victoria stated that ‘to date the Community Visitors Program has not been effective in preventing abuse’.\(^{109}\) In their submission, JacksonRyan Partners highlighted that the Community Visitors identify matters of abuse and neglect in their annual reports, but stated that:

\[...\text{while it is one thing to report trends, it is entirely another to report more specifically and then to actually seek to have the abuse addressed...}\]

The volunteer Community Visitors, despite being well meaning and no doubt carrying out their role in accordance with the legislation, have clearly been ineffectual in actually preventing abuse, neglect, exploitation and violence.\(^{110}\)

In evidence to the Senate Community Affairs References Committee that is currently undertaking an inquiry into abuse of people with disability, Ms Sandra Guy expressed her views as a parent of a son with disability:

\[\text{The problem is that I cannot tell you how many times I have called the community visitors in relation to the concerns at my son’s house, which have been going on now for six long years, and what happens is that they might go to my son’s house but you have no idea what went on. They might lodge a report with the department and that is as far as it goes—end of story. What you do not see is any change.}\(^{111}\)

In the same day of hearings, Mr Peter Cross from United Voices for People with Disability also stated that he had questioned the value of the Community Visitors Program with the Public Advocate.\(^{112}\)

In the context of their more specific functions in reporting cases of suspected abuse, the Phase 1 Report identified issues regarding the Community Visitors escalating matters they report on. The Report identified a reluctance of some Community Visitors to escalate issues either because they do not fully understand the process or they may have a tendency to take ownership of issues.

In addition, the Ombudsman stated that the Community Visitors Board (Disability) should make more use of its statutory powers. The Report identified that in 5 years only three matters had been referred under Section 33 and in all instances they were referred to the Ombudsman.\(^{113}\)

\(^{109}\) Submission S028A, Disability Advocacy Victoria, p.5.

\(^{110}\) Submission S003, JacksonRyan Partners, p.15, 19.

\(^{111}\) S. Guy, Transcript of evidence, Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, Melbourne, 30 June 2015, p.15.

\(^{112}\) P. Cross, President, United Voices for People with Disabilities, Transcript of evidence, Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, Community Affairs Reference Committee, Parliament of Australia, Melbourne, 30 June 2015, p.44.

In the evidence received by the Committee, participants expressed views that Community Visitors find it difficult to access information relevant to their role, such as incident reports. AMIDA explained that “Presently Community Visitors who have access to house records cannot detect if initial incident reports have been destroyed.”

The Community Visitors themselves told the Inquiry that despite requirements under legislation and associated penalties, they experience difficulties accessing incident reports:

That process is still very varied. In many cases it is not a very open access case. Some of the community service organisations under the belief of privacy have all incident reports locked away in a cupboard somewhere. The protocol between community visitors, the department and NDS states that a hard copy of an incident report should be placed on the client file. That is becoming quite problematic. Either it is not being done or it is in the electronic system that we are unable to access on our visits.

The Committee sought further information regarding the difficulties Community Visitors experience in accessing incident reports. Despite the possibility of service providers being fined up to $9,100 for not providing access to incident reports:

In 2013-14, Community Visitors recorded 202 issues in relation to incident reports and of those 141 or 70% related to a lack of access to incident reports.

Participants also expressed concerns about the skills of the Community Visitors to undertake their role effectively and the impacts that this can have on reporting. For example, AMIDA stated that residents do not always share their views with community visitors. In a Department of Health and Human Services funded project they provide peer to peer training to residents in shared supported accommodation about their right to be free of abuse. AMIDA was:

... only able to visit 86 houses. In so doing we were made aware of numerous cases of abuse that had not been reported to community visitors or anyone else.

This is because we had time without staff present where we provided information specific to rights, presented by people with a disability and in a very accessible way that people understood. We made repeat visits and people trusted us as advocates who were independent and would help them.

Distinctive Options questioned the ability and skills of Community Visitors to undertake their role:

Do the residents and/or the community visitor have the communication skills to raise their concerns in a way that is understandable to the community visitor? If an issue is raised by a resident does the community visitor have sufficient skill to explore the issue sufficiently to determine there is a legitimate issue of abuse to be addressed?

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115 Transcript of evidence, Community Visitors, p.7.
116 See Chapter 1 – Background and Context. Also refer to Section 130 of the Disability Act 2006 (Vic)
117 Supplementary evidence, Response to request for information, Community Visitors, 20 July 2015, p.2.
119 Submission S019, Distinctive Options, p.16.
In addition, Distinctive Options also pointed out that ‘The next step in that process is the capacity and skill of the community visitor to acknowledge the complaint, assess the level of concern and to take the necessary steps to support and report.’\footnote{Submission S019, Distinctive Options, p.16.} The Community Visitors provided information to the Inquiry about the nature of training they receive:

> Training in identifying abuse or neglect and the processes for follow up is provided to Community Visitors in the Induction sessions and in the stream specific sessions.\footnote{Supplementary evidence, Response to request for information, Community Visitors, 20 July 2015, p.2.}

In their evidence to the Inquiry, the Community Visitors also highlighted the challenges in fulfilling their responsibilities as volunteers in an increasingly complex sector:

> ... you are actually sort of working with a quasi-workforce because of the obligations and the requirements placed on the community visitors. Now, it might be okay to say community visitors can do this, that and all these other things, but there is a certain amount of capacity that you need to have to be able to do that. Even a simple thing like referring a matter on; well [we] are volunteers. If we refer a matter on, what have we got to do to prepare and refer that on and sort of prosecute the case? It is a bit out of the realm of a volunteer.\footnote{Transcript of evidence, Community Visitors, p.11.}

The Committee heard that in view of this complexity, the majority of matters are referred to the Public Advocate as the Chair of the Board, who then takes such issues to the Department. This is part of a relatively new process of escalation, which was discussed in the Phase 1 Report tabled by the Ombudsman.

In evidence to the Inquiry, the Disability Services Commissioner noted that there can be delays with referral:

> The Community Visitors Board under section 33(b) of the Act can refer matters to the VDSC to deal with. However, the construct of the CV program can prevent timely referral.\footnote{Submission S011, Disability Services Commissioner, p.18 of Attachment 2.}

The Committee questioned the Community Visitors about their six monthly reports to the Disability Services Commissioner, and one Committee member asked if the matters they pass on are of a serious nature. The Community Visitors responded that ‘It is the Public Advocate’s meeting with the Disability Services Commissioner’ and that information about their reports from visits are passed on that way.\footnote{Transcript of evidence, Community Visitors, p.13.}

### 5.6.3 Administration of Community Visitors function

The Community Visitors have been historically located within the Office of the Public Advocate, despite broader changes to the disability landscape. The Community Visitors program was an initiative of the first Public Advocate,
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Mr Ben Bodna and began as an implementation project by Mr Bodna with the Attorney General’s department to replace Official Visitors. According to a PhD thesis:

Bodna’s personal investment in the initiation and design of the updated scheme meant ‘he loved’ the Community Visitors in a way which was unmatched for the other Office activities.

In the context of Community Visitors in the mental health sector, in 1988 during the Parliamentary debate for the introduction of the Mental Health (Amendment) Act 1988 (Vic) members suggested that ‘the appointment of community visitors should be by the Minister for Health and not by the Public Advocate’ and that:

...one must always be aware that some community visitors may prove to be inappropriate, which will become apparent when their activities are monitored. It is inappropriate to give these responsibilities to the Public Advocate rather than to the Minister, especially in respect of dismissals.

At the time, the amendment was passed so that Community Visitors are appointed by the Governor in Council on advice of the Minister. The Public Advocate now makes a recommendation to the Minister regarding the appointments of Community Visitors.

In the context of the administration of the volunteer program, the Office of the Public Advocate provides board, program and administrative support to Community Visitors. The Community Visitors program is made up of both volunteers and paid staff:

- Regional Convenors—experienced volunteers who act as team leaders. They organise visits, capture the visit reports and advocate with local service providers to resolve issues identified by Community Visitors
- the Community Visitors Board (Disability) comprising the Public Advocate and two elected Community Visitors, with the ability to report matters to the Public Advocate or the responsible Minister. The Board also has powers to refer matters to any other person including the Secretary, the Commissioner, the Senior Practitioner or the Ombudsman
- the Community Visitor Program Coordinator—an Office of the Public Advocate employee responsible for coordinating and supporting the work of Community Visitors and Regional Convenors in regions of Victoria.

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It is evident that the Community Visitors in Victoria have broad functions that are not specific to matters relevant to the Public Advocate’s role. As outlined in Chapter 6, the Public Advocate’s role is more aligned to working within the community where there are concerns about the care or support of people with disability. The functions have less involvement in disability services.

The Committee asked the Community Visitors how they distinguish between the role of the Public Advocate as the Chair of the Community Visitor Board and as the Public Advocate. The Community Visitors responded, stating:

It is a difficult one, because my understanding is that the public advocate needs to remain pretty well independent, and to a degree the board needs to remain independent. The disadvantage of that is that the board itself is then a little bit restricted in how it might communicate with others and also, shall we say, push for change, because the public advocate has to remain independent. I think the board itself functions pretty well, but again, it comes back a little bit to this issue of how one escalates matters and what the appropriate time and mechanism is to do that.130

The Committee concluded that the administrative function performed by the Public Advocate is a historical one and that with the introduction of new statutory entities under the Disability Act it is not clear that the Public Advocate remains the most appropriate body for Community Visitors to make notifications to.

### 5.6.4 Role of volunteers and scope for paid functions

The Commissioner recommended an evaluation of the Community Visitor models and to consider them in the context of models operating in other jurisdictions, including New Zealand. The Office of the Public Advocate also recommended the need for a national evaluation of the role of Community Visitors.

A number of Inquiry participants suggested that the function of visiting performed by Community Visitors is important, but that it would be better performed by paid inspectors or official visitors. For example, in her evidence to the Senate Community Affairs References Committee Inquiry, Ms Sandra Guy stated that:

We need paid disability inspectors, absolutely, who would be part of a similar office, operating under a similar situation as occupational health and safety whereby people can go into building sites.131

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130 Transcript of evidence, Community Visitors, p.12.
131 S. Guy, Transcript of evidence, p.15
Ms Guy made her view clear in her submission to this Inquiry that ‘the volunteer Community Visitors program is untenable’.\(^{132}\) Similarly, JacksonRyan Partners emphasised there would be value in piloting a scheme of paid officials similar to those in operation in other jurisdictions. They propose a system of paid ‘disability compliance officers’\(^{133}\).

In its submission to the Inquiry, the Office of the Public Advocate recommended that in the interim period during the transition to the NDIS, Community Visitors should continue for the full four year period. In addition, the Office of the Public Advocate recommends that relevant legislation be amended to enable the Community Visitors to function in the context of the NDIS.

The Committee considered that this evidence raises a number of questions for stage two of its Inquiry.

**QUESTION 5.4:** In view of the skills necessary in identifying and responding to abuse and neglect, should consideration be given to paid inspectors or paid official visitors in Victoria?

**QUESTION 5.5:** If a paid official inspector or paid official visitor role is introduced in Victoria, should they be located with an independent oversight body or other entity?

**QUESTION 5.6:** In relation to visiting schemes and the existing Community Visitor scheme:

- Should volunteer Community Visitors continue to be part of the safeguarding framework in Victoria?
- If Community Visitors continue to be part of a safeguarding framework in Victoria, should they be located within the Office of the Public Advocate, a new independent oversight entity or another body?

As noted in Chapter 2, the Committee considers that there is value in considering the establishment of an official inspector scheme with paid officials who have the appropriate skills and experience. It also discussed the role of a Community Visitor scheme within a single, independent oversight body.

The Committee considers it important for a national evaluation of the program to be conducted to consider:

- how the program might function in the NDIS environment
- whether there could be benefit in Community Visitors continuing to operate within in a state-based advocacy body
- whether, similar to the WorkSafe scheme in Victoria, there could be value in official inspectors being located within an independent oversight body.

\(^{132}\) Submission S013, S. Guy, p.21.

\(^{133}\) Submission S003, JacksonRyan Partners, p.20.
RECOMMENDATION 6: That the Victorian Government recommend to the Disability Reform Council that a national evaluation is conducted of the Community Visitor program with a view to determining how it will function in the NDIS environment.

5.7 Mandatory reporting to an independent body

Evidence to the Inquiry referred to the value of mandatory reporting in the context of abuse and neglect of people with disability.

A critical consideration in any system of mandatory reporting is what authority are mandated reports to be made to and for what purpose. For example:

- criminal investigation—compulsory reporting to police to instigate a criminal investigation?
- investigation into handling of allegations—mandatory reporting by specified professionals to an oversight body of allegations of abuse in a disability service to initiate an investigation into handling of the allegation by the organisation?
- guardianship investigation—mandatory reporting by specified professionals to an oversight body relating to concerns about the health and safety of a person with disability to initiate a guardianship investigation?

Currently disability service providers are required to report incidents to the Department. Yet there is no mandatory legal requirement for disability services or individuals to report allegations of abuse involving people who access disability services to an independent body.

Some Inquiry participants advocated for the introduction of mandatory reporting of abuse involving vulnerable people to an independent body. The Committee considers this is an option worth considering, particularly in the case of people with severe or profound disability, in order to legitimise reporting of abuse and provide clarity around the obligation to report, however the pathways for reporting would need careful consideration.

Both the Disability Services Commissioner and the Ombudsman raised the possibility of mandatory reporting to an independent body. The Commissioner suggested lessons could be drawn from the Western Australian model of mandatory reporting.

The Victorian Ombudsman’s report identified that a transformation of Victoria’s system for handling allegations of abuse should include mandatory reporting to an independent oversight body of serious incidents by service providers.

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134 See, for example Submission S001, J. Pianto, p.2; Submission S003, JacksonRyan Partners, p.8; Submission S010, Life Without Barriers, p.7.
135 Submission S011, Disability Services Commissioner, p.15 of Attachment 2.
The scheme in New South Wales introduced in 2014 requires the Department of Family and Community Services and funded providers of disability supported group accommodation to notify the Ombudsman of the following types of allegations:

- any sexual offence, sexual misconduct, assault, fraud, ill-treatment or neglect of a person with disability living in the accommodation by an employee
- an assault of a person with disability living in the accommodation by another person with disability living in the same place that is a sexual offence, causes serious injury, involves the use of a weapon, or is part of a pattern of abuse
- an incident involving the contravention of an apprehended violence order made for the protection of a person with disability
- an incident involving an unexplained serious injury to a person with disability living in supported group accommodation.

Part 3C of the *Ombudsman Act 1974* (NSW) requires and enables the Ombudsman, independently of the funding department, to:

- receive and assess notifications concerning reportable allegations or convictions
- scrutinise agency systems for preventing reportable incidents, and for handling and responding to allegations of reportable incidents
- monitor and oversight agency investigations of reportable incidents
- respond to complaints about inappropriate handling of any reportable allegation or conviction
- conduct direct investigations concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable incident or conviction
- conduct audits and education and training activities to improve the understanding of, and responses to, reportable incidents, and
- report on trends and issues in connection with reportable incident matters.

The Ombudsman observed that mandatory reporting to an independent body would help to ‘minimise confusion, ensure consistency and build confidence in the disability sector.’

The Committee also identified that parallels could be drawn between the handling of abuse in disability services and in child protection services. In child protection, the legislated requirement of mandatory reporting by certain professionals to the Department did not require individuals to report instances

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137 *Ombudsman Act 1974* s. Part 3C, introduced by the *Disability Inclusion Act 2014*
138 *Ombudsman Act 1974* s. Part 3C.
of abuse in services to police. This gap led to a new offence being introduced in 2014 for failure to disclose child sexual abuse to police. Such an approach places an onus on individuals within organisations to report suspicions and instances of abuse and could aid in legitimising reporting of suspicions to police or, alternatively, to an independent body.

**QUESTION 5.7:** Should the Victorian Government introduce mandatory reporting of serious or critical incidents to a new independent oversight body? If so:

- What individuals and organisations should be mandated to make such reports?
- What current functions of the Department of Health and Human Services regarding the management of critical incidents should be transferred to the new body? And should the Department retain any functions relating to critical incident management?

**RECOMMENDATION 7:** That the Victorian Government recommend to the Disability Reform Council that it establishes a mandatory reporting scheme for specified individuals and organisations to report incidents of abuse, neglect or exploitation to an independent oversight body with responsibility for managing and investigating the handling of reportable incidents.

**RECOMMENDATION 8:** That the Victorian Government recommend to the Disability Reform Council that it ensures there are consequences for those who are responsible for abuse of people accessing disability services and that service providers take steps to learn from the incident to prevent its reoccurrence.
Other oversight roles

AT A GLANCE

Background
This chapter has a specific focus on two additional and specific components of the statutory oversight of people who access disability services that have very distinct purposes—the guardian of last resort (the Public Advocate) and the oversight of restrictive practices (the Senior Practitioner (Disability)).

Questions for Stage 2
• Should the Senior Practitioner be independent from the Department of Health and Human Services in its role in oversight of restrictive practices?
• If the view is that the Senior Practitioner should be independent, what option would be most appropriate for the nature of that independence:
  – a specific entity with independent statutory powers and its own office
  – a new single independent oversight body?
• Should Authorised Program Officers in disability services have minimum qualifications for making decisions in relation to emergency restrictive practices, such as restraint?
Previous chapters have detailed the oversight functions that relate to prevention of and responding to abuse, neglect and exploitation in services.

This chapter has a specific focus on two additional and specific components of the statutory oversight of people who access disability services that have very distinct purposes—the guardian of last resort (the Public Advocate) and the oversight of restrictive practices (the Senior Practitioner (Disability)).

These roles in Victoria have important functions and powers and the Committee considers that it is essential that in considerations about a national quality and safeguarding framework that they are retained and strengthened in ways that enhance the rights of people with disability.

### 6.1 Oversight of restrictive practices

As outlined in Chapter 1, Victoria has a robust mechanism for monitoring restrictive practices within the office of the Senior Practitioner. The Committee heard that the Victorian model of the Senior Practitioner is highly regarded. The Senior Practitioner stated that:

> The role itself is comprehensively and well structured by legislation and has been used as an exemplary model both nationally and internationally.\(^1\)

And when asked why the Senior Practitioner considered the Victorian model to be the most contemporary nationally, the current Senior Practitioner, Dr Frank Lambrick, explained that:

> It is the requirements around reporting the restrictive practices [and] unlike any other jurisdiction, it is also in legislation under the role of the senior practitioner to conduct research and to educate.\(^2\)

The Victorian Ombudsman’s report on *Reporting and investigation of allegations of abuse in the disability sector: Phase 1—the effectiveness of statutory oversight* (Phase 1 Report) did not specifically review the role and effectiveness of the Senior Practitioner, having determined that the management of restrictive interventions is outside the scope of the investigation.\(^3\) The Report does highlight that the Senior Practitioner is:

> ... an important source of professional expertise both to the DSC and in managing restrictive interventions and compulsory treatment by service providers.\(^4\)

The investigation did give some consideration to the intersections across the Disability Services Commissioner and the Senior Practitioner.

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1. Transcript of evidence, Senior Practitioner (Disability), Melbourne, 15 June 2015, p.3.
2. Transcript of evidence, Senior Practitioner (Disability), p.9.
Chapter 6 Other oversight roles

The Committee heard that the role of the Senior Practitioner is well regarded and that there is an ongoing need for a body that oversees restrictive practices and works towards their elimination.

AMIDA provided an explanation of why it considers the oversight of restrictive practices to be so important:

Restrictive practices are a risk factor in abuse as they deny freedoms and if not warranted is a form of abuse. If restrictive practices are recommended or practised, then there must be strict supervision/reporting of these practices, and of course restrictive practices must only be used as a last resort. Restrictive practices should only be authorised by an independent decision maker resourced in alternatives, such as the Senior Practitioner.5

6.1.1 The positioning of the Senior Practitioner within the Department

A number of people who provided evidence indicated that the Senior Practitioner is incorrectly positioned in the Department of Health and Human Services (the Department) and recommended that the role be made independent:

... the independence of the practitioners ought to be strengthened as an independent Governor-in-Council appointment. The focus on legislative compliance, promoting practice change, treatment and research are critical for its effectiveness. Yooralla customer feedback strongly endorses the Victorian model or some similar model.6

The Committee recognises that the Senior Practitioner also has responsibility for the oversight of restrictive interventions and compulsory treatment that are used by Department providers of disability services, including disability forensic services.

6.1.2 Role in educating disability service providers

The Committee heard that the Senior Practitioner has a key role in supporting disability service providers to develop and use alternative strategies to restrictive practices in the management of behaviour of people with disability. The Senior Practitioner told the Inquiry that:

The behaviour support plan toolkit training is a 4-hour course on how to develop high-quality behaviour support plans. Participants learn how to identify the best positive behaviour support interventions that would reduce the person’s need to use behaviours of concern, as well as how to tell if the interventions are working. This training was delivered 35 times during 2013–14 to a total of 960 participants. Results show that people who have attended this training produce better quality plans than people who have not undertaken the training.7

6 Submission S006, Yooralla, p.29 of Submission to NDIS Consultation Paper.
7 Transcript of evidence, Senior Practitioner (Disability), p.4.
A number of Inquiry participants indicated that the educational functions of the Senior Practitioner are valuable.

### 6.1.3 Role of Authorised Program Officers

In considering the role of Authorised Program Officers in disability services, the Committee asked the Senior Practitioner what minimum qualifications they have for undertaking their role and making decisions about emergency use of restraint. The Senior Practitioner explained that:

... with the authorised program officer role there is no particular qualification that is specified. The important characteristic associated with the authorised program officer role is that the person obviously needs to be in a senior enough role to be a decision-maker.\(^8\)

The Senior Practitioner emphasised that the person who makes the decision about the use of restraint in these circumstances needs to be removed from the day to day operations.\(^9\)

### 6.1.4 Emerging themes and questions for Stage 2

In view of the evidence, it will be important to consider arrangements that are essential for the interim period prior to the full transition to the NDIS.

Some of the emerging themes for Stage 2 of the Inquiry relate to the role of the Senior Practitioner and a number of questions have arisen that will inform the Committee’s consideration of the interim arrangements in relation to the Senior Practitioner during the period of transition to the NDIS. These relate to the independence of the Senior Practitioner’s role and the qualifications of Authorised Program Officers.

**QUESTION 6.1:** Should the Senior Practitioner be independent from the Department of Health and Human Services in its role in oversight of restrictive practices?

**QUESTION 6.2:** If the view is that the Senior Practitioner should be independent, what option would be most appropriate for the nature of that independence:

- a specific entity with independent statutory powers and its own office
- a new single, independent oversight body?

**QUESTION 6.3:** Should Authorised Program Officers in disability services have minimum qualifications for making decisions in relation to emergency restrictive practices, such as restraint?

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\(^8\) Transcript of evidence, Senior Practitioner (Disability), p.5.
\(^9\) Transcript of evidence, Senior Practitioner (Disability), p.5.
6.2 Guardian of last resort

As discussed in Chapter 1, the guardianship role of the Office of the Public Advocate makes up the main component of the office. However, the Committee determined that in the context of a safeguarding system that has gaps, the Public Advocate has been willing to assume responsibility for filling these gaps in the absence of action by other safeguarding entities, including advocacy and investigation of complaints. The Public Advocate takes on this role in her capacity as the Chair of the Community Visitors Board.

6.2.1 Role in the community

The Committee identified that the role of the Public Advocate is largely performed outside the context of disability service provision, yet at times can have involvement within the disability service system. The primary role of the Public Advocate relates to guardianship and related investigations.

While the majority of people under guardianship or subject to investigations by the Office of the Public Advocate are ‘not people who reside in funded disability services … [but] are more likely to be in the community’,\(^\text{10}\) the Public Advocate has assumed a role in providing guidance to disability service providers and frequently enters the debate about the adequacy of disability service provision in Victoria.

The Public Advocate also explained to the Inquiry the nature of the work that is undertaken by her Office:

> The majority of the work done by the Office of the Public Advocate concerns people who reside outside the funded disability services sector... The abuse we see is predominantly in the community. So it is about the ability to investigate that abuse in the community in the broader sense... Other than community visitors ... our work is predominantly where we remove a person from the community and place them in some kind of service through an accommodation order.\(^\text{11}\)

6.2.2 Powers of investigation

The Inquiry heard that the Office of the Public Advocate is seeking increased investigation powers. In its submission to the Inquiry, the Office of the Public Advocate recommended that:

> The Guardianship and Administration Act 1986 (Vic) should be amended to give the Public Advocate broader power to conduct investigations into ‘the abuse, neglect or exploitation of people with impaired decision-making ability’ as recommended by the Victorian Law Reform Commission Guardianship Final Report 2012 (recommendations 328 and 329).\(^\text{12}\)

\(^{10}\) Transcript of evidence, Office of the Public Advocate, Melbourne, 15 June 2015, p.6.

\(^{11}\) Transcript of evidence, Office of the Public Advocate, p.10.

\(^{12}\) Submission S018, Office of the Public Advocate, p.3.
The Phase 1 Report of the Ombudsman’s investigation identified that the Public Advocate is seeking increased powers of investigation. The report states that:

OPA’s investigation powers only apply to applications relating to guardianship or where an application for guardianship might be warranted. The Public Advocate does not otherwise have the ability to initiate an investigation of her own volition.\(^\text{13}\)

In addition, the Phase 1 Report makes reference to the provision of advocacy stating that ‘There has been a significant increase in individual advocacy within the program due to the inclusion of advocacy in the NDIS trial in the Barwon region and the Supported Decision Making Pilot Project’.\(^\text{14}\) Chapter 3 discusses in further detail the disability advocacy system and the role of the Office of the Public Advocate.

The Committee sought clarification regarding the nature of the investigatory powers that the Public Advocate is seeking. In evidence provided to the Inquiry on 15 June 2015, the Manager, Policy and Education, Dr John Chesterman, explained that:

... the origins of that recommendation go towards filling what we would call an investigations gap that exists where a person in the general community is suffering obviously but there is no obvious medical emergency and there is no obvious crime that has been committed. Who at the moment has the power to go in and investigate? We are saying there is a gap there and that we can fill that gap.\(^\text{15}\)

The Committee requested further information about the nature of the Public Advocate’s recommendations to extend its powers. The Public Advocate, Ms Colleen Pearce, explained that:

Broader powers would enable the Public Advocate to undertake complaint-based and own-motion investigations. In a practical sense, it would mean that where concerns are raised about exploitation, neglect or abuse or a person where cognitive impairment is not established and the matter is not related to guardianship, that the Public Advocate would be empowered to investigate. For example, this may involve a person with a mental illness or an elderly person where no other body has the power to investigate concerns.\(^\text{16}\)

While there was some evidence supporting the extension of the Public Advocate’s investigative powers, recommendations regarding these powers are outside the scope of this Inquiry.

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\(^{15}\) *Transcript of evidence*, Office of the Public Advocate, p.10.

\(^{16}\) *Supplementary evidence*, Response to request for information, Office of the Public Advocate, 20 July 2015, p.1.
Appendix 1
Submission guide

INQUIRY INTO ABUSE IN DISABILITY SERVICES
STAGE 1

SUBMISSION GUIDE

The Family and Community Development Committee has been asked by the Legislative Assembly to inquire into abuse in disability services in two stages.

This Guide is intended to assist organisations and individuals who want to make a written submission to the Committee for the first Stage of the Inquiry.

The questions in this Guide provide an indication of the issues the Committee will be considering, but they are not intended to be exhaustive. It is not necessary to address all the questions in a submission.

The Inquiry will be carried out in two stages. This Guide relates solely to Stage 1 of the Inquiry. There will be further opportunity to contribute to Stage 2 of the Inquiry, including a second call for submissions to respond directly to the terms of reference outlined for Stage 2.

1. THE INQUIRY—STAGE 1

Stage 1 is outlined in the Terms of Reference, which state that:

A. the Committee should consider the strengths and weaknesses of Victoria’s regulation of the disability service system with a view to informing Victoria’s position on appropriate quality and safeguards for the National Disability Insurance Scheme, this may include issues being considered for the quality and safeguards framework including:

   I. workforce recruitment, screening, induction, training and supervision;

   II. provider registration requirements;

   III. systems for handling complaints; and

   IV. the impact of current systemic safeguards on the rights and protections of people accessing disability services.

The full Terms of Reference (Stage 1 and Stage 2) are included at the end of this Guide.

The Committee notes there are current inquiries into abuse in disability services being undertaken by the Victorian Ombudsman and the Commonwealth Senate Community Affairs References Committee. The Family and Community Development Committee is committed to avoiding duplication and ensuring it does not prejudice work carried out by these and other bodies.

2. THE SUBMISSION PROCESS

The overarching purpose of this Inquiry is to examine why abuse is not reported or acted upon and how it can be prevented.

All interested parties can make submissions to the Inquiry. The Family and Community Development Committee is seeking submissions from both individuals and organisations relating to Stage 1 of the Inquiry.

While the Committee will be examining systems and processes only, it welcomes the views of those affected by abuse in disability services regarding the effectiveness or otherwise of processes. These views will help inform the Committee’s findings. Importantly, however, the Committee will not investigate individual cases.

This Guide is intended to assist in the process of preparing a submission. There is no single way for any person or organisation to approach a submission. The Committee understands that people will want to approach their submissions differently.

The Committee seeks to ensure it minimises any experiences through the Inquiry that may further traumatised victims of abuse and/or their families and supporters.

3. CONFIDENTIALITY

All submissions are treated as public, unless otherwise requested. The Committee can receive written submissions on a confidential basis or can withhold names where this is requested and...
agreed to by the Committee. This will often be in situations in which victims of abuse believe that giving evidence publicly may have an adverse effect on them or their families.

Please indicate if you want your submission treated as confidential or your name withheld and provide a brief explanation.

4. INQUIRY CONTEXT—TRANSITION TO THE NATIONAL DISABILITY INSURANCE SCHEME

In considering the quality and safeguarding frameworks in place to prevent and respond to abuse in disability services, the Committee has been asked to consider such frameworks in the context of the transition to the National Disability Insurance Scheme (NDIS).

The NDIS is the new way of providing individualised support for eligible people with permanent and significant disability, their families and carers.

Since 2013, launch sites across Australia have been trialling the scheme. In July 2013, the Barwon site started its trial.

During the trial phase of the Scheme, states and territories and the Commonwealth are continuing to operate their quality and safeguarding systems for providers registering with the NDIS.

In the lead up to the transition, the Commonwealth has been working on two related strategies in collaboration with states and territories:

- a nationally consistent quality and safeguarding framework
- an integrated market, sector and workforce strategy.

The Committee has been asked to inform Victoria’s position on the quality and safeguarding framework that will be developed nationally. The Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework can be found at: https://engage.dss.gov.au/wp-content/uploads/2015/01/Proposal-for-an-NDIS-Quality-and-Safeguarding-framework-7.pdf.

Victoria will transition to the NDIS between 2016 and 2019.

5. DEFINITIONS AND TERMINOLOGY

The Committee acknowledges that there are terms and definitions relating to the Terms of Reference that require further clarification.

People with a disability

The Disability Act 2006 (Vic) (the Disability Act) defines disability as an impairment that may be sensory, physical, neurological or an acquired brain injury, which results in substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication. The definition of disability also includes an intellectual disability or developmental delay but does not include ageing.

Disability services

In Victoria, legislation governing disability services is provided by the Disability Act.

The Department of Health and Human Services provides and funds services for people with disabilities. It also funds a range of specialist disability supports that are available to people with a disability and their families, to help the person with a disability participate actively in the community and reach their full potential.

The support provided by disability services fall into two categories:

- short-term supports—such as respite services, behaviour supports, case management and therapy
- ongoing supports—such as Individual Support Packages and supported accommodation.

Individuals can request disability support if they have a disability and:

- the disability impacts on their mobility, communication, self-care or self-management
- the support request meets specific requirements related to the service they are seeking.

The Disability Act says a person with a disability, or a person on their behalf, may request services from a disability service provider. This may be the Department of Health and Human Services or another disability service provider.

The Commonwealth also provides funding for some disability support services, including Disability Employment Services and Australian Disability Enterprises.
Abuse of people with disability

In the context of abuse of people with disability, abuse can include:

- physical, emotional abuse and/or neglect
- financial abuse
- sexual abuse offences, such as rape or indecent assault under the Victorian Crimes Act 1958
- an incident that has resulted in a serious outcome, such as a client death or severe trauma
- forced treatments and interventions
- violations of privacy and willful deprivation.

Safeguards

Within the NDIS, safeguards are defined as including:

... natural safeguards such as personal relationships and community connections, and formal safeguards such as service standards, regulations and quality assurance systems that apply to individuals and organisations providing supports.

For information on safeguards and the NDIS see: http://www.ndis.gov.au/participants/safeguards.

6. WORKFORCE RECRUITMENT AND OTHER PRACTICES

The Terms of Reference ask the Committee to consider the extent to which employee screening, professional development and other workforce issues are effective safeguards against abuse in disability services.

The Committee is aware that a national workforce strategy is currently being developed that will address a number of workforce issues.

Disability service providers have practices that guide their recruitment processes and employee screening.

In addition, the Department of Health and Human Services in Victoria requires disability services to undertake employment safety screening. Specifically its Disability services employment safety screening compliance policy has the following requirements:

- Employee screening must include information collected from sources in addition to police checks, and in compliance with privacy legislation
- Employee screening must be undertaken for all staff, not just those involved in direct care
- Compliance with the Department’s policy must be declared on an annual basis

In addition, in disability residential services a new scheme has been introduced that aims to ensure people who pose a threat to the health, safety or welfare of people with disability are excluded from working in these services. The Disability Worker Exclusion Scheme is a scheme to collect, store and use information about people who are unsuitable to work with clients in funded disability residential services.

The Disability Worker Exclusion Scheme Unit maintains the Disability Worker Exclusion List. Employers must check applicants for direct support worker roles in disability residential services against the list.

Individual organisations also have internal processes for induction, training and supervision for their employees.

6.1 How effective are employee recruitment and screening practices at preventing abuse in disability services?

6.2 How effective are training and supervisory practices at preventing abuse in disability services?

6.3 Are the Department of Health and Human Services requirements for disability services adequate?

6.4 Are there differences in workforce practices across services provided by government and community service organisations?

6.5 Should the National Disability Insurance Scheme adopt a similar quality assurance and safeguard framework to that used in Victoria? If not, why not?

6.6 What improvements could be made to internal practices for recruiting and training disability services workers?

6.7 How effective are community service organisations at monitoring staff recruitment, employee screening and other workforce practices when they engage in sub-contracting arrangements? And to what extent does the Department effectively monitor these arrangements?
7. Provider Registration Requirements

Under the Disability Act, service providers must register with the Department of Health and Human Services as a disability service provider. Entities that apply for registration must demonstrate their capacity to comply with the Human Service. Providers are required to complete a Self-assessment report and quality improvement plan and undertake an independent review within 12 months of registration.

The Department’s Standards and Regulation Unit has endorsed a number of independent review bodies to conduct reviews of funded service providers against the Standards. Renewal of a provider’s registration will require an independent review, self-assessment or accreditation, as determined by the Department.

In the transition to the NDIS, new providers not registered under existing State arrangements are expected to emerge in the disability sector. Once the NDIS is fully rolled out, the Chief Executive Officer of the National Disability Insurance Agency (as the registrar of providers) will have primary responsibility for deciding whether individuals and organisations proposing to provide supports meet the quality and safeguards standards for the NDIS.

7.1 Are Victoria’s Human Services Standards adequate to prevent abuse in disability services?

7.2 Is self-assessment an adequate way for service providers to demonstrate their understanding of their clients’ rights?

7.3 What changes or improvements, if any, might be required?

8. Complaints and Monitoring

In instances of an allegation of abuse in a disability service, there are a number of avenues for response that relate to internal processes and reporting, and external processes and monitoring. The Disability Act governs quality assurance and safeguards in areas such as standards and monitoring of performance and internal processes for complaints.

Internal processes and reporting

Service providers need to have processes in place for managing critical incidents, including allegations of abuse within their service. In Victoria, service agreements for funded agencies include critical client incident management and reporting requirements. Processes for reporting and handling serious incidents are contained in the Department of Health and Human Services document—Critical client incident management instruction.

Internal complaint handling processes include:
- support to the victim and staff
- stand down the person accused to allow an investigation to occur
- disciplinary action if appropriate, ranging from improved supervision to dismissal.

These agreements have remained in place during the launch of the National Disability Insurance Scheme in the Barwon trial site.

8.1 How effectively do staff and disability services respond to critical incidents relating to abuse in their service? Are the internal processes used by service providers rigorous enough to prevent abuse reoccurring?

8.3 What are the strengths and weaknesses of the Department of Health and Human Services in the management of critical incidents relating to funded services and the services it provides?

External processes and monitoring

Where there are reasonable grounds to believe abuse has occurred, service providers are required to report allegations to the police. Guidelines are included in current service agreements outlining processes for reporting allegations of physical and sexual assault to the police.

Reports of abuse in disability services can also be made to other bodies with authority to investigate complaints, such as the Disability Services Commissioner, the Community Visitors and the Senior Practitioner (Disability). External bodies carry out their own investigations.
Appendix 1 Submission guide

Disability Services Commissioner

The Disability Services Commissioner can respond to complaints about Victorian disability services, including disability services provided by the Department of Health and Human Services. It can also provide information about how a disability service has handled a complaint and the Disability Act.

Anyone can make a complaint to the Disability Services Commissioner, including:

- people with a disability and their networks
- families, carers and guardians
- advocates
- staff working in disability services.

8.3 What are the strengths and weaknesses of the Disability Services Commissioner model? Should the model be considered for the National Disability Insurance Scheme quality and safeguards framework?

Community Visitors

Community Visitors are independent volunteers appointed under the Disability Act and managed by the Office of the Public Advocate.

Community Visitors visit the premises of registered disability service providers and Department-managed disability services where residential services are provided.

They can respond to concerns about the quality of service provision and they report annually to the Parliament of Victoria on the quality and standard of care and support provided to residents.

8.4 Is the Community Visitors program effective in preventing and responding to abuse in disability services?
8.5 Are their powers adequate for responding to allegations of abuse and preventing further abuse? How can they be improved?
8.6 Do the Community Visitors use their powers adequately to achieve the best outcomes for people who use disability services?

The Senior Practitioner (Disability)

The Senior Practitioner (Disability) is part of the Office of Professional Practice in the Department of Health and Human Services.

The Senior Practitioner (Disability) has powers under the Disability Act for ensuring that the rights of persons who are subjected to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to these practices are complied with.

8.7 Is the Senior Practitioner (Disability) effective in preventing and responding to the use of restrictive interventions and compulsory treatment in disability services?
8.8 Are the powers of the Senior Practitioner (Disability) adequate for identifying, preventing and responding to the misuse of restrictive interventions and compulsory treatment? If not, how can these be improved?
8.9 Does the Senior Practitioner (Disability) use its powers adequately to achieve the best outcomes for people who use disability services?

9. IMPACTS ON RIGHTS AND PROTECTIONS OF PEOPLE USING DISABILITY SERVICES

In Stage 1 of the Inquiry, the Committee will consider the impact of current systemic safeguards on the rights and protections of people accessing disability services.

9.1 Are there any impacts on the rights and protections of people accessing disability services under the current system of safeguards in Victoria?
9.2 Do these bodies use their powers adequately to achieve the best outcomes for disability services users?
9.3 Are these safeguards effective models for the National Disability Insurance Scheme to integrate into its safeguard framework?
11. SUBMISSIONS

The Committee welcomes written submissions addressing one, multiple or all Terms of Reference for Stage 1 of the Inquiry.

Submissions close 10 June 2015.

Submissions can be provided in either hard copy or by email to the Executive Officer.

Electronic submissions should be sent via:

- The eSubmission form on the Committee’s website: http://www.parliament.vic.gov.au/fcdc-
- Or by email to: fcdc@parliament.vic.gov.au

Hard copy submissions should be sent to:

Family and Community Development Committee
Parliament House
Spring Street
EAST MELBOURNE VIC 3002

The Committee draws your attention that all submissions are public documents unless confidentiality is requested.

Please contact the Committee if confidentiality is sought, as this has bearing on how evidence can be used in the report to Parliament.

12. MAKING A WRITTEN SUBMISSION

Who can make a submission?

Any person or organisation can make a submission to a Committee. Individuals, community groups, private organisations, representatives of government departments and agencies and anyone else interested in an inquiry currently before the Committee are encouraged to make a submission.

Terms of Reference

Before preparing your submission, it is important that you read the Inquiry’s Terms of Reference, as your submission must be relevant to the committee’s Inquiry. If you do not have a copy of the Terms of Reference, please contact the Committee’s office.

Please indicate in your submission whether you wish to give verbal evidence to the Committee. The Committee will indicate to you whether it would like to appear at a hearing to give verbal evidence.

Preparing a submission

Your submission may address all or part of the terms of reference. You do not have to comment on every aspect of the Terms of Reference, nor are you confined to just one aspect.

The Terms of Reference are intended to cover a wide range of issues relating to the causes and effects of abuse in disability organisations, whether such abuse is responded to, and the adequacy of such responses.

The Terms of Reference enable individuals to recount their experiences of instances of abuse, the response to such abuse and the consequences of such abuse.

Your submission can contain factual information, opinion or both. You may want to draw the attention of the Committee to something relevant to the Inquiry. You may choose to emphasise solutions to the matter or issue before the Committee. This is entirely your choice.

Your submission will be welcomed by the Committee provided it is relevant, not frivolous or offensive in nature, and addresses the terms of reference.

Submission format

There is no specific method for organising or presenting a submission. Your contribution can take the form of a letter, a short summary paper or a longer research document. You can include relevant data in appendices or incorporate them in the body of the text. It is important that the structure, argument and conclusions of your submission are clear.

Hard copy or electronic submissions

You can send your submission in hard copy, or electronically. If you send it in hard copy, a typed document on A4 paper is preferred. If this is not possible, a handwritten submission is acceptable.

Electronic submission

You can provide your submission electronically, by email, on CD/DVD or by eSubmission (see the Committee website). If you have any questions about the suitability of your file format/size, please contact the committee office.
Verification of your details

Please sign the submission. Sign on behalf of yourself, or on behalf of the organisation you are representing. If you are representing an organisation, please indicate your position in the organisation. If relevant, specify at what level the submission has been authorised: branch, executive, president, sub-committee, executive committee, national body, etc. If you are sending your submission electronically, please provide your name, and relevant contact details (such as address or phone number).

Supplementary material

You may wish to support your submission with other forms of material, such as a video, photographs or objects. Please contact the staff of the Committee if you plan to do this, so that appropriate arrangements can be made. This may involve material in your possession being loaned or donated to the Committee. Any material borrowed by the Committee will be returned on completion of the inquiry.

Tone of submissions

Submissions form part of the Committee’s proceedings, and help inform the Committee about matters relevant to the investigations. Most submissions are made public by the committee, and can be published on the committee’s website. Submissions should be relevant, not contain offensive language or remarks, and should not be vexatious. A Committee can choose not to accept a submission if the Committee feels it breaches any of these guidelines.

The Committee may return any evidence that it considers irrelevant to its proceedings, offensive or possible defamatory.

Parliamentary Privilege

A submission to a Committee becomes a Committee document once the Committee formally decides to accept it as a submission. A Committee may decide not to accept a submission as evidence if it is not relevant to the Terms of Reference, or is offensive.

Once the Committee has authorised the release of a submission, any subsequent publication of it by the Committee is protected by parliamentary privilege. This means that what you say in your submission cannot be used in court against you.

Parliamentary privilege only extends to submissions that are published by the Committee. If a submission is published in another form or for another purpose, that publication will not be protected by parliamentary privilege. This means that you should not reproduce the submission in another format or context. You can, however, refer others to your submission on the Committee’s website, or advise them to contact the Committee directly.

It is against parliamentary rules for anyone to try to stop you from making a submission by threats or intimidation. It is also a breach of these rules for anyone to harass you or discriminate against you because you have made a submission, and Parliament can take action against this behaviour.

Confidentiality

If you wish to have your submission kept confidential, please say so clearly at the top of the submission or in a covering note, explaining why you want it to be kept confidential. If you want part of the submission to be confidential, please put that part on a separate page. The committee will respect requests for confidentiality. If you have concerns about confidentiality, please discuss these with the Committee’s Executive Officer before you make a submission.

The circumstances under which the Committee may consider receiving evidence confidentially include whether victims believe that giving evidence publicly may have an adverse effect on them or their families. Oral evidence may also be received on a confidential basis if requested.

The Committee may use confidential evidence in its deliberations, but will not quote from confidential evidence in its report.

13. TERMS OF REFERENCE

To the Family and Community Development Committee — for inquiry, consideration and completion of an interim report no later than 31 July 2015 and a final report by no later than 1 March 2016 an inquiry into abuse in disability services and —

(a) in particular the inquiry will include but not be limited to:

(i) why abuse is not reported or acted upon; and
(ii) how it can be prevented:

(b) the Committee should note that the Victorian Ombudsman is currently conducting an investigation into how allegations of abuse in the disability sector are reported and investigated, including the effectiveness of the statutory oversight mechanisms in reviewing incidents and reporting on deficiencies (Ombudsman’s investigation) and that this investigation will cover services which include residential, respite and day programs funded by the Victorian Government;

(c) in undertaking the inquiry, the Committee should:

(i) seek not to prejudice any investigations being undertaken by the Ombudsman or any Victorian Government agencies or any legal proceedings; and

(ii) work cooperatively with the Ombudsman to avoid unnecessary duplication;

(d) the inquiry will be conducted in two stages:

(i) Stage 1:

(A) the Committee should consider the strengths and weaknesses of Victoria’s regulation of the disability service system with a view to informing Victoria’s position on appropriate quality and safeguards for the National Disability Insurance Scheme, this may include issues being considered for the quality and safeguards framework including:

(I) workforce recruitment, screening, induction, training and supervision;

(II) provider registration requirements;

(III) systems for handling complaints; and

(IV) the impact of current systemic safeguards on the rights and protections of people accessing disability services;

(B) the Committee should have regard to any preliminary findings, recommendations or advice from the Ombudsman’s investigation, and any other evidence that the Committee considers appropriate;

(C) the Committee is requested to provide an interim report to the Parliament (on the matters set out in paragraph (d)(i)(A)) no later than 31 July 2015;

(ii) Stage 2:

(A) the Committee should consider any further systemic issues that impact on why abuse of people accessing services provided by disability service providers within the meaning of the Disability Act 2006 are not reported or acted upon and this should include:

(I) any interim measures to strengthen the disability services system prior to transition to the National Disability Insurance Scheme;

(II) any measures to strengthen the capacity of providers to prevent, report and act upon abuse to enhance the capability of service providers to transition to the National Disability Insurance Scheme; and

(III) any measures to support people with a disability, their families and informal supports to identify, report and respond to abuse;

(B) the Committee should undertake research to determine best practice approaches to how abuse of people accessing services provided by disability service providers within the meaning of the Disability Act 2006 can be prevented and this should include:

(I) identifying early indications of abuse;

(II) strategies to prevent abuse occurring;

(III) consideration of needs specific to particular cohorts;

(C) the Committee should examine the powers and processes of Victorian investigation and oversight bodies with jurisdiction over abuse of people with a disability, with particular focus on the ongoing role of these bodies in the context of the National Disability Insurance Scheme; and

(D) the Committee should have regard to the final report, findings and recommendations of the Ombudsman’s investigation, and any other evidence that the Committee considers appropriate.
## Appendix 2
### List of submissions

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<th>Submission No.</th>
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<td>Julie Pianto</td>
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<td>2</td>
<td>Lifestyle in Supported Accommodation Inc (L.I.S.A.)</td>
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<td>3</td>
<td>JacksonRyan Partners</td>
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<tr>
<td>3A</td>
<td>JacksonRyan Partners – supplementary submission</td>
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<td>JacksonRyan Partners – supplementary submission</td>
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<td>3C</td>
<td>JacksonRyan Partners – supplementary submission</td>
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<td>Dinah Phillips</td>
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<td>Yooralla</td>
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<td>AMIDA (Action for More Independence &amp; Dignity in Accommodation)</td>
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<td>St Laurence Community Services Inc</td>
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<td>Distinctive Options</td>
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<td>Communication Rights Australia and Disability Discrimination Legal Service – supplementary submission</td>
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<td>Peter Thomas</td>
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<td>Carmen Harris</td>
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Appendix 3
Public hearings

The committee held the following public hearings:

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<td>15 June 2015</td>
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<td>22 June 2015</td>
<td>Melbourne</td>
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<tr>
<td>29 June 2015</td>
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15 June 2015, Melbourne

**Senior Practitioner (Disability)**
- Dr Frank Lambrick

**Office of the Public Advocate**
- Ms Colleen Pearce
- Dr John Chesterman
- Mr Michael Wells

22 June 2015, Melbourne

**Victorian Advocacy League for Individuals with Disability (VALID)**
- Mr David Craig

**National Disability Services**
- Ms Sarah Fordyce
- Mr James Bannister

**Disability Services Commissioner**
- Mr Laurie Harkin, AM
- Ms Miranda Bruyniks

22 June 2015, Melbourne

**Community Visitors**
- Mr David Roche
- Ms Fay Richards
- Ms Rosemary Shaw
### Appendix 3 Public hearings

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<tr>
<th>Name</th>
<th>Title/Position</th>
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<tbody>
<tr>
<td>Ms Colleen Pearce</td>
<td>Public Advocate</td>
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<tr>
<td><strong>Department of Health and Human Services</strong></td>
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<tr>
<td>Mr Arthur Rogers</td>
<td>Deputy Secretary, Social Housing and NDIS Reform</td>
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<tr>
<td>Ms Janine Toomey</td>
<td>Director, Service Outcomes, Service Design and Operations Division</td>
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<td><strong>Victorian Ombudsman</strong></td>
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<tr>
<td>Ms Deborah Glass, OBE</td>
<td>Ombudsman</td>
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<tr>
<td>Mr Glenn Sullivan</td>
<td>Principal Investigator</td>
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<tr>
<td>Ms Jenny Hardy</td>
<td>Director, Investigations</td>
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